

**FREE WEBINAR**

# Rural Realities

**Advancing Health Equity in  
Western MA's Rural Communities**

**Nov 14, 2025  
at noon**

## FEATURED SPEAKERS:



**State Senator  
Jo Comerford**

Hampshire, Franklin,  
Worcester district



**Laura  
Kittross**

Berkshire Regional  
Planning Commission



**Lisa  
Ranghelli**

Public Health Institute  
of Western MA

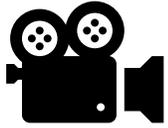


**Phoebe  
Walker**

Franklin Regional  
Council of Governments



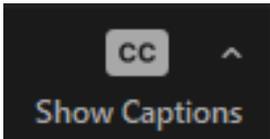
# Housekeeping



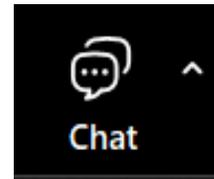
**We are recording this webinar.**



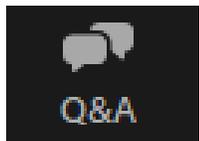
**The recording and materials will be emailed to registrants and posted on our website.**



**Click “Show Captions” to enable automatically generated closed captioning.**



**If you encounter technical issues, please message the host, and we will do our best to assist you in resolving them.**



**There will be Q&A after we hear from the speakers. To submit a question, use the Q&A feature found in your zoom menu.**



**Before you sign off, please take a survey to tell us how we did.**

# What does the data say about our rural communities?

Findings from *Rural Realities: Financial insecurity and health inequities in our rural communities* and the Western MA Community Health Needs Assessments

# What is a rural community?

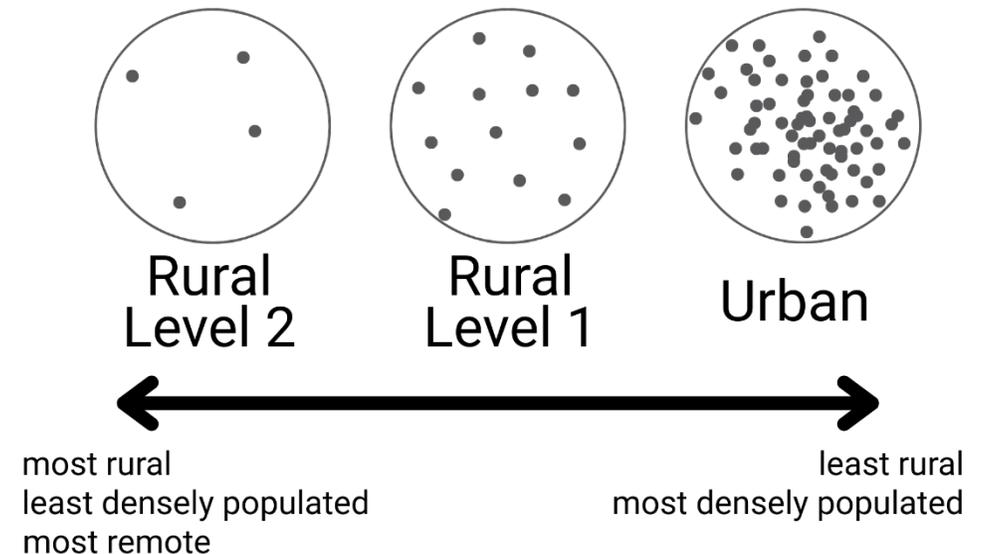
According to the MA State Office of Rural Health, a municipality in Massachusetts is considered rural if it meets **one** of the following criteria:

- Meets at least one of three federal rural definitions at the sub-county level (Census Bureau, OMB, or RUCAs)
- Has a population less than 10,000 people and a population density below 500 people per square mile
- Has an acute care hospital in the town that meets the state hospital licensure definition of a small rural hospital (SRH), or is a certified Critical Access Hospital (CAH)

Adapted from Massachusetts Department of Public Health. MA State Office of Rural Health Rural Definition. Published online November 13, 2018. <https://www.mass.gov/doc/rural-definition-detail-0/download>  
Photo: Gardner Falls, courtesy of Franklin Regional Council of Governments

# Levels of rurality in Massachusetts

- The Statewide Office of Rural Health defines rural communities as rural level one or two using a composite scoring system
- **Rural level two** towns are less densely populated and more isolated from urban core areas than **rural level one** towns
- Throughout this presentation, we will refer to “rural level one” towns as “**less rural**” and “rural level two” towns as “**most rural**”
- All towns that are not rural are defined as **urban**



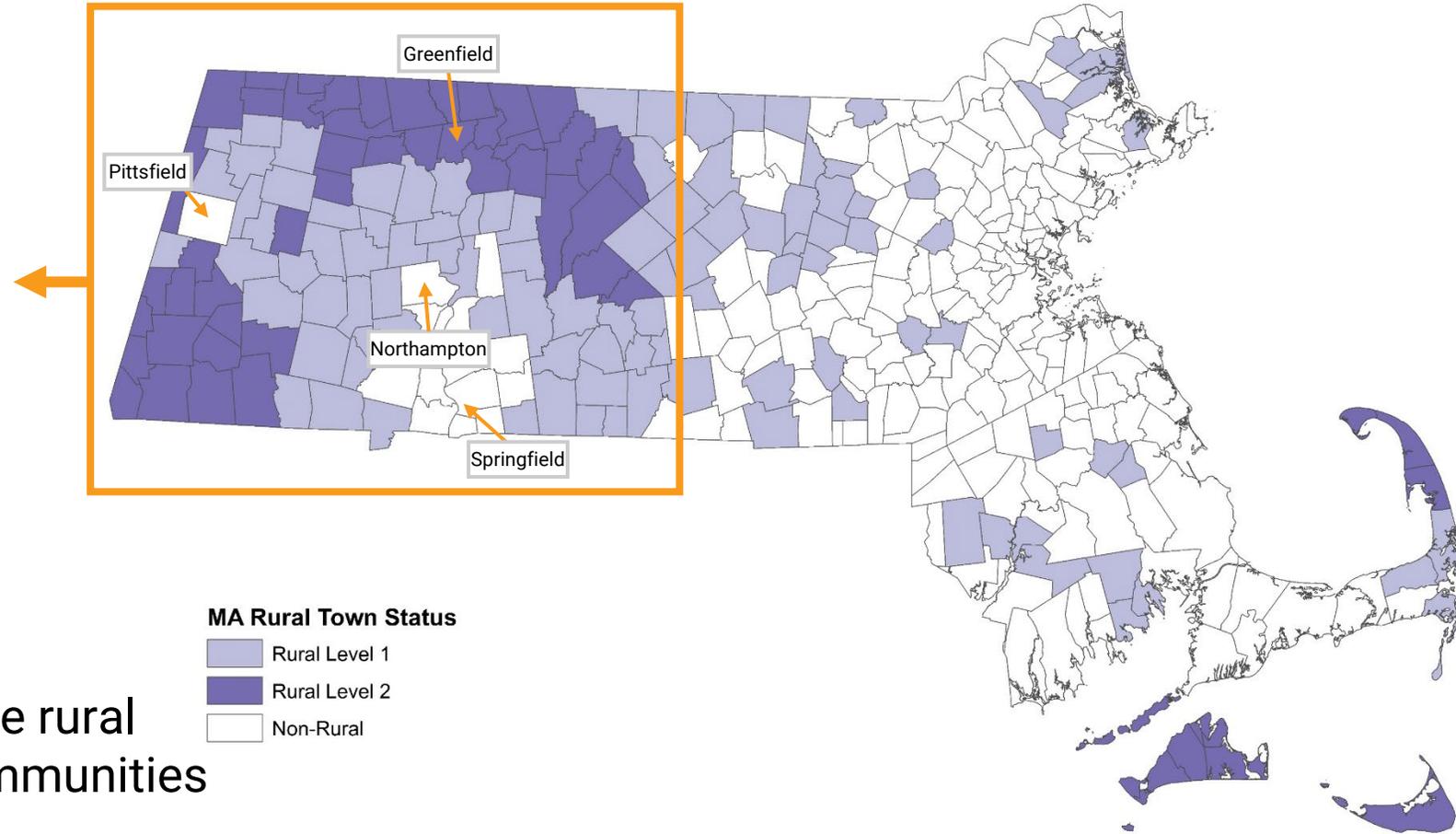
Learn more about how rurality is determined from the MA State Office of Rural Health:

Adapted from Massachusetts Department of Public Health. MA State Office of Rural Health Rural Definition. Published online November 13, 2018. <https://www.mass.gov/doc/rural-definition-detail-0/download>

# Western MA is one of the most rural parts of the state.

## Western Massachusetts has:

- 86 rural communities
- 40 out of the 56 *most rural* communities in MA
- 266,000 people living in rural communities

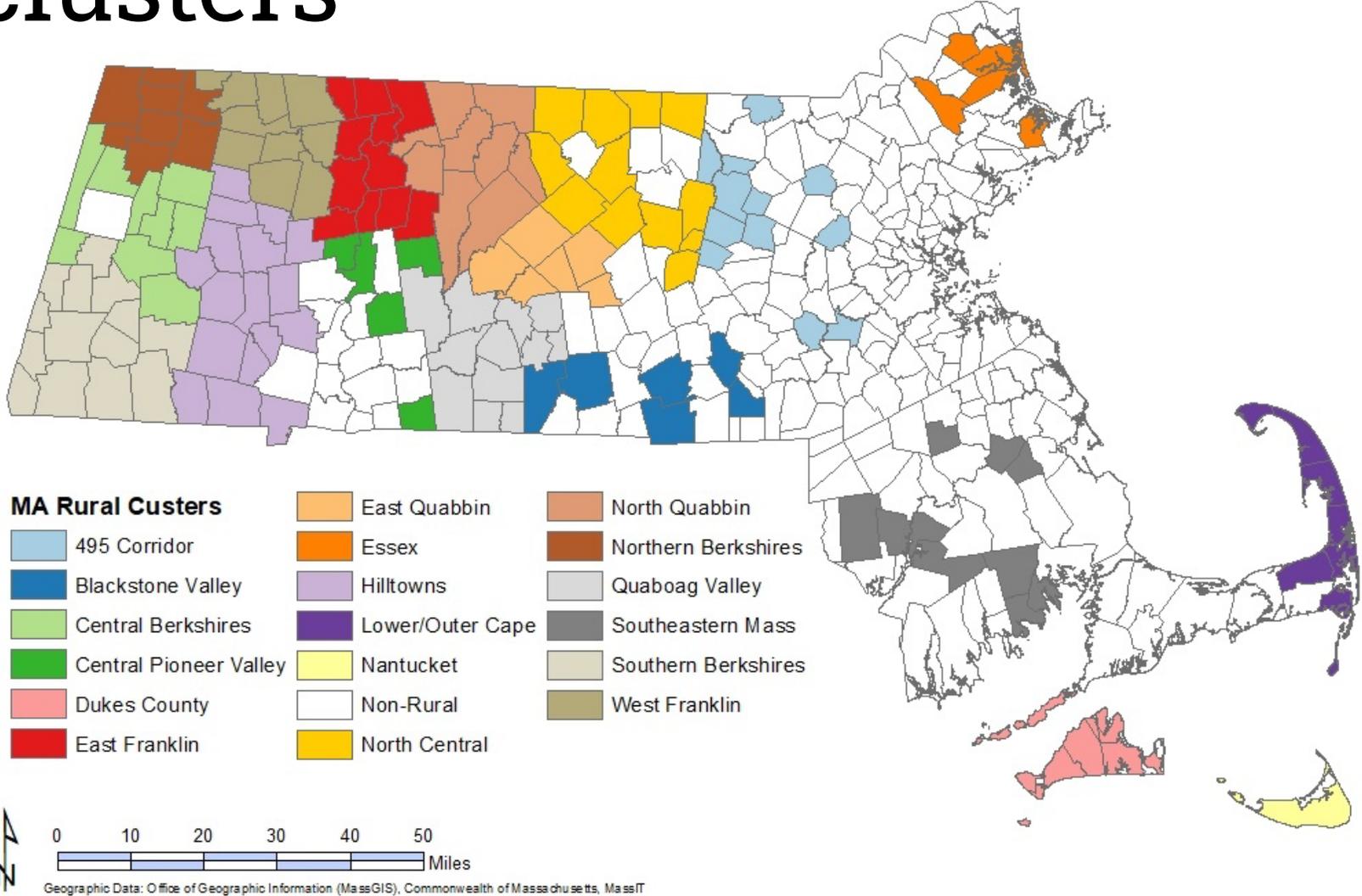


## Statewide:

- 160 out of 351 communities are rural
- 717,000 people live in rural communities

Map: Massachusetts Department of Public Health  
Population data from U.S. Census Bureau. 2019-2023 American Community Survey (ACS), 5-Year Estimates. Published online 2024.

# Rural clusters



# CHNA: Common Rural Themes

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Several cross-cutting themes emerged from focus groups and key informant interviews, impacting rural populations:

**Access to Healthcare:** provider shortages, lack of adequate translation services & culturally responsive care, insurance gaps

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**Mental Health/Substance Use Needs:** increased demand for trauma-informed care, long waitlists, high levels of stress among care givers

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**Transportation Barriers:** limited public transit options especially in rural areas

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**Economic Hardship:** financial stress due to inflation, difficulty meeting basic needs (especially housing, transportation, food)

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**Technology Access and Literacy:** challenges using digital care platforms and telehealth persist

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# CHES Urban and Rural Respondents

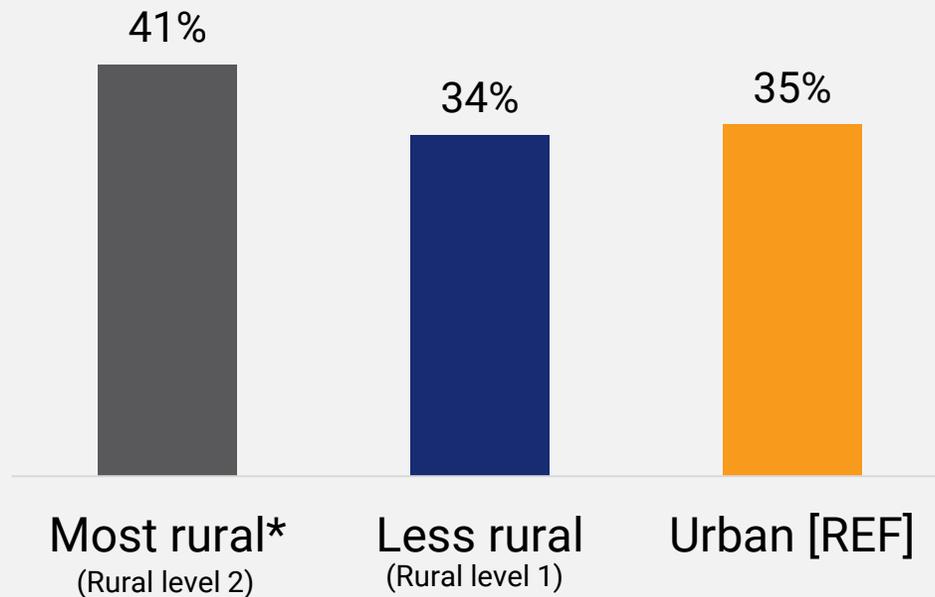
## Percent of CHES respondents from Western MA



Note: Participants had to report their municipality in order to be categorized as urban or rural; responses from those who skipped this question are not included in these data. Percentages displayed on this slide are unweighted.

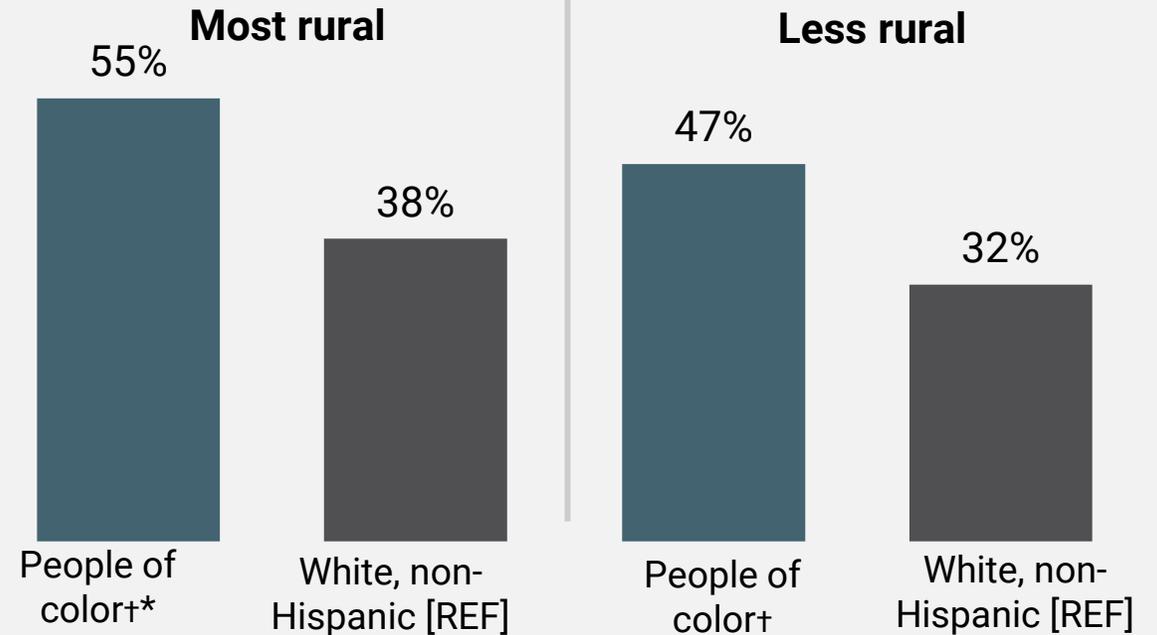
# The *most rural* respondents to CHES have the highest percentage of residents experiencing **trouble paying for basic needs**.

Percentage of CHES respondents in MA who reported having trouble paying for any basic needs



\*Denotes rate is significantly different ( $p < 0.05$ ) compared to the reference group [REF].

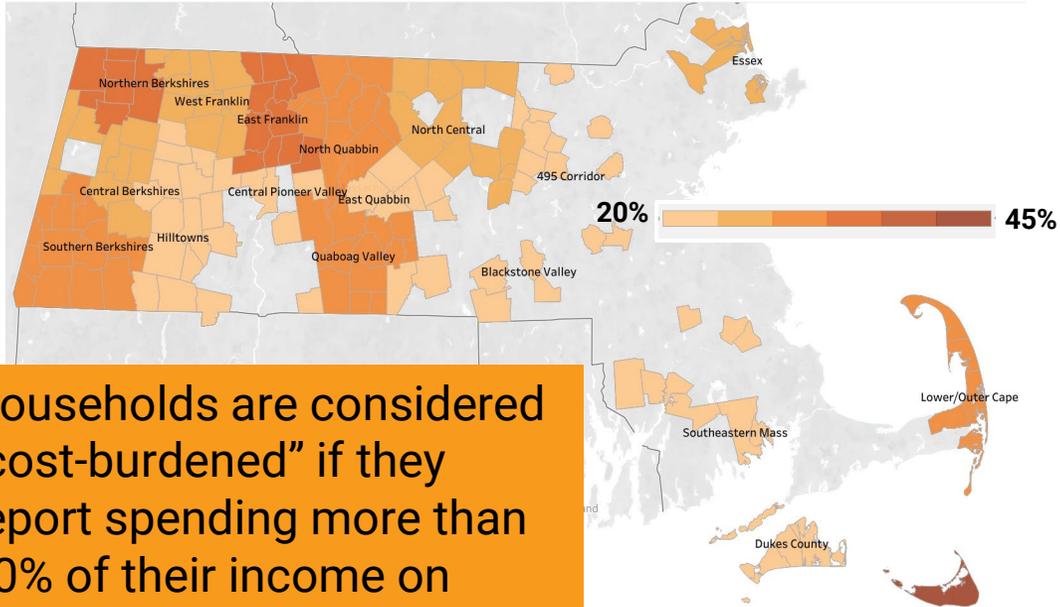
Percentage of rural CHES respondents in MA who reported struggling to pay for any basic needs in the past year



\*Denotes rate is significantly different ( $p < 0.05$ ) compared to the reference group [REF].

† People of color include respondents who reported one of the following race/ethnicities: American Indian / Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern / North African, or Multiracial.

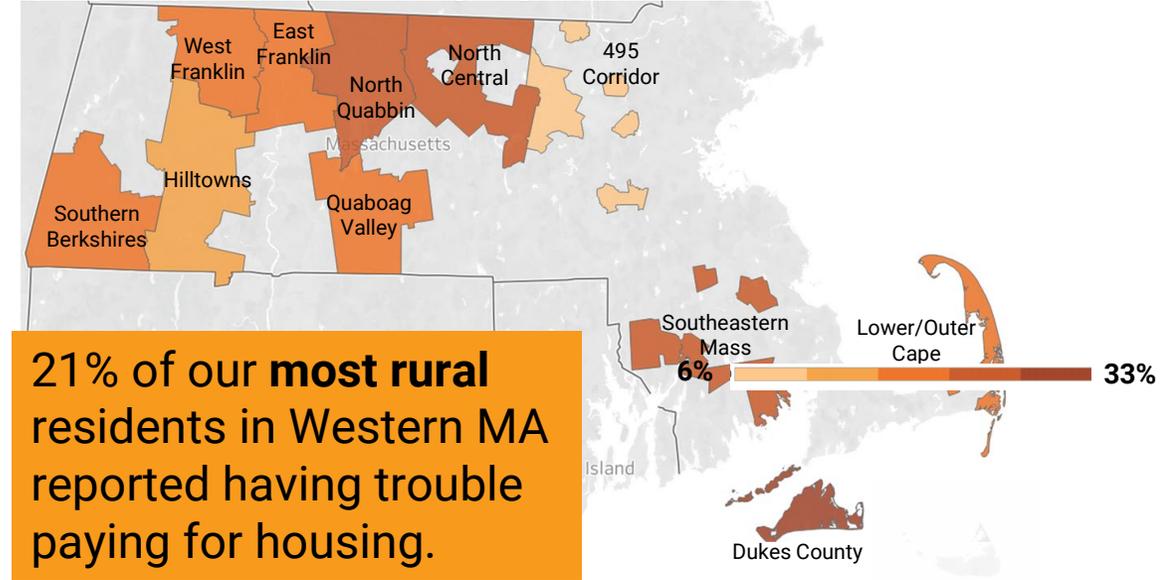
## Cost-burdened households by rural cluster



Households are considered “cost-burdened” if they report spending more than 30% of their income on housing and utilities.

Source: Map data from the U.S. Census Bureau. 2019-2023 American Community Survey (ACS), 5-Year Estimates. Published online 2024.

## CHES respondents who reported trouble paying for housing by rural cluster

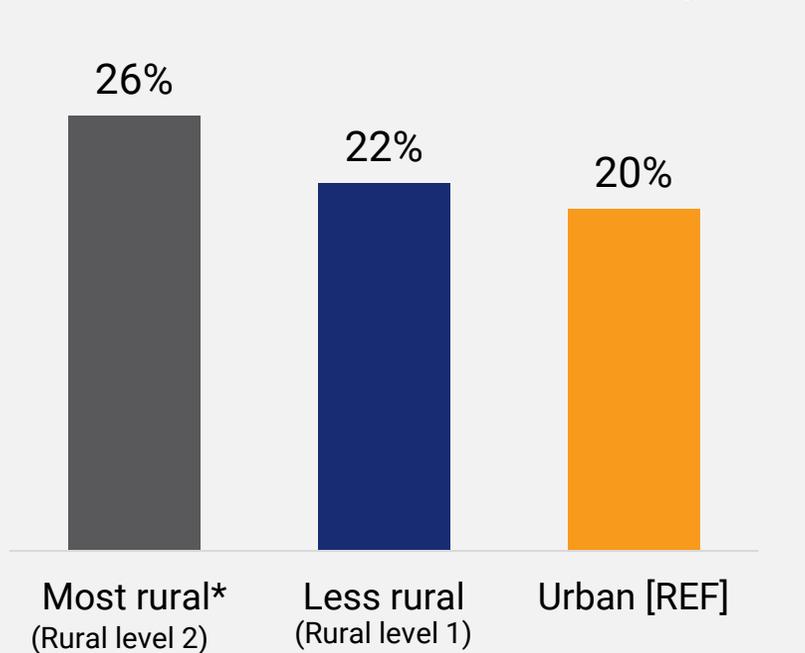


21% of our **most rural** residents in Western MA reported having trouble paying for housing.

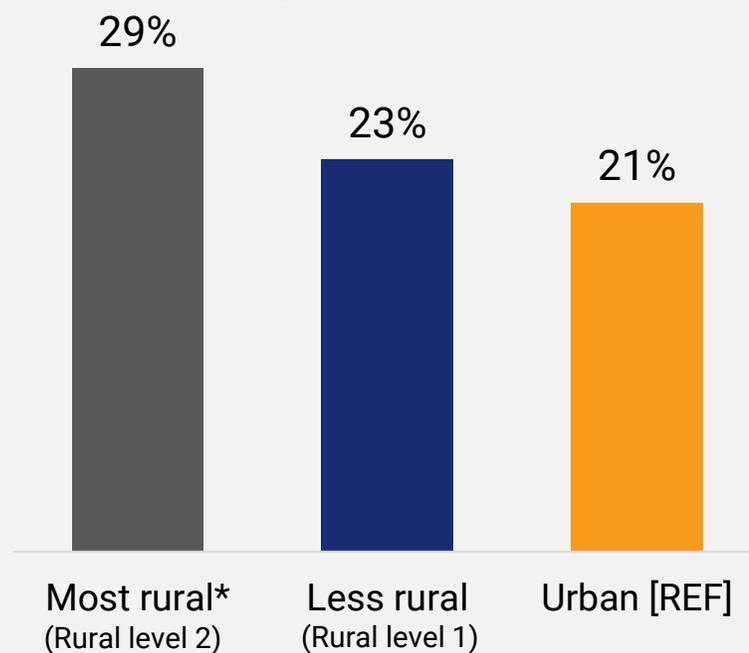
Note: Some geographies may not be shown due to low sample size.  
Source: Map data from Massachusetts Department of Public Health, Bureau of Community Health and Prevention. Published online 2/26/2025.

# The *most rural* respondents to CHES have the highest percentage of residents **working multiple jobs** and residents **without paid sick leave**.

Percentage of respondents in MA who work more than one job



Percentage of respondents in MA who have no paid sick leave at work



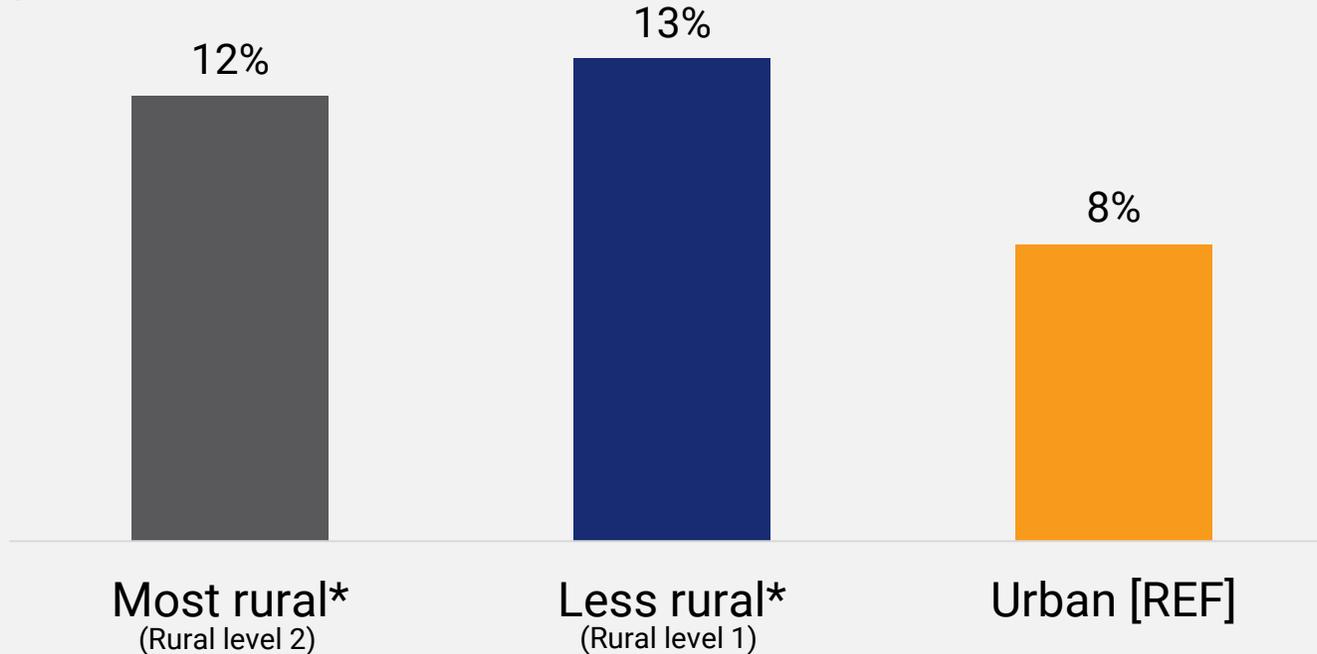
\*Denotes rate is significantly different ( $p < 0.05$ ) compared to the reference group [REF].

Among Western MA respondents from our *most rural* communities (Rural level 2):

- 26% reported having more than one job
- 24% did not have paid sick leave

# Reliable internet is now a basic necessity—yet many rural residents have poor internet.

Percentage of CHES respondents in MA who reported poor internet



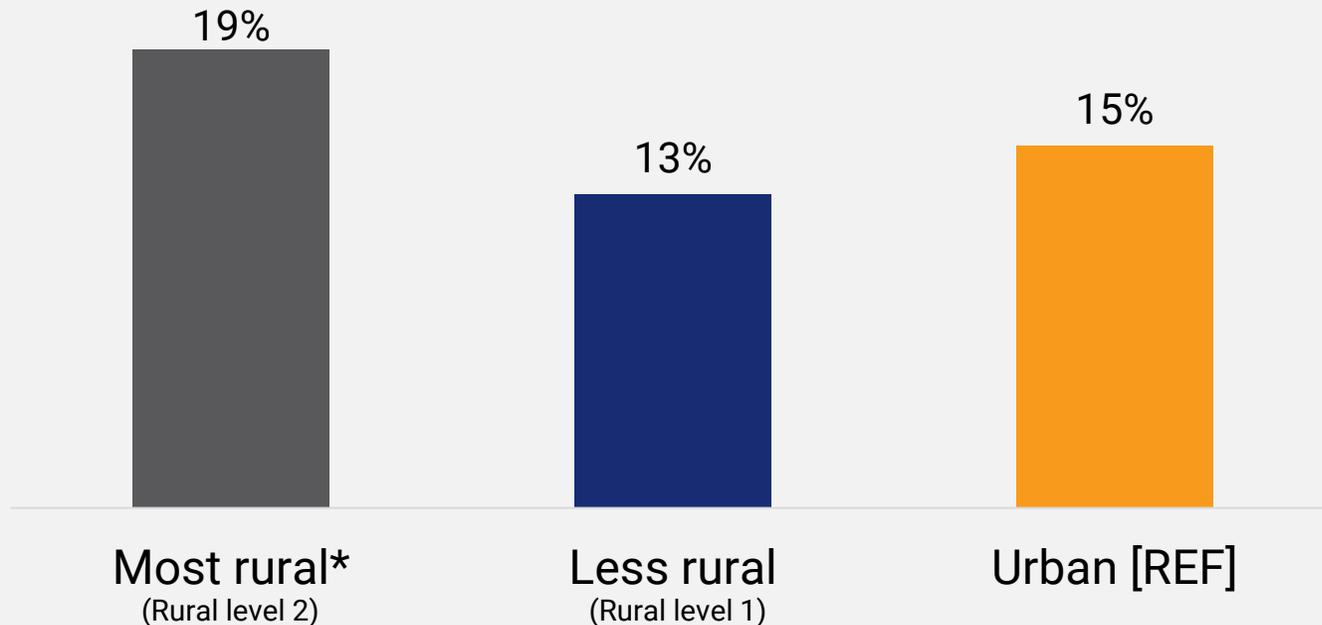
\*Denotes rate is significantly different ( $p < 0.05$ ) compared to the reference group [REF].

Among Western MA respondents from our *most rural* (rural level 2) communities:

- 11% had Internet that does not work well
- 2% did not have Internet

# Rural residents struggle with access to health care.

Percentage of CHES respondents in MA who had unmet health care needs<sup>^</sup>



\*Denotes rate is significantly different ( $p < 0.05$ ) compared to the reference group [REF].

<sup>^</sup>Among respondents 14+ who needed any type of care in the past year, including short-term illness care, injury care, chronic illness care, home and community-based services, mental health care, sexual and reproductive health care, substance use or addiction treatment.

Among Western MA respondents from our *most rural* communities:

- 18% had unmet healthcare needs



# CHNA: Mental Health & Substance Use



The Prevalence of adults with depression increased from before the COVID-19 pandemic.

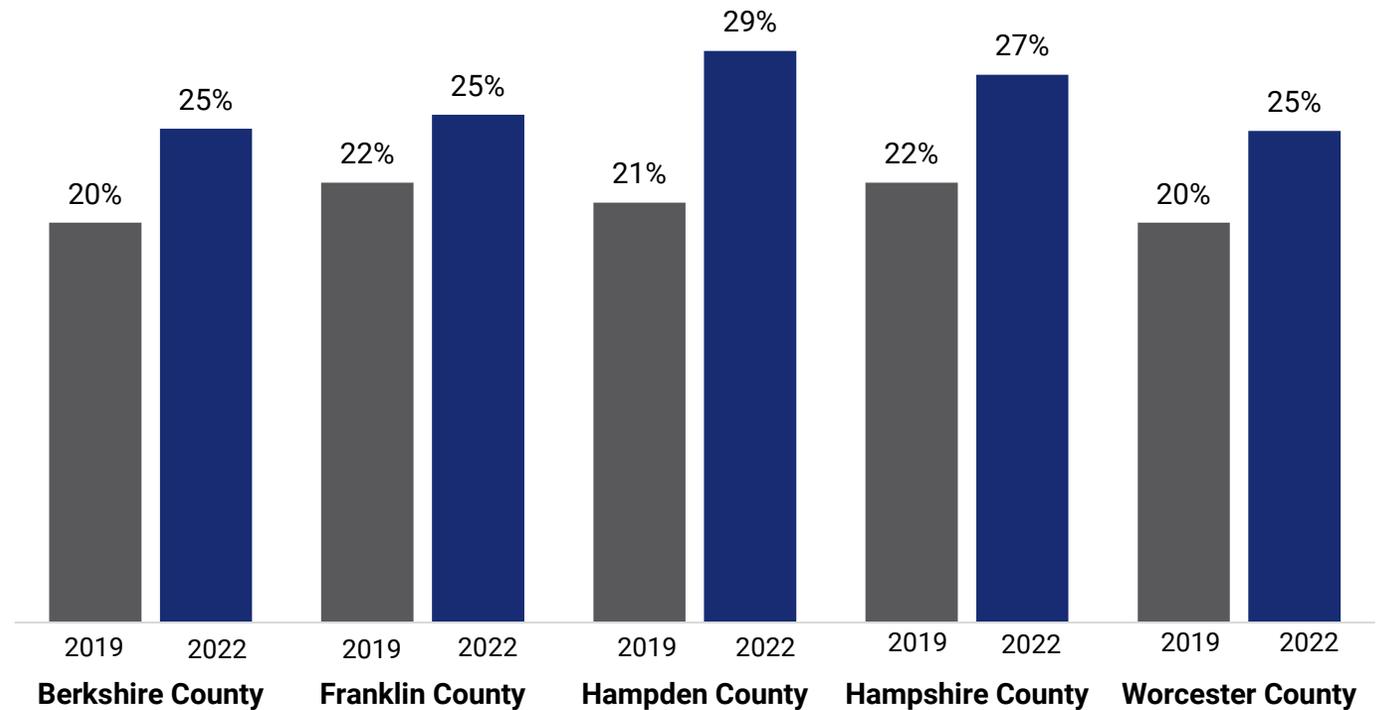


"People are more open to talking about mental health than they were before. That's a step in the right direction."



- Service provider

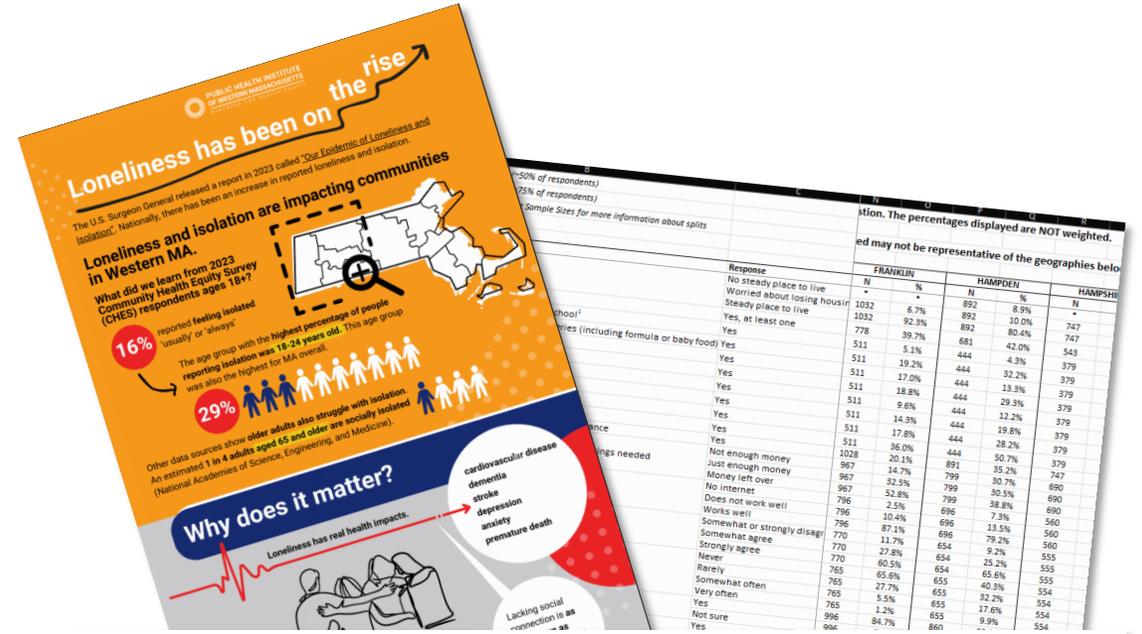
### Depression Rates by Year and County, 2019-2022



# CHEI Resources

Visit the CHEI site at [mass.gov/chei](https://mass.gov/chei)

- Learn more about CHES
- Access CHES data tables, full reports, and dashboard
- Request customized data and 1:1 assistance in using data to support your work



Visit the PHIWM CHEI page at [publichealthwm.org/reports/chei](https://publichealthwm.org/reports/chei)

- View regional data products
- Watch Data and Action workshops

Explore Community Health Equity Initiative Data

[Racial Justice Framing](#) →



Review resources to interpret data with a racial equity lens.

[Access the CHEI Data](#) →



Access the CHEI data dashboard, data tables, and reports.

[Data & Action Resources](#) →

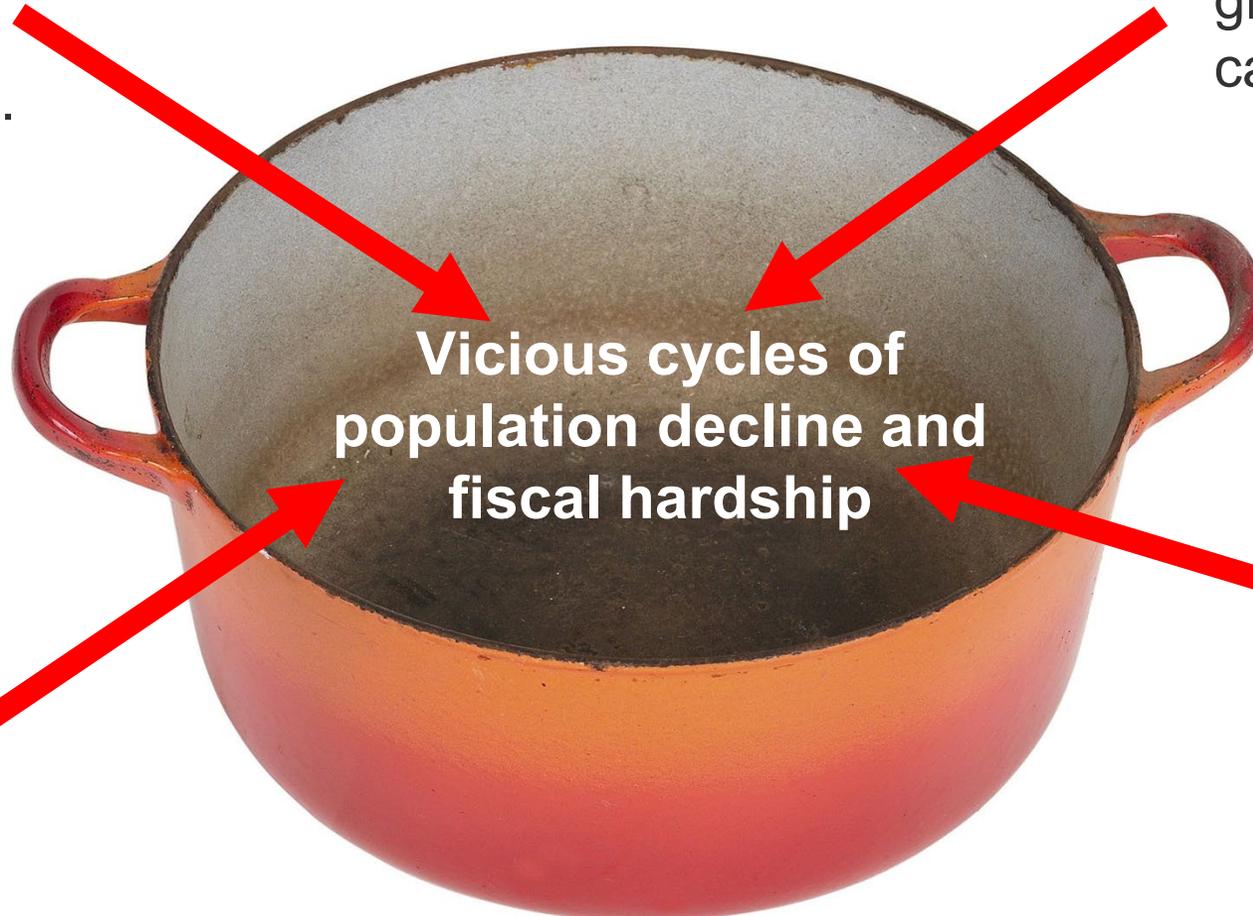


Request customized data analyses and 1:1 assistance in using the data to support your work.

# Rural communities: challenges

Inequitable formulas:  
Chapter 90, PILOT,  
Chapter 70, Unrestricted  
Government Aid,  
MassHire funding, etc.

Competitive disadvantage  
for discretionary funds like  
grants, reduced municipal  
capacity



**Vicious cycles of  
population decline and  
fiscal hardship**

Less access to  
health care, social  
services, public  
transportation

Lack of  
representation on  
statewide  
boards and  
commissions

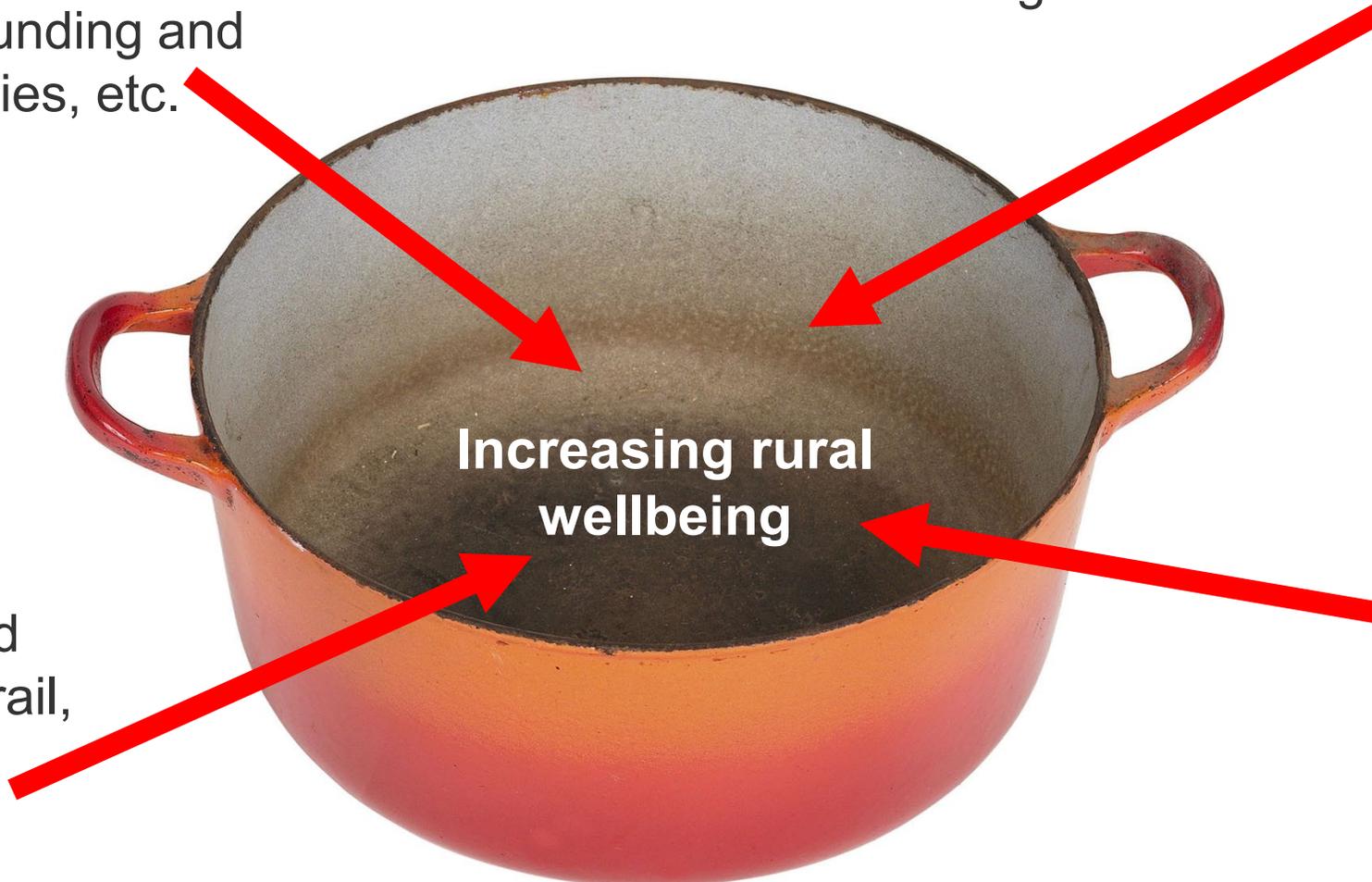
# Rural communities: opportunities

Chapter 90 funding via road miles, PILOT reform, Rural School Aid, Local Education Funding and transportation studies, etc.

Changes to grant programs and scoring criteria; changes to funding for rural-serving entities

Public health shared services, free RTAs, microtransit, dirt road funding, passenger rail, housing production dashboard, etc.

Adding *more* rural voices to statewide boards and Commissions (Judges, BESE)



**Increasing rural wellbeing**

# State Action for Local Public Health Excellence

## Policy advances

- Universal statewide performance standards
- Training and credentialing
- Statewide data collection
- State funding to supplement local funding for public health

## Funding advances

- \$160 million in ARPA funds
- Public health excellence grants to support shared service agreements (Note: Every rural town in MA is in a shared-service arrangement.)



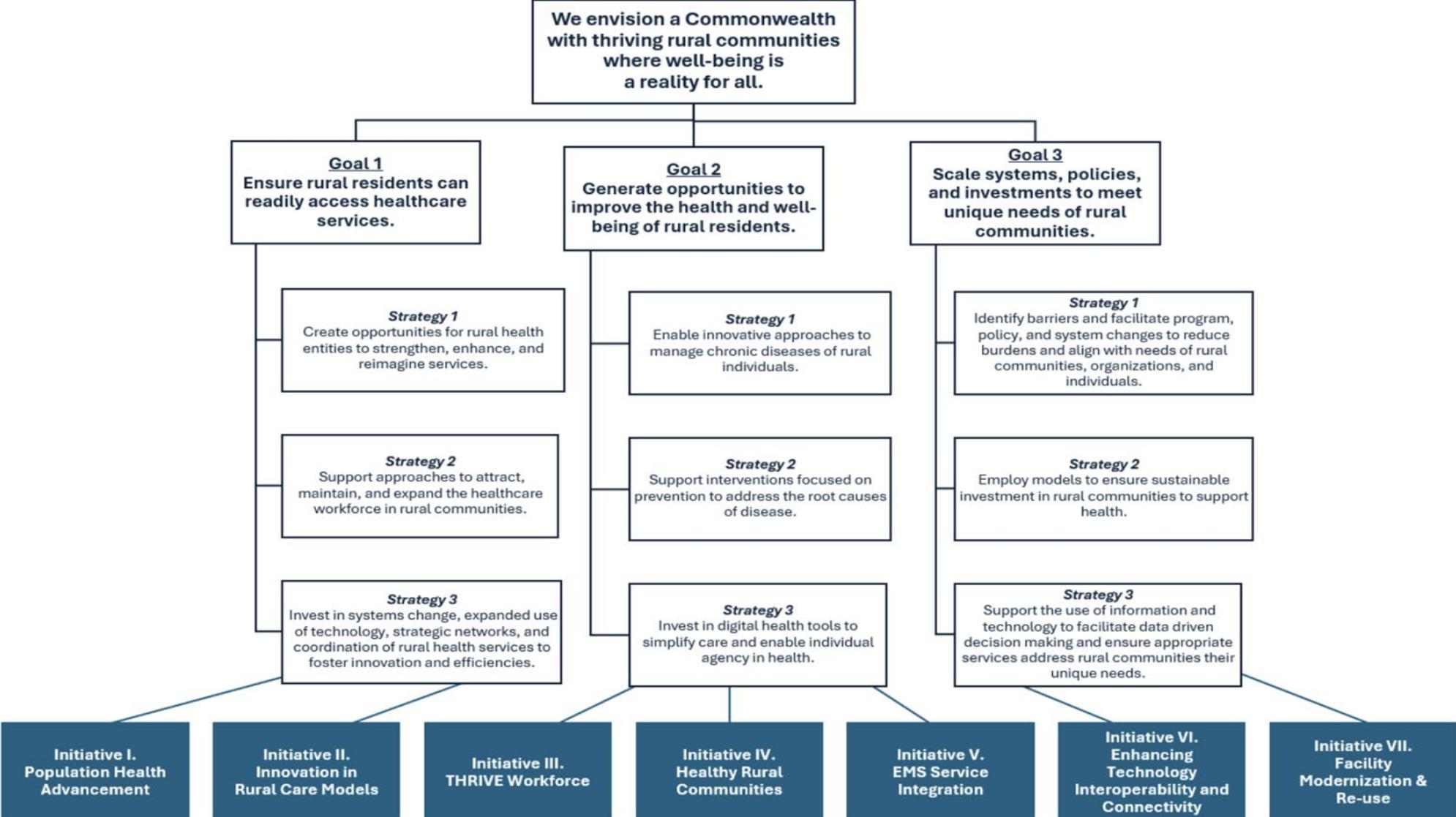
# State Investments + Rural Transformation Fund

In mid-September, the legislature directed \$234 million to hospitals, community health centers, and to the Health Safety Net Trust Fund.

- In mid-October, the legislature directed \$2 billion to MassHealth, \$18.5 million to public health hospitals, and \$5 million to reproductive health care. We also reached an agreement to recapitalize and stabilize the Health Safety Net Trust Fund to maximize possible federal reimbursements.
- At the end of October, the Healey Driscoll Administration completed an application to the federal government's ***Rural Health Transformation Fund***, focusing on:
  - ◆ population health
  - ◆ Innovations in rural care
  - ◆ rural workforce training and retention
  - ◆ emergency response
  - ◆ improving technology, and
  - ◆ facility modernization

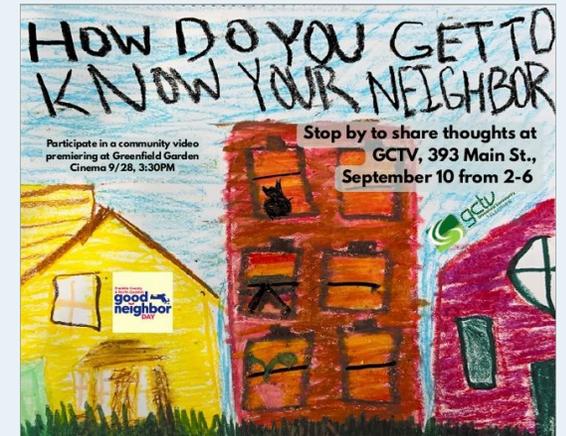


# Goals of the Rural Transformation Fund





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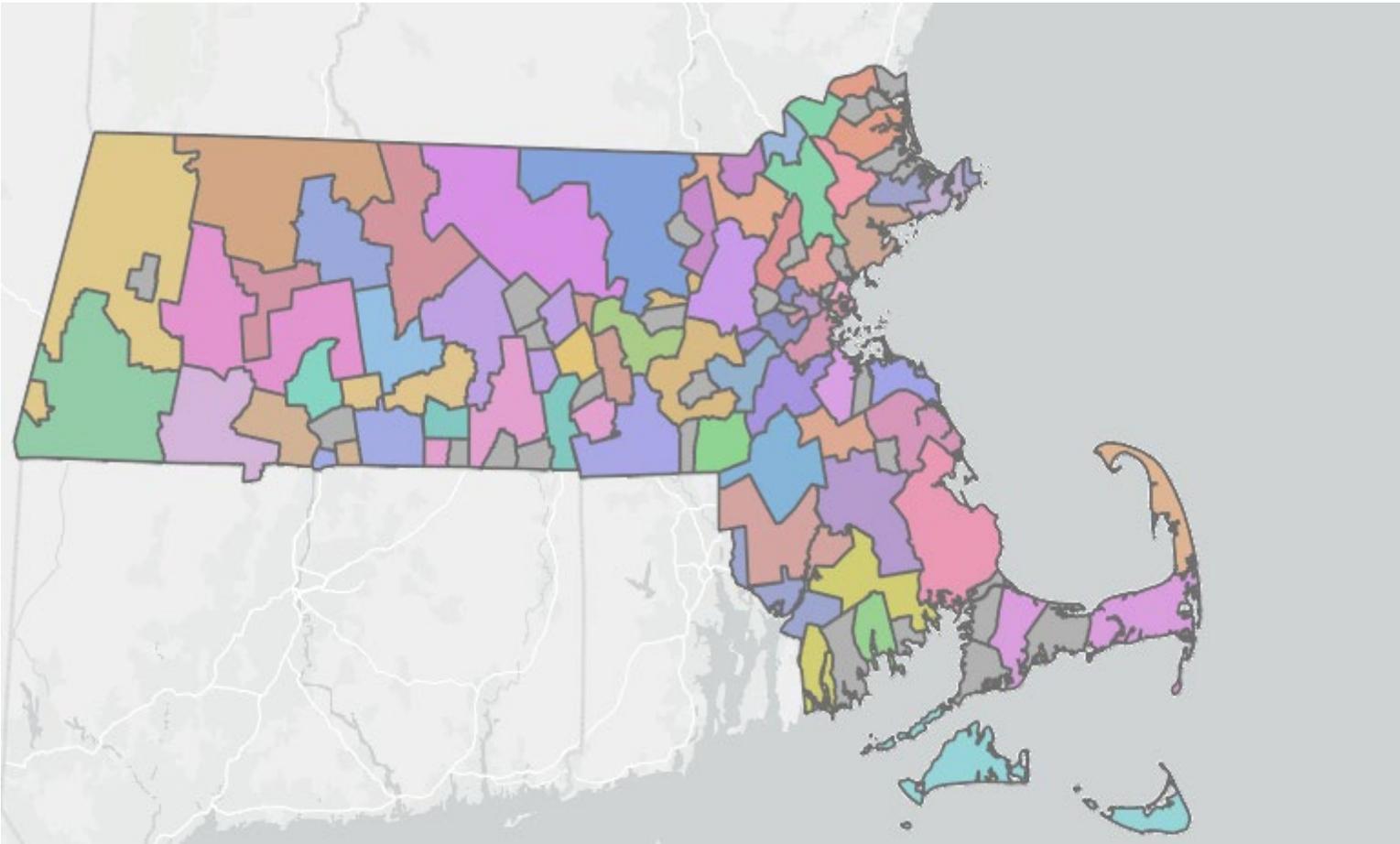


# Rural Health Improvement Highlights from Berkshire and Franklin County

11/14/25

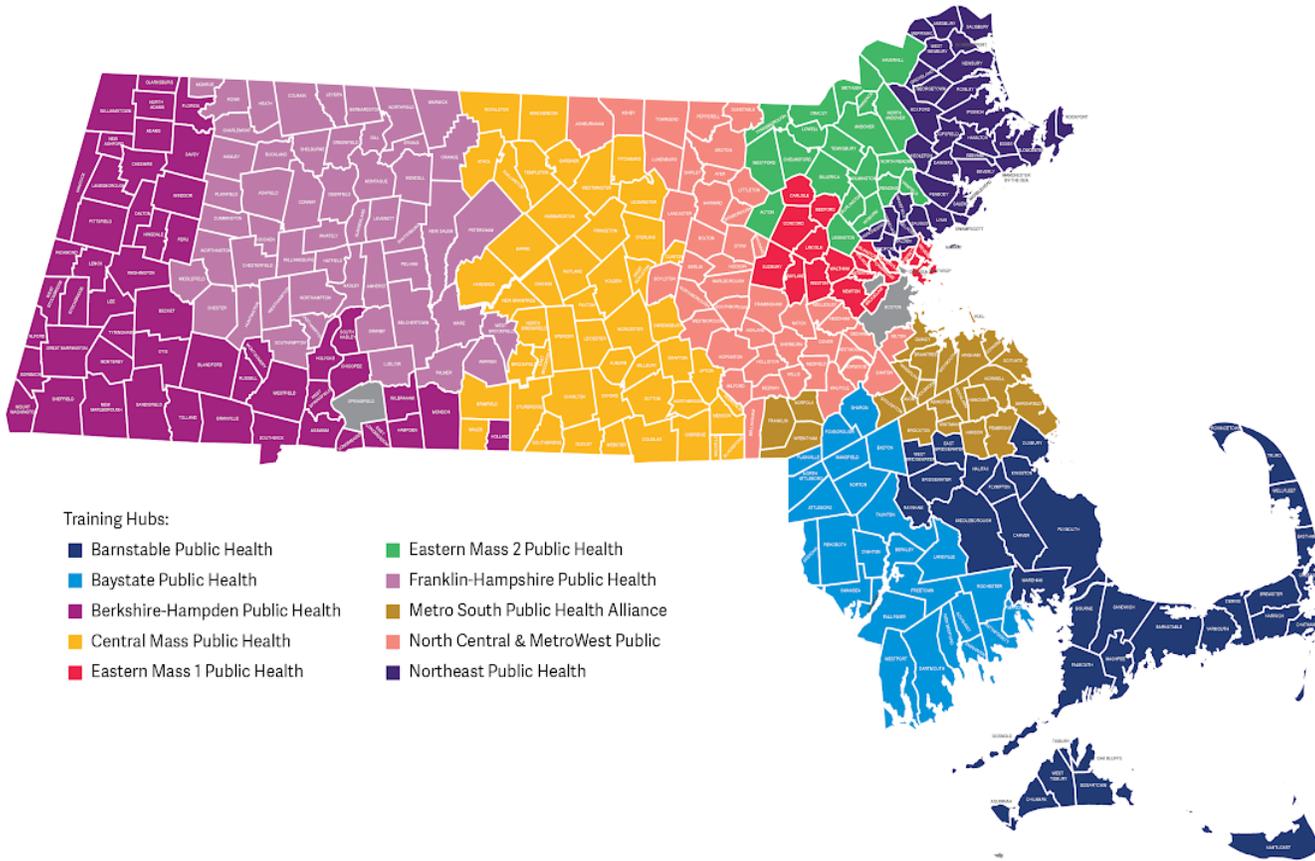


# Public Health Excellence Funding is changing the map and improving equity!



- \$26.2M in grant funding distributed statewide
- 270+ public health workers funded across Massachusetts
- 54 Shared Service Arrangements supporting 324 municipalities
- PHE funding also supports 2 standalone municipalities – Boston and Worcester – ensuring statewide equity
- Especially important to small, rural municipalities

# Public Health Training Hubs



## Available training:

- Tier 1: Foundational Knowledge
- Tier 2: Intensive Classroom Training
- Tier 3: Applied Practice

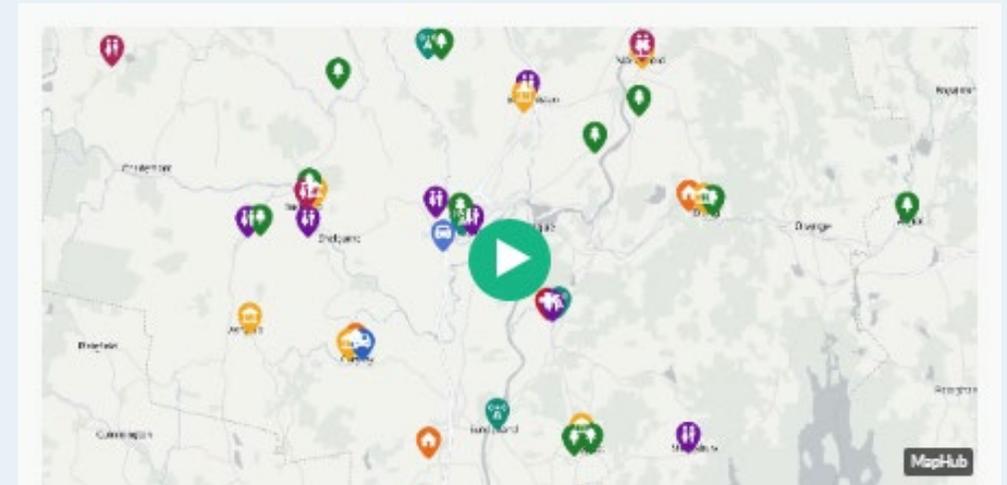
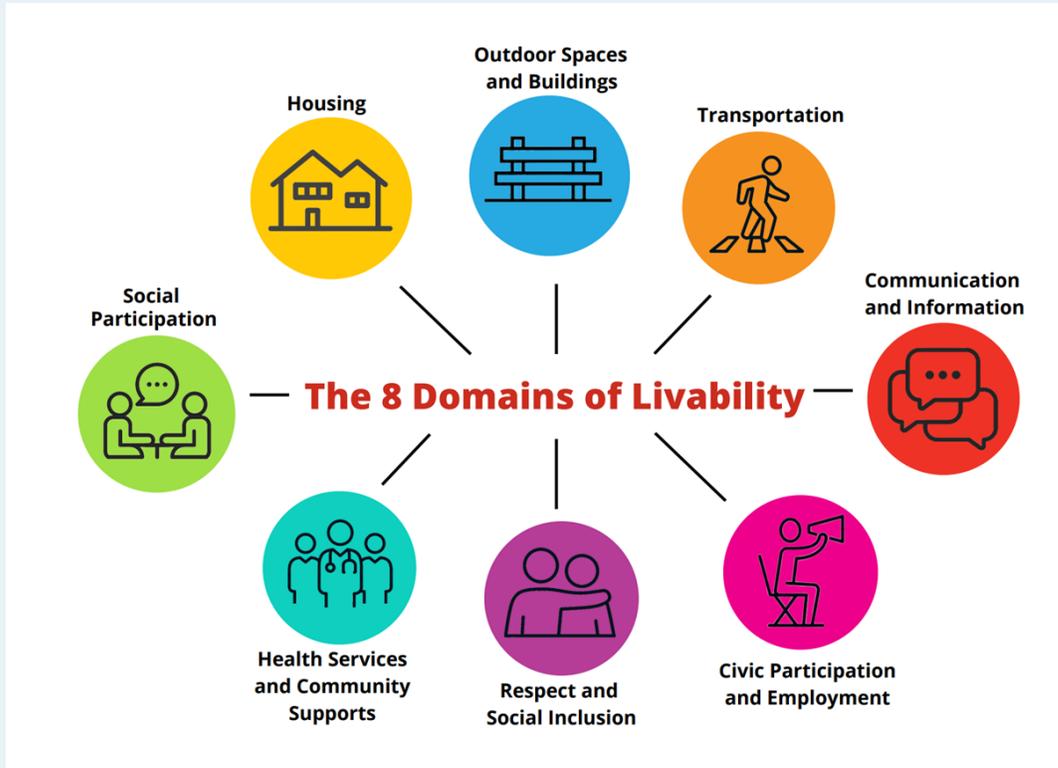
## Workforce Standards

- Required certifications (Food Manager, SE/SI, etc.)
- Required professional credentials (RS, CHO)
- Required education levels



# AGE & DEMENTIA FRIENDLY

Franklin County & North Quabbin



# Community Health Improvement Planning (CHIP): Berkshire County

## Berkshire County Community Health Improvement Plan (CHIP)

### GOALS

Reduce **mental health** concerns like anxiety & depression.

Ensure **equitable access** to health care services.

Increase opportunities & access to living a **healthy lifestyle**.

### OBJECTIVES



**STRENGTHEN** social connections & decrease isolation.



**INCREASE** resilience to climate change.



**DECREASE** barriers to equitable health care.



**REDUCE** alcohol use.

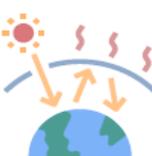


**INCREASE** physical activity through engagement with the outdoors.

### STRATEGIES



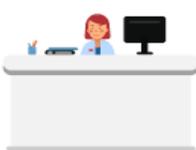
**ENCOURAGE** "neighborliness".



**IMPROVE** response to chronic climate change effects.



**IMPROVE** equity in emergencies.



**IMPROVE** health care office contact & encounters.



**RECRUIT** & retain new providers.



**CHANGE** social norms around drinking.



**PROVIDE** support for those who want to change their drinking.



**INCREASE** access to outdoor recreation & exercise opportunities for all abilities.

# Community Health Improvement Planning (CHIP): Franklin County

## Community Health Improvement Plan 2024-28 Priorities

**Expand access to health care**, including: mental health care, healthcare for the unhoused, and healthcare for rural residents.

**Improve digital equity:** both digital literacy and access to technology and broadband, with a focus on older adults, children, parents, and vulnerable populations.

**Diversify housing stock** throughout our region, including rental apartments, long-term housing for those with history of SUD, accessory dwelling units, affordable townhomes.

**Build a more connected and resilient community** by implementing the recommendations of Surgeon General's Report on Loneliness.

**Increase access to affordable cars, driving education, and licenses.**

Increase institutional **diversity, equity, justice, and belonging** work.

**Increase access to and education on air quality:** Publicize and expand local air quality sensors and increase public education about how to interpret the data.

**Address critical shortage of home health aides, nurses, and early childhood educators.**

**Increase use of restorative practices in schools:** discipline reform built on improved school culture and climate.

Implementation of the five year **Age and Dementia Friendly Action Plan** for Franklin County and the North Quabbin.

**Reduce childhood trauma** through regional policy and systems change campaign.

Outreach to **close SNAP gap and expand Healthy Incentives Program (HIP)** vendors, products, and use.

Reduce **CORI-related and eviction history barriers to housing** for people in the region.

Learn more: <https://frcog.org/chip>



Multiple Categories

Social Environment

Healthcare Quality & Access

Employment & Income

Built Environment

Environmental Quality

# Making the most of small dollars: Regional Opioid Settlement Collaborative



In the 15 CPHS member Towns,  
settlement disbursements ranged  
from \$389 to \$194,562 over the 18  
years of the State Settlement  
Agreement.

18-year Total Funds: **\$623,824**

Average Annual Amount: **\$34,600**



# Substance Use Disorder & Prevention

## Harm Reduction/Overdose Prevention

- BOAPC
- North Berkshire Opioid Abatement Collaborative
- Community outreach workers
- Post-overdose engagement
- Naloxone distribution
- Recovery centers
- Doorknock Days of Action



## Youth Prevention

- Youth (MassCall)
- Young children (5-11) and families



# Thank you!

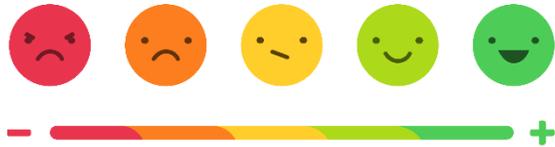
- **Laura Kittross, Public Health Program Manager, BRPC**  
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Berkshire Regional Planning Commission



**Before you sign off, please take a  
1-minute survey to give us feedback**



<https://www.surveymonkey.com/r/RuralRealitiesWebinar>