

# 2019 Community Health Needs Assessment

Adopted by the Baystate Health Board of Trustees on September 10, 2019



**PUBLIC HEALTH INSTITUTE  
OF WESTERN MASSACHUSETTS**  
PARTNERS FOR HEALTH EQUITY



# Acknowledgments

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- **Sarah Bankert**, Collaborative for Educational Services
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- **Gloria Wilson**, Western Massachusetts Black Nurses Association

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# Consultant Team

## Lead Consultant

The **Public Health Institute of Western Massachusetts'** (PHIWM) mission is to build measurably healthier communities with equitable opportunities and resources for all through civic leadership, collaborative partnerships, and policy advocacy. Their core services are research, assessment, evaluation, and convening. The range of expertise enables PHIWM to work in partnership with residents and regional stakeholders to identify opportunities and put into action interventions and policy changes to build on community assets while simultaneously increasing community capacity. PHIWM was formerly known as Partners for a Healthier Community.

## Consultants

**Community Health Solutions**, a department of the **Collaborative for Educational Services** (CES), provides technical assistance to organizations including schools, coalitions, health agencies, human service, and government agencies. They offer expertise and guidance in addressing public health issues using evidence-based strategies and a commitment to primary prevention. CES believes local and regional health challenges can be met through primary prevention, health promotion, policy and system changes, and social justice practices. They cultivate skills and bring resources to assist with assessment, data collection, evaluation, strategic planning, and training.

**Franklin Regional Council of Governments** (FRCOG) is a voluntary membership organization, serving the 26 towns of Franklin County, Massachusetts, a 725 square mile area. Services include regional and local planning for land use, transportation, emergency response, economic development, and health improvement. FRCOG convenes a number of public health projects including a community health improvement plan network, emergency preparedness and homeland security coalitions, two local substance use prevention coalitions, and a regional health district serving 12 towns. FRCOG also provides shared local municipal government services on a regional basis, including inspections, accounting, and purchasing. To ensure the future health and wellbeing of our region, FRCOG staff are also active in state and federal advocacy.

**Pioneer Valley Planning Commission** (PVPC) is the regional planning agency for the Pioneer Valley region (Hampden and Hampshire Counties), responsible for increasing communication, cooperation, and coordination among all levels of government as well as the private business and civic sectors to benefit the region and to improve quality of life. Evaluating our region – from the condition of our roads to the health of our children – clarifies the strengths and needs of our community and where we can best focus planning and implementation efforts. PVPC conducts data analysis and writing to assist municipalities and other community leaders develop shared strategy to achieve their goals for the region.

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# I. Executive Summary

## Introduction and Methods

**Baystate Noble Hospital** (Baystate Noble) is a 97-bed acute care community hospital helping people in the greater Westfield community, offering direct access to world-class technology, diagnostics, and specialists. The hospital works to ensure that patients have access to exceptional healthcare, close to home. Skilled and compassionate nurses and medical support staff offer an ideal combination of “high tech” and “high touch”, complementing an outstanding team of doctors. Services include obstetrics and gynecology, emergency, laboratory, gastroenterology, surgery, cardiopulmonary services and rehabilitation, cancer care, behavioral health, urology, neurology, inpatient rehabilitation, and diagnostic imaging, including 3D mammography.

Baystate Noble is a member of **Baystate Health**, a not-for-profit, multi-institutional, integrated health care organization serving more than 800,000 people throughout western Massachusetts. Baystate Health, with a workforce of about 12,000 employees, is the largest employer in the region and includes: Baystate Medical Center, Baystate Franklin Medical Center, Baystate Wing Hospital (and Baystate Mary Lane Outpatient Center), Baystate Noble Hospital, Baystate Medical Practices, Baystate Home Health, and Baystate Health Foundation.

Baystate Noble is a member of the **Coalition of Western MA Hospitals/Insurer** (“the Coalition”), a partnership between eight non-profit hospitals, clinics, and insurers in the region. The Coalition formed in 2012 to bring hospitals in western Massachusetts together to share resources and work in partnership to conduct their community health needs assessments (CHNA) and address regional needs. Baystate Noble worked in collaboration with the Coalition to conduct this assessment and update the findings of the Baystate Noble 2016 CHNA.

### **The goals of the 2019 CHNA were to:**

- improve the hospital’s understanding of the health needs of the communities it serves
- meet its fiduciary requirement as a tax-exempt hospital
- serve as a resource for community organizations for data that is not readily available in other ways
- guide Baystate Noble’s Community Benefits Strategic Implementation Plan (SIP) development efforts

The assessment focused on **Baystate Noble’s primary geographic service area**, which includes ten communities, nine of which are located in the western portion of Hampden County. This service area includes Huntington in Hampshire County, and the Hampden County communities of Blandford, Chester, the Feeding Hills portion of Agawam, Granville, Russell, Southwick, Westfield, West Springfield, and Woronoco.

The 2019 CHNA was conducted with **equity as a guiding value**, understanding that everyone has the right to a fair and just opportunity to be healthy and that this requires removing the obstacles to health. Obstacles range from poverty, discrimination, systemic racism and their consequences, such as unequal access to jobs, education, housing, safe environments, and health care.

When identifying the areas that can be addressed to improve the health of the population, the assessment used the Massachusetts Department of Public Health (MDPH) **social and economic determinants of health framework**, recognizing that these factors contribute substantially to population health. The MDPH framework also offers guidance for community engagement for CHNAs and Determination of Need processes when hospitals make capital improvements and allocate funds for community benefits.

The **prioritized health needs** identified in the 2019 CHNA include community level social and economic determinants that impact health, access and barriers to quality health care, and health conditions and behaviors. The assessment included analysis and synthesis of 1) a variety of social, economic and health data; 2) findings from recent Hampden County and regional assessment reports; 3) information from one focus group and interviews with six key informants, as well as five interviews with public health leaders, conducted for the 2019 Baystate Noble CHNA; and 4) community input from one Community Conversation and 19 Community Chats. In total, almost 880 individuals across Hampden County pertaining to Baystate Noble were engaged in outreach and data collection. Occasionally the experiences of community members who gave input in focus groups or key informant interviews in other regions was considered relevant to this service area and was also included.

**Priority populations** were identified using a health equity framework with available data. Knowing that health inequities exist for communities of color, we focus on inequities among those who are Latino and black because 1) they are the largest communities of color in the service area and 2) available data was limited for other racial and ethnic groups, such as Asian, Native American, and others. We use the terms white, black, and Latino, recognizing that these terms do not always capture how every individual identifies themselves. For more information on the terminology of race and ethnicity as well as other definitions, please see the Glossary in Appendix II.

Information from this CHNA will be used to inform the development of Baystate Noble Hospital's Community Benefits Strategic Implementation Strategy (SIP), the Coalition's regional efforts to improve health, and County Health Improvement Plans (CHIPs) in all Coalition counties.

## Findings

Below is a summary of the prioritized community health needs identified in the 2019 CHNA.

### COMMUNITY LEVEL SOCIAL AND ECONOMIC DETERMINANTS THAT IMPACT HEALTH

A number of social, economic, and community level factors were identified as prioritized community health needs in Baystate Noble's 2016 CHNA and continue to impact the health of the population in the Baystate Noble service area. Social, economic, and community level needs identified in the 2019 CHNA include:

- **Social environment** - includes relationships between people, connectedness to community, and broader societal values and norms. Different people may experience different health outcomes as a result of inequities in social environments. In general, the population of the Baystate Noble service area is older than the state level, with related health and social outcomes. Westfield and West Springfield have racially and ethnically diverse populations. Social isolation and experiences of interpersonal and structural racism and other oppressions create barriers to being able to access services and social determinants of good health.
- **Housing needs** - over one-third of residents experience housing insecurity, paying more than 30% of their income on housing. For a typical household people pay more than half of their income on housing and transportation. Hampden County has the highest amount of homelessness in western Massachusetts. Poor housing conditions also impact the health of residents. Older housing combined with limited resources to maintain the housing leads to conditions that can affect asthma, other respiratory conditions, and safety. In a focus group for people coaching others to overcome substance use disorder, housing needs was cited as a priority need.

*"You can't do treatment [for substance use disorder] without a place to live. You can't do it if you're living on the street."*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

- **Lack of access to transportation and healthy food** - decisions about how the environment is constructed impact transportation choices and access to healthy food, among other determinants. Nearly 8% of Baystate Noble service area residents do not have a car. While public transportation connects Noble service area residents to the greater Springfield area, there are limited options for public transportation that connect communities within the service area. The Pioneer Valley Transit Association (PVRTA) raised rates and decreased service in 2018. Planning decisions have led to parts of Hampden County being considered food deserts, which are areas where low-income people have limited access to grocery stores. Food insecurity continues to restrict the access of many Hampden County residents to healthy food. West Springfield and Westfield have high rates of food insecurity experienced by over 15% of residents in some areas of these communities.



*“Almost all towns here are farm-friendly, but food is a different story.”*  
Key Informant Interview, Hilltown Community Health Center Staff, Coalition Hospital

- **Lack of resources to meet basic needs** - many Baystate Noble service area residents are struggling economically, with the incomes at or below 200% of the federal poverty level for 32% of West Springfield residents and 25% of Westfield residents. The current unemployment rate in the region is 6%. Focus group members and key informant interviewees mentioned poverty as a priority challenge that impacts overall health, access to health care, and access to programs and services that promote health.
- **Need for financial health** - having the skills and knowledge to manage personal finances to fulfill personal goals affects health and well-being. Rates of homeownership and savings are lower in communities of color than for whites and for women compared to men. Across Massachusetts, over 1 in 10 people have low levels of financial literacy, or knowing how to manage one’s own finances.
- **Educational needs** - lower levels of education contribute to unemployment, the ability to earn a livable wage, and many health outcomes. About 9% of Baystate Noble service area residents aged 25 and older do not have a high school diploma and only 31% of Hampden County residents have a bachelor’s degree or higher (compared with 42% in the state overall).
- **Violence and trauma** - similar to the 2016 CHNA, personal and community safety were elevated as a concern in the 2019 CHNA. Regionally, about 13% of all sexual assaults in the state were in western Massachusetts, and almost 7,000 restraining orders were filed in the region in 2018. In 12th graders at the Gateway School District, 1 out of 3 had a friend who had been abused by a dating partner, and 1 out of 5 had been pressured into sexual activity by a dating partner. Seven percent stated that their families had been investigated by the Department of Children and Families for abuse or neglect.

## **BARRIERS TO ACCESSING QUALITY HEALTH CARE**

The lack of affordable and accessible medical care was identified as a need in the 2016 CHNA and continues to be a need today. The following barriers were identified:

- **Insurance and health care related challenges** - the ability to navigate both what health insurance will cover and medical care systems was raised by multiple community stakeholders and interviewees. Despite high rates of health insurance coverage, people cited high costs of co-pays, deductibles, tests, and medication as barriers. Also, the difficulty of knowing what is covered or not, constant changes in coverage, lack of coverage for substance use disorder prevention and treatment, and barriers of bureaucracy were mentioned as examples.

*“Without a coordinator, people may get lost in the system and not get what they need. Health insurers and the medical community don’t seem to understand the need for advocates/health coordinators.”*

Key Informant Interview, director of an agency serving older adults, Hampden County

- **Limited availability of providers** - Baystate Noble service area residents experience challenges accessing care due to the shortage of providers. Westfield and West Springfield are medically underserved areas. Shortages in psychiatrists who can prescribe and dental providers were also identified. Focus group participants and key informant interviewees overwhelmingly reported a need for increased access for both mental health and addiction services for acute, maintenance, and long-term care.
- **Need for culturally sensitive care** - public health leaders, focus group participants, and other interviewees called for increased training, experience, and sensitivity for health care and social service providers to a variety of different cultures. Cultures of race and ethnicity as well as the cultures of people with mental health and substance use disorders, older adults, transgender patients, ex-offenders, people experiencing homelessness, and adults and children with disabilities were mentioned.
- **Lack of transportation** - transportation arose as a barrier to care among interviewees in the 2016 CHNA, and it was one of the most frequently cited barriers to accessing care in key informant interviews and focus groups for the 2019 CHNA. Poor access to transportation is a barrier to medical care, other appointments, picking up medication, work, and non-work activities.
- **Lack of care coordination** - increased care coordination continues to be a need in the community. Areas identified in focus group and interviews include the need for coordinated care between providers in general, a particular need for increased coordination to manage comorbid substance use and mental health disorders, a need to provide “warm handoffs” and better communications when a person is released from an institution such as jail, foster care, or substance use treatment programs, and the need for hospitals to coordinate with community health centers should hospitalization take place.
- **Health literacy, language barriers** - the need for health information to be understandable and accessible was identified in this assessment. Data from focus groups indicate the need for increased *health literacy*, including understanding health information, types of services and how to access them, and how to advocate for oneself in the healthcare system. The need for provider education about how to communicate with patients about medical information also arose. Focus group participants and key informant interviewees noted the need for more bilingual providers, translators, and health materials translated into a wider range of languages. About 2% of all of Baystate Noble’s encounters required interpreter services.

## HEALTH OUTCOMES

- **Mental health and substance use disorders** - substance use and mental health were identified as urgent health needs/problems impacting the area in virtually every type of stakeholder engagement in the 2019 CHNA. The main cities in the Baystate Noble service area, West Springfield and Westfield, have nearly double the rate of mental health hospitalizations as the state. Substance use admissions to treatment programs have risen by 42% from 2012 to 2017 in Hampden County, with alcohol and heroin as the drivers of admissions. Opioid use disorder continues to be a public health crisis, with the number of opioid-related deaths in Hampden County increasing annually from 32 in 2000 to 113 in 2017. Between 2016 and 2017, there were over 300 opioid overdoses in West Springfield and Westfield. There was overwhelming consensus among focus group participants and health care providers and administrators about the need for increased education across all sectors to reduce the stigma associated with mental health and substance abuse as well as the need for more treatment options and in particular treatment for people with mental health co-morbidity.

*“The newspaper put a person’s photo on the front page for possession charge – not dealing or anything serious. We don’t treat people with diabetes or other diseases that way.”*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

- **Chronic health conditions** - high rates of obesity, diabetes, cardiovascular disease, asthma, and associated morbidity previously identified as prioritized health needs in the 2016 CHNA continue to impact Baystate Noble’s service area residents. An estimated 29% of Hampden County adults, and 20% of West Springfield students are obese. Heart disease is the leading cause of death in Hampden County, with cardiovascular disease hospitalization 20% higher than the state in West Springfield. Four out of five adults over 65 have hypertension, a risk factor for cardiovascular disease. An estimated 11% of county residents have diabetes, with diabetes hospitalizations higher than the state in Southwick, Agawam, and West Springfield. Emergency department use due to asthma for adults is higher than the state rate in Chester, Russell, and Westfield, and about 10% of children have asthma in Westfield and West Springfield.
- **Need for increased physical activity and nutrition** - the need for increased physical activity and consumption of fresh fruits and vegetables was identified by Hampden County residents. Key informant interviewees mentioned barriers to accessing healthy food. Low rates of physical activity and healthy eating contribute to high rates of chronic disease and also impact mental health.
- **Infant and perinatal health** - infant and perinatal health factors were identified as health needs in the 2016 CHNA and continue to impact Baystrate Noble’s service area residents. A need for increased utilization of prenatal care and a decrease in smoking during pregnancy were identified. The need to reduce the incidence of teen birth arose, particularly noting that teen mothers had lower rates of adequate prenatal care than mothers over the age of 19. Disparities

in prenatal care and birth outcomes are correlated with whether a person has private or public insurance.

- **Alzheimer’s disease and dementia** - Baystate Noble service area’s rate of Alzheimer’s disease is about 15%, with even higher rates in some towns. By 2035, the percentage of people over the age of 60 is expected to increase to 28% in Hampden County.

## PRIORITY POPULATIONS

Available data indicate that children and youth, older adults, and Latinos and blacks experience disproportionately high rates of some health conditions or associated morbidities when compared to that of the general population in Hampden County. Children experienced high rates of asthma and are particularly impacted by obesity and sexually transmitted infections (STIs). Older adults had higher rates of chronic disease and hypertension. Latinos and blacks experienced higher rates of hospitalizations due to some chronic diseases, mental health, and substance use disorders.

Data also indicated increased risk for poorer mental health and substance use disorder among youth and particularly girls, GLBQ+ (gay/lesbian/bi-sexual/queer/questioning) youth, transgender individuals, older adults, Latinos, women, people reentering society after incarceration, people experiencing homelessness, and those with dual diagnoses (mental health and substance use disorder).

When considering those with disproportionate and inequitable access to the social determinants of health, data identified people who are Latino and black, youth, older adults, people with lower incomes, women, people who have been involved in the criminal legal system, those with mental health and substance use disorders, immigrants and refugees, and people with disabilities.

*“Structures of power get in the way. It’s not a lack of resources, it’s isolation of systems... you have to be intentional to understand this, the way structures interact with each other.”*

Key Informant Interview, Public Health Official, Hampden County

## Summary

The Baystate Noble service area of Hampden County, continues to experience many of the same prioritized health needs identified in the Baystate Noble 2016 CHNA. Social and economic challenges experienced by the population in the service area contribute to the high rates of chronic and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health inequities observed among priority populations, which include children, older adults, Latinos, blacks, GLBQ+ youth, transgender individuals, people with low-incomes, women, people with mental health and substance use disorders, people released from jail, those experiencing homelessness, and people living with disabilities, including children. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The Baystate Noble service area's population continues to experience a number of barriers that make it difficult to access affordable, quality care, some of which are related to the social and economic conditions in the community, and others which relate to the healthcare system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed.

## II. Introduction

### 1. About Baystate Noble Hospital

Baystate Noble Hospital (Baystate Noble) is a 97-bed acute care community hospital helping people in the greater Westfield community. The hospital has a staff of over 570 employees, including 210 nurses and over 250 affiliated physicians. Baystate Noble offers direct access to world-class technology, diagnostics, and specialists, working to ensure that patients have access to exceptional healthcare, close to home. Skilled and compassionate nurses and medical support staff offer an ideal combination of “high tech” and “high touch”, complementing an outstanding team of doctors. Services include obstetrics and gynecology, emergency, laboratory, gastroenterology, surgery, cardiopulmonary services and rehabilitation, cancer care, behavioral health, urology, neurology, inpatient rehabilitation, and diagnostic imaging, including 3D mammography.

Baystate Noble is a member of Baystate Health, a not-for-profit, multi-institutional, integrated health care organization serving more than 800,000 people throughout western Massachusetts. Baystate Health, with a workforce of about 12,000 employees, is the largest employer in the region and also includes: Baystate Medical Center, Baystate Franklin Medical Center, Baystate Wing Hospital (and Baystate Mary Lane Outpatient Center), Baystate Noble Hospital, Baystate Medical Practices, Baystate Home Health, and Baystate Health Foundation.

**Mission:** To improve the health of the people in our communities every day with quality and compassion.

**Community Benefits Mission Statement:** To reduce health disparities, promote community wellness and improve access to care for priority populations.

### 2. Coalition of Western Massachusetts Hospitals/Insurer

Baystate Noble is a member of the Coalition of Western Massachusetts Hospitals/Insurer (Coalition). The Coalition is a partnership between eight non-profit hospitals/insurer in western Massachusetts: Baystate Medical Center, Baystate Franklin Medical Center, Baystate Noble Hospital, Baystate Wing Hospital, Cooley Dickinson Hospital, Mercy Medical Center (a member of Trinity Health – New England), Shriners Hospitals for Children – Springfield, and Health New England, a local health insurer whose service areas covers the four counties of western Massachusetts. The Coalition formed in 2012 to bring hospitals within western Massachusetts together to share resources and work in partnership to conduct their community health needs assessments (CHNA) and address regional needs.

### 3. Community Health Needs Assessment (CHNA)

Improving health and equitable distribution of health outcomes across western Massachusetts is a shared mission across the Coalition. To gain a better understanding of these needs, and as required by the 2010 Patient Protection and Affordable Care Act (PPACA), Coalition members conducted CHNAs in 2018-2019 to update their 2016 CHNAs. The PPACA requires tax-exempt hospitals and insurers to “conduct a Community Health Needs Assessment [CHNA] every three years and adopt an implementation strategy to meet the community health needs identified through such assessment.”

Integral to this needs assessment was the participation and support of community leaders and representatives who provided input through the **CHNA Regional Advisory Council (RAC)** and **Baystate Noble Hospital Community Benefits Advisory Council (CBAC)**, stakeholder interviews and focus groups, Community Conversations, and Community Chats (more detail on these elements of the process in the Stakeholder Engagement section below). Special thanks to the Baystate Noble CBAC members who participated in the RAC: Beth Cardillo of Armbrook Village and Eliza Lake of the Hilltown Community Health Center.

Based on the findings of the CHNA and as required by the PPACA, Baystate Noble will develop a **community benefits strategic implementation plan (SIP)** to address select prioritized needs. The CHNA data also inform the **Hampden County Health Improvement Plan (CHIP)**.

## III. Methodology for the 2019 CHNA

### 1. Equity as a Guiding Value

The CHNA process was conducted with a focus on equity. Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health – such as poverty and discrimination – and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.<sup>1</sup>

The Coalition and the CHNA RAC created a proposition that the CHNA reflect values of health equity, cultural humility, and social justice within a framework of social determinants of health. As part of this, the CHNA was conducted with an inclusive, community-engaged process that strove for 1) a transparent account of the conditions that affect health of all people in western Massachusetts, and 2) an actionable CHNA for communities in western Massachusetts at the local level.

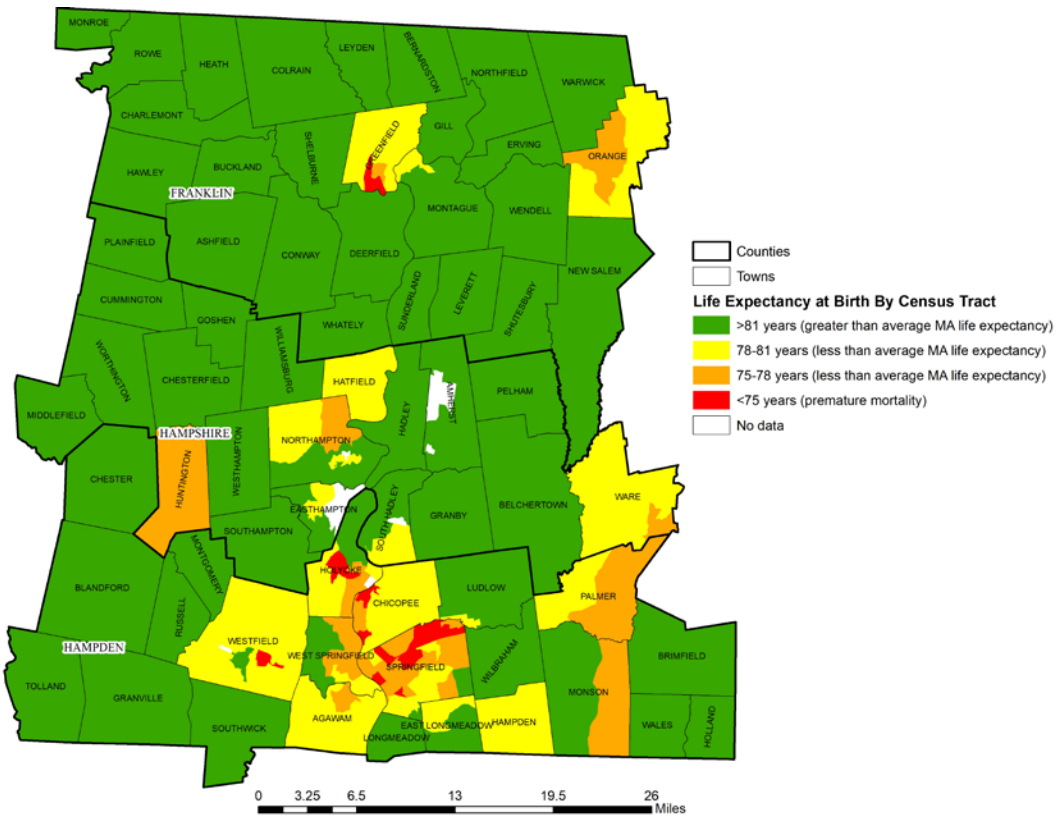
The Coalition, guided by the RAC (see below for description of the RAC) used the following methods to conduct this CHNA with a guiding belief in the need to consider health equity:

- having a more diverse collection of community representatives as part of the RAC than in previous years
- engaging substantially more residents from diverse organizations in the community in data collection and outreach activities than in prior years
- disaggregating outcomes and health determinants by race whenever possible
- including discussion of the impact that systemic and institutional policies and practices have on social determinants of health

Opportunities to lead a long and healthy life vary dramatically by neighborhood. Life expectancy in Massachusetts overall is 81 years (80.7), the sixth highest in the nation; however there are large differences depending on where you live. In some areas of western Massachusetts people live to be as old as 91 on average; others only live to the age of 70. Low life expectancy areas have lower incomes, higher unemployment, and lower educational attainment, lack health insurance, and have more nonwhite residents among other measures.<sup>2</sup> Inequity impacts health. For example, in Hampden County there is almost a 15 year difference in life expectancy between areas with the lowest (the Metro Center neighborhood of Springfield – 70.3), and the highest (Longmeadow and West Springfield – 84.6) (Figure 1).



**Figure 1. Life Expectancy, Western Massachusetts: Hampden, Hampshire, and Franklin Counties**



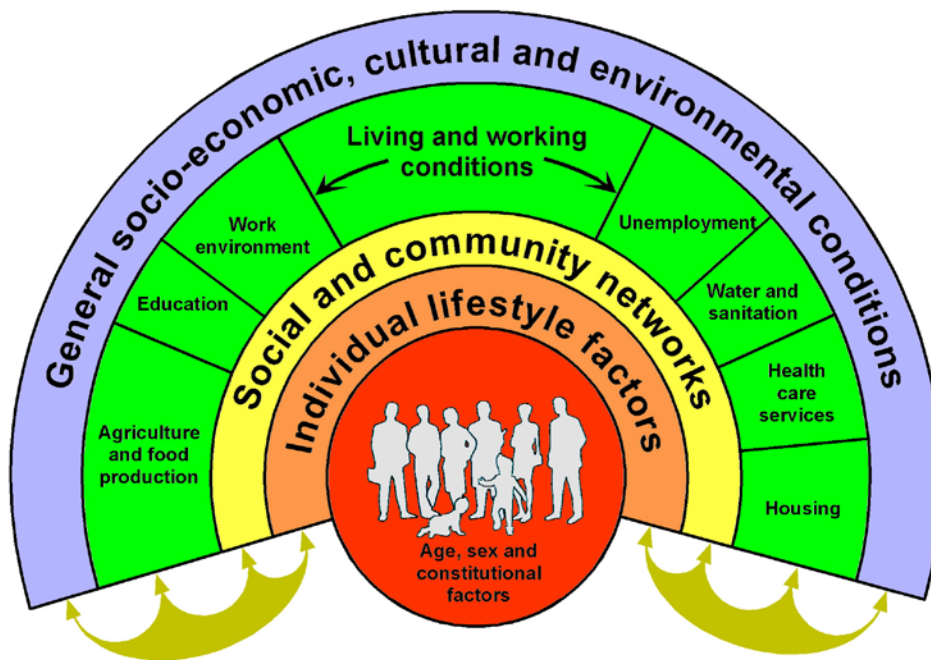
Data Source: For data files: National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates File for Massachusetts, 2010-2015]. National Center for Health Statistics. 2018. Available from: <https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html>. Mapping: Public Health Institute of Western Massachusetts.

Source: National Center for Health Statistics, *Life Expectancy for Massachusetts 2010-2015*

## 2. Social and Economic Determinants of Health Framework

Similar to the 2016 CHNA, this CHNA was conducted using a determinant of health framework recognizing that social and economic environments contribute substantially to population health. Research shows that genetics or biology account for less than a third of health status.<sup>1</sup> Health is largely determined by the social, economic, cultural, and physical environments that people live in and the health care they receive (Figure 2).

Figure 2. Determinants of Health



Source: Dahlgren and Whitehead, 1993

Among modifiable factors that affect health, research shows that social and economic environments have the greatest impact. The County Health Rankings model (Figure 3), developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, estimates the proportion of health that modifiable factors contribute to, based on reviews of the scientific literature. It is estimated that social and economic factors account for 40% of people's health, followed by health behaviors (30%), clinical care (20%), and the physical environment (10%).<sup>3</sup> Many health disparities occur as a result of inequities in these determinants of health.

Figure 3. County Health Rankings Model - Health Factors

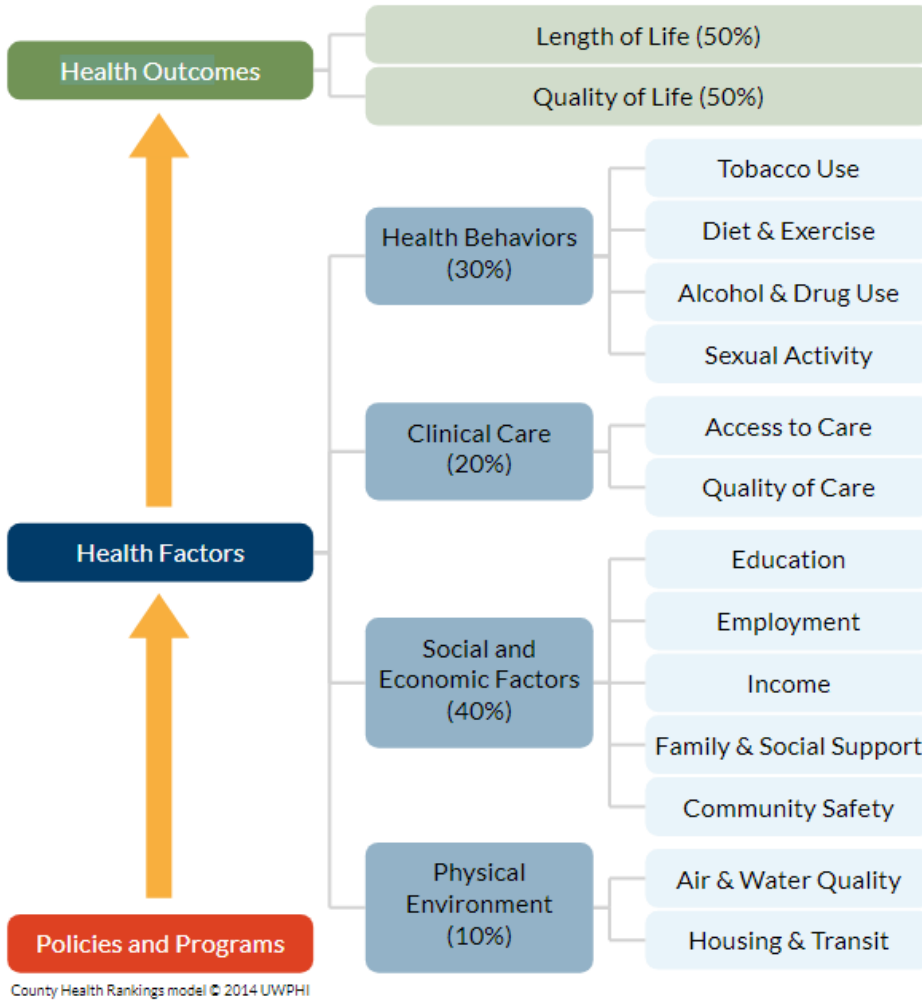


Figure 4. Massachusetts Department of Public Health Priorities



Since the 2016 CHNA, MDPH has prioritized six broad categories of determinants, which they refer to as health priorities: housing, employment, education, violence and trauma, the built environment, and the social environment.<sup>4</sup> (Figure 4) MDPH also has delineated health issues of focus: substance use, mental illness and health, and chronic disease. This CHNA is organized according to the MDPH categories and focus issues.

### 3. Assessment Methods

The 2019 CHNA updates the prioritized community health needs identified in the 2016 CHNA. The prioritized health needs identified in the 2019 CHNA include community level social and economic determinants that impact health, barriers to accessing care, and health behaviors and outcomes. We also provide context for the role that social policies and the practices of systems have on health outcomes.

Assessment methods included: 1) analysis of social, economic, and health quantitative data from MDPH, the U.S Census Bureau, the County Health Ranking Reports, the Massachusetts Healthy Aging Collaborative, Social Explorer, and a variety of other data sources; 2) analysis of findings from one focus group, 11 interviews with key informants (6 with content and community experts plus five with local and regional public health officials), one Community Conversations, and 19 Community Chats conducted by the consultant team and the RAC as part of the Baystate Noble CHNA (occasionally the experiences of community members who gave input in focus groups or key informant interviews in other regions were considered relevant to this service area and was included); and 3) review of existing assessment reports published since 2016 that were completed by community and regional agencies serving Hampden County. The assessment focused on county-level data and select community-level data as available. Given data constraints, the following communities were identified for the majority of the community level data analyses: Chicopee, Holyoke, Palmer, Springfield, West Springfield, and Westfield. Other communities were included as data was available and analysis indicated an identified health need for that community. Health Equity Workgroup members of the Regional Advisory Council identified that there are health needs specific to rural areas of Hampden County, however due to small numbers and lack of existing data, there is limited discussion of rural health issues in Hampden County.

CHNAs are required to identify “vulnerable populations”. With equity as a guiding principle for our process, assessment, and report, we intentionally use the term “priority populations”. This decision was intentional as language matters; our words reflect mindsets, influence behaviors, empower or stigmatize people within our communities. To the extent possible, given data and resource constraints, priority populations were identified using qualitative and quantitative information. Qualitative data included focus group findings, interviews, input from our RAC and CBACs, and community outreach. We used quantitative data to identify priority populations by disaggregating by race/ethnicity, age with a focus on children/youth and older adults, and GLBQ+ (gay/lesbian/bi-sexual/queer/questioning) and transgender individuals.

Some of the data sources supplied data in rates (e.g., rates per 100,000 of the population), including the main source of data for health outcomes, the MDPH. Creating rates allows us to compare outcomes from geographies that might be drastically different in size, e.g., the state of Massachusetts and the town of Southwick. If all we could report was the number of people hospitalized, for example, it would not be possible to assess how Southwick is doing compared to the state. If 164 people in a town of about 9,700 (Southwick) were hospitalized in one-year for cardiovascular disease, the rate is 1,276 per 100,000. If over 92,000 people across the approximately 6.9 million people in the state of Massachusetts were hospitalized for the same thing in one-year, the rate is 1,216 per 100,000. Thus, we can see that

the town of Southwick had a higher rate of hospitalization even though they had far fewer people hospitalized.

## 4. Prioritization Process

The 2016 CHNA priorities were used as a baseline for the 2019 assessment, with a goal of reprioritizing if quantitative and qualitative data, including community feedback, indicated changes. For the 2016 CHNA prioritization, health conditions were identified based on consideration of magnitude and severity of impacts, populations impacted, and rates compared to a referent (generally the state rate). In the 2016 CHNA, prioritized health needs were those that had the greatest combined magnitude and severity or that disproportionately impacted priority populations in the community. Quantitative, qualitative, and expanded community engagement data confirms that priorities from 2016 continue in 2019.

## 5. Community and Stakeholder Engagement

The input of the community and other important regional stakeholders was prioritized by the Coalition as an important part of the CHNA process. In the region, the Coalition engaged almost 1,200 people in the 2019 CHNAs. Below are the primary mechanisms for community and stakeholder engagement, and the number engaged for the Baystate Noble Hospital CHNA. See Appendix 1 for a list of public health, community representatives, and other stakeholders included in the process.

- The **CHNA RAC** included representatives from each Coalition member hospital/insurer as well as public health and community stakeholders from each hospital service area. Stakeholders on the RAC include local and regional public health and health department representatives; representatives from local and regional organizations serving or representing medically underserved, low-income or populations of color; and individuals from organizations that represent the broad interests of the community. The Coalition conducted a stakeholder analysis to ensure geographic, sector (e.g. schools, community service organizations, healthcare providers, public health, and housing), and racial/ethnic diversity of RAC. The RAC met in workgroups (Data and Reports, Engagement and Dissemination, and Health Equity) to guide the consultants in the process of conducting the CHNA, and prioritize community health needs, CHNA findings, and dissemination of information. Assessment methods and findings were modified based on the Steering Committee feedback. The RAC consisted of 31 people, including community representatives and Coalition members. The RAC met monthly from September 2018 through June 2019.
- **Key informant interviews** and **focus groups** were conducted to gather information used to identify priority health needs and engage the community. Key informant interviews were conducted with health care providers, health care administrators, local and regional public health officials, and local leaders that represent the interests of the community or that serve

medically underserved, low-income, or populations of color in the service area. Interviews with local and regional public health officials identified priority health areas and community factors that contribute to health needs. Focus group participants included community organization representatives, community members (low-income, people of color, and others), and other community stakeholders. Topics and populations included: substance use, transgender health, older adults, youth, mental health, cancer care, gun violence, and rural food access. Key informant interviews and focus groups were conducted from February 2019 through March 2019. Focus groups and key informant interviews engaged people primarily in Hampden County but also across the region; this CHNA also used qualitative data from other hospital service areas as appropriate.

- Baystate Noble held one **Community Conversation** and approximately 12 **Community Chats** that were pertinent to Baystate Noble’s CHNA. Community Conversations were larger bi-directional information-sharing meetings conducted for each Baystate Hospital service area and one done in Spanish in Springfield. For Community Chats, RAC members brought information about the CHNA and gathered priorities in regular meetings of service providers, community-based organizations, and hospital clinical staff and administrators. While these outreach efforts were spearheaded by Baystate Health, the engagement and findings benefitted all Coalition member hospitals/insurer. Conversations and Chats were held from January 2019 through April 2019 and engaged approximately 832 people in Hampden County.
- A **Community Forum** was held upon completion of this report to share the findings. The Community Forum included individuals representing the broad interests of the community, participants in the focus groups, interviews, Conversations, Chats, and community stakeholders representing medically underserved, low-income, and populations of color.

*“We are too often talking about people, not with people. Community needs to be at the table, have their voices valued. They don’t feel heard.”*

Key Informant Interviewee, Public Health Official, Hampden County

## 6. Limitations and Information Gaps

Given the limitations of time, resources and available data, our analysis was not able to examine every health and community issue. Data for this assessment was drawn from many sources. Each source has its own way of reporting data, so it was not possible to maintain consistency in presenting data on every point in this assessment. For example, sources differed by:

- geographic level of data available (town, county, state, region)
- racial and ethnic breakdown available
- time period of reporting (month, quarter, year, multiple years)
- definitions of diseases (medical codes that are included in counts)

A limitation frequently hindering data collection and reporting across all the Baystate Health hospitals is the problem of small numbers. When the number of cases of a particular characteristic or condition is small, it is usually withheld from public reports, so as to protect confidentiality. For example, the MDPH will report on suspected opioid overdoses by town if there are five or more in the given time period. If fewer, the report indicates <5. This is common practice in reporting public health data.

The small numbers problem extends beyond the availability of data. When numbers are small, estimates can be unstable and have large margins of error. That is, it can be deceptive to report a statistic when numbers are small, because that statistic may change substantially year to year without indicating that something meaningful has happened to make the numbers different. When estimates based on small numbers are presented in this assessment, the text will note that margins of error are large and that estimates are unstable and should be interpreted with caution.

Ideally, we would disaggregate data for a better understanding of people who identify with different races and ethnicities, yet this data is often not available, or is based on estimates that come with a large margin of error. Beyond broad categories, we recognize that there are differences among those who identify as Mexican, Puerto Rican, or Cuban that aren't captured by the term "Latino," and differences among those who identify as Chinese, Japanese, or Korean that aren't captured by "Asian." Similarly, within the "black" population there are culturally and linguistically diverse identifies, including, but not limited to, West Indian, Caribbean, African, and African-American. We recognize that some groups are underrepresented in this CHNA, such as Native Americans, Asian Americans, non-English speaking populations, people with disabilities, and undocumented immigrants. It is also important to consider intersectionality, the holistic and integrated identities of people. What impact does being young, black, and gay in Hampden County or the Hilltowns have on health? Or being transgender and living on an income below the poverty line? We were unable to explore these differences with the quantitative data available. We were able to gather valuable information through focus groups with specific priority populations, while recognizing that a handful of focus groups cannot begin to cover the broad diversity of our people present in our community.

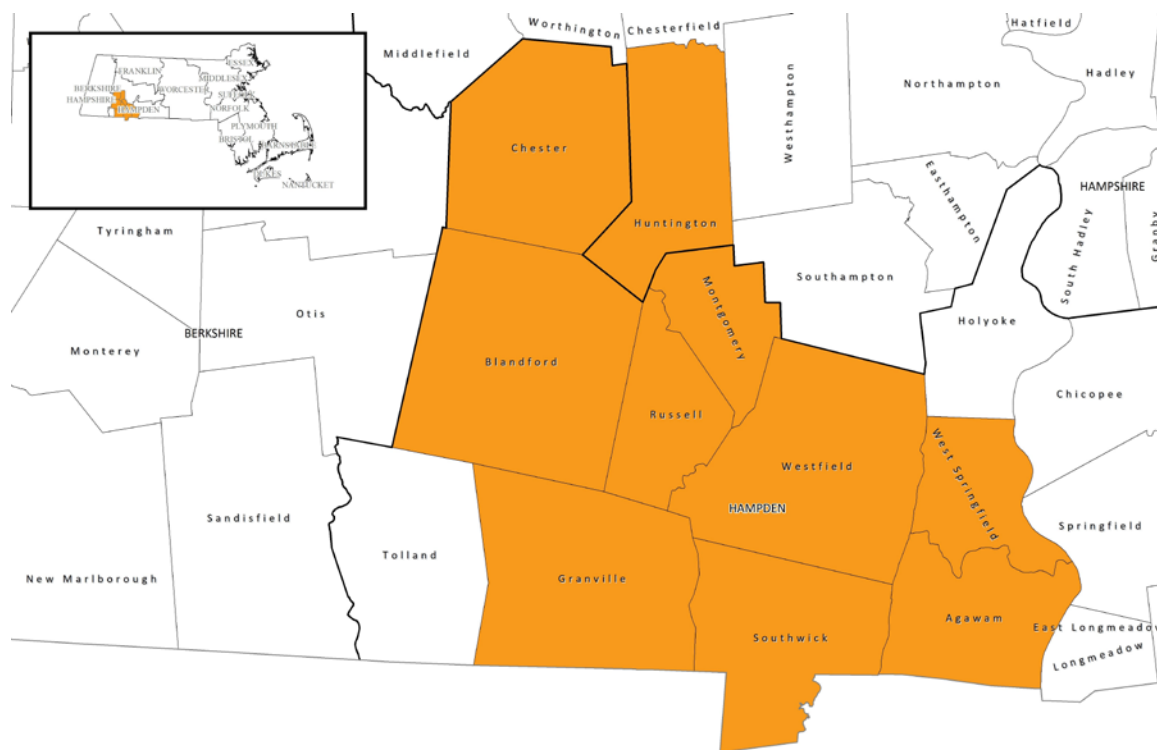
These issues also affect reporting by geography. Many sources provide data by county, and much of the data in this assessment is specific to Hampden County. When sources report by town, the larger towns in the area often have enough cases so that data is not suppressed, so in many charts in the report, data is primarily shown for West Springfield and Westfield.

## 7. Hospital Service Area

The service area for Baystate Noble includes ten communities, nine of which are located in the western portion of Hampden County (Table 1 and Figure 5), over 100,000 people, and a majority of this population lives in the cities of West Springfield and Westfield. There is a mix of rural and urban populations. The U.S. Census defines urban areas as consisting of census tracts and/or blocks which meet the minimum population density requirement (2,500-49,999 for urban clusters and over 50,000 for urbanized areas) or are adjacent and meet additional criteria. The population is densest surrounding Westfield, West Springfield, and Agawam (US Census Bureau, Decennial Census 2010). The median age of residents in these cities is approximately 42 years.

The Pioneer Valley Transit Authority connects three of the communities to the Springfield metropolitan area to the east, and to the hospital itself. Paratransit service is also available for people with disabilities within three-quarter mile of a fixed route to facilitate access to medical care.

**Figure 5. Baystate Noble Hospital Service Area**



Source:

Public Health Institute of Western Massachusetts



The service area has more racial and ethnic diversity than many other parts of western Massachusetts (Table 2). County-wide, 24% of the population is Latino, 8% is black and 2% is Asian (ACS, 2013-2017), though this diversity is not equally spread throughout the region and tends to be concentrated in the urban core. In the Baystate Noble service area, 86% of the population is white, 7% is Latino, 2% is black and 3% is Asian (ACS, 2013-2017). A substantial proportion of the County's population is from other countries. In 2017, 22% of the state's immigrants came to western Massachusetts.<sup>5</sup> West Springfield has welcomed the highest proportion in Hampden County, and 15% of the city's populations are immigrants.<sup>6</sup> The current political climate has exacerbated threats to immigrant health related to threats to the behavioral, cultural, and structural systems that determine individual health decision on a daily basis.<sup>7</sup> According to the MDPH, in the past 5 calendar years (2014-2018), there were 2,314 refugees with health assessments in western Massachusetts.<sup>8</sup> This assessment is the first medical screening provided to refugees; it is their gateway into the medical system.

Economically, the Baystate Noble service area is near many of the largest employers in the region as well as numerous colleges and universities. The largest industries and employers include health care, service and wholesale trade, and manufacturing.

Compared to the state, the Baystate Noble service area has slightly lower unemployment and poverty rates, and higher levels of educational attainment. The median household income in the service area is about \$61,000 (almost \$17,000 less than the state). The poverty rate is 9% (slightly lower than the state rate of 11%). The child poverty rate is 13% (compared to 14.6% at the state level) (ACS, 2013-2017). Despite being near the Knowledge Corridor region, only 31% of the population aged 25 and over has a bachelor's degree, compared to 43% statewide. Unemployment is slightly lower than the state average.

The median age for the service area is 41.6 years of age which is older than that of Hampden County and of the state. The population over 45 years old is growing as a percentage of the total population (Table 2). To give a sense of the change in service needs, between 2010 and 2035, the proportion of people over age 60 in Hampden County is projected to grow from 20% of the population to 28%, with the number of older adults increasing from approximately 92,000 in 2010 to an estimated 140,000 in 2035.<sup>9</sup> Aging projection data specific to the service area was unavailable.

In Hampden County 14% of the population has a disability compared to the state rate of 12%. In West Springfield and Westfield, disability rates are comparable to the county at 14% and 15% respectively.

**Table 1. Municipal Communities in Baystate Noble Service Area**

Hampden County	2017 Population Estimate
Blandford	1,260
Chester	1,529
Agawam*	28,748
Granville	1,624
Huntington	665
Russell**	1,793
Southwick	9,758
Westfield	41,700
West Springfield	28,704
<b>Total Service Area</b>	<b>117,354</b>

Source: Population Division, U.S. Census Bureau

\*Only the Feeding Hills section of Agawam is part of service area

\*\*The village of Woronoco is in the eastern part of Russell and is part of service area

**Table 2. Sociodemographic Characteristics of Baystate Noble Service Area**

Sociodemographic Characteristic	Hampden County	Baystate Noble Service Area	West Springfield	Westfield	MA
<b>Age</b>					
Median age (years)	38.7	41.6	38.2	38	39.4
>18 years	22%	20%	22%	20%	20%
18-64	62%	63%	63%	65%	64%
65 and over	16%	17%	15%	16%	16%
<b>Race and Ethnicity*</b>					
Latino or Hispanic	24%	7%	10%	8%	11%
White	64%	86%	83%	93%	73%
Black or African American	8%	2%	5%	2%	7%
American Indian and Alaska Native	0.1%	0.1%	0.7%	0.1%	0.1%
Asian	2%	3%	5%	2%	6%
Native Hawaiian and Other Pacific Islander	0.0%	0.1%	0%	0.1%	0.0%
Some other race	0.2%	0.4%	4%	2%	0.7%
Two or more races	2%	1%	2%	1%	2%
<b>Language Spoken at Home (population over 5)</b>					
Speaks language other than English at home	25%	15%	24%	14%	24%
<b>Educational Attainment</b>					
Population 25 years and over					
Less than high school graduate	15%	9%	11%	8%	9%
High school graduate (includes equivalency)	30%	30%	28%	31%	24%
Some college or associate's degree	29%	30%	30%	29%	23%
Bachelor's degree or higher	27%	31%	31%	32%	43%
<b>Income</b>					
Median household income	\$52,205	\$60,687	\$51,735	\$62,212	\$77,385

Source: U.S. Census, ACS, 2013-2017; for MA Census Reporter

\*Note that all races except Latino/Hispanic and "Two or More races" are among those reporting non-Latino/Hispanic

## IV. Prioritized Health Needs of the Community

The following are the prioritized health needs identified for the Baystate Noble service area in Hampden County. The prioritized health needs of the communities served by Baystate Noble are grouped into three categories: 1) social and economic determinants that impact health, 2) barriers to accessing quality health care, and 3) health conditions and behaviors.

### 1. Social and Economic Determinants that Impact Health

Based on analysis, the prioritized community level social and economic determinants of health that impact Baystate Noble's service area are:

- Social environment - social isolation, connection to community, and interpersonal, institutional, structural, and historical discrimination
- Housing needs - housing affordability, housing quality, and homelessness
- Lack of access to transportation and healthy food
- Lack of resources to meet basic needs - poverty, income, unemployment, and workplace policies
- Need for financial health - saving, homeownership, and financial literacy
- Educational needs - educational attainment and systemic barriers to quality education
- Violence - interpersonal and community violence and violence-related trauma

The organization of the 2019 CHNA differs slightly from the 2016 CHNA. By aligning with the MDPH's determinants of health framework, we assessed all of the MDPH prioritized determinants. This shift created more data points than in 2016, however determinants that were prioritized as community health needs in Baystate Noble's 2016 CHNA continue to contribute to the health challenges experienced in its service area.

#### A. SOCIAL ENVIRONMENT

The social environment consists of the demographics of a region, including distribution of age, race, ethnicity, immigration status, and ability; community-level factors such as language isolation, participation in democracy, social isolation or support, experiences of interpersonal discrimination; and the policies and practices of systems of government, cultural norms, and institutional racism, all of which impact people's health every day. The social environment – and specifically social isolation and institutional discrimination and racism – was a prioritized need in the 2016 CHNA. These elements, with an expanded consideration of structural or systemic racism and other oppressions, continue to be elevated needs in 2019.

**Community-level factors** - a variety of community level factors contribute to a social environment that impacts health, with some positively impacting health such as social support and participation in society, and some negatively impacting health such as experiences of oppression. Social isolation and participation in communities arose during focus groups and interviews for the CHNA. Factors mentioned that can lead to social isolation are:

- emotional implications of having a disability
- poor, unreliable, and disrespectful transportation options
- decreased day services for people with mental health problems
- for older adults, limited availability of Meals on Wheels, limited Senior Center hours and activities, and hearing, vision, and dental problems
- linguistic isolation in Hampden County, with over 25% speaking a language other than English at home and 9% stating they speak English “less than very well.” In West Springfield, one- fourth of the population speaks a language other than English as well (ACS, 2013-2017)

*“Social connections and networks for social activities and support are as important as medical and mental health care. Older adults want to feel valued and involved in the community.”*

Community Forum Participant, Older Adults Community Forum, Coalition Hospital

**Being a connected part of a community is health-protective** – participants of focus groups and interviews gave many examples:

- food pantry users stated that one always has something to eat if you get together with your neighbors
- substance abuse prevention advocates highlighted support groups that have emerged for grandparents raising the children of loved ones that they have lost

Public health leaders strongly advised health practitioners to practice cultural humility and become knowledgeable about different communities in order to be better health care practitioners.

**Experiences of interpersonal discrimination, systemic racism and other forms of exclusion** can serve to socially isolate people, and have consequences for mental and physical health.<sup>10,11</sup> Participants in focus groups and key informant interviews shared their experiences:

- lack of sensitivity of transgender issues socially isolates transgender people who don’t pass as the gender they identify as
- people with substance abuse and mental health disorders face discrimination in the medical system
- rural populations feel that their priorities get “kicked down the road”

- youth of color report being stereotyped by peers, teachers, and mention that “doctors shame and threaten parents that they should take better care of their kids.” One young woman said, “A guy told me I was unattractive because I was black. It took a toll on me.”
- children with disabilities face a high rate of bullying in schools

**Policies and practices** of systems of government, cultural norms, and institutional discrimination impact people’s health every day. The 2016 CHNA identified institutional racism as a driver of health inequities. In the 2019 CHNA, **institutional and systemic racism** continue as major sources of health inequities. Institutional racism is racial inequities, created by policies and practices of an institution, in access to goods, services, and opportunities such as quality education, housing, employment opportunities, medical care and facilities, and a healthy physical environment.<sup>12</sup> **Systemic or structural racism** extends beyond one institution. Policies and practices of systems and institutions that result in racial inequities and other forms of discrimination become the norm, are often codified by law or policy, and can manifest as inherited disadvantage. These practices do not necessarily transpire at the individual level, but are embedded in our systems, regulations, and laws. Institutional racism is perpetuated by bureaucratic barriers and inaction in the face of need.<sup>13</sup> Structural racism is mutually reinforcing systems (criminal justice, poorly funded public schools, and housing policies, for example) that perpetuate discrimination in all areas of daily life and results in unequal distribution of social resources.<sup>13</sup> The policies and practices of systems and institutions are directly influenced by who has power and how they use it. Racially-motivated and other forms of discrimination, whether conscious or built into the practices of systems, can lead to adverse health outcomes such as poor mental health, chronic stress, hypertension, and cardiovascular disease.<sup>14, 15, 16, 17, 18</sup>

Focus group participants and interviewees provided examples of institutional racism and other forms of institutionalized oppression:

- substance use disorder recovery coaches are not paid or have very low pay, and there is very little training and no certification, which systematically marginalizes and devalues recovery services
- marginalized youth don’t often see teachers, counselors, community staff who look like them or have had the same kinds of experiences they have
- the administrative level of health care does not feel friendly to transgender people. Forms and protocol disregards preferred names and gender identity, and asks patients to fill out forms with inscrutable questions about transgender status

This CHNA includes examples in the sections that follow of how systemic policies and practice impact the social determinants of health.

Racial residential segregation is one of the most significant forms of institutional racism with detrimental impacts on health. This segregation limits opportunity environments and embeds communities with structural barriers that directly impact access to quality education, jobs, quality housing, healthy food, and a number of other social determinants of health.<sup>19</sup> The University of Michigan’s Center for

Population Studies in 2013 ranked the Springfield Metropolitan Statistical Area (Hampden, Hampshire and Franklin counties) as the most segregated in the U.S. for Latinos, and 22nd in the country for blacks.<sup>20</sup>

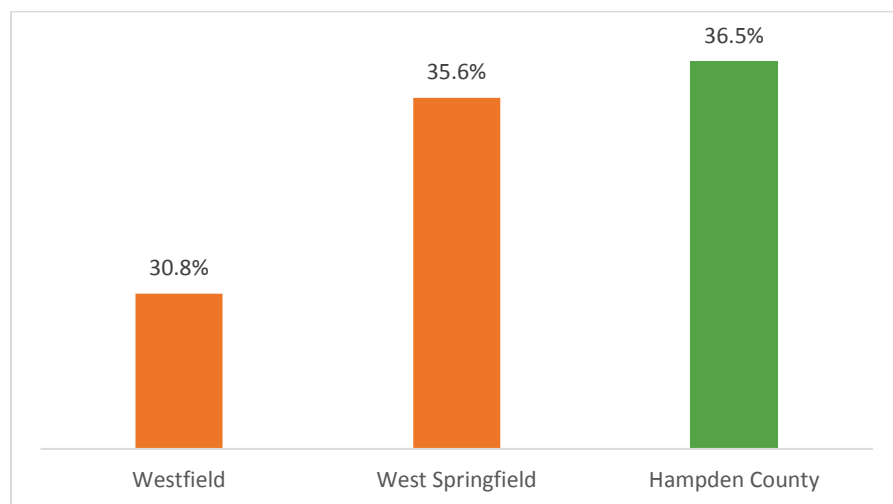
Mass incarceration and criminalization are examples of institutional racism that result in racial inequities at every stage of the criminal legal system, with health implications. In 2015, admissions to the Hampden County Jail were more than double the Massachusetts rate (458 in Hampden County compared to 216 people per 100,000 in Massachusetts). The average daily population in the jail was 1,428 people. Blacks and Latinos are jailed at disproportionately higher rates, comprising 60% of the jail's population compared to an estimated 32% in the county as a whole. Only 36% of the Hampden County jail population is white. The incarceration of women in jails is on the rise, with Hampden County jail incarcerating 84% more women between 2011 and 2015.<sup>21</sup>

## B. HOUSING NEEDS

Affordable, accessible, and supportive housing is a key contributor to health. Focus group participants, interviewees from varied sectors, and prioritization in Community Chats identified housing as one of the top health-related concerns for the 2019 CHNA.

Housing insecurity continues to impact Hampden County residents. Approximately one-third of the population in Baystate Noble's service area is housing cost burdened, with rates close to 36% in West Springfield (U.S. Census Bureau, ACS 2013-2017) (Figure 6). For homeowners in Hampden County, 7% experienced being cost-burdened compared to 31% of renters. Housing cost burden is defined as more than 30% of income going towards housing. Lack of affordable housing can contribute to homelessness and housing instability, which leads to increased stress and can often force families to prioritize housing costs over factors that can influence health, such as purchasing healthy foods and medications.

**Figure 6. Housing Cost-Burdened, Hampden County and Select Communities**



Source: U.S. Census, ACS 2013 – 2017

A more complete picture of affordability adds the cost of transportation. In Hampden County for a typical household income, people spend 52% of their income on housing and transportation costs combined. However, those with a lower household income spend 62% of their income on housing and transportation. In Westfield, households spend up to 5% more on housing and transportation.<sup>22</sup>

In focus groups, the availability and quality of affordable housing was identified as a challenge. Older adults felt that finding housing could be challenging due to affordability – adult living communities are plentiful but very expensive.

**Homelessness** - a “Point-in-Time” count done by the Western Massachusetts Network to Eliminate Homelessness found that there were almost 2,900 people homeless on one night in January 2018 in western Massachusetts, of which 80% were in Hampden County. An estimated 20% were chronically homeless. When someone is chronically homeless, providing housing combined with social and health services is necessary. Many people experiencing homelessness need housing, social and health services, and an expedited pathway to these services. Approximately 55% of the homeless population is children under the age of 18. Of youth aged 18 – 24 who are unstably housed, more than half have been involved in the juvenile, foster, or jail systems. And more than 80% of mothers who are homeless are survivors of domestic violence.<sup>23</sup> In Springfield in 2017, almost 600 youth aged 18 – 24 stayed in emergency shelters in Hampden County.<sup>24</sup>

Key recommendations from focus groups and interviews to prevent homelessness are to:

- provide resources including more housing combined with supportive services, more rapid rehousing after being in a residential program or incarcerated, and more affordable housing
- target audiences include people who are leaving institutional settings (e.g., foster care, jail, hospital stays), those at risk of losing housing, people living with physical or psychological disabilities, and survivors of domestic violence<sup>24</sup>

In a focus group with people experiencing homelessness, the most common health issue mentioned was the need for treatment services for mental illness and substance use disorders. In a focus group with recovery coaches for people with substance use disorders, the first need mentioned was housing, particularly for women as well as for people with CORI issues.

*“You can’t do treatment [for substance use disorder] without a place to live.*

*You can’t do it if you’re living on the street.”*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County



When discussing what would be helpful for people who are living unsheltered, people recommended supportive services, such as having warm places during the day when shelters are closed, having something meaningful to do, and using the time and skills of people who are homeless to rehab old buildings. Interviews with staff helping people reenter the community after incarceration indicated that the issue of finding housing was critical. This population faces many barriers to finding housing, such as limitations placed on them due to their conviction and needing dual diagnosis or sober housing, which is in short supply.

*“Some people might be stable in transitional housing their whole lives, some may be able to move on to independent living. Everyone’s unique, their bodies are different, need different types of treatment and housing.”*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

**Poor housing conditions** also impact the health of residents. Older housing combined with limited resources for maintenance can lead to problems (e.g. exposure to mold, pests/rodents, lead paint, asbestos, and lead pipes) that affect asthma, other respiratory illnesses, and child development. Housing conditions are important for the safety and accessibility for children, elderly or disabled populations. Hampden County has a large older housing stock with 32% of housing built before 1940. Similarly, in West Springfield and Westfield about one- third of homes were built before 1940 (U.S. Census Bureau, 2014-2017).

### C. LACK OF ACCESS TO TRANSPORTATION AND HEALTHY FOOD

There is a vast research base demonstrating that decisions about how the world around us is constructed can impact health behaviors. Transportation systems and choices, environmental exposures from industry, access to food, community spaces, retail, and institutions all serve to help or harm.

**Transportation** arose as a barrier to care in the 2016 CHNA, and continues to be a major obstacle to good health (see Barriers section for more detail on Transportation as a barrier to quality health care). Reliable transportation is a critical part of daily life, allowing individuals to go to work, travel to the grocery store, or get to medical appointments. In the Baystate Noble service area, approximately 8% of the population does not have access to a vehicle (US Census Bureau, ACS 2013-2017). In key informant interviews, lack of access to transportation was identified as a major barrier for accessing food and treatment and recovery services for substance use disorders.

For the Baystate Noble service area, the PVRTA primarily connects the communities of West Springfield, Westfield, and Feeding Hills to the Greater Springfield area. However, there are limited public transportation options available that connect communities within the service area. This can be especially challenging for the rural communities where, according to one key informant who serves the Hilltowns, there are only two vans available for public transportation, and they only serve older adults.

Unequal access to appropriate transportation options exacerbates racial and ethnic health disparities. Communities of color and those with lower incomes have less access to transportation options compared to majority white and higher income communities.<sup>25,26</sup> Public transportation plays a significant role in filling transportation needs for many of these households. The PVTA reports that the majority of its customers – over 62% – are people of color. A 2017 equity analysis examining proposed bus line service cuts and fare hikes concluded that the changes would have a negative impact on communities of color.<sup>27</sup>

*“Transportation is a big issue. A lot of our patients financially aren’t doing that great, so transportation is a big issue. A lot of patients struggle to get to appointments so transportation is a big support service need.”*

Key Informant Interviewee, Oncology Program Coordinator, Hampden County

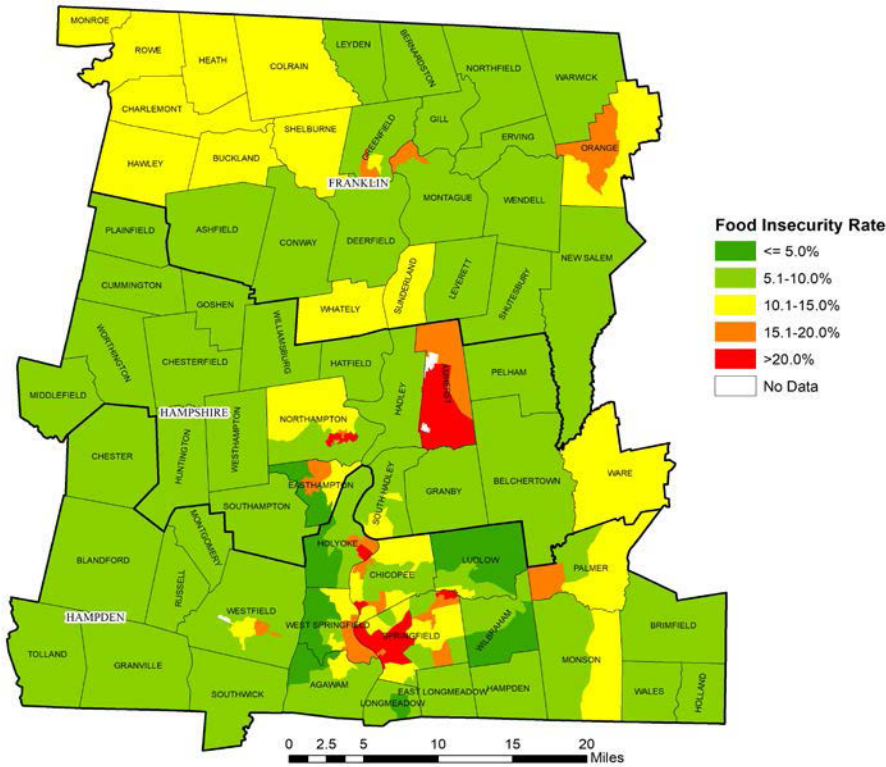
**Food Access** - food insecurity, or being without reliable access to sufficient affordable and nutritious food, continues to impact many Hampden County residents. Eating nutritious food promotes overall health and helps manage many chronic health conditions. However, not all individuals and communities have equal access to healthy food. As can be seen in a map of food insecure census tracts in Hampden, Hampshire and Franklin counties, portions of West Springfield and Westfield have rates of food insecurity greater than 15% (Figure 7). In 2018, the Conway School conducted a food network study of the Merrick neighborhood in West Springfield which has a significant immigrant and refugee population. It suggests that although the community has great access to healthy foods, there are multiple barriers including limited English proficiency, limited access to a vehicle, and limited access to SNAP benefits that makes it difficult to purchase healthy foods.<sup>28</sup>

Key informant interviewees cited access to transportation as one the primary factors for food insecurity. For those with limited access to transportation, it can be difficult to access the large food retailers in the area. One of the suggested methods to increase access to healthy foods was to promote local agriculture through community gardens and farm stands. However, policy barriers have prevented the development of these resources.

*“Almost all towns here are farm-friendly, but food is a different story”*

Key Informant Interview, Hilltown Community Health Center Staff, Coalition Hospital

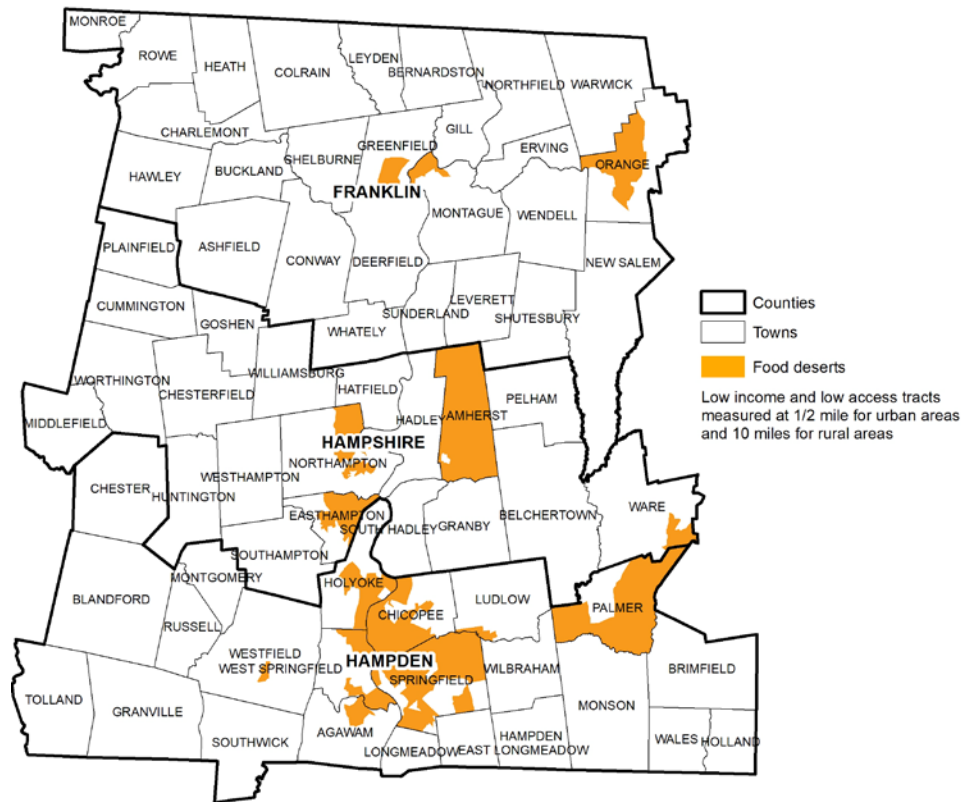
**Figure 7. Percent Food Insecure Hampden, Hampshire, and Franklin Counties**



*Data source: Gundersen C Dewey A, Crumbaugh A, Kato M, Engelhard E. 2018. Map the Meal Gap 2018: A Report on the County and Congressional District Food Cost in the United States in 2016. Feeding America, 2018. Provided courtesy of the Food Bank of Western Massachusetts. Mapping: Public Health Institute of Western MA.*

Historical planning decisions created highways that split cities and separated white areas from black areas. One of many legacies has been that communities of color have worse access to grocery stores, more access to unhealthy fast foods, and more liquor retailers in their communities.<sup>29</sup> In addition, marketing of fast food, junk food, sugary drinks, tobacco and alcohol more often targets communities of color.<sup>30</sup> Hampden County also has several food deserts, or areas where grocery stores and other options to purchase healthy foods are far away and difficult to access for people that either do not own a vehicle or live where public transportation is limited. People with lower incomes are more likely to live in food deserts. As identified in the 2016 CHNA, parts of Springfield, Holyoke, and surrounding communities have areas that the USDA has identified as food deserts (Figure 8).

**Figure 8. USDA Food Atlas Food Desert Areas in Hampden County**



Source: USDA ERS Food Access Research Atlas – 2015; US Census Bureau’s Cartographic Boundary Files; Mapping: Public Health Institute of Western Massachusetts. 3/21/2019. USDA Food desert: at least 500 low-income people in a census tract live more than one mile away from a grocery store in urban areas and more than 10 miles from a grocery store in rural areas

#### **D. LACK OF RESOURCES TO MEET BASIC NEEDS**

In the Baystate Noble service area of Hampden County, many residents struggle with a lack of resources to meet basic needs, making income and employment a priority need. Hampden County has **high rates of poverty** and **low levels of income**. The connections between poor health and poverty, low levels of income, and access to fewer resources are well established. People with lower incomes are more likely to be negatively impacted by chronic stress associated with challenges in securing basic necessities that impact health, such as housing, food, and access to physical activity opportunities.

The median household income of \$60,687 in the Baystate Noble service area is about one quarter less than that of the state. In the Baystate Noble service area, the Census estimates that black families make less than 80% and Latinos make less than 70% the income of white families (Table 3). The unemployment rate in the Baystate Noble service area among the black and Latino population is more than triple that of the white population.

Just over 9% of Baystate Noble service area residents live in poverty, with rates of poverty over 10% of the population concentrated in areas of West Springfield (12%) (Figure 9). An estimated 32% of West Springfield residents and 25% of Westfield residents live at or below 200% of the poverty level, which is a better indicator of people in need as the federal poverty level is extremely low and does not capture all of those who are economically struggling (US Census, ACS, 2013-2017).

Across all Hampden County focus groups, Community Conversations, and Chats, poverty was identified as a factor that impacts overall health, access to health care, and access to programs and services that promote health. Although incomes are generally higher in the Baystate Noble service area compared to Hampden County, they are still lower on average than the statewide level, and are much lower for blacks and Latinos. A key informant highlighted that high costs of living impact the individual’s ability to meet their basic needs, specifically for food. Having a higher income but an inability to meet needs can create barriers with accessing social supports. For example, the Supplemental Nutrition Assistance Program (SNAP) has very low-income thresholds for eligibility.

**Table 3. Socioeconomic Status Indicators**

	Baystate Noble Service Area				Massachusetts*
	Overall	White**	Black**	Latino	
Median Household Income	\$60,687	\$61,783	\$48,044	\$43,317	\$77,385
Unemployment	6%	5%	10%	11%	6%
Poverty	9%	7%	21%	27%	11%

Sources: UC Census, ACS 2014-2017; poverty is 100% below federal poverty level; \*US Census, Fact Finder, Massachusetts Profile; \*\*Data for white residents is among those reporting non-Latino white. Contrary to previous years, recent census data does not separate people who identify as non-Hispanic black or Hispanic black. Therefore, these estimates cannot be compared to previous years.

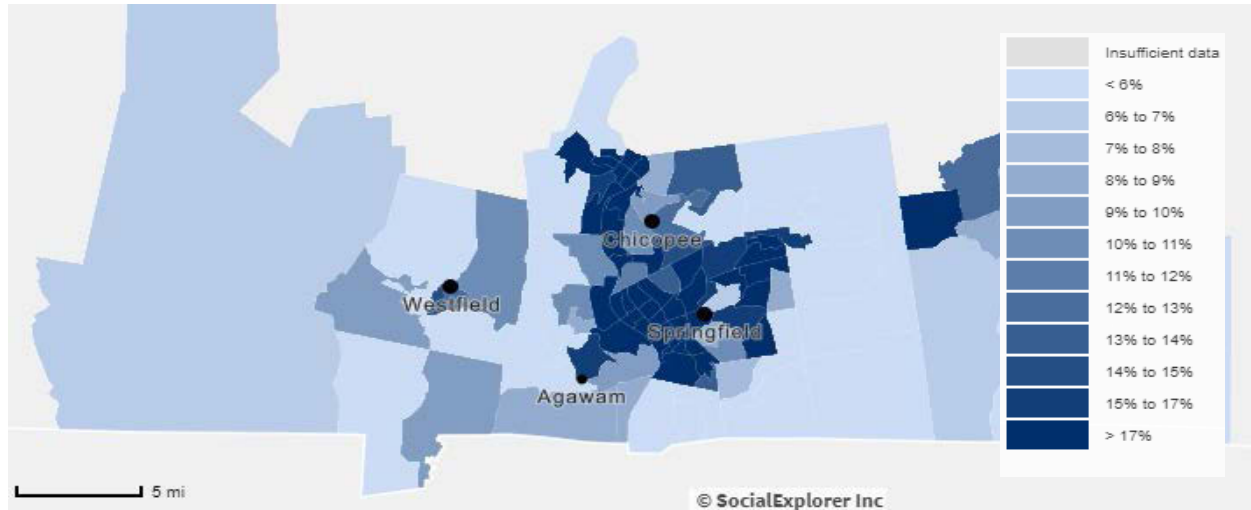
Hiring and workplace discrimination affect people of color more frequently than white people.<sup>31</sup> Historically, laws passed during the 1990’s “Tough on Crime” era decreased the ability of people who have been arrested, convicted, or incarcerated to find jobs. The National Inventory of Collateral Consequences documents tens of thousands of limitations placed on people who have been convicted<sup>32</sup> of which an inequitable proportion, due to discriminatory policies and practices, are people of color.<sup>33</sup>

“Health issues unique to people of color? It’s harder to get hired.”  
Focus Group Participant, Youth Of Color Focus Group, Coalition Hospital

Workplace policies and practices can help or hinder well-being and health. Access to work-subsidized health care benefits, affordable childcare, sick and personal leave, a living wage, wellness programs, reasonable advance knowledge of scheduling, and workplace discrimination can mean the difference

between direct health or illness as well as chronic stress.<sup>34,35,36</sup> Number of hours worked and predictability of scheduling are other employer practices that have a large health impact.<sup>37</sup>

**Figure 9. Hampden County Poverty Rates**



Source: Social Explorer 2019, U.S. Census Bureau, 2013-2017; poverty is 100% below federal poverty level

Women, children, and populations of color are disproportionately affected by poor socioeconomic status in Hampden County. Women in Hampden County earn 83 cents compared to every \$1.00 earned by men, and women of color earn even lower proportions; 57 cents for Latinas, and 71 cents for black women.<sup>38</sup> Almost 60% of children living in Hampden County qualify for free or reduced lunch and 27% are in families with incomes below the poverty level (U.S. Census Bureau, ACS 2013-2017). With regard to race and ethnicity, median income levels are lower and unemployment and poverty rates are higher among Latinos and blacks (U.S. Census Bureau, ACS 2013-2017). Hiring and workplace discrimination affects people of color more frequently than whites.

## E. NEED FOR FINANCIAL HEALTH

Financial health is a measure of how one's financial and economic resources are able to support their physical, mental, and social well-being.<sup>39</sup> Financial resources that impact health include: amount of savings, money set aside for retirement, and proportion of income spent on daily living, among others. Financial health describes how well a person's finances support their ability to be healthy every day and in the future. In 2019, Baystate Noble has included financial health as a prioritized community health need.

This section includes three indicators: savings, homeownership, and financial literacy. Unfortunately, there is not much local data available so we use national, statewide, and when possible local data.

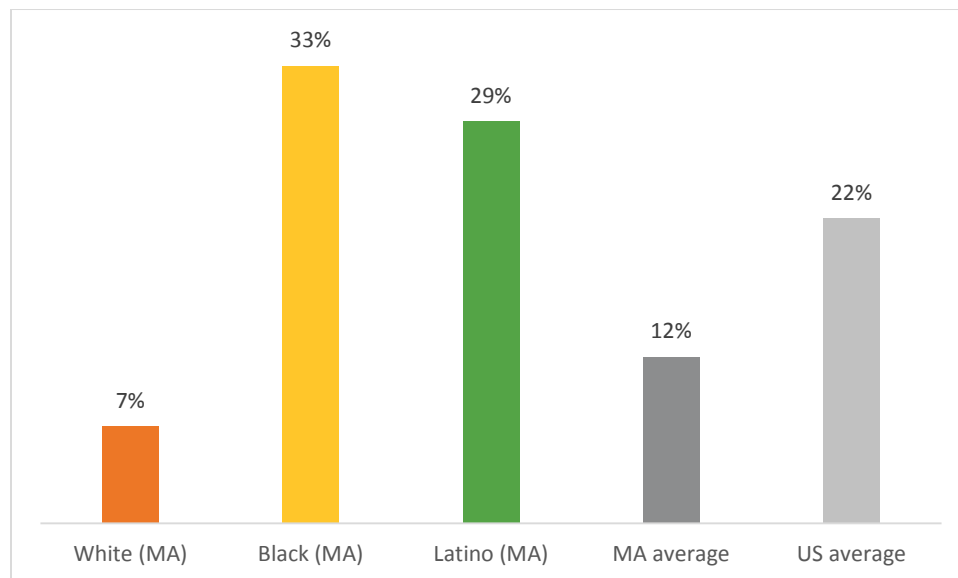
**Savings** - saving money can help with financial security and can provide a safety net in case of an emergency. In 2016, the median amount of savings in the United States was \$7,000. The median is often used to describe savings because it is a more accurate approximation of what most Americans have saved since the average (mean) is heavily skewed by high-income outliers. Women have a much lower median savings of \$2,500 compared to \$9,200 for men. In addition, blacks and Latinos have an average savings account balance of \$1,500, which is substantially lower than that of whites (\$9,700).<sup>40</sup>

**Homeownership** - for many, the primary way to build wealth is through homeownership. Homeownership can be a path to wealth and has the potential to be more stable than renting.<sup>41</sup> In the Baystate Noble service area, 70% of people own their home and 30% rent (US Census, ACS, 2013 – 2017). Historically, redlining lending practices, racial discrimination related to mortgage acquisition in the GI bill, and higher incidence of predatory lending in communities of color have denied black and Latino communities the ability to create stability and generational wealth via home ownership.<sup>42,43</sup> Reflecting inequitable policies and practices, in West Springfield, although over 59% of people own their home, only 34% of the black population and 20% of the Latino population own their homes. Similarly, in Westfield, although 69% of people own their home, only 27% of the black population and 53% of the Latino population own their home (U.S. Census, ACS, 2013-2017).

**Financial literacy** is having the skills and knowledge to manage personal finances so that a person can fulfill their goals.<sup>44</sup> It includes the knowledge to understand financial choices and the ability to make informed judgments and take effective actions, such as planning for the future, spending wisely, saving for retirement, paying for a child's education, and managing challenges associated with life events like a job loss. For example, individuals need to understand how to balance a checkbook, comprehend personal income taxes, and understand the concept of budgeting in order to make wise decisions with money.<sup>45</sup>

The National Center for Education Statistics measures financial literacy. The Program for International Student Assessment (PISA) rates students on a scale, with the top level (level 5) defined as students understanding a wide range of financial concepts. Lower levels of financial literacy show some baseline level of understanding of the difference between needs and wants and being able to make decisions on everyday spending. Students at lower levels can apply basic numerical operations (addition, subtraction, or multiplication) but not create percentages, use budgets, or make longer term financial decisions taking into account the impact on their financial health.<sup>46</sup> There is no local data available in Hampden County, but in Massachusetts, 12% of students nearing the end of mandatory schooling (generally about 15 years old) scored at the lowest level of financial literacy. By race and ethnicity, however, only 7% of whites in Massachusetts scored that low, while almost one-third of blacks and over one-fourth of Latinos did (Figure 10).

**Figure 10. Percent of Students Scoring at the Lowest Level of Proficiency in Massachusetts, by Race/Ethnicity**



Source: National Center for Education Statistics. 2015. *Financial Literacy Proficiency Levels*

## F. EDUCATIONAL NEEDS

**Educational attainment** is a prioritized community health need as it contributes longevity, availability of resources to meet basic needs, higher health literacy, and access to less physically dangerous jobs. Levels of education are strongly correlated with employment status, the ability to earn a livable wage, and many health outcomes.<sup>47</sup> Approximately 9% of Baystate Noble service area residents age 25 and older do not have a high school diploma. In West Springfield, 11% of eligible individuals do not have a high school diploma. In addition, although 42% of the population of Massachusetts has a bachelor's degree or higher, only 31% of the Baystate Noble service area population has a bachelor's degree or higher (U.S. Census, ACS, 2014-2017) .

Communities of color face systemic barriers to education. Historically, people who were enslaved were not allowed to learn how to read or write, and Jim Crow laws required schools to be racially segregated.<sup>48</sup> Segregation of lower income students of color into underfunded schools continues today.<sup>49</sup> In addition, differentially applied school discipline policies negatively affect students of color and disabled students, resulting in higher dropout rates and more involvement in the criminal justice system.<sup>50</sup>

In focus groups and key informant interviews, schools were called out in many ways as being a key social determinant of health. Comments included the importance of the school environment as well as how school systems could be a powerful partner to improve health. Participants raised elements of the school environment such as bullying. Youth of color talked about the stress of school requirements on



top of work or other tasks; having experienced racism in schools; and the need for teachers and staff to recognize trauma in students' behaviors, particularly when students have experienced violence.

*"In school, they don't teach you how to deal with emotional stress.  
You can end up being depressed about it."*

Focus Group Participant, Youth of Color Focus Group, Coalition Hospital

Suggestions for how schools could help included:

- training teachers and staff to be trauma-informed and have cultural humility
- including Social Emotional Learning<sup>51</sup> in the curriculum
- distributing information about developmental milestones to parents so they can detect disabilities early
- incorporating restorative justice circles to deal with school discipline issues
- hiring staff and teachers who have experience with the same types of neighborhood issues students face, such as gun violence
- policy suggestions include passing statewide public school budget bills being considered in the legislature

## G. VIOLENCE AND TRAUMA

Violence arose as a health need in the Baystate Noble service area in 2019. Interpersonal and collective violence affects health directly, via death and injury, as well as indirectly through the trauma that impacts mental health and healthy relationships.<sup>52</sup>

**Interpersonal violence** includes sexual and intimate partner violence, childhood physical and sexual abuse and neglect, and elder abuse and neglect. Western Massachusetts does not have any surveillance systems that measure incidence, prevalence, risk and protective factors, and related negative health outcomes associated with interpersonal violence (including intimate partner, dating, and sexual violence, violence against children, and child exploitation). Data was gathered from subject matter experts across western Massachusetts and the State (MDPH and Executive Office of Public Safety and Security), in addition to publicly available statewide-level datasets and reports. The only data source directly applicable to Baystate Noble's service area was the Gateway School District's Prevention and Needs Assessment Survey, so results for all of Hampden County must take into consideration that those include cities and towns that are not part of the Baystate Noble service area, such as Springfield, Holyoke, and Chicopee.

- **Sexual violence** - of the over 2,900 Provider Sexual Crime Reports (PSCRs) submitted in 2017 and 2018, 13% were from assaults that reportedly occurred in western Massachusetts and only

57% were reported to the police. Of PSCRs in the region, 55% (or 218) were in Hampden County. Females comprised 94% of victims/survivors, and one-third were youth under age 18.<sup>53</sup> In the Gateway School District, 20% of 12th graders in 2017 stated that they had been in a dating relationship with someone who forced or pressured them into sexual activity when they did not want to.<sup>54</sup>

- **Intimate partner violence** - in 2018, nearly 6,900 restraining orders were filed in all of western Massachusetts. The YWCA of Western Massachusetts in Hampden County fielded 5,116 calls to its Intimate Partner Violence (IPV) hotline; 94% were in English, 4% were in Spanish.<sup>55</sup> In the Gateway School District, 33% of 12th graders in 2017 reported that they had a friend who had been abused by a dating partner.<sup>56</sup>
- **Child abuse and neglect** - the Massachusetts Department of Children and Families (DCF) reports that in the last quarter of 2018 in western Massachusetts, over 3,000 reports of child abuse or neglect were filed and screened for investigation and 42% of them were deemed true and in need of services.<sup>57</sup> In the Gateway School District, almost 7% of 12th graders in 2017 reported that their family had been investigated by DCF.<sup>58</sup>
- **Elder abuse and neglect** - nationally, 1 in 10 older adults reports some type of financial, emotional, physical, or sexual mistreatment or potential neglect in the prior year.<sup>59</sup> The Massachusetts Executive Office of Elder Affairs reported 9,800 confirmed abuse and neglect cases in 2017, nearly 40% more than in 2015.<sup>60</sup> In the Springfield Area Service Access Point - where reports would be filed - there were 2,438 intakes completed in 2018, up from 1,401 in 2014.<sup>61</sup>
- **Bullying** - more than 1 out of every 5 students nationally reports being bullied, with girls, children with disabilities, and GLBQ+ and transgender students at increased risk. In the Gateway Schools, about 35% of youth have been bullied, with the most bullying happening in the school hallways and classrooms. When asked if actions to stop bullying really work, 63% said no.<sup>62</sup>

## 2. Barriers to Accessing Quality Health Care

The following prioritized barriers to accessing health care were identified as needs in Baystate Noble's 2016 CHNA and continue to be needs today based on the data that follows:

- Insurance and health care related challenges
- Limited availability of providers
- Need for increased cultural humility
- Need for transportation and financial assistance
- Lack of care coordination
- Health literacy and language barriers

### A. INSURANCE AND HEALTH CARE RELATED CHALLENGES

While 97% of Hampden County residents are covered by health insurance (US Census Bureau, ACS, 2013-2017), the ability to navigate both what health insurance will cover as well as the medical care systems continue to be barriers to accessing quality health care. People in focus groups talked about the difficulty of navigating without having an advocate. Nearly every population studied in focus groups or represented through interviews mentioned navigation of these systems as challenging: people with substance use disorder or mental health issues; transgender patients; people with disabilities; parents of children with disabilities; and older adults.

*"The whole system needs a group of people who know what's going on and know the system and can help people navigate it and coordinate all the different parts that affect a person."*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

Some examples of insurance challenges that people in focus groups and interviews identified having to traverse include:

- lack of health insurance coverage for substance abuse prevention and treatment services
- acquiring the funds necessary to take advantage of a housing opportunity (first and last month's rent and a security deposit in addition to monthly rent) often makes a person ineligible for MassHealth
- providers not taking MassHealth
- insurance companies changing their products

Despite high rates of coverage by health insurance, the cost of health care co-pays, deductibles, tests, and medication is a barrier for many to having optimal health. Beyond the expense of portions of health

care that insurance doesn't cover, additional costs include programs, equipment, and therapies that are typically not covered by insurance but are suggested by medical providers and help patients, e.g., acupuncture. A public health leader noted, for example, an increase in demand for free immunizations because people cannot afford co-pays. The high cost of home care for people with disabilities impacts the quality and quantity of those services. Older adults can fall into a gap where they are too young or have too much money to qualify for services they need, yet cannot afford to privately pay for these services. The financial counseling that hospitals offer is helpful but there are not enough counselors to serve the need.

*“Without a coordinator, people may get lost in the system and not get what they need. Health insurers and the medical community don't seem to understand the need for advocates/health coordinators.”*

Key Informant Interview, Director of Agency Serving Older Adults, Hampden County

## **B. LIMITED AVAILABILITY OF PROVIDERS**

Hampden County residents continue to experience challenges accessing care due to the shortage of providers. Lack of primary care providers (PCPs) and specialty care providers pose a significant challenge to individuals needing health care services. Community location (rural or urban), and/or insurance restrictions can impact accessibility to an already limited number of providers. Low-income individuals are more negatively impacted by insurance related issues of access.

Focus group participants report long wait times; use of “Minute Clinic” because they cannot get in to see their own doctor; providers not accepting new patients; a wait time of 4 – 6 months between initial scan of lung cancer and surgery; a wait of a month to get replacement dentures; and other constraints that impact quality of life and health outcomes.

Population to provider ratios are one indicator of how many healthcare professionals there are in an area. Hampden County has 1,400 people for every primary care physicians, compared with a ratio of 960:1 in Massachusetts. Hampden County has 1,210 people for every dentist, compared to 990 in the state.<sup>63</sup> Although there is greater access to mental health providers for Hampden County residents as compared to the state (120:1 versus 180:1 in Massachusetts), focus group participants and key informant interviewees overwhelmingly reported:

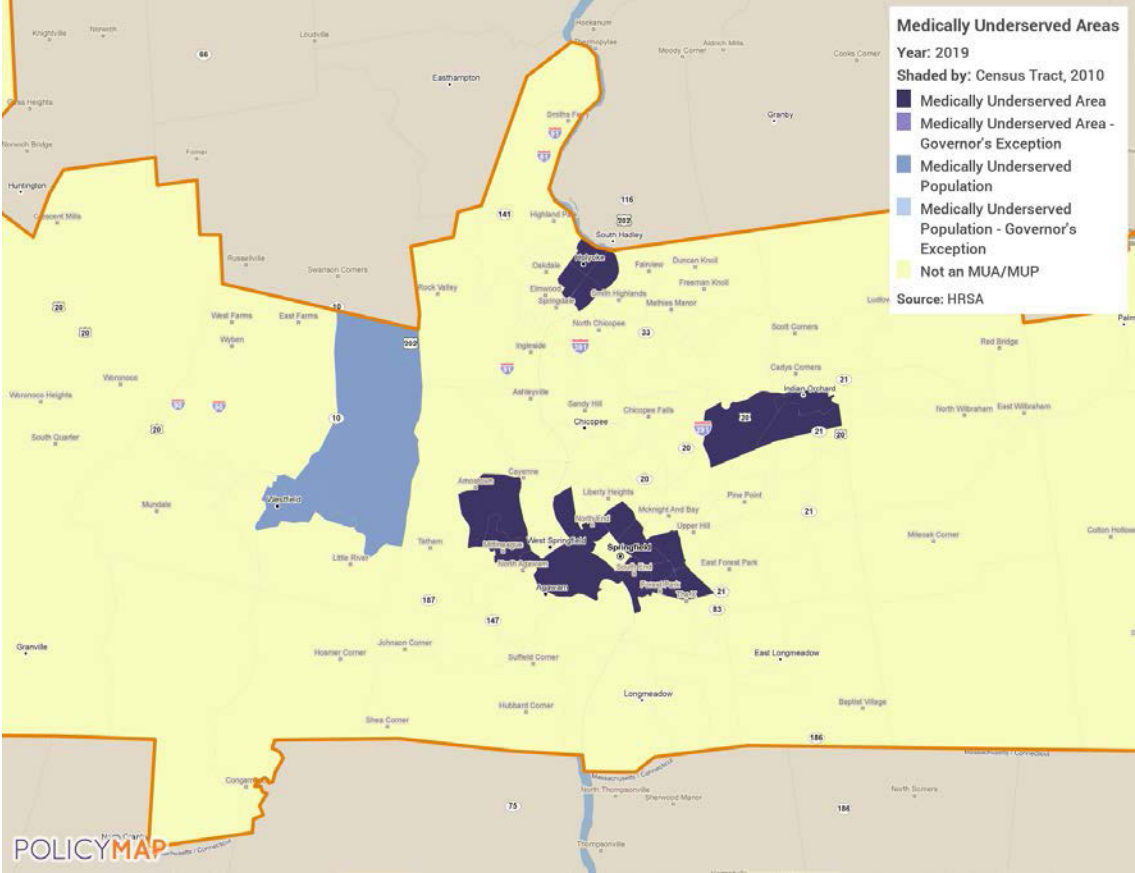
- a need for increased access to mental health and addiction services, with specific mentions of need for Medication Assisted Treatment (MAT)
- psychiatrists who can prescribe medications
- neuropsychology for children with disabilities
- specialists for adults and children with disabilities

- a variety of other specialists including Ear Nose and Throat providers, rheumatologists, and oral surgeons

“We have a lot of therapists, but not enough psych[iatric medication] prescribers.”  
 Key Informant Interviewee, Public Health Official, Coalition Hospital

Within the Baystate Noble service area, Westfield is part of a medically underserved population. In addition, parts of West Springfield are within medically underserved areas (Figure 11).

**Figure 11. Medically Underserved Areas/Populations in Hampden County**



Source: Community Commons, Health Resources and Services Administration (HRSA) 2015

### C. NEED FOR CULTURAL HUMILITY

The need for cultural humility in healthcare and social services remains a priority, as it was in the 2016 CHNA, with training in cultural humility as one strategy. Cultural humility refers to a commitment among health care and social service providers to self-reflection and evaluation in order to reduce the power imbalance between patients and providers, and to the development of care partnerships that are based on mutual respect and equality.<sup>10</sup>

*“Patients should not be in the position of educating their medical providers.”*

Focus Group Participant, Transgender, Non-Binary, Gender Non-Conforming Focus Group, Coalition Hospital

Many immigrants and refugees in the Baystate Noble service area travel to Caring Health Center in Springfield (outside of the service area) for their care because they are known for serving that population well.

Results from 2019 CHNA interviews with public health leaders and focus groups identified cultural differences between the community and providers and implicit bias as a barrier to health. They called for:

- an assessment of where and when this happens
- increased training, experience, and sensitivity for health care providers to a variety of different cultures
- accountability for lack of cultural humility and bias

Focus group participants noted that cultural humility is not limited to a racial or ethnic culture, but also includes care for stigmatized groups, such as: people who are formerly incarcerated; homeless individuals; people with mental health or substance use issues; the elderly; transgender, non-binary, and gender non-conforming individuals; and adults and children with disabilities. The need for providers competent in racial and cultural issues was also raised.

*“We need providers who look like and are from the community, who understand the culture. We need education for providers, a sense of what the community is. Some doctors are very conscious, but providers need to be immersed in the community, know how to navigate it.”*

Key Informant Interviewee, Public Health Official, Hampden County

## D. NEED FOR TRANSPORTATION

Transportation and the cost of health care arose in every focus group, interviews with key informants and public health officials, and Community Chats and Conversations as major and chronic barriers to health care (see also Transportation section in the Social and Economic Determinants of Health section).

Transportation is a particularly difficult issue for children and adults living with disabilities, older adults, low-income populations, and cancer patients. People in focus groups mentioned challenges due to lack of transportation in getting to medical appointments, the food pantry, places for disabled children to exercise, the grocery store, and the pharmacy.

Focus group participants had many creative ideas, ranging from:

- expanding existing PVTA bus service
- increasing eligibility for vans that are Americans with Disabilities Act (ADA) compliant
- telehealth
- more transportation vouchers (Uber, taxis, bus passes)
- mobile health vans that go to people to do lab draws and fill prescriptions
- pharmacies that deliver
- EMS doing wellness checks

*“If walking or taking the bus is an option - that is preferable to provider-scheduled transportation.”*

Focus Group Participant, Focus Group with People with Disabilities, Hampden County

## E. LACK OF CARE COORDINATION

Lack of care coordination is a prioritized community health need, as it was in the 2016 CHNA. Care coordination refers to the coordination of patient care, including the exchange of information between all parties involved in patient care.<sup>64</sup> In the 2019 CHNA, informants went beyond simply identifying that providers need to coordinate individuals’ care. Several called for “one-stop shopping,” “consolidation of services that already exist”, and reduction of the duplication of services, suggestions that were also made in the 2016 CHNA.

Focus group participants and interviewees identified important areas where care provided by multiple providers continues to be uncoordinated and results in challenges. Examples include:

- lack of follow up when a person is discharged from a mental health treatment program, substance use disorder program, or jail

- lack of coordination among agencies that provide support services for transgender clients
- lack of coordination between the emergency department and primary care
- need for survivor planning for people after cancer as they separate from the health care industry
- need to integrate mental health and substance use disorder services with primary care
- need for transitions, communication, and “warm handoffs” from jail to the community for a population that has a high rate of trauma and more needs

*“Lack of care coordination is a life or death situation. It is so difficult for patients to be seen as whole people and not just their individual ailments; people have to be strong advocates for themselves when they are the most vulnerable.”*

Regional Advisory Committee Member

## F. HEALTH LITERACY AND LANGUAGE BARRIERS

Public health leaders, as well as focus group participants and interviewees continued to identify the need for health information to be accessible, understandable, and more widely distributed.

Health literacy is the capacity for an individual to find, “communicate, process, and understand basic health information and services to make appropriate health decisions.”<sup>9</sup> Data from focus groups illustrate the need for increased access to information about providers, services, resources, how to advocate for themselves and their families, and health education. Several focus groups pointed to the need to have all information in one place. In focus groups for transgender, non-binary, and gender non-conforming people as well as parents of children with disabilities, participants mentioned needing a hub of information, such as an on-line resource for their specific needs, which is known as the place to go. One person noted that they had three separately compiled documents with resources for transgendered people, and how helpful it would be if everything were in one spot. While a support group is not a replacement for an institution or organization providing needed information, participants in the Cancer Support Group identified as vital the role the group played in teaching members self-advocacy, providing information about various resources, and health education.

Data from the Community Conversations also highlights the need to consider cultural differences when addressing health literacy. Participants pointed out that cultural differences affect people’s understanding of treatments and what treatments and services are available to them.

Language barriers can create multiple challenges for both patients and health care providers and was previously identified as a need. Increasing the availability of interpreters and translated health materials are specific actions that health care institutions can help to address these barriers. Baystate Noble had



almost 1,790 interpreter service requests in 2018 out of almost 80,000 inpatient and outpatient encounters, meaning that about 2.3% of encounters required interpreter services.<sup>65</sup>

Baystate Health held a Community Conversation in Spanish in Springfield. Turnout was high, and Latino participants were appreciative of the effort to hear their needs. RAC members identified a need to integrate the perspective of people who speak other languages as well. There is a need for bilingual providers, translators, and health materials translated in a wider range of languages. The refugee and immigrant populations in Hampden County make for an increasingly diverse linguistic population. In Hampden County, a quarter of the population speaks a language other than English at home, and 9% of Hampden County households are linguistically isolated (U.S. Census, ACS 2013-2017). Linguistic isolation is defined by the U.S. Census Bureau as a household in which all members older than the age of 14 speak a non-English language and have difficulty with English. Cities with the largest proportion of linguistically isolated households in Hampden County are Springfield (14%) and Holyoke (17%) (US Census, ACS 2013-2017).

### 3. Health Conditions and Behaviors

This section focuses on the health conditions and behaviors that have the largest impact on the communities served by Baystate Noble. Based on our analysis, the priority health conditions and behaviors are the following:

- Mental health and substance use
- Chronic health conditions - obesity, cardiovascular disease, diabetes, asthma, cancer, and the need for increased physical activity and healthy diet
- Infant and perinatal health and teen pregnancy - low birth weight, preterm birth, utilization of prenatal care, smoking during pregnancy, and teen pregnancy
- Alzheimer's disease and dementia

#### A. MENTAL HEALTH AND SUBSTANCE USE

Substance use and mental health were among the top urgent health needs/problems impacting the area based on focus groups, interviews with public health officials, content experts, service providers, and Community Chats. Substance use disorders and opioid use specifically were identified as top issues. There was overwhelming consensus about the need for:

- more treatment options, including Medication Assisted Treatment (MAT), long term care options, treatment beds external to the criminal justice system, and treatment for people with dual diagnoses

- increased education across all sectors to reduce the stigma associated with mental health and substance use
- more sober and transitional housing for people with mental health issues, those dually diagnosed, and for those leaving institutions (incarceration, foster care, etc.)
- increased integration between the treatment of mental health and substance use disorders
- recognition of the impact of mental health conditions and substance abuse on families

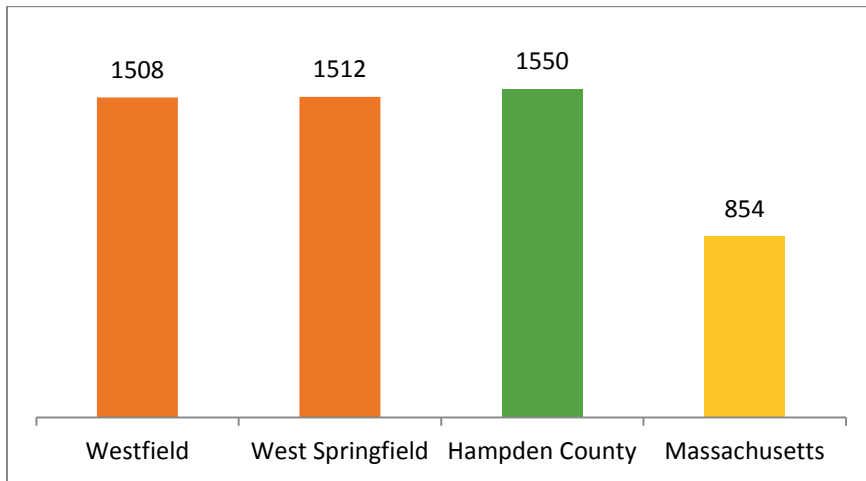
## **Mental Health**

Though mental health is commonly thought of as the absence of mental illness, mental well-being extends beyond the presence or absence of mental disorders. The World Health Organization defines mental health as the “state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”<sup>16</sup> Only an estimated 17% of U.S adults are “in a state of optimal mental health.”<sup>17</sup> More than one out of four adults nationally live with a mental health disorder in any given year, and 46% will have a mental health disorder over the course of their lifetime.<sup>66</sup> Mental health is an indicator of health itself, but also contributes to physical health and inequities.

In Hampden County, people reported 4.5 mentally unhealthy days in the last 30 days, comparable to the statewide rate of four unhealthy days.<sup>67</sup> Hampden County has nearly double the rate of mental health hospitalizations (1,550 per 100,000) as the state wide rate (854)(Figure 12). Latinos experience drastically higher hospitalization rates (2,345 per 100,000) than the county average (Figure 14).

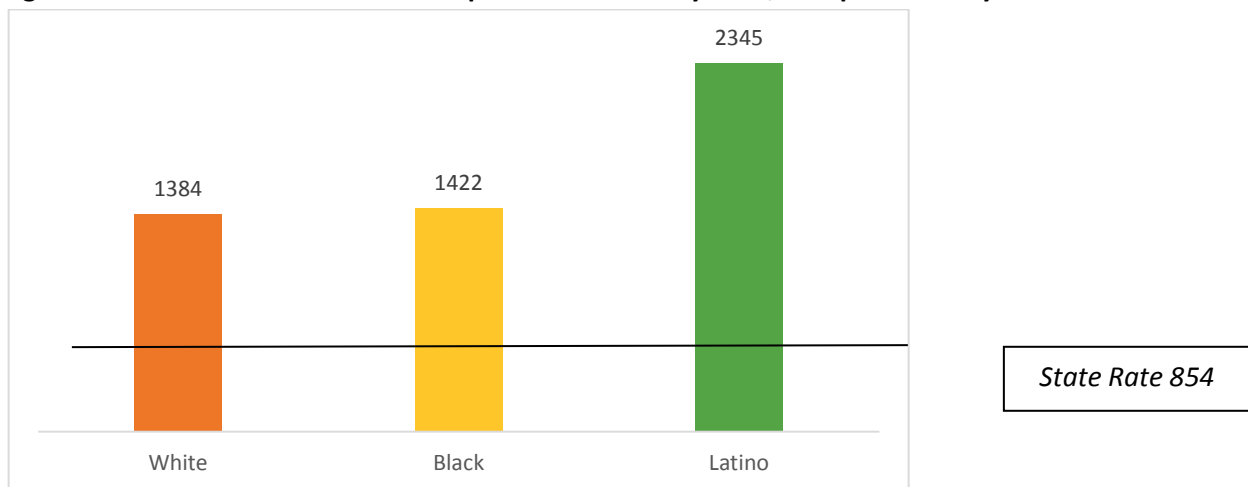
Depression is the most common type of mental illness, and it affects more than 26% of U.S adults.<sup>17</sup> Depression is the leading cause of disability worldwide.<sup>68</sup> Suicide has risen 27% from 2005 to 2015 in Massachusetts,<sup>69</sup> and the rate in Hampden County is higher than the Massachusetts rate (29 per 100,000 compared to 26).<sup>70</sup> Substance use disorder often co-occurs with mental illness and impacts physical health as well.

**Figure 12. Mental Health Disorder Hospitalization Rates for Select Communities**



Source: MDPH, 2014. Age-adjusted per 100,000

**Figure 13. Mental Health Disorder Hospitalization Rate by Race, Hampden County**



Source: MDPH, 2012 – 2015. Age-adjusted per 100,000

### Priority Populations

Youth are disproportionately impacted by mental health issues. Over 51% of youth in the Westfield Public School system report depressive symptoms.<sup>71</sup> Similarly, data from the Gateway Regional School District, which serves a number of rural Hilltown communities, indicates that 32% of 8th grade students, 47% of 10th grade students, and 40% of 12th grade students.<sup>72</sup> experienced depressive students. While similar data was unavailable for other Baystate Noble service area communities, youth surveys in the region (Franklin and Hampshire counties and cities of Springfield and Worcester) consistently report high rates of depression, suicidal ideation, and suicide attempts.<sup>73 74 75 76</sup>

GLBQ+ and transgender youth are also disproportionately impacted with symptoms of depression and suicide risk. While no data specific to the Baystate Noble service area was available, we found that 61% of GLBQ+ and transgender 10th and 12th grade students responding to the 2017 Springfield Youth Risk Behavior Survey reporting feeling sad or hopeless two weeks or more, one in five report that they tried

to commit suicide in the past year and 38% had engaged in self-harm.<sup>77</sup> In Franklin County in 2018, 72% of GLBQ+ youth had the risk factor “Depressive Symptoms,” compared to 41% of their heterosexual peers.<sup>78</sup> Nationally, teen suicide risk for GLBQ+ youth is higher than straight youth.<sup>79</sup>

Out of all Massachusetts communities statewide, nine of the ten communities with the highest rates of mental health-related hospital admissions among women were in western Massachusetts (MDPH, 2014).

About 1 out of 3 older adults experience depression in select communities in Hampden County. In West Springfield 31% of older adults have depression and 29% in Westfield.<sup>80</sup>

Latinos experienced high hospitalization rates for mental disorders with rates 70% greater than whites and over 50% greater than Hampden County rates overall. These disparities have worsened since the 2016 CHNA (Figure 13).

The Substance Abuse and Mental Health Services Agency (SAMHSA) estimates that 26% of people who experience **homelessness** have a severe mental illness and 35% have chronic substance use issues.<sup>81</sup>

*“People are falling through the cracks. We’re not healthy, we’re not doing great, we’re suicidal, struggling to maintain employment and pay the bills, so it’s difficult to do self-care. There’s a lot of personal responsibility on me taking care of myself, but I need those resources to be there and available and accessible, and to be treated like a human being.”*

Focus Group Participant, Transgender, Non-Binary And Non-Conforming Focus Group, Coalition Hospital

## Substance Use

High rates of substance use continue to be a prioritized health need for the community.

- An estimated 18% of Hampden County residents smoke tobacco as compared to 14% statewide.<sup>82</sup>
- In Westfield, approximately 10% of eighth grade students report using alcohol and 8% report using marijuana in the last 30 days.<sup>83</sup> Data from the Gateway Regional School District, which serves a number of rural Hilltown communities, indicates that 14% of 8th grade students, 29% of 10th grade students, and 39% of 12th grade students reported using alcohol in the last 30 days. Rates of reported marijuana use in the district were 6%, 15%, and 13% among the 8th, 10th, and 12th grade students, respectively.<sup>84</sup>
- In key informant interviews, health care providers noted vaping and marijuana use among youth as a rising concern after legalization in the state.
- A national study found that vaping has doubled in high school youth between 2017 and 2018, from 11% to 21%.<sup>85</sup>

- Among adults over the age of 65 in Massachusetts, 7% report substance use. The proportion is higher in West Springfield with 8%.<sup>80</sup> Westfield has lower proportions than the state average.

*“Some high schoolers with learning disabilities can have lots of trouble with anxiety, take drugs to help with the anxiety. We’re not picking up on this fast enough to stop the drug use.”*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

**Substance use disorders (SUD)** refer to the recurrent use of drugs or alcohol that result in health and social problems, disability, and inability to meet responsibilities at work, home, or school. Risk factors for SUD include genetics, age at first exposure, and a history of trauma.

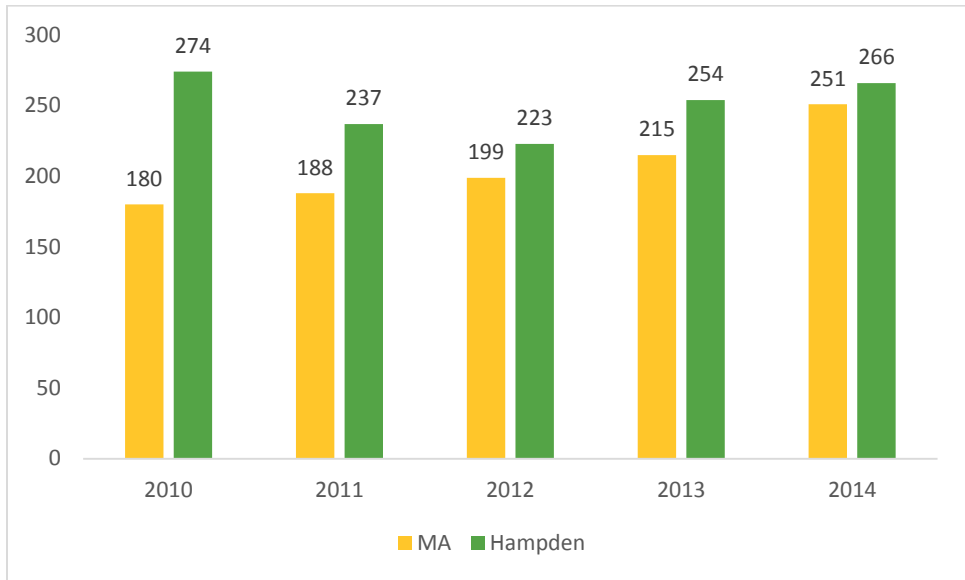
- In Hampden County, emergency department visits for substance use rose from a rate in 2012 of 223 emergency department visits per 100,000 to 266 in 2014. The rate in 2014 is similar to the rate in Massachusetts overall (251) (Figure 14).
- Rates of emergency department use are higher than the state rate in Westfield (350) for substance use disorders (MDPH, 2010– 2014).
- Data disaggregated by race/ethnicity was unavailable.

*“The newspaper put a person’s photo on the front page for possession charge – not dealing or anything serious. We don’t treat people with diabetes or other diseases that way.”*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

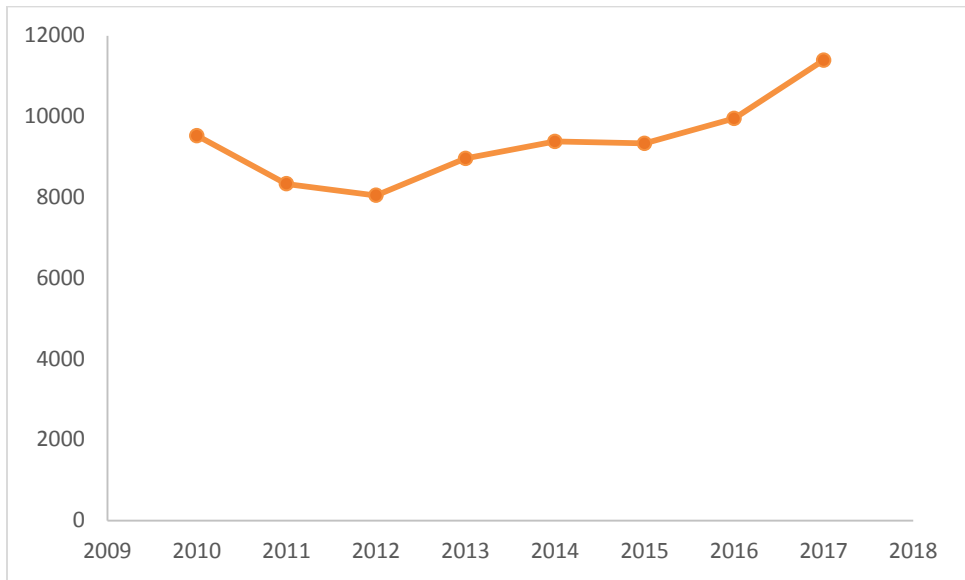
Substance use admissions to treatment programs have increased over time. Total admissions in Hampden County have risen by 42% from 2012 to 2017, and from 8,047 in 2012 to 11,394 in 2017 (Figure 15). Admissions for heroin and alcohol drive admissions, with heroin increasing over time. Crack/cocaine, marijuana, and other opioids account for fewer than 10% each (Figure 16).

**Figure 14. Substance Use Disorder Emergency Department Visits, Hampden County and Massachusetts**



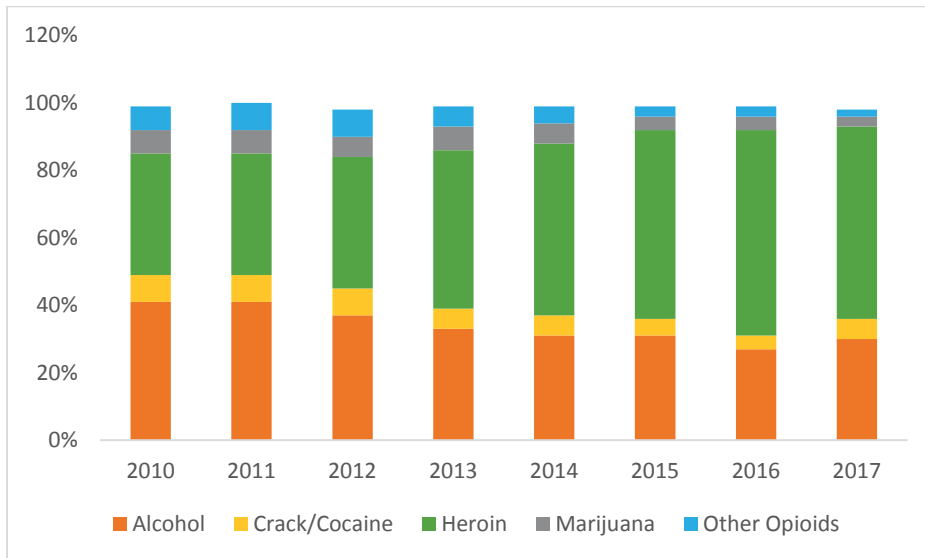
Source: MDPH, 2010 – 2014. Age-adjusted per 100,000

**Figure 15. Substance Use Admissions to Treatment Programs in Hampden County, 2010 – 2017**



Source: Massachusetts Department of Public Health. Bureau of Substance Addiction Services. 2018. Geographic Fact Sheets FY 2017, Admission Statistics by County

**Figure 16. Substance Use Admissions to Treatment Programs in Hampden County by Primary Drug of Admission, 2010 – 2017**

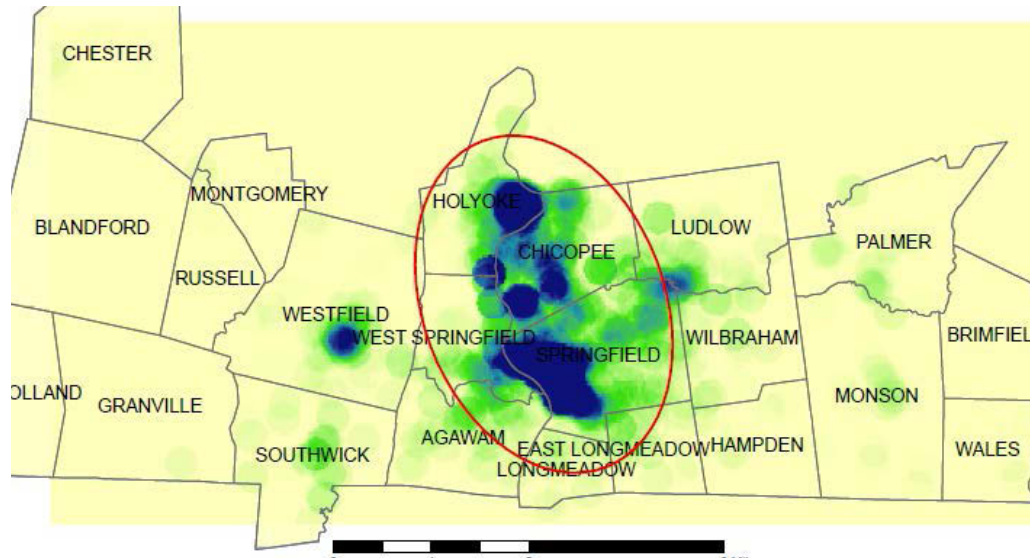


Source: Massachusetts Department of Public Health. Bureau of Substance Addiction Services. 2018. Geographic Fact Sheets FY 2017, Admission Statistics by County

**Opioid use disorder** continues to be a public health crisis in Massachusetts and across the country. In Massachusetts, the number of opioid-related deaths in 2014 represents a 65% increase from 2012.<sup>86</sup> From 2016 to 2017 there was a 4% decrease in the number of opioid-related deaths in Massachusetts, however in the prior year there had been a 28% increase. In 89% of deaths from opioids, fentanyl was present.<sup>87</sup>

- In Hampden County, the number of opioid-related deaths has increased annually, from 32 in 2000, trending upward until 2017, with 113 deaths.<sup>88</sup> The 2016 CHNA reported lower opioid overdose hospitalization rates in Hampden County than the state (80 vs. 104 per 100,000).
- In Westfield and West Springfield, there were over 300 opioid overdoses from 2016 and 2017.<sup>89</sup> Westfield and West Springfield are a small “hot spot” of opioid overdose incidents, with some incidents also in Southwick (Figure 17).
- According to provisional data from the Pioneer Valley Opioid Data Committee (PVODC), approximately 50% of overdoses in Hampden County went to Baystate Medical Center, with about 20% going to Mercy Medical Center, about 20% to Holyoke Medical Center, 7% to Baystate Noble, and 1% to Baystate Wing.<sup>90</sup>
- Increased use of harm reduction approaches, such as naloxone, reduces morbidity and mortality of opioid overdose.<sup>91</sup> In addition, stakeholders called for increased access to long-term treatment programs; more provider and patient education to reduce stigma and as a means to get people the care they need; and more support for youth, particularly those with histories of trauma.

**Figure 17. Opioid Overdose Incidents Density, Hampden County, 2016-2017**



Source: Pioneer Valley Opioid Data Committee, 2019

### Priority Populations

- Youth substance use and abuse can affect the social, emotional, and physical well-being of youth and lead to lifelong substance dependence problems. As described above, an estimated 10% of 8th graders drink alcohol and 8% use marijuana in Westfield.
- Latinos experienced high rates of substance use emergency department visits, double that of whites in Hampden County (MDPH, 2012-2015).
- In select Hampden County communities older adults have higher proportions of some form of substance use disorder than statewide, as stated above.
- People reentering society after incarceration, particularly if their incarceration was related to drugs in any way. Studies consistently show high risk of overdose in the first two weeks after reentry.<sup>92</sup>
- People who have dual diagnoses. People who have both mental health and substance use disorders face greater challenges accessing services, according to focus group participants and interviewees.

*“There are not many dual programs. Many addicts have mental health issues as well, but programs usually do not treat both – just addiction – so they recover but it doesn’t last and they go back in and out of rehab.”*

Focus Group Participant, Substance Use Disorder Focus Group, Hampden County



## B. CHRONIC HEALTH CONDITIONS

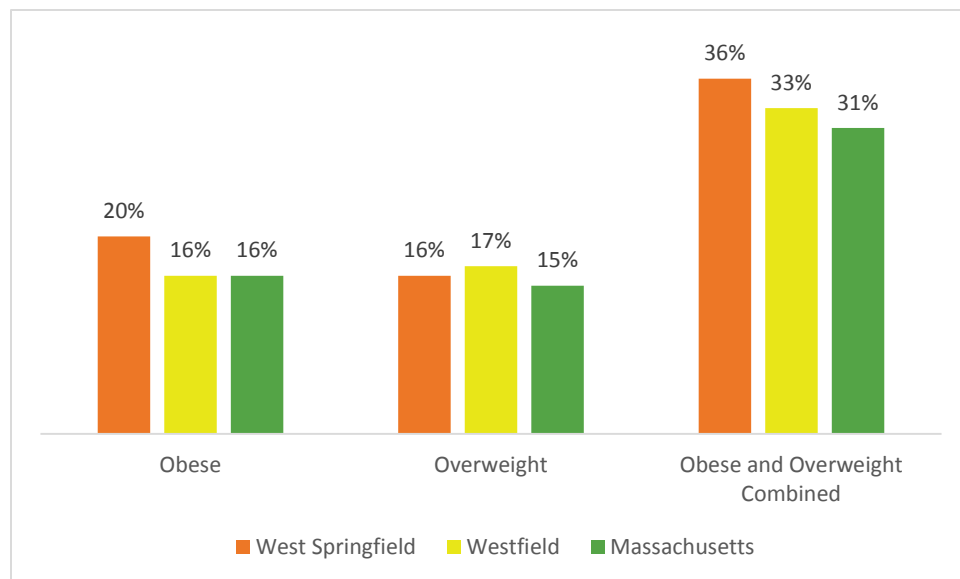
Chronic health conditions continue to remain an area of prioritized health need for Hampden County residents. Residents continue to experience high rates of chronic health conditions and associated morbidity, particularly for obesity, diabetes, cardiovascular disease, cancer, and asthma. A chronic health condition is one that persists over time and typically can be controlled but not cured. According to the Center for Disease Control (CDC), chronic disease is the leading cause of death and disability in the U.S. By 2020 it is estimated that 81 million Americans will have multiple chronic conditions.<sup>93</sup> A healthy diet and physical activity play an important role in preventing and managing chronic diseases.

### Obesity

In Hampden County 29% of adults are obese compared to the Massachusetts rate of 24%.<sup>94</sup> Obesity is a national epidemic and contributes to chronic illnesses such as cancer, heart disease, and diabetes. Obesity can impact overall feelings of wellness and mental health status. A healthy diet and physical activity play an important role in achieving and maintaining a healthy weight.

Though childhood obesity rates have been falling nationally and within some communities in the region over the last few years, it remains concerning. Children develop lifelong dietary and physical activity habits in their early years, and children who are obese are more likely to continue to be obese adults in addition to having adult risk factors that are more severe.<sup>95</sup> In the 2014 – 2015 school year, the proportion of children in West Springfield (20%) and Westfield (16%) who were obese is similar to or higher than the state as a whole (16%). When combining the proportion of children who are overweight to those that are obese, a high proportion emerges – up to 36% of children in West Springfield are either overweight or obese (Figure 18).<sup>96</sup> County-level obesity rates are not available.

**Figure 18. Percentage of Childhood Obesity and Overweight in Select Communities**



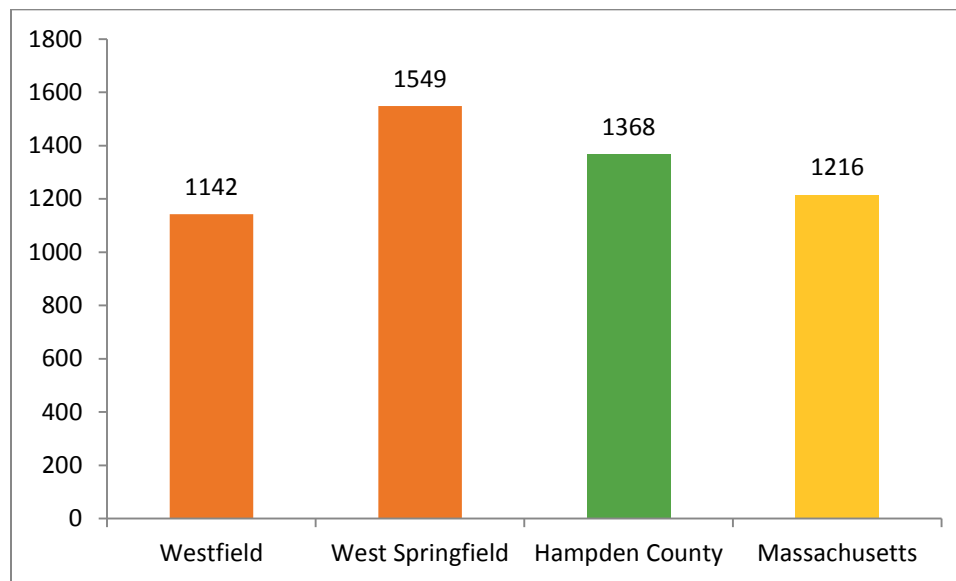
Source: MDPH. 2017. Results from the Body Mass Index Screening in Massachusetts Public School Districts, 2015

## Cardiovascular Disease (CVD)

Cardiovascular disease (CVD) includes diseases that affect the heart and blood vessels, including coronary heart disease, angina (chest pain), hypertension, heart attack (myocardial infarction), and stroke. Heart disease is the leading cause of death in Hampden County (MDPH, Massachusetts Deaths 2016).

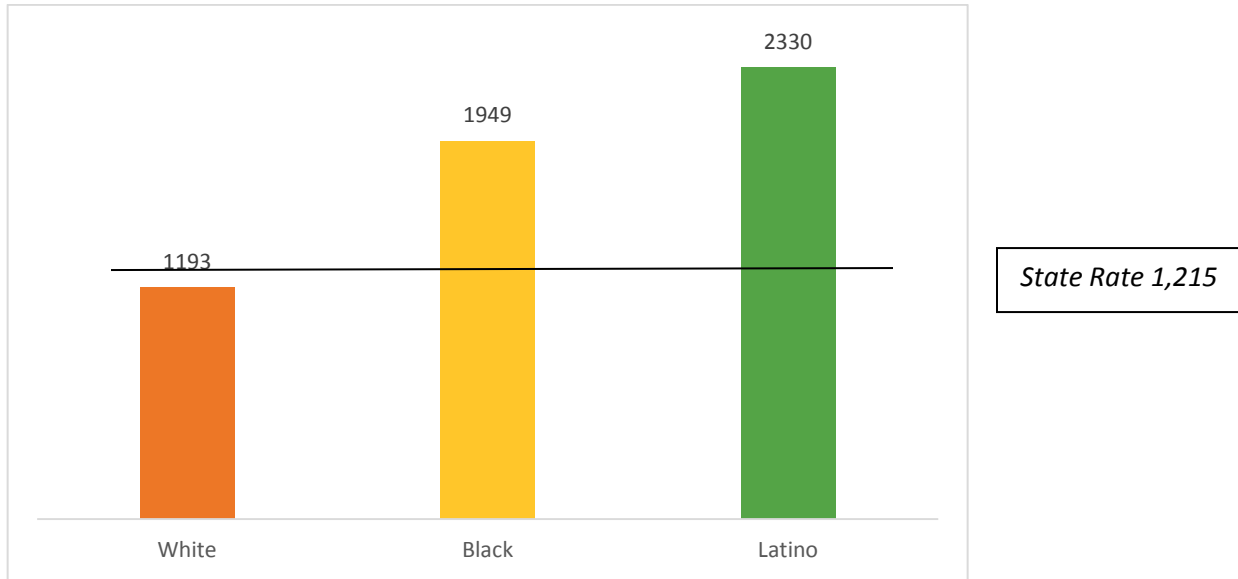
- The rate of cardiovascular disease hospitalization in West Springfield is over 20% higher than the state (Figure 19).
- Westfield (232 per 100,000) and Agawam (281) have higher rates of stroke hospitalization compared to the state (219) (MDPH, 2014).
- Hypertension (high blood pressure) affects about 4 out of 5 adults over age 65 in Hampden County, slightly higher than the statewide proportion, and coronary heart disease in older adults affects about 40%, with similar proportions in West Springfield and Westfield.<sup>80</sup>
- CVD hospitalization rates for the Latino population in Hampden County are almost double that of whites and about 65% higher for blacks (Figure 20).

**Figure 19. Cardiovascular Disease Hospitalization Rates, Hampden County and Select Communities**



Source: MDPH, 2014. Age-adjusted per 100,000

**Figure 20. Cardiovascular Disease Hospitalization Rates by Race in Hampden County**



Source: MDPH, 2012 – 2015. Age-adjusted per 100,000

### Priority Populations

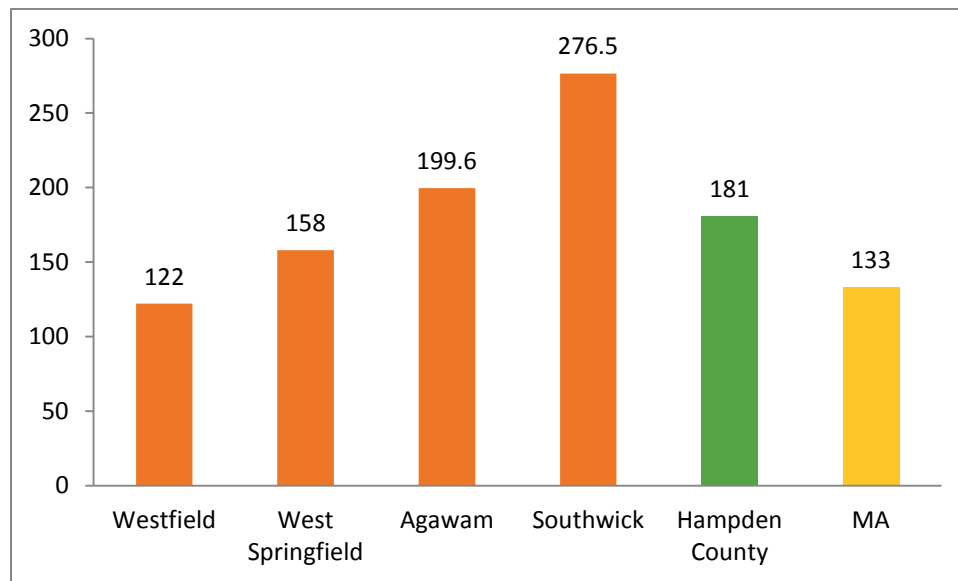
- Older adults experience higher rates of CVD: for example, about four of every five people over age 65 have hypertension, which is reflective of the high rates in the state overall (76%).<sup>80</sup>
- Latinos and blacks had stroke and heart disease hospitalization rates much higher than whites.

## Diabetes

An estimated 11% of Hampden County residents have diabetes, which is greater than the state rate of 9%.<sup>97</sup> The vast majority of diabetes is Type 2 diabetes, which is one of the leading causes of death and disability in the U.S. and a strong risk factor for CVD. The CDC estimates that 9% of people in the U.S. have diabetes, of which 24% are undiagnosed.<sup>98</sup> Pre-diabetes is when a person has high blood sugar levels that are not high enough for a diagnosis of diabetes. An estimated 15-30% of people with pre-diabetes will develop Type 2 diabetes within five years.<sup>13</sup>

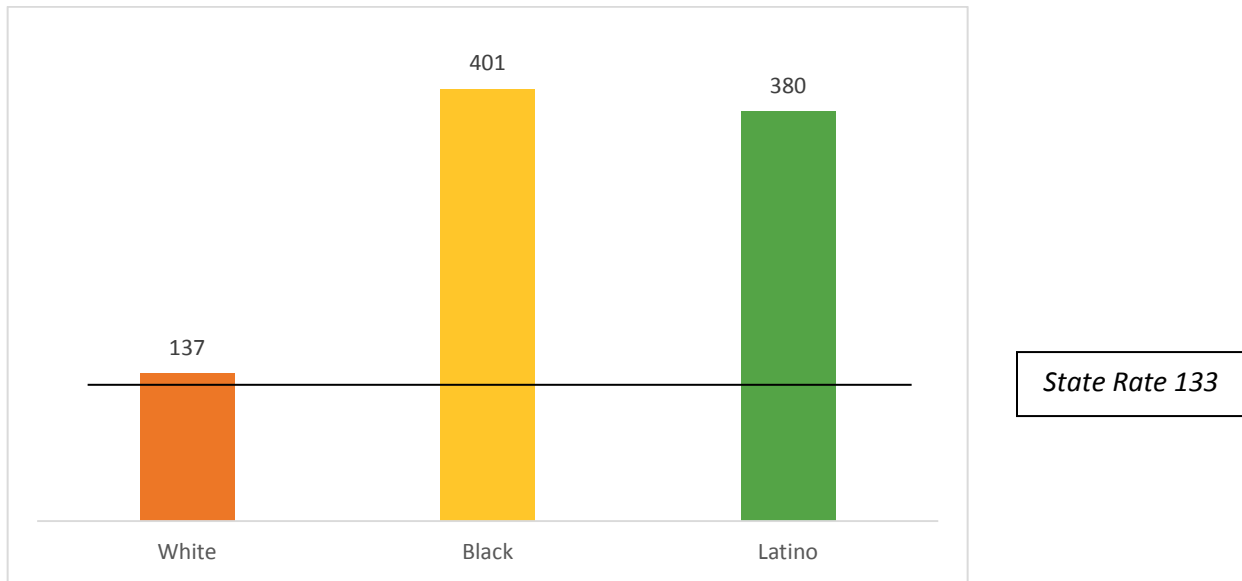
Diabetes hospitalization rates are a measure of severe morbidity due to diabetes. Southwick, Agawam, and West Springfield have high diabetes hospitalization rates (277, 199, and 158 per 100,000 people) when compared to the state (Figure 21). Older adults experience high rates of diabetes, and the proportion of adults over age 65 who have diabetes is high in Agawam (34%) and West Springfield (33%) as compared to the state rate of 32%.<sup>80</sup>

**Figure 21. Diabetes Hospitalization Rates, Hampden County and Select Communities**



Source: MDPH, 2012 – 2015. Age-adjusted per 100,000

**Figure 22. Diabetes Hospitalization Rates by Race in Hampden County**



Source: MDPH, 2012 – 2015. Age-adjusted per 100,000

### Priority Populations

- Older adults in select communities in Hampden County experience higher rates of diabetes than the state. Nearly 2 out of 5 older adults have diabetes, as cited above.
- Latinos and blacks in Hampden County experienced about three times the rates of diabetes hospitalizations (380 and 401 per 100,000 people, respectively) compared to whites and the statewide rate which are similar to each other (137 and 133, respectively) (Figure 22).

### Asthma

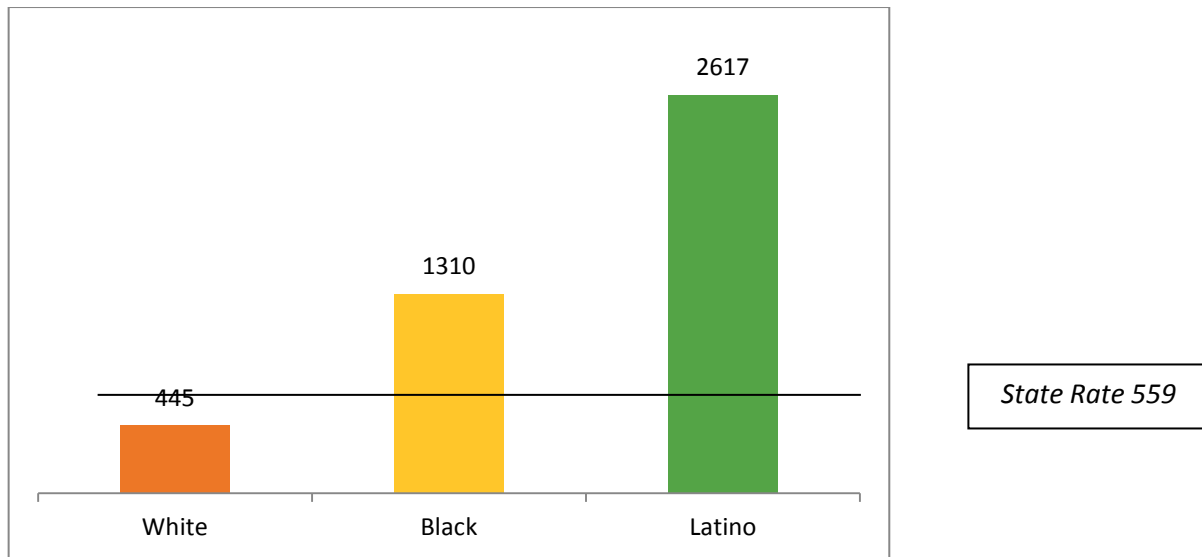
Asthma impacts many Hampden County residents. Asthma was elevated as a priority health need in the 2016 CHNA and continues to be a need. The Springfield Metropolitan District, which includes the Baystate Noble service area, was identified as the most challenging place to live with asthma in the U.S., according to the Asthma and Allergy Foundation’s 2018 Asthma Capital rankings. The rankings are based on prevalence of asthma, emergency department visits, mortality, and presence of risk factors.<sup>99</sup> Asthma emergency department visits are much higher in Hampden County for Latinos (all ages and specifically children under 18, Figures 23 and 24), and higher in blacks for all ages (Figure 23).

Asthma is a common chronic respiratory disease that affects the health and quality of life of children and adults. Asthma can be impacted by different factors in the environment, including cigarette smoke, second hand smoke, air pollution, pollen levels, mold, dust, and other household contaminants or exposures. Asthma is the most common chronic disease in children, and is a driver of emergency

department use for children.<sup>100</sup> Asthma also affects the physical, social, and emotional lives of children.<sup>101</sup>

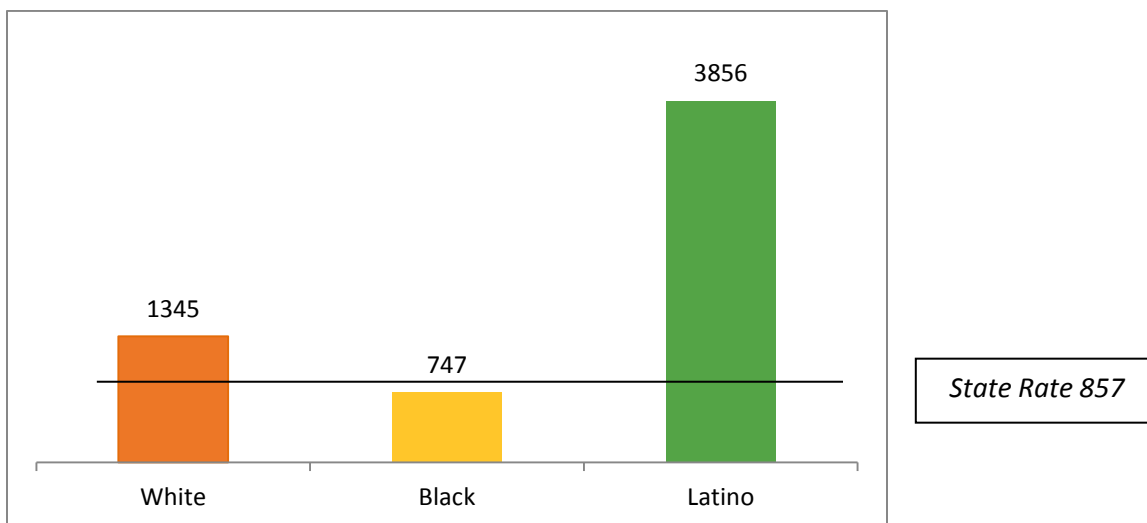
Pediatric asthma rates are as high as or higher than the state rate of 12% in Agawam and Southwick. Trips to the emergency department for asthma were higher than the state rate in Chester, Russell, and Westfield. Asthma hospitalizations were higher in Chester and Westfield than the state rate (Table 4). In most towns in the Baystate Noble service area, about 15% of adults over age 65 have asthma, similar to the state rate, but Agawam (16%) and Huntington (18%) are slightly higher.<sup>102</sup>

**Figure 23. Emergency Department Visit Rates by Race for Asthma, Hampden County**



Source: MDPH, 2012-2015. Age-adjusted per 100,000

**Figure 24. Emergency Department Visit Rates by Race for Pediatric Asthma, Hampden County**



Source: MDPH, 2012-2015. Age-adjusted per 100,000

**Table 4. Asthma Prevalence, Emergency Department Use, and Hospitalizations for Baystate Noble Service Area Select Communities**

	Pediatric Asthma Prevalence (%)*	Emergency Department Use for Asthma (per 100,000)**	Asthma Hospitalizations (per 100,000)**
Agawam	12	75	478
Blandford	11	100	421
Chester	NS	142	902
Granville	5	95	495
Huntington	9	52	343
Russell	8	126	436
Southwick	19	61	479
Westfield	10	125	791
West Springfield	10	113	657
Massachusetts	12	120	709

Sources: \*MDPH, Environmental Population Health Tracking, 2016-2017; \*\*MDPH, 2014

### Priority Populations

- Children and older adults are priority populations for asthma. There is a higher prevalence of asthma for older adults in Agawam and Huntington and for children in Agawam and Southwick compared to the state. As in the 2016 CHNA, children are hospitalized in Hampden County at lower rates than the state.
- Asthma hospitalization disaggregated by race was unavailable for the Baystate Noble service area communities; however Latinos and blacks in Hampden County experience large asthma-related disparities. Emergency department use for asthma among Latinos is nearly six times that of whites and pediatric emergency department use nearly three times that of whites in Hampden County (Figures 23 and 24). Blacks have three times the rate of emergency department use as whites in Hampden County (Figure 23).

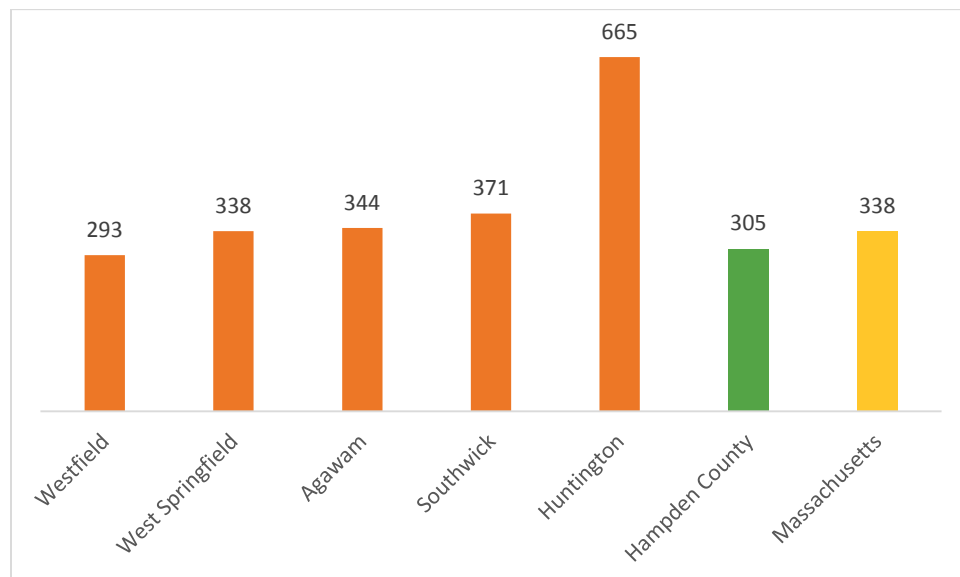
### Cancer

Cancer is the second leading cause of death in Hampden County.<sup>103</sup> Advancing age is the most important risk factor for cancer, and the proportion of the population over age 60 in Hampden County will increase from 20% in 2010 to 28% in 2035.<sup>104</sup> While Hampden County's rate of hospitalization for cancer is 10% lower than that of the state (305 per 100,000 in Hampden County compared to 338 statewide) (MDPH, 2014), the age-adjusted rate of death from cancer is higher (171 per 100,000 compared to 160).<sup>105</sup> Huntington, Southwick, West Springfield, and Agawam have higher rates of cancer hospitalization compared to the statewide rate (Figure 25). Cancer hospitalization rates were nearly double the rate of whites in Hampden County (MDPH, 2012 – 2015).

Statewide, the most prevalent forms of cancer for men are prostate (23%), bronchus/lung (14%), colon/rectum (8%), and urinary/bladder (8%). For women, the most prevalent forms are breast (30%),

bronchus/lung (14%), colon/rectum (8%), and uterine (7%). Cancer of the bronchus/lung accounted for approximately 27% of all cancer deaths from 2011 – 2015 statewide.<sup>106</sup>

**Figure 25. Cancer Hospitalization Rate, Hampden County and Select Communities**



Source: MDPH, 2012-2015. Age-adjusted per 100,000

### Need for Increased Physical Activity and Healthy Diet

Increasing physical activity and consuming more fresh fruits and vegetables is another identified need in Hampden County. Healthy eating and physical exercise are important habits to create and keep to prevent poor health outcomes such as CVD, diabetes, dementia, and depression.<sup>107</sup> Community level access to affordable healthy food and safe places to be active, as described in the Social Determinants of Health section, as well as individual knowledge and behaviors affect these rates.

Among Massachusetts residents in the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) 2013 survey, only 11% of respondents met the vegetable consumption recommendation and 14% met the fruit consumption recommendation. In general, women, Latinos, and those with higher incomes are more likely to meet recommended intake levels.<sup>108</sup> Key informants suggested that knowledge of healthy food, knowledge of ways to access it, and cultural barriers may play a role in people’s choice and understanding of healthy foods. They also mentioned small stores that do not have refrigeration or capacity to store fresh produce, the lack of transportation to large grocery stores, and that there are many small initiatives to get healthy food out to people who need it but no large organized service providers.

In Hampden County, 1 of 4 residents over the age of 20 reports getting no leisure-time physical activity in the past month, slightly higher than the state rate of 22%.<sup>109</sup> The need for increased youth programming and access to places that encourage physical activity was cited by individuals across



several focus groups and interviews conducted for this CHNA, and particularly sports and after school programming that are affordable to those with low-incomes.

### **C. INFANT AND PERINATAL HEALTH AND TEEN PREGNANCY**

Infant and perinatal health risk factors continue to impact Baystate Noble service area residents, causing poor infant outcomes. Preterm birth (<37 weeks gestation) and low birth weight (about 5.5 pounds) are among the leading causes of infant mortality and morbidity in the U.S., and can lead to health complications throughout the life span. Early entry to prenatal care and adequate prenatal care are crucial components of health care for pregnant women that directly impact birth outcomes, including preterm birth, low birth weight, and infant mortality (infant death before age 1). Smoking during pregnancy is a risk factor that increases the risk for pregnancy complications and affects fetal development.<sup>110</sup>

Rates of preterm birth (PTB) and low birth weight (LBW) were similar or lower than the state rate in almost all of the Baystate Noble service area communities, however there are inequitable outcomes by race/ethnicity. When examining by race/ethnicity, only Agawam, West Springfield, and Westfield had large enough numbers for MDPH to be able to report. In those communities black and Latina women had higher rates of preterm birth, with Westfield not having large enough numbers to report outcomes for blacks (Figure 26). Similarly, there are higher rates of low birth weight in the Latina population than in whites in the same communities.

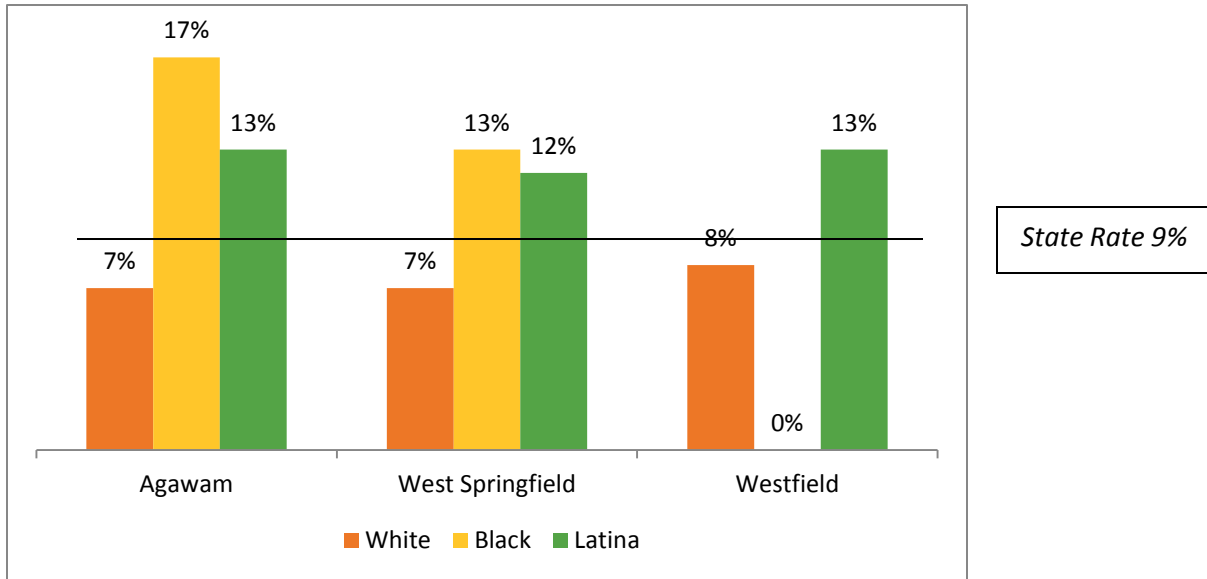
Similarly, the percentage of women not receiving adequate prenatal care in the Baystate Noble service area communities is lower than the state rate of 18%, but higher for blacks and Latinos in the communities that have large enough populations to aggregate data by race/ethnicity. Rates of inadequate prenatal care in these select communities range from 9% in Blandford to 18% in Russell, with a range in between (MDPH, 2012-2016). National guidelines suggest that women receive routine checkups once a month for weeks 4 through 28 of pregnancy, twice a month during weeks 28 through 36, and weekly from weeks 36 to birth. The Adequacy of Prenatal Care Utilization Index (APNCU) measures utilization of prenatal care based on the time when care is initiated and frequency of care received. In Agawam, West Springfield, and Westfield, the percentage of white women who are not receiving adequate prenatal care is consistently lower than the state rate, but for Latina women the rate is above the state rate of 9% and hovers near 13%, with up to 17% of black women in Agawam not receiving adequate prenatal care (Figure 27). Studies suggest that racial and ethnic disparities in receiving adequate prenatal care are linked to systemic injustices facing many individuals of color, including practitioners stereotyping women of color when providing care, and unequal education opportunities.<sup>111</sup>

Rates of smoking during pregnancy were high in the Baystate Noble service area. Compared to the rate in Massachusetts (5%), rates ranged from 8% in Agawam and West Springfield to 16% in Huntington (MDPH, 2012-2016).

Pregnant teens had low rates of accessing adequate prenatal care. In the majority of towns that had a large enough population of pregnant teens to have adequate data, a larger proportion of teens had less

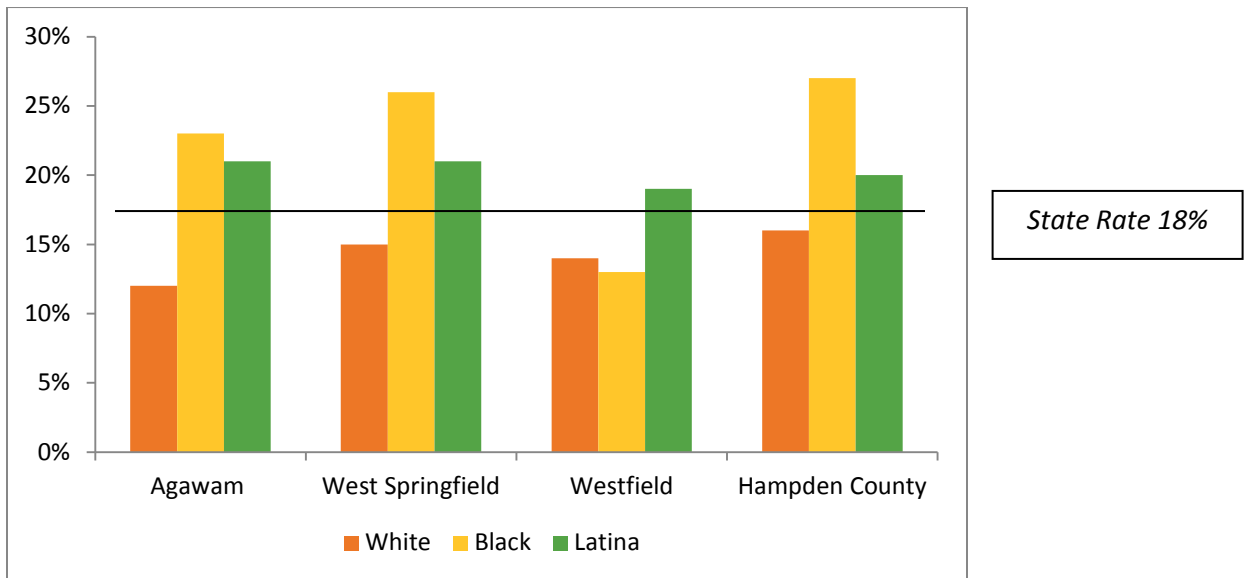
than adequate prenatal care than the state level of 18% (teens had less than adequate prenatal care at the following rates: Agawam – 21%; Huntington – 25%; West Springfield – 28%; and Westfield – 21%)(MDPH, 2012-2016).

**Figure 26. Preterm Birth by Race, Baystate Noble Service Area Select Communities**



Source: MDPH, 2012-2016

**Figure 27. Less than Adequate Prenatal Care by Race, Baystate Noble Service Area Select Communities**



Source: MDPH, 2012-2016

## Priority populations

- Outcomes by race/ethnicity illustrate inequitable outcomes in the Baystate Noble service area for preterm birth, low birth weight, and receiving less than adequate prenatal care (Figures 26 and 27).
- Pregnant teenagers had low rates of receiving adequate prenatal care. Huntington, Russell, and West Springfield had high rates of teen pregnancy (30, 25, and 18.3 per 1,000 females age 15 - 19 respectively)(MDPH, 2016). However, these rates should be interpreted with caution due to being generated from small numbers. Even though data was aggregated from five years, the numbers were still small.
- Income also makes a difference. With the proxy being type of insurance, we see that only 9% of those with private insurance were without adequate prenatal care, compared to 16% of those with public insurance. Women with private insurance have lower rates of poor birth outcomes than those with public insurance (6% of privately insured compared to 10% of publicly insured women had low birth weight babies; 8% of privately insured compared to 11% of publicly insured women had preterm births) (MDPH, 2016).

## D. ALZHEIMER'S DISEASE AND DEMENTIA

Approximately 1 in every 10 people over the age of 65 has some form of dementia, as do over one-third of those over age 85.<sup>112</sup> The proportion of those living with Alzheimer's disease in West Springfield (16%) and Agawam (15%) was larger than that of Massachusetts (14%).<sup>113</sup> By 2035, the proportion of people over the age of 60 is projected to grow from 20% of the population to 28% in Hampden County, with the number of older adults increasing from approximately 92,000 in 2010 to an estimated 140,000 in 2035.<sup>114</sup>

The Alzheimer's Association notes that between 2000 and 2017, the number of deaths from Alzheimer's disease has increased 145%.<sup>115</sup> The disease places a high toll on the health care system, as well as on caregivers, who are mostly family members. Compared with caregivers of people without dementia, twice as many caregivers of those with dementia indicate substantial emotional, financial, and physical difficulties.<sup>116</sup>

## 4. Priority Populations of Concern

Available data indicate that children and youth, older adults, Latinos, and blacks experience disproportionately high rates of some health conditions when compared to that of the general population in Hampden County. Children experienced high rates of asthma and obesity. Teens experienced higher rates of depression and lower rates of adequate prenatal care when pregnant. Older adults had higher rates of hypertension and asthma. Latinos and blacks experienced higher rates of hospitalizations due to asthma, stroke, CVD, diabetes, cancer, and also experienced poor birth outcomes and lower rates of prenatal care.

With regard to mental health and substance use disorder, data indicate increased risk for youth for depression, substance use, and suicide. In particular, girls have higher rates of some types of substance use and GLBQ+ and transgender youth have particularly high rates of depression and suicide. Older adults are at risk for substance use disorder. The data show that in Hampden County, Latinos in particular have much higher rates of mental health hospitalizations and substance use emergency department visits. Others at risk include women, who have higher rates of mental health hospitalization, people reentering society after jail who are at high risk for overdose, and people with dual diagnoses. People experiencing homelessness have high rates of severe mental illness and substance use disorder.

When considering those with disproportionate access to the social determinants of health, the Latino and black population experience a host of inequities, including that of poverty, unemployment, income, educational attainment, interpersonal and institutional racism, affordable and safe housing, and access to transportation and healthy food. Youth were identified as at risk with regard to childhood poverty and interpersonal violence, and older adults experience needs in affordable housing, income, and social isolation. People with lower incomes experience poverty, unemployment, income concerns, lack of access to affordable and safe housing as well as poor housing conditions, and lack of access to transportation and healthy food. People with disabilities tend to have higher rates of poverty and lower levels of education, and in Hampden County, people living with a disability have more than double the rate of poverty as those with no disability. Women earn less than men, and have high rates of experiencing interpersonal violence and trauma. People who have been involved in the criminal legal system have barriers to housing and employment, and experience stigma and trauma. People with mental health and substance use disorders experience stigma and homelessness at higher rates. Community Forum participants encouraged inclusion of immigrants and refugees, who face challenges to behavioral, cultural, and structural determinants of health.

## 5. Geographic Areas of Concern

West Springfield, Westfield, Southwick, and Agawam had consistently higher rates for the majority of health conditions identified as prioritized health needs. These communities also disproportionately experience numerous economic and social challenges which contribute to the health inequities existing in these communities.

## V. Community and Hospital Resources to Address Needs

Hospital Resources		
<b>Organization Name</b>	<b>Description of Services Provided</b>	<b>Contact/Website</b>
Public Health Wellness Nurse	The nurse at the Westfield Senior Center is on site Tuesday and Friday from 9:00 am – 12:00 pm. The nurse provides health care services including general health assessment, blood pressure measurement, blood glucose monitoring, medication review, simple first aid procedures, and health education. Health care screenings are also offered to detect new health problems and/or monitor ongoing health problems.	Tina Gorman <a href="mailto:t.gorman@cityofwestfield.org">t.gorman@cityofwestfield.org</a>
Fowler Unit and Crisis	The Fowler Wing is a twenty bed acute care psychiatric unit designed to treat patients requiring intensive care in a hospital setting. Focusing on individualized care, the program provides patient assessment, diagnosis and effective intervention to accelerate integration back into family and community life. A staff of psychiatrists, social-workers, therapists and psychiatric nurses works in this inpatient unit.	<a href="http://baystatenoblehospital.org/services/psychiatric-services/fowler-wing/">http://baystatenoblehospital.org/services/psychiatric-services/fowler-wing/</a>
Baystate Noble Opioid Task Force (OTF)	The OTF developed a Naloxone Distribution Toolkit that can be distributed to patients in the ED upon hospital discharge. Simultaneously, patients are educated by a registered nurse or ED provider around how to use the naloxone kit through an education packet and a video on Naloxone administration to ensure competency on safety measures and medication administration. The BNH certified mental health clinician and case manager then develops a <i>plan of care</i> which will include follow up, monitoring of progress and setting our patients and families up with community resources.	Kelley Crowley <a href="mailto:Kelley.Crowley@baystatehealth.org">Kelley.Crowley@baystatehealth.org</a>

## Community Resources

<b>Organization Name</b>	<b>Description of Services Provided</b>	<b>Contact/Website</b>
Armbrook Village	Armbrook Village provides residential housing for older adults in Westfield to enjoy an independent lifestyle with gracious accommodations, amenities, programs and services that support their well-being, essential to maintaining good health and an enriching life.	<a href="https://www.seniorlivingresidences.com/communities/westfield-armbrook-village/">https://www.seniorlivingresidences.com/communities/westfield-armbrook-village/</a>
Ascentria Care Alliance	Strengthen communities by empowering people to respond to life's challenges. Services include: child and family services, in home care, language bank, mental health and disability services, services for new Americans, and older adults.	<a href="https://www.ascentria.org">https://www.ascentria.org</a>
Behavioral Health Network  <i>Carson Center</i>	Offers services in addiction, crisis services, family services, developmental services, mental health services, and domestic violence.	<a href="https://bhninc.org/content/outpatient">https://bhninc.org/content/outpatient</a>
Berkshire Healthcare	Provides elderly care including: life care, independent living care, assisted living, memory care, skilled nursing, hospice, specialty care, and more.	<a href="https://www.berkshirehealthcare.org">https://www.berkshirehealthcare.org</a>
Boys and Girls Club of Greater Westfield	Inspire and enable all young people, especially those who need us most, to reach their full potential as productive, caring and responsible citizens.	<a href="https://www.bgcwestfield.org">https://www.bgcwestfield.org</a>
Brown Bag-Food for Elders Program	Food bank of Western Massachusetts provides a free bag of healthy groceries to eligible seniors once a month at local senior centers and community organizations.	<a href="https://www.foodbankwma.org/get-help/brown-bag-food-for-elders/">https://www.foodbankwma.org/get-help/brown-bag-food-for-elders/</a>
Caring Health Center (CHC)	CHC ensures that patients receive comprehensive care that addresses their cultural, economic, and language needs. Behavioral health specialists deliver services to address emotional and other issues. Provide nutrition education, group physical exercise, and other services to support healthy and productive lives among patients.	<a href="http://Caringhealth.org/index.html">http://Caringhealth.org/index.html</a>
Domas	Revitalize the downtown city district of Westfield by developing more affordable housing in the heart of the City of Westfield.	<a href="http://www.domusinc.org/index.html">http://www.domusinc.org/index.html</a>
Forum House	Provides adults who have been socially and vocationally disabled by mental illness the opportunity to gain confidence and self-esteem, learn vocational skills, and obtain employment.	<a href="http://humanresourcesunlimited.org/hdocs/forum_program.php">http://humanresourcesunlimited.org/hdocs/forum_program.php</a>
Gándara Center	The Gándara Center promotes the well-being of Hispanics, African-Americans and other culturally diverse populations through innovative, culturally competent behavioral health, prevention and educational services.	<a href="https://gandaracenter.org">https://gandaracenter.org</a>

## Community Resources

<b>Organization Name</b>	<b>Description of Services Provided</b>	<b>Contact/Website</b>
Governor's Center	Provide post-acute services, rehabilitative services, skilled nursing, short and long term care through Physical, Occupational, and Speech Therapists; Registered and Licensed Practical Nurses; and Certified Nursing Assistants. This is complemented by Social Services, Activities, Nutritional Services, Housekeeping, and Laundry Services.	<a href="http://governorcenter.com/">http://governorcenter.com/</a>
Head Start	Committed to providing low-income children and their families with a Beacon of Hope and source of support for a brighter future, by providing high-quality comprehensive child development services to enrolled children and empowering families to achieve stability in their home environment.	<a href="http://www.hcsheadstart.org/">http://www.hcsheadstart.org/</a>
Healthy Hampshire	Focused on reducing rates of chronic disease in its partner communities by effecting changes to policies and systems that encourage physical activity, healthy food access, improved patient care, and linkages between healthcare systems and community-level prevention activities.	<a href="http://www.healthyhampshire.org">www.healthyhampshire.org</a>
Highland Valley Elder Services	Serves older adults and their families through collaboration, education, advocacy and a range of programs designed to support them where they live.	<a href="http://www.highlandvalley.org">www.highlandvalley.org</a>
Hilltown Community Health Center	Creating access to high-quality integrated health care and promoting well-being for individuals, families, and our communities. Services include: medical and dental care, behavior health care, community programs, health education programs, insurance navigation, social services, family supports, and more.	<a href="http://www.hchcweb.org">http://www.hchcweb.org</a>
Huntington Family Center	Diverse, year-round programming designed to strengthen individuals and families in a safe, caring environment.	<a href="https://www.huntingtonfamilycenter.org">https://www.huntingtonfamilycenter.org</a>
Jewish Family Services	Provides behavioral health programs and new American programs, as well as supports for older adults.	<a href="http://www.jfswm.org">www.jfswm.org</a>
Pioneer Valley Asthma Coalition	Community partnership that works to improve the quality of life for individuals, families, and communities affected by asthma.	<a href="https://www.pvasthmacoalition.org">https://www.pvasthmacoalition.org</a>
Planned Parenthood	Provides sexual health and reproductive services including: abortion services, birth control, emergency contraception, general healthcare, HIV/STI testing, pregnancy testing, GLBQ+ and transgender services, and more.	<a href="https://www.plannedparenthood.org/get-care/our-services">https://www.plannedparenthood.org/get-care/our-services</a>

## Community Resources

<b>Organization Name</b>	<b>Description of Services Provided</b>	<b>Contact/Website</b>
Tapestry Health	Provides sexual and reproductive health services, GLBQ+ and transgender health services, HIV health and prevention, family nutrition services, syringe access and disposal, overdose prevention, and community trainings.	<a href="https://www.tapestryhealth.org">https://www.tapestryhealth.org</a>
The Food Bank of Western Massachusetts	Mission is to feed our neighbors in need and lead the community to end hunger.	<a href="https://www.foodbankwma.org">https://www.foodbankwma.org</a>
The Samaritan Inn	A comprehensive program that teaches self-sufficiency and life skills to meet the needs of individuals and families experiencing homelessness, as well as provides beds for individuals and families in need.	<a href="http://saminn.org">http://saminn.org</a>
Thom Child and Family Services	Offers an array of services to families, children, and other professionals, including early intervention, pregnancy support, and regional consultation.	<a href="https://www.thomchild.org">https://www.thomchild.org</a>
United Way of Pioneer Valley	Mobilizes people and resources to strengthen our communities. THRIVE program offers free services that help users overcome financial difficulties.	<a href="https://www.uwpv.org">https://www.uwpv.org</a>
Valley Opportunity Council	Dedicated to eliminating poverty by providing the opportunity for our low- and moderate-income neighbors, families, and friends in the Greater Hampden County area to achieve greater independence and a higher quality of life.	<a href="https://www.valleyopp.com">https://www.valleyopp.com</a>
Westfield Drug Task Force	Focused on creating a community of prevention, intervention, and recovery to improve the quality of life in Westfield by addressing all facets of substance abuse and addiction.	<a href="https://www.cityofwestfield.org/718/Drug-Task-Force">https://www.cityofwestfield.org/718/Drug-Task-Force</a>
Westfield Senior Center	The Westfield Council on Aging offers a wide range of services and programs to older adults. Our goal is to facilitate access to services available in Westfield by providing assistance and making information readily available.	<a href="https://cityofwestfield.org/147/Council-On-Aging">https://cityofwestfield.org/147/Council-On-Aging</a>
YMCA of Greater Westfield	Recreation and physical health classes for youth through adults, including nutrition and diet. MIGHTY pediatric obesity prevention program.	<a href="https://www.westfieldymca.org/programs/youth-teen/mighty">https://www.westfieldymca.org/programs/youth-teen/mighty</a>



# VI. Input and Actions Taken Since Previous CHNA

## 1. Community Input on Previous CHNA and Implementation Strategy

To solicit written input on Baystate Noble's prior CHNA and Implementation Strategy, both documents are available on our hospital website ([www.baystateyhealth.org/communitybenefits](http://www.baystateyhealth.org/communitybenefits)). They are posted for easy access and we include contact information for questions or comments. We have verified and confirmed that we have not received any written comments since posting the 2016 CHNA and Implementation Strategy.

## 2. Impact of Actions Taken by Hospital Since Last CHNA

It is important to highlight that the actions taken by Baystate Noble as described below address at least one, if not multiple health priorities and populations. In addition, many of the actions taken since the prior CHNA iteration reflect the collaborative efforts of the Baystate Noble Hospital Community Benefits Advisory Council (CBAC).

### COMMUNITY LEVEL SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

**Back to School Drive** - an initiative taken on by Baystate Noble to donate school supplies to local public schools. Donations from employees are collected in bins throughout the hospital. It is a response to the continued call from the community to increase resources to meet basic needs. For the 2019 school year, donations benefited the Abner Gibbs Elementary School.

### BARRIERS TO ACCESSING QUALITY HEALTH CARE

Baystate Noble continued to provide much needed **financial counseling** services to its community and patients who have concerns about their health care costs. Financial Counselors are dedicated to: identifying and meeting their clients' health care needs; providing assistance to apply for health insurance; navigating the health care industry; as well as determining eligibility for the Baystate Financial Assistance Program. They can also assist in linking their clients to health insurance and community resources. There has been an increase in providing additional community support, including assisting patients with finding a new primary care physician, providing information on behavioral health services, and also contacting pharmacies to straighten out insurance issues.

**Baystate Financial Assistance Program - Baystate Health is committed to ensuring that the community has access to quality health care services** provided with fairness and respect and without regard to a patients' ability to pay. Baystate hospitals not only offers free and reduced cost care to the financially needy as required by law, but has also voluntarily established discount and financial assistance programs that provide additional free and reduced cost care to additional patients residing within the communities served by the hospitals. Baystate hospitals also make payment plans available based on household size and income.

Another initiative taken on by the hospital in early 2019 was the complete **integration of the hospital's electronic medical record (EMR)** into the Baystate Health Cerner system. Having Baystate Noble Hospital integrated into the health systems EMR is a step forward towards enhancing care coordination and continuity of care among all Baystate entities.

**Teletracking** improves the daily process for patient bed transfers, intake, placement, and tracking. In 2017, Baystate Medical Center pioneered the massive Teletracking project that replaced Baystate Medical Center's throughput management system Allscripts Patient Flow, providing enhanced features to track patients and logistics reporting/management. The next phase consisted of rolling out this system to the community hospitals, which was accomplished at Baystate Noble in 2019. Teletracking will provide system-wide management of throughput and optimization of bed availability to ensure care for patients in the right setting closest to their home.

**Dispatch Health** - a mobile urgent care service designed to reduce emergency department visits for non-emergencies and ensure patients with acute healthcare needs get the care they need in a timely manner so they can return to primary care supervision quickly and conveniently. Baystate Health's partnership with Dispatch Health has brought a high level of mobile clinical care to Hampden and Hampshire counties. Seven days a week, from 8:00 am to 10:00 pm, patients from Hampden and Hampshire counties needing urgent care services can now receive these services in the comfort of their own residence. Dispatch Health is contracted with major health insurance companies including Medicare and Medicaid.

**Public Health Nurse** - the nurse at the Westfield Senior Center is on site Tuesday and Friday from 9:00 am to 12:00 pm. The nurse provides health care services including general health assessment, blood pressure measurement, blood glucose monitoring, medication review, simple first aid procedures, and health education. Health care screenings are offered to detect new health problems and/or monitor ongoing health problems. The nurse is responsible for assessing the effects of medications and treatments for various health conditions, while explaining education materials regarding risk factors, diagnosis, and treatments of various health conditions including diet, medications, and healthy lifestyle options. The nurse also makes appropriate health care referrals to health care providers, as well as to the Council on Aging Director regarding Protective Services and Elders at Risk cases.

## HEALTH CONDITIONS AND BEHAVIORS

**MIGHTY (Moving, Improving and Gaining Health Together at the Y)** is a community-based multi-disciplinary pediatric obesity treatment program. It is held at the YMCA of Greater Springfield, YMCA of Greater Westfield, YMCA in Greenfield, and includes 14 – two-hour sessions which include physical activity, nutrition and behavior modification. It targets children and adolescents age 5-21 and lasts for one-year. Sessions are augmented by individual exercise training, weekly phone calls, monthly group activities, cooking classes, free swimming lessons with the YMCA, behavioral health consults and gardening experience. In addition, participants and their families are given a free six-month long membership to their local YMCA. Ongoing monthly maintenance groups are available to all previous program participants. In fiscal year 2018 the MIGHTY program had a very successful and busy year, enrolling and serving over 200 obese children and their families, and continues to expand with several new programmatic options and increased staff for both exercise and nutrition. Almost 50% of our participants decreased their body mass index during the program this year.

In 2019, a **Baystate Noble Hospital Opioid Task Force (OTF)** was convened to administer a \$50,000 earmarked grant awarded to Baystate Noble to go towards addressing the opioid epidemic. The overall objective was to reduce opioid mortality by targeting opioid overdose patients in the Baystate Noble Emergency Department (ED). The OTF developed a Naloxone Distribution Toolkit that can be distributed to patients in the ED upon hospital discharge. Simultaneously, patients are educated by a registered nurse or ED provider around how to use the naloxone kit through an education packet and a video on Naloxone administration to ensure competency on safety measures and medication administration. The BNH certified mental health clinician and case manager then develops a plan of care which will include follow up, monitoring of progress, and setting our patients and families up with community resources.

The second portion of this grant funding went towards organizing a community event to bring awareness around the local opioid epidemic and foster a collective community response. The event was held on Saturday May 25, 2019 at Strathmore Park in Russell and had over 100 community attendees. The event created an opportunity for BNH OTF to discuss their program implementation at the hospital level and introduce other local supports and resources. Table vendors present included: Tapestry Health, Right Choice, Behavioral Health Network, Narcotics Anonymous, Reiki, mindfulness, and other relaxation techniques and Montgomery Fire. Westfield Fire and Baystate Noble Nursing Staff paired up to provide Narcan administration education and demonstrations. The key speaker was Mr. Kirk Jonah from the Jack Jonah Foundation.

## COMMUNITY BENEFITS ADVISORY COUNCIL (CBAC) INVESTMENTS

Since its inception in 2017, the **Baystate Noble CBAC** has continued convening regularly on the third Friday of each month and is inclusive of employees, representatives of the community, and priority populations that the hospital serves. The CBAC's core roles include advocacy for community benefits within Baystate and in the community, reviewing the hospitals annual community benefits reports, providing input into the hospitals community health needs assessment and strategic implementation plan, formerly referred to as implementation strategy, and helping the hospital link its community

benefits strategy to an overall vision of reducing health disparities, promoting community wellness, and improving access to care for vulnerable populations.

Baystate Noble and its CBAC continued to foster community partnerships and has awarded grant funding to community partners to further address health needs identified in the 2016 CHNA, including:

- **It Takes A Village (ITAV)** – In July 2019, Baystate Noble donated 7,776 diapers and 240 packs of wipes to It Takes a Village. Located in Cummington, It Takes A Village’s mission is “to increase practical and emotional support and decrease social isolation, all while engaging the community to understand their responsibility in welcoming the newest members of their Village”. It Takes A Village provides free home visit services for participating families during an infant’s first 12 weeks of life. The organization also hosts support groups for new and expecting parents. Baystate Noble funding went towards adding support for The Village Closet, a community resource that offers free baby items such as clothing, diapers, highchairs, bedding and more, for any family in need.

## VII. Summary

The Baystate Noble service area continues to experience many of the same prioritized health needs identified in Baystate Noble's 2016 CHNA. Social and economic challenges experienced by the population in the service area contribute to the high rates of chronic conditions and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health inequities observed among priority populations, including children; older adults; Latinos; blacks; GLBQ+ youth; transgender individuals, people with low-incomes; women; people with mental health and substance use disorders; people involved in the criminal legal system; people experiencing homelessness; and people living with disabilities. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The Baystate Noble service area population continues to experience a number of barriers that make it difficult to access affordable, quality care, some of which are related to the social and economic conditions in the community, and others which relate to the health care system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. Also prioritized are chronic health outcomes, such as CVD, asthma, cancer, and diabetes among others.

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## IX. Appendices

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## Appendix I. Stakeholders Engaged in the 2019 CHNA Process

### Regional Advisory Committee (RAC)

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low- Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
Bankert, Sarah	Program Manager, Healthy Hampshire	Collaborative for Educational Services	X	X	
Bruno, Kathleen*	Health Management Program Manager	Health New England	X	X	
Cardillo, Beth	Executive Director	Armbrook Village	X	X	
Darling, Ann	Director of Planning and Resource Development	Community Action Pioneer Valley	X	X	
Douglas, Henry Jr.	Recruitment & Retention Specialist	Men of Color Health Awareness (MOCHA), MLK Family Services	X	X	
Fallon, Sean*	Manager of Community Benefits and Health	Mercy Medical Center; Trinity Health of New England	X	X	
Frutkin, Jim	Senior Vice President Business IFU	ServiceNet; Western Massachusetts Veterans Outreach	X	X	
Golden, Annamarie*	Director, Community Relations	Baystate Health	X	X	
Goldman, Doron	Freelance baseball researcher/historian	Cooley Dickinson Hospital Patient Family Advisory Council	X	X	
Gonzalez, Brittney*	Community Benefits Specialist	Baystate Health	X	X	
Gorton, George*	Director of Research, Planning & Business Development	Shriners Hospital for Children - Springfield	X	X	
Harris, Aumani	Project Manager	Springfield Department of Health & Human Services	X	X	X
Harness, Jeff*	Director, Community Health and Government Relations	Cooley Dickinson Health Care	X	X	
Kaufmann, Sally*	Director, Post Acute Business Integration and Development	Baystate Health	X	X	
Knapik, Michael*	Vice President, Government and Community Relations	Baystate Health	X	X	
Lake, Eliza	Chief Executive Officer	Hilltown Community Health Center	X	X	
Lamas, Kelly	Project Coordinator	Baystate Springfield Educational Partnership	X	X	

<b>Name (Last, First)</b>	<b>Title</b>	<b>Organization</b>	<b>Organization Serves Broad Interests of Community</b>	<b>Organization Serves Low- Income, Minority, &amp; Medically Underserved Populations</b>	<b>State, Local, Tribal, Regional, or Other Health Department Staff</b>
Landrau, Madeline	Senior Relationship Manager	Mass Mutual	X		
Lee, Jennifer	Systems Advocate	Stavros Center for Independent Living	X	X	
Lopez, Luz	Executive Director	Metrocare of Springfield	X	X	
Patrissi, JAC	Director of Domestic Violence & PATCH Services	Behavioral Health Network, Inc.	X	X	
Perez-McAdoo, Sarah	Board of Health Member	East Longmeadow Board of Health	X	X	X
Pluguez-Moldavskiy, Melissa	President	National Association of Hispanic Nurses of Western Massachusetts	X	X	
Puleo, Elaine	Community Member	Town of Shutesbury Baystate Franklin Medical Center Community Action Council	X		
Reed-McNally, Maureen	Director	Mass Mutual	X		
Robinson, Frank*	Vice President, Public Health	Baystate Health	X	X	
Rosenthal, Sarah*	Administrative Coordinator	Shriners Hospital for Children - Springfield	X	X	
Silverman, Risa	Outreach Director	Western MA Health Equity Network, University of Massachusetts - Amherst School of Public Health & Health Sciences	X	X	
Stevens, David P.	Executive Director	Massachusetts Councils on Aging	X	X	
Walker, Phoebe	Director of Community Services	Franklin Regional Council of Governments	X	X	
Wilson, Gloria M.	ACO Care Manager MSC, RN	Western Massachusetts Black Nurses Association	X	X	

\*Coalition of Western Massachusetts Hospitals/Insurer member

## Focus Group Participants

Findings from focus groups conducted in Hampden County and other western Massachusetts counties informed this CHNA. In total, 14 focus groups were conducted for the full Coalition CHNA effort, and unique perspectives that were appropriate to this CHNA from different geographic areas informed this CHNA. Each focus group had a specific topic, and participants represented a range of age, gender, and race/ethnicity. Focus groups included:

### Hampden County

#### ***Baystate Noble Hospital: Service Providers and Family Members of People with Substance Use Disorder***

- 8 participants
- 5 women and 3 men
- 6 were over age 40; 2 were between 20 - 40
- 6 people were white and 2 were Latino

### Hampshire County

#### ***Cooley Dickinson Hospital: Community forum with Older Adults - Northampton***

- 47 participants
- Mostly women
- All participants were older adults, mostly age 60+
- Roughly 90% white, 10% people of color

#### ***Cooley Dickinson Hospital: Community Forum with Older Adults - Amherst***

- 40 participants
- Mostly women
- All participants were older adults, mostly age 60+
- Roughly 90% white, 10% people of color

### Franklin County

#### ***Baystate Franklin Medical Center: Youth of Color***

- 11 participants
- 5 women, 4 men, 2 no gender selected
- 10 under 18 years; 1 age 18 - 21
- 5 Latinx; 2 black; 2 Asian; 2 Bi-Racial (black/American Indian and Asian/Other)

***Baystate Franklin Medical Center: People who are Transgender, Non-Binary, and/or Gender Non-Conforming***

- 5 participants
- People identified as unmanifested genderless/manifested female, transgender (1); female, male, & non-binary, prefer not to say whether transgender (1); male, transgender (1); non-binary transgender (2)
- 4 age 22 – 30; 1 51 - 60
- 4 white, 1 Semitic

***Baystate Franklin Medical Center: People Who Use a Rural Food Pantry***

- 13 participants
- 10 women and 3 men
- 1 age 22 – 30; 1 age 31 – 40; 2 age 41 – 50; 5 age 51-6-; 3 age 61 – 70; 1 age 71 - 80
- 10 white; 2 American Indian; 1 Biracial (white/American Indian)

## Key Informant Interviewees

Findings from interviews with individuals conducted in Hampden County and from other western Massachusetts counties informed this CHNA. Interviewees from Hampden County were the primary data sources; however, unique perspectives that were appropriate to this CHNA from different geographic areas also informed this CHNA. Key informants were health care providers, health care administrators, local and regional public health officials, and local leaders that represent the interests of the community or serve people who are medically underserved, have low incomes, or are people of color. Key informants were:

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low-Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
<b>Baystate Noble Hospital</b>					
Evans, Rose	Vice President of Operations	Behavioral Health Network		X	
Rai, Chitra	Senior Case Manager	Ascentria		X	
Savery, Kim	Case Manager	Hilltown Community Health Center	X	X	
Sitler, Kathey	Director	Drug Task Force	X		
<b>Baystate Franklin Medical Center</b>					
Pascucci, Cheryl	Family Nurse Practitioner	Baystate Franklin Community Hospital Acceleration, Revitalization & Transformation Program (CHART)		X	
Calabrese, Jessica Carey, Cameron Ewart, Jared Hamilton, Wes Heidenreich, Maria Hoynoski, Arley Jacobson, Allie Luippold, Susan Petrie, Maegan Sayer, Ed	Chief Operating Officer Development Director Accountant Chief Information Officer Medical Director	Community Health Center of Franklin County	X	X	

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low- Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Departme nt Staff
Van der Velden, Allison Welenc, Susan	Chief Financial Officer Information Officer Human Resources Accountant Chief Executive Officer Dental Director  Population Health				
Avery, Jennifer Brzezinski, Jen Chartrand, Ken Laurel, Charles Margosian, Alex Mercado, Reuben Neubauer, Deb Pliskin, Ariel Schwartz, Levin	Reentry Caseworker Reentry Caseworker Reentry Coordinator Clinician LICSW Clinician Reentry Caseworker Clinician Clinical Intern Director, Clinical and Reentry Services	Franklin County Sheriff's Department		X	
<b>Public Health Personnel</b>					
Caulton-Harris, Helen	Commissione r of Public Health	City of Springfield, Public Health Department			X
Cluff, Ben	Veterans' Services Coordinator	Massachusetts Department of Public Health, Bureau of Substance Use Services			X
Federman, Julie	Health	Town of Amherst			X

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low- Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Departme nt Staff
	Director				
Hyry-Dermith, Dalila	Supervisor	Massachusetts Department of Public Health, Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit			X
Walker, Phoebe	Director of Community Services	Franklin Regional Council of Governments			X



## Community Chats

RAC and CBAC members identified existing community or provider meetings to bring information about the CHNA and gather priorities. Findings informed prioritization of CHNA health needs.

Organization (46)	Population	Location	# of Participants (total: 759)
<b>Hampden County</b>			
Alzheimer’s Support Group	Caretakers and Alzheimer’s Patients	Westfield	6
Armbrook Village	Older Adult Community Members	Westfield	27
Baystate Health Financial Counselors	Health Care Professionals	Springfield	16
Baystate Medical Center Adult Patient Family Advisory Council	Youth Patients	Springfield	5
Baystate Medical Center Community Benefits Advisory Council	Community Leaders	Springfield	15
Baystate Medical Center Pediatric Patient Family Advisory Council	Community Members	Springfield	5
Baystate Medical Center Team Member Engagement Council	Health Care Professionals	Springfield	8
Baystate Noble Hospital Community Benefits Advisory Council	Community Leaders	Westfield	11
Baystate Noble Hospital Community Care Team Meeting	Non-Profit Staff	Westfield	15
Baystate Noble Hospital Healthcare Professionals	Health Care Professionals	Westfield	30
Baystate Noble Hospital Patient Family Advisory Council	Health Care Professionals	Westfield	5
Baystate Springfield Educational Partnership (BSEP) Career	Youth Community Members	Springfield	19

Organization (46)	Population	Location	# of Participants (total: 759)
Interdisciplinary Course			
Baystate Wing Hospital Leadership Council	Health Professionals	Palmer	30
Baystate Wing Hospital Team Member Engagement Council	Health Care Professionals	Palmer	11
BeHealthy Partnership (ACO) Patient Family Advisory Council	Community Members	Springfield	14
Boys and Girls Club of Greater Westfield	Youth Community Members	Westfield	10
C3 Mason Square	Community Members	Springfield	18
C3 South End	Community Members	Springfield	19
Dean High School	Youth Community Members	Holyoke	22
Falcetti Towers	Community Members	Holyoke	9
Gándara	Community Members	Springfield	13
Girls Inc. - Holyoke	Youth Community Members	Holyoke	8
Girls Inc. - Springfield	Youth Community Members	Springfield	13
Hampden County Health Coalition	Non-Profit Staff	Springfield	16
Healthy Hill Initiative, Seniors	Older Adult Community Members	Springfield	10
Holyoke Community College Community Health Worker Class	Health Care Professionals	Holyoke	16
Interfaith Council	Faith Leaders	Springfield	11
Jewish Family Services	Non-Profit Staff	Springfield	28
Kamp for Kids, Behavior Services	Adults with Disabilities	Westfield	14

Organization (46)	Population	Location	# of Participants (total: 759)
Mason Square CAB	Community Members	Springfield	12
Mass in Motion	Municipal Staff	Palmer	7
Maternal and Child Health Commission	Non-Profit Staff	Springfield	13
Mental Health Association	Non-Profit Staff	Springfield	40
Morgan School	Non-Profit Staff	Holyoke	19
Out Now Youth	GLBQ+ and Transgender Youth	Springfield	8
Parent Villages	Community Members-Parents	Springfield	18
Pastors Council of Greater Springfield	Faith Leaders	Springfield	30
Project Coach	Youth	Springfield	27
Shriners Medical Home Meeting	Health Care Professionals	Springfield	40
Springfield Dept. Health & Human Services	Municipal Staff	Springfield	35
Square One	Non-Profit Staff	Springfield	18
Square One, Young Childrens Council	Community Members-Parents	Springfield	7
The Carson Center	Non-Profit Staff	Westfield	18
UMMS-Baystate Community Faculty	Health Care Professionals	Springfield	11
UniTy of Pioneer Valley	Transgender Adults	Springfield	9
Westfield Residents with Mild Cognitive Impairment	Community Members with Mild Cognitive Impairment	Westfield	10
Westfield Senior Center	Older Adults	Westfield	13

## Community Conversations

Community Conversations were bi-directional information sharing meetings conducted for each Baystate Health hospital service area. Findings informed prioritization of community health needs.

### ***Baystate Noble Hospital: At Westfield Senior Center***

- 10 participants, primarily from Westfield area
- Women and men participated
- All participants were age 40 and up
- Most were white

## Appendix II. Glossary of Terms

- **Built Environment** - man-made structures, features, and facilities viewed collectively as an environment in which people live, work, pray, and play. The built environment includes not only the structures but the planning process wherein decisions are made.
- **Community** - can be defined in many ways, but for the purposes of the CHNA we are defining it as anyone outside of the Coalition of Western Massachusetts Hospitals/Insurer, which could be community organizations, community representatives, local businesses, public health departments, community health centers, and other community representatives.
- **Community Benefits (hospitals)** - services, initiatives, and activities provided by nonprofit hospitals that address the cause and impact of health-related needs and work to improve health in the communities they serve.
- **Community Health Needs Assessment (CHNA) and Strategic Implementation Plan (SIP)** - an assessment of the needs in a defined community. A CHNA and strategic implementation plan are required by the Internal Revenue Service in order for nonprofit hospitals/insurers to maintain their nonprofit status. The SIP uses the results of the CHNA to prioritize investments and services of the hospital or insurer's community benefits strategy. **Note:** the Internal Review Service uses the term "implementation strategy", however, Baystate Health as opted to use the term, "strategic implementation plan".
- **Community Health Improvement Plan (CHIP)** - long-term, systematic county-wide plans to improve population health. Hospitals likely participate, but the CHIPs are not defined by hospital service areas and typically engage a broad network of stakeholders. CHIPs prioritize strategies to improve health and collaborate with organizations and individuals in counties to move strategies forward.
- **Cultural Humility** - an approach to engagement across differences that acknowledges systems of oppression and embodies the following key practices: (1) a lifelong commitment to self-evaluation and self-critique, (2) a desire to fix power imbalances where none ought to exist, and (3) aspiring to develop partnerships with people and groups who advocate for others on a systemic level.
- **Data Collection**
  - **Quantitative Data** - information about quantities; information that can be measured and written down with numbers (e.g., height, rates of physical activity, number of people incarcerated). You can apply arithmetic or statistical manipulation to the numbers.
  - **Qualitative Data** - information about qualities; information that cannot usually be measured (e.g., softness of your skin, perception of safety); examples include themed focus groups and key informant interview data.

- **Primary Data** - collected by the researcher her/himself for a specific purpose (e.g., surveys, focus groups, interviews that are completed for the CHNA).
- **Secondary Data** - data that has been collected by someone else for one purpose, but is being used by the researcher for another purpose (e.g., rates of disease compiled by MDPH).
- **Determination of Need (DoN)** - proposals by hospitals for substantial capital expenditures, changes in services, changes in licensure, and transfer of ownership by hospitals must be reviewed and approved by MDPH. The goal of the DoN process is to promote population health and increased public health value by guiding hospitals to focus on the social determinants of health with a proportion of funds allocated for the proposed changes.
- **Ethnicity** - shared cultural practices, perspectives, and distinctions that set apart one group of people from another; a shared cultural heritage.
- **Food Insecure** - lacking reliable access to sufficient quantity of affordable, nutritious food.
- **Health** - a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization).
- **Health Equity** - the highest standards of health should be within reach of all, without distinction of race, religion, political belief, and economic or social condition (World Health Organization).
  - Health equity is concerned with creating better opportunities for health and gives special attention to the needs of those at the greatest risk for poor health
  - Health equity is when everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.
- **Housing Insecurity** - the lack of security about housing that is the result of high housing costs relative to income, poor housing quality, unstable neighborhoods, overcrowding, and/or homelessness. A common measure of housing insecurity is paying more than 30% of income toward rent or mortgage.
- **GLBQ+** - gay, lesbian, bisexual, queer, questioning, and all other people who identify within this community.
- **Transgender** - refers to anyone whose gender identity does not align with their assigned sex and gender at birth.
- **Non-Binary** - people whose gender is not male or female.
- **Gender Nonconforming** - a person who has, or is perceived to have, gender characteristics that do not conform to traditional or societal expectations.

- **Race** - groups of people who have differences and similarities in biological traits deemed by society to be socially significant, meaning that people treat other people differently because of them, e.g., differences in eye color have not been treated as socially significant but differences in skin color have. Race is a socially created construct as opposed to true categorization.
  - **Black** - we use the term “black” instead of African American in this report in reference to the many ethnicities with darker skin, noting that not all people who identify as black descend from Africa.
  - **Latino/a** - we use the term “Latino” or “Latina” in this report in reference to the many cultures who identify as Latin or Spanish-speaking. We chose to use Latino/a instead of Hispanic or Latinx, noting that there is a current discussion on how people identify. Latinx is a gender-neutral term, a non-binary alternative to Latino/a.
- **Social Determinants of Health** - the social, economic, and physical conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. (World Health Organization)
- **Social Justice** - justice in terms of the distribution of wealth, opportunities, and privileges within a society.

## Appendix III. Focus Group Summaries

### Coalition of Western Massachusetts Hospitals/Insurer 2019 Community Health Needs Assessment

#### Focus Group Report: Substance Use

**Primary Hospital/Insurer:** Baystate Noble Hospital

**Topic of Focus Group:** Substance Use

**Date of Focus Group:** 3/11/2019

**Facilitator:** Gail Gramarossa

**Note Taker:** Karen Auerbach

#### Executive Summary

##### A. Participant Demographics:

- Middle-aged adults with substance use issues, or with adult children with substance use issues
- Eight people
- Five women, three men
- Six people were white, two were Hispanic/Latino
- Six people seemed to be over age 45, and two seemed to be in their early 30's
- One man who was Latino and in his early 30's did not talk at all

##### B. Areas of Consensus:

- People who are receiving treatment for substance use disorders need housing for treatment to be effective, but it is often very difficult for them to get affordable housing.
- Not having adequate transportation from a treatment/recovery center to home or work can be a big barrier to receiving effective treatment.
- There aren't enough beds in hospitals and inpatient substance use treatment centers. Even if someone does get a bed, the length of stay is very short.
- There is stigma around receiving addiction support, so typically people who live in Westfield go outside Westfield for addiction treatment and recovery, and people who live outside Westfield go to Westfield for these services.
- There is typically little to no follow-up for people who are discharged from medically assisted treatment programs.
- Grandparents who are raising grandchildren because their children are addicts need more support.

##### C. Key Recommendations:

- There should be more recovery options, like sober houses and recovery coaches, in Westfield.



- Addiction treatment and recovery programs should include mental health services and support because most people who are addicted to drugs also have mental health issues, which if untreated can lead to relapse.
- There need to be therapists in Westfield who are trained in addiction. There aren't any currently.

D. Quotes:

- "You can't do treatment without a place to live. Can't do it if you're living on the street."
- "Some people might be stable in transitional housing their whole lives, some may be able to move on to independent living. Everyone's unique, their bodies are different, need different types of treatment and housing."

**Key Issues**

Question	Synthesis of Responses
<p><b>1. What are the most serious barriers or service gaps that consumers face in accessing mental health and substance use care?</b></p>	<ul style="list-style-type: none"> <li>● There are very few beds in hospitals and other inpatient substance use treatment centers that are available when they are needed (without a long wait time) for people without private insurance. Even if someone does get a bed, the length of stay is very short.</li> <li>● There aren't enough options in Westfield for post-inpatient treatment and recovery. There are options in Holyoke and Springfield, but these places may be too far away from Westfield (especially if people don't have adequate access to transportation) to be realistic options. As a result, it can be difficult for parents who live in Westfield to support their children's recovery in Holyoke or Springfield.</li> <li>● People who need or are receiving treatment for a substance use disorder need a place to live for treatment to be effective, but it's often very difficult for people in treatment to find and get affordable housing, especially people with CORI issues. Background checks and credit checks that are done when people apply for housing can be a barrier.</li> <li>● Inadequate transportation to or from treatment and recovery locations to home, family, or work can also be a big barrier to recovery.</li> <li>● Judges may not understand the substance use treatment and recovery process. People who are convicted of drug offenses and are in drug treatment don't get access to methadone or suboxone when in pretrial. If they go to jail or the street, they also won't get access to this treatment.</li> <li>● Judges and others may not understand what drug addiction is. One judge said an addicted person can't be addicted if he's working full time and has a car and place to live. Another didn't believe someone's</li> </ul>

Question	Synthesis of Responses
	<p>son who was a great athlete with an injury could be addicted to heroin. Some believe that if a drug is a prescription drug, there can't be addiction.</p> <ul style="list-style-type: none"> <li>● Probation should be integrated with the legal system and hospitals, but it is not. Recovering addicts on probation are made to jump through hoops, like call in every day or go to court by 4 pm even if they have no transportation. There should be a separate probation for drug issues - currently they're all for crime.</li> <li>● Most addicts have mental health issues as well, but typically addiction treatment and recovery programs only address addiction issues. As a result, recovery may not last very long.</li> <li>● Most clinics help with addiction and provide counseling and women's support groups, but they don't provide the other services and support that people in recovery need to become financially self-sufficient, be better parents, and so on.</li> <li>● There are no therapists in Westfield who are trained in treating addiction. Patients are usually just treated by interns at the hospital who are in training. But these interns typically leave for other, better paying jobs when they're done with their internships.</li> <li>● The whole system needs a group of people who know what's going on and understand the system who can help people seeking or receiving treatment to navigate it and coordinate all the different parts.</li> </ul>
<p><b>2. Are there specific vulnerable populations that you are most concerned about in relation to addiction and substance use? Who are they and why?</b></p>	<ul style="list-style-type: none"> <li>● It's hard to help high schoolers deal with anxiety and depression with meds effectively, so they often turn to drugs.</li> <li>● Some high schoolers with learning disabilities can have lots of trouble with anxiety, and take drugs to help with the anxiety.</li> </ul>
<p><b>3. What about mental health care and substance use/addiction care for people who have young children? What are the major needs and issues for those age groups?</b></p>	<ul style="list-style-type: none"> <li>● Getting affordable housing can be very difficult for mothers in recovery whose children were taken away from them. They often cannot get their children back without having housing, but may need to have their children living with them to obtain affordable housing.</li> <li>● Often grandparents are raising their grandchildren because their children are addicted to drugs or are in treatment and recovery. There is not enough support for these grandparents to raise their grandchildren and deal with their children's addiction and recovery.</li> <li>● Some addiction recovery support groups don't allow children to be present or don't provide child care, so some parents can't attend these support groups.</li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>● Because most state services can only be accessed in Springfield (like applying for MassHealth), it can be very hard for grandparents to access these services for their grandchildren.</li> </ul>
<p><b>4. Are there enough providers who can prescribe Medication Assisted Treatment (MAT) such as suboxone? Is there a methadone clinic in Westfield? If not, should there be?</b></p>	<ul style="list-style-type: none"> <li>● There are two providers for medically-assisted recovery in Westfield— 1 doctor who can prescribe suboxone and one methadone recovery center.</li> <li>● There is a lot of stigma around receiving this treatment, so people who live in Westfield tend to get MAT outside of Westfield (like Riverbend and Clean Slate), and people who get MAT in Westfield tend to live elsewhere. There is community pushback and stigma against having more services available in Westfield.</li> <li>● The protocol for MAT is often not effective, especially when therapy is not provided at the same time, which can lead patients to relapse.</li> <li>● When most people are discharged from an MAT program at a hospital or clinic, they are itching to get out and don't use other services available to continue their recovery, and often relapse. There is typically no follow-up 24-48 hours after discharge.</li> <li>● One place had a grant for two years to follow-up with people who were discharged. After they lost grant funding, follow-up was just a phone call. People were just cut off after discharge.</li> <li>● Sometimes the police were sent to find people after they were discharged from Noble hospital, but there wasn't enough money and training to support police to keep doing that.</li> </ul>
<p><b>5. What about long-term substance use and recovery care needs? What are the needs for such services?</b></p>	<ul style="list-style-type: none"> <li>● Recovery coaches can help people recover from having a substance use disorder, but there are very few recovery coaches in Massachusetts. Gándara, the Behavioral Health Network, and Caring Center provide recovery coach training. People with lived experiences, who have overcome their mental health or addiction issues, can be effective coaches and help addicts throughout their recovery process. They can help with the spiritual and emotional aspects of recovery and can be there every step of the way for a recovering addict. But there isn't much training for them, they're not paid very much, and may not get paid if they don't meet some requirements (like meeting with a client 5 times or more in a month).</li> </ul>
<p><b>6. In relation to opioid use, what are the most pressing issues and needs around prevention, intervention and</b></p>	<ul style="list-style-type: none"> <li>● The Westfield task force can't do a Narcan training. Only the police can, so they have done a couple trainings. But this isn't enough.</li> <li>● The police force is having some issues with getting Narcan – sometimes it's because of unions, and sometimes police officers don't</li> </ul>

Question	Synthesis of Responses
<p><b>access to care? How about overdose issues such as prevention and who carries Narcan?</b></p>	<p>want to carry Narcan. Sometimes officers get ill from fentanyl and need treatment.</p>
<p><b>7. What is happening in this area related to substance use prevention? Should there be more prevention efforts and what would that look like?</b></p>	<ul style="list-style-type: none"> <li>• There is proper education for HIV and free condoms are available everywhere. But there isn't very much around drug use. One program is just starting in Westfield for 6<sup>th</sup>, 8<sup>th</sup>, and 10<sup>th</sup> graders, which will integrate drug addiction education.</li> </ul>
<p><b>8. How do substance use disorders and addiction impact overall community health and stability?</b></p>	<ul style="list-style-type: none"> <li>• The police forces often have to diagnose and place people with addiction issues, but they're not trained and equipped to handle things like this.</li> <li>• The Westfield community seems economically and socially divided by neighborhoods. People think drug problems exist in other neighborhoods, but not theirs.</li> <li>• There is a huge impact of young adults dying from overdoses on other young adults and their families, and the community in general. Grief is often not recognized or dealt with. "It's like a lost generation." There is sadness and weariness in the community as a result. There is an impact on businesses, faith leaders, and family-owned funeral homes as well.</li> </ul>

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Focus Group Report: Transgender, Non-Binary, and Gender Nonconforming (GNC) People**

**Primary Hospital/Insurer:** Baystate Franklin Medical Center

**Topic of Focus Group:** Transgender, non-binary, and gender nonconforming (GNC) people

**Date of Focus Group:** 2/19/2019

**Facilitator:** Kat Allen

**Note Taker:** Jeanette Voas

**Executive Summary**

A. Participant Demographics:

- Five participants
- Four participants were between the ages of 22 and 30. One was between the ages of 51 - 60
- Four were white, one was Semitic
- One Unmanifested genderless, manifested female, transgender; one Female, male, & non-binary, prefer not to say whether transgender; one Male, transgender; two Non-binary transgender

B. Areas of Consensus:

- “Transgender, non-binary, and gender nonconforming” works as an acceptable set of labels. There are many other culturally specific identities like “two-spirit.” [In this report “trans” – the word the participants used most often – is used as short hand to cover a range of identities.]
- The health care system needs to be more trans-friendly and trans-knowledgeable at all levels. There are a few good PCPs that trans/GNC people go to, but not enough, and sometimes other providers use the fact that someone else is trans-friendly as an excuse to *not* need to become more informed. And most specialists do not have the needed sensitivity and knowledge.
- There are not enough behavioral health care providers who are transgender (the ideal situation) or trans-friendly and trans-competent.
- Medical providers should be expected to meet a higher bar for trans-competence than the general public does. Patients should not need to be in the position of educating their medical providers.
- The administrative level of health care does not feel trans-friendly, e.g. forms and protocol disregarding information provided about preferred names, asking patients to fill out forms with inscrutable questions about transgender status.
- The lack of coordination among agencies can make it difficult to find trans-friendly care and services.
- There’s a general lack of sensitivity in the community, which can be socially isolating, especially for transgender people who don’t “pass.”

- All of the participants agreed that they felt uncomfortable or afraid going to any of the gyms in town.
- C. Recommendations:
- Recruit trans-friendly and trans-knowledgeable providers (including and especially behavioral health specialists), and providers who are themselves transgender. Involve trans people in the hiring/interviewing process.
  - Train everyone in the hospital or medical practice in trans issues to build competence throughout the organization.
  - Provide training to community organizations to make them trans-friendly and motivate them to involve transgender people. Gyms are a good place to start.
  - Create a single GLBQIA+ and transgender hub that people know about and can go to for information about providers, resources, events, etc. (Cooley Dickinson just hired someone for a similar role.)
- D. Quotes:
- “I need Baystate to understand that people are falling through the cracks. We’re *not* healthy, we’re *not* doing great, we’re suicidal, struggling to maintain employment and paying all the bills, so it’s so difficult to do self-care. There’s a lot of personal responsibility on me taking care of myself, but also I need those resources to be there and available and accessible, and to be treated like a human being.”
  - “I have never been in a gym where I have not felt terrified 100% of the time I was there. I just want to exercise!”
  - “I can’t go to the gym and do the things I want to do, be with people in that setting, and maybe develop a friendship. I can’t have that because I don’t think they’re ready for it. And specifically in my case, it’s because I do not pass.”
  - “Not passing is a huge barrier to everything.”
  - “When I feel like I am expressing myself in a way that’s true to myself, most people in society don’t know how to read that or be with it.”
  - “There’s this idea that you’re moving from one side of the binary to the other, you’re in transition, and you’re always trying to get somewhere. I’m non-binary but that doesn’t mean I’m trying to find a means to an end. I hope that health care can get used to the idea of people just being people and identifying as themselves without having to reach some gender identity. This idea that people have to look at you and have to diagnose you as something is really frustrating.”
  - “Even the hormones they put trans people on were usually designed for cis people. So much of what happens with trans people, there’s no research, there’s no knowledge.”
  - “Before coming here I went to Fenway Health in Boston, which is specifically for GLBQIA+ and transgender community. Here I feel like providers lack interest in becoming well-read and accepting and caring. It feels like they’re doing it because they’re being mandated to, or because people are reacting against the things that they’re not doing.”
  - “I swear medical school steals people’s souls. Every time I deal with a medical assistant or nurse practitioner, they’re so great...doctors terrify me.”
  - “I seek out only trans-friendly physicians. I go to people I trust.”

- “If they’re taking new patients.”
- “There’s no network. Coming here and finding a therapist who’s trans-friendly... In Boston, there’s a network you can go to and there’s actual information about the providers and what their experiences are with trans people. Here I have no idea.”
- “Resources are so fragmented. I’ve seen at least 3 separately compiled documents made by different groups that list all the trans-friendly providers in the area, with 90% overlap, but people at three different organizations had to painstakingly put these together separately and then give them to like the five people they interact with.”
- “In this area, people think, ‘everyone’s queer,’ so we don’t need queer-specific resources, we don’t need a GLBQ+ and transgender center like Fenway.”
- “Some weeks what I do to stay healthy is I eat well and I exercise and some weeks what I do to stay healthy is I eat McDonalds and I sleep for 15 hours and I try again the next week. I don’t want a health care system that’s going to shame me because I have to do that sometimes.”

**Key Issues**

Question	Synthesis of Responses
<p><b>1. Obstacles to being healthy</b></p>	<p>Lack of awareness, sensitivity, and competence around trans issues in the health care system</p> <ul style="list-style-type: none"> <li>● Providers need to be better educated about trans issues. Otherwise the burden falls on the patients to teach the providers.</li> <li>● Ideally, there would be good providers who are themselves transgender. Second choice: loving, caring providers who have the knowledge and understanding.</li> <li>● There are not enough mental health providers who are transgender themselves or trans-friendly and trans-competent. And mental health support is a big need for trans people.</li> <li>● It’s difficult to seek behavioral health. Five years ago I knew I’d be approached a certain way, asked to do certain tests. Now I get a lot of apologies. It’s just too much.</li> <li>● Some providers lack sensitivity, and others will say, “I treat transgender people like everyone else.” But there are extra issues with being transgender. The providers need to be knowledgeable about that.</li> <li>● There are a few providers who are known to be trans-friendly, and everyone goes to them. Because those few providers are out there, other providers, especially specialists, seem to feel they don’t need to become trans-knowledgeable themselves.</li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>• I have health issues that have nothing to do with being trans, but when I go to a specialist, all they want to know is whether I'm on testosterone.</li> <li>• The administrative level needs training as well. They're the first line. They don't use your preferred name and they give you forms with questions that are not helpful and hard to answer.</li> </ul> <p>Lack of sensitivity in the community, no welcome feeling</p> <ul style="list-style-type: none"> <li>• The gyms in town do not feel welcoming. Fear that someone will freak out in the locker room and call 911. Gyms aren't ready for us. "I have never been in a gym when I have not felt terrified."</li> </ul> <p>Social isolation if you don't fit in</p> <ul style="list-style-type: none"> <li>• If you don't pass, you're a provoker. Not passing is a huge barrier to everything. There are lots of non-passing transgender women who don't leave the house.</li> <li>• People don't see us as we are.</li> </ul> <p>Capitalism!</p> <ul style="list-style-type: none"> <li>• We live in a system that funnels power and wealth to people who don't tend to be transgender or care about transgender people.</li> </ul>
<p><b>2. Health challenges unique to transgender people &amp; how well are they being addressed</b></p>	<ul style="list-style-type: none"> <li>• Not enough research on health issues for transgender people. <ul style="list-style-type: none"> <li>○ What are long-term effects of hormones?</li> <li>○ What about interaction of hormones and other medications?</li> <li>○ How best to deal with other health issues that are different for transgender people?</li> <li>○ It's like we're being experimented on.</li> </ul> </li> <li>• There are not many providers who are themselves transgender. Getting into those fields can be hostile to transgender people.</li> <li>• A lot of trans-specific health care happens to people before they're 18, when they can't speak or decide for themselves. <ul style="list-style-type: none"> <li>○ One participant reported medical abuse as a child, including having medications and treatments that weren't explained to them, perhaps because of their gender nonconformity.</li> </ul> </li> <li>• I worry that if you have a history in the mental health system, as many transgender people have, that can affect how you're treated in the medical system. You say something's going on and they say, "It's just in your head."</li> <li>• Trans people don't all want the same things, the same combination</li> </ul>



Question	Synthesis of Responses
	<p>of hormones &amp; surgery.</p> <ul style="list-style-type: none"> <li>○ One participant said: Insurance has had restrictive rules, e.g. you can't get top surgery unless you're on hormones</li> <li>○ Another said: rules have changed in Massachusetts, so that's no longer the case</li> <li>○ Another said: providers need to be able to educate patients about things like that</li> <li>● At times, there have been shortages of HRT meds and I have been unable to get them at the pharmacy. It's awful.</li> </ul>
<p><b>3. Where do you get medical care &amp; do you get the care you need?</b></p>	<ul style="list-style-type: none"> <li>● CHC, Baystate, VMG, CSO, alternative providers</li> <li>● Mix of satisfaction with providers: I'm comfortable, I'm ready to move, I don't talk with my doc about anything</li> <li>● Dental is awesome at CHC!</li> <li>● Bad experiences: <ul style="list-style-type: none"> <li>○ Hole in the system: I hit my head at work, I have symptoms that prevent me from working, but I don't have a diagnosis and without a diagnosis, I can't get disability or any kind of assistance.</li> <li>○ In CT, when I was suicidal I was admitted to hospital into awful conditions, with people freaking out all around and guards. There was no trans support, no recognition. You've got to make accommodations and be trans knowledgeable. I was ready for help and that's how I got treated.</li> <li>○ I've been in Baystate psych ward. They're not trans knowledgeable. And the reason why is that they send trans people up to Brattleboro Retreat, but that unit is poorly resourced, as compared to other units.</li> </ul> </li> </ul>
<p><b>4. Local resources that have helped you be healthier</b></p>	<ul style="list-style-type: none"> <li>● (Long silence before anyone answered)</li> <li>● Recovery Learning Center, for community and mental health support</li> </ul>
<p><b>5. What else/what other services would be helpful?</b></p>	<ul style="list-style-type: none"> <li>● A central go-to place for trans people to find out where to get trans-friendly services. An GLBQ+ and transgender resource center. A hub that people know about, one entry point. <ul style="list-style-type: none"> <li>○ There's word of mouth, and everyone says to go to the same provider and that provider is booked solid</li> <li>○ For someone new in town, it's hard to navigate</li> </ul> </li> <li>● When people go into crisis here, they often get sent to respite. But respite sucks for trans people. Their policies make no sense, so they usually don't accept trans people. Trans people who could be in a</li> </ul>

Question	Synthesis of Responses
	<p>less locked-down situation end up getting pushed into the hospital.</p> <ul style="list-style-type: none"> <li>• Opportunities for improving health &amp; talks about health resources that don't all go back to exercise and eating well. Some of us can't exercise, and the healthy food is the most expensive food.</li> </ul>
<p><b>6. What do you do to stay healthy?</b></p>	<ul style="list-style-type: none"> <li>• Exercise, take care of yourself be fit &amp; active, mentally healthy and happy</li> <li>• Dance, as often as possible</li> <li>• I need Baystate to understand that people are falling through the cracks.</li> <li>• Marijuana has been helpful. Looking for increased accessibility and lower price.</li> </ul>
<p><b>7. Recommendations from one participant who wrote up her thoughts for us</b></p>	<ul style="list-style-type: none"> <li>• Remove gender-specific signage</li> <li>• Stockpile and make available HRT meds when supplies become low</li> <li>• Set a gift fund for transgender surgical procedures for those who cannot afford them.</li> <li>• Hire health care providers—especially mental health providers—who are themselves trans or GNC</li> <li>• Recruit medical professionals with specific training with trans people.</li> <li>• Conduct mandatory training of all health care employees for trans-friendly environment</li> <li>• Involve trans people in provider hiring &amp; interviewing process</li> <li>• Get involved in retraining influential people and the community at large to create a more inclusive environment</li> </ul>

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Focus Group Report: Youth of Color**

**Primary Hospital/Insurer:** Baystate Franklin Medical Center

**Topic of Focus Group:** Youth of Color

**Date of Focus Group:** 2/19/2019

**Facilitator:** Kat Allen

**Note Taker:** Jeanette Voas

**Executive Summary**

- A. Participant Demographics: Eight participants
  - Five women, three men
  - Six people seemed to be over age 45, and two seemed to be in their early 30's
  - Six people were white, two were Latino
  
- B. Areas of Consensus:
  - Life is stressful, with multiple demands of school, homework, chores at home, and for many, work.
  - School can be a stressful environment, with social expectations, cliques, unnecessary drama, and a school environment that doesn't help young people deal with the emotions and the stress.
  - The students said they see a lot of anxiety, eating disorders, and depression among their peers.
  - They report instances of being stereotyped by their peers, being treated unfairly at school because of race, or being less likely to be hired because of race.
  - Young people need a place to hang out that's not school.
  
- C. Key Recommendations:
  - Support social emotional learning in schools
  - Work to destigmatize mental health issues
  - Provide lots of support for students transferring into a school
  - Train students and staff in diversity/cultural humility
  - Continue support for programs like CAYP Shout Out group.
  - Consistently and fairly apply school discipline policies and school dress code across gender, race, ethnicity, class, and appearance.
  - Incidents of teachers and school staff not respecting students' physical space (i.e. dress code violations) are not uncommon and should be avoided.
  - Community activities and resources such as "lightskating" and a skate park and greater access to the YMCA would provide healthy ways for youth to feel more connected and engaged.

D. Quotes:

- “School’s supposed to be a learning environment, but it stresses you out. There’s not enough time to socialize, time to learn social skills.”
- “There aren’t enough hours in the day to get everything done in a way that’s acceptable to your peers and your parents.”
- “When I get angry, I don’t show my emotions for nothing. People can use it against you. I feel bottled up by too much emotion. Sometimes I don’t pay attention because I’m so stressed, it slows me down.”
- “It’s not good for your body to be so stressed out. You get panic attacks, anxiety. We see lots of it. I know so many people at school who have eating disorders or anxiety.”
- “If you transfer in to our school, it’s not easy to integrate in. Everyone stays with their own friend group.”
- “Teachers care about the work, not the student – well, not every teacher. I can stay after to talk about school work, but I can’t stay after to talk with a teacher about emotional problems.”
- “In school they don’t teach you how to deal with emotional stress. You can end up being depressed about it.”
- “There’s a lot of stigma against mental health. I know a girl who’s depressed and her friends told her, ‘I don’t get it, just be happy.’ She’s afraid to go to therapy because people don’t understand.”

**Key Issues**

Question	Synthesis of Responses
<b>Things that get in the way of being healthy</b>	<ul style="list-style-type: none"> <li>● Financial issues               <ul style="list-style-type: none"> <li>○ Expense of health insurance and health care</li> <li>○ Some people don’t have enough money to go to the doctor and doctors shame and threaten parents that they should take better care of their kids.</li> <li>○ It’s too expensive to go to the Y or to have exercise equipment</li> </ul> </li> <li>● Family has moved a lot, and that makes it hard to be healthy. You have to adjust to everything, to new schools.</li> <li>● No rides; it takes a long time to get places</li> <li>● Lack of a healthy social environment in school               <ul style="list-style-type: none"> <li>○ It’s hard to transfer into a new school and fit in</li> <li>○ Peer pressure to spend money and have certain clothes, shoes, technology. It makes people stressed out.</li> </ul> </li> <li>● Stressors               <ul style="list-style-type: none"> <li>○ People compare their body types to others. I know a lot of</li> </ul> </li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>○ people with eating disorders.</li> <li>○ School + work + homework + chores + sports is exhausting. It's hard to stay awake during the day.</li> <li>○ We see lots of anxiety, panic attacks, depression</li> <li>● JUULing, including in school</li> <li>● Some parents are against vaccination; kids can't decide on their own to get vaccinated</li> </ul>
<p><b>2. Health issues unique to young people of color?</b></p>	<ul style="list-style-type: none"> <li>● It's harder to get hired.</li> <li>● There are social expectations – people expect you to be something you're not, and that adds to stress.</li> <li>● Because of Asian stereotype, everyone wants to be in a group with me and make me do all the work.</li> <li>● People get labeled for how they look or act.</li> <li>● People get called messed up names.</li> <li>● There's drama that's unnecessary and so common.</li> <li>● There's unequal treatment, for example in dress code violations. It doesn't happen to white girls like it does to me.</li> </ul>
<p><b>3. How well are those challenges addressed</b></p>	<ul style="list-style-type: none"> <li>● Some teachers care about school work, not about the students.</li> <li>● We complain, for example about school food, and nothing is done about it.</li> <li>● Teachers can be disrespectful, for example, yanking off a hood instead of asking you to take it off.</li> </ul>
<p><b>4. Discrimination that impacts health</b></p>	<ul style="list-style-type: none"> <li>● A guy told me I was unattractive because I'm black. It took a toll on me.</li> <li>● I keep my emotions bottled up.</li> <li>● In school they don't teach you how to deal with emotional stress. You can end up being depressed about it.</li> <li>● There's a stigma against mental health. Someone might not go to therapy because people don't understand.</li> </ul>
<p><b>5. Local resources that contribute to health</b></p>	<ul style="list-style-type: none"> <li>● CAYP, Family Center.</li> <li>● The Shout Out advisor bought me a planner and helped me plan.</li> <li>● Therapy</li> <li>● Friends can be therapists, too</li> <li>● Family members</li> <li>● It's good to have someone you can trust</li> <li>● Being alone</li> </ul>

Question	Synthesis of Responses
<p><b>6. What else is needed</b></p>	<ul style="list-style-type: none"> <li>• A place for youth to go hang out               <ul style="list-style-type: none"> <li>○ Friday night “Lightskating” with lights and DJ was good, but they don’t do it anymore</li> <li>○ Skatepark is gone and Turners is so far</li> <li>○ Boredom makes kids do crazy things</li> </ul> </li> <li>• Transportation – Leyden Woods is so far from everything</li> </ul>
<p><b>7. How do you stay healthy</b></p>	<ul style="list-style-type: none"> <li>• Sports</li> <li>• Spending time alone</li> <li>• Hike to Sachem’s Head – it’s so peaceful</li> <li>• Dance when I clean</li> <li>• Go to the Y</li> <li>• Have pets</li> </ul>

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Focus Group Report (based on 2 Community Forums)**

**Primary Hospital/Insurer:** Cooley Dickinson Health Care, but the focus group results are applicable to:

- Baystate Franklin Medical Center
- Possibly Baystate Wing Hospital for rural similarities
- Health New England for needs of older adult members across western Massachusetts

**Topic of Focus Group:** Older Adults

**Date of Focus Group:** February 26, 2019 in Northampton and March 4, 2019 in Amherst

**Facilitator:** Jeff Harness

**Note Taker:** Gail Gramarossa

**Executive Summary**

A. Participant Demographics:

- 47 participants in Northampton, 40 participants in Amherst
- Mostly women
- Roughly 90% white, 10% people of color at both sessions
- Older adults, mostly age 60+

B. Areas of Consensus:

- Older adults want to stay as independent and safely live in their own homes/apartments as long as possible.
- Social connections and networks for social activities and support are as important as medical and mental health care. Older adults want to feel valued and involved in the community.
- Having access to health care provides a sense of safety and security.
- Reliable and accessible transportation to and from appointments and other activities is still a huge barrier to services, especially during winter.
- Managing chronic diseases requires that there be adequate education, support, and ability to navigate the complexities of the medical care system.
- Older adults want their providers to discuss alternative treatments and end-of-life care issues more openly and frequently.
- Knowing how to access mental health care is a challenge and there are too few providers with expertise in older adults' mental health care needs.

C. Key Recommendations:

- Need more home-based services
- Need more "elder friendly" affordable housing options.
- Need more congregate housing options that allow people to keep their pets, such as assisted living
- Need more specialty providers with expertise in geriatrics

- Primary care and behavioral health care need to be more integrated and providers need to communicate with each other more consistently
  - Need more deliberate and direct outreach to older adults, rather than waiting for them to come to you as health care providers
- D. Quotes:
- "We are not our mothers – our health and social needs are very different from our parents' generation."
  - "We want to make new 'families' and create our own supportive communities, especially if our children/grandchildren live far away from us."
  - "We need help to manage the mental aspects of having a chronic disease such as stress, depression, and anxiety."
  - "Our needs really vary by decade – what I need in my 60s may not be what I need in my 70s or 80s or 90s, so tailor services to my changing needs."
  - "Be sure that providers and patients are 'tapping the resources', for example, the Diabetes Education Center at CDH. Many primary care doctors do not refer to the Center; I learned so much from the Step Up program and was able to avoid going on medication for 15 years based on diet and exercise. Diabetes is an illness that people feel guilty about, they feel they brought it on themselves, but I have learned to manage it well. No primary care doc can give me what I received from the Center."
- E. Was there anything that could be relevant to another hospital service area? If so, which geographic area and describe:
- This information could be useful for other hospitals that serve a suburban and rural community with many retirees and older adults. This audience was also fairly well-educated and aware of services in the region.



## Key Issues

Question	Synthesis of Responses
<p><b>1. What makes life fulfilling as you grow older? What is important to aging successfully?</b></p>	<ul style="list-style-type: none"> <li>● Social connections and people you can call upon for help</li> <li>● Feeling valued and involved</li> <li>● Sense of safety and capacity to get health care when you need it</li> <li>● Quality of life, control over your life, having a say in your life</li> </ul>
<p><b>2. What supports and services do you or other older adults in our community need to support good health? Where are there gaps in services, and how do these gaps impact older adults? Think about older adults with limited English, or who are people of color, or live in a rural area, identify as GLBQ+, transgender, or from other underrepresented groups.</b></p>	<ul style="list-style-type: none"> <li>● Transportation</li> <li>● Affordable housing, down-sized and smaller</li> <li>● Provider with expertise in elder care issues/needs</li> <li>● Financial advice and information to avoid financial “scams”</li> <li>● Home-based services</li> <li>● Day programs for frail elders</li> <li>● Care coordination services to integrate care more seamlessly</li> </ul>
<p><b>3. Most older adults in our community have at least 1 chronic or serious illness. What helps older adults manage chronic disease?</b></p>	<ul style="list-style-type: none"> <li>● Behavioral health support to manage the psychological impact/stress and anxiety of having a chronic disease</li> <li>● Help with managing and following a medication regimen</li> <li>● Case management services</li> <li>● Pharmacy home delivery</li> <li>● Help with navigating insurance and Medicare issues</li> <li>● More follow-up and “check-ins” from my primary care provider</li> <li>● Health education for managing chronic illness provided in a non-hospital setting</li> <li>● Be sure that providers and patients are aware of and referred to key health education and support programs that help with managing chronic disease such as the Diabetes Education Center at CDH; too many primary care doctors do not refer to the Center or other similar supports</li> <li>● It is important for CDH to let the community know about all of the resources that are available to help older adults manage chronic illnesses</li> <li>● Primary care needs to be better integrated with the other</li> </ul>

	<p>resources within the community</p> <ul style="list-style-type: none"> <li>● For someone who is not able to get themselves there, perhaps a coach or someone to help people get to outside resources</li> <li>● Could each office have 1 nurse who works specifically on integrating the office with other resources in the area? They could work with primary care around how to link the patients with those resources, using resources guides and websites about local services</li> <li>● CDH should make sure that their primary care doctors/office staff are fully knowledgeable about what is out there in terms of other local resources and support services to manage chronic illness</li> </ul>
<p><b>4. What would you like to see in your community that would make it a better place for older adults to live?</b></p>	<ul style="list-style-type: none"> <li>● More support for “aging in place”</li> <li>● Better sidewalks and recreation areas</li> <li>● Home visiting</li> <li>● More entertainment and social activities</li> </ul>
<p><b>5. <i>Optional if time allows:</i> Do you have adequate access to health care services, including mental health care? Is it working for you? Is it easy to get a qualified provider?</b></p>	<ul style="list-style-type: none"> <li>● Need more elder-friendly psychiatric services with expertise in older adults’ needs, but it's hard to find a good therapist</li> <li>● There are insurance barriers to ongoing care</li> <li>● When you are new to the area, hard to find a primary care provider, need a navigator</li> </ul>

**2019 Community Health Needs Assessment Focus Group Report  
Charlemont Federated Church in Greenfield, Jan 31, 2019**

**Focus Group Report: Users of a Rural Food Pantry**

**Primary Hospital/Insurer:** Baystate Franklin Medical Center

**Topic of Focus Group:** Users of a Rural Food Pantry

**Date of Focus Group:** 1/31/2019

**Facilitator:** Kat Allen

**Note Taker:** Jeanette Voas

**Executive Summary**

- A. Participant Demographics: 13 participants
  - Ten women, three men
  - Ten non-Hispanic white; two American Indian; one white/American Indian
  - One age 22-30; one age 31-40; two age 41-50; five age 51-60; three age 61-70; one age 71-80
- B. Areas of Consensus:
  - Transportation is the #1 issue
  - Shortage of good primary care physicians, mental health providers, and participants often have to go to Springfield for specialists.
  - Insurance doesn't cover things the participants feel they need, and trying to get referrals or deal with insurance is frustrating.
  - Social networks among neighbors are recognized as an asset.
  - Pretty good access to healthy food; participants said the Charlemont Federated Church food pantry was the best. HIP at farmers' markets is a plus.
- C. Key Recommendations:
  - Satellite or mobile clinics would be very useful for rural residents.
  - Telehealth and telemental health services would be very useful
  - Pharmacy delivery services (which used to exist) would be very useful
  - A clothing closet (perhaps mobile, perhaps paired with other mobile services) would be very useful
  - Expand community health nursing programs
- D. Quotes:
  - "Some places you get frowned on because you get food stamps whether you live in the Hilltowns or in the city."
  - "If you get together with your neighbors, you will always have something to eat."
  - "Transportation is the ultimate question. It's a big trip to Greenfield. You ask the neighbors, 'Who's going in today?'"
  - "What is needed? *Anything* mobile."
  - "Because our population is small, our priorities get kicked down the road."

## Key Issues

Question	Synthesis of Responses
<p><b>1. Biggest things that make it hard for you to be as healthy as you would like to be</b></p>	<ul style="list-style-type: none"> <li>• Transportation!               <ul style="list-style-type: none"> <li>○ Bus comes through 2-3 times a day. Some people can't get down to the bus. If you go into Greenfield you have to wait around to catch a bus back.</li> <li>○ People can get PT-1, but people not on MassHealth need rides, too.</li> </ul> </li> <li>• Shortage of primary care physicians, not enough mental health care, providers not accepting new patients. No ENT, No rheumatology. You get sent to Springfield.</li> <li>• Referrals get complicated confusing. You get frustrated and you go without care.</li> </ul>
<p><b>2. Sources of food, and access to healthy food</b></p>	<ul style="list-style-type: none"> <li>• Charlemont Federated Church food pantry is the best. Difference of opinion about others (from "food pantries and offerings are good" to "they ask you lots of questions and the food is not very good.")</li> <li>• Farmers' markets and HIP are good. Several in the group had used HIP; not everyone knew about it.</li> </ul>
<p><b>3. What you do if you run out of food</b></p>	<ul style="list-style-type: none"> <li>• Go hunting</li> <li>• Turn to family and neighbors ("Stone Soup")</li> </ul>
<p><b>4. Source and adequacy of medical care</b></p>	<ul style="list-style-type: none"> <li>• Various, mostly in Greenfield, including Valley Medical, CHCFC, Franklin Adult Medical, Shelburne Family Practice, CHD, and Minute Clinic (participant says she has been unable to get her own doc)</li> <li>• Had to go to Orange for dental care because it's easier to get in there</li> <li>• Medication can be hard to get; insurance doesn't cover supplements and some tests we need</li> <li>• Walk-in clinics at the church are helpful</li> </ul>
<p><b>5. Transportation</b></p>	<ul style="list-style-type: none"> <li>• The ultimate question!</li> <li>• There's a bus in the morning, and 11:20, and then you're stuck all day.</li> <li>• I've hitchhiked.</li> <li>• People who have bicycles use them</li> </ul>
<p><b>6. Missing services, other things that would help</b></p>	<ul style="list-style-type: none"> <li>• Sidewalks. To get to the bus I have to walk ¼ mile in the road.</li> <li>• The town plans a bicycle trail and sidewalks, with construction to begin in the spring.</li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>• Even two more buses would help.</li> <li>• A rural clinic for all the towns around here.</li> <li>• Anything mobile, e.g. a mobile unit from Baystate or CHCFC that would do lab draws, prescriptions.</li> <li>• Pharmacies that deliver up here.</li> <li>• Ambulance could take people to appointments when it's not on call.</li> <li>• Telehealth</li> <li>• Group exercise classes</li> <li>• Clothing closet (there's one in Colrain at First Baptist)</li> </ul>
<p><b>7. What you do to stay healthy, despite the challenges</b></p>	<ul style="list-style-type: none"> <li>• I don't smoke or drink</li> <li>• I go to bed at a reasonable hour</li> <li>• I walk my dog</li> <li>• I garden</li> <li>• We have a strong social network</li> </ul>

## Appendix IV. Key Informant Interview Summaries

### Coalition of Western Massachusetts Hospitals/Insurer 2019 Community Health Needs Assessment

#### Key Informant Interview Report

**Hospital/Insurer:** Baystate Noble Hospital (Substance Abuse)

**Interviewer:** Catherine Brooks

**Interview Format:** Phone interviews, approximately 45 minutes - 1 hour in length.

#### **Participants:**

- Rose Evans, Vice President of Operations, Behavioral Health Center
- Chitra Rai, Senior Case Manager, Ascentria
- Kathleen Sitler, Task Force Coordinator, Westfield Drug Task Force

Question	Synthesis of Responses
<p><b>1. What are the 3 most urgent substance use-related issues or needs for adults in your community/service area?</b></p>	<p>The needs noted included:</p> <ul style="list-style-type: none"> <li>● Lack of access to methadone and other medication-assisted treatment (MAT)</li> <li>● Affordable housing and transportation</li> <li>● Access to child care during treatment hours</li> <li>● A detox facility in Westfield</li> <li>● A step-down program</li> <li>● Substance abuse programming and education</li> </ul> <p>Chitra Rai reported that there is some alcohol abuse in the refugee community, but it is rare and he does not usually deal with substance abuse issues.</p>
<p><b>2. What substance use issues have emerged and/or dramatically increased in prevalence in the last 1-2 years?</b></p>	<p>New issues are related to ongoing opioid epidemic. These include a new unwillingness to engage in or continue with treatment, and overdoses from fentanyl or carfentanil. Suboxone has also become a commodity with a street value. Vaping has also become a big problem for people of all ages.</p>
<p><b>3. What specific service gaps or barriers to accessing substance use treatment are you most concerned about? For whom are these</b></p>	<p>Kathleen Sitler reported an overall lack of facilities, while Rose Evans believes that there is sufficient capacity for acute detox but not for the longer-term management of addiction. This includes stabilization and recovery services and sober housing. Both women noted the issue of stigma around drug addiction and how it prevents people from learning</p>

Question	Synthesis of Responses
<b>treatment services most critical?</b>	<p>about and seeking access to services.</p> <p>Other barriers include the need for child care and transportation in order to access services.</p>
<b>4. What about substance use prevention in your community? What is working well? What opportunities exist or are needed for better prevention?</b>	<p>Prevention efforts often happen at the school level and in community forums, with speakers and presentations about substance use. Housing agencies also provide prevention programming to residents. However, it's difficult to know how effective these programs are.</p> <p>Opportunities for prevention include carving out time in existing meetings and forums to present information about substance abuse prevention. However, people's attention to the need for substance abuse prevention tends to wane if there is no immediate crisis being reported in the news.</p>
<b>5. Do you see any particular issues/needs in families where grandparents are raising grandchildren because the parent is an addict or user? What services do these families need that they are not getting?</b>	<p>This is a frequently-seen problem in the Westfield area. Grandparents are mourning the loss of their hopes for their child, sometimes feeling guilty about their own substance use, and working through the same need for supports noted above - housing, transportation, child care, food assistance. They also need social support and help with their and their grandchildren's mental health needs.</p> <p>Westfield has an organization called Grandparents Raising Grandchildren, which provides supports and brings in speakers addressing issues such as health care, supports from the Department of Children and Families, school issues, and other areas.</p>
<b>6. In light of the opioid use epidemic, what are the most pressing issues and needs around access to care for detox, long-term treatment, criminalization, and stigma?</b>	<p>Kathleen Sitler perceived a lack of programming, lack of access to treatment, and stigma. She reported that at some treatment facilities, you have to go in "dirty," which is a problem when people don't realize that they need treatment until they are clean.</p> <p>Rose Evans noted that as families enter the criminal justice system, this has an impact on custody issues. She noted the importance of diversion programs and how work around this has begun. She also noted the need for MAT in county houses of correction, and reported that this has begun in some areas.</p> <p>As noted before, Rose Evans also said that there are not enough exit strategies after treatment - the logjam into recovery centers makes it difficult for people to leave treatment and makes beds unavailable for new people entering. Insurance issues can also complicate accessing detox centers. She reported a need for more community treatment centers so that people don't need to enter more involved treatment programs.</p>

Question	Synthesis of Responses
<p><b>7. What are the major needs, service gaps or barriers for accessing mental health and substance use care in a crisis situation, such as urgent/emergency care in the Emergency Department? What is working well and what can be improved?</b></p>	<p>There is a lack of substance abuse counselors in the area. In addition, treatment programs need to be able to deal with co-occurring mental health and substance abuse issues. These often go together but care and treatment for either is usually provided by people who understand one or the other, but not both. New programs that will treat both will be opening soon, however. There continues to be a problem with coordinating medications and prescribing for people being treated for both mental health and substance abuse issues. There is a need to decrease siloes and increase understanding of the complexities of both addiction and mental health issues. Doctors can also be reluctant to prescribe MAT - this is a high-need, complex population.</p>
<p><b>8. What kind of structural and social changes are needed to tackle health inequities in the area of substance abuse prevention and treatment?</b></p>	<p>As noted before, the lack of access to affordable housing, accessible transportation, and child care hinders access to treatment. Insurance coverage can also be an issue. In addition, there needs to be work on undoing the stigma surrounding addiction issues. Recognizing addiction as an illness would go a long way toward getting people the treatment that they need.</p>
<p><b>9. Is there anything else you would like to share with us regarding adult substance abuse and its impact on families in the Baystate Noble service area region?</b></p>	<p>Marijuana abuse is also significant. There is no breath test for impairment. Marijuana use is increasing with legalization, and vaping is providing an entryway into marijuana and other drugs.</p>

**Quotes:**

- "People are very divided about addiction and illness - it's difficult to have conversations - people either see it as an illness or a choice." Kathleen Sitler
- "When something big happens, people turn out, then go back to their daily lives. We're trying to continue to raise awareness, bring people in." Kathleen Sitler



**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Noble (Food Insecurity)

**Interviewer:** Catherine Brooks

**Interview Format:** Phone interviews, approximately 45 minutes - 1 hour in length.

**Participants:**

- Chitra Rai, Senior Case Manager, Ascentria
- Kim Savery, Director of Community Programs, Hilltown Community Health Center

Question	Synthesis of Responses
<b>1. Where do most people in the area get most of their food?</b>	<p>Closer in to Westfield, most people go to large grocery stores such as Price-Rite, Big Y, Wal-Mart, Costco. There are also some convenience stores.</p> <p>Further out in the Hilltowns, the people who have access to transportation go to the big stores once or twice per week. People without transportation in the Hilltowns rely on small general stores. There are also food pantries that distribute food once per week. There are a few farm stands but this is not a significant source of food for residents. There are no Community-Supported Agriculture (CSA) programs, large-scale farm stands, or community gardens.</p>
<b>2. What barriers do people face when accessing food resources?</b>	<p>Transportation is a major barrier. Food supports are also insufficient - Supplemental Nutrition Assistance Program (SNAP) funding is low and the income threshold to qualify for services is low. There is also a lack of information about healthy food and where to get it. For recent immigrants, language is a barrier and also different customs and systems around food access and preparation that are difficult to implement here.</p>
<b>3. What makes it easier for people to get healthy foods? What makes it harder to get healthy foods?</b>	<p>Easier:</p> <ul style="list-style-type: none"> <li>● A few summers ago, there was a CSA in Huntington</li> <li>● SNAP recipients get Healthy Incentive Program (HIP) funding to spend at farmers markets</li> <li>● There are plans to have a mobile food market in the Hilltowns</li> <li>● For Ascentria clients, case managers help them connect with resources</li> </ul> <p>Harder:</p> <ul style="list-style-type: none"> <li>● Lack of transportation to large markets</li> <li>● Small general stores don't have refrigeration, capacity to store fresh produce</li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>● Prices at farmers markets and small stores are high</li> <li>● Lack of knowledge about healthy foods, particularly among recent immigrants</li> <li>● Case management at Ascentria is time-limited</li> </ul>
<p><b>4. What portion of your community takes advantage of free food distributions or meals? Are there people who are food insecure but don't take advantage of free food distribution/meals? If so, why don't they utilize these services?</b></p>	<p>Among recent immigrants, many receive SNAP benefits for the first year and then get jobs. School-age children receive subsidized breakfast and lunch, and the schools in Westfield have food pantries. In the Hilltowns, there is a significant portion that is eligible but not participating. There is stigma involved, and in two separate cases the religious affiliation of the provider caused reluctance to participate. Sometimes people will bring food or gift cards to the Hilltown Community Health Center (HCHC) to distribute to clients, but this is sporadic and HCHC is not able to store perishable food. As noted earlier, transportation is a barrier here as well.</p>
<p><b>5. Are there local policies or ordinances that affect the community's food security?</b></p>	<p>There are barriers to having community gardens in the Hilltowns. There had been one in in Russell, but it wasn't well-maintained and the landowner didn't want it to continue. Many planning boards have adopted policies against community gardens. Some towns also have business districts which are very small, and food stores cannot locate outside of these districts.</p>
<p><b>6. Are there sufficient resources available to meet the needs of people who need emergency or supplemental food?</b></p>	<p>In Westfield, there are resources, but people lack knowledge of how to access them and in some cases, transportation. In the Hilltowns, there are limited resources. There are a lot of small initiatives going on, but no large organized service providers. Most communities have someone who is willing to help out, but you have to know who to call.</p>
<p><b>7. What kind of structural and social changes are needed to tackle health inequities around food security?</b></p>	<p>Needs mentioned included:</p> <ul style="list-style-type: none"> <li>● Widespread availability of information about healthy foods</li> <li>● Better methods of access, delivery, distribution of healthy foods</li> <li>● Stability for farmers</li> <li>● An understanding of how isolation affects food access</li> <li>● Access to healthy food in satellite centers</li> <li>● Linkage of people in need with social services</li> </ul>
<p><b>8. Is there anything else you would like to share about food insecurity in the Baystate Noble service area region?</b></p>	<p>There are several food access groups and initiatives all working in the same area - can Baystate Noble help get them together and coordinate their efforts?</p>

**Quotes:**

- “Almost all of the towns here are farm-friendly, but food is a different story” Kim Savery
- “People get stuck in a rut with what’s available” Kim Savery

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center

**Interviewer:** Ilana Gerjuoy, with Jeanette Voas taking notes

**Interview Format:** In person interview, 1.25 hours

**Participant:** Cheryl Pascucci, Community Hospital Acceleration, Revitalization, & Transformation (CHART) Program

Question	Synthesis of Responses
<b>What are the 3 most urgent health needs/problems in your community/service area?</b>	<p>The CHART Program worked with the highest utilizers of emergency department &amp; inpatient services. For these patients (n=543), primary issues were <i>pain, suffering*</i>, and <i>substance use disorder</i>. 55% of this population had substance use disorder (SUD), and those who did not typically had severe mental illness or were chronic disease/end of life cases.</p> <p>*Suffering can include psychological distress, SUD and withdrawal, trauma, and troubles related to social determinants of health.</p>
<b>What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area?</b>	<ul style="list-style-type: none"> <li>• SUD is escalating, particularly in rural areas.</li> <li>• Our health care system is too medicine and procedure-based. There’s very little attention to self-care or instilling hope.</li> </ul>
<b>What specific vulnerable populations are you most concerned about?</b>	<ul style="list-style-type: none"> <li>• People who have pain and don’t have a plan.</li> <li>• People who are suffering with mental illness.</li> <li>• People who are dually eligible for Medicare &amp; Medicaid but are under age 65 are a very high risk population.</li> </ul>
<b>What specific gaps to health care are you most concerned about? For whom are these most critical?</b>	<ul style="list-style-type: none"> <li>• Fee for service and medical models are not equipped to deal with the enormity of people’s problems. Clinicians’ “person-centered care” shouldn’t be disease-specific; what’s missing is attention to whatever the person says they need.</li> <li>• There’s a lack of integration of medicine, behavioral health and social services.</li> </ul>

Question	Synthesis of Responses
<p><b>What specific barriers to health care are you most concerned about? For whom are these most critical?</b></p>	<ul style="list-style-type: none"> <li>• The way health care is paid for (before transition to ACO model).</li> <li>• Lack of capacity of clinicians to spend time with people.</li> </ul>
<p><b>What does the available data NOT show about health needs and gaps, meaning, what's missing?</b></p>	<ul style="list-style-type: none"> <li>• We need a team to work with high-needs population under age 65 who are dually eligible for Medicare &amp; MassHealth. We don't have a good way of working with this population here. The North Quabbin is completely left out.</li> <li>• There are successful models in Springfield. In rural areas, we need to collaborate to make it work.</li> </ul>
<p><b>What are the opportunities for better prevention to keep people you serve out of the hospital? In addition to more funding, what other resources do you need to better address emerging or increasing health concerns?</b></p>	<ul style="list-style-type: none"> <li>• Community Health Workers trained for person-centered care, including helping patients develop their own action plans, build their confidence, advocate for themselves. (WRAP – Wellness Recovery Action Plan is a model.)</li> <li>• Telemedicine</li> <li>• Integrated teams, with outside agency (e.g. CSO, DMH) real time access to someone in the hospital for communication when a client comes into the emergency department/hospital.</li> <li>• CHWs fare better as part of a team. When they're in it by themselves they burn out quickly and there is high turnover.</li> </ul>
<p><b>Externally, what do you wish you could refer people to?</b></p>	<p>Police are being trained to recognize individuals experiencing a mental health crisis or in withdrawal, but there is no place for police to call in or drop people off other than the ED for overnight &amp; weekends.</p>
<p><b>How would you recommend that the western Massachusetts Hospital Coalition work in closer partnership with local and regional public health organizations after the CHNA is completed?</b></p>	<p>Commonwealth Care Alliance (OneCare for &lt;65) is the model with teams providing and coordinating a full spectrum of health services. The patient experience is enhanced and the cost of care goes down.</p>
<p><b>What specific ways can such a partnership be supported and sustained?</b></p>	<p>Follow the money. We need to partner with the entity that is financially responsible for the outcomes of the human being. The ACO needs to step up.</p>
<p><b>Other</b></p>	<p>CHART data shows reductions in emergency department visits and inpatient admissions over the (short) span of the program.</p>

**Quotes:**

- “The way we deliver health care is medicine- and procedure-based, with very little attention to self-care. There’s very little hope instilled by primary care or in the hospital.”
- “Change the experience of care to make it person-centered. The person says it’s better and they stop coming to the hospital because they’re connected to community.”
- “We need to sell the story that models with integrated primary care, mental health, and social services work. We need the ACO to look at the data, say this is valuable, and get them to pay for it.”
- “How is LifePath is going to survive when money all goes to primary care? Part of it is proving your value. It’s a huge leap. Primary care is afraid they’re going to fail under the ACO model.”
- The CHART team’s progression in working with patients was: “Do for, do with, cheer on.”

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center

**Interviewer:** Kat Allen, with Jeanette Voas taking notes

**Interview Format:** In person interview, 1 hour

**Participants:** Community Health Center of Franklin County Leadership Team of Ed Sayer (CEO), Jared Ewart (Acctnt), Arcey Hoynoski (CFO), Maria Heidenreich (Med Dir), Cameron Carey (Dev Dir), Maegan Petrie (Acctnt), Allison van der Velden (Dental Dir), Allie Jacobson (Info), Jessica Calabrese (COO), Susan Welenc (pop health), Susan Luippold (Human Res.), Wes Hamilton (CIO)

Question	Synthesis of Responses
<p><b>1. 3 most urgent health needs/problems</b></p>	<ul style="list-style-type: none"> <li>• Homelessness</li> <li>• Access issues (including # providers, transportation, social determinants, expenses), e.g. for oral health – urgency because of lack of access</li> <li>• Behavioral health; too few psych prescribers, so primary care providers end up prescribing outside their comfort zones</li> <li>• Shortage of dental specialists, so dental providers work outside their comfort zones</li> </ul>
<p><b>2. Health issues that have emerged and/or dramatically increased in prevalence in the last 1-2 years</b></p>	<ul style="list-style-type: none"> <li>• Opioid crisis isn't new but it's gotten more visible in past couple of years</li> <li>• Anxiety and depression – everyone has some psych diagnosis that needs managing</li> <li>• Obesity continues to mount, and that causes other health problems</li> <li>• New diagnoses of PTSD including from dysfunctional families. We may be identifying it more than before. People see a behaviorist and things start to come out.</li> </ul>
<p><b>3. Specific vulnerable populations of concern</b></p>	<ul style="list-style-type: none"> <li>• Migrant seasonal agricultural workers (we take care of about 300 – there are close to 2,000 in FC) with usual problems plus language, cultural barriers, insurance. They are unfamiliar with our system &amp; don't advocate for themselves. CHC doesn't have enough bilingual staff</li> <li>• Pediatric population:             <ul style="list-style-type: none"> <li>○ More kids with anxiety, OCD, ADD</li> <li>○ When our dental providers see kids, they're often well down the path of oral disease</li> </ul> </li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>○ Behavioral health issues affect school attendance, health regimes &amp; take a toll on families</li> <li>● GLBQ+ and transgender – we’re trying to get better at providing services for them</li> <li>● Elderly – we don’t tend to their needs specifically, e.g. no fall risk screening</li> </ul>
<b>4. Gaps to health care of most concern</b>	<ul style="list-style-type: none"> <li>● Transportation</li> <li>● Gaps in reimbursement structure, e.g. telehealth, community health workers</li> <li>● When people shift to high deductible plans, docs will wait until the end of the year to see them when deductible is paid</li> <li>● Lack of coordinated care (primary care, oral health, behavioral health)</li> </ul>
<b>5. Barriers</b>	<ul style="list-style-type: none"> <li>● Transportation</li> <li>● Language</li> <li>● Psychiatric services</li> <li>● Housing</li> <li>● Food insecurity – has gotten worse</li> <li>● Poverty</li> <li>● Illiteracy</li> </ul>
<b>6. What’s missing that we’re not seeing in the data</b>	<ul style="list-style-type: none"> <li>● Just starting to capture social determinants</li> <li>● We have data on those who are using the system; we don’t know about those who are not.</li> </ul>
<b>7. Opportunities for prevention to keep people out of hospital</b>	<ul style="list-style-type: none"> <li>● Transitions of care: we contact discharged patient within 48 hours and follow up on meds, questions, services, appointments. It’s reimbursed through CMS (Centers for Medicare &amp; Medicaid Services) if patient not readmitted within 30 days.</li> <li>● Complex case management is not reimbursable or sustainable</li> <li>● Work on getting patient buy-in, holding patients accountable, responsible for self-care</li> <li>● More oral health providers and space where people can get regular restorative care. emergency department visits for dental issues are a waste of \$\$.</li> </ul>
<b>8. What’s needed apart from more funding</b>	<ul style="list-style-type: none"> <li>● Access to healthy food</li> <li>● Healthy social support systems to address loneliness, isolation, lack of transportation</li> <li>● Places to congregate</li> <li>● Exercise opportunities and associated social connections</li> <li>● More community health workers</li> </ul>
<b>9. Resources to refer people to from the CHC</b>	<ul style="list-style-type: none"> <li>● Dental specialists (oral surgeons, periodontists, orthodontists). We have regional shortages, and it’s even worse in the public service</li> </ul>



Question	Synthesis of Responses
	sector. <ul style="list-style-type: none"> <li>• Groups for social support, weight loss, etc</li> <li>• Psychiatry for ongoing care</li> </ul>
<b>10. Recommendations for connections between hospitals and public health</b>	<ul style="list-style-type: none"> <li>• This is important. Now we have a Balkanization of health services.</li> <li>• Hospitals can:               <ul style="list-style-type: none"> <li>○ Attract and recruit specialists</li> <li>○ Fund common electronic health record</li> <li>○ Provide clearinghouse for best practices</li> <li>○ Legal services to help people navigate issues, e.g. with landlords</li> </ul> </li> </ul>
<b>11. How to support such a partnership</b>	<ul style="list-style-type: none"> <li>• Subscription. CHCFC would be ready to pay into a menu of services.</li> </ul>
<b>12. Other</b>	<ul style="list-style-type: none"> <li>• It's shocking how weak the connection is between the hospital and the CHCFC.</li> <li>• More than 80% of our patients are below 200% poverty. There needs to be a lot more cooperation. CHC has the most comprehensive picture of the low-income population.</li> <li>• It's a struggle to recruit and staff the health center. Loan reimbursement can help attract doctors, but not nurses, dental assistants, etc. What can we do to make this a destination career?</li> </ul>

**Quotes:**

- “There are too few psychiatric prescribers, so primary care providers end up prescribing outside their comfort zones.”
- “There are too few dental specialists, so dental providers have to work outside their comfort zones, too.”
- “Anxiety and depression have increased. It seems like everyone has some psychiatric diagnosis that needs managing.”
- “I’m concerned about migrant seasonal agricultural workers. We take care of about 300 of them and there are close to 2000 in Franklin County. Apart from the usual problems, they have barriers of language, culture, insurance. They are unfamiliar with our system and don’t advocate for themselves. The Community Health Center doesn’t have enough bilingual staff.”
- “When we see children in the dental clinic, they’re often well down the path of oral disease.”
- We are seeing more kids with anxiety, OCD, ADD. Behavioral health issues impact school attendance and health regimes, and they take a toll on families.”
- “It’s a struggle to recruit and staff the health center. Loan reimbursement can help attract doctors, but not nurses, dental assistants, etc. What can we do to make this a destination career?”
- “Hospitals are the hub of the healthcare system. It’s shocking how weak the connection is between the hospital and the CHCFC. More than 80% of our patients are below 200% poverty. CHC has the most comprehensive picture of the low-income population. There needs to be a lot more cooperation.”

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center

**Interviewer:** Kat Allen, with Jeanette Voas taking notes

**Interview Format:** In person interview, 1.25 hours

**Participants:** Reentry team of Ken Chartrand (Reentry Coordinator), Jen Brzezinski (Reentry Caseworker), Charles Laurel (Clinician), Ariel Pliskin (Clinical Intern), Levin Schwartz (ADS, Director, Clinical & Reentry Services), Reuben Mercado (Post-Release Reentry Caseworker), Jennifer Avery (Post-Release Reentry Caseworker), Deb Neubauer (Clinician), Alex Margosian, LICSW (Clinician)

Question	Synthesis of Responses
<p><b>1. 3 most urgent health needs</b></p>	<ul style="list-style-type: none"> <li>• Livable wages/Housing               <ul style="list-style-type: none"> <li>○ Housing with support for mental health challenges</li> <li>○ Housing for people with mental health issues <i>and</i> sex offense charges or arson in their histories.</li> <li>○ Greenfield has about 200 homeless people; many are formerly incarcerated</li> <li>○ Many leave here and end up couch surfing in environments that aren't safe</li> </ul> </li> <li>• Residential treatment, particularly for dual diagnosis (which is true of most of our clients here).               <ul style="list-style-type: none"> <li>○ To get into a dual diagnosis program you have to be suicidal. People may have to lie to get in.</li> <li>○ And there are guys in East Spoke who have a plan to kill themselves, but when their insurance hits a limit, they're out of the program.</li> <li>○ Or any violent behavior can get them dismissed from East Spoke.</li> </ul> </li> <li>• Case workers and coordination of services in the community               <ul style="list-style-type: none"> <li>○ We have 3 reentry caseworkers here and hundreds of clients who have left the jail</li> <li>○ Many services do not communicate with one another</li> <li>○ Points of transition are when things fall apart the most. There are disconnects between services and levels of care.</li> <li>○ Barriers to successful reentry are huge for clients with mental health, substance issues and trauma history.                   <ul style="list-style-type: none"> <li>▪ It's hard for them to engage in any community apart from the one that landed them in jail in the first</li> </ul> </li> </ul> </li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>place               <ul style="list-style-type: none"> <li>▪ Or some have no family, no friends</li> <li>▪ It's hard when they have to go to new providers to retell their story and ask for services.</li> </ul> </li> <li>• Trauma, retraumatization, passed through generations</li> </ul>
<p><b>2. Emergent issues, increased problems</b></p>	<ul style="list-style-type: none"> <li>• Commercial sex trade has come onto our radar since we started housing women.               <ul style="list-style-type: none"> <li>○ It's a huge issue in our community, and there are no resources out here for it.</li> <li>○ Many have been exploited &amp; experienced trauma as a result</li> <li>○ On release, that's how they know how to make money, and it leads back to substance use for coping</li> </ul> </li> <li>• Proliferation of MAT services               <ul style="list-style-type: none"> <li>○ While intended as a harm reduction measure, it doesn't always function that way.</li> <li>○ In the jail, we have clinical services, intense therapy to go with the MAT, when clients get out, if they're on MAT, they're more likely to decline services. MAT alone isn't working.</li> <li>○ It's problematic that they can be on Suboxone and not be required to be clean on anything else. People are using the Suboxone not as prescribed or selling it and using other substances.</li> <li>○ We've had some success with Vivitrol.</li> </ul> </li> </ul>
<p><b>3. Specific vulnerable populations you're worried about</b></p>	<ul style="list-style-type: none"> <li>• Anyone incarcerated</li> <li>• Homeless and everyone connected to them</li> <li>• Sex offenders</li> <li>• People with mental health, substance use, complex trauma issues who don't have natural supports of family and friends               <ul style="list-style-type: none"> <li>○ Their connections are to professionals, and those are vulnerable to funding shifts &amp; staff turnover.</li> </ul> </li> <li>• Young people               <ul style="list-style-type: none"> <li>○ They need to develop skills for emotional regulation, impulse control.</li> <li>○ How can you expect them to grow up differently if they're not taught how to deal with adversity, how to deal with emotions</li> </ul> </li> </ul>
<p><b>4. Specific gaps to health care you are most concerned</b></p>	<ul style="list-style-type: none"> <li>• Transitions, hand offs               <ul style="list-style-type: none"> <li>○ A client might have a few days in East Spoke, then respite, then back to homelessness.</li> </ul> </li> </ul>

Question	Synthesis of Responses
<b>about</b>	<ul style="list-style-type: none"> <li>○ Handoffs from the jail to the community. Clients get intense support here, and they don't get that on the outside.</li> <li>○ We have a Nurturing program and family-focused programming, but we don't know who's providing services to the family. We don't know what context our clients are returning to.</li> <li>○ One barrier to warm handoffs is that outside therapists cannot bill for treating people in jail. Inreach could help.</li> <li>● People are free to NOT show up for services. <ul style="list-style-type: none"> <li>○ How many follow through with reentry plans and resources, and for those who don't, why not?</li> <li>○ Because our clients suffer from chronic anxiety, depression and trauma, it's hard for them to follow up, and we should start from the assumption that they're not going to go.</li> <li>○ Agencies should share data so clients don't have to retell their stories multiple times. We don't need to ask so many questions at intake.</li> <li>○ Gaps in insurance – restrictions on what's available to whom, for how long</li> </ul> </li> <li>● Effective contingency programs for MAT.</li> <li>● Lack of options for people who have mental health needs and CORIs. <ul style="list-style-type: none"> <li>○ They're high-need, not best served in jail, but there's no place for them to go. So they come here.</li> </ul> </li> <li>● Clinicians to do ride-alongs with police to use discretion to help keep people out of the criminal justice system</li> <li>● Community case workers who are not tied to a particular agency, so clients aren't cut off when they're no longer connected to the agency</li> </ul>
<b>5. What's missing, what important things are not showing up in the data</b>	<ul style="list-style-type: none"> <li>● Generational legacies <ul style="list-style-type: none"> <li>○ Children are removed from parents who can't take care of them, but what's the long-term success of foster care?</li> </ul> </li> <li>● What happens to clients who haven't been able to complete treatment because of insurance? <ul style="list-style-type: none"> <li>○ For example, they go into intensive treatment to normalize the situation, but may have to leave when they don't feel they're ready.</li> </ul> </li> </ul>
<b>6. What else is needed to better address health issues</b>	<ul style="list-style-type: none"> <li>● We're pruning the tree, not going for the cause in the roots.</li> <li>● The skewed distribution of wealth has put us in this position.</li> <li>● Our system of judgment and punishment is proven not to work. We need to unravel this narrative and orient ourselves towards a more</li> </ul>

Question	Synthesis of Responses
	<p>scientifically valid perspective.</p> <ul style="list-style-type: none"> <li>• We have a DBT program here, and it applies to teaching skills to clients and to staff, to structuring the environment to make it conducive to this work, and to generalizing skills to clients’ natural environments. It’s a strategy for applying what you learn in different environments.</li> </ul>
<p><b>7. What do you wish you could refer people to outside the jail?</b></p>	<ul style="list-style-type: none"> <li>• Housing, housing, housing.</li> <li>• There’s hardly any sober housing in the western region.</li> <li>• The GAAMHA House in Greenfield, with 6 beds for women (no children) is a model. It’s where I would want to refer my clients who don’t need constant supervision. For those without supports, it’s like a family. But it can accommodate only six!</li> <li>• More community reentry caseworkers.</li> <li>• Adult leisure services <ul style="list-style-type: none"> <li>○ Provide outdoor experiences, music, theater, something to engage in creatively</li> <li>○ No-cost/inexpensive outlets for leisure</li> <li>○ Community center with safe environment</li> <li>○ Being bored is a trigger</li> <li>○ DMH invested in a Club House model in Boston. It’s a turned-up community center, with prosocial stuff, voc rehab, meals. You go and you’re participating in community.</li> </ul> </li> </ul>
<p><b>8. Partnerships between hospital and public health organizations?</b></p>	<ul style="list-style-type: none"> <li>• Let’s sit down and talk about how we can work together, including Mayor’s office, DA, probation. We need to talk the same language and share the same vision.</li> <li>• Baystate plans to relocate behavioral health to one place. How will the hospital help people to relocate back to their own communities?</li> <li>• With hospitalization, the emphasis is on stabilization (with drugs so patients don’t kill themselves) and release. How can we make subsequent services more available?</li> </ul>
<p><b>9. What else?</b></p>	<ul style="list-style-type: none"> <li>• We need collaboration across agencies not just at administrative level but among people on the ground working with clients.</li> <li>• Instead of implementing a program and thinking it’s done, we need long-term planning and ongoing implementation.</li> <li>• Here at the jail, we have latitude to experiment, to see what works and what doesn’t. We’ve focused on transitions, specific needs, and reinforcement throughout the system.</li> <li>• When we look at vulnerable groups, we mustn’t get sucked into silos – physical health, mental health, co-occurring, homeless, etc)</li> </ul>

## Quotes:

- “There are guys at East Spoke who have a plan to kill themselves, but when their insurance hits a limit, they’re out of the program.”
- “We work with clients on the outside no matter what. They will tell us, “I can use all the drugs I want and still get Suboxone.” They can sell it.”
- On Suboxone: “The thing I’m in jail for is like a door prize they give me as I leave. Do I really need to go to meeting?”
- “It would be great if we had naturally flowing levels of care. Step downs, with direct partnerships instead of hoping, hoping. Now it’s all reliant on an incredible amount of effort and resourcefulness.”
- “We see trauma and retraumatization. When you can’t get housing, that’s traumatizing. When kids are taken away, that’s traumatizing. It’s a generational problem for most of our clients.”
- “One client said the jail was the only home he had ever experienced. When he had a baby, he brought the baby back as if to meet his family.”
- “We need warm handoffs. Our clients have chronic anxiety, depression and have experienced trauma. We say to them, “When you get out of here, you’re going to talk to some new people and they’re going to help you.” Of course they’re not going to go! The way we’ve created transitions is not suited to the clients. We should start from the assumption that they’re not going to go.”
- “We have family-focused programming here, but we don’t have another half to this. We don’t know who’s working with the family. We’re kind of hoping. What’s the context people are returning to?”
- “There are problems with how people get sorted out – who goes to jail, who goes to mental health treatment. I have people here who don’t belong in jail. They won’t come out of here any better. ”
- “Even the way we think about collaboration needs to be rethought. We tend to connect administrators together. I talk to clients every day and I have no idea what’s going on out there. We need collaboration among people who are actually doing the work. ”

**Coalition of Western Massachusetts Hospitals/Insurer  
2019 Community Health Needs Assessment**

**Public Health Interview Summary Report**

**Interviewer:** Catherine Brooks

**Interview Format:** Phone interviews, approximately 30-45 minutes in length.

**Participants:**

- Helen Caulton, Commissioner of Public Health, City of Springfield
- Ben Cluff, Massachusetts Department of Public Health, Bureau of Substance Use Services
- Julie Federman, Health Director, Town of Amherst
- Dalila Hyry-Dermith, Supervisor, Massachusetts Department of Public Health, Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit
- Phoebe Walker, Director of Community Services, Franklin Regional Council of Governments

Question	Synthesis of Responses
<p><b>1. What local policies and social conditions predispose people in your community/ service area to good health and mental wellness?</b></p>	<p>Some of the conditions and policies mentioned included schools, education around prevention issues, nutrition, and health. In more rural areas, there are farms that have farm stands and Community Supported Agriculture programs, and institutional support for local healthy food. In urban areas, there is good access to services. The hospitals do a good job with outreach to communities in general and to people of color. Communities in this area are attuned to wellness and health in implementing policies throughout local government.</p>
<p><b>1a. Are there groups of people who benefit from these policies/social conditions more than others?</b></p>	<p>The people who benefit most are white people and people with higher levels of education. The system is oriented toward prevention, so people who are able to hear and incorporate that message are better served. Implementation takes more time and money than prevention does. There is a lack of cultural competence in provider community - it is difficult for people of color to access mental health supports from people who understand their culture.</p>
<p><b>2. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</b></p>	<p>There is a need to integrate services that are provided from different organizations. We need an integrated approach to health care, removing structures that get in the way of collaboration. Physician training should include racial equity, family-centered care. We need a graduated income tax, and greater investment in education, child care, transportation, and community health workers. We need one-stop shopping with health care services under one roof. We need cultural humility, diversified offices and staff, public schools with staff who look like the students.</p>

Question	Synthesis of Responses
<b>3. What are the 3 most urgent health needs/problems in your service area?</b>	The issues most frequently named were mental health, substance use, obesity, chronic diseases.
<b>4. In the last 1-2 years what health issues have emerged or increased dramatically in prevalence in your area? What evidence or data do you have to illustrate this increase?</b>	Public health officials in Hampshire and Franklin counties mentioned tick-borne diseases. These are tracked through the University of Massachusetts, which tracks ticks sent in for testing, and through the Massachusetts Virtual Epidemiologic Network, which tracks diagnoses. Other health issues mentioned include pertussis being spread through unvaccinated people, and influenza. Health departments are facing bigger issues, such as mental health, substance use, and opioids, but these have been around longer.
<b>5. What gaps in services exist in addressing these needs? What are barriers to filling these gaps?</b>	We need a coordinated system of roles, the widespread use of Community Health Workers, and recovery coaches. Public health professionals need to be out in the community, and value community voices. We need a centralized public health system - some small towns do not have services. We need better transportation in rural areas - I would love it if hospitals would buy vans. Emergency Medical Technicians can provide wellness checks and preventive services. This would be especially important for mental health - there are not enough providers, people have to travel to find them. We need more racial and cultural competence, especially for mental health providers. The current education system for health providers lacks this.
<b>6. In addition to more funding, what resources do you need to better address these emerging or increasing health concerns?</b>	We need policy changes at the state level - established minimal expectations for public health services at the town level. We need a good public health response and resources around marijuana legalization. We need culturally sensitive practices in health care, which includes providers who look like and are from the community, who understand the culture, and who understand the history of racism. Hospitals need to develop a transportation infrastructure, and to develop the workforce to provide mobile health care (Boston is making a start with this). There needs to be outreach to mental health patients and an increase in prescribers for mental health issues, especially those who accept MassHealth health insurance.
<b>7. What specific vulnerable populations are you most concerned about? And why?</b>	Populations mentioned included: <ul style="list-style-type: none"> <li>• People with mental health issues</li> <li>• People coming out of jail</li> <li>• African-Americans</li> <li>• Transgender population</li> <li>• Isolated elders</li> <li>• New Americans, from specific communities that lack</li> </ul>



Question	Synthesis of Responses
	<p>established outreach</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• Residents of rural communities</li> <li>• Inner city residents</li> </ul> <p>All of these communities lack resources, access, culturally sensitive providers.</p>
<p><b>8. Externally, what resources/services do you wish people in your area had access to?</b></p>	<p>Resources and services mentioned included:</p> <ul style="list-style-type: none"> <li>• Transportation</li> <li>• Better pain management services (Stanford has a course about creative, non-medical approaches to pain management)</li> <li>• Housing for people coming out of jail</li> <li>• Supports for new Americans</li> <li>• Funding for social determinants of health</li> <li>• Workforce issues - recruiting and retaining physicians</li> <li>• Drop-in day services for people with mental health issues and people experiencing homelessness</li> <li>• Easy-to-navigate public health insurance accepted by most providers</li> </ul>
<p><b>9. How would you recommend that your local hospitals/insurers and/or Coalition of Western Massachusetts Hospitals/Insurer work in closer partnership with local and regional municipal public health entities after the CHNA is completed? What specific ways can such a partnership be supported and sustained?</b></p>	<p>Hospitals are the big organization in any partnership. They need to step back and not always take a leadership role, let smaller community-based organizations lead at times. There is a need to clarify roles and responsibilities within partnerships.</p> <p>Some suggestions for what hospitals can do include:</p> <ul style="list-style-type: none"> <li>• Working with public health nurses on readmission prevention and discharge planning</li> <li>• Partnering with local health departments for workshops on pain management</li> <li>• Putting pressure on the state to provide public health, put political power behind the need for a better system</li> <li>• Providing Community Health Needs Assessment data for their communities to local health agents</li> <li>• Providing forums for community people to come together and talk</li> <li>• Supporting partnerships between public health nurses and community liaisons from hospitals. Jeff Harness does this very well, but he is one person</li> </ul> <p>Sustainability suggestions include:</p> <ul style="list-style-type: none"> <li>• Using community benefits funding to support and sustain the partnership</li> <li>• Working from a project list to sustain momentum</li> </ul>

Question	Synthesis of Responses
	<ul style="list-style-type: none"> <li>The Massachusetts Department of Public Health can provide financial support for forums</li> </ul>
<p><b>10. What issues do you see emerging in the next 5 years?</b></p>	<p>Issues mentioned included:</p> <ul style="list-style-type: none"> <li>The opioid crisis will keep evolving, with new types of drugs</li> <li>The warming climate will lead to an increase in tick-borne diseases, mold, respiratory ailments</li> <li>Youth marijuana and vaping</li> <li>Pertussis</li> <li>Child and maternal health</li> <li>Obesity</li> <li>Aging population, especially veterans</li> <li>The rising cost of health insurance</li> <li>The immigrant community being afraid to access health insurance and health services</li> <li>Autism spectrum disorders</li> </ul>

**Quotes:**

- “We’re too often talking about people, not with people.” Helen Caulton-Harris
- “Hospitals see themselves as taking leadership roles in places where they should be taking supportive roles, especially in public health.” Helen Caulton-Harris
- “Health disparities are seriously affected by where you live, your race, your income.” Ben Cluff
- “We consider health in all our policies - we look at impact on health, not just on traffic, finances” Julie Federman
- “People whose mental health needs are not met become poorer in physical health” Julie Federman
- “Mental health has a social component - it’s hard to treat people who don’t look like you” Dalila Hyry-Dermith

## Appendix V. Community Conversation Summary

### Coalition of Western Massachusetts Hospitals/Insurer 2019 Community Health Needs Assessment

#### Community Conversation Summary Report

**Primary Hospital/Insurer:** Baystate Noble Hospital

**Topic of Focus Group:** Health Needs and Social Determinants of Health

**Date of Focus Group:** 2/20/2019

**Facilitator:** Gail Gramarossa

**Note Taker:** Eve Sullivan

**Location:** Westfield Senior Center

#### Executive Summary

A. Participant Demographics (# people, geographic area):

- Ten people, primarily Westfield residents
- Most were white
- Men and women participated
- All participants were ages 40 and up

B. Areas of Agreement: Top 3 social determinants of health:

- Built environment
- Financial health
- Education

Question	Synthesis of Responses
<b>1. What are the top 3 most pressing health needs in your community?</b>	<ul style="list-style-type: none"><li>● When transportation is difficult, people can't go to medical appointments, grocery shopping, the pharmacy</li><li>● When there is a crisis, or when a person has a substance use disorder, the person is likely to have very limited access to care because of an insufficient number of beds.</li><li>● There is a lack of training and education for people in the medical professions to work with people with intellectual or other disabilities. The creation of a greater network of peer support or coaches could help with this.</li><li>● The availability and quality of affordable housing is an issue. People need enough money to pay first and last month's rent and a security deposit in addition to monthly rent. But having this money may make</li></ul>

Question	Synthesis of Responses
	<p>a person ineligible for MassHealth.</p> <ul style="list-style-type: none"> <li>● Poor sidewalk quality can affect children, people in wheelchairs, people with disabilities, and the elderly.</li> <li>● Poor water quality has long term effects for everyone.</li> <li>● Noise pollution from the airport can affect people's quality of sleep and ability to relax, and their pets' well-being.</li> <li>● Other issues include: <ul style="list-style-type: none"> <li>○ Shortage of medical professionals, especially those who take Medicaid</li> <li>○ Getting the right cane or other device</li> <li>○ Affordability of care</li> <li>○ Lack of food security</li> <li>○ Homelessness</li> </ul> </li> </ul>
<p><b>2. How do these health needs disproportionately affect the most vulnerable people and communities?</b></p>	<ul style="list-style-type: none"> <li>● People from different cultures and people with disabilities may not be treated appropriately by medical professionals.</li> <li>● Cultural differences can also affect people's willingness to access health care, their understanding of treatment, and their understanding of what treatment and services are available.</li> <li>● Stigma around medical marijuana can affect people's access and use of this type of treatment.</li> <li>● People with financial hardships often need help with transportation to access health care.</li> </ul>
<p><b>3. Who do you think is being missed in the CHNA process? Who should we reach out to and invite to become more involved?</b></p>	<ul style="list-style-type: none"> <li>● Immigrant and refugee groups</li> <li>● People who are homeless</li> <li>● People who are disabled</li> <li>● The elderly</li> <li>● People of color and other minorities</li> <li>● People who use community health clinics to access health care</li> </ul>

## Appendix VI. Community Chat Summary

### **Community and Stakeholder Engagement**

The Coalition prioritized the input of the community and other regional stakeholders as an important part of the CHNA process. In an effort to increase community engagement, the CHNA RAC brought information about the CHNA and gathered priorities at the regular meetings of service providers, community-based organizations, support groups, and hospital-based groups in the form of Community Chats.

### **Methodology**

From January 2019 July 2019, the RAC held over 70 Chats throughout Hampden (46+), Hampshire (10), Franklin (2), and Worcester (2) counties. The Chats were selected by Baystate Health through the input of RAC members, CBAC members, and through leveraging existing community relationships. Participation snowballed throughout the process with the assistance of Chat participants suggesting other community groups to include in the process. In total, the RAC reached over 1,200 people through these Chats. Figure 1 shows the role participants identified with during the Chats.

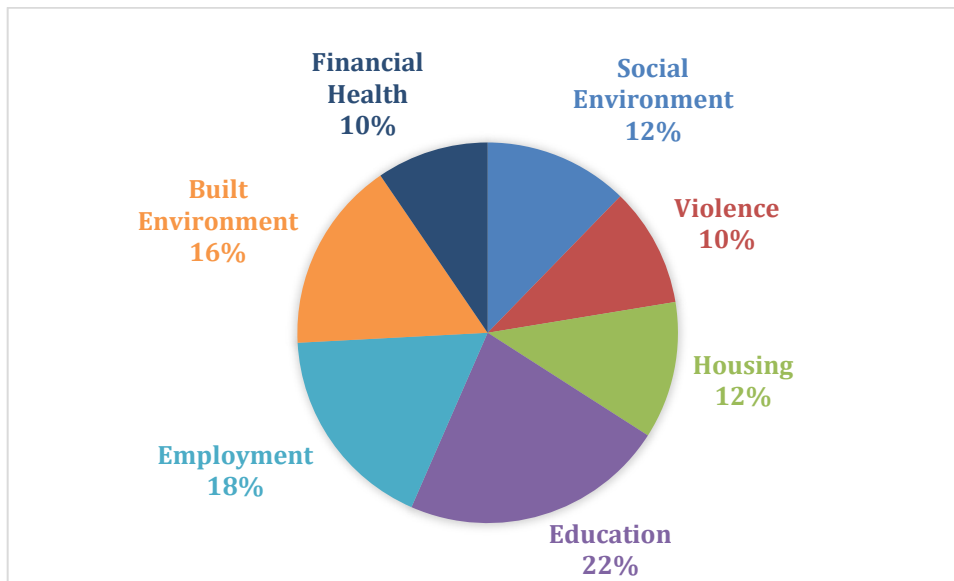
**Figure 1: Chat Participants**

Nonprofit Staff	23%
Health Care Professionals	21%
Community Members	19%
Youth	13%
Older Adults	8%
Municipal Staff	5%
Community Leaders	5%
Individuals with Disabilities	3%
Transgender and GLBQ+	2%
Faith Leaders	1%

## Health Needs, Issues, and Concerns

In 42 of the more than 70 Chats conducted, participants were given two sticker dots and asked to mark on a poster what they believed were the two most pressing health issues in their communities. Facilitators presented options organized by the MDPH Social Determinants of Health Framework, which included: social environment, violence, education, employment, housing, built environment, financial health, as well as more specific subsets of each topic listed. Figure 2 lists how Chat participants voted.

**Figure 2: Social Determinants of Health Priorities 2019**



## Priorities from Chat Participants

- **Education** - the top priority of Chat participants throughout western Massachusetts. Resources and opportunities for education were identified as the most pressing issues, followed by social and psychological education, and knowledge and behavior. A lack of health literacy was a common issue for communities as well. Participants identified limited knowledge of available services, and the need for a reference list of all available services and resources within their communities.
- **Employment** - also identified as a top priority in western Massachusetts. Within the category of employment, Chat participants specifically elevated the issue of income and poverty over some of the other options, such as benefits and resources, employer policies, and physical workspace.

- **Built Environment** - top priorities included transportation, health care access, and food access, respectively. Many Chat participants reported living in transportation deserts or reported inadequate transportation services. Participants also mentioned a lack of sidewalks and sidewalk upkeep. Community members reported issues such as food deserts, unaffordable healthy food, lack of fast-food zoning laws, and stigma around food pantries as challenges. In addition, lack of health care access was indicated in many Chats. This includes: inability to pay for services, difficulty navigating healthcare and health insurance systems, long wait times in the emergency department and to see a health care specialist, and limited service providers. Overwhelmingly, participants reported a lack of mental health and substance use disorder treatment as an issue.
- **Social Environment** - encompasses factors such as language, isolation, racism, poverty, gender discrimination, immigration status, ageism and more. Through the Chats, challenges with the social environment were found at the individual, community, and societal (systems and policies) level. Increased cultural humility among providers, as well as a need for bilingual providers, were areas where participants identified needs. Institutionalized racism was consistently mentioned as a significant contributor to poor health in western Massachusetts. Community members also identified a lack of community engagement and specifically requested more after-school programs and mentoring programs for youth.
- **Housing** - participants named homelessness as the top issue within the housing category, with some participants also reporting housing stability and quality as an area of concern. Chat participants specified that affordable housing was low quality and aging, but also limited, leading to long waitlists.
- **Financial Health** - is built through having access to safe, high-quality financial products and services that help people save, spend, borrow, and plan. Financial health not only improves a person's life today, but it also creates opportunity for their future generations. Overall, Chat participants reported financial health as a general problem.
- **Violence** - most frequently reported as a problem at the interpersonal level (such as domestic violence, bullying, and homicide). Self-directed violence, including self-harm and suicide, was also reported as a community concern.

## **Priority Populations**

Commonly cited priority populations and common challenges include:

- Immigrants, refugees, and non-English speakers: lack of access to care, low health literacy, and lack of cultural humility from providers;
- Older adults: isolation, loneliness, unaffordable care, and lack of transportation;
- Youth: substance use (vaping, alcohol, and marijuana), limited school resources, poor mental health;
- GLBQ+ and Transgender: stigma, lack of family and community support, untreated mental health, and lack of GLBQ+ and transgender affirming and knowledgeable providers;
- Low-income people and people of color: adversely impacted by all the challenges and lack of resources stated above in prioritized health challenges;
- People with disabilities: lack of transportation, lack of health care providers.

## **Community Assets**

Community assets were often very specific to the community where the chat was held. However, some consistent community assets included: community centers, local hospitals, schools, support groups, faith communities, libraries, and community colleges.

## **Limitations and Recommendations**

The Chat data has some limitations. Many of the Chats were clustered within Hampden County, particularly within Springfield and Westfield. In addition, older adults, people with disabilities, and youth participated less in the quantitative assessment (voting on social determinants of health) due to the nature of the activity, leading to the potential that this may have skewed the data. In addition, Chats were facilitated by approximately ten different RAC members; questions may have been asked or framed differently depending on who facilitated the conversation. In the future, we hope to select a more geographically diverse population, capture the demographic make-up of the Chat participants, and begin the Chats earlier in the CHNA process to better guide CHNA priorities.



Paper copies of this document may be obtained at Baystate Health, Office of Government and Community Relations, 280 Chestnut Street, Springfield, MA 01199 or by phone 413-794-1016. This document is also available electronically via the hospital website [www.baystatehealth.org/communitybenefits](http://www.baystatehealth.org/communitybenefits).