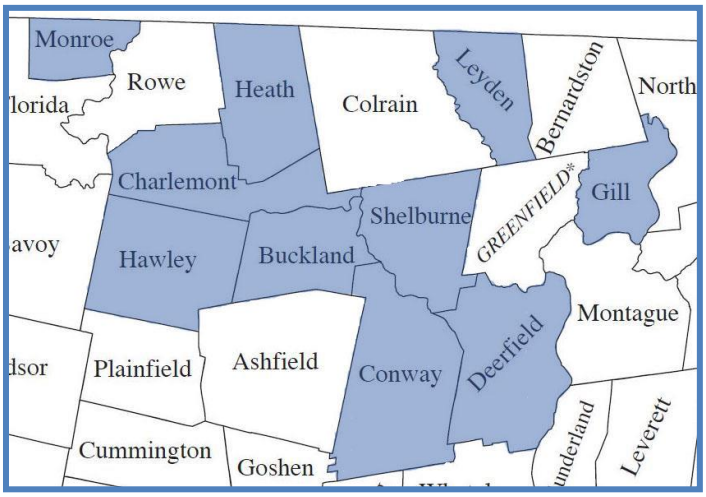
Franklin County Public Health Services

Annual Data Dashboard:
Summary of Key Indicators for State Mandated & Recommended Public Health Services

January 2014



Institute for Community Health
Building sustainable community health, together
A collaboration of the Cambridge Health Alliance, Mount Auburn Hospital, and Partners Healthcare

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The Institute for Community Health (ICH) in collaboration with the Massachusetts Department of Public Health (MA DPH) is evaluating the process and outcomes associated with shared public health services delivery for the Public Health District Incentive Grantees (PH DIG). As part of this evaluation, ICH has compiled a report that summarizes Franklin County Public Health Services (CPHS) progress towards meeting key deliverables for the District Incentive Grant (DIG) initiative of Year 2 of the initiative. ICH has gathered information from various sources including MA DPH, municipality websites, phone conversations with DIG Grantees and their Quarterly Reports to MA DPH. This annual data dashboard highlights data on Food Inspection, Board of Health Training, Communicable Disease Management, Beach Inspection, Lead Screening Capacity, Sharp Disposal, Governance, Community Health Assessment, District Health Initiative, Workforce Qualifications and any accomplishments and/or collaborative efforts undertaken by CPHS. Additionally, this report will summarize the progress CPHS has made in each of these delivery areas since the publication of the Year 1 Data Dashboard (2012).

Franklin County Public Health Service has 10 member towns. In CPHS, there are three towns, Conway, Deerfield, and Shelburne, that have elected to regionalize only public health nursing services. The remaining towns utilize a comprehensive set of public health services, including housing, food, septic, camp, pool and other inspections, as well as grant writing and public health nursing. One of the comprehensive towns has their own nurse, so they participate only in the three other programs (Food Safety, Septic and Private Well, and Community Sanitation).

KEY HIGHLIGHTS/SUMMARY

FOOD INSPECTION
• % of towns in district submitted food inspection reports to DPH: ○ **30% of towns** (3/10) in 2010 ○ **80% of towns** (8/10) in 2011 ○ **90% of towns** (9/10) in 2012
• % of towns in district meeting state mandate for food inspection – 2 inspections per establishment (based on average inspections completed per establishment): ○ **33% of towns** (1/3) in 2010 ○ **0% of towns** (0/8) in 2011 ○ **22% of towns** (2/9) in 2012

BOARD OF HEALTH TRAINING
• **% of towns** in district have BOH members participating in MAHB or BCBOH training: ○ **0% of towns** (0/10) have all BOH members trained ○ **50% of towns** (5/10) have at least half of BOH members trained
• No written plans for training of BOH members

COMMUNICABLE DISEASE REPORTING
• MAVEN Status - IMM/EPI Database: ○ **80% of towns** (8/10) as of October 2012 ○ **100% of towns** (10/10) as of September 2013
• MAVEN Status - TB Database: ○ **0% of towns** (0/10) as of October 2012 ○ **100% of towns** (10/10) as of September 2013
• Communicable Disease Reporting: Please refer to the Communicable Disease Surveillance section for details on communicable disease investigation activities for the district by year

BEACH INSPECTION
• **0% of towns** (0/10) in district have at least one beach in 2012

LEAD INSPECTION
• **80% of towns** (8/10) in district have capacity to conduct lead determination in 2013

SHARPS DISPOSAL
• **90% of towns** (9/10) in district have access to a regular sharps disposal site in 2013
• **90% of towns** (9/10) in district held hazardous waste day(s) in 2013

Met all category requirements
Met some category requirements
Area for Improvement
Not reported
Information pending / in progress
Not Applicable

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*Data for towns receiving comprehensive services

GOVERNANCE STATUS
• By-laws/other formal documentation of governance have been **established**
• 10 meetings held since January 2013
• 4 towns were represented at 80% meetings held since January 2013†
• Intermunicipal agreements **in place** in accordance with district by-laws

COMMUNITY HEALTH ASSESSMENT (CHA)
• CHA stage of completion: **In progress**
• Sharing of CHA results with key stakeholders: **TBD**

DISTRICT HEALTH INITIATIVE
• Type of Health Initiative: **Tobacco**
• Stage of implementation for Health Initiative: **In progress**
• Policy change component of Health Initiative: **Yes**
• Stage of implementation for policy component: **In progress**

WORKFORCE QUALIFICATIONS
• # of staff positions paid (full & partial) with DIG funds: **2 staff**—Public Health Nurse and Health Agent
• Written qualifications for staff employed through DIG funds: **In place**
• **100%** of DIG-funded staff meet workforce qualifications

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†Denominator varies by town depending on if towns were members in FY13 or FY14

Met all category requirements
Met some category requirements
Area for Improvement
Not reported
Information pending / in progress
Not Applicable

FOOD INSPECTION

According to MA DPH requirements put forth in 105 CMR 590.010(F), each town must submit a food inspection report to MA DPH annually. According to MA DPH requirements put forth in section 8-401.10(A) of the Food Code, each town (using a standard inspectional services model) must complete a minimum of two food inspections per licensed food establishment per year. Note that a selection of towns in the state are approved to use a risk-based inspectional services model instead of a standard model; these towns are only required to complete one inspection per licensed food establishment per year. Additionally, there are a number of food service entities that are only inspected once per year, including seasonal kitchens and temporary food booths and establishments. No towns in CPHS use a formal risk-based food inspectional strategy.

All municipalities in CPHS follow the standard food inspectional services model. The table below reflects data on food establishments and inspections completed for 2011 and 2012 as per information submitted to MA DPH for each town. If no report was submitted for either of these years, this is noted. In 2012, 9 towns (90%) submitted food inspection reports to MA DPH.

Town	Submitted Food Inspection Report to DPH		Number of Licensed Food Establishments[1]		Number of Food Inspections Completed		Average Number of Food Inspections Per Establishment[3]		Town Met State Mandate for Food Inspection Completion in 2012?
	2011	2012	2011	2012	2011	2012	2011	2012	
Buckland	Yes	Yes	11	11	31	20	2.8	1.8	Uncertain due to data limitations
Charlemont	Yes	Yes	35	38	51	44	1.5	1.2	Uncertain due to data limitations
Conway[2]	Yes	Yes	14	23	39	37	2.7	1.6	Uncertain due to data limitations
Deerfield[2]	Yes	Yes	20	22	30	30	1.5	1.4	Uncertain due to data limitations
Gill	Yes	Yes	11	11	7	21	0.6	1.9	Uncertain due to data limitations
Heath	Yes	Yes	22	22	26	24	1.1	1.1	Uncertain due to data limitations
Hawley	Yes	Yes	1	1	2	2	2.1	2.0	Uncertain due to data limitations
Leyden	No	Yes	Not reported	3	Not reported	3	Not reported	1.0	Uncertain due to data limitations
Monroe	Yes	Yes	1	1	2	2	2.0	2.0	Uncertain due to data limitations
Shelburne[2]	No	No	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Uncertain due to data limitations
			67	**132**	**102**	**183**	**1.5**	**1.4**	

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[1] This data includes food establishments that are temporary/seasonal. Temporary/seasonal food establishments only require *one food inspection per year*, however, this level of data is neither reported to DPH nor can it be obtained from DPH. Thus, in determining whether each town met the state mandate of a minimum of two inspections per establishments per year, it is assumed that if the average number of inspections per establishment per year is at least two, then each establishment had at least two inspections.

[2] Please note these towns are public health nursing towns only

[3] The above data only provides the average number of inspections per food establishment per year; individual-level data on number of inspections completed per establishment is not available.

BOARD OF HEALTH (BOH) MEMBER TRAINING

Training requirements put forth by MA DPH call for all current BOH members to complete formal training on BOH responsibilities provided by MAHB, the Local Public Health Training Institute, or another approved entity. BOH Training data is updated from CPHS as of November 21, 2013. Presently, 41% of BOH members from participating municipalities of CPHS have completed formal BOH training. Additionally, MA DPH requires towns to have a written plan in place for training BOH members. CPHS does not have a formal written plan in place for training, however, they did send 10 local board of health representatives to the MAHB training this fall, and plan to hold another in the early spring through the Berkshire County BOH Association. CPHS is also working toward having each town adopt regulations stating each member must be trained within a year of joining the BOH.

Town	# of BOH Members	# of BOH Members Ever Trained	% of BOH Members Ever Trained in 2013	BOH Member Names	Year of Most Recent Training
Buckland	3	1	33%	Richard Warner	
				Jim Bauerlein	2013
				Terry Estes	
Charlemont	5	3	60%	Douglas Telling	2013
				Ronald Smith	
				Ruth Cannavo	Unsure
				Trice Hyer	
				Robert Lingle	2013
Conway[2]	4	1	25%	Carl Nelke	
				Gina McNeeley	Unsure
				Sue Bridge	
				William McCloughlin	
Deerfield[2]	3	2	66%	Mark Gilmore	
				Carolyn Shores-Ness	Unsure
				David Wolfram	2013
Gill	3	1	33%	Douglas Edson	
				Randy Crochier	2013
				Edward Galipault	
Hawley	3	0	0%	Philip Keenan	
				John Sears	
				Robert MacLean	
Heath	4	2	50%	Jon Doherty	
				Jenna Day	
				Karen Brooks	2013
				Rebecca Allen	2013
Leyden	3	2	66%	Gloria Fisher	2013
				Andrea Zimmerman	
				Kathie Benson	2013
Monroe	2	1	50%	David Nash	2013
				Gloria Richard	
Shelburne[2]	3	1	33%	Bob Gonzales	
				Deborah Coutinho	Mid-2000s
				Rob Hicks	

[2] Please note these towns are public health nursing towns only

COMMUNICABLE DISEASE

All PH DIG participating municipalities are required to implement MAVEN, a web-based disease surveillance and case management system. Municipalities are required to be on MAVEN IMM/EPI Database and the MAVEN TB Database is optional. A municipality is "online" if they have someone trained and set up to use the MAVEN online database system for communicable disease reporting.

Maven Status

Since the initiation of the DIG grant, 5 of the 10 (50%) CPHS municipalities have come on to the MAVEN Database. All nine municipalities (100%) have come online to the TB database in 2013. MAVEN online dates are from MA DPH as of September 12, 2013.

Town	MAVEN IMM/EPI Database		MAVEN TB Database	
	Town on Database?	***If online:* Database Online Date**	**Town on Database?**	***If online:* Database Online Date**
Buckland	Yes	7/30/2008	Yes	3/14/2013
Charlemont	Yes	4/14/2010	Yes	3/14/2013
Conway	Yes	3/6/2008	Yes	3/14/2013
Deerfield	Yes	3/6/2008	Yes	3/14/2013
Gill	Yes	3/13/2008	Yes	3/14/2013
Hawley	Yes	2/15/2011	Yes	3/14/2013
Heath	Yes	12/15/2011	Yes	3/14/2013
Leyden	Yes	5/14/2013	Yes	5/14/2013
Monroe	Yes	2/15/2011	Yes	3/14/2013
Shelburne	Yes	5/13/2013	Yes	5/13/2013

Communicable Disease Surveillance Summary

Communicable disease surveillance requires local boards of health, state public health officials, and healthcare providers to work collectively to monitor the occurrence of notifiable diseases, as required by Massachusetts law.

In late 2011, the MDPH Bureau of Infectious Disease (BID) began a long-term project to evaluate the state's infectious disease surveillance system using data contained in MAVEN and made changes to the way in which Key Indicator Reports data is collected and reported with the purpose of improving the quality of data collected through local board of health reporting. The disease-specific indicators were developed based on essential programmatic components of an investigation and CDC mandates, meaning components deemed essential to an investigation for each particular disease. The data presented in this year's annual report reflects the new MDPH BID Key Indicator Reports. This report includes 36 reportable diseases and does not include revoked events. The additional column, "completeness of key indicators" was created by MDPH BID to reflect important indicators for each notifiable disease.

In 2012, CPHS had 2 events involving diseases that require immediate reporting. Of these events, 0% had all key indicators completed. There were no immediate disease events that were lost to follow up in 2012. For communicable disease events requiring routine follow up, CPHS towns had 12 cases, of which 6 (50%) had all key indicators completed, and there were 0 cases across CPHS towns where a patient was lost to follow up.

Overall in 2010-2012, CPHS has had a total of 4 cases involving immediate reporting, of which 1 (25%) had all key indicators completed. There were no cases lost to follow up. For routine disease reporting, 46 events occurred between 2010-2012. Seventeen (37%) had all key indicators completed and there were 12 cases (26%) that were lost to follow up.

Disease Priority	Event Year	Total Events	Completeness of Key Indicators		Loss to Follow Up[5]	
			#	%	#	%
Immediate[3]	2010	0	0	0%	0	0%
	2011	2	1	50%	0	0%
	2012	2	0	0%	0	0%
	Total	**4**	**1**	**25%**	**0**	**0%**
Routine[4]	2010	18	3	17%	8	44%
	2011	16	8	50%	4	25%
	2012	12	6	50%	0	0%
	Total	**46**	**17**	**37%**	**12**	**26%**

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[3] Immediate Diseases include: GAS, HEPA, LIST, MEAS, MUMPS, NMEN, RUB, TB_ACTIVE, TUL

[4] Route Diseases include: AMEB, BAB, CALI, CAMP, CHOL, CRYPT, CYCLO, EEE, EHR, ENCEP, ENTRO, GIAR, HFLU, HGA, HUS, LEG, LEP, MAL, PERT, RMSF, SAL, SHIG, SP, STEC, TRICH, WNI, YER

[5] Lost to Follow-Up (LTFU): if outreach has been attempted to either doctor or patient for event/cases, the LBOH representative fills out the variable "lost to follow-up" as "Yes."

BEACH DATA

In accordance with the Massachusetts Beaches Act, MA DPH requires that all beaches (except for Tier 3 beaches) be sampled at least weekly during the 2012 beach season (defined as late May/early June through late August/early September). Towns are listed as having met DPH beach sampling requirements if all beaches were sampled at least weekly in 2012 according to the MA DPH database. Additionally, when a water sample from a beach exceeds bacterial standards, state law requires that the beach be closed, and that the local BOH notifies MA DPH within 24 hours of the exceedance and the closure. Beaches listed in the table below only include those owned and operated by the town and does not include beaches that are operated by the MA Department of Conservation and Recreation (DCR). In CPHS, there are no town owned/operated beaches.

Town	# of Beaches Owned/ Operated by Town	Beach Name	Marine or Freshwater	Submitted Field Reports on Beach Conditions to DPH in 2012?	Beach had Weekly Water Sampling in 2012?	Met DPH Beach Sampling Requirements for 2012?	Number of Single Sample Bacterial Exceedences for Beach in 2012[1]	Closure Posting Form Submitted for Exceedence?[2]
Buckland	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Charlemont	0							
Conway[2]	0							
Deerfield[2]	0							
Gill	0							
Hawley	0							
Heath	0							
Leyden	0							
Monroe	0							
Shelburne[2]	0							

[2] Please note these towns are public health nursing towns only

[1] Beach data on single sample bacterial exceedences for 2012 from MA DPH "Marine and Freshwater Beach Testing in Massachusetts" Annual Report: 2012 Season, produced by MA DPH, the MA Bureau of Environmental Health, and the MA Environmental Toxicology Program in May 2012. A beach is listed as having a bacterial exceedence for 2012 in any instance where sampled bacterial levels exceeded bacterial standards for the corresponding beach type (marine or freshwater). Note that the bacterial standards for marine beaches are 104 enterococcus and a geometric mean of 35, and the bacterial standards for freshwater beaches are 235 e. coli or a geometric mean of 126 and 61 enterococcus or a geometric mean of 33. Also note that bacterial exceedences can be impacted by environmental factors such as high rainfall, tides, and greater bather usage.

[2] Beach data on closure postings from MA DPH. Note that in some cases a single beach closure posting could cover several exceedences, for example if a beach closure had already been posted because of a prior exceedence and a follow-up sample also shows bacterial exceedence.

LEAD DATA

CPHS has the capacity to conduct lead determination across, most (80%) of CPHS towns. CPHS has a certified Lead Determinator that conducts lead inspections/ determinations for all the comprehensive towns in CPHS. The remaining towns have a town- funded lead determinator.

Lead Inspection/Determination

Lead inspections occur in the context of Chapter 2 housing inspections that result from a housing complaint. If a house has not been deleaded, there are children under the age of 6 living in the house, and the inspector obtains parental consent, a lead inspection may be done.

Town	Have Capacity to Conduct Lead Determination in 2013?	When is lead determination conducted? (eg. regularly, complaint based)	Are lead determination conducted by a regional inspector or by individual towns?	How are lead determination services funded?
Buckland	Yes	During all housing inspections when a child under 6 is a resident	Regional	DIG funding
Charlemont	Yes		Regional	DIG funding
Conway[2]	No	Information not available	Information not available	
Deerfield[2]	Yes	During all housing inspections when a child under 6 is a resident	Town	Town
Gill	Yes		Regional	DIG funding
Hawley	Yes		Regional	DIG funding
Heath	Yes		Regional	DIG funding
Leyden	Yes		Regional	DIG funding
Monroe	Yes		Regional	DIG funding
Shelburne[2]	No	Information not available	Information not available	

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[2] Please note these towns are public health nursing towns only

SHARPS

MA DPH sharps requirements stipulate that a town have access to a sharps disposal site. A town is considered to have met this requirement if they have access to a sharps disposal site within the town, access to a regional sharps facility, or if a town holds a Hazardous Waste day.

Nine towns (90%) have access to a sharps disposal site and 9 towns (90%) held Hazardous Waste Days in 2013. All towns in CPHS, except Monroe, are covered by the Franklin County Solid Waste Management District. In addition to trash and recycling services, the Franklin County Solid Waste Management District provides coverage for sharps, hazardous waste, and medication take-back programs. For sharps, they provide individual sharps boxes to residents who regularly use sharps and lancets. Sharps can be taken to various locations throughout the region or given to CPHS's regional public health nurse. The public health nurse can give out sharps boxes and receive sharps when they are full from any resident in all 10 CPHS towns, including Monroe, which is not in the Franklin County Solid Waste Management District. Additionally, the Franklin County Solid Waste Management District holds yearly Hazardous Waste Days and has 2 super sites for hazardous waste which serve the entire region. The super sites are located at the Bernardston Transfer Station, Conway Transfer Station, and Colrain Transfer Station.

Town	Town Access to Regular Sharps Disposal Site in 2013?	Number of Disposal Locations	Were there Hazardous Waste Days in 2013?	Number of Hazardous Waste Days Held in 2013
Buckland	Yes	9 locations, or public health nurse take-back	Yes	1; Fall 2013
Charlemont	Yes		Yes	1; Fall 2013
Conway[2]	Yes		Yes	1; Fall 2013
Deerfield[2]	Yes		Yes	1; Fall 2013
Gill	Yes		Yes	1; Fall 2013
Hawley	Yes		Yes	1; Fall 2013
Heath	Yes		Yes	1; Fall 2013
Leyden	Yes		Yes	1; Fall 2013
Monroe	No; can be given to public health nurse	Public health nurse take-back	No	--
Shelburne[2]	Yes	9 locations, or public health nurse take-back	Yes	1; Fall 2013

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[2] Please note these towns are public health nursing towns only

GOVERNANCE

DIG performance evaluation requirements put forth by DPH require each DIG district to have a governance structure established with by-laws or other formal documentation of governance established in place, a governance board that meets regularly and appropriate inter-municipal agreements (IMA) in place.

Governing Structure

CPHS has an Oversight Board that serves to provide input and oversight, by developing goals and priorities, assessing staffing, establishing a membership fee formula, reviewing financial documents, drafting budgets, and reviewing and act on reports from staff. Each municipality has a town-appointed Board of Health member who sits on this Oversight Board. A second representative from each town is an alternate, and only votes when the full member is not in attendance. The alternate is not required to be a BOH member.

The Oversight Board has Co-Chairs that preside over meetings, which are held monthly. Both the Co-Chairs are elected by nomination and vote of the quorum to serve term of office for one year. Voting occurs at the last meeting of the fiscal year. Each member municipality gets one vote by scope of involvement in the issue, meaning that every municipality votes on shared priorities, such as policies and cross-cutting services. However, only municipalities who use a service may vote on matters specific to that service.

Meetings

Since January 2013, CPHS has met 10 times with an average attendance of 72%. In fiscal year 2014, which began in July 2013, two new towns, Leyden and Shelburne, joined CPHS. In the 2013 calendar year, 4 of the 10 towns (40%) participated in at least 80% of meetings.†

Meeting Dates Since January 2013	Number of Towns Represented	Percent of Towns Represented
1/2013	6	75%
3/2013	5	63%
4/2013	5	63%
5/2013	5	63%
6/2013	5	63%
7/2013	7	70%
9/2013	7	70%
10/2013	10	100%
11/2013	6	60%
12/2013	7	70%
Average for 2013	--	**72%**

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†Denominator varies by town depending on if towns were members in FY13 or FY14

COMMUNITY HEALTH ASSESSMENT (CHA)

DIG performance evaluation requirements put forth by DPH require each DIG district to complete a community health assessment, which should include multiple sources and types of data, diverse stakeholder representation, analysis of assets and needs, and dissemination/sharing of results back to communities. The community health assessment and a plan to disseminate its findings must be completed by April 30, 2014. The establishment of a Community Health Improvement Plan (CHIP) for how the data will be utilized is optional but encouraged.

CHA Stage of Completion?		
Data Collection & Analysis	**Interpretation and prioritization**	**Development of CHA Report**
Complete	In progress	In progress

Phoebe Walker serves on the advisory board for a collaborative CHA that was conducted in conjunction with seven area non-profit hospitals. The quantitative and qualitative data gathered through that effort is being analyzed for its implications for just the towns of the CPHS. HRiA is reviewing a draft of the CHA report.

Strategy for Dissemination

- To be determined at an upcoming Oversight Board meeting

List of Collaborating Partners

- Baystate Franklin Medical Center.
- The Literacy Project
- Community Action
- Service Net
- The Partnership for Youth
- Greenfield Board of Health
- Center for Human Development
- Food Bank of Western Mass
- Behavioral Health Network
- American Lung Assn., Heart Assn, Cancer Assn.
- Franklin County Home Care
- DIAL/SELF Youth Services
- Center for New Americans
- North Quabbin Community Coalition
- Massachusetts Department of Public Health Western Region Office (representatives from 11 different programs)

Sources of CHA Data

The data was collected through:

- Interviews with health-focused social service agencies and community based organizations, county-wide
- A survey that was distributed to residents at the county level
- Examination of hospital discharge data for all of the hospitals in the region, and analysis by zip code
- Extensive health status data gathering from MassCHIP and national sources

Currently, CPHS is in the process of extracting district level data from the county-wide data set for the CPHS region.

Community Health Improvement Plan (CHIP)

Baystate Franklin Medical Center has already completed a CHIP, and CPHS is determining if they will create their own CHIP or work with the existing framework completed by Baystate Franklin Medical Center.

DISTRICT HEALTH INITAITIVE

Each DIG Grantee is required to implement a health initiative around either tobacco or obesity with a policy change component. CPHS is planning to continue working on a tobacco initiative which is in the early implementation stages. CPHS is focusing on updating the tobacco regulations in each member town to meet the latest recommended standard from the Mass Tobacco Control Program (MTCP). These regulations include bans on individual cigar sales, blunt wraps, for example, and ban smoking in parks. Currently, updated regulations have been adopted by Buckland, Deerfield, Gill and Shelburne.

Currently, with the towns of Monroe, Hawley, Leyden and Charlemont are not members of the MTCP-funded Franklin/Hampshire STOPP Coalition, so CPHS is looking into expanding the MTCP partnership into these towns using DIG funding. FHSTOPP Coalition staff would do the implementation work.

Type of Health Initiative	Description of Health Initiative	Stage of Implementation for Health Initiative[2]	Description of Policy Change Component	Stage of Implementation for Policy Component[3]	Which Stakeholders are Involved?
Tobacco	Updating local tobacco regulations to one uniform regional standard	In progress	Yes	In progress	FH STOPP Coalition, CPHS member boards of health.

WORKFORCE QUALIFICATIONS

CPHS has 2 staff members that are partially funded through DIG. Both are existing staff that meet the workforce recommendations set forth by DIG.

Staff Position (DIG Funding only)	New Staff or Existing Staff	Are There Written Qualifications in Place for Staff Employed through DIG Funds?	Does Each DIG-Funded Staff Member Meet Workforce Recommendations?
Public Health Nurse	Existing Staff	Yes	Yes [Bachelor of Nursing, PhD(c) in Science of Nursing program]
Health Agent	Existing Staff	Yes	Yes [MS, Registered Sanitarian, Certified Health Officer, many additional public health certifications]

OTHER COLLABORATIVE EFFORTS/ACCOMPLISHMENTS

This table lists any additional collaborative efforts undertaken by CPHS or any accomplishments they have achieved.

Additional Health Focus Area	Description	Collaborating Partners	If other than DIG funding, what is the funding source?
Lyme Disease Prevention and Treatment	Public education on Lyme Prevention, including trail signs, bus signs, billboards, and tick ID cards.	CPHS Member Boards of Health and Highway Departments, Franklin Land Trust, MA DCR, Trustees of Reservation, Audubon Society, Northfield Mountain Recreation Area, Zoar Outdoor, Berkshire East, and others	DIG and DPH MAHB BOH Mini-Grant
Chronic Disease Self-Management	Public Health Nursing project to teach an evidence-based curriculum to people living with chronic disease	Franklin County Home Care, Local Senior Centers and Councils on Aging, GCC School of Nursing, Baystate Franklin Medical Center	Franklin County Home Care Baystate Franklin Medical Center DON funds
Green Cleaning in Food Service	Project involving surveying food service operations about their use of potentially hazardous materials, distributing information about alternatives; doing a post-survey	UMass Toxics Use Reduction Institute (TURI), Berkshire County Boards of Health Association, Pittsfield, Williamstown, Lanesboro Health Departments, and Foothills Health District	UMass Toxics Use Reduction Institute (TURI)
Mercury Thermometer Exchange	Available at all Public Health Nurse Wellness Clinics	Franklin County Solid Waste Management District	N/A
Emergency Dispensing Site Planning and Exercise	Work with local Public Health preparedness coalition and local EDS regions to plan and implement flu clinics as EDS drills.	Local Boards of Health, Mohawk Area Public Health Coalition (MAPHCO)	DIG, MAPHCO, town funds

This report was prepared on January 2014 by the Institute for Community Health. If you have further questions about its content, please contact Justeen Hyde at jhyde@challiance.org or 617-449-6684.