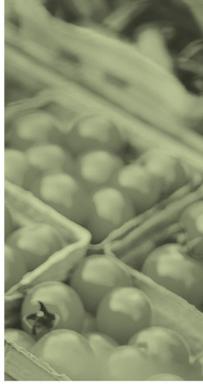


# GREATER MONADNOCK COMMUNITY HEALTH IMPROVEMENT PLAN



Setting the strategic direction for  
the Healthy Monadnock initiative  
**UPDATED NOVEMBER 2020**



# Overview

The Greater Monadnock Community Health Improvement Plan (CHIP) is a product of the Leadership Council for a Healthy Monadnock (LCHM) and all CHIP Workgroup members with support from Cheshire Medical Center. This plan incorporates the input of numerous public health partners and community members. The LCHM is grateful for the many partners who contribute their passions, knowledge, and perspectives to ensure that all Monadnock Region residents have the opportunity to achieve their highest potential for health.

The purpose of the CHIP is to provide a roadmap to focus and solidify community health improvement activities in the Greater Monadnock region. This process began in June 2015 when the Leadership Council for a Healthy Monadnock reviewed the State Health Improvement Plan and identified local needs and assets that were in alignment with the state plan. This led to the creation of the first CHIP in 2015.

Progress has been made since 2015 and the LCHM committed resources to meaningfully update the CHIP. The goal is that with sustained and aligned efforts, diverse community partners can accelerate progress on improving the overall health of people and places in the region, while prioritizing the reduction of health disparities.

The CHIP is not intended to address all health issues facing residents in the Monadnock Region, nor does it provide information on every program and initiative that is taking place in the region. However, the CHIP can be used by a wide variety of organizations to inform their own health-related strategic planning and better align their efforts with existing work. The information in the CHIP can also be a resource to officials, employers, planners, and others to learn about and measure progress towards important health targets. The CHIP is intended to be a living document that can be revisited and updated to meet the evolving needs of the region and ensure that these efforts continue to be collaborative and coordinated.



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# Introduction of the Community Health Improvement Plan

The Leadership Council for a Healthy Monadnock (LCHM) recognizes the value community health plays in the social and economic well-being of its neighborhoods, towns, and communities. Improving the health of the entire region is essential to enhancing one’s quality of life. One of the roles of the LCHM is to oversee the Healthy Monadnock initiative as well as be the public health advisory council for the Monadnock Region.

The LCHM has led the effort to update a detailed and evolving plan to improve the health of all residents living and working in the Monadnock Region. The LCHM and its partners are committed to placing equity at the forefront of the work. Through both the community health improvement planning and implementation phases, the LCHM has strived to keep asking, “Who is not thriving?” and “How will those experiencing inequities continue to be engaged?” The answers to these questions will help shape public health strategy implementation decisions.

While progress has been made, there is more work to be done. The LCHM’s vision for the updated CHIP is to continue to be mindful of inequities; and to use their sense of agency and authenticity to bring this topic to the forefront of community conversations. This plan outlines the priority areas and goals community members have co-designed in an effort to advance health in the Monadnock Region.

The LCHM defines the Monadnock Region as all 23 municipalities in Cheshire County and the 10 western-most towns in Hillsborough County, which is in alignment with the Greater Monadnock Public Health Network, one of 13 Public Health Networks in New Hampshire.

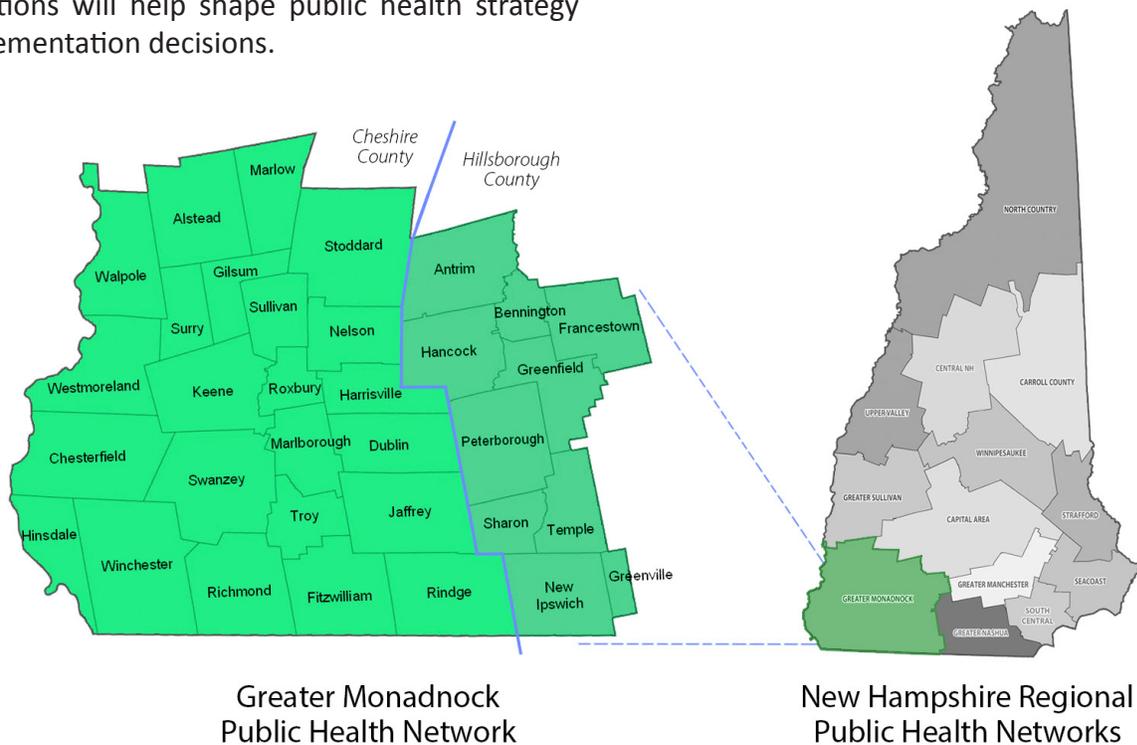


Figure 1: Map of the Greater Monadnock Public Health Network Region

The Greater Monadnock CHIP outlines priority areas and sets the strategic direction for the Healthy Monadnock initiative, along with aligning and raising up regional health priorities.

Figure 2 shows key planning and implementation milestones achieved to date. The LCHM believes that utilizing skills based on the Community of Solutions framework are necessary to lead community transformation work. This framework advances the following set of interconnected skills communities must lead from within, lead together, lead for outcomes, lead with equity, and lead for sustainability in order to achieve a culture of health.

Ideally, city, town, and county government leaders, non-profits, businesses, and residents will clearly see how they fit into the implementation of the CHIP. It is the goal of the LCHM that people and organizations will review this plan and determine what specific role they can play in supporting the improvement of health outcomes in the region. This plan can be used as policies are being developed and revised as well as when workgroups and coalitions are being created and evolve. The plan can be modified as needed when local conditions change.

Starting in 2020, the CHIP Priority Areas will be:

- Behavioral Health,
- Emergency Preparedness,
- Food Access & Active Living,
- Healthcare Access, and
- Protective Factors & Risk Factors.

Criteria for ranking the priorities were based on regional interest and current momentum as well as impact and feasibility. In 2017, LCHM members, subject matter experts, voices of lived experience, and interested parties, among others were invited to be join priority area workgroups, members to advance this work by developing goal statements and moving from a planning to action.

The workgroups range from seven to over 15 participants. The previous Tobacco Use and Substance and Alcohol Misuse Workgroups elected to change their name to Protective Factors and Risk Factors in an effort to focus more on root causes of addiction and less on specific substances. The original Obesity Workgroup also elected to change their name to Food Access and Active Living to more appropriately convey the true work being done.

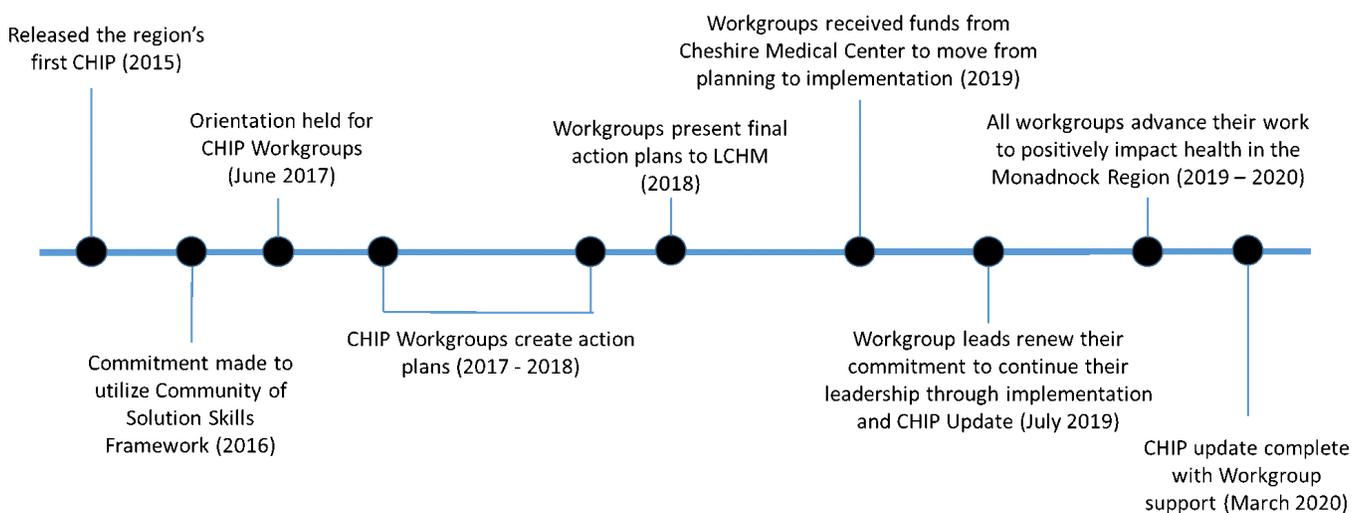
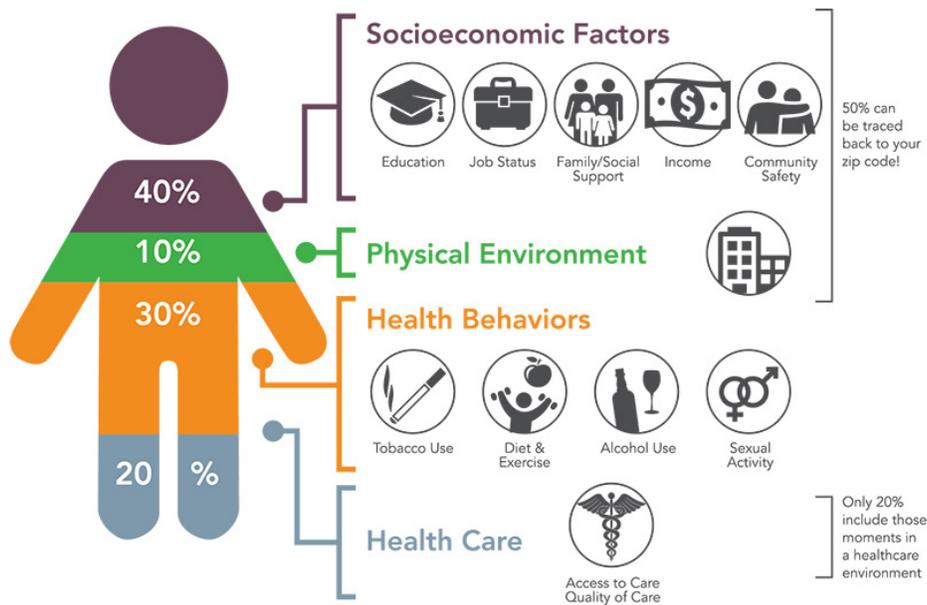


Figure 2: Greater Monadnock Community Health Improvement Plan Timeline

# Social Determinants of Health (SDoH), Equity & Trauma

The LCHM and all the CHIP Workgroups utilized very broad definitions of health and equity. Health is so broad that all sectors are considered key players in improving health in the Monadnock Region. Since 2015, the Monadnock Region has made a renewed commitment to address root causes of poor health outcomes. Through working directly with community members, service providers, workplaces, not-for-profit agencies, and others, the LCHM supports a wide range of opportunities from programs to policy, system, and environmental changes.

The LCHM knows that social determinants of health, equity, and exposure to trauma impact health outcomes; they do not however impact all CHIP priority areas equally. This section reflects a process that was used to engage stakeholders on the ground level in ranking which SDoH and equity lenses affect their priority area the most. This section is a reminder that each priority area can be viewed through many lenses which help to address equity and target interventions in the most impactful ways.



Source: [Institute for Clinical Systems Improvement \(ICSI\)](#) and [Omar Pineda Jr.](#)

Figure 3: Social Determinants of Health Model

## Social Determinants of Health (SDoH)

In the Monadnock Region there is a high degree of overall good health for most, but not for all. The [Centers for Disease Control and Prevention](#) (CDC) recognizes that conditions in the environments in which people are born, live, learn, work, play,

worship, and age affect a wide range of health, functioning, and quality of life outcomes and risks. These conditions are known as Social Determinants of Health (SDoH).

The LCHM understands that poverty limits access to healthy foods and safe neighborhoods, and that more education is a predictor of better health. The LCHM also acknowledges that differences in health are striking in communities with unstable housing, low income neighborhoods, poor air quality, and lack of living wage jobs. Fifty percent of one’s health outcomes is directly linked to socio-economic and physical environment factors.

Because of these facts, the CHIP is framed from a SDoH model as exemplified in Figure 3.

The US Department of Health and Human Service’s (DHHS) [Healthy People program](#) has organized [literature summaries](#) around the key domains through which the CHIP Workgroups will address social determinants of health in their work.

## Equity

Equity is defined in a few ways around the world. The [Robert Wood Johnson Foundation](#) (RWJF) explains it like this, “Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality

education and housing, safe environments, and healthcare.” Equity is visually shown Figure 4. Simply put, equity is providing people what they need to thrive, not providing everyone the same thing. Some components of equity are: age, ethnicity, gender, income, race, veteran status, and zip code.



Source: [Robert Wood Johnson Foundation](#)

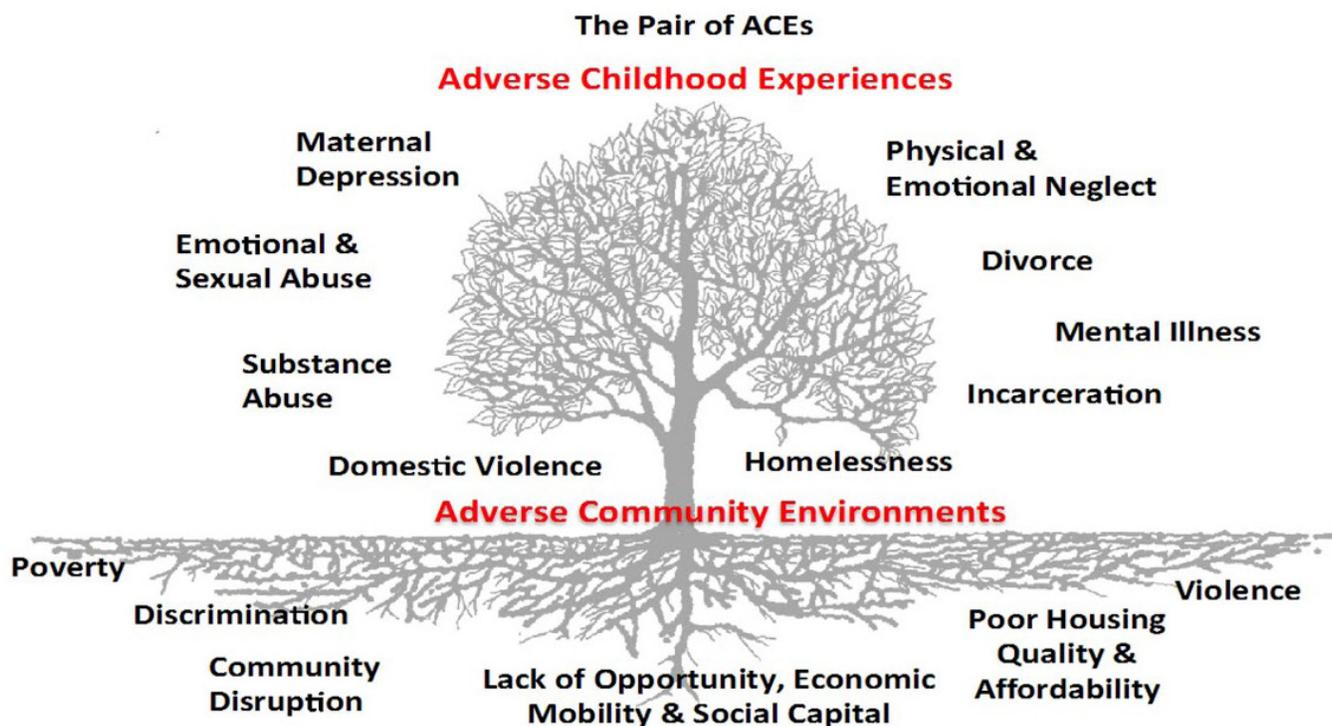
Figure 4: Visual Explanation of Equity

# Trauma

The LCHM acknowledges the pervasiveness of trauma across the Monadnock Region’s population, the breadth of effects on all areas of health, and the importance of trauma-sensitive care. Trauma results from an event, series of events, or set of circumstances experienced individually or collectively as harmful or life-threatening with lasting adverse effects on daily functioning, and mental, physical, social, emotional and/or spiritual well-being. Integrating six core principles of trauma-informed care into the CHIP can prevent further harm and promote better outcomes, particularly by addressing trauma-driven health disparities.

The principles include safety, trustworthiness and transparency, collaboration, empowerment, choice, and intersectionality. Essential components of a trauma-informed policy are the valuation of lived experience (indigenous knowledge and authentic understanding) and acknowledgment of specific populations’ disproportionate experience of trauma due to structural inequalities.

Adverse Community Environments can lead to Adverse Childhood Experiences (ACEs). Figure 5 depicts the relationship between poverty, lack of opportunity, violence, poor housing and other environmental factors and ACEs such as abuse, homelessness, neglect, and mental illness.



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Source: [GWU Center for Community Resilience](#)

Figure 5: Framework for Addressing Adverse Childhood & Community Experience

# Community Health Improvement Plan Priority Areas

This table summarizes the equity and Social Determinants of Health (SDoH) lenses decided on by the workgroups by priority area. These lenses allow the LCHM to assess both quantitatively (such as data, numbers, counts, and percentages) and qualitatively (such as stories and experiences) where the work will have the greatest impact. By considering all these factors and having a more holistic approach to population health improvement, LCHM partners can more appropriately and with a deeper lasting effect impact the health and well-being of those in the Monadnock Region.

Priority Area	SDoH Lenses	Equity Lenses
<b>Behavioral Health</b>	<b>Social and Community Context</b> Civic participation, discrimination, incarceration, social cohesion	Race, Ethnicity, Age, Gender, Veteran Status
<b>Emergency Preparedness</b>	<b>Economic Stability</b> Employment, Food Insecurity, Housing Instability, Poverty	Income
<b>Food Access &amp; Active Living</b>	<b>Neighborhood and Built Environment</b> Access to foods that support healthy eating patterns, crime and violence, environmental conditions, quality of housing	Zip Code
<b>Healthcare Access</b>	<b>Health and Healthcare</b> Access to health care, access to primary care, health literacy	Race, Ethnicity, Age, Gender, Veteran Status
<b>Protective Factors &amp; Risk Factors</b>	<b>Economic Stability</b> Employment, Food Insecurity, Housing Instability, Poverty	Income

Figure 6: SDoH & Equity Lenses by CHIP Area

Priority Area Key	
<b>Goals</b> 	<i>These concepts are what each priority area workgroup has set as focus of their efforts.</i>
<b>SDoH/Equity Main Lens</b> 	<i>These lenses allow the LCHM to assess where the work will have the greatest impact.</i>
<b>Strategic Partner</b> 	<i>These groups work as partners with the priority area workgroups in the assessment, planning, implementation and evaluation of the priority area goals.</i>

# Behavioral Health

## Goals



1. **Foster an accepting community** that supports positive behavioral health.
2. **Enhance behavioral health** of adults and youth in the region.
3. **Ensure that all people** in the region have the opportunity for a life free from violence, trauma, abuse, and neglect.
4. **Enhance behavioral health** of adults and youth in the region through improvement of social connections among residents and their communities.

## SDoH/Equity Main Lens



### Social and Community Context

Civic participation, Discrimination, Incarceration, Social cohesion

### Equity

Race, Ethnicity, Age, Gender, Veteran Status

## Strategic Partner



**Monadnock Family Services**

Behavioral Health is as important to overall health as any other condition a person may experience in their lives.

Just as heart, lung, circulatory, dental, musculoskeletal and any number of physical dimensions contribute to the overall health of an individual, so do behavioral dimensions, such as the ways individuals process information, experience emotions, cope with life's stresses, or react to overwhelming setbacks. Mental health affects everyone.

Rather than existing in isolation, physical and emotional health quite often influence each other. For example, medications to treat behavioral health issues may increase the risk for cardiovascular conditions and conversely, cardiovascular conditions may contribute to the onset of conditions like anxiety or depression.



**... the decrease in average daily time spent socializing among 65+ year-olds in the United States from 2003-2018.**

*U.S. Bureau of Labor Statistics, 2018*

*Figure 7: Trend in Socializing Among Older Adults*

In developing this plan, the Workgroup purposefully recognized the following:

- mental and physical health are intertwined and affect everyone;
- mental health conditions can be as disabling as any physical condition;
- mental health conditions often come with a social stigma against the person experiencing these challenges;
- this stigma must be replaced with an understanding that mental health is equal to physical health in all aspects; and,
- there is a separate and comprehensive section of the CHIP dedicated specifically to protective factors and risk factors that impact substance misuse.

Many positive changes are already occurring in the region and beyond. For example, while the medical field had traditionally treated mental and physical health conditions in isolation, more and more providers and insurance companies are integrating their care and treatment plans to include all aspects of health.

There are also many examples of community education about mental health conditions, violence prevention programs, access to mental health services in schools, and an array of treatment providers in the region that can offer professional treatment services. One peer support agency provides emergency crisis services that are available every hour of every day of the year.

**Mental well-being is a fundamental component of WHO's definition of health. Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities.**

*World Health Organization*



# Emergency Preparedness

## Goals



1. **Provide training** and exercise opportunities to regional partners.
2. **Develop a regional strategy** to promote personal preparedness.
3. **Promote personal and family preparedness** for those living in poverty.

## SDoH/Equity Main Lens



### Economic Stability

Employment, food insecurity, housing instability, poverty

### Equity

Income

## Strategic Partner



**Greater Monadnock Public Health Network –  
Public Health Emergency Preparedness**

National health security is attained when the nation and its people are prepared for, protected from, and resilient in the face of incidents with health consequences. Public Health Emergency Preparedness is a regional priority to support municipalities and community members to prepare for and respond to public health emergencies that may happen in the region such as flooding, long-term power outages, road washout or infectious disease.

The focus of this priority area is to help raise awareness as well as initiate and sustain actions associated with personal preparedness for all. During the pre-disaster phase, this work involves engaging the public to create a healthy, resilient, sustainable community vision around emergency preparedness. Through a regular jurisdictional risk assessment and hazard vulnerability assessment there are defined goals and priorities. Multi-sectoral stakeholders are regularly assembled to determine roles and responsibilities and build relationships prior to a high stress emergency



**“Cost-burdened” households in Cheshire County. (Housing costs exceed 30% of total household income)**

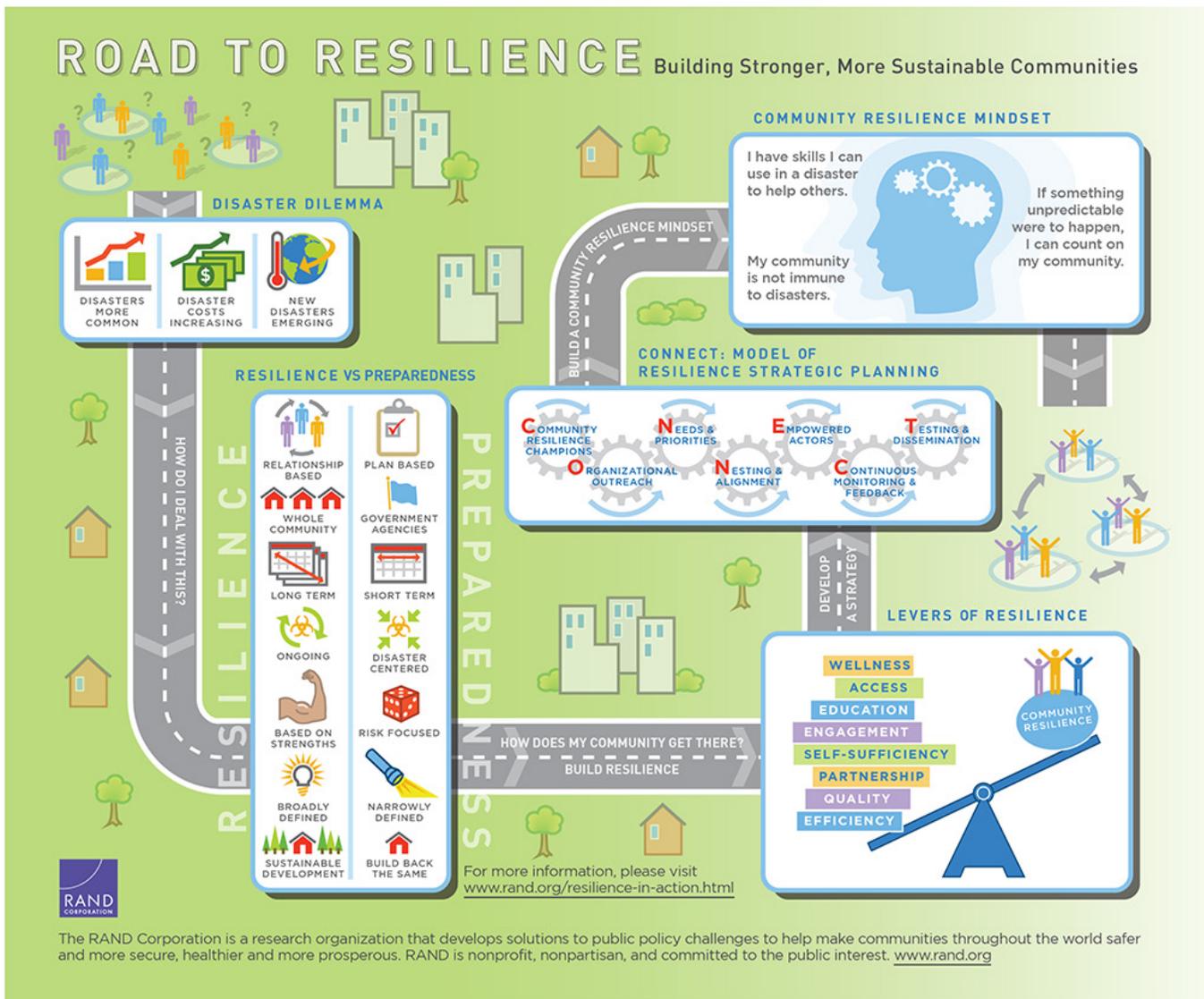
*American Community Survey, 2017*

*Figure 8: Cost-Burdened Households*

response. Through this planning phase, key leaders and community champions are able to have a clear picture of next steps to seek and apply resources, as well as set benchmarks and targets to sustain a healthier, more resilient, and sustainable community.

Psychological resilience is a key element of overall community resilience. Different types of emergencies and disasters will result in different medical needs; but all traumatic events will result

in behavioral health casualties. Behavioral health is an all-hazards concern. No single priority area stands alone, and all priority areas are impacted in various ways by SDoH, equity, and trauma. Integration can be seen in this work through educational offerings, such as psychological first aid and similar trainings that help to increase community member preparedness.



Source: **RAND Corporation Road to Resilience**

Figure 9: Road to Resilience

# Food Access & Active Living

## Goals



1. **Expand local food access** to include low and moderate-income families.
2. **Encourage support** of local food system.
3. **Educate consumers** on the benefits of locally produced food, especially youth and low-income populations.
4. **Promote active living** through physical activity, active transportation, and recreation.

## SDoH/Equity Main Lens



### Neighborhood and Built Environment

Access to foods that support healthy eating patterns, crime and violence, environmental conditions, quality of housing

### Equity

Zip Code

## Strategic Partner



**Monadnock Farm and Community Coalition (MFCC)**

**Monadnock Alliance for Sustainable Transportation**

In the Monadnock Region, there has been a concerted effort to increase local healthy food access points, such as providing Electronic Benefit Transfer (EBT) machines at farmers' markets and locations that accept Supplemental Nutrition Assistance Program (SNAP) benefits. As of January 2020, the region had 13 access points. As the work evolves, voices of people who have experienced food insecurity are being engaged to learn new and unique ways to increase utilization of these access points and increase participation in programs like Granite State Market Match where people utilizing SNAP benefits are able to receive produce for half-price.

Additional work is underway with schools, food establishments, businesses, and other sectors to help provide increased access to local food, which helps farmers and producers as well as community members. Many new and innovative ideas are



# 10,890

**Cheshire County Households with low access to grocery store.**

*Figure 10: Households with Limited Access to Healthy Food*

being explored, such as a Veteran’s Appreciation program to provide farmers’ market vouchers to veterans during the month of September, and investigating opportunities for new ideas such as an edible playground. Access to free seeds and garden-tools-on-loan are now provided for all community members at the Keene Public Library. Community Garden Connections (CGC) at Antioch University New England continues to work to support social service agencies and home gardeners in their efforts to grow food, and to-date has donated over 6,000 pounds of produce to the Community Kitchen in Keene from the Westmoreland Garden Project.

Active living focuses on traditional and nontraditional ways for people of all ages to be active. The public health sector has become less concerned about excess weight and more focused on overall physical health, which can influence people’s ability to carry out daily activities of living.

Not all communities have equitable access to resources or environments that support active lifestyles. Poor physical health is not just a matter of individual behavior. It also involves supporting municipalities to adopt complete streets policies, such as safe routes to school programs, age-friendly planning initiatives, such as increased access to recreation areas, and providing opportunities for people to be physically active at work.



# Healthcare Access

## Goals



1. **Improve access to healthcare** through transportation via increased availability of volunteer drivers to positively impact health, well-being, and independence.

## SDoH/Equity Main Lens



### Health and Healthcare

Access to health care, access to primary care, health literacy

### Equity

Race, Ethnicity, Age, Gender, Veteran Status

## Strategic Partner



**Community Volunteer Transportation Company (CVTC)**

By making healthcare access a regional priority, the LCHM is committing to the importance of access in both traditional and nontraditional ways. People having health insurance and understanding their benefits is one piece of a larger puzzle that includes items such as health literacy, appointment availability, and access to transportation.

Independence through transportation is something that can easily be taken for granted. Transportation challenges within the region include a lack of affordable transportation options, limited public transportation services, no weekend or evening public transportation, and limited wheelchair accessible transportation. Increasing access to volunteer driver services, especially in rural areas that lack public transit options, is critical for individuals without personal transportation who often have to rely on family and friends to get about. The current strategy of leveraging volunteers to support transportation needs is resulting in increased healthcare access, as well as increased volunteerism and social connection in the region.



 **34%**

**“Vehicle poor” households in Cheshire County (fewer vehicles than household occupants)**

*American Community Survey, 2017*

*Figure 11: Vehicle Poor Households*

# Protective Factors & Risk Factors

## Goals



1. **Increase regional youth access** to protective factors.
2. **Decrease regional youth exposure** to risk factors.
3. **Continue to shift cultural norms** around substance use in the region through education, awareness, environmental changes, and policy.

## SDoH/Equity Main Lens



### Economic Stability

Employment, food insecurity, housing instability, poverty

### Equity

Income

## Strategic Partner



**Greater Monadnock Public Health Network – Substance Misuse Prevention**

The previous Tobacco Workgroup and Substance and Alcohol Misuse Workgroup merged into one Workgroup, which focused less on specific substances and more on overall prevention. The Protective Factors and Risk Factors Workgroup is focused on upstream opportunities to boost protective factors specifically in youth and young adults, while recognizing the importance across the lifespan.

Young adults with multiple risk factors have a greater likelihood of experiencing substance misuse problems or engaging in other related harmful behaviors, while individuals with multiple protective factors are at a reduced risk.

This priority area is focused on the importance of intervening early and implementing programs and practices that target multiple factors to have the largest impact based on the widely recognized correlations.

Some risk and protective factors are fixed, meaning they do not change over time. Other



**Decrease in household income from 2009 to 2017 among those <25 years-old in Cheshire County**

*American Community Survey, 2017*

*Figure 12: Trends in Household Income*

factors are considered variable and can change over time, which include income level, peer/social group, adverse childhood experiences (ACEs), and employment status. There are also individual-level risk factors, which may include a person’s genetic predisposition to substance use disorder or prenatal exposure to alcohol. Individual-level protective factors include positive self-image, self-control, or social competence.

These factors do not live in isolation. Targeting only one context when addressing a person’s risk or protective factors is unlikely to be successful because people do not exist in isolation. Substance use among young adults is often the result of multiple contributing factors. Young adults are influenced by their specific personality traits or genetics, and also by their relationships with others, the institutions and communities to which they belong, and the broader society in which those institutions are embedded.



Figure 13: Ecological model of risk and protective factors

Risk Factors	Protective
<p>Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems associated with use</p> <p><b>Source:</b> <a href="#">Substance Misuse Prevention for Young Adults</a></p>	<p>Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems</p> <p><b>Source:</b> <a href="#">Substance Misuse Prevention for Young Adults</a></p>
Common Risk Factors	Common Protective Factors
<ul style="list-style-type: none"> <li>• Early initiation of substance use</li> <li>• Internalizing behaviors (depression, anxiety, social withdrawal)</li> <li>• Family history of substance abuse</li> <li>• Family conflict</li> <li>• Academic failure</li> <li>• Availability of substances</li> <li>• Laws/norms favoring substance use, firearms, crime</li> <li>• Income and parental education</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy diet, exercise, and development</li> <li>• Reliable support and discipline from caregivers</li> <li>• Emotional self-regulation</li> <li>• Optimism</li> <li>• Good peer relationships</li> <li>• Economic/financial security</li> <li>• Future orientation</li> <li>• Set of moral beliefs</li> </ul> <p><b>Source:</b> <a href="#">American Mental Wellness Association</a></p>

## Partnerships, Programs, Policy, System, and Environmental changes (PPPSE)

Partnerships, Programs, Policy, System, and Environmental changes (PPPSE) is an approach used to create large-scale, sustainable change. It stresses an awareness that these factors often work hand-in-hand, influence one another, and should all be considered. For example, an environmental change may be implemented due to a newly formed partnership, or a program may be developed to encourage people to follow a new system change. The PPPSE process is not linear, and it functions best when all five elements are working together in unison.

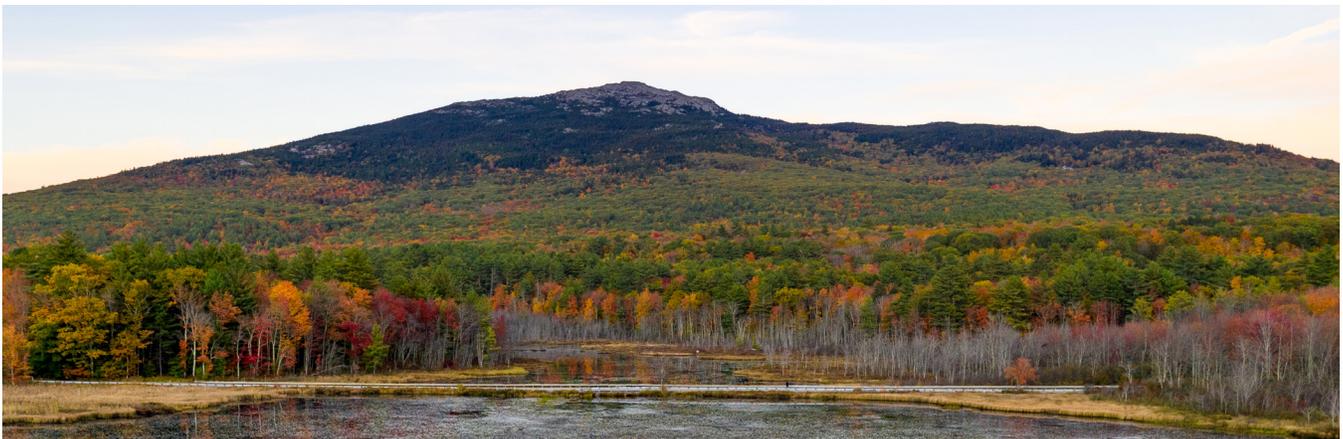
**Partnerships:** A partnership in its most basic form is when two or more people or organizations come together around a common cause—such as the Healthy Monadnock Alliance. Partnerships are key to creating community-wide improvements, not just to share the workload, but also to minimize the duplication of efforts, and to make sure all populations are being represented.

**Programs:** Programs often focus on individual behavior change, and are short term—meaning they have a specified start and end date. Programs are often used as an engagement tool to coincide with a policy and/or environmental change. An example of this is the community-wide Safe Routes to School program that was developed to promote walkability in conjuncture with a new policy.

**Policy Change:** Policy change can happen on an organizational, local, or governmental level and represents the rules and protocols that need to be followed for specific situations. These policies are wide ranging and can include anything from changing the statewide smoking age from 18 to 21, to setting rules for what is or isn't allowed to be served in school cafeterias. Policy change can be incredibly effective in creating lasting change throughout the populations it serves.

**System Change:** System changes involve changes made to the rules within an organizational structure, i.e. “how things are done”, and often work hand-in-hand with a policy change. As an example, this could include a business creating a new system for how employee orientation is run, based on state-wide recovery policies that were recently enacted.

**Environmental Change:** Environmental change is a change made to the physical environment. Environmental changes can be as simple as installing bike signage on already established bike routes, or as complex as sidewalk installation and pedestrian friendly intersections to promote walking and biking.



## Moving the CHIP Forward

As a region, we have a need to set realistic expectations regarding the pace of change. This community-made, succinct CHIP is the first step in the right direction. With clear and manageable goals set by the Workgroups themselves, the community health improvement journey will be both meaningful and attainable.

The Monadnock Region is lucky to have many passionate and dedicated people who spend their days doing what they can to improve the lives of others. This CHIP process has continued to show how many people are dedicated to improvement

and ready for new and continued action. To further support the success of CHIP implementation, the LCHM has made a commitment to support and track the progress to sustain efforts of these priority areas, as well as design a process to change priority areas in the future.

As the LCHM continues into implementation, all who are interested are invited and encouraged to join a CHIP Workgroup to provide their passion, expertise, time, resources, and energy to improve equity and health of those in the Monadnock Region.

To get involved, please e-mail: [healthymonadnock@cheshire-med.com](mailto:healthymonadnock@cheshire-med.com)