2014-2019 Action Plan: 2016 Report

A Community Health Network area (CHNA) is a local coalition of public, non-profit, and private sector groups that work together to build healthier communities in Massachusetts through community-based prevention planning and health promotion. The geographic definition of the South Coast region for this report is defined as Community Health Network Areas 25. To enhance readability of this report, CHNA 25 will be referred to as “Greater Fall River,” which is the population area for Partners for a Healthier Community Communities: Fall River, Somerset, Swansea, and Westport. Since many statistics also include the City of Fall River and the surrounding area, the term “South Coast” will refer to the 15-town area that surrounds these two cities. The report is assembled to provide a detailed description of the 2014-2019 Community Health Action Plan for Partners for a Healthier Community and a vehicle for reporting progress on each of the identified objectives.

Introduction and Invitation to Participate

Every five years, Greater Fall River Partners for a Healthier Community, Inc. (Partners) conducts a community-wide health needs assessment upon which an Action Plan for the following five-year period is built. The process occurred first in 2004 with the creation of the Healthy City Fall River initiative that used a citywide survey to create the first five-year Action Plan for the City. It was enlarged again in 2009 with the addition of the Mass In Motion initiative that shifted to a focus on system, policy and environmental changes to support healthier lifestyles.

Through this process, much has been gained. Our smoking rates have dropped fourteen percent. Our youth violence rate has dropped 37 percent. Teen pregnancy rates are at their lowest rate in the past twenty years. And, our high school completion rate has improved from 57 percent in 2007 to almost 80% percent in 2011, the highest rate ever. In addition, we have added three farmers’ markets, a healthy dining program in our restaurants, a healthy market program in our neighborhoods. Three of our parks have had major improvements and plans are well underway to expand a new bicycle and walking trail through the heart of the City. In February 2013, Fall River was chosen by the Robert Wood Johnson Foundation as one of six communities across the nation doing the most to improve community health.

Despite these accomplishments, the City of Fall River still has challenges. Too many people are obese and at increased risk of developing diabetes, already at the highest rate in the state. Too many people are addicted to substances, including tobacco, alcohol, heroin and prescription drugs. Our emergency rooms are filled with people who could best be served outside of the hospital, in some cases by community health workers. We lose an average of twelve people a year to overdoses. Street crime and gang violence prevents many from getting outdoors for physical activity. While educational levels are increasing, far too many young people fail to complete at least a high school education. Most of

these factors are also significantly higher for persons who do not speak English at home or who are recently arrived from other countries. And, while the surrounding towns of Somerset, Swansea and Westport are less affected by these factors, problems such as binge drinking are significantly higher when compared with state averages.

It would be wonderful if we had all of the resources needed to address all of these problems. Though we have been able to capture grant funding from another of sources and mobilized the resources we have within the community to attack some of these problems, we still must prioritize our efforts and focus on problems that are especially destructive as well on approaches that we know will produce tangible results. This is the reason that we conduct a Needs and Assets Assessment and develop a planned approach every five years to improving the health of the community.

Outline of the Process

The Action Planning Process began in September 2013 with the designation of eight short-term Task Forces (see chart, below) mobilized around a subset of issues related to the health of the community. Building on the work of America's Health Rankings and the University of Wisconsin Population Health Institute, the approach was based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live.

Task Force groups of between five and twenty people were convened to review the available data on both needs and assets and then asked to come up with a list of no more than ten recommendations, listed in order of priority. These lists were then presented at a series of Community Health Assessment Forums in the spring of 2014 where representatives of all eight Task Forces met to present their findings. The entire group then prioritized the top recommendations that constituted a draft Action Plan. The Action Plan was then reviewed at a public forum on June 10, 2014 for further input. A final Action Plan was prepared and approval voted on June 26, 2014.

The Action Plan is reviewed and updated annually. Where quantitative measures of progress can be monitored, data on trends are reported to the community. Approaches that demonstrate improvement will be continued or, if possible, amplified. Where measures show a lack of progress, new approaches have been launched and monitored. All approaches to health improvement will be based on scientifically validated methods, paying special attention to new studies that demonstrate promising results. The following report summarized progress on all 60 Action Plan Goals as of June 2016.

Health Factor Description, Action Plan Goals and Page Numbers

Health Determinants	#	Factors Affecting Health Status	Specific Measures	Examples of Outcomes
Health Behaviors (30%)*	I	Diet & Exercise Goals 1-24 (Pages 4-19)	Poor diet, inactivity, knowledge of and access to healthy food	Lower diabetes, heart disease, some cancers rates
	II	Tobacco, Alcohol and Other Drug Use Prevention Goals 25-32 (Pages 20-26)	Smoking, prescription and illegal drug use	Less drug or alcohol addiction, overdose
	III	Sexual Activity & Infectious Diseases Goals 33-35 (Pages 27-29)	STDs, HIV, teen pregnancy	Less infertility, AIDS, premature parenting
Clinical Care (20%)*	IV	Access to Dental, Health, Mental Health & Substance Abuse Care Goals 36-39 (Pages 30-33)	Insurance coverage, waiting times, lack of support outside medical settings	Less delayed or inappropriate treatment, oral pain, stress, depression, suicide
Social and Environmental Factors (40%)*	V	Education, Employment, Income & Disability Goals 40-42 (Pages 34-37)	Low graduation rates, job creation, adult education	Lower unemployment, health illiteracy, economic stress
	VI	Community Safety and Violence Prevention Goals 43-47 (Pages 38-41)	Crime, abuse, bullying	Less PTSD, premature death
	VII	Family, Cultural and Social Support, and Housing Goals 48-53 (Pages 42-46)	Language, race, ethnicity, cultural values, maternal care, single parent households, homelessness	Decreased racism, stress, disconnection from community resources
Physical Environment (10%)*	VIII	Environment and Infrastructure Goals 54-60 (Pages 47-51)	Transportation	Increased physical activity and physical infrastructure improvements and added resources

*Percentage of contribution to the overall health of the population (Source: Population Health Institute, County Rankings and Roadmaps, Robert Wood Johnson Foundation)

Factor I: Nutrition and Physical Activity

Good nutrition is essential for health. Insufficient nutrition can hinder growth and development. Excessive calorie consumption, however, can lead to overweight and obesity, especially when paired with too little physical activity. Inadequate physical activity itself also contributes to increased risk of a number of conditions including coronary heart disease, diabetes, and some cancers .

Healthy food and regular exercise are important to health. Yet, half of adults and nearly 72% of high school students in the US do not meet the CDC's recommend physical activity levels, and American adults walk less than adults in any other industrialized country. As of 2013, 29 million Americans lived in a food desert, without access to affordable, healthy food. Those with lower education levels, already at-risk for poor health outcomes, frequently live in food deserts .

More than two-thirds of all American adults and approximately 32% of children and adolescents are overweight or obese. Obesity is one of the biggest drivers of preventable chronic diseases in the US. Being overweight or obese increases the risk for many health conditions, including type 2 diabetes, heart disease, stroke, hypertension, cancer, Alzheimer's disease, dementia, liver disease, kidney disease, osteoarthritis, and respiratory problems. Unhealthy food intake and insufficient exercise have economic impacts for individuals and communities. Current estimates for obesity-related health care costs in the US range from $147 billion to nearly $210 billion annually, and productivity losses due to job absenteeism cost an additional $4 billion each year.

Increasing opportunities for exercise and access to healthy foods in neighborhoods, schools, and workplaces can help children and adults eat healthy meals and reach recommended daily physical activity levels.

Health Behaviors

Health behavior is defined as the actions taken by individuals or groups thereof to change or maintain their health status or to prevent illness or injury. This category includes behaviors related to healthy eating and active living, and highlights include:

- Across the region, fewer than half of all adults reported engaging in physical activity for exercise regularly: just 45.7% in Greater Fall River compared to 53.0% in Massachusetts.
- Over three-quarters of South Coast adults do not consume the recommended five servings daily of fruit and vegetables. In Greater Fall River, a slightly higher percent of adults (19.9%) consume the recommended servings, compared to 18.8% of residents statewide.
- Since 2000, the population of South Coast adults who are overweight or obese has increased dramatically in Fall River. As of 2011, 65.7% of Greater Fall River adults were overweight (defined as having a Body Mass Index of more than 25). Approximately half of this group weighed enough to qualify as obese (BMI>30).

Nutrition

Over three-quarters of South Coast adults do not consume the recommended five servings daily of fruit and vegetables, but in Greater Fall River, 19.9% of adults consume the recommended servings, compared to 18.8% of residents statewide . It should also be noted that the proportion of adults in the region (and in Massachusetts) who consume the recommended servings of fruit and vegetables has declined since 2000.

Physical activity

Higher rates of the region's adults engaged in physical activity for exercise over the span of a month: 73.1% of those in Greater New Bedford and 65.5% of Greater Fall River residents, compared to 76.5% of Massachusetts adults as a whole. Adults in the City of Fall River exercise at particularly low rates, with just 55.9% reporting engaging in exercise in the past month. Across the region, fewer than half of all adults reported engaging in physical activity for exercise regularly: just 45.7% in Greater Fall River and 49.5% in Greater New Bedford, compared to 53.0% in Massachusetts .

Diet and physical activity

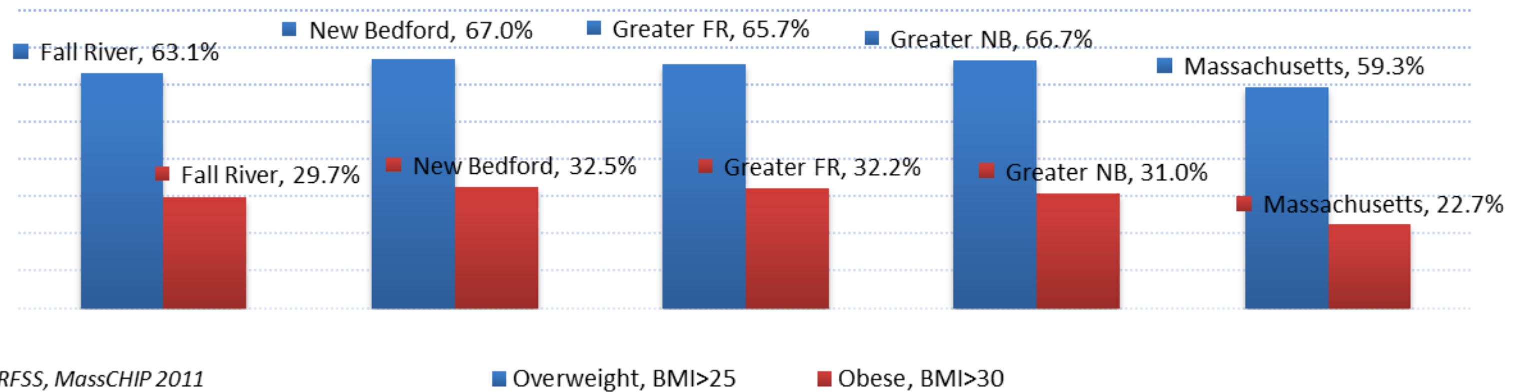
	Fall River	CHNA 25	SE Mass.	Mass.
Diet of Fruits and Vegetables, 5+/day	21	21.9	27.4	28.7
Regular Physical Activity	44.8	47.1	51.8	52.1
Any Physical Activity for Exercise in Past Month	64.6%	68.4	77.5	78.7

Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007

Healthy Weight

The ability to maintain a healthy weight is both a health behavior and a health outcome associated with nutrition and physical activity. Since 2000, the population of South Coast adults who are overweight or obese has increased dramatically. As of 2011, 63.1% of Greater Fall River adults were overweight (defined as having a Body Mass Index of more than 25). Approximately half of this group (32.2%) in Greater Fall River weighed enough to qualify as obese (BMI>30). Comparatively, 59.3% of Massachusetts adults were overweight in 2010, and 22.7% were obese (see Graph 17).

Healthy Weight



Source: BRFSS, MassCHIP 2011

Regular physical activity, which is an essential component to weight loss and managing chronic diseases, is practiced by 44.8% of adults in Fall River. While this percentage is much lower than the state's (52.1%), it is significantly higher than the national percentage of 20.4%. A recent report indicates that certain sections of Fall River have even higher obesity prevalence than the citywide number reported by MDPH. The city's south and east ends have the lowest income residents and the largest immigrant population, and were classified as high priority communities in the state based on obesity prevalence rates and higher risks for chronic diseases such as diabetes and hypertension.

Overweight and obesity among school age children was measured in grades 1, 4, 7 and 10 from school years 2003-2004 to 2009-2010. BMI averages were calculated per grade and gender and percentages of each category: underweight, normal, overweight, and obese were calculated. The percentages of overweight and obese children were calculated for each grade (where data was available) and the school year average of overweight/obese children for the entire sample was determined.

Though the 2009 statewide report showed slightly lower rates for Fall River school children, there was a conspicuous trend of increasing overweight/obese BMI values from School Year 2003-2004 to 2009-2010. The data suggests a progressive increase in the proportion of children categorized as being overweight and obese. The overweight/obese category BMI average for this sample was at its lowest at 21% in the School Year 2006-2007, progressing to a recent high of 38% which demonstrates an increase of 80% in a three year span.

Health Factor I: Goal 1	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase rate of fruit and vegetable consumption	Increase the availability of healthy produce	Increase outlets which offer healthy produce	Increase access and availability of farmers' markets	Number of hours markets are open and number of locations	Count hours and locations
2015: We might want to consider aquaculture as well as farmers' markets. Also, it would be great to develop an app that people could use on their phones to locate a healthy market near them. 2016. Plans are in place to beta test an all-day farmers' market at Re-Creation on Rock Street starting after July 4th to make locally-grown produce available at low prices. If successful, a similar market could be added at HealthFirst and at SSTAR. Unsold Southcoast farmers' market produce is donated to homeless families in the shelters. HWB and People, Inc. continue to provide transportation to families in motels to the food pantry at Church of Our Saviour. UN continues its bi-monthly "fruit and vegetable" day. We also continue to distribute the left over produce from the Southcoast Hospital Group's Farmer's Market to the families in shelter.						

Health Factor I: Goal 2	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase rate of fruit and vegetable consumption	Increase the availability of healthy produce	Increase outlets which offer healthy produce	Mass in Motion Healthy Neighborhood Market expansion	Increase number of markets offering healthy produce	Count of markets offering health produce
2015: Mass in Motion is planning to create a "Five Minute Walk to a Healthy Market" project that will select five neighborhood markets in the South End that are willing to increase their offerings of healthy food items (e.g., produce, non-processed foods, non-sugary drinks, etc.). 2016: The "Five Minute Walk to a Healthy Market" project has created maps for three sections of the City that will be incorporated into the 1422/WalkFallRiver website.						

Health Factor I: Goal 3	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase rate of fruit and vegetable consumption	Increase number of school and community gardens	Work with school and organization staff with an interest in gardens	Link experienced gardeners with those willing to learn	Number of gardens and gardeners	Count of gardens and gardeners
2015: This would be a great project to link with the various school summer programs (21st Century, YMCA, etc.). Our SCI “Food Guru”, Micah Sativtsky, has expressed an interest in promoting more community gardens. 2016: No activity in this area over the past year, but the new 7th Street Community Garden will bring school children to learn about gardening. The Bishop Eid Apartment garden continues to do well under the leadership of Katie Goldman who was provided with a scholarship to take the Master Gardeners’ course at Bristol Community College.						

Health Factor I: Goal 4	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase rate of fruit and vegetable consumption	Create permaculture gardens throughout the community	Plan, organize, create and maintain plantings	Mass in Motion grant, Permaculture expert	Number of plantings	Count of plantings
2015: A plan is currently in place for a permaculture garden at the Baressi and Cattell Apartment grounds in the Flint with Lydia Moses using funds from the Vela Foundation. She is thinking about starting in the Spring of ’15. 2016: Permaculture garden is in place on the Cattell Apartment grounds and George Burton reports that things are going well this spring. He’s even seen some fruit beginning to form on one of the trees!						

Health Factor I: Goal 5	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase rate of fruit and vegetable consumption	Increase education around the selection and preparation of healthy produce	Expand nutrition education opportunities	Umass-Amherst Nutrition Education Program staff	Increased number of locations where nutrition education is offered	Count of nutrition education opportunities
2015: We should connect UMass Nutrition Education staff with Whitsons to see what they might be able to do together in FR schools. 2016: The UMass Extension SNAP-ED Program has provided 30 or 45 minute classes for four weeks over the past year to teach second grade students in all Fall River elementary schools basic information on nutrition that can help children make healthier food choices. They also held two cooking demonstrations for families at Doran and Watson. HWB convened a heath eating, healthy cooking day for residents in shelter.						

Health Factor I: Goal 6	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Improve the quality of food offered at work locations	Educate and incentivize employers to adopt healthy nutrition policies	Introduce healthy workplace nutrition guidelines to local employers	Partners educational materials; Worksite Wellness Coordinator's time	Number of employers that adopt healthy worksite nutrition policies	Count of worksites with healthy nutrition policies
2015: Worksite Wellness Coordinator will distribute Partners healthy meeting and events brochure along with healthy meeting and event guide via DPH to local businesses. Worksite Wellness Coordinator will offer technical assistance regarding written policy change for healthy meetings and events at worksites. Worksite Wellness Coordinator will educate and suggest healthy vending options and substitutes for food at every meeting. 2016: Above goals were met and worksites received training in health vending practices by Gina Deluca of the RI Department of Health at the annual worksite wellness conference as wells as a tool book.						

Health Factor I: Goal 7	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Improve the quality of food offered in public and private schools	Educate and incentivize school systems to adopt healthy nutrition policies	Work with School Wellness Policy development teams to address nutrition guidelines	School Wellness Coordinator's time	Number of school systems that adopt health nutrition policies	Count of school systems
2015: Some of this is already underway with the new School Wellness Policy that limits what parents and others can bring to the school for events. 2016. Fall River Public School Wellness Policy has been reviewed, updated and approved by the School Committee and a notice sent to all staff and parents. Training of staff will take place again at the beginning of the 2016-2017 school year.						

Health Factor I: Goal 8	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Improve the quality of food offered in civic and religious organizations	Educate and incentivize civic and religious organizations to adopt healthy nutrition policies	Work with civic and religious organizations to adopt healthy nutrition policies	Healthy City Fall River Coordinator's time	Number of civic and religious organizations that adopt	Count of organizations
2015: Healthy City Coordinator Dave Weed plans to do some education on this with the “Fed Up” video. 2016: Fifteen weeks of healthy nutrition classes were offered to 40+ participants through the Fitness Challenge and the Fall River Parent Academy. Presentations were also given to the Mass Public Health Association and the Mass Dietetic Association. A sermon on health eating was preached in Fall River and New Bedford, and one is planned for Swansea.						

Health Factor I: Goal 9	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase the availability of nutrition education opportunities	Arrange for nutrition education, especially for low-income and special populations at-risk of nutrition problems	Offer teaching opportunities at soup kitchens and food distribution sites	Voluntary instructors from BCC, Johnson & Wales, and Umass-Amherst Nutrition Education Program	Number and locations of nutrition education opportunities offered	Count of nutrition activities offered
2015: It would be great to replicate the microwave cooking event that volunteers from the White Church in Swansea arranged. 2016: Healthy cooking demonstration were held for homeless family members, at Nurturing Fathers, at Ships Cove by various presenters, and at the DTA office by SNAP-Ed staff. HWB facilitated a healthy eating, healthy cooking day at The7th Day Adventist Church for the families in shelter. UN helped facilitate Nutrition Cafés for early childhood education teachers through UMASS grant						

Health Factor I: Goal 10	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase the availability of nutrition education opportunities	Promote the "Look Who's Cooking" Series	Advertise series through multiple outlets	Community Media on-line service and CDs distributed widely	Frequency of views	Count of views
2015: This series needs to be "re-marketed", especially to specific populations that rely on fast foods. 2016: The ten-episode series was re-packaged and is currently available on a continuous basis on the Healthy City web page. A link will be posted quarterly on MyFallRiver.org with an offer of free cookbooks to gauge responses.						

Health Factor I: Goal 11	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase the availability of nutrition education opportunities	Promote Family Fun Night nutrition education	Promote Family Fun Nights in all elementary schools	Local nutrition educators	Numbers of attendees	Count of attendance

2015: School Wellness Coordinator Marcia Picard has a full schedule of Family Fun Nights set up for the current school year.
2016: Family Fun Nights were offered at sixFall River elementary schools, one middle school, Atlantis Charter School. They were also offered at one Somerset school, two in Swansea, and one in Westport. A summer event is being planned for patients of the Highland Pediatrics office.

Health Factor I: Goal 12	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase the availability of nutrition education opportunities	Promote nutrition education opportunities for those with diabetes and prediabetes	Hold cooking demonstrations at a variety of venues	People Incorporated Diabetes Association staff	Numbers of attendees	Count of attendance

2015: Diabetes Association Coordinator John Quintas does monthly cooking demonstrations and shopping tours.
2016: Cooking demonstrations are conducted monthly by the Diabetes Association. HWB facilitated a healthy eating, healthy cooking day at The7th Day Adventist Church for the families in shelter. UN helped facilitate Nutrition Cafés for early childhood education teachers through UMASS grant

Health Factor I: Goal 13	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population Nutrition is poor, obesity and diabetes rates are high	Increase the availability of nutrition education opportunities	Promote WIC "Cooking Matters" and shopping tour program to 3,000+ enrollees	Hold cooking and shopping demonstrations at a variety of venues	HealthFirst WIC program staff	Number of attendees	Count of events and attendees
2015: The WIC program does both cooking demonstrations and market shopping tours. 2016: In addition to WIC, regular demonstrations also take place monthly at Ship's Cove. Family Fun Nights have included several demonstrations as have some of the Fitness Challenge nutrition classes. Wick does a shopping trip every other month to Walmart.						

Health Factor I: Goal 14	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Organize, promote and operate a year-around Fitness Challenge for residents for the Greater Fall River Area	Engage voluntary participation of professional fitness providers; fund-raise for incentives	Partners paid coordinator's time to organize and promote Challenge	Number of attendees for each event and event totals	Count of participants
2015: Re-Creation staffer Annemarie Holly is preparing for the 8th year of Fitness Challenge activities starting with a Resource Fair on January 10, 2015. 2016: The 9th year of the Fitness Challenge ran for 15 weeks from January through April and involved more than 500 participants.						

Health Factor I: Goal 15	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Organize and promote a school-based Challenge series for local schools	Engage voluntary participation of physical education teachers and principals	Partners School Wellness Coordinator's time	Number of children participating	Count of teachers and child participants
2015: School Wellness Coordinator Marcia Picard will arrange for School Fitness Challenge activities in all four communities. 2016: Over 5,500 children were involved in the School Fitness Challenge at 16 schools in Fall River, Swansea and Westport.						

Health Factor I: Goal 16	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Organize a Safe-Routes-To-School Walking program at elementary schools	Engage parent volunteers, principals, teachers and community health workers	Partners School Wellness Coordinator's time	Number of children participating	Count of teachers and child participants
2015: Marcia Picard is working with School Safety Officer Brenda Racine to extend the walking school bus from Doran Elementary to other schools. 2016: The Doran Community School (part of the year) and the Letourneau Elementary School organized and ran regular walk-to-school programs with school staff and dozens of children which is being recognized statewide.						

Health Factor I: Goal 17	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Engage behavioral health clients in a program of regular exercise	Organize and operate a daily fitness program at the SSTAR Outpatient Program	SSTAR staff	Number of participants and frequency of sessions	Count of sessions and participants
2015: SSTAR now provides a daily fitness program for outpatients. This should be expanded to other behavioral health settings. 2016: SSTAR continued to provide the daily fitness program throughout the year.						

Health Factor I: Goal 18	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Engage housing authority residents in a program of regular exercise	Run a wellness program that includes regular physical activity for adults and children	SCHHWI staff	Number of participants and frequency of sessions	Count of sessions and participants
2015: Given that Southcoast Y did not receive the PICH grant from CDC, it is unclear where funding can come from for this. 2016: No exercise program took place in the Fall River Housing Authority though a walking club is being explored through 1422.						

Health Factor I: Goal 19	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Engage new moms in a program of regular exercise	Run a FitWIC program at HealthFirst	WIC staff	Number of participants and frequency of sessions	Count of sessions and participants

2015: The FitWIC program was planned for WIC recipients.
2016: The FitWIC program for parents of young children did not occur for lack of dedicated staff. A video-based Go Noodle program will be explored. WIC is planning two field days this coming summer, and Wiggle Kids has provided activity for children of homeless families on six occasions.

Health Factor I: Goal 20	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Operate a program at Bristol Community College that engages students in physical exercise	Operate a physical fitness program in the Commonwealth Center open to all students	Bristol Community College staff	Number of participants and frequency of sessions	Count of sessions and participants

2015: Worksite Wellness Coordinator will connect worksites to low or no cost physical activity programs, including but not limited to the Fall River Fitness Challenge.
2016: Several worksites organized teams to participate in the Fitness Challenge, including two at People Incorporated.

Health Factor I: Goal 21	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Increase the availability of organized fitness activities throughout the community	Run a weekly fitness program for seniors designed to increase balance, flexibility and strength	Run two groups at the Niagara Senior Center on a weekly basis	Senior Center staff and YMCA instructor	Number of participants and frequency of sessions	Count of sessions and participants
2015: One group now meets twice a week at the Niagara Senior Center. 2016: Two fitness groups ran at the Niagara Senior Center in collaboration with Family Service Association who received a United Way grant.						

Health Factor I: Goal 22	Diet & Exercise	Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food		Goal:	To lower diabetes, heart disease, some cancers rates	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Create a walking map of Central Fall River showing distances between points and walking times	Increase knowledge of walkability of Central Fall River	Print and distribute maps widely; hold promotional events to encourage walking	Mass In Motion Coordinator and BikeFall River volunteers	Numbers of maps printed and distributed	Count of number of maps printed and distributed
2015: Mass in Motion just published a walking map specific to seniors as part of the WalkBoston walkability project. 2016: Mass in Motion ran a Five-minute Walk to a Healthy Market and developed walking maps in three neighborhoods linked with local markets who provide healthy food items. A complete system of maps, wayfinding signs and interactive web site will soon launch funded under the 1422 Project.						

Health Factor I: Goal 23	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Promote increased safe use of bicycles by children	Organize programs to teach bicycle safety	Offer bicycle safety training classes; distribute free helmets	Mass In Motion Coordinator and BikeFall River volunteers	Numbers of participants and helmets distributed	Count of participants and helmets
2015: Mass in Motion Coordinator Julie Kelly is working to turn over the bike safety and helmet give-away programs to school safety officers. 2016: Bicycle safety trainings and helmet distribution events were held at Letourneau, Doran and Talbot Middle Schools, Kennedy Park, Sunset Hill and on the South Watuppa Bicycle Path this year. This year, events will be held at Britland and Lafayette Parks. Cycle Kids will be held at Letourneau and then moved to Viveiros and other schools if funds for materials can be found.						

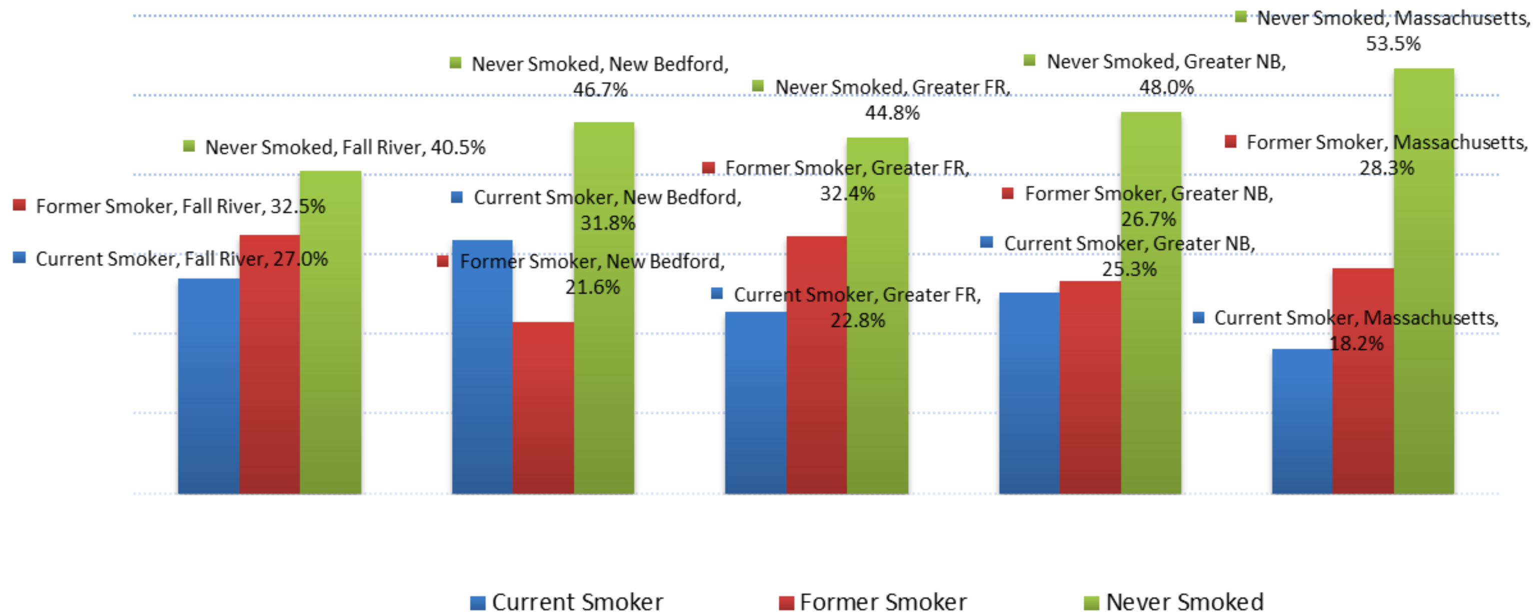
Health Factor I: Goal 24	**Diet & Exercise**	**Problems with poor diet, inactivity, and lack of knowledge of and access to healthy food**		**Goal:**	**To lower diabetes, heart disease, some cancers rates**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population fitness levels are low; too few people get the recommended hours of moderate physical activity per week	Promote personal engagement in fitness through a community campaign	Plan, organize, and promote a personal "Get Fit" program for the community	Hold events to promote personal fitness; advertise the benefits of fitness widely	Healthy City Fall River Coordinator's time	Numbers of events and participants	Count of events and attendees
2015: A prototype “Wellness Champion” format has been completed for several seniors and can be expanded to include people of all ages. 2016: As a grant from the Harvard-Pilgrim Foundation was not obtained, a program to sell frozen foods at HealthFirst and SSTAR did not begin. Other sources of funding will be pursued. Funding from major frozen food producers and a video on the topic will be explored.						

Healthy Factor II: Tobacco, Alcohol and Other Drug Use Prevention

Smoking is much more prevalent among South Coast adults as compared to incidence of this behavior statewide. More than a quarter of adults in the region are current smokers compared to less than twenty percent statewide. Smoking is most prevalent in New Bedford where 31.8% of adults are current smokers. Graph A illustrates current smoking behavior across the region.

Secondhand smoke exposure is also more prevalent in our region with almost one-quarter of South Coast adults allowing smoking in their home: while just 19.5% of Massachusetts residents allow smoking in their homes either sometimes or always, 29.4% of Greater Fall River residents allow this exposure to secondhand smoke[1].

Smoking Prevalence



[1] BRFSS 2011, via MassCHIP

South Coast residents exhibit similar patterns of alcohol use as residents of Massachusetts as a whole. The proportion of adults who report binge drinking (defined as consuming 5+ drinks on an occasion for men or 4+ drinks for women) within the past 30 days is 18.2% in Greater Fall River and 16.7% in Greater New Bedford (17.8% is the statewide rate).

Rates of heavy drinking, or consuming an average of more than two drinks per day (men) or more than one drink per day (women), are actually slightly lower in the South Coast as compared to Massachusetts. The proportion of adults who report drinking this amount regularly is 6.6% in Greater Fall River and 5.9% in Greater New Bedford, compared to 6.7% across the state.

Data is available to measure admissions to Department of Public Health funded substance abuse treatment programs among males and females ages 15-19. While hospitalizations in the region are comparatively lower than statewide rates, substance abuse treatment admissions are generally above state levels. Among males, rates per 100,000 for males ages 15-19 are 1,401 in Greater Fall River and 1,265 in Massachusetts. Among females, rates are 1,315 in Greater Fall River and 700 in Massachusetts[2].

In FY 2012, there were 104,224 admissions to substance abuse treatment programs statewide; 3.45% (3,595) of these admissions reported being from the City of Fall River. 1.53% (55) of admissions from the City of Fall River were under 18 years of age. (Note that these statistics represent admissions to treatment and not distinct individuals.)

In FY 2012, adult admissions to substance abuse treatment services from the City of Fall River reported the following characteristics:

- 67% were male and 33% were female.
- 67% were between the ages of 21-39.
- 89% were white, 3% were black, 4% were multi-racial and 5% were of other single race.
- 5% were Hispanic.
- 71% were never married, 8% were married, and 21% reported not to be married now.
- 35% had less than high school education, 43% completed high school, and 21% had more than high school education.
- 12% were employed.
- 24% were homeless.
- 54% had prior mental health treatment

[2] Instant topics - Adolescent Health Report, 2009.

Health Factor II: Goal 25	**Tobacco, Alcohol and Other Drug Use Prevention**	**Smoking, prescription and illegal drug use**		**Goal:**	**Reduced smoking rates, less drug or alcohol addiction, fewer overdoses**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Opiod overdose deaths are rising	Reduce opioid overdoses and deaths resulting by making Narcan more readily available	Permit law enforcement officers to carry Narcan kits and train in its administration	Equip and train local law enforcement officers	State funding provided through Seven Hills	Number of officers trained	Count of officers trained
Update June 2016: FR Police officers have been trained; however, due to lengthy Union negotiation process, they have not yet begun to use Narcan. Retraining will likely be required once the Union gives its approval and officers receive Narcan to carry/utilize.						

Health Factor II: Goal 26	**Tobacco, Alcohol and Other Drug Use Prevention**	**Smoking, prescription and illegal drug use**		**Goal: Reduced rates of drug or alcohol addiction, fewer overdoses**		
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Opioid overdose deaths are rising	Reduce opioid overdoses and deaths resulting by making Narcan more readily available	Permit Emergency Room staff to be trained and distribute Narcan to OD patients	Train ER staff, address hospital policy/procedure to allow this.	Seven Hills-Narcan pilot for training purposes, hospital staff and pharmacies	Hospital ERs distribute Narcan/education	Reduction in overdose deaths
Measures have been taken already to begin this protocol at St. Anne's and Southcoast Hospital is currently in discussions with their legal department regarding this request, as of March, 2015.						

Health Factor II: Goal 27	Tobacco, Alcohol and Other Drug Use Prevention	Smoking, prescription and illegal drug use		Goal:	Reduced smoking rates, less drug or alcohol addiction, fewer overdoses	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Opiod overdose deaths are rising	Expand drug courts in Fall River	Fund and authorize a drug court in Fall River	Secure funding and authorization	State funding for a local drug court	Drug court operational	Evidence of drug court operations
Update June 2016: The FR Drug Court is operational. There should be an ongoing goal of ensuring good collateral contacts and relationships between the referring court and local providers.						

Health Factor II: Goal 28	Tobacco, Alcohol and Other Drug Use Prevention	Smoking, prescription and illegal drug use		Goal:	Reduced smoking rates, less drug or alcohol addiction, fewer overdoses	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Track substance abuse related problems in surrounding towns	Administer the YRBS in Somerset, Swansea and Westport	Offer additional programs to reach youth in Somerset, Swansea and Westport	Arrange and provide educational presentations in youth agencies and schools	BSAS funding through a variety of local grants	Number of educational presentation	Count of presentations
FOLLOWING DISCUSSION WITH THE GROUP, THIS GOAL MAY BE REMOVED. There has been a shift in intervention method to providing support for adolescents with substance use issues as well as providing education/training to schools regarding substance use disorders and treatment for adolescents in MA.						

Health Factor II: Goal 29	**Tobacco, Alcohol and Other Drug Use Prevention**	**Smoking, prescription and illegal drug use**		**Goal:**	**Reduced smoking rates, less drug or alcohol addiction, fewer overdoses**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Track substance abuse related problems in surrounding town	Administer the YRBS in Somerset, Swansea and Westport	Work with local school committees and town councils to ensure funding and administration	Run a YRBS and Youth Health Survey in all public schools	Grant funding and support from Partners if needed	Offer YRBS and YHS in each school at least every other year	Evidence of surveys offered
FOLLOWING DISCUSSION WITH THE GROUP, THIS GOAL WILL BE REMOVED. See above						

Health Factor II: Goal 30	Tobacco, Alcohol and Other Drug Use Prevention	Smoking, prescription and illegal drug use		Goal:	Reduced smoking rates, less drug or alcohol addiction, fewer overdoses	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Tobacco use is high among youth	Provide compliance checks of vendors in all area towns	Provide ongoing "stings" in each of the four towns	Provide random compliance checks of all area tobacco vendors	BSAS funding through a variety of local grants	Compliance checks administered among local tobacco vendors	Number of compliance checks; number of violations and Board of Health sanctions
Since July 1, 2015, 123 Compliance checks were completed in Fall River with 47 sales; 25 compliance checks were completed in Somerset with no sales; 21 compliance checks were completed in Swansea with 10 sales; 22 compliance checks were conducted in Westport with 5 sales. All compliance check failures through our program were issued monetary citations and the 2nd and 3rd offense violators were brought before the Board of Health for possible suspensions. The Fall River BOH has been doing suspension hearings at the rate of 5 and 6, per month, since January 1, 2016. The towns of Somerset, Swansea and Westport have not held suspension hearings for their 2nd offenses.						

Health Factor II: Goal 31	Tobacco, Alcohol and Other Drug Use Prevention	Smoking, prescription and illegal drug use		Goal:	Reduced smoking rates, less drug or alcohol addiction, fewer overdoses	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Tobacco use is high among youth	Provide compliance checks of vendors in all area towns	Increase uniformity of compliance checks across the four towns	Work with Boards of Health and Selectmen to create uniform procedures	BSAS funding through a variety of local grants	Compliance checks administered among local tobacco vendors	Number of compliance checks; number of violations and Board of Health sanctions
The compliance check protocol is issued by Mass. Tobacco. We do not vary from that protocol. All compliance checks are conducted in exactly the same way. It is only the product requested that varies. The number of check and violations for FY 16 are listed above. Copies are attached to this email.						

Health Factor II: Goal 32	Tobacco, Alcohol and Other Drug Use Prevention	Smoking, prescription and illegal drug use		Goal:	Reduced smoking rates, less drug or alcohol addiction, fewer overdoses	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Tobacco use is high among youth	Increase educational offerings to youth	Establish The84.org chapters in all four towns	Work with local schools to create organizations	BSAS funding through a variety of local grants; Partners funding if needed; Life together fellows	The number of The84.org chapters established	Count of The84.org chapters
There is no BSAS funding for tobacco compliance checks. There is an established an 84 chapter at Durfee H.S. through Recreation (Durfee Youth Leadership Team). This group is facilitated by Annemarie Holly. There are also chapters at SSTAR under B.O.L.D. and at Westport H.S. (S.A.D.D.). Kathy Wilbur from Seven Hills Behavioral Health has been working with me to register chapters in my 13-community collaborative. We have been successful in getting chapters in all 3 high schools in Taunton as well as the Attleboro Mayor's Youth Council and the N. Attleboro Hockamock YMCA. We were unsuccessful in starting chapters at Somerset HS and at Case and will continue trying in the 16/17 school year. We will be working to get a chapter started at Diman Regional in the Fall.						

Health Factor III: Sexual Activity and Infectious Diseases

Teen births in Fall River have been historically higher than both regional and statewide figures over the past twenty years. In the same time period, prenatal care has lagged behind state rates, and maternal smoking rates have been very high, resulting in lower birth weights. Fetal and infant health indicators relate to care, maternal behavior, and outcomes. In both Greater Fall River and Greater New Bedford, levels of care and outcomes are generally suboptimal compared to Massachusetts. First, fewer infants' mothers begin prenatal care during the first trimester: 81.2% in Greater Fall River and 76.5% in Greater New Bedford, compared to 83.0% statewide

Fall River ranks among the top ten cities in the Commonwealth of Massachusetts where HIV infection is linked to injection drug use. There are 221 people living with HIV/AIDS in the city. The most reported mode of transmission for individuals with HIV in the area is injection drug use. According to SSTAR's (Does SSTAR need to be spelled out here too?) data on HIV testing, 82% of those tested identify as an injection drug user (IDU) or a partner of an IDU (01/01/10 CMAR data). An additional 8% identify as the partner of a person living (Both lower case or is that consider a proper noun title?) with HIV/AIDS. While AIDS and HIV-related deaths are twice the crude rate of the state, other infectious diseases in Greater Fall River are well below state rates.

Health Factor III: Goal 33	**Sexual Activity and Infectious Diseases**	**Problems with STDs, HIV, teen pregnancy**		**Goal:**	**Less infertility, AIDS, premature parenting**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Teen pregnancy rates are higher than state averages	Continue after-school, peer-led programs in all area schools	Offer peer-led programs, counseling and resources in all schools	Offer PREP Program at Youth Build, BCC Gateway Program, etc.	DPH funding for teen pregnancy prevention	The number of peer-led programs offered	Count of peer-led programs
Citizen's for Citizen's Family Planning has now become a permanent part of the curriculum for the Nurturing Fathers Programs at United Neighbors. 3 programs a year 15+ men in each program. Teen pregnancy ranking, though 8th in the state, is down from 4th. Chlamydia rates are above the State average but seem to have stayed level.						

Health Factor III: Goal 34	**Sexual Activity and Infectious Diseases**	**Problems with STDs, HIV, teen pregnancy**		**Goal:**	**Less infertility, AIDS, premature parenting**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
STDs (Clamidia, Syphilis, Gonnoreha) rates continue to rise	Increase screenings for STDs at all medical facilities	Incentivize both patients and physicians to perform screenings on a routine basis	Provide educational programs for both professionals and patients	DPH funding for teen pregnancy prevention	The number of educational offerings	Count of educational offerings
HWB convened 2 Health & Well Being Days with follow up appointments as necessary and transportation to initial appointment for families in shelter. Patient education continues at Project Aware at SSTAR and Family Planning in one on one counseling sessions and as part of group outreach education. Project Aware performed 529 RPR for Syphilis in Calendar year 2015. 10 were positive (2%). SSTAR treated 10 for Syphilis and 7 contacts to syphilis. 52 individuals were treated for Gonorrhea or Chlamydia as a result of testing positive, having been listed as a contact or presenting with symptoms. SSTAR Family Health Care Center's Primary Care Providers tests and treats as indicated. Performance standards are currently being reviewed and incorporated in the Electronic Medical Record. At Family Planning 63 individuals were treated for Gonorrhea and/or Chlamydia as a result of testing positive. Everyone over 25 is screened.						

<table>
<tr><td>Health Factor III: Goal 35</td><td>Sexual Activity and Infectious Diseases</td><td colspan="2">Problems with STDs, HIV, teen pregnancy</td><td>Goal:</td><td colspan="2">Less infertility, AIDS, premature parenting</td></tr>
<tr><td>Problem Area</td><td>Strategic Goal</td><td>Strategy</td><td>Activity</td><td>Resources</td><td>Measures</td><td>Achieved</td></tr>
<tr><td>HIV/AIDs rates continue at a steady rate</td><td>Ensure continuation of educational efforts</td><td>Advocate for continued funding after expiration of Ryan White funding</td><td>Advocate for continued funding through DPH</td><td>Organize local advocacy efforts</td><td>Evidence of advocacy for continued funding</td><td>Descriptions of advocacy efforts</td></tr>
<tr><td colspan="7">Funding seems to be steady. Participation in Project Able y8ielded level funding. The cases rise and the demand for services increases. The complicated nature of case management brings issues of poverty, cost of living, mental health, substance misuse, etc... to the forefront. These issues need to also be addressed if HIV is to be managed.

The Commonwealth has taken some new steps in trying to get to zero new infections. The introduction of 4th generation EIA testing allows the identification of acute infections which allows for early introduction of HIV meds which can lower the HIV set point and improve treatment outcomes. Field Epidemiologists from Partner services are now reaching out to newly diagnosed positives to describe partner notification services and ensure linkage to medical care.

Testing for HIV stays about the same number each year (900). Through the state program HIV testing is now coupled with Hepatitis C testing.

Of note is the discontinuation of Hepatitis C Case Management services. The state will no longer support this. With the hurdles insurers put in place to pre authorize the medications, we are concerned fewer will gain access to life saving treatment. The IDU population does not have the political presence to fight this. The stigma of addiction is manifested in lack of access to sterile injecting equipment, increases in overdoses, more frequent use of fentanyl, restriction on Hepatitis C medication access and the continued shortage of treatment resources.</td></tr>
</table>

Health Factor IV: Access to Quality Dental, Health, Mental Health and Substance Abuse Care

Generally speaking, South Coast residents have access to care that is comparable to residents of Massachusetts , and when it comes to having a relationship with a care provider, residents of the South Coast are well served :

- 87.1% of Greater Fall River residents reported having a personal health care provider, compared to 87.8% of residents statewide. However, the number of Fall River residents (84.5%) who have a personal health care provider is below the state level.
- 86.2% of adults in Fall River and 89.1% in Greater Fall River have had a checkup in the past year which is somewhat greater than the statewide average of 78.8%. Access to care is determined according to the following indicators: percentage of adults with a personal health care provider, percentage of adults who could not see a doctor due to cost, and percentage of adults who had a checkup in the past year.
- Similarly, the proportion of South Coast adults as a whole who report being unable to see a doctor due to cost has declined over the past decade for each of these areas. As with many of the health indicators this assessment is measuring, however, residents in Fall River have greater barriers to care.

Dental health, and gum disease in particular, is linked to health outcomes like diabetes, heart disease, and stroke, and maternal dental health is shown to affect neonatal outcomes[3]. Limited data is available to gauge access to dental care in the South Coast, but that which is available indicates that the region is underserved in this area. While 77.8% of Massachusetts residents reported a dental visit in the past year, just 66.4 % of Fall River residents visited a dentist[4]. In Bristol County, which encompasses Fall River and New Bedford, the rate was 75%, while the state average was 83 %[5].

Depression is one of the most common complications of chronic disease. It is estimated that up to one-third of individuals with a serious medical condition experience symptoms of depression. In some cases, the occurrence, management, and progression of a chronic disease can trigger clinically significant depression. According to the most recent Behavioral Risk Factor Surveillance System (BRFSS), a high percentage of Fall River residents reported experiencing poor mental health and depression compared to the county, state and nation. The suicide rate for the area is

[3] http://www.healthypeople.gov/2020/LHI/oralHealth.aspx
[4] BRFSS 2008.
[5] CHNA data not available; BRFSS 2006-10 via Community Commons.

slightly higher than the state but less than the other two comparable geographic areas. MDPH data found that 55% of suicide victims had a mental health problem, 29% had a history of substance or alcohol abuse and 22% had a job loss or financial problems.

High unemployment and loss of insurance due to job loss have affected residents' ability to access health care. Data from the Behavioral Risk Factor Statewide Survey (BFRSS) indicates a high percentage of residents report they could not see a physician due to cost (10.9% verses 7.0% for the state).

While Fall River can be characterized as an urban area, its public transportation service does not reflect that of an urban center. Access to reliable and affordable public transportation for the city is limited and does not meet the needs of the community. In 2010, the Southeastern Massachusetts Transportation Alliance conducted a focus group on the transportation needs of Fall River and surrounding communities. The study found that the existing transit system covers a limited geographic area and that cost is a major barrier for residents that need to access public transportation. For example, residents reported that students with no income, who are self-reliant to get to school, couldn't afford the bus. If they need to transfer buses to get to the high school, it costs them $2 per day to get to school. Transportation barriers have also posed a challenge to the patients we serve and have had an adverse effect on health outcomes among this population.

Through needs assessment, we have learned that transportation is a major barrier for the parents of our pediatric patients. Access to affordable and reliable transportation has always been a challenge for many of our patients, but over the past year, it has become an even greater obstacle due to the high unemployment rate.

HealthFirst Family Care Center and SSTAR Family Health Clinic have a long and proud history of providing interpreter services for our ethnic populations. We have accomplished this by recruiting bi/tri-lingual speaking staff and contracting with a telephone language line which offers interpreting services in over 50 languages, 24 hours a day, seven days a week. An increase in the Hispanic population in the area and deaf patients being seen at the health centers have placed a greater demand for Spanish and deaf interpreters. We are finding it challenging to recruit professional medical interpreters for Spanish speakers and hard of hearing patients.

Health Factor IV: Goal 36	**Access to Quality Dental, Health, Mental Health and Substance Abuse Care**	**Problems with insurance coverage, waiting times, lack of support outside medical settings**		**Goal:**	**Less delayed or inappropriate treatment, oral pain, stress, depression and other mental health disorders**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population experiences high rates of chronic depression and other mental health disorders	Increase access to behavioral health resources throughout the region	Increase the availability of mental health services and providers	Advocate for improved reimbursement rates and coverage of wrap-around services	Southcoast Hospitals PACT program employees to organize advocacy effort	Numbers of persons involved in the advocacy process; increase in reimbursement rates; expansion of coverage to include wrap-around	Count of persons; documentation of rate increase and coverage expansion

Health Factor IV: Goal 37	**Access to Quality Dental, Health, Mental Health and Substance Abuse Care**	**Problems with insurance coverage, waiting times, lack of support outside medical settings**		**Goal:**	**Less delayed or inappropriate treatment, oral pain, stress, depression and other mental health disorders**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population experiences high rates of chronic depression and other mental health disorders	Increase access to behavioral health resources throughout the region	Development of a single intake and screening tool to identify needs for services that could be universally used by multiple agencies and service providers	Develop prototype of an inter-agency referral tool to be used by multiple service providers	Prevention and Wellness Trust Fund SHIFT Project for two zip codes each in Fall River and New Bedford	Development of electronic referral system	Documentation of electronic referral system developed in conjunction with MA DPH
This effort is now being organized as part of the Mass in Motion 1422 Project and an inter-agency on-line referral tool has been implemented with the YMCA. This tool could be expanded to other organizations in the future.						

Health Factor IV: Goal 38	**Access to Quality Dental, Health, Mental Health and Substance Abuse Care**	**Problems with insurance coverage, waiting times, lack of support outside medical settings**		**Goal:**	**Less delayed or inappropriate treatment, oral pain, stress, depression and other mental health disorders**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population experiences high rate of poor dental hygiene	Provide education, especially to parents and children to teach dental hygiene	Increase the numbers of presentations on dental health at public venues	Include dental hygiene education in all Partners tableing events	HealthFirst Dental Hygiene Program	Numbers of presentations to parents and children in public venues	Count of presentations
A representative of HealthFirst Dental Hygiene Program is available at all of the Family Fun Nights in the public and Charter schools. HWB facilitated two Dental Days for families living in shelter.						

Health Factor IV: Goal 39	**Access to Quality Dental, Health, Mental Health and Substance Abuse Care**	**Problems with insurance coverage, waiting times, lack of support outside medical settings**		**Goal:**	**Less delayed or inappropriate treatment, oral pain, stress, depression and other mental health disorders**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Public transportation system makes accessing medical, dental and behavioral health services difficult	Reform current SRTA bus system to make it more responsive to consumer needs	Make route and schedule changes and add Saturday and Sunday hours; eliminate language barriers	Advocate for improved transportation system through local groups	Coalition for Social Justice; United Interfaith Action	Improvements in bus schedule and routes	Documentation of schedule and route changes
Greater Fall River Partners for a Healthier Community has joined with other local organizations as a member of the Bus Riders United Coalition (BRU) in a campaign to establish Sunday service in the Fall River/New Bedford area.						

Health Factor V: Education, Employment, Income and Disability

In terms of clinical care disparities based on income, perhaps unsurprisingly, access to and utilization of clinical care is more challenging to the South Coast's lower income residents as compared to those earning more than $50,000 per year. For example, across the board, a greater percentage of those with higher incomes have participated in health screenings, which mirrors statewide breakdowns between income groups. But in some cases, even fewer of the South Coast's lower income residents engage in screenings than their lower income counterparts across Massachusetts, including breast exams, pap smears, and colonoscopies.

Since education levels are correlated with income levels, it follows that among those with lower levels of educational attainment, there is less access to clinical care. Among those without a college degree, many more cannot see a doctor due to cost.

- Where participation in screening is concerned, some education-specific disparities include lower rates of clinical breast exams in Greater Fall River, (where just 75% of this subgroup reports having had this exam), pap smears, and colonoscopies among those without a college degree.
- Approximately four times as many South Coast adults who earn less than $50,000 per year report having fair or poor health as compared to those who earn above that threshold. In Greater Fall River, 25.0% of low-income earners report having fair or poor health compared to 6.2% of higher earners.
- A significant difference in general health exists between those with and without a college degree; while fewer than nine percent of those with a degree report having fair or poor health, 27.1% in Greater Fall River of those with a high school degree or less report having fair or poor health.

Poverty is one of the primary social determinants of health. Fall River has one of the highest poverty rates in the state: 21.4% of Fall River residents are below the U.S. Census Bureau's poverty threshold, which compares to 14.5% for the South Coast and 10.7% statewide. Importantly, not only does Fall River have the highest poverty rates in the region, but Fall River and New Bedford together also account for the majority of the region's poor in absolute numbers. Family poverty levels in the South Coast as a whole are higher than the state average with rates highest in the region's cities.

- 11.5% of South Coast families live below the federal poverty level compared to 7.6% of families statewide.
- 19.1% of South Coast families with children live below the federal poverty level compared to 11.8% of families statewide.
- 32.1% of South Coast female headed by females live below the federal poverty level compared to24.5% statewide.

Average unemployment rates in the region are historically higher than the statewide average throughout the business cycle with much of the difference driven by high unemployment rates in Fall River and New Bedford. While the region's unemployment rate declined steadily during the 1990s and slowly closed the gap with the statewide unemployment rate, this gap is beginning to increase once again. The 2012 annual average unemployment rate in the South Coast was 10.4%, which compares to a statewide average unemployment rate of 6.7% and a national rate of 8.1%.The annual unemployment rate in Fall River of 13.0% was significantly higher than the state average in 2012.

Families Below Poverty

Families Below Poverty Level

Town/City	Enroll	Low Income	# Families	Families<Poverty	Percent
Fall River	12,104	6,079	22,270	4,120	18.5%
New Bedford	14,609	8,431	23,627	4,418	18.7%
Somerset	2,844	264	4,851	116	2.4%
Swansea	2,295	283	4,666	135	2.9%
Westport	1,976	336	4,364	105	2.4%
SouthCoast	**33,828**	**15,393**	**59,778**	**8,895**	**14.9%**
Massachusetts	**1,603,940**				**7.6%**

Source: U.S. Census Bureau American Community Survey Estimates, 2007-2011

Health Factor V: Goal 40	Education, Employment, Income and Disability	Problems due to low graduation rates, job creation, adult education		Goal:	Lower unemployment, health illiteracy, economic stress	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population experiences high rates of school drop-out and unemployment	Provide opportunities to engage youth who are at-risk of dropping out in meaningful and engaging work	Provide an after-school project at the Resiliency Preparatory School that connects local artists with youth	Offer after-school YEAH! program for 18 weeks for up to twenty students	Grants from local banks and the Donaldson Trust; staff of the RPS	Number of after-school sessions offered; number of students involved	Count of participating students; count of sessions
A Culinary Arts Program and a Peer Leadership program were funded by YEAH! Where 18 students out of 21 students completed the 11 week program and 6 students got jobs.						

Health Factor V: Goal 41	Education, Employment, Income and Disability	Problems due to low graduation rates, job creation, adult education		Goal:	Lower unemployment, health illiteracy, economic stress	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Population experiences high rates of school drop-out and unemployment	Provide opportunities to engage youth who are at-risk of dropping out in meaningful and engaging work	Provide an after-school project at the Resiliency Preparatory School that connects local artists with youth	Training workshops to fill the gap of skills possessed by individuals seeking employment	Fall River Office of Economic Development; Chamber of Commerce	Number of workshops offered	Count of workshops offered
A Culinary Arts Program and a Peer Leadership program were funded by YEAH! Where 18 students out of 21 students completed the 11 week program and 6 students got jobs.						

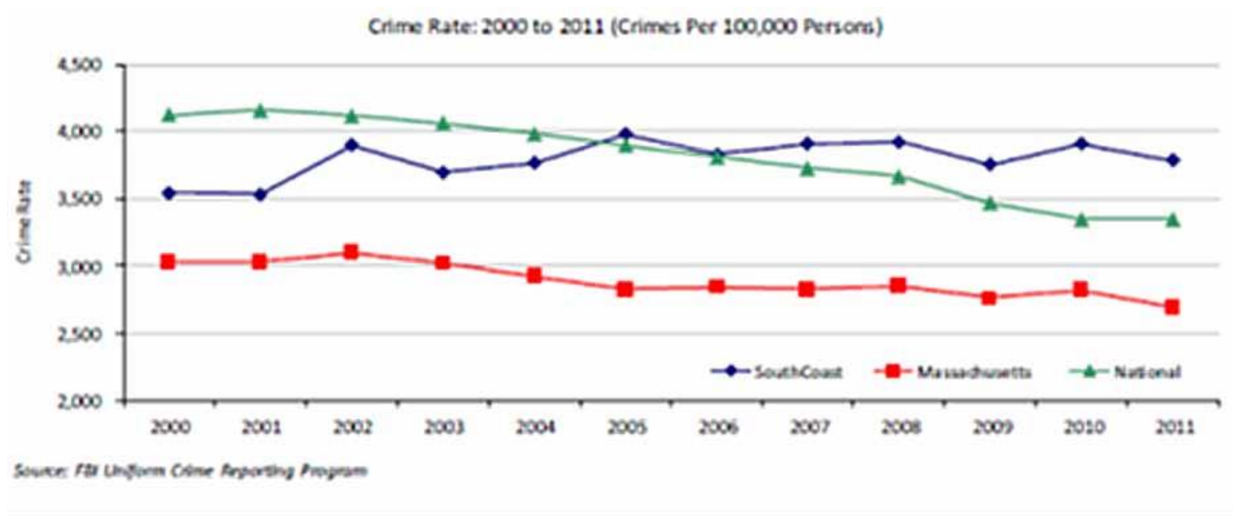
Health Factor V: Goal 42	Education, Employment, Income and Disability	Problems due to low graduation rates, job creation, adult education		Goal:	Lower unemployment, health illiteracy, economic stress	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Workforce exhibits levels of poor overall nutrition, fitness and smoking rates	Provide information and resources available to employers tro promote wellness	Workshops and/or informational collateral for employers regarding corporate programs available to promote wellness	Annual Worksite Wellness conference; monthly meetings on relevant topics for employers	South Coast Worksite Wellness Collaborative; Partners staff	Number of sessions held	Count of sessions held
An annual Worksite Wellness Conference has been held in each of the past two years. This year's keynote speaker was Mari Ryan who described how local businesses could take advantage of the DPH Working On Wellness program.						

Health Factor VI: Community Safety and Violence Prevention

Crime rates are both a predictor and a consequence of important economic and social indicators such as drug use, perceived and actual levels of safety, economic conditions, and changing demographics. The number of crimes reported in the South Coast increased by 14.9% from 2000 to 2011, although they have declined by 3.6% since 2005.

- 12,971 crimes in the South Coast were reported to police in 2011; 2,595 (20.0%) violent crimes and 10,376 (80.0%) non-violent crimes.
- Property crimes such as larceny/theft (6,724 crimes or 51.8%) and burglary (2,760 crimes or 21.3%) accounted for the majority of crimes in the South Coast.
- Fall River and New Bedford accounted for 67.6% of the total crimes reported in the region, while the two cities accounted for 54.1% of the South Coast's total population.

Graph 16. Crime Rate 2000 to 2011 (Crimes Per 100,000 Persons)



Health Factor VI: Goal 43	**Community Safety and Violence Prevention**	**Problems with crime, abuse, bullying**		**Goal:**	**Less PTSD, premature death**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Mental health issues and trauma histories, including their impact on violence toward self and others, are of a major concern in this city	Reduce rates of psychological trauma and self-harm	Increase trauma-informed care training	Increase relationship violence training in schools and agencies	Local agencies who provide relationship training programs	Number of trainings held	Count of trainings
UN convened Peace by Piece – Breaking Down the Walls to inform on communication and violence prevention. 150 youth, 50 staff.						

Health Factor VI: Goal 44	**Community Safety and Violence Prevention**	**Problems with crime, abuse, bullying**		**Goal:**	**Less PTSD, premature death**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Mental health issues and trauma histories, including their impact on violence toward self and others, are of a major concern in this city	Reduce rates of psychological trauma and self-harm	Increase trauma-informed care training	Provide training in Search Institute Developmental Assets to all adults who have contact with youth	New Bedford Responsible Attitudes toward Pregnancy, Parenting & Prevention Program	Number of trainings held	Count of trainings

Health Factor VI: Goal 45	**Community Safety and Violence Prevention**	**Problems with crime, abuse, bullying**		**Goal:**	**Less PTSD, premature death**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Mental health issues and trauma histories, including their impact on violence toward self and others, are of a major concern in this city	Reduce rates of psychological trauma and self-harm	Increase trauma-informed care training	Increase teacher and parent involvement in parent cafes and facilitated training	Children's Trust Fund and United Neighbors of Fall River	Number of parent cafes held	Count of parent cafes
Parent Cafes continue to be facilitated by UN & CFS. 6 Cafes this year including our first at a charter school – Atlantis. Train the trainer presented to Head Start, Early Head Start and Little People's College staff to help them facilitate their own Parent Café's on a regular basis.						

Health Factor VI: Goal 46	**Community Safety and Violence Prevention**	**Problems with crime, abuse, bullying**		**Goal:**	**Less PTSD, premature death**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Mental health issues and trauma histories, including their impact on violence toward self and others, are of a major concern in this city	Reduce rates of psychological trauma and self-harm	Increase conflict resolution and social skills	Extend Peace by Piece efforts beyond a one-day event	Grant funding and support from Partners if needed	Number of Peace By Piece extended activities held	Count of activities
Peace by Piece now includes a staff evening with the speaker the night before the conference. In addition, we will be convening 5 sessions with youth on micro aggression and implicit bias starting in September. We have convened 3 girl's groups at each of the High Schools – Durfee, Diman and RPS. These groups WAVE (Women, Action, Voice and Empowerment) are a trust building leadership group to help to begin to address the issues of violence and rhetoric.						

Health Factor VI: Goal 47	Community Safety and Violence Prevention	Problems with crime, abuse, bullying		Goal:	Less PTSD, premature death	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Mental health issues and trauma histories, including their impact on violence toward self and others, are of a major concern in this city	Reduce rates of psychological trauma and self-harm	Increase conflict resolution and social skills	Hold an annual meeting with school and community personnel to develop a strategy	School - Community Partnership Task Force	Annual meeting held	Documentation of meeting held
Peace by Piece now includes a staff evening with the speaker the night before the conference. In addition, we will be convening 5 sessions with youth on micro aggression and implicit bias starting in September. We have convened 3 girl's groups at each of the High Schools – Durfee, Diman and RPS. These groups WAVE (Women, Action, Voice and Empowerment) are a trust building leadership group to help to begin to address the issues of violence and rhetoric.						

Health Factor VII: Family, Cultural and Social Support, and Housing

The region's total population has changed little over the past 10 years and is likely to grow slowly over the next decade, although the proportion of residents age 65 years and older continues to increase modestly. The population is less diverse in the South Coast than it is statewide; 79.5% of South Coast residents are white non-Hispanic, compared to 70.8% of residents across the state.

Population growth and residential development have been uneven within the region; the total population in the cities of Fall River and New Bedford declined by 7.3% (-14,746 residents) between 1970 and 2010, while the South Coast's suburban towns experienced population growth of 43.3% during the same period (+47,730 residents). The area's uneven growth pattern – population declines in the cities and population increases in its suburbs - is putting pressure on the physical infrastructure, school systems, and administrative capacities of many local governments. Age cohorts in the South Coast are similar to statewide averages, although the South Coast has a slightly higher percentage of residents age 65 and older in comparison to the state. Population cohorts have remained relatively stable over the past two decades.

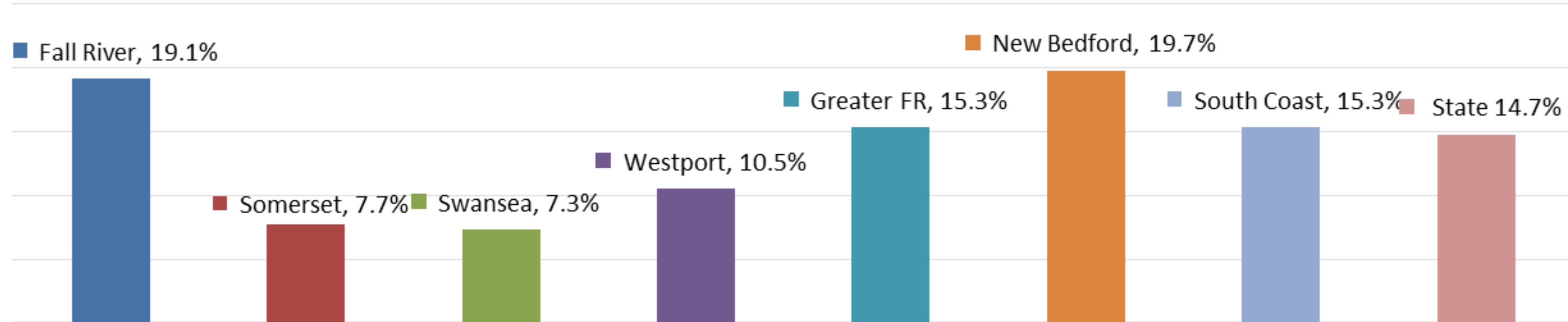
The population is less diverse in the South Coast than it is statewide; 79.5% of South Coast residents are White non-Hispanic, compared to 70.8% of residents across the state. Additionally, 7.3% of South Coast residents are Hispanic, 3.5% are African American, 0.5% are American Indian, 1.4% are Asian, 0.03% are Pacific Islander, 4.6% are some other race, and 3.1% are two or more races. The 2010 Greater Fall River Area is 90.6% White, 3.6% Black, 3.0% Other, 2.2% Asian and less than one percent American Indian or Hawaiian. Of these, 5.0% are Hispanic. The City of Fall River is 86.6% White, 5.2% Black, 4.3% Other, 2.9% Asian, and less than 1% American Indian and Hawaiian. Of these, 7.2% are Hispanic.

Table 2. Race and Ethnicity 2010

Town/CHNA	White	Black	Asian	Am. Indian	Hawaiian	Other	Hispanic	Total
Fall River	**78,846**	**4,737**	**2,612**	**741**	**195**	**3,888**	**6,552**	**91,019**
	86.6%	5.2%	2.9%	0.8%	0.2%	4.3%	7.2%	
Somerset	**17,865**	**132**	**190**	**77**	**7**	**86**	**191**	**18,165**
	98.3%	0.7%	1.0%	0.4%	0.0%	0.5%	1.0%	
Swansea	**15,404**	**101**	**110**	**13**	**1**	**172**	**173**	**15,801**
	97.5%	0.6%	0.7%	0.1%	0.0%	1.1%	1.1%	
Westport	**15,469**	**116**	**133**	**52**	**11**	**81**	**143**	**15,862**
	97.5%	0.7%	0.8%	0.3%	0.1%	0.5%	0.9%	
CHNA	**127,584**	**5,086**	**3,045**	**883**	**214**	**4,227**	**7,059**	**140,847**
	90.6%	3.6%	2.2%	0.6%	0.1%	3.0%	5.0%	

The South Coast has always been an attractive place to settle for immigrants. Over fifteen percent (15.3%) of residents in the region are foreign-born, which is just over the statewide average of 14.7%. Fall River (19.1%) has the highest percentage of foreign-born residents in the region.

Percent Foreign-Born Population



While persons with limited English proficiency reside throughout the City of Fall River, those with limited English proficiency are concentrated in three areas of Fall River: 1) the Columbia Street Neighborhood, located South of Route 195 on the western side of the City, composed primarily of Portuguese-Speakers, 2) the Flint Neighborhood, located just north of Route 195 in the center of the City, composed of Cambodian, Portuguese (including Brazilian Portuguese) and Spanish-speakers, and 3) the Sandy Beach Neighborhood, located at the far South West corner of the City, composed primarily of Azorean Portuguese-speakers.

Table 3. Language Spoken at Home (Ages 65+): Greater Fall River

	Area Count	Area Percent	State Percent
Speak Language other than English at Home	7,759	32.4	16.5
Speak English Not Well or Not at All	2,649	34.1	29.0
Speak Spanish at Home	118	0.5	1.6
Speak English Not Well or Not at All	13	11.0	48.4

MassCHIP 12/6/2010, Massachusetts Department of Public Health

Health Factor VII: Goal 48	Family, Cultural and Social Support, and Housing	Problems with language, race, ethnicity, cultural values, maternal care, single parent households, homelessness		Goal:	Decreased racism, stress, disconnection from community resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
The number of people experiencing homelessness is continuing to rise as is the population of homeless families in local motels.	Increase the availability of resources to homeless individuals and families	Develop and maintain a listing of locally-available resources for homeless individuals and families	Create and distribute resource listing	Life Together Fellow and SCI interns at United Neighbors and United Way	Listing created and distributed	Number of listings distributed
UN has created a new and larger version of the Emergency Resource Guide in paper form. In addition, we have added to the resource list on MFR.org. The new 16-page booklet has additional support services and all numbers and organizations have been vetted for accuracy.						

Health Factor VII: Goal 49	Family, Cultural and Social Support, and Housing	Problems with language, race, ethnicity, cultural values, maternal care, single parent households, homelessness		Goal:	Decreased racism, stress, disconnection from community resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
The number of people experiencing homelessness is continuing to rise as is the population of homeless families in local motels.	Increase the availability of resources to homeless individuals and families	Educate landlords about housing resources	Provide information to local landlords	Life Together Fellow and SCI interns at United Neighbors and United Way	Information provided	Documentation of information provided
Steppingstone program is working with local landlords to identify housing and is planning an informational session for all landlords.						

Health Factor VII: Goal 50	Family, Cultural and Social Support, and Housing	Problems with language, race, ethnicity, cultural values, maternal care, single parent households, homelessness		Goal:	Decreased racism, stress, disconnection from community resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
The number of people experiencing homelessness is continuing to rise as is the population of homeless families in local motels.	Increase the availability of resources to homeless individuals and families	Continue job support with SER-Jobs and Community Health Worker Training projects	Create job and job training opportunities to homeless individuals	SER-Jobs and United Interfaith Action CHW job development and training projects	Number of jobs and job training slots provided	Count of jobs and job training slots

Health Factor VII: Goal 51	Family, Cultural and Social Support, and Housing	Problems with language, race, ethnicity, cultural values, maternal care, single parent households, homelessness		Goal:	Decreased racism, stress, disconnection from community resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
The number of people experiencing homelessness is continuing to rise as is the population of homeless families in local motels.	Increase the availability of resources to homeless individuals and families	Increase transportation opportunities to families in local motels	Organize regular bus transportation to Fall River resources to families in Somerset and Swansea	People Incorporated transportation grant; Vela Foundation grant	Number of bus trips provided	Count of bus trips to Fall River
HWB and People. Inc have provided transportation for people in shelter to get to programs, medical appointments, health and dental days, nutrition days, social connections trips, job fairs, parent academy courses, etc.						

Health Factor VII: Goal 52	Family, Cultural and Social Support, and Housing	Problems with language, race, ethnicity, cultural values, maternal care, single parent households, homelessness		Goal:	Decreased racism, stress, disconnection from community resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
The number of people experiencing homelessness is continuing to rise as is the population of homeless families in local motels.	Increase the availability of resources to homeless individuals and families	Establish a food bank warehouse accessible to all Fall River food pantries	Identify suitable location and fund renovations needed	Fall River Food Pantry, Project Bread, and donated location	Food Bank warehouse opened and operational	Food bank opened

Health Factor VII: Goal 53	Family, Cultural and Social Support, and Housing	Problems with language, race, ethnicity, cultural values, maternal care, single parent households, homelessness		Goal:	Decreased racism, stress, disconnection from community resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
The number of people experiencing homelessness is continuing to rise as is the population of homeless families in local motels.	Increase the availability of resources to homeless individuals and families	Hire a full-time "food guru" at United Way to organized food resources on a 24/7 basis	Write grant application, recruit and hire person, supervise and link with existing resources	United Way of Greater Fall River with Social Capital Inc providing funding and recruiting interns	Position funded and person hired	Funding in place a person hired

Health Factor VIII: Environment & Infrastructure

An understanding the influence of the physical environment on health status have led to efforts to revitalize the waterfront, improve streets and sidewalks and deal with some of the City's deteriorating housing . Over seven miles of streets and sidewalks have been replaced as part of a Combined Sewer Overflow project that mandated new water lines, thus providing the opportunity to make the city more walkable. Several housing projects constructed to house returning World War II veterans have been upgraded or rebuilt, and major plans to reconstruct the City's waterfront area and connecting highways are moving into construction. Even the City's boardwalk along the Taunton River that attracts thousands of walkers year-round is being refurbished. Each of these projects demonstrates a commitment by the City to improve the physical structures that support a healthier lifestyle and the willingness to pursue state and federal resources needed to accomplish them.

The Open Space and Recreation Plan, rewritten in 2010, spells out a vision of walkable streets, a bicycle friendly city, and care and access to open spaces. Major new funding resources identified by the City officials and the Mass in Motion coordinator is helping to provide millions of dollars in improvements to existing parks as well as the creation of a major new bicycle and walking path through the center of one of the most neglected natural spaces in the City. A recently-completed path now connects three elementary schools, a middle school, three high schools and two community colleges. New construction on Plymouth Avenue includes bicycle lanes, thanks to the advocacy of the Mass in Motion coordinator and the newly formed Fall River Bicycle Committee, and regional planning has begun for a South Coast Bikeway linking Fall River to Wareham is well underway. A new bus station and front-mounted bike racks on the buses are helping to make the City truly multi-modal. The City's parks are also being improved with the advocacy of volunteer Park Advocate volunteers and an Adopt-a-Park program that worked with neighborhood associations to install handicapped accessible playground equipment. Plans are underway for the creation of a walking path completely surrounding Cook Pond in the City's South End, an area that has been neglected for much of the past century but one that offers spectacular water views and a path that can connect residents with some of the wild and natural areas of the City.

Health Factor VIII: Goal 54	Environment & Infrastructure	Problems with non-vehicular transportation		Goal:	Increased physical activity and access to recreational resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Improved access to public transportation and its connectivity to schools, jobs, parks, medical centers and shopping needed	Develop a Bicycle Master Plan for the City of Fall River	Map routes to key destinations (school, work, shopping, recreation) to ensure bicycle access	Create maps designating bicycle routes throughout the Area	Mass in Motion and Fall River Bicycle Committee	Map created and distriubted	Number of maps distributed
15: Julie has a working version of this map now. 16: Mass in Motion has produced a detailed map of South Coast bicycle routes. Eric as included a layer of bicycle routes on the WalkFallRiver.org web site.						

Health Factor VIII: Goal 55	Environment & Infrastructure	Problems with non-vehicular transportation		Goal:	Increased physical activity and access to recreational resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Improved access to public transportation and its connectivity to schools, jobs, parks, medical centers and shopping needed	Develop a Bicycle Master Plan for the City of Fall River	Create a bicycle culture that recruits new cyclists and addresses bicycle safety in a vehicle-oriented community	Plan and implement a comprehensive bicycle safety program; Trips for Kids, Bike Fall River	Southeastern Regional Planning & Economic Development District, MASSBIKE, Safe Routes to School	Number of safety sessions offered, number of organized bicycle trips offered for children and adults	Count of safety sessions and bicycle trips
2015: A total of 38 bicycle racks purchased through a grant from SRPEDD will be installed in Nov. 2014 throughout the city on public property, i.e., schools, housing sites, parks, libraries, etc. 2016: A Trips for Kids program is operational at the Boys and Girls Club. Bike Fall River continues to organize rides. MassBike conducted a Safe Routes to School Training and a Cycle Kids program at Fonseca Elementary School.						

Health Factor VIII: Goal 56	Environment & Infrastructure	Problems with non-vehicular transportation		Goal:	Increased physical activity and access to recreational resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Improved access to public transportation and its connectivity to schools, jobs, parks, medical centers and shopping needed	Standardize Physical Education Curriculum to include Safe Walking and Cycling	Review and revise School Wellness Plan to address safe walking and cycling	Standardize the PE curriculum for the FR Public Schools to include walking and cycling	Partners School Wellness Coordinator's time and Mass In Motion participation on the Wellness Committee	Inclusion of language in the Wellness Plan to address pedestrian and bicycle participation and safety	Wellness Policy language included
2015: Marcia Picard will work with the Fall River Schools new physical education department head. 2016: District PE Director Brad Bustin has standardized the PE curriculum in FR Schools and has added an annual physical fitness test event for middle schools and added national standards for physical fitness and a “Fitness Gram” data collection program.						

Health Factor VIII: Goal 57	Environment & Infrastructure	Problems with non-vehicular transportation		Goal:	Increased physical activity and access to recreational resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Increase physical access to healthy food, especially to low-income areas and people who lack automobile transportation	Create a Five-Minute Walk to a Healthy Market Program	Identify potential markets that agree to upgrades using the Healthy Market Toolkit	Expand shelf space and improve locations of healthier food options	MIM staff to locate markets based on owner interest to increase and promote healthier choices	Five markets with interest and potential to expand availability of healthier food options identified	Number of participating markets
2015: See item #2, above. 2016: The Five-Minute Walk to a Healthy Market program was organized. Efforts are underway through the Mass in Motion 1422 project to improve healthier food options in several local markets. Work has begun with managers of Stop & Shop, Price Rite and Walmart to increase healthy options.						

Health Factor VIII: Goal 58	Environment & Infrastructure	Problems with non-vehicular transportation		Goal:	Increased physical activity and access to recreational resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Increase physical access to healthy food, especially to low-income areas and people who lack automobile transportaion	Create a Five-Minute Walk to a Healthy Market Program	Create map of the 1/2 mile radius of all markets offering healthy food options	Locations plotted and analyzed; healthy market locations plotted; map produced and publicized	MIM staff; Cancer prevention project staff; Healthy City Coordinator	Map created and distributed	Number of maps distributed
2015: See Goal # 2, above. 2016: A complete interactive on-line map of 24 local markets has been produced for the WalkFallRiver.org web site.						

Health Factor VIII: Goal 59	Environment & Infrastructure	Problems with non-vehicular transportation		Goal:	Increased physical activity and access to recreational resources	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Increase physical access to healthy food, especially to low-income areas and people who lack automobile transportaion	Create a Five-Minute Walk to a Healthy Market Program	Brand a Five-Minute Walk to a Healthy Market program and advertise using English and non-English messages	Five-minute walk program created in multiple languages and widely publicized	MIM staff; Cancer prevention project staff; Healthy City Coordinator	Branding project completed	Branding advertisement count
2015: See Goal # 2, above. 2016: Three neighborhood brochures for the Five-Minute Walk to a Healthy Market have been produced in English and distributed widely.						

Health Factor VIII: 60	**Environment & Infrastructure**	**Problems with non-vehicular transportation**		**Goal:**	**Increased physical activity and access to recreational resources**	
Problem Area	**Strategic Goal**	**Strategy**	**Activity**	**Resources**	**Measures**	**Achieved**
Improve and increase resources and awareness of active living resources	Improve and expand parks and open spaces and awareness of and access to both	Search and identify funding sources for park and open space improvements; complete planning and apply for funding	Grant opportunity search; coordination with Mayor's Office and Grantwriter	City grant writer; Parks and Recreation Department; Department of Community Maintenance	Grants identified and secured; projects underway and completed	Number of grants; number of improved and expanded parks and open spaces
2015: City Grantwriter Jane Dibiasio will work on this as opportunities for funding arise. Grant applications pending decision: PARC Grant to install new basketball courts in 5 parks (Abbott Court, Kennedy Park, Maplewood Park, North Park & Ruggles); LWCF Grant to install an inclusion playground at North Park (DCS has approved, but we're still waiting for the NPS to give final approval so work can begin). 2016: Grant applications were written and submitted for the Mass in Motion 1422 Project, Community Funding from the Bristol County District Attorney for a Summer Field Day, Harvard-Pilgrim Healthy Food Grant, KEEN Effect Grant, Working Cities Grant, and Southcoast Community Benefits Grant, an inclusion playground at North Park, a GroundWork project, and a PARC grant for five ball fields. A Master Plan for parks has also been completed.						