

# Community Health Needs Assessment

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## 2016

*Prepared for*



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*By*

Partners for a Healthier Community  
Collaborative for Educational Services  
Pioneer Valley Planning Commission



## Consultant Team

### Lead Consultant

**Partners for a Healthier Community** is the Public Health Institute of Western Massachusetts. Our mission is to build measurably healthier communities with equitable opportunities and resources for all through civic leadership, collaborative partnerships, and policy advocacy. We provide skills, expertise and experience to create successful campaigns and systems to improve health and well-being in the Pioneer Valley. Our efforts focus on activities and policy changes that build on community assets while simultaneously increasing community capacity. Partners for a Healthier Community has a strong track record of supporting coalitions, engaging community members and incorporating public policy advocacy in its work. As a Public Health Institute, we provide “backbone” infrastructure support to the region in a variety of areas, including convening of multi-sector partnerships, design and implementation of population-based health programs, research and program evaluation.

### Consultants

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

**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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# Executive Summary

## Introduction and Methods

Mercy Medical Center, located in Springfield, Massachusetts, is a member of the Trinity Health System and is a fully-accredited and nationally recognized high quality health care institution. Mercy is a licensed acute care medical facility, offering inpatient and outpatient surgery, emergency care, intensive care, critical care, cardiac care, maternity services, cancer treatment, breast care, diagnostic imaging, diabetes education, and community health services. Mercy Medical Center's behavioral health campus, Providence Behavioral Health Hospital in Holyoke, is one of the largest providers of acute behavioral health services in the entire state of Massachusetts. Services include inpatient and outpatient psychiatric care for children and adults, an inpatient substance abuse treatment unit, and two outpatient Methadone Maintenance Treatment programs.

Mercy Medical Center is a member of the Coalition of Western MA Hospitals ("the Coalition") a partnership between 10 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. Mercy Medical Center worked in collaboration with the Coalition to conduct this assessment. The assessment was conducted to update the findings of Mercy's 2013 CHNA so that Mercy can better understand the health needs of the communities it serves and to meet its fiduciary requirement as a tax-exempt hospital.

The assessment focuses on Hampden County, the primary service area of Mercy Medical Center. When identifying the areas that can be addressed to improve the health of the population, the assessment used the social and economic determinants of health framework since it is recognized that these factors contribute substantially to population health. The prioritized health needs identified in the 2016 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 assessment reports; and 3) information from 4 focus groups and 22 key informant interviews conducted by the Coalition for the 2016 CHNA. Vulnerable populations were identified using a health equity framework with available data. Information from this CHNA will be used to inform the updating of Mercy Medical Center's community health improvement plan (CHIP) and to inform the Coalition's regional efforts to improve health.

## Findings

Below is a summary of the prioritized community health needs identified in the 2016 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 Mercy's 2013 CHNA and continue to impact the health of the population in Mercy's service area. Social, economic, and community level needs identified in the 2016 CHNA include:

- **Lack of resources to meet basic needs** – Many Hampden County residents struggle with poverty and low levels of income with 17% of Hampden County residents living in poverty and a median family income 30% lower than that of the state. Though unemployment rates have dropped, they continue to impact the county with rates of 8%. Lower levels of education contribute to unemployment and the ability to earn a livable wage.
- **Housing needs** – *Housing insecurity* is a need that continues to impact Hampden County residents. Almost half of the population is housing cost burdened, with more than 30% of their income going towards housing. *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.
- **Lack of community safety** – Lack of community safety was a prioritized health need in the previous CHNA and continues to impact Hampden County residents. Crime rates are high, with violent crime rates in Hampden County almost 50% higher than that of the state. In addition to crime, youth bullying was also identified as a concern in this assessment
- **Food insecurity and food deserts** – *Food insecurity* continues to impact the ability of many Hampden County residents to have access to healthy food. Springfield, Holyoke, and Chicopee have high rates of food insecurity with over 20% of some areas in these communities experiencing food insecurity. In addition, parts of these communities and several others in Hampden County are also considered *food deserts*, which are areas where low-income people have limited access to grocery stores.
- **Environmental concerns** - *Air pollution* impacts the health of Hampden County residents. Springfield experiences poor ambient air quality due to multiple mobile and point sources. Near roadway air pollution impacts the community members that live, work, or attend school in close proximity to the highway. Air pollution impacts morbidity of several chronic diseases that have a high prevalence in Hampden County, including asthma, cardiovascular disease, and recent studies also suggesting an association with diabetes.
- **Institutional racism** – Addressing institutional racism has been identified as a prioritized health need in this CHNA. Key informant interviews and focus groups conducted for both the 2013 CHNA and the 2016 CHNA identified institutional racism as a structural factor driving health inequities that needs to be addressed. In particular, racial residential segregation corresponding with low levels of opportunity in communities of color was identified as one form of institutional racism that impacts health. The Springfield Metropolitan Statistical Area was identified as the most segregated in the U.S. for Latinos and 22<sup>nd</sup> most segregated for Blacks in an analysis conducted by the University of Michigan.

### **Barriers to Accessing Quality Health Care**

The lack of affordable and accessible medical care was identified as a need in the 2013 CHNA and continues to be a need today. The following barriers were identified.

- **Limited availability of providers** - Hampden County residents experience challenges accessing care due to the shortage of providers. 54% of county residents live in a healthcare professional shortage area. Focus group participants reported long wait times for urgent care and wellness visits. Primary care and dental providers were identified as shortage areas with high provider to patient ratios. 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.
- **Lack of transportation** - Transportation arose as a barrier to care among interviewees in the 2013 CHNA, and it continues to be a major barrier to accessing care as the most frequently cited barrier in key informant interviews and focus groups for the 2016 CHNA. These challenges relate to both the overall transportation system and public transit.
- **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 co-morbid substance use and mental health disorders, and the need for health care providers to coordinate care with schools as well as faith-based communities.
- **Health literacy, language barriers and need for culturally sensitive care** – 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 in a wider range of languages. The need for *culturally sensitive care* was identified as a prioritized health need in the 2013 CHNA and continues to remain so. Interviews with public health leaders and focus groups with mothers and faith-based community leaders all identified cultural and language differences between the community and providers as a gap in service, and called for increased training in this area for health care providers.

### **Health**

- **Chronic health conditions** – High rates of **obesity, diabetes, cardiovascular disease, asthma,** and associated morbidity previously identified as prioritized health needs in the 2013 CHNA continue to impact Hampden County residents. An estimated 30% of adults in the population are obese with high rates also observed among children. Heart disease is the leading cause of death in Hampden County. One third of Hampden County adults have hypertension, a risk factor for cardiovascular disease, with rates increasing in older adults to an estimated 55%. Approximately 20% of the population has pre-diabetes or diabetes, and 12% of adults and 19% of school children have asthma. Asthma morbidity rates were particularly high among Latinos.

- **Physical activity and nutrition** - The need for increased physical activity and consumption of fresh fruits and vegetables was identified among Hampden County residents. Low rates of physical activity and healthy eating contribute to high rates of chronic disease and also impact mental health. Community level access to affordable healthy food and safe places to be active, as well as individual knowledge and behaviors affect these rates.
- **Mental health and substance use disorders** - Substance use and mental health were identified as two of the top three urgent health needs/problems impacting the area in interviews with local and regional public health officials and among local physician leaders at Mercy and in the Springfield community. Substance use disorders overall (including alcohol) and opioid use were of particular concern. *Opioid use disorder*, which has been declared a public health emergency in Massachusetts, is impacting Hampden County residents with fatality rates higher than that of the state. 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. *Tobacco* use continues to remain high with an estimated 21% of adults that smoke. *Youth substance use* is also an issue with 15% of Springfield 8<sup>th</sup> grade students reporting drinking alcohol in the past 30 days and 12% using marijuana.
- **Infant and perinatal health risk factors** - Infant and perinatal health factors were identified as health needs in the 2013 CHNA and continue to impact Hampden County residents. Needs for increased utilization of prenatal care and a decrease in smoking during pregnancy were identified. This impacts rates of adverse birth outcomes, with 8-9% of Hampden County births born preterm or low birth weight.
- **Unsafe sexual behavior** - High rates of unsafe sexual behavior was previously identified as a health need and continues to remain a need in Hampden County. Sexually transmitted infection (STI) rates continue to be high, with Hampden County *chlamydia* and *HIV* rates approximately 40% higher than that of the state. *Youth STI rates* are particularly high with rates of chlamydia and syphilis 2-4 times higher than that of the state. Though teen pregnancy rates have decreased due to collaborative initiatives to address this issue, Hampden County *teen pregnancy* rates continue to be high with rates double that of the state.

### **Vulnerable Populations**

Available data indicate that **children and youth, older adults**, and some communities of color, particularly **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 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 disorder.

Data also indicated increased risk for poorer mental health among **LGBTQ** (lesbian, gay, bi-sexual, trans-sexual, queer) youth and **refugee** populations. However, available data was very limited and more data is needed to better understand inequities experienced by these populations.



Individuals with **low income** levels and those living in **poverty** are also disproportionately impacted by poor health. Though data was not available for health conditions by income/poverty level, these health determinants have been consistently documented with poorer health outcomes.

### *Summary*

The Mercy service area of Hampden County, MA continues to experience many of the same prioritized health needs identified in Mercy's 2013 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 disparities observed among vulnerable populations, which include children, older adults, Latinos, Blacks, LGBTQ youth, and refugees. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The Mercy 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 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. The opioid crisis has emerged as a top issue impacting the health of the community. Progress has been made to address some of the prioritized health needs previously identified, such as teen pregnancy and childhood obesity; however, rates remain high and work needs to be continued.

## Introduction

### About Mercy Medical Center

**Mercy Medical Center** (referred to as Mercy), located in Springfield, Massachusetts, is a part of the local Sisters of Providence Health System and is also a member of the national Trinity Health System and is a fully-accredited and nationally recognized as a high quality health care institution. Mercy is a licensed 383 bed, acute care medical facility, offering inpatient and outpatient surgery, emergency care, intensive care, critical care, cardiac care, maternity services, cancer treatment, breast care, diagnostic imaging, diabetes education, and community health services. Mercy's hallmark programs include the newly expanded Sister Caritas Cancer Center, the Mercy Breast Care Center, and specialized neurosurgery, the Family Life Center for Maternity, an updated Emergency Department and the state-of-the-art Mary E. Davis Intensive Care Unit. **Providence Behavioral Health Hospital** is the behavioral health campus of Mercy Medical Center located in Holyoke, Massachusetts. Providence Behavioral Health Hospital is a 126-bed facility and one of the largest providers of acute behavioral health services in the entire state of Massachusetts. Services include inpatient and outpatient psychiatric care for children and adults, an inpatient substance abuse treatment unit and two outpatient Methadone Maintenance Treatment programs.

**Mission:** We, Sisters of Providence Health System and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. We are sustained by an unwavering trust in God's Providence.

### The Coalition of Western Massachusetts Hospitals

Mercy Medical Center is a member of the Coalition of Western Massachusetts Hospitals (Coalition). The Coalition is a partnership between ten non-profit hospitals/health plan in Western Massachusetts: Baystate Medical Center, Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Baystate Noble Hospital, Baystate Wing Hospital, Cooley Dickinson Hospital, Holyoke Medical Center, Mercy Medical Center (a member of Sisters of Providence Health System), 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. The Coalition has since expanded to ten members and is currently conducting collaborative work to address mental health needs in the region.

## Community Health Needs Assessment (CHNA)

Improving the health of Western Massachusetts is a shared mission across the Coalition of Western Massachusetts Hospitals. To gain a better understanding of these needs, and as required by the 2010 Patient Protection and Affordable Care Act (PPACA), Coalition members conducted community health needs assessments (CHNA) in 2012-2013. Integral to this needs assessment was the participation and support of community leaders and representatives who provided input through steering committee participation, a community survey, and stakeholder interviews and focus groups. Based on the findings of the CHNA, and as required by the PPACA, the hospitals developed community health improvement plans (CHIP) to address select prioritized needs.

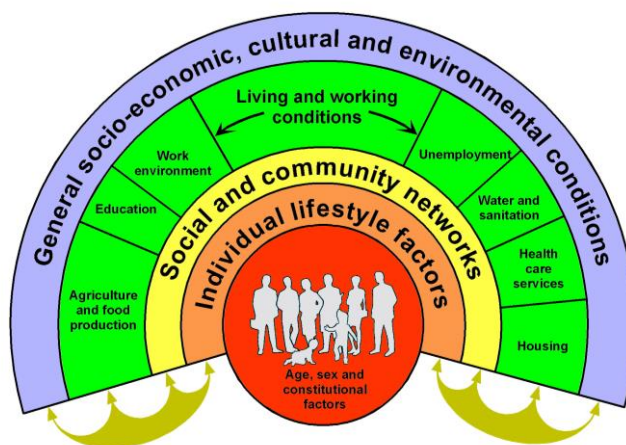
The 2016 CHNA was conducted to update the 2013 CHNA findings so that Mercy can better understand the health needs of the community it serves and to meet Mercy's fiduciary requirement as a tax-exempt hospital. The PPACA requires tax-exempt hospitals and insurers to "conduct a Community Health Needs Assessment [CHNA] every three years and adopt an implementation strategy to meet the community health needs identified through such assessment." Information from this CHNA will be used to update the CHIPs developed in 2013 and to identify regional needs and areas of action to address needs.

# Methodology for 2016 CHNA

## Social and Economic Determinant of Health Framework

The 2016 CHNA was conducted using a **determinant of health framework** as it is recognized that social and economic determinants of health contribute substantially to population health. It has been estimated that less than a third of our health is influenced by our genetics or biology.<sup>1</sup> Our health is largely determined by the social, economic, cultural, and physical environments that we live in and healthcare we receive (Figure 1.).

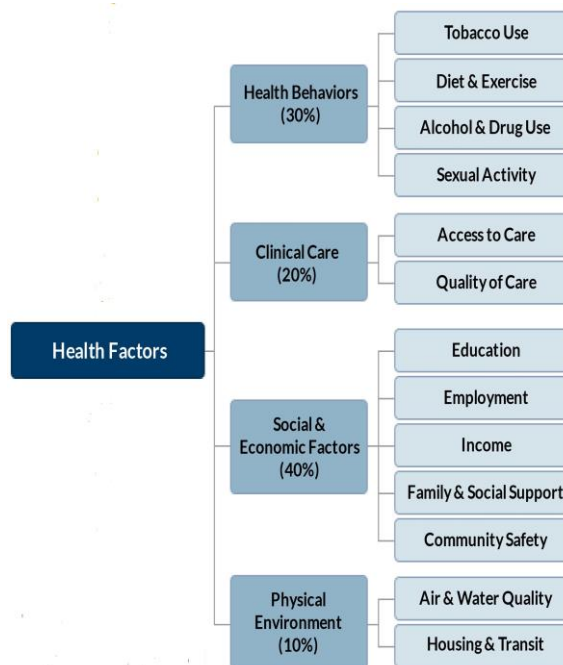
Figure 1. Determinants of Health



Source: Dahlgren & Whitehead, 1993

Among these “modifiable” factors that impact health, social and economic factors are estimated to have the greatest impact. The County Health Rankings model (Figure 2), 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 our health, followed by health behaviors (30%), clinical care (20%), and the physical environment (10%). Many health disparities occur as a result of inequities in these **determinants of health**.

Figure 2. County Health Rankings Model - Health Factors



Source: County Health Rankings

## Assessment Methods

The primary CHNA goals were to update the list of prioritized community health needs identified in the 2013 CHNA conducted by Verite Healthcare Consulting and to the extent possible, identify potential areas of action. The prioritized health needs identified in the 2016 CHNA include **community level social and economic determinants that impact health, health behaviors**, and specific **health needs** within the population. Assessment methods included: 1) analysis of social, economic and health **quantitative data** from MA Department of Public Health, the U.S Census Bureau, the Centers for Disease Control and Prevention [CDC]

Behavioral Risk Factor Surveillance System [BRFSS], the County Health Ranking Reports, Community Commons, and a variety of other data sources; 2) analysis of findings from 5 **focus groups** and 24 **key informant interviews** (including with local and regional public health officials) conducted by the consultant team as part of this CHNA (Appendix II); and 3) review of 17 existing assessment reports published since 2013 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.

To the extent possible given data and resource constraints, vulnerable populations were identified using information from focus groups and interviews as well as quantitative data stratified (or broken down) by race/ethnicity; age with a focus on children/youth and older adults; and LGBTQ (lesbian/gay/bi-sexual/transgender/queer) populations.

## Prioritization Process

A systematic process was conducted to update the list of prioritized community health needs. Community level social and economic determinant of health factor related needs and access to care needs were updated as appropriate from the previous 2013 CHNA with quantitative and qualitative data gathered for this CHNA. Health conditions were identified based on consideration of the following: magnitude of impact (low, moderate, high), severity of impact (low, moderate, high), populations impacted (including vulnerable populations), and rates compared to a referent (generally the state rate). Prioritized health needs were those that had the greatest combined magnitude and severity or that disproportionately impacted vulnerable populations in the community.

## 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. Below are the primary mechanisms for community and stakeholder engagement (see Appendix I for list of public health, community representatives and other stakeholders included in process)

- A **CHNA Steering Committee** was formed that included representatives from each hospital/insurer Coalition member as well as public health and community stakeholders from each hospital service area. Stakeholders on the Steering Committee included local and regional public health and health department representatives; representatives from local and regional organizations serving or representing medically underserved, low-income or minority populations; and individuals from organizations that represented the broad interests of the community. When identifying community and public health representatives to participate, a stakeholder analysis was conducted by the Coalition and Consultants to ensure geographic, sector (e.g. schools, community service organizations, healthcare providers, public health, and housing) and racial/ethnic diversity of community representatives. By including these stakeholders on the Steering Committee, the community and public health representatives had input on the 2016 CHNA process used to identify and prioritize community health needs,

CHNA findings, and dissemination of information. Assessment methods and findings were modified based on the Steering Committee feedback. The Steering Committee met monthly from October 2015 – June 2016.

- **Key informant interviews** and **focus groups** were conducted to both gather information that was utilized 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 organizational leaders that represent the broad interests of the community or that serve medically underserved, low-income or minority populations in the service area. Interviews with the local and regional public health officials were used to identify current and emerging high priority health areas and healthcare and community factors that contribute to health needs. Focus group participants included individuals representing the broad interests of the community, including community organizational representatives, vulnerable population community members (low-income, people of color, etc.), and other community stakeholders. Topics included: maternal and child health, mental health and substance use, behavioral health and emergency department care, and faith-based leaders and community engagement. Key informant interviews and focus groups were conducted from February 2016 – April 2016.
- A **community listening session** will be held upon completion of this report to obtain input about the identified prioritized health needs, better understand the prioritized community health, and to obtain input about the needs that will be focused on for the CHIP process. The community listening session will include individuals representing the broad interests of the community and community stakeholders representing medically underserved, low-income and minority populations.

## 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. Much of the quantitative data gathered for this report was provided by the Massachusetts Department of Public Health (MDPH) as part of a pilot effort to provide data for community health needs assessments. Challenges were experienced as this was their first effort to pull this data across multiple divisions in the short timeframe needed for this assessment. MDPH was very supportive in pulling together supplemental data, and this experience will inform the continued development of data for future CHNAs. The assessment used the best available data given these time and resource constraints.

Limited data was available to assess some vulnerable populations. We were able to identify health needs among some vulnerable populations; however, more data is needed. We have included emergent health needs that were identified primarily through qualitative data, though additional data may be needed to better understand the impact of the need or potential actions to address the need.

## Hospital Service Area

The service area for Mercy Medical Center includes all 23 communities within Hampden County (Table 1), including the third largest city in Massachusetts – Springfield (population over 150,000). Three adjacent cities (Holyoke, Chicopee and West Springfield) create a densely-populated urban core that includes over half of the population of the service area (270,000 people). Smaller, 'bedroom' communities exist to the east and west of this central core area. Many of these communities have populations under 20,000 people. The service area has more racial and ethnic diversity than many other parts of Western Massachusetts (Table 2). County-wide, 22.1% of the population is Latino, 8.7% is Black and 2.1% is Asian (ACS, 2010-2014), though this diversity is not equally spread throughout the region and tends to be concentrated in the urban core. The Pioneer Valley Transit Authority, the second largest public transit system in the state serves, 11 communities in the service area, and connects suburban areas to the core cities and services.

Economically, the Mercy service area is home to many of the largest employers in the region as well as numerous colleges and universities and provides a strong economic engine for the broader region. The largest industries and employers include health care, service and wholesale trade and manufacturing. At the same time, the county struggles with higher rates of unemployment and poverty, lower household incomes and lower rates of educational attainment (Table 2). The median household income in the service area is about \$50,000 (\$17,000 less than the state). At the same time, the cost of housing is almost \$400/month lower than that statewide. Still, the poverty rate is more than 5% higher than that statewide, and the child poverty rate is an alarming 27%, more than 10% higher than the state rate. (ACS, 2010-2014). Despite being at the core of the Knowledge Corridor region, only 25.6% of the population age 25 and over has a bachelor's degree. Unemployment is somewhat higher than the state average. The median age for the service area is similar to that of Massachusetts, though the population over 45 years old is growing as a percentage of the total population (Table 2).



**Table 1. Communities in Mercy Medical Center Service Area**

Hampden County	2014 Population Estimate
Agawam	28,772
Blandford	1,255
Brimfield	3,723
Chester	1,365
Chicopee	55,795
East Longmeadow	16,123
Granville	1,620
Hampden	5,195
Holland	2,502
Holyoke	40,124
Longmeadow	15,882
Ludlow	21,436
Monson	8,754
Montgomery	860
Palmer	12,174
Russell	1,787
Southwick	9,689
Springfield	153,991
Tolland	492
Wales	1,878
Westfield	41,608
West Springfield	28,627
Wilbraham	14,509
<b>Total Service Area</b>	<b>468,161</b>

Source: Population Division, U.S. Census Bureau, <http://www.census.gov/popest/index.html>

**Table 2. Sociodemographic Characteristics of Mercy Medical Center Service Area**

Sociodemographic Characteristic	Hampden County
<b>Age</b>	
Median age (years)	38.7
Under 5 years	5.9%
5 to 17 years	17.1%
18-64	62.3%
65 and over	14.7%
<b>Race and Ethnicity</b>	
One race	97.7%
White	78.2%
Black or African American	8.7%
American Indian and Alaska Native	0.3%
Asian	2.1%
Native Hawaiian and Other Pacific Islander	0.0%
Some other race	8.4%
Two or more races	2.3%
Latino or Hispanic origin (of any race)	22.1%
White alone, not Latino or Hispanic	66.1%
<b>Language Spoken at Home (population over 5)</b>	
Speaks language other than English at home	25.0%
<b>Educational Attainment</b>	
Population 25 years and over	
Less than high school graduate	15.9%
High school graduate (includes equivalency)	30.6%
Some college or associate's degree	28.1%
Bachelor's degree or higher	25.5%
<b>Income</b>	
Median per capita income	\$25,416

Source: U.S. Census, ACS, 2010-2014

# Prioritized Health Needs of the Community

The following are the prioritized health needs identified for Mercy’s service area, Hampden County. The prioritized health needs of the community served by Mercy Medical Center are grouped into three categories: (I) community level social and economic determinants that impact health, (II) access and barriers to quality health care, and (III) health conditions and behaviors.

## I. Community Level Social and Economic Determinants that Impact Health

Below are the community level social and economic determinants of health that impact Mercy’s service area, many of which were identified as prioritized community health needs in Mercy’s 2013 CHNA and continue to contribute to the health challenges experienced in its service area.

### Lack of Resources to Meet Basic Needs

In Mercy’s service area of Hampden County, many residents struggle with **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. Low-income individuals are more likely to be negatively impacted by the chronic stress associated with challenges in securing basic necessities that impact health, such as housing, food, and access to physical activity.

The median family income of \$61,898 in Hampden County is almost 30% lower than that of the state (Table 3). Similarly, rates of unemployment in Hampden County are 40% higher than the state. Just over 17% of county residents live in poverty with high rates of poverty concentrated in areas of Springfield and Holyoke (Figure 3). Across all four focus groups, poverty was identified as a factor that impacts overall health, access to health care, and access to program and services that promote health.

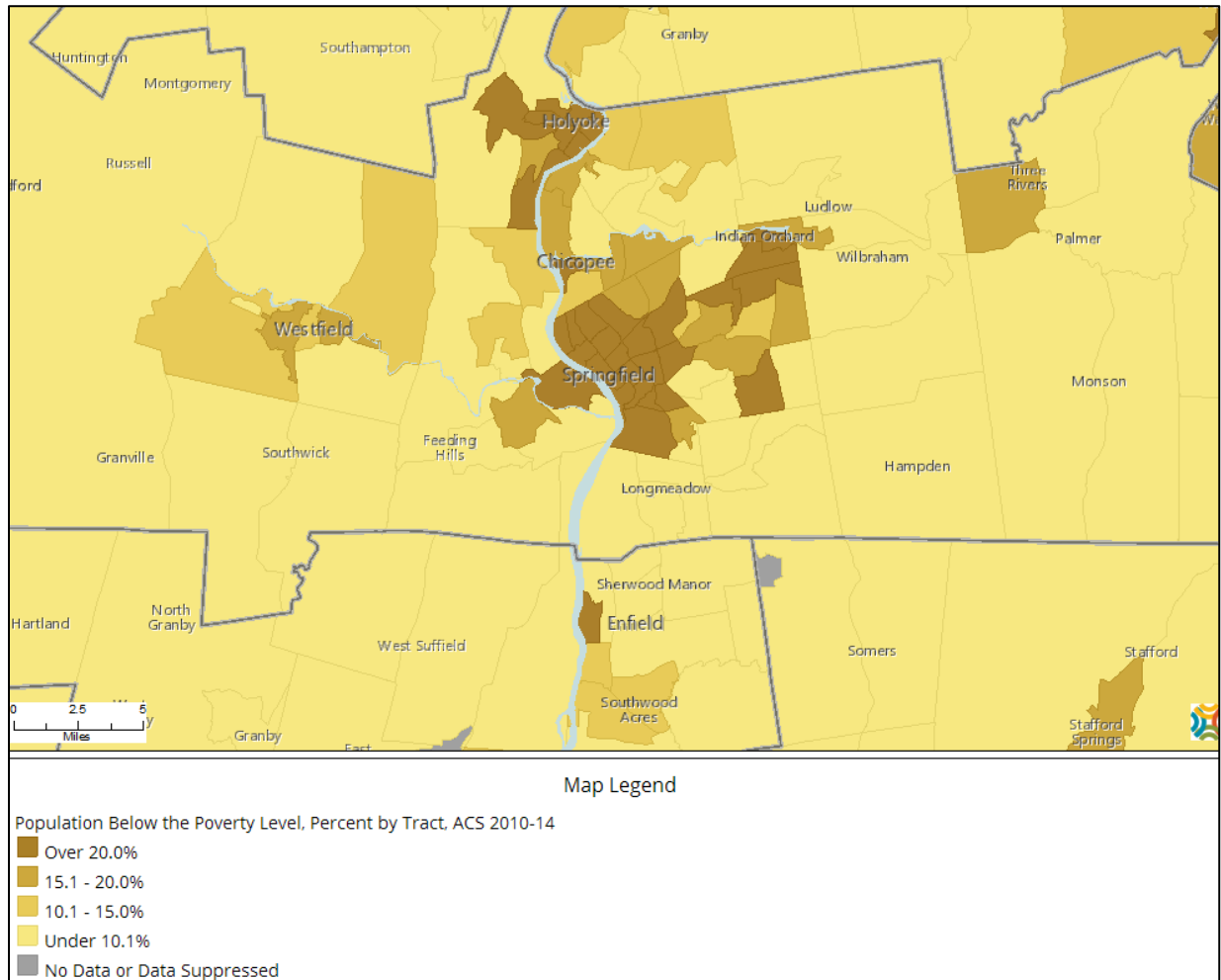
**Table 3. Socioeconomic Status Indicators**

	Hampden County	Massachusetts
Median Family Income*	\$61,898	\$86,132
Unemployment**	6.9%	4.9%
Poverty*	17.1%	11.6%
Child Poverty*	27.4%	15.1%
Children eligible for free or reduced lunch*	59.8%	38.3%
No high school diploma*	15.9%	10.5%

Sources: \*Community Commons 2016, U.S. Census Bureau, 2010-2014; poverty is 100% below federal poverty level; no high school diploma among adults age 25 and older

\*\*Community Commons 2016, US Department of Labor, Bureau of Labor Statistics. 2015

**Figure 3. Hampden County Poverty Rates**



Source: Community Commons 2016, U.S. Census Bureau, 2010-2014; poverty is 100% below federal poverty level

**Low levels of educational attainment** also contribute to availability of resources to meet basic needs. Levels of education are strongly correlated with both employment status and the ability to earn a livable wage. Approximately 16% of Hampden County residents age 25 and older do not have a high school diploma. In the communities of Springfield, Chicopee, and Ludlow, over 20% of eligible individuals do not have a high school diploma (Community Commons, 2016).

***Vulnerable Populations***

Children and populations of color are disproportionately impacted by poor socioeconomic status in Hampden County.

- Almost 60% of **children** living in Hampden County qualify for free or reduced lunch and 27.4% live below the poverty level
- Median income levels are lower and unemployment and poverty rates are higher among **Latinos and Blacks** (Community Commons, 2016)

### **Housing Needs**

Focus group participants and key informant interviewees identified housing as an influential stressor that contributes to poor health.

**Housing insecurity** is an issue that continues to impact Hampden County residents. Over a third of the population in Mercy’s service area is housing cost burdened, with rates close to 50% in Springfield. Among renters in the Mercy service area, over 50% are housing cost burdened (U.S. Census Bureau, 2010-2014). 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, medications, and gym memberships. In 2013 there were approximately 800 homeless individuals in Springfield, of which 551 were families with children.

**Poor housing conditions** also impact the health of residents. Older housing combined with limited resources for maintenance can lead to problems (e.g. mold, pest/rodent exposure) that affect asthma and other respiratory illnesses; exposure to environmental contaminants such as lead paint, asbestos, and lead pipes; and safety and accessibility of children, elderly or disabled populations. Hampden County has a large older housing stock with 30% of housing built before 1940. Springfield and Holyoke have a greater number of older homes, with 41% and 50% of homes built before 1940, respectively (U.S. Census Bureau, 2010-2014).

*“How do you relax when you don’t know where you are going to live?”*  
-Focus group participant

### **Lack of Community Safety**

Lack of community safety was a prioritized health need in the previous 2013 CHNA and continues to impact Hampden County residents. A safe community is one that is free from violence and danger. It is a place where people do not have to consider whether they will be safe or not when deciding where and when they will go outside of their homes. Crime rates are high, with violent crime rates in Hampden County almost 50% higher than that of the state. According to the FBI Uniform Crime Reports (2010-2012), rates of violent crimes in Hampden County were 641 per 100,000 compared to 431 in MA and 396 nationally (County Health Rankings, 2016). A criminal justice survey conducted by the city of Springfield in 2014 reported that 89% of overall arrests were males and 15% were gang related. Of all assault arrests, 67% were for domestic violence offenses.<sup>2</sup>

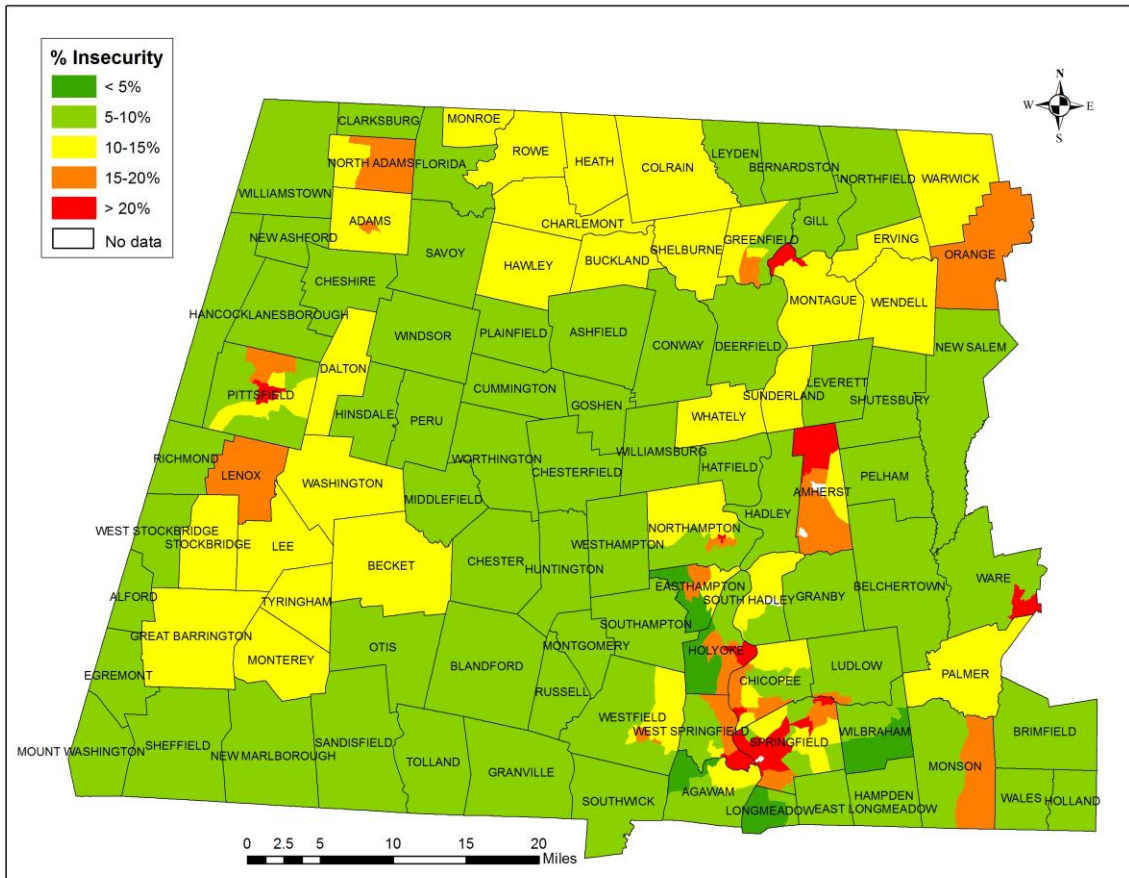
For youth, a safe community includes feeling safe at school. Bullying impacts youth feelings of safety. Findings from the Springfield Youth Health Survey (2015) indicate that 33% of Springfield 8th grade students were bullied in the past year.<sup>3</sup>

### **Food Insecurity and Food Deserts**

**Food insecurity** continues to impact the ability of many Hampden County residents to access to healthy food. Eating nutritious food is good for promoting overall health and is important for managing many chronic health conditions. However, not all individuals and communities have equal access to healthy food. Food insecurity is a measure of inadequate or uncertain access to food,

including healthy food, and is estimated based on social and economic characteristics such as income. As can be seen in a map of food insecure census tracts in Western MA (Figure 4), large portions of Springfield, and parts of Chicopee, Holyoke, Ludlow, Monson, West Springfield, and Westfield have rates of food insecurity greater than 15%.

**Figure 4. Food Insecurity Rates in Western MA**

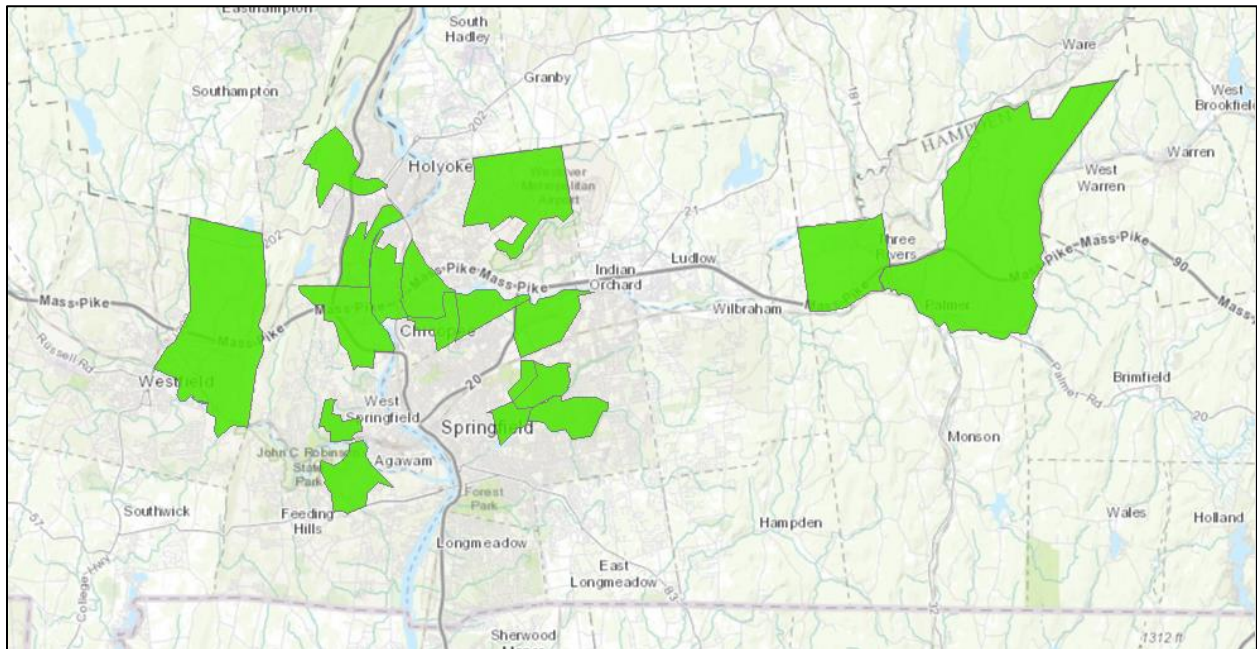


Data source: Gundersen, C., A. Satoh, A. Dewey, M. Kato & E. Engelhard. *Map the Meal Gap 2015: Food Insecurity and Child Food Insecurity Estimates at the County Level*. Feeding America, 2015. Feeding America. Source: Provided courtesy of the Food Bank of Western Massachusetts. Mapping: Provided courtesy of Baystate Medical Center Biostatistics and Epidemiology Core

Hampden County also has several **food deserts**. Low-income individuals are more likely to live in food deserts, which are 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 where public transportation is limited. Figure 5 highlights in green the parts of Springfield, Holyoke, and surrounding communities that have areas that the USDA has identified as food deserts.



**Figure 5. USDA Food Atlas Food Desert Areas in Hampden County**



Source: USDA Food Access Research Atlas; accessed 4/25/16

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

### **Environmental Concerns**

**Air pollution** impacts the health of Hampden County residents. Air pollution is associated with asthma, cardiovascular disease and other illnesses. Springfield experiences poor ambient air quality due to multiple mobile and point sources including a large inter-state highway, several state highways, railroad lines running through the city and directly through its neighborhoods, and the fact that the city is in a valley into which air pollution travels from other sources and settles. In addition, exposure to near roadway air pollution has a particularly detrimental impact on health with the highway and heavily trafficked roadways running through or adjacent to some Springfield neighborhoods. An analysis conducted as part of the Western MA Casino Health Impact Assessment found that Springfield Latino populations, who experience disparities in asthma and other respiratory conditions, are particularly impacted by near roadway pollution along I-91 and several other busy roadways running through downtown and the I-91 corridor.<sup>4</sup>

### **Institutional Racism**

In both the 2013 and 2016 CHNA focus groups and interviews, institutional racism was identified as a factor driving health inequities and a structural and social problem that needs to be addressed to reduce these inequities. Institutional racism contributes to racial and ethnic health disparities in our society and has been defined as racial inequities in access to goods, services, and opportunities such as quality education, housing, employment opportunities, medical care and facilities, and a healthy physical environment.<sup>5</sup> Dr. Camara Jones, the President of the American Public Health Association, describes institutional racism as “normative, sometimes legalized, and often manifests as inherited disadvantage.” It does not necessarily transpire at the individual level, but is structurally embedded in our systems, regulations, and laws. Institutional racism is perpetuated by structural barriers and inaction in the face of need.<sup>5</sup> An example of institutional racism described by

interviewees in the 2013 CHNA was that “many people of color and non-English speaking patients feel that they must take more steps in order to get care.”

Racial residential segregation is a form of institutional racism that is considered to have one of the most detrimental impacts on health by creating limited opportunity environments and embedding communities with structural barriers that directly impact access to quality education, socioeconomic attainment, and a number of other social determinants of health, such as food, and quality housing.<sup>6</sup> The University of Michigan’s Center for Population Studies ranked the Springfield Metropolitan Statistical Area (Hampden, Hampshire and Franklin counties) as the most segregated in the U.S. for Latinos, and 22<sup>nd</sup> in the country for Blacks,<sup>7</sup> with the largest number of Latinos and Blacks residing in Hampden County, particularly the urban cores of Springfield and Holyoke. Both Springfield and Holyoke were identified in an analysis by Ohio State’s Kirwan Institute as “very low opportunity” communities (Figure 6).<sup>8</sup>

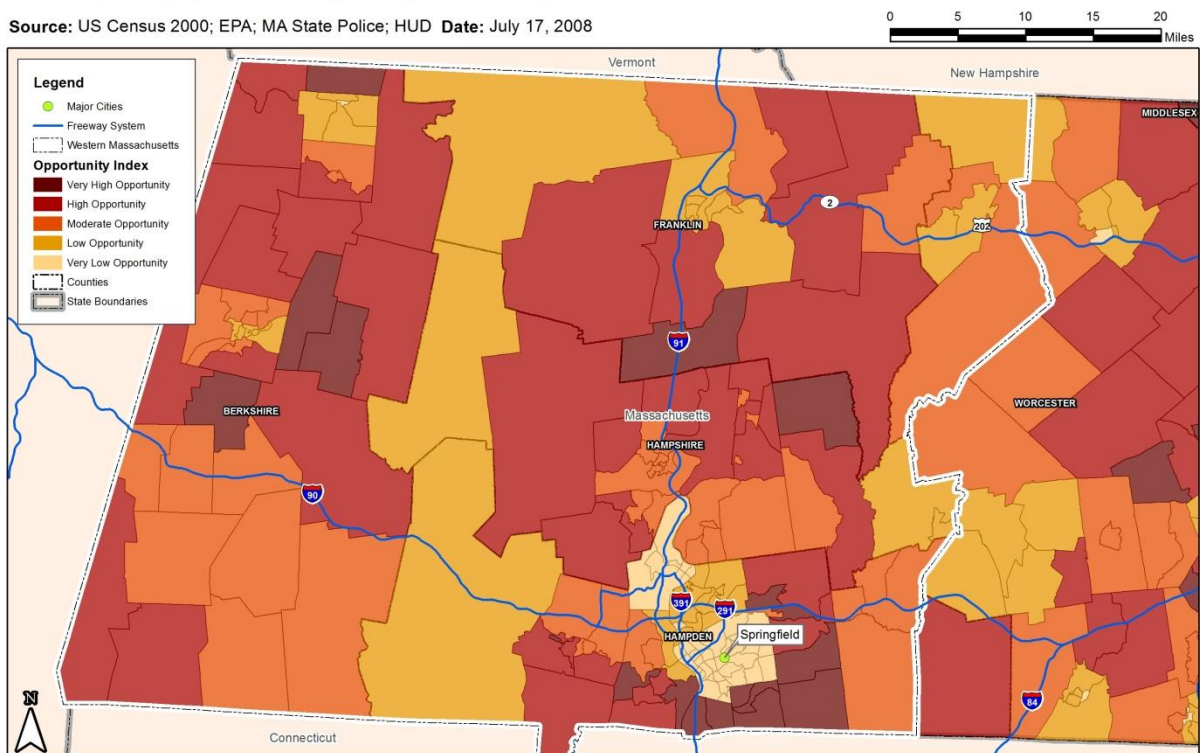
**Figure 6. Kirwan Institute Comprehensive Opportunity Map of Western Massachusetts**

### Comprehensive Opportunity Map WESTERN MASSACHUSETTS



This map displays the spatial pattern of distribution of opportunity based on Education, Economic & Mobility, and Housing & Neighborhood indicators

Source: US Census 2000; EPA; MA State Police; HUD Date: July 17, 2008





## II. Barriers to Accessing Quality Health Care

The lack of affordable and accessible medical care was identified as a need in the 2013 CHNA and continues to be a need today.

### *Limited Availability of Providers*

Hampden County residents 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. Accessibility to an already limited number of providers can be impacted by community location (rural or urban), and/or insurance restrictions. Low-income individuals are more negatively impacted by insurance related issues of access.

Fifty-four percent of Hampden County residents live in a healthcare professional shortage area (HPSA), compared to 14.6% for Massachusetts residents overall (Community Commons, 2016). In addition, the U.S. Health Resources and Services Administration (HRSA) has designated medically underserved areas and populations (MUAs/MUPs) in Hampden County, which are primarily found in Holyoke, Springfield, West Springfield, Westfield, Blandford, and Chester (Figure 7). MUAs and MUPs are identified based on availability of primary care providers, infant mortality rate, poverty rate and proportion of older adults. Focus group participants report long wait times for urgent and routine wellness care. Shortages are noted specifically for primary care physicians and dentists, which have population to provider ratios of 1410:1 and 1300:1 in Hampden County, respectively (statewide- 910:1, 1070:1 in MA) (County Health Rankings, 2016). Although there is greater access to mental health providers for Hampden County residents as compared to the state (160:1 vs. 200:1 in MA), 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.

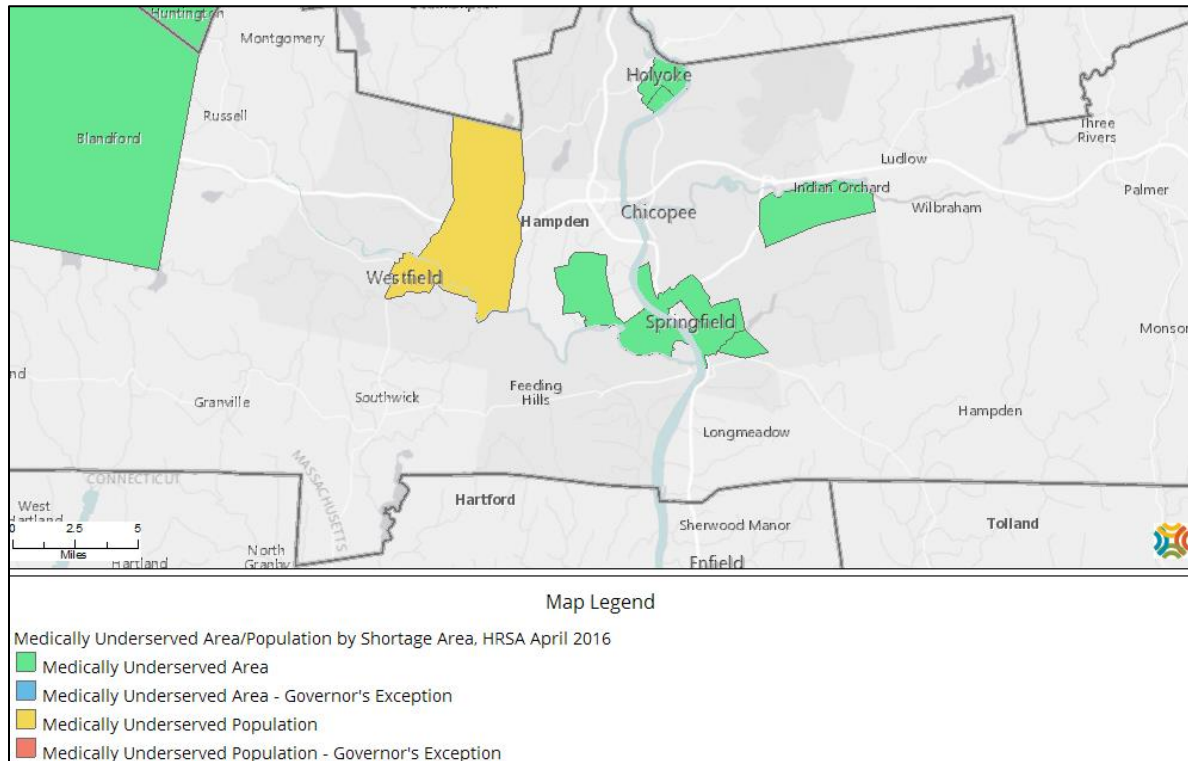
*“Children under the age of 14 with serious mental health and substance abuse issues have no place to go locally; many parents can’t work if their child needs treatment in a program that is so far away”*

- Holyoke behavioral health specialist key informant interviewee

### *Lack of Transportation*

Transportation arose as a barrier to care among interviewees in the 2013 CHNA, and continues to be a major barrier to accessing care. In key informant interviews with local and regional public health officials for the 2016 CHNA, transportation was most frequently cited as a barrier to care. Similarly, mothers participating in a focus group in Springfield for this CHNA cited transportation as a barrier to receiving routine and follow-up care.

**Figure 7. Medically Underserved Areas/Populations in Hampden County**



Source: Community Commons, HRSA 2015

Transportation barriers relate to challenges with the overall transportation infrastructure in the region and with public transit. An estimated 14% of households in Hampden County do not have vehicles, and in Springfield, rates are higher at 23.2% (U.S. Census Bureau 2010-2014). Public transit challenges previously identified relate to limitations in service options resulting in lengthy wait/trip time and limited access.<sup>4</sup> The Pioneer Valley Transit Authority has made some progress addressing needs cited by transit customers resulting in increases in ridership, (up 18.1% since 2010), however, challenges remain.

***Lack of Care Coordination***

Lack of care coordination was identified as a prioritized community health need in the 2013 CHNA and continues to remain an issue. Care coordination refers to the coordination of patient care, including the exchange of information between all parties involved in patient care (AHRQ, 2007). In the 2016 CHNA, focus groups and key informant interviews identified important areas where care provided by multiple providers continues to be uncoordinated and results in challenges. Examples include: lack of coordination in managing the overlap between mental health and substance use; more linkages between clinics/hospitals and emergency responders to better manage the opioid crisis; challenges of separate visits for postpartum and well-baby checkups for new mothers; and issues related to

***“We need more navigators and supports to find out about and use services”***  
 -Focus group participant

keeping track of appointments with multiple providers. Additionally, the barriers that occur as a result of decentralized health care services (i.e. having to travel to multiple locations for care, testing, and medications) were identified as impacting patient compliance. In their key informant interviews, public health officials described improving care coordination as key to addressing health inequities in the region. Health care administrators/providers described a need for increased collaboration as resources become more limited.

Focus group participants and key informant interviewees identified a need for stronger clinic-community linkages as a means to improve health for Hampden County residents.

Community members identified:

- Increased connections between clinic/hospital and school system to help parents advocate for children with special needs;
- Clinic-school collaboration for intervention/early education around mental health and substance use;
- Connecting clinic to faith-based community to help patients better navigate the health care system.

### *Health Literacy, Language Barriers and Culturally Sensitive Care*

The need for health information to be understandable and accessible was identified in this assessment.

**Health literacy** is defined by the CDC as 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 among faith-based providers in Hampden County and mothers in the Springfield area illustrate the need for increased health literacy, including the need for education about health information, types of services and how to access them, and support on how to advocate for themselves to ensure they are getting the information and services they need. Responses of participants indicate both a need for patient education but also provider education to ensure that patients understand what they are being told during a clinical encounter. This includes: giving them time to process information, asking if they understand what they are being told, and using less medical jargon.

*“In general people need a little more education. And easy access [to information on health care options], [it’s] available on websites, but to find an answer to exact question is very difficult for people.*

*- Focus group participant*

**Language barriers** can create multiple challenges for both patients and health care providers. Increasing availability of interpreters as well as translation of health material are specific actions that health care institutions can help to address this barrier. Focus group

*“[Moms] may not ask because they don’t want to feel stupid.”*

*- Focus group participant*

participants and key informant interviewees reported a need for more bilingual providers, more translators, and health materials translated in a wider range of languages. In the faith-based focus group, participants noted the growing refugee and immigrant populations, and the increasingly diverse linguistic population in the Springfield area. In Hampden County, a quarter of the population speaks a language other than English at home, and 6% of Hampden County households are linguistically isolated (U.S. Census 2010-2014).

Linguistic isolation is defined by the U.S. Census Bureau as a household in which all members older than age 14 speak a non-English language and have difficulty with English. The largest concentrations of linguistically isolated households living in Hampden County are in Springfield, Holyoke, Chicopee, Ludlow, Westfield, and Feeding Hills (Community Commons-US Census 2010-2014).

*“Hispanic clinicians are like gold and I know we struggle to recruit and retain them”*

-Holyoke provider key informant interviewee

### **Need for Increased Culturally Sensitive Care**

The need for culturally sensitive care was identified as a prioritized health need in the 2013 CHNA and continues to remain so. Cultural sensitivity refers to a commitment among health care providers to self-reflection and evaluation in order to reduce the power imbalance between patients and providers, and to the development of health care partnerships that are based on mutual respect and equality.<sup>10</sup>

2016 CHNA interviews with public health leaders as well as focus groups with mothers and faith-based community leaders all identified cultural and language differences between the community and providers as a gap in service. They all called for increased training for health care providers in this area. Focus group participants noted that cultural sensitivity is not limited to a racial or ethnic culture, but also includes care for stigmatized groups, such as ex-offenders, homeless individuals, and people with mental health or substance use issues. Focus group participants also noted that in some cultures, asking providers a question is seen as disrespectful.

### III. Health Conditions and Behaviors

This section focuses on the health conditions and behaviors that have the largest impact on the communities served by Mercy Medical Center. Data is summarized for each condition or behavior included. See Appendix III for detailed hospitalization (overall and by race/ethnicity) and prevalence data as available for select communities in Hampden County.

#### Chronic Health Conditions

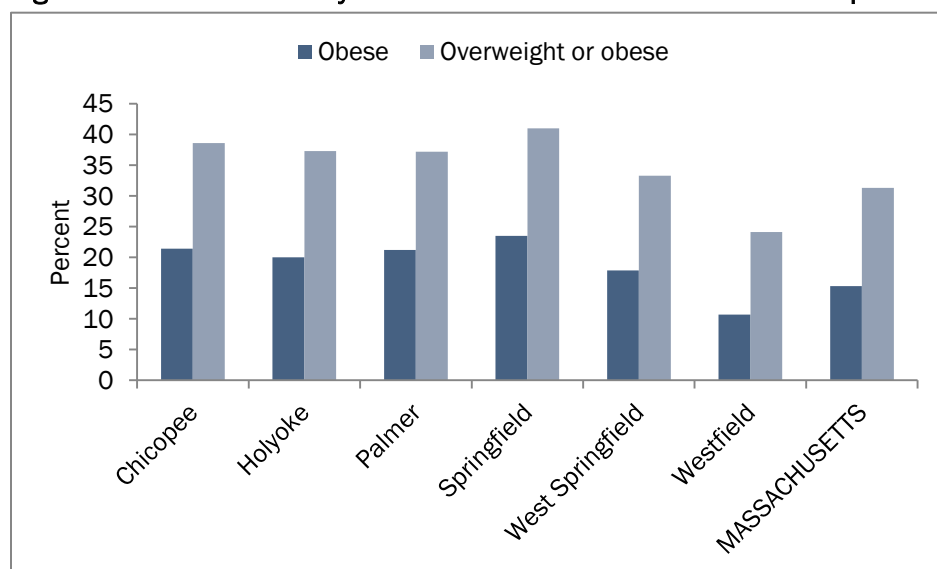
Chronic health conditions continue to remain an area of prioritized health need for Hampden County residents. Residents continue to experience high rates of chronic health conditions and associated morbidity, particularly for **obesity, diabetes, cardiovascular disease** and **asthma**. A chronic health condition is one that persists for a long period of time, and typically can be controlled but not cured. According to the 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>11</sup> A **healthy diet** and **physical activity** play an important role in preventing and managing chronic diseases.

#### Obesity

In Hampden County almost 30% of adults struggle with obesity and 65% are overweight or obese (MA: obese - 24%; overweight/obese - 59%)(BRFSS 2011). 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, rates among children remain high when examining school districts in select communities in Hampden County, with rates over 20% observed in Springfield, Palmer, Chicopee and Holyoke (Figure 8). County-level childhood obesity data is not available.

Figure 8. Childhood Obesity Rates for Select School Districts in Hampden County



Source: "Results from the Body Mass Index Screening in Massachusetts Public School Districts, 2014"  
Children are screened in grades 1, 4, 7, 1.

### Cardiovascular Disease (CVD)

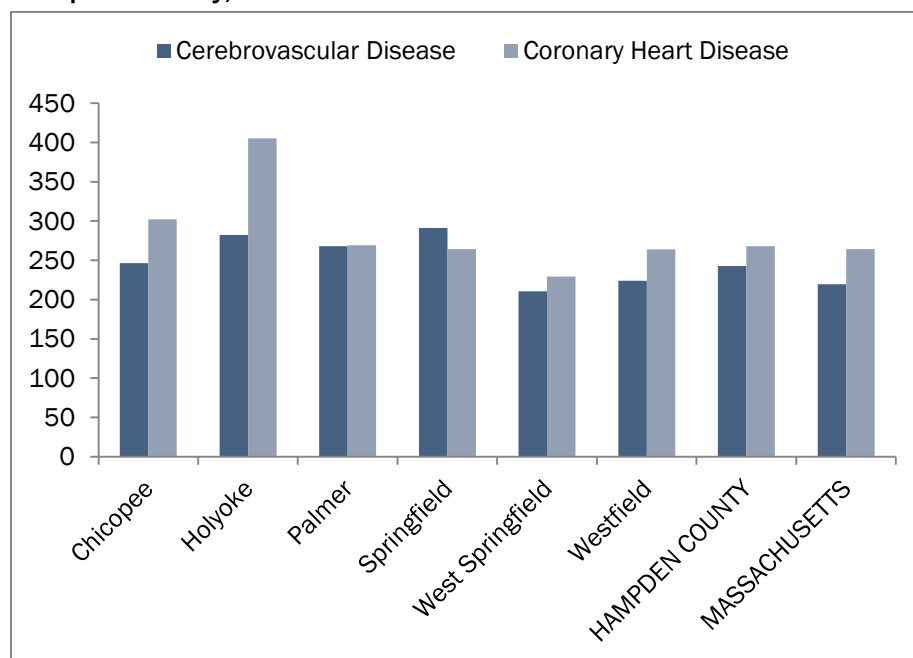
Cardiovascular disease (CVD) includes diseases that affect the heart and blood vessels, including coronary heart disease, angina (chest pain), heart attack (myocardial infarction), and stroke. Heart disease is the leading cause of death in Hampden County, along with cancer (MDPH, Massachusetts Deaths 2013). An estimated 7.9% of Hampden County residents have coronary heart disease, 5.1% have had a heart attack, and 3.4% have had a stroke (BRFSS 2012-2014). Rates for these conditions are comparable to those of the state with slightly higher rates of stroke among Hampden County residents (MA rate - 2.4%). Hampden County hospitalization rates for coronary heart disease were comparable to that of the state (268 vs. 264.5 in MA) and rates for stroke slightly higher than hospitalization rates statewide in 2012 (242.7 vs. 220.0 in MA). Rates of coronary heart hospitalizations were particularly high in Holyoke, with a rate 50% higher than that of the County (Figure 9).

Hypertension, or high blood pressure, and high cholesterol are conditions that increase risk for CVD and have a high prevalence in Hampden County. In 2011, an estimated 33.5% of adults in Hampden County had hypertension and 37.8% had high cholesterol (BRFSS).

### Vulnerable Populations

- **Older adults** experience higher rates of CVD. In Hampden County, an estimated 22.6% of Medicare enrollees 65 years and older had heart disease (23.7% for Massachusetts). More than half of Medicare enrollees had hypertension (61.8%) which is reflective of the high rates in the state overall (55.9%)(Medicare 2014, one-year estimate).
- **Latinos** had stroke and heart disease hospitalization rates 50-60% higher than Whites. **Blacks** also experience comparable disparities for stroke (MDPH, MassCHIP 2012).

Figure 9. Hospitalization Rates for Stroke and Coronary Heart Disease in Select Communities in Hampden County, 2012



Source: MDPH, MassCHIP; age-adjusted per 100,000

## Diabetes

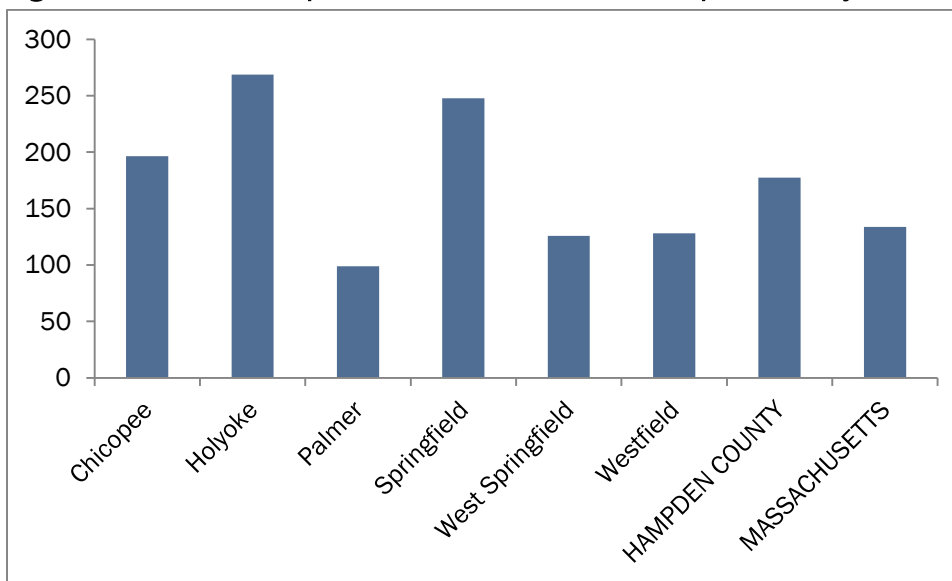
An estimated 13% of Hampden County residents have **diabetes**, which is greater than the state and national rate, and approximately one in five Hampden County residents has **pre-diabetes or diabetes** (BRFSS, 2010-2012). Diabetes (the vast majority of which is Type 2 diabetes [T2D]) is one of the leading causes of death and disability in the U.S. and is a strong risk factor for cardiovascular disease. The CDC estimates that 9.3% of people in the U.S. have diabetes, of which 27.8% are undiagnosed.<sup>12</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 T2D within 5 years. T2D can be prevented and managed with a combination of weight loss, exercise, medication, and maintaining a healthy diet.<sup>13</sup>

Diabetes hospitalization rates, which are a measure of severe morbidity due to diabetes, are 30% higher in Hampden County when compared to the state overall (Figure 10). Rates are highest among Holyoke and Springfield residents, who experience rates 40-50% greater than that of the county.

### Vulnerable Populations

- **Older adults** experience higher rates of diabetes with Medicare data indicating that an estimated 26.4% of Medicare enrollees age 66 and older in Hampden County have diabetes (Medicare 2014, one-year estimate).
- **Latinos and Blacks** experienced over 3 times the rates of diabetes hospitalizations compared to Whites in Hampden County and the statewide rate overall (MDPH, MassCHIP 2012). Rates among Latinos and Blacks were particularly high in Chicopee with rates 6 times higher than the statewide rate and 4 times higher than Whites in Chicopee. Rates were also high among Latinos and Blacks in Springfield and among Latinos in Holyoke.

Figure 10. Diabetes Hospitalization Rates in Select Hampden County Communities, 2012



Source: MDPH, MassCHIP; age-adjusted per 100,000



## Asthma

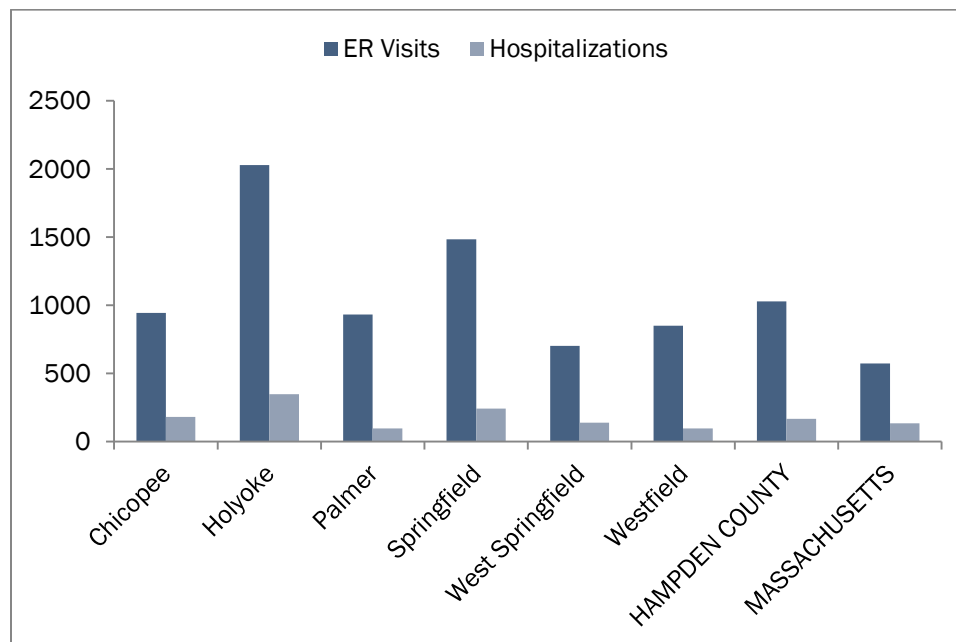
**Asthma** impacts many Hampden County residents with an estimated 12.1% of Hampden County adults (BRFSS 2008-2010) and 16.8% of Hampden County school children having asthma (12.4% statewide)(MDPH EPHT, 2013-2014). Asthma is a common chronic respiratory disease that affects the health and quality of 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, and mold, dust, and other household contaminants or exposures.

Hospitalization rates are 30% higher than that of the state and ER rates are almost double statewide rates (MDPH, MassCHIP 2012). Hospitalization and ER visit rates are highest among Springfield and Holyoke residents (Figure 11).

### Vulnerable Populations

- **Children and older adults** are vulnerable populations for asthma. As discussed above, childhood asthma prevalence rates are high in Hampden County. Though pediatric hospitalization (age 0-14) rates are slightly lower than that of the state (168.1 vs. 214.4 per 100,000), ER visit rates are almost double the rates statewide (1,662 vs. 881.6 per 100,000)(MDPH, MassCHIP 2012). Older adults in Springfield and Holyoke experience estimated asthma prevalence rates of 15%. Older adults in Hampden County experience slightly higher hospitalization (247 vs 210 per 100,000) and almost 50% higher rates of asthma ER visits (612 vs 419 per 100,000)(MDPH, Mass CHIP 2012).
- **Latinos** experience large asthma related disparities, with hospitalization rates 5 times that of Whites and 4 times that of the state hospitalization rate overall (MDPH, MassCHIP, 2012).

**Figure 11. Asthma ER Visit and Hospitalization Rates in Select Hampden County Communities, 2012**



Source: MDPH, MassCHIP; age-adjusted per 100,000



### *Need for Increased Physical Activity and Healthy Diet*

The need for increased physical activity and consumption of fresh fruits and vegetables was identified among Hampden County residents. Among Massachusetts residents in the CDC's BRFSS 2013 survey, only 9% of respondents met the vegetable consumption recommendation and 14% met the fruit consumption recommendations,<sup>14</sup> which are comparable to national rates. Only half of Hampden County adults (53%) met the guidelines for aerobic physical activity, and only about a quarter (21%) met the guidelines for both aerobic and muscle-strengthening activity,<sup>15</sup> which are also comparable to national rates. Community level access to affordable healthy food and safe places to be active (as described above), as well as individual knowledge and behaviors affect these rates.

The need for increased youth programming that encourages physical activity, among other program area needs, was cited by individuals across all focus groups and key informant interviews conducted for this CHNA. Multiple health care providers/administrators called for programs that can engage families in physical activity, more financial support for team sports, and after school programming that does not only focus on homework.

*“Mental health and substance abuse are overlapping - we should not look at them as separate”*

-Focus group participant

### *Mental Health and Substance Use*

Substance use and mental health were among the top three urgent health needs/problems impacting the area in interviews with local and regional public health officials and among local physician leaders at Mercy and in the Springfield community. Substance use disorders overall, and opioid use specifically, were identified as top issues. 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;
- More treatment options, including long term care;
- Increased integration between the treatment of mental health and substance use disorders;
- The impact of mental health conditions and substance abuse on families.

*“Waiting for a bed to open is ridiculous- when you have a heart attack or a stroke, you get care in the ER and then they help you with all sorts of after care and follow up; where is that with mental health and addiction treatment services?”*

- Focus group participant

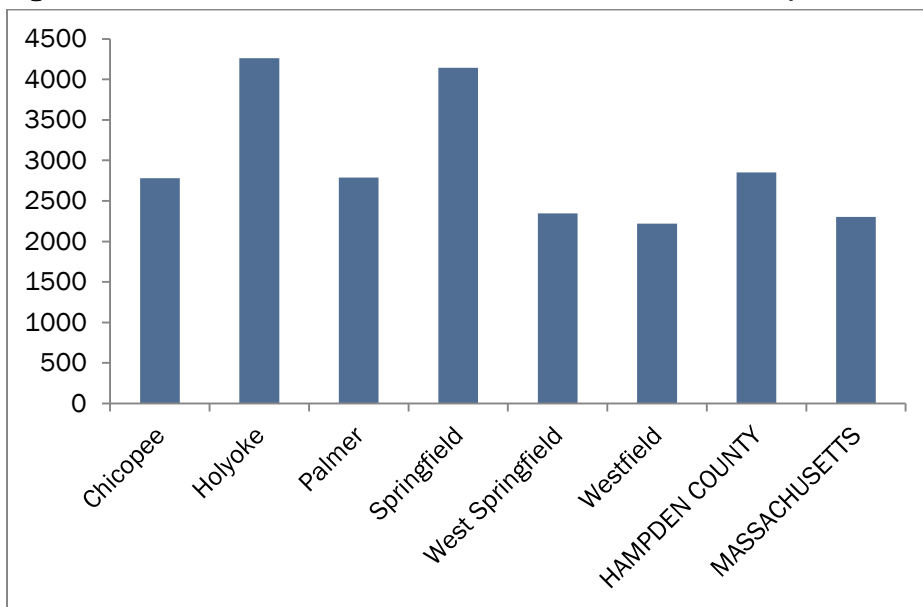
### **Mental Health**

An estimated 15.9% of Hampden County residents have poor mental health on 15 or more days in a month (11.1% statewide)(BRFSS 2012-2014). 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, and has been defined by the World Health Organization 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 17% of U.S adults are estimated to be “in a state of optimal mental health.”<sup>17</sup> Mental health is an indicator of health itself, but also contributes to physical health and inequities.

Depression is the most common type of mental illness, and it affects more than 26% of U.S adults.<sup>17</sup> It is estimated that by 2020, depression will be the 2<sup>nd</sup> leading cause of disability worldwide, and children are a particularly vulnerable population.<sup>17</sup> Mental illness often co-occurs with substance use disorders and impacts physical health as well. ER visit rates for mental disorders in Hampden County are 24% higher than that of the state with particularly high rates in Holyoke and Springfield (Figure 12).

**Figure 12. Mental Health Disorder ER Visit Rates in Select Hampden County Communities, 2012**



Source: MDPH, MassCHIP; age-adjusted per 100,000

### Vulnerable Populations

- **Youth** are disproportionately impacted with mental health issues. Data from the 2015 Springfield Youth Health Survey indicated that 34% of Springfield 8<sup>th</sup> graders “felt so sad or hopeless that they stopped doing their usual activities” (20% statewide).<sup>3</sup>
- **LGBTQ** youth are also disproportionately impacted with 56% of LGBTQ 10<sup>th</sup> and 12<sup>th</sup> grade students responding to the 2015 Springfield Youth Risk Behavior Survey reporting

*“The behavioral health and addiction treatment systems seem to be designed so that you have to fail over and over before you get what you really need”*  
- Focus group participant

feeling sad or hopeless two weeks or more and 23% reporting that they tried to commit suicide in the past year.

- **Latinos** experienced high hospitalization rates for mental disorders with rates 65% greater than Whites and over 40% greater than Hampden County rates overall.
- Information from an administrator at a Springfield-based federally qualified community health center suggests that **refugee** populations seeking treatment for depression seem to be a growing vulnerable population in the Springfield area.

### Substance Use

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

- An estimated 21% of Hampden County residents smoke *tobacco* as compared to 16% statewide (BRFSS 2012-2014).
- 15% of 8<sup>th</sup> graders in Springfield reported drinking *alcohol* in the last 30 days and 12% reported *marijuana* use (Springfield Youth Health Survey, 2015). In key informant interviews, health care providers noted marijuana use among youth as a rising concern as legalization is being considered in the state.

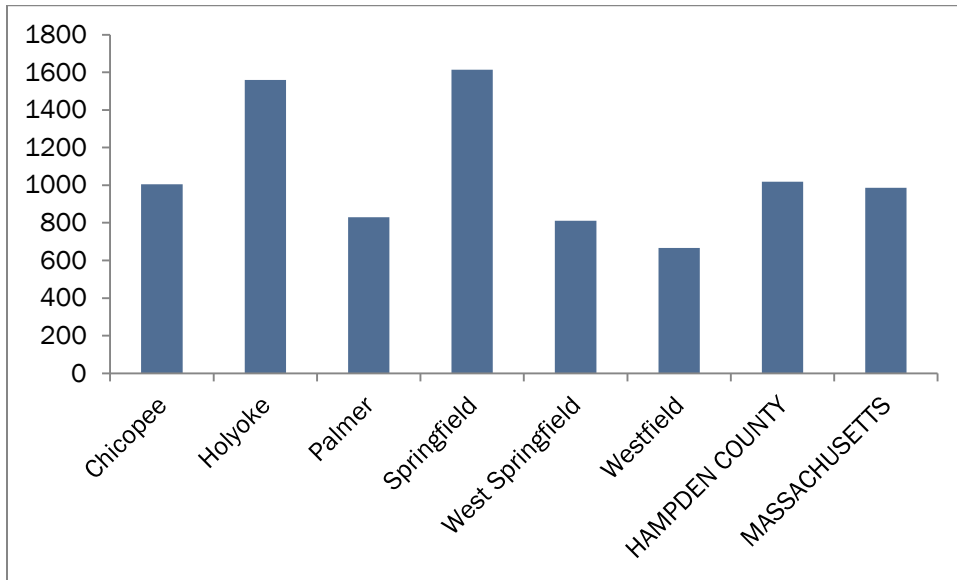
*“Kids are being raised by aunts, uncles, or grandparents because of parents’ drug use and mental health issues. This cycle continues unless it is nipped in the bud. We all need to start earlier.”*

- Focus group participant

**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.

- Substance use related ER visit and hospitalization rates (including alcohol) were among the highest ER visit and hospitalization rates of those examined for the 2016 CHNA. Substance use (including alcohol) emergency room visits in Hampden County are comparable to that of the state with rates in Springfield and Holyoke 50% higher than county rates (Figure 13).
- **Opioid use disorder** has rapidly emerged as a public health crisis in Massachusetts and across the country. Between 2002 and 2013 in the U.S, there has been a 286% increase in opioid-related deaths.<sup>18</sup> In Massachusetts alone, the number of opioid-related deaths in 2014 represents a 65% increase from 2012.<sup>19</sup>
- Opioid overdose fatalities in Hampden are higher than that of the state with 12.7 fatalities per 100,000 as compared to 10.7 statewide. This is despite lower opioid overdose hospitalization rates in Hampden County (79.4 vs. 103.9 per 100,000).<sup>20</sup> In Mercy Medical Center’s key informant interviews, health care providers and administrators identified the need for increased institutional support to promote harm reduction approaches, such as Narcan, to reduce morbidity and mortality that occur as a result of opioid overdose; more 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 13. Substance Use Disorder ER Visit Rates in Select Hampden County Communities, 2012



Source: MDPH, MassCHIP; age-adjusted per 100,000

#### Vulnerable 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 16% of 8<sup>th</sup> graders drink alcohol and 12% use marijuana in Springfield.
- **Latinos** experienced high substance use ER visit rates at a rate double that of Whites in Hampden County (MDPH, MassCHIP, 2012).

### *Infant and Perinatal Health Risk Factors*

Infant and perinatal health risk factors were identified as health needs in the 2013 CHNA and continue to impact Hampden County residents.

Preterm birth (<37 weeks gestation) and low birth weight (<2,500 grams) 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, as well as 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>21</sup>

*“I had tons of morning sickness. [My doctor’s office’s policies are] if you are more than 15 minutes late, you have to reschedule. They should have more common courtesy and be flexible.”*

*-Focus Group Participant*

In Hampden County, 9.4% of births were born **preterm birth** and 7.9% were born **low birth weight**. County preterm birth rates were slightly higher than those of the state (MA - 8.6%) and **low birth weight** rates were comparable to the state (MA -7.5%)(MDPH 2014).

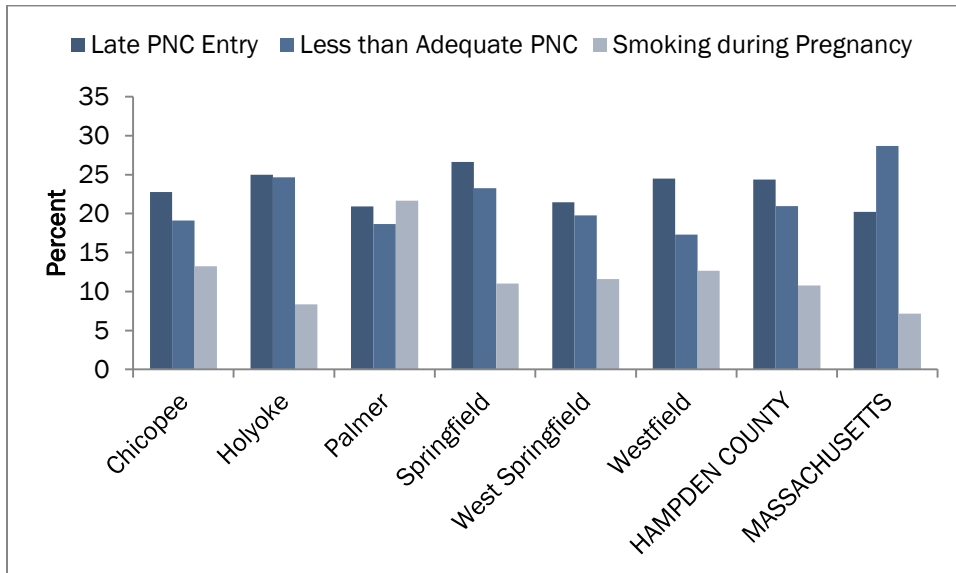
In Hampden County, an estimated 21% of women did not receive adequate **prenatal care** and 25% started prenatal care after their 1<sup>st</sup> trimester (Figure 14). Adequacy of prenatal care is based on whether a woman entered prenatal care early in pregnancy and number and timing of prenatal visits. Though rates are comparable to the state, they indicate a continued area of need (MDPH, MassCHIP, 2012). Another area of need is smoking during pregnancy with 10.8% of women reporting smoking during pregnancy among births to Hampden County residents (MDPH, MassCHIP, 2012).

*“Don’t forget the fathers.”*

*-Focus Group Participant*

Participants in focus groups conducted for the 2016 CHNA expressed a need for more the health care system to be more understanding about the challenges women experience managing their own care as well as the care of their families. Additionally, participants agreed on the need for support around stress and anxiety, particularly in the postpartum period; feelings of social isolation; and the need for increased parenting education and support for fathers.

**Figure 14. Percent of Women with Late Entry to Prenatal Care, Less Than Adequate Prenatal Care, or that Smoked During Pregnancy in Select Hampden County Communities, 2012**



Source: MDPH, MassCHIP; adequate prenatal care includes women that received adequate or adequate plus care  
 \*Late PNC entry is entry to prenatal care after the 1<sup>st</sup> trimester

### Sexual Health

High rates of STIs and teen pregnancy were identified as prioritized needs in the 2013 CHNA and continue to be elevated. **Unsafe sexual behavior** contributes to these high rates.

### Sexually Transmitted Infections

**Chlamydia** rates are elevated in Hampden County with rates 37% higher than the state (506 vs. 369 per 100,000). The highest rates were observed in Springfield (904), Holyoke (670), Chicopee (607), and Ludlow (578) (MDPH, 2014). Rates of **HIV** are also elevated, with rates of 441 per 100,000 in Hampden County vs. 315 per 100,000 statewide (CDC 2013).

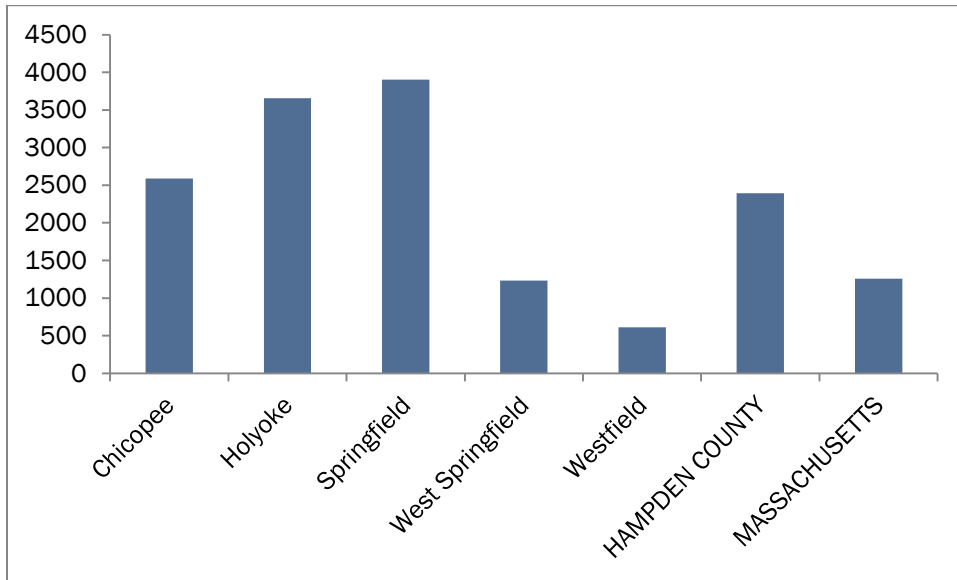
### Teen Pregnancy

Though collaborative community efforts have made great strides in lowering the teen pregnancy rates in Hampden County, the rates remain high in comparison to the state, with rates double that of the state (21.4 vs. 10.5 per 100,000).

### Vulnerable Populations

- Hampden County **youth** STI rates are high with rates of chlamydia and syphilis 2-4 times higher than that of the state (MDPH, MassCHIP, 2012)(Figure 15). Chlamydia rates are highest among Springfield and Holyoke youth.
- Teen pregnancy rates are particularly high among **Latinas** with rates of 65.5 per 100,000.

Figure 15. Chlamydia Rates Among Youth Age 15-19 in Select Hampden County Communities, 2012



Source: MDPH, MassCHIP

## IV. Vulnerable Populations of Concern

Available data indicate that **children and youth, older adults**, and some communities of color, particularly **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 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 disorder.

Data also indicated increased risk for poorer mental health among **LGBTQ** (lesbian, gay, bi-sexual, trans-sexual, queer) youth and **refugee** populations. However, available data was very limited and more data is needed to better understand inequities experienced by these populations.

Individuals with **low income** levels and those living in **poverty** are also disproportionately impacted by poor health. Though data was not available for health conditions by income/poverty level, these health determinants have been consistently documented with poorer health outcomes.



## V. Geographic Areas of Concern

Springfield and Holyoke had consistently higher rates for the majority of health conditions identified as prioritized health needs. These communities also disproportionately experience numerous social and economic challenges which contribute to the health inequities existing in these communities. In addition, as both of these communities are majority people of color, health disparities experienced by these communities contribute to the many racial and ethnic disparities observed in Hampden County.

## **Community & Hospital Resources to Address Identified Needs**

Community and hospital resources to address identified needs can be found in Appendix IV.

## **Input and Actions Taken on Previous CHNA**

### **Community input on previous 2013 CHNA and CHIP**

To solicit written input on Mercy's prior CHNA and Implementation Strategy, both documents are available on our hospital website (<http://www.mercycares.com/community-benefit>). They are posted for easy access along with a request for comments. The link on our website also includes our federal IRS 990 tax return and an overview of Community Benefits at Mercy. We have verified and confirmed that we have not received any written comments since posting the last CHNA and Implementation Strategy.

### **Impact of Actions Taken by Hospital Since Last Community Health Needs Assessment**

Community and hospital resources to address identified needs can be found in Appendix IV.

## Summary

The Mercy service area of Hampden County, MA continues to experience many of the same prioritized health needs identified in Mercy's 2013 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 disparities observed among vulnerable populations, which include children, older adults, Latinos, Blacks, LGBTQ youth, and refugees. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The Mercy 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 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. The opioid crisis has emerged as a top issue impacting the health of the community. Progress has been made to address some of the prioritized health needs previously identified, such as teen pregnancy and childhood obesity; however, rates remain high and work needs to be continued.

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## **Appendix I: Stakeholders Involved in CHNA Process**

**Steering Committee Members**

**Focus Group Participants**

**Key Informant Interviewees**



## Steering Committee Members

Name (Last, First)	Title	Organization	Organization Serving Broad Interests of Community	Organization Serving Low-Income, Minority, And Other Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
Allard, Andrea	President/CEO	YMCA of Westfield	X	X	
Amador, Ruth	President	National Association of Hispanic Nurses – Western MA Chapter	X	X	
Ayres, Jim	Executive Director	United Way of Hampshire County	X	X	
Barber, Tania	President/CEO	Caring Health Center	X	X	
Blanchette, Mary Ellen	Nurse Leader	Palmer Public Schools	X	X	
Caisse, Ed	C3/Safe Neighborhood Initiative – South Holyoke	Hampden County Sheriff's Dept.	X	X	
Christopolis, Dave	Executive Director	Hilltown CDC	X	X	
Garozzo, Salvatore	Executive Director	United Cerebral Palsy Assoc. of Berkshire County, Inc.	X	X	
Graves, Marie	Program Director	Springfield Dept. Health & Human Services	X		X
Koehn Rudder, Shannon	Executive Director	MotherWoman	X	X	
Lee, Jennifer	Systems Advocate for Change	Stavros Center for Independent Living	X	X	
Lewandowski, Sue	Representative for Worcester County	Assumption College	X	X	
Lopez, Luz	Springfield Organizer	Stand for Children	X	X	
McCafferty, Gerry	Director of Housing	City of Springfield, Office of Housing	X	X	
Prullage, Beth	Clinical Social Worker	Providence Behavioral Health		X	

Name (Last, First)	Title	Organization	Organization Serving Broad Interests of Community	Organization Serving Low-Income, Minority, And Other Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
Reeves, Halley	Community Health Planning and Engagement Specialist	MA Dept. of Public Health			X
Silverman, Risa	Coordinator, Office for Public Health Practice & Outreach	UMASS Amherst School of Public Health and Health Sciences	X	X	
Simmons, Tony	Community Liaison	Hampden County District Attorney's Office	X	X	
Simonds, Jane	Sr. Program Manager	Behavioral Health Network - Outpatient Services	X	X	
Walker, Phoebe	BFMC CBAC Co-chair	Franklin Regional Council of Governments (FRCOG)	X		X
Wilson, Gloria	Member	Western MA Black Nurses Association	X	X	
Wood, Ben	Healthy Community Design Coordinator	MA Dept. of Public Health			X

## Focus Group Participants

Findings from four focus groups conducted in Hampden County informed this CHNA. Each focus group had a specific topic, and participants represented a range of age, gender, and race/ethnicity. Focus groups included:

### *Mercy Medical Center, Mental Health and Substance Use*

- 13 participants
- Primarily female, white, between the ages of 51-60

### *Mercy Medical Center and Baystate Medical Center: Leaders from the Faith-Based Community*

- 11 participants
- Half male, half female
- Identified as white and Black

### *Baystate Medical Center: Maternal and Child Health*

- 7 participants
- All females between 21-30
- Identified as Black, Latina, and multi-racial

### *Holyoke Medical Center: Mental Health and Substance Use*

- 9 participants
- Primarily male, aged 51-60
- Identified as white, Latino, and Black

### *Springfield Shriners Hospital: Pediatric Disabilities*

- 10 participants
- 5 participants were Spanish speaking; a translator was provided
- Primarily females, all parents of children under the age of 18 with physical disabilities
- Identified as Latina, Black, and White

## Key Informant Interviewees

Name (Last, First)	Title	Organization	Organization Serving Broad Interests of Community	Organization Serving Low-Income, Minority, And Other Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Depart- ment Staff
<i>Mercy Medical Center</i>					
Balder M.D., Andrew	Director	Mason Square Neighborhood Health Center and Health Care for the Homeless	X	X	
Durkin M.D., Louis	Director, Emergency Medicine	Mercy Medical Center		X	
Roose M.D., Robert	Chief Medical Officer of Addiction Services Member	Sisters of Providence Health System Governor's Task Force on Opioid Abuse	X	X	
Russo-Appel M.D., Maria	Chief Medical Officer	Providence Behavioral Health Hospital (PBHH)		X	
<i>Public Health Personnel</i>					
Caulton- Harris, Helen	Commissioner of Public Health	City of Springfield	X		X
Dennis, Soloe	Western Region Director	Massachusetts Department of Public Health (MDPH)			X
Garcia, Luz Eneida	Care Coordinator	MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit			X
Hyry-Dermith, Dalila	Supervisor	MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit			X
Metcalf, Judy	Director	Quabbin Health District	X		X
O'Leary, Meredith	Director	Northampton Health Department	X		X
Steinbock, Lisa	Public Health Nurse	City of Chicopee	X	X	X
Walker, Phoebe	Director of Community Services	Franklin Regional Council of Governments (FRCOG)	X		X

Name (Last, First)	Title	Organization	Organization Serving Broad Interests of Community	Organization Serving Low-Income, Minority, And Other Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Depart- ment Staff
White, Lisa	Public Health Nurse	Franklin Regional Council of Governments (FRCOG)	X		X
<b><i>Baystate Medical Center</i></b>					
Benjamin M.D., Evan	Chief Quality Officer & Sr. VP, Quality & Population Health	Baystate Medical Center (BMC)		X	
Boos M.D., Stephen	Medical Director	Family Advocacy Ctr., Baystate Health	X	X	
Brewer, Joni Beck	Vice President, Parent Services	Square One	X	X	
Hettler M.D., Joeli	Chief	Pediatric Emergency Medicine, BMC		X	
Johnson, Yolanda	Executive Officer for Student Services	City of Springfield Public Schools		X	
Rathlev M.D, Neils	Chair	Emergency Medicine, BMC		X	
Shendell- Falik, Nancy	President and Senior VP, Hospital Operations	BMC		X	
<b><i>Holyoke Medical Center</i></b>					
Cavanaugh, Eva	Nursing Director, Emergency Department	Holyoke Medical Center		X	
O'Connor, Laura	Social Worker, Oncology	Holyoke Medical Center		X	
Perry, Melissa	Director of Behavioral Health	Holyoke Medical Center		X	
Roberts, Cherelyn	Director, Discharge Transitions	Holyoke Medical Center		X	

## **Appendix II: Focus Group and Key Informant Interview Summaries**

### **Focus Group Reports**

- Mental Health and Substance Use
- Maternal and Child Health
- Leaders from the Faith-Based Community
- Mental Health and Substance Use
- Pediatric Disabilities

### **Key Informant Interviews**

- Mercy Medical Center
- Public Health Personnel
- Baystate Medical Center
- Holyoke Medical Center

# Focus Group Report: Mental Health and Substance Use

**Participants:** Families of Consumers of Mental Health and Substance Use Treatment Services

**Primary Hospital/Insurer:** Mercy Medical Center

**Date:** February 11, 2016

## Executive Summary

### *Participant Demographics*

The 13 participants were family members (primarily the parents) of consumers of mental health and substance use treatment services; they were also members of the Holyoke *Learn to Cope* meeting held weekly at Providence Behavioral Health Hospital. Demographically, the participants were:

- 82% female
- 90% white
- 10% Asian
- 100% not Hispanic
- 10% were between the ages of 31-40
- 63% were between the ages 51-60
- 27% were over the age of 60

### *Areas of Consensus*

- Care is extremely fragmented; there needs to be better communications between primary care and behavioral health programs and services
- Stigma is applied to both the consumers/patients and their families members and is a tremendous barrier to accessing care and feeling welcome into systems of care; this stigma significantly adds to the stress faced by families in a complex and disjointed system of behavioral health care
- Physicians and the pharmaceutical industry should be held accountable for contributing to the opioid crisis and industry must make amends for their actions
- Widespread education and media campaigns to educate the public about addiction and mental health needs are essential to reduce the stigma associated with behavioral health issues



### Recommendations

- More staff training around the disease of addiction and mental illnesses and how behavior is affected by the disease process
- Treatment services need to be better matched to disease progression and take into account the chronic, progressive and relapsing characteristics of mental illness and substance use disorders
- Look at models like Mass General Hospital where they have an ARMS (Addiction recovery management Services) team that meets with families in the ED when young adults are seen for mental or substance use crisis needs
- More patient navigators and facilitators to help families navigate through the system, know more about levels of care and types of treatments and what is available for long-term support and recovery services
- More treatment services need to be longer and in much greater supply; we need significantly more in-patient beds and insurance must cover services for much longer periods of time
- Staff communications with patients and family need to be more consistent and frequent – staff need to return phone calls and have to engage in more mutual planning of treatment with patients and families

### Quotes

- “Addiction treatment needs to be longer, longer, longer; detox is not a treatment and it puts my child at risk for overdose”
- “We need to treat mental health and addiction just like we treat cancer or diabetes, it’s a chronic, progressive disease”
- “Why is it that when my mother has dementia I get all of this support and help and the ability to make decisions for her, but when my addicted son is not capable of making decisions based on his illness, I am told I can’t do that?”
- “We should not have to work so hard to get access to services for our loved ones, we need more navigators and supports to find out about and use services, this waiting for a bed to open is ridiculous - when you have a heart attack or a stroke, you get care in the ER and then they help you with all sorts of after care and follow-up; where is that with mental health and addiction treatment services? Why is that not as available to us?”
- “At the very least, I should be given adequate information about follow-up services and resources when my family member is in crisis and is in the ER”
- “Many of the staff and organizations that are treating mental illness and addictions are caring and want to help, but many also need significantly more training and understanding of the disease progression that is part of addiction; some staff should not be in the field at all”
- “The behavioral health and addiction treatment systems seem to be designed so that you have to fail over and over before you get what you really need”

## Key Issues

Question	Synthesis of Responses
<p><b>1. What has you/your family member's experience with the mental health care system been like?</b></p> <ul style="list-style-type: none"> <li>▪ What has worked well? Why?</li> <li>▪ What has not worked well? Why?</li> <li>▪ Can you share any positive experiences with the hospital's mental health care services? What about negative experiences?</li> </ul>	<ul style="list-style-type: none"> <li>▪ Care is episodic and fragmented</li> <li>▪ Section 35 rules are confusing and cumbersome</li> <li>▪ HIPPA can be a barrier to family engagement and support</li> <li>▪ More information should be provided in terms of resources, pamphlets, websites , etc. to family members to tap into after the crisis</li> <li>▪ Primary care and other doctors seem to know little about addiction and mental illness yet are treating patients for them</li> </ul>
<p><b>2. What are the most serious barriers or service gaps that have you/your family faced in accessing mental health care?</b></p>	<ul style="list-style-type: none"> <li>▪ lack of information about what the system and levels of care look like and how to enroll into hem</li> <li>▪ system that requires families to make the calls and pursue empty beds for treatment on a daily basis</li> <li>▪ lack of access to care locally when the family member is ready to engage in treatment</li> <li>▪ insurance coverage does not adequately pay for the lengths of stay need for MH and SA care</li> </ul>
<p><b>3. If you have used crisis services in the ER, what has your experience been like?</b></p>	<ul style="list-style-type: none"> <li>▪ ED care can be helpful to stabilize someone in crisis, but also lacks follow-up and continuity</li> <li>▪ EDs need to have more privacy and staff training in how to more appropriately work with patients with behavioral health needs</li> <li>▪ Overdose patients are released too soon after seeking ED care</li> </ul>
<p><b>4. When you think about how you currently connect to mental health services, what would make it easier or more helpful for you?</b></p>	<ul style="list-style-type: none"> <li>▪ More information about local supports earlier in the process and at the first time of a crisis</li> <li>▪ More availability of beds and services in the region</li> <li>▪ Staff need to return phone calls and be more engaged with patients and families</li> </ul>
<p><b>5. How does the integration of primary care and Mental Health care work for you or your family? What are the up-sides and down-sides of this?</b></p>	<ul style="list-style-type: none"> <li>▪ Many primary care providers are not well-versed in behavioral health needs and issues and the current standards of care, especially around pain management and risks of addiction</li> <li>▪ There is not enough screening for behavioral health needs and referral being done by primary care providers</li> </ul>

Question	Synthesis of Responses
<p><b>6. Are there some services available now but you cannot access them because of when or where they are offered? What are they and what are the barriers?</b></p>	<ul style="list-style-type: none"> <li>▪ Too few inpatient beds and supports for long-term recovery</li> <li>▪ Insurance is a barrier to enrolling into and sustaining certain types of care for the recommended length of time</li> </ul>
<p><b>7. What are the most pressing issues around access to care for detox, long-term treatment, criminalization, and stigma, especially in light of the emerging opioid use epidemic?</b></p>	<ul style="list-style-type: none"> <li>▪ Need many more options for longer term care and supports for stabilization after initial care</li> <li>▪ Need much more peer supports for ongoing care and treatment</li> <li>▪ Post-treatment needs for stable housing, employment, training, etc.</li> <li>▪ Need a massive education and public awareness campaign to address stigma</li> </ul>
<p><b>8. How much input do you have in setting the goals and priorities in your or your family member's treatment plan? How much input and choice do you have about which services you receive to help you meet those treatment plan goals and priorities?</b></p>	<ul style="list-style-type: none"> <li>▪ Participants feel that choices are severely limited by the short supply of treatment services and rigid eligibility criteria</li> <li>▪ Laws and regulations often prohibit family from being involved with the planning and decision-making for young adults in need of treatment</li> </ul>
<p><b>9. What would recovery look like for you/family member?</b></p>	<ul style="list-style-type: none"> <li>▪ Stable living situation with hope for employment, healthy family relationships and social connections</li> <li>▪ Supports are available for long-term recovery and self-management of illness</li> <li>▪ Well-managed symptoms and improved functionality</li> </ul>

# Focus Group Report: Maternal and Child Health

*Participants:* Mothers

*Primary Hospital/Insurer:* Baystate Medical Center

*Date:* March 7, 2016

## Executive Summary

### *Participant Demographics*

The 7 participants were recruited through informal networks primarily by CHNA Steering Committee members. Several worked or had previously worked in health related field.

- All participants were women who had at least one child.
- 6/7 were in the 21-30 age range.
- 4 identified as Hispanic/Latino; 3 as African-American; 2 as more than one race.

### *Areas of Consensus*

- Women face a variety of challenges in terms of managing medical care for themselves and their families, among many other responsibilities (work, child care, children's education, housing, etc.).
- Stress, anxiety, depression all make it difficult to make decisions, manage health care, and take care of oneself as a new parent.
- Appointment scheduling: women are consistently frustrated with challenges in scheduling timely appointments. They often have to wait for weeks to address immediate needs.
- Payment/cost frequently hinders access to care.
- Women rely on informal support systems (family and friends) for information, guidance, and shared resources. They would be very interested in health services that work with or build support systems among mothers.
- Many are interested in expanded supports and education for fathers, so they can be more effective and active in the parenting role.
- Many women feel that medical providers are working from a protocol, rather than tuning in to a specific woman's needs. They identify several instances where providers don't follow-up on issues or appropriately attend to patient concerns.

### *Recommendations*

- **Build (on) informal support systems:** women expressed an interest in accessing health care that has built into informal support systems (for example, a support group that is initiated early in prenatal care). They tend to share information through family members, who could potentially be recruited to help women access appropriate care.
- **Build formal support structures:** for example, include a patient advocate, social worker, or case manager early in prenatal care to support care coordination for mothers and their children. This role would check in with mothers on mental and physical health, barriers to accessing care, and other stressors and help women to navigate the various support systems.

- **Identify ways to make health care service delivery more patient-centric:**
  - Use accessible (non-technical) language; translate documents
  - Ease access to appointments: Recognize that pregnant and parenting women have many obstacles to getting to appointments on time. Increase flexibility to allow for short-term appointment scheduling and late arrivals for appointments.
  - Prior to any testing or treatment, provide relevant and accessible information; time for parents to process information, ask questions, and make decisions; and a clear consent process.
  - Immediately after delivery, women are engaged in intense physical recovery and emotions. Hospital staff should look at policies and practices to alleviate the pressure on mothers to make decisions and prepare for discharge.
  - Add some luxury services to help relieve stress (e.g., massage, manicure).
- **Coordination and Access:**
  - Provide multiple services under one roof: let women and children access health care appointments in one location.
  - Facilitate sharing of information among patients and their providers including, prenatal, postpartum, pediatricians, and specialists. For example, women are more likely to see their newborn's pediatrician over the first six months than their own ob/gyn. Consider how staff in pediatric offices could follow-up with mother's on mental and physical health issues.
- **Communication:** Use multiple methods of communication, and communicate information more than once. Follow-up with mothers before and after appointments.

### Quotes

- **Scheduling challenges:**
  - *"I tell them to call me as soon as they get an appointment. I harass them every day?"*
  - *"My daughter is always sick, so I need to be able to get in. I can't wait for a long time for an appointment."*
  - *"I had tons of morning sickness. [My doctor's office policies are] if you are more than 15 minutes late, you have to reschedule. They should have more common courtesy and be flexible."*
- **Provider sensitivity and communication:**
  - *"[hospital staff] see people having babies everyday; it's no big deal. They don't see it from a new mom's eyes."*
  - Providers need to talk in "regular English" – break it down; Moms "may not ask because they don't want to feel stupid."
- **Ease of access/ one-stop shopping:**
  - *"If there was one place we could go, we would get there."*

## Key Issues

Question	Synthesis of Responses
<b>1. Urgent health needs among pregnant and parenting women:</b>	<ul style="list-style-type: none"> <li>● Responsive prenatal care</li> <li>● Mental health: stress reduction, postpartum depression, anger mgmt</li> <li>● Follow-up medical/emotional care and supports after postpartum visit(s)</li> <li>● Diabetes management and follow-up</li> <li>● Providers to pay attention to women’s concerns and issues that arose in previous pregnancies</li> </ul>
<b>2. Other supports needed:</b>	<ul style="list-style-type: none"> <li>● Groups for parents of children with special needs (managing health and school issues)</li> <li>● Childcare</li> <li>● Individualized Educational Program (IEP) advocacy with schools</li> </ul>
<b>3. Barriers to accessing appropriate care:</b>	<ul style="list-style-type: none"> <li>● Difficult to schedule appts</li> <li>● Insurance; high cost of services; lack of money to cover co-pay</li> <li>● Provider-centric policies (e.g., scheduling, late arrivals) put women off</li> <li>● Mother’s feeling that providers are not listening or following-up on issues</li> <li>● Awareness of appropriate services</li> <li>● Transportation</li> <li>● Understanding all the information and making decisions (e.g., vaccine information given at birth)</li> <li>● Lack of knowledge/information regarding birthing classes</li> </ul>
<b>2. How did you find a health care provider (for PNC or Ped):</b>	<ul style="list-style-type: none"> <li>● Mother, sister</li> <li>● ER</li> <li>● Internet/google</li> <li>● Hospital (where gave birth) recommended pediatrician</li> <li>● MD/nurse recommendations</li> <li>● School referral for counselors</li> <li>● Early Intervention</li> <li>● Rick’s Place</li> <li>● Square One</li> </ul>
<b>3. Trusted sources of iformation:</b>	<ul style="list-style-type: none"> <li>● Pediatrician (but some don’t trust MD recommendation)</li> <li>● Family/Friends</li> <li>● WIC</li> <li>● Family/personal history with specific MD</li> <li>● Knowledge/reputation of area hospitals strengths and weaknesses for OB (e.g., liked Rlverbend/Mercy for PNC and likes patient portal; like Baystate for delivery because the NICU is there)</li> </ul>

Question	Synthesis of Responses
4. Ever had trouble finding a provider:	<ul style="list-style-type: none"> <li>● Yes, for mothers and for kids, particularly for mental health for moms, and special therapeutic services for kids</li> <li>● Helps to be connected through one provider: e.g., Square One</li> </ul>
5. What works about health care services you have received:	<ul style="list-style-type: none"> <li>● Convenient location: my OB was in the same place I worked</li> <li>● Had own transportation</li> <li>● Hours worked around work schedule</li> <li>● Doctor made me feel really comfortable</li> <li>● Meeting pediatrician in hospital (at delivery) and continuing to work with that MD</li> <li>● WIC is good at frequently reminding/checking-in with women about service options, decisions that need to be made</li> </ul>
6. Would you recommend to others?	<ul style="list-style-type: none"> <li>● “Absolutely”</li> <li>● Others will warn friends about providers they were dissatisfied with</li> </ul>
7. What didn't go well:	<ul style="list-style-type: none"> <li>● Scheduling appointments for routine and urgent care: <ul style="list-style-type: none"> <li>○ Difficult to get appointment quickly</li> <li>○ If need to re-schedule may have to wait for a long time</li> <li>○ Had to switch doctors because couldn't get an appointment</li> <li>○ Difficult to get through to scheduling</li> </ul> </li> <li>● Switching doctors</li> <li>● Unfriendly/insensitive nurses, doctors</li> <li>● Providers going through their “checklists,” but not paying attention to individual patient responses and needs; patient is treated as a diagnosis, not as a person</li> <li>● Payment challenges: <ul style="list-style-type: none"> <li>○ providers say we won't see you any more if you can't pay; one mother had to find a new provider for PNC, because she owed money to previous provider</li> <li>○ If supposed to bring co-pay at time of visit, often postpone appts</li> <li>○ Huge co-pays for labs, visits, and prescriptions</li> </ul> </li> <li>● Lack of information about procedures and options; <ul style="list-style-type: none"> <li>○ One mother reported routine drug, STD testing without information or consent</li> </ul> </li> </ul>



Question	Synthesis of Responses
<p><b>8.How could we do it better:</b></p>	<ul style="list-style-type: none"> <li>● Provide easy-to-read handouts with clear explanations of what patient can expect, and what lab work they are doing.</li> <li>● Flexibility in scheduling appointments – be more accessible on short notice. Follow-up promptly on needed appointments.</li> <li>● Recognize the demands and challenges for moms – if they are late for an appoint, figure out how to accommodate</li> <li>● Be more sensitive to patient perspective and needs; speak in easy-to-understand language (avoid technical jargon)</li> <li>● Home visits for PNC and post-partum</li> <li>● Attention to individual woman’s issues and follow-up (e.g., don’t just ask once how the mom is feeling postpartum; ask again in a week or a month; pay attention to stressors). <ul style="list-style-type: none"> <li>○ Assign a counselor or therapist that really pays attention to mom’s status and needs</li> </ul> </li> <li>● Moms need someone to talk to; providers or other supports services need to find time to listen and talk</li> <li>● Cover mom’s post-partum health and baby visits at the same time</li> <li>● Don’t do treatment, tests, or even little things (e.g., pacifier) without getting consent</li> <li>● Skype call (“mobile doctor”) so you can get quick access to a MD</li> <li>● Group visits: appealed to many; create support group early in pregnancy. Women who can share information and ideas with each other. Perhaps they can have medical visits at the same time.</li> <li>● Includes supports for fathers and families; family counseling to help manage stress and help new parents work together.</li> <li>● Should have all services together in one place!! <ul style="list-style-type: none"> <li>○ Services are set up at convenience of doctors and hospitals; patients/women are not at the center of the service design</li> </ul> </li> <li>● Let mom rest for the hours after delivery; <i>“don’t rush us out and try to cram everything in”</i></li> <li>● Pregnant/postpartum: women are feeling “fat and ugly” and tired. Provide “feel good” services: e.g., manicure, massage, hair cut</li> </ul>
<p><b>9.What prenatal services did you not receive that you wish you had:</b></p>	<ul style="list-style-type: none"> <li>● Education, support resources for fathers</li> </ul>

Question	Synthesis of Responses
<p><b>10. What advice would you give your friend or sister about prenatal care:</b></p>	<ul style="list-style-type: none"> <li>• Go to the birthing classes</li> <li>• Request frequent reminders about different service options, decisions they will need to make</li> <li>• Get ongoing support for nursing</li> <li>• Get more information for after the baby is born: what to expect from baby and what you can expect (e.g., hair loss)</li> </ul>
<p><b>11. WHEN YOU WERE PREGNANT, what was the most helpful advice/information you received:</b></p>	<ul style="list-style-type: none"> <li>• MD said: “just relax”; relax and be calm; one day at a time</li> <li>• Nothing: <i>“I’m pregnant now, and I can’t think of one helpful thing that anyone has told me”</i></li> </ul>
<p><b>12. Where did you turn for information about <u>pregnancy</u>:</b></p> <p><b>Where did you turn for information about <u>parenting</u>:</b></p>	<ul style="list-style-type: none"> <li>• Mom, sisters, sister-in-law</li> <li>• Internet</li> <li>• Nurses</li> <li>• No one</li> <li>• Family, mother-in-law</li> <li>• Early Intervention “helps more than doctors offices” <ul style="list-style-type: none"> <li>○ EI came to house to evaluate child and helped get them the stuff she needed for her child (braces, shoes)</li> </ul> </li> <li>• DCF sponsored parenting class</li> </ul>
<p><b>13. How do you prefer to get information:</b></p> <p><b>Information challenges:</b></p>	<ul style="list-style-type: none"> <li>• Text messages and emails</li> <li>• Mail - hard copies</li> <li>• Needs to be translated</li> <li>• In person</li> <li>• Want test results whether they are normal or abnormal.</li> <li>• Patient portal – can see all your results</li> <li>• Online videos: yes interested, but how are you going to know what’s out there</li> <li>• Davis Foundation: has texting campaign to let people know about things going on in Springfield</li> <li>• Baystate Pediatrics is very helpful</li> <li>• Can’t always make it to everything and then you miss out on information, <ul style="list-style-type: none"> <li>○ Often don’t find out about things until after it’s over (e.g., free shoes and hair cut for your kids)</li> </ul> </li> <li>• Phone calls: often too rushed; don’t get complete information</li> <li>• Need more coordination among different providers, so getting same information from everyone</li> </ul>

Question	Synthesis of Responses
<p><b>14. How many different doctor's offices do you have between yourself and your children:</b></p>	<ul style="list-style-type: none"> <li>• Some just have one doctor (pediatrician)</li> <li>• Several said 3</li> <li>• Ranged up to 5, including primary care/gyn, pediatrician, therapists, and specialists</li> <li>• Others included ER as one of their providers</li> <li>• Most have to go to multiple buildings or practices for parents and children</li> <li>• Get different information from different providers: "crazy"; huge waste of time and money</li> </ul>
<p><b>15. Are you able to use the same practice for prenatal and postpartum:</b></p>	<ul style="list-style-type: none"> <li>• Many "yes",</li> </ul>
<p><b>16. How do you navigate multiple providers:</b></p>	<ul style="list-style-type: none"> <li>• Good calendar systems</li> <li>• Moms as navigator for family</li> <li>• Reminder calls are really helpful</li> <li>• Patient care coordinator – they were going to get the patients calendars and help patient follow-up on appointments</li> </ul>
<p><b>17. Things that you need to have to take care of a baby or children:</b></p>	<ul style="list-style-type: none"> <li>• Money: <i>"this is what gets you access to everything else"</i></li> <li>• Shelter/housing</li> <li>• Support system</li> <li>• Information</li> <li>• Patience</li> <li>• Milk/formula – when you first come out of the hospital; food</li> <li>• Clothing</li> <li>• Support group for sharing resources (e.g., knowledge and needed resources, e.g., formula)</li> <li>• Transportation to get to appointments</li> <li>• Free services</li> <li>• Timely appointment (ease of access to medical appointments)</li> <li>• Need help addressing the multiple challenges: education, job, child care</li> <li>• Supportive employers– <i>"really really hard to go back to work after you've had a baby"</i> <ul style="list-style-type: none"> <li>○ Employee assistance program</li> </ul> </li> <li>• Car seats</li> <li>• Father support/education</li> <li>• Child care</li> </ul>

Question	Synthesis of Responses
<p><b>18. Which have you had difficulty obtaining:</b></p>	<ul style="list-style-type: none"> <li>• Milk/formula</li> <li>• Child care</li> <li>• Education</li> <li>• Resources for fathers</li> <li>• Father groups/supports</li> <li>• Father education</li> <li>• Fathers don't know what it entails to take care of a baby/family</li> <li>• They need to be educated on how to support mom</li> <li>• Lack of access to support system</li> <li>• Timely appointments: <ul style="list-style-type: none"> <li>○ E.g., son having a reaction to a medication, and they say wait for 3 weeks for an appointment</li> <li>○ Don't schedule time-sensitive appointments 1-2 weeks out</li> </ul> </li> <li>• Information on short-term decisions/things to do for your baby (e.g., circumcision)</li> </ul>
<p><b>19. Challenges with housing while pregnant or parenting:</b></p> <p><b>Could health care providers help with housing?</b></p>	<ul style="list-style-type: none"> <li>• YES! And know many other moms</li> <li>• Some live with mother, other family members</li> <li>• Unforeseen circumstances, out of their control, can change stability quickly: <i>"How do you relax when you don't know where you are going to live"</i></li> <li>• Have a newborn in far below acceptable housing is very stressful (e.g., with rodents)</li> <li>• Could have someone helping with all social services -- make sure all essential supports are in place</li> <li>• How do they help people who aren't eligible for services? <ul style="list-style-type: none"> <li>○ Services aren't there if you are in the upper low-income range: <i>"they want you to give up your car, take the bus, and then you are late for appointments ..."</i></li> </ul> </li> </ul>
<p><b>20. Last thoughts:</b></p>	<ul style="list-style-type: none"> <li>• Interest in awareness/support groups for various issues: sickle-cell, pain management, IEP needs and advocacy, sharing material goods</li> <li>• <i>"Don't forget the fathers."</i></li> <li>• Provide postpartum mental health supports</li> <li>• Build and build on support systems!</li> <li>• Provide "really lovely" treatment for stressed moms (e.g., massage)</li> </ul>

# Focus Group Report: Leaders from the Faith-Based Community

*Participants:* Faith Based Leaders

*Primary Hospital/Insurer:* Baystate Medical Center and Mercy Medical Center

*Date:* February 29, 2016

## Executive Summary

### *Participant Demographics*

The focus group included 11 faith-based leaders from Hampden County, including Springfield, Holyoke, and several other towns. A small number specifically referenced their work with low-income or homeless populations. Several reflected primarily on the needs of working or middle class and older populations. The group included:

- 6 women and 5 men
- 9 White and 2 African-American participants

### *Areas of Consensus*

- Faith leaders are clearly interested in enhanced communication and coordination with hospital staff. Several agreed they want to be able to count on communication from the hospital when congregants are hospitalized or need community supports. They see personal outreach from hospital chaplain's office as an effective way to build relationships and bridges. Several would facilitate health outreach and education efforts aimed at their parishioners/community.
- There was general consensus about the breadth of substance use and addiction problems affecting diverse populations. The opioid crisis is appearing in all communities. All noted that drug use is prevalent among youth, and many pointed to alcohol addiction in older populations. Some are particularly concerned with the dual challenges of homelessness and addiction. All agreed on the need for enhanced short and long term treatment options for those with and without insurance.
- Many pointed to the widespread need for greater health literacy; access to information about wellness, health promotion, diseases, and service options. Several said they would work with the hospital to organize community events promoting wellness, at which health care providers could provide education, information, and referral services.
- For many consumers, navigating and advocating within the health care system is a major challenge. Many consumers simply don't know where to go or how to access certain services. Particularly those with multiple issues--several mentioned increasingly complex health concerns faced by seniors--have trouble finding providers and coordinating among multiple providers, treatments, and medications.
- Faith leaders identified a number of issues affecting health equity. These include: financial status, noting that MassHealth doesn't offer the same quality and access to services as private insurance and that those above the MassHealth threshold face greater challenges in

accessing care; cultural insensitivity among providers; education and cultural background affecting patient advocacy skills; and stigma relative to certain populations (those who use drugs, ex-offenders, homeless, mentally ill, e.g.).

### Recommendations

- Hospitals are well-positioned to collaborate with churches on outreach and education. This process needs to respect community stakeholders as equal partners who have essential knowledge about community needs and engagement. Church leaders would welcome hospital representatives to provide education on specific health issues and to offer community-based health services at church organized events. Collaboration with parish nursing programs could benefit health providers and faith communities by enhancing or expanding health education and screening opportunities for congregants. However, only a few of the churches have such programs or other informal health care educators (e.g., retired health professionals).
- One particular area to address is coordination of care and managing transitions for seniors. Hospitals could consider expanding on municipal senior service programs to reach a broader swath of the elderly. Collaboration between churches and hospital services could promote effective communication with the seniors and family members and help get community supports in place as seniors require an expanded array of services.
- Faith leaders often find themselves ill-informed or lack the time to help congregants with health advocacy and navigation. They suggested that health care providers could help to train church representatives on service availability, resources, and advocacy skills, so that these lay leaders could support congregants in accessing appropriate care. Hospital and faith leaders could work together to identify other ways to create a “health care clearinghouse.”
- This focus group provided a forum that faith leaders were excited to participate in. They welcomed the opportunity to come together to share ideas and challenges. Baystate and Mercy should consider opportunities to follow-up with these participants and those from other faith communities. Personal outreach and relationships will offer a foundation for creating a stronger network of health system and faith community leaders working together to address community health issues.

### Quotes

- **Substance use:**
  - *“Immensity of [opioid use] overwhelms me.”*
  - *“Especially when dealing with drug addiction, a parishioner’s depression when not well managed can lead to drug abuse. Insurance may be done but his health needs are far from done. People need ongoing care to stay clean.”*
- **Health literacy and access to information:**
  - *“In general people need a little more education. And easy access [to information on health care options], [it’s] available on websites, but to find an answer to an exact*

*question is very difficult for people. They don't use official sources, word of mouth, sometimes it is not the real useful information."*

- *"People need services and don't know to ask for them, don't know they exist, don't know who to ask."*
- **Coordination of care:** *"[A big problem is ] parishioners that have many medications and many doctors. Miss the days one doctor was looking at all of it."*
- **Collaboration between hospitals and communities/churches:**
  - *"How do you collaborate with community with integrity? ... Agencies from health care go to organizations with credibility, credibility means we [community stakeholders] have to have say."*
  - *"Relationship building that would benefit populations that we serve: [hospitals] could serve the target populations far better than they do [through] outreach and collaboration."*
- **Navigation and advocacy:**
  - *"Sometimes we are the only rational person in the room, have to broker a lot of deals. [We could use] local formal training. We know the people and they know us."*
  - *"One minute I'm a pastor, the next I'm navigating their care. They are looking at their doctor like what are they talking about."*
  - *"When these things happen, people are in crisis. [It's] hard to navigate, make [the needed] phone calls."*
- **Health care coverage:**
  - [This is] *"a moral issue! When did healthcare become for profit, immoral to me."*

## Key Issues

Question	Synthesis of Responses
<p><b>1. Emergent and/or urgent health issues: what issues are facing your community/ congregation?</b></p>	<ul style="list-style-type: none"> <li>● Opioid crisis (in all types of communities).</li> <li>● Drug use among youth.</li> <li>● Alcoholism among older populations.</li> <li>● Chronic health issues: heart disease, diabetes, obesity; even more extensive in minority communities</li> <li>● Autism</li> <li>● Health care coverage: people losing coverage when they change jobs</li> <li>● Domestic violence</li> <li>● Dementia and Alzheimer's</li> <li>● Teen pregnancy</li> <li>● Homelessness prevents access to health care</li> <li>● Health care literacy: congregants unaware of insurance and service availability, questions to ask doctor, the information that they receive from physician, navigation through health care system</li> </ul>
<p><b>2. Availability of services: what types of health care services are working well?</b></p>	<p>Participants identified several strengths in the health care delivery system, including:</p> <ul style="list-style-type: none"> <li>● Holyoke Med Ctr emergency facility</li> <li>● Clinics -- particularly those that offer multiple services in one site</li> <li>● Maternity services at BMC and Mercy</li> <li>● Urgent care clinics</li> <li>● Electronic records: improving coordination of care and information sharing among providers</li> <li>● Community/church-based refugee supports to help connect immigrants to health services</li> <li>● Health services/education provided in church/shelter settings</li> </ul>



Question	Synthesis of Responses
<p><b>3. Priority needs for more/enhanced services?</b></p>	<ul style="list-style-type: none"> <li>● Opioid crisis/substance use: overdose recovery, treatment beds, longer-term interventions</li> <li>● Homeless supports in conjunction with substance use services</li> <li>● Insurance – access to coverage for all income levels; MassHealth and other supports leave out lower middle class</li> <li>● Chronic disease screenings (easily accessible)</li> <li>● Wellness promotion, including community education and easy access to information and supports.</li> <li>● Mental health services, particularly tied to substance use</li> <li>● Homeless shelters</li> <li>● Elder care: assistance with managing health access and life transitions associated with aging, including supports for the senior and for families.</li> <li>● Improved health information communication (to promote health literacy, knowledge of services, and access to care). E.g., “Ohio Benefit Bank”: web-based individual health profiles that identify appropriate services and provide information on access. Another person suggested creating a web-based health care clearinghouse.</li> <li>● Coordination of care across providers. Management of multiple medications and complex health issues. Medications and dementia symptoms.</li> <li>● Advocacy: many consumers are not skilled or knowledgeable to advocate for themselves with insurers and providers, particularly in times of health crisis. Church leaders find themselves in this role, but also don’t have the knowledge or time. Some suggested they would like to see health providers offering this consumer service.</li> </ul>

Question	Synthesis of Responses
<p><b>4. How do faith communities address health care?</b></p>	<ul style="list-style-type: none"> <li>● Meal program for homeless and impoverished: community nurses work with congregants: they speak with individuals and can intervene as case manager, provide HIV screening and counseling.</li> <li>● Mental health orgs know they can find clients at the church, particularly when meals are being served.</li> <li>● Informal health care expertise shared among congregants; e.g., retired nurses or other medical personnel help to guide other congregants. Some provide health education (wellness and prevention theme) at events.</li> <li>● A few of the churches have parish nursing programs, in which retired and active nurses provide education: column in monthly church bulletin, health education, act in a clearinghouse role, help parishioners understand specific diagnoses and questions they need to ask their doctor.</li> <li>● Pastoral counseling/caregiving: church officials, deacons, and lay people check in at congregants' homes, hospitals, nursing homes, hospice; keep congregants connected and ministers informed; provide informal supports: meals, company, transportation; support individuals and families through age-related transitions.</li> <li>● Community events: invite health care organizations to provide information/education, screenings, wellness programs</li> <li>● Occasional groups or events: e.g., exercise class, flu clinic, walking group</li> </ul>

Question	Synthesis of Responses
<p><b>5. What types of health inequities do you see in your community?</b></p>	<ul style="list-style-type: none"> <li>● Most agreed that health equity is a <i>“huge problem.”</i></li> <li>● Described equity as <i>“Making sure that people have access to the same kind of quality of care, [that is] sensitive to cultural and other aspects.”</i></li> <li>● Inequities caused by: <ul style="list-style-type: none"> <li>○ <i>“Not profitable”</i> for hospitals to serve some populations, those with significant health challenges</li> <li>○ Insurance coverage and reimbursement affect medical provider's decisions</li> <li>○ Refugees vs. immigrants (refugees have better access to coverage)</li> <li>○ Racial injustice; implicit racism; cultural insensitivity (medical providers need to be trained)</li> <li>○ Economic status: those just above the MassHealth level not having coverage; MDs not taking MassHealth patients; MassHealth and private insurers have different coverage</li> <li>○ Education and class: those with more education and wealth are better able to access and navigate complex systems</li> <li>○ Culture: some traditions/styles less comfortable challenging medical authority or advocating</li> <li>○ Age: challenge to keep up with health status changes and health care options</li> <li>○ Stigma around mental health, substance use “junkie”, ex-offenders, homeless</li> </ul> </li> </ul>
<p><b>6. What public policies and practices are getting in the way of health care?</b></p>	<ul style="list-style-type: none"> <li>● Insurance policies and practices are a huge impediment to health. Some people don't have any coverage. For others, coverage, rather than doctors recommendation, determines service availability.</li> <li>● Emergency room practices: patients need advocates</li> <li>● Cost of medications</li> </ul>

Question	Synthesis of Responses
<p><b>7. How can hospitals work more effectively with church groups?</b></p>	<ul style="list-style-type: none"> <li>● Networking with faith communities: let them know what you can offer. Hospitals can use faith communities to “market” services, to let consumers know about health issues and available services.</li> <li>● Invite active community participation in designing and planning services, providing community education (e.g., Sister Talk with women in churches).</li> <li>● Offer training for church representatives so that they can be a resource for congregants. Create cohort of health outreach and education workers, advocates, and “navigators” through church communities. Most ministers don’t have time to be the primary liaison and health educator for the parish. Hospitals could work with churches to identify lay health leaders.</li> <li>● Hospital Chaplains office could actively engage in ongoing outreach to a broad base of church leaders. Personal outreach and individual relationships would help build bridges and trust between hospitals and faith leaders.</li> <li>● Continue to bring together clergy (like this focus group) with health care representatives to identify shared opportunities and resources. Engage clergy as community advocates.</li> <li>● Ensure hospital patients are invited to provide church/minister contact, so the church can be informed when congregant is hospitalized. Create information sharing protocols so that hospital pastoral counselors can update ministers.</li> <li>● Provide more neighborhood/community-based health clinics/services.</li> <li>● Culturally sensitive services in ER and other hospital-based programs.</li> </ul>

# Focus Group Report: Mental Health and Substance Use

**Participants:** Service Providers and Public School Leaders

**Primary Hospital/Insurer:** Holyoke Medical Center (HMC)

**Date:** February 18, 2016

## Executive Summary

### *Participant Demographics*

The 9 participants were service providers and leaders from the local public schools; Hampden County Sheriff's Department/corrections; Massachusetts Department of Public Health; Holyoke Community College; Homework House; Behavioral Health Network; Holyoke Health Center and Holyoke Medical Center. Demographically, the participants were:

- 63% male; 37% female
- 87% white
- 13% African-American
- 0% Asian
- 87% not Hispanic
- 13% Hispanic
- 13% were between the ages of 31-40
- 25% were between the ages of 41-50
- 50% were between the ages 51-60
- 13% were over the age of 60

### *Areas of Consensus*

- The recent increase in opioid abuse is a major health issue, but the drug trade and negative impact of substance use and addiction on the Holyoke community is not necessarily anything new.
- There is still a widespread need for more bilingual services, providers and educational materials that are written in accessible ways with attention to low-literacy rates in both English and Spanish; need to look at materials and online resources written at a 3<sup>rd</sup> grade level.
- Trauma, intergenerational substance use, gang violence, and mental health issues are closely tied together and result in significant need for mental health and substance use disorder treatment services; there is a lack of adolescent psychiatric and shelter services; substance use prevention, intervention and mental health support services must start at much younger ages.
- The HMC service area still faces a significant percentage of community members who are not insured; there is a significant homeless population or families “doubling up” and that has a huge impact on young children and school age youth.
- Holyoke is a small enough community that with leadership and enough collaboration, we could go after money on a larger scale; with a significant amount of funding, could do something like the Harlem Children’s Zone which includes intensive wraparound services for

children and families. The Flats, South Holyoke - these neighborhoods are small enough to make a huge impact on education, jobs, and resources for the parents.

### Recommendations

- We need to focus on our collaborations more. There are a variety of networks and partnerships in Holyoke, but they are not talking to each other. Around issues of drug and alcohol dependence, the Hospital could work with and convene other entities, in order to continue this type of collective 'big picture' dialogue and problem-solving. The Hospital can play a leadership role to bring people together. We can then advocate for more services in the schools and community, and strategize on ways to better address underlying social-economic issues that impact health. A strong collaborative network would be important.
- There is a need for more mental health counselors in the schools and community; we need to find a way to collaborate with school nurses and work toward creating a better and more standardized referral process for behavioral health services in the community
- We need to look more closely at the LGBTQ+ community's health needs, as this population may need more support, but may currently get the least.

### Quotes

- "Kids are being raised by aunts, uncles, grandparents or other relatives because of parents' drug use and mental health issues. This cycle continues unless it is nipped in the bud. We all need to start earlier."
- "We can't talk about this (the opioid abuse crisis) without mentioning big pharma; they are pushing opioids, now they push drugs for opioid-induced constipation. One of our doctors works here and in Greece; in Greece, they don't prescribe opioids, just Tylenol. Here, everyone gets opioids. Drugs are pushed in the U.S."
- "My instincts are that there is more of a stigma around behavioral health and mental health than substance abuse. We have gotten numb to addiction issues."
- "The heroin trade is not new in Holyoke. In 1999, the drug trade in Holyoke was estimated at \$50 million annually. We have always dealt with families that are gang involved, involved with drug abuse."

## Key Issues

Question	Synthesis of Responses
<p><b>1. What are the 3 most urgent health needs/problems in your service area?</b></p>	<ul style="list-style-type: none"> <li>• opioid abuse; (opiates are a problem, but also substance abuse in general; with marijuana seen as legalized, there has been an increase in marijuana smoking and use in youth)</li> <li>• obesity</li> <li>• asthma</li> <li>• mental health issues, especially among children</li> </ul>
<p><b>2. What specific vulnerable populations are you most concerned about? And why?</b></p>	<ul style="list-style-type: none"> <li>• Youth ages 15-25 , because of the availability of drugs;</li> <li>• alcohol use starting with younger kids; age 10+ as shown by alcohol drinking on the school bus, coming to school drunk and what incarcerated persons tell us about their use of drugs at very young ages</li> </ul>
<p><b>3. 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>• Lack of transportation.</li> <li>• Language; there is need for more bilingual capacity in services and educational materials</li> <li>• Kids who are inappropriately medicated is a big issue; too many kids are suffering from trauma and not being treated.</li> <li>• Lack of insurance; people think everyone has insurance, but if you live under a bridge, you do not have insurance.</li> </ul>
<p><b>4. What are the major needs, service gaps or barriers 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>	<ul style="list-style-type: none"> <li>• Need to allocate funds to organizations working with schools and the hospital around improving crisis and emergency care</li> <li>• Kids don't get the follow-up care they need once they're in the system. For example, a child whose mom or dad is in the criminal justice system, or kids go into foster care, they go off the radar completely and are disconnected from care.</li> <li>• There are no placement options for children after crisis care; lack of emergency youth shelters, even temporary ones.</li> <li>• If a student is homeless, there is no place to take them after the crisis; they can easily get disconnected from school, and other services.</li> </ul>

Question	Synthesis of Responses
<p><b>5. What about long-term mental health and substance use care needs? What are the needs for such services? Who is most vulnerable when those services are not available?</b></p>	<ul style="list-style-type: none"> <li>• Geriatric patients are lacking placement options. Nursing homes don't take behavioral patients outside of small dementia units. With Medicaid/ Mass Health, some nursing homes don't accept these because of payment issues.</li> <li>• LGBTQ - this population needs the most and gets the least.</li> <li>• At Holyoke Community College, there is a growing population of students facing issues of homelessness, bullying and behavioral health needs. In the LGBTQ student group, there is concern about bullying, discrimination; levels of stress are very high.</li> </ul>
<p><b>6. What are other needs or trends in opioid addiction in this area and what impact does that have on providers and services?</b></p>	<ul style="list-style-type: none"> <li>• Holyoke Health Center has been proactive in educating staff about opioid overdose prevention. Staff members are trained in the use of Narcan; they have Narcan kits and information in English and Spanish. What is not working as well is that people are still afraid to talk about it.</li> <li>• There is a lot of education going on right now to train providers in safer prescribing.</li> <li>• MDPH working with medical schools in MA on teaching doctors about opioid overuse.</li> <li>• Overdose deaths have been significant in past year and this is waking up people. All of a sudden, wealthy children are dying and this is opening up minds and resulting in more media attention</li> <li>• There's also a problem with social acceptability of drug use. People have in their minds that marijuana use is OK.</li> </ul>
<p><b>7. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</b></p>	<ul style="list-style-type: none"> <li>• We need more sports, things to do, to keep youth involved, have conversations. Get to know kids, families. Not just sports, also arts, music, crafts, computers.</li> <li>• We have the Youth Task Force and it got money from SAMHSA, but not in that kind of coordinated, big-picture way. We need more capacity than any small organization can manage. Coalitions are doing a great job, but coalitions come, make an impact, move on; we need more permanence.</li> <li>• Universal Pre-K is a huge need in a community like Holyoke; the sooner kids are in the system, the better they will be. Starting earlier, we can identify issues before they become big problems. By the time they start school, it's harder to address them.</li> </ul>



Question	Synthesis of Responses
<p><b>8. What do you think community leaders think about the philosophy of harm reduction for addiction including the use of Narcan and needle exchange?</b></p>	<ul style="list-style-type: none"> <li>• No clear consensus about it, depends how you define community. There is more acceptance in some communities than others.</li> <li>• The majority believes that harm reduction is the way to go, but strong vocal minority (45%) don't think it's right. In some sense, it's all political noise. The real data need to come from health organizations.</li> <li>• In looking at first responders (police and fire departments), do they have Narcan, and are they willing to administer it? In departments within the HMC service area, some do, some don't.</li> <li>• HCC has Narcan and some public schools have it. We need to advocate for all schools to have it and for it to be accessible.</li> <li>• There should be a bigger effort to educate about Narcan.</li> </ul>
<p><b>9. How would you recommend that your local hospitals/insurers and the Western Massachusetts Hospital Coalition work in closer partnership with local and regional municipal public health entities and other community partners after the CHNA is completed? What specific ways can such partnerships be supported and sustained?</b></p>	<ul style="list-style-type: none"> <li>• There are limited resources. Organizations must collaborate with others to seek out best practices, find a way to solve the problem. There are a lot of programs, but limited resources, need to develop a mindset of working together. The MA DPH can assist as possible.</li> <li>• There is a lot of collaboration already going on. We need to cultivate more positive influences on young people. Need supports like Homework House, different after school programs; connections to mentors and more mentor volunteers;</li> <li>• Need to include higher education as it is critical to process. There is currently a disconnect between academia and community groups. Holyoke Community College is in the process of developing an office to engage higher education around opioids and other health needs so that we can write grants, help solve problems.</li> </ul>

# Focus Group Report: Pediatric Disabilities

**Participants:** Parents of children with disabilities

**Primary Hospital/Insurer:** Springfield Shriners Hospital

**Date:** February 3, 2016

## Executive Summary

This focus group consisted of parents of children who participate in the Be Fit program at Shriners, an exercise program for children with orthopaedic medical needs. Participants in the focus group were very positive about Shriners and about the services that they receive there. They also believe that they have adequate access to specialized medical care for their children, although some reported going to Boston to obtain services.

The biggest issue for many of the parents was the lack of support that they receive from the public schools where their children are enrolled. Parents spoke of children not receiving services despite demonstrated need, and the difficulty in advocating for their children within the bureaucracy of the school system. This was the primary area in which they expressed a need for more support from Shriners. They also said that while they appreciate Be Fit and similar programs, they would like to have more frequent opportunities for specialized physical activity for their children.

### **Participant Demographics**

Ten individuals participated in the focus group: seven women and three men. Five participants were Latina, four were white, and one was African-American. Shriners provided a translator for the five participants whose primary language was Spanish. Participants represented a range of ages, but all were parents of children under age 18.

### **Areas of Consensus**

Participants generally believed they had good access to specialized medical care for their children, at Shriners and at other area hospitals. They also all appreciated the Be Fit and other exercise programs that Shriners and other organizations (such as the YMCA) offer to them, although they were eager to find out about additional similar opportunities.

Many participants reported struggling with the public schools in which their children were enrolled. The children usually are in substantially separate programs and are isolated from the mainstream of the school. Schools sometimes do not provide the services that the children need in order to succeed. At times, the focus group became more of a support group for parents as they shared resources and tips among themselves.

### **Recommendations**

Parents of children with disabilities need a great deal of information about the resources that are available to their children, and how best to advocate for their needs. Over the course of the focus group it became clear that the needs of this community are not around medical interventions, which are available through Shriners and the many other hospitals in the area. What they really need is a way to access and share information about the opportunities and resources around school issues and extracurricular activities. Some suggestions for how Shriners and/or WMHC could provide this are:

- A meeting space and translation services for parents to meet regularly, preferably during a time when they are already at Shriners for existing programs such as Be Fit.

- A centralized list of resources available in the community to children with disabilities. Ideally, this would be available in both physical and electronic forms, such as a bulletin board, a website, an e-mail listserv, and/or handouts.
- Information, in simple language, about the legal obligations of public schools with regard to children with disabilities, and connections to resources to help parents advocate for their children.

Parents also would like to see more extensive opportunities for physical activity for their children. They would like Shriners to offer the Be Fit program more weeks of the year, and more than once per week. Some were also seeking more intensive physical exercise, and/or for opportunities in their own communities. If Shriners is not able to meet this need in-house, perhaps the hospital could research other opportunities in the area and provide this information to families.

## Key Issues

Question	Synthesis of Responses
<p><b>1. Tell me about the types of access issues your family/child is facing. What types of health care needs or mobility issues are involved?</b></p>	<ul style="list-style-type: none"> <li>● Child is nonverbal; occupational and physical therapy were cancelled at school.</li> <li>● Child needs sensory building skills; the public school does not recognize the need for this.</li> <li>● Child is legally blind and needs adaptive school services - looking for help with finding services through school.</li> <li>● Looking for information and help around nutrition and how to teach this to a young child</li> <li>● Some families have run out of the insurance-allotted number of sessions for services and cannot continue.</li> <li>● Big issues are around insurance coverage and school resources.</li> </ul>
<p><b>2. Where do you receive help obtaining specialty medical services (Shriners, other organizations, other hospitals)? Which organizations do you access for services? What services do you access?</b></p>	<p>Most reported receiving medical services at Shriners or at other area hospitals. One parent mentioned the muscular dystrophy clinic as providing services. Another reported seeing an endocrine specialist outside of Shriners. Some areas of need reported were:</p> <ul style="list-style-type: none"> <li>● Access to a nutritionist</li> <li>● Evaluation (for a young child) that would show how therapists and teachers can help the child</li> <li>● Needed to go to Boston for neuropsychology, neurosurgery</li> </ul>
<p><b>3. What are some of the barriers you face in obtaining access to the types of specialty medical services that your child needs? (awareness, availability/waitlists, insurance/cost, travel, etc.)</b></p>	<p>Insurance coverage was noted as a barrier, and sometimes parents found it necessary to travel in order to access a high level of care. But in general, access to specialty services was not perceived as a problem by this group.</p>

Question	Synthesis of Responses
<p><b>4. Where do you receive help with your child’s access to physical activity opportunities (Shriners, other organizations, other hospitals)? Which organizations do you access for services?</b></p>	<p>Participants mentioned:</p> <ul style="list-style-type: none"> <li>● The Be Fit program</li> <li>● An adaptive swimming program</li> <li>● An exercise program at school</li> <li>● East Longmeadow has a summer camp that is accessible to special needs students</li> <li>● Sled hockey at CHD - they also have other programs for individuals with special needs</li> </ul>
<p><b>5. What do you need to help your child gain greater access to physical activity opportunities, that you currently lack access to (at Shriners or in the area)? What is not offered here in western MA?</b></p>	<p>Areas of help needed and barriers cited included:</p> <ul style="list-style-type: none"> <li>● Need to travel to get to Shriners - 30 minutes each way, traffic can be a problem</li> <li>● Children don’t want to participate in available programs</li> <li>● More intensive physical therapy (beyond Be Fit) is needed</li> <li>● Need Be Fit to be longer duration (full-year program) and/or more frequent (more than once per week)</li> <li>● Children don’t want to be odd ones out in traditional classes, even if they have adaptations</li> <li>● Need more outreach programs</li> <li>● Lack of transportation to programs outside of Shriners</li> </ul>
<p><b>6. What are some of the barriers you or your child face in obtaining access to physical activity opportunities? (equipment, accessibility, awareness, availability/waitlists, insurance/cost, travel, etc.)</b></p>	
<p><b>7. Do you have ideas for other ways that Shriners or other hospitals could be helpful to you around access to physical activity opportunities? If so, what are they?</b></p>	<p>Participants would like to see:</p> <ul style="list-style-type: none"> <li>● Satellite programs in different communities</li> <li>● Bring programs to the families, rather than families come to them</li> <li>● Transportation to opportunities for physical activity (CHD programs)</li> </ul>

Question	Synthesis of Responses
<p><b>8. We also have questions about your child’s integration at their school. Do you feel your child is fully included in their school community?</b></p>	<p>Participants generally believe their child is not integrated into their school community. There was also a general consensus that students are not receiving the opportunities they need in the schools. Specific observations included:</p> <ul style="list-style-type: none"> <li>● Schools have limited ability to provide access to students with special needs</li> <li>● Structured adaptive physical education in the school setting is almost non-existent - schools try to lump special needs students into traditional physical education programs</li> <li>● Students are expected to adapt to the school rather than the school adapting to them</li> <li>● Some children are completely separate from the mainstream school population - no opportunity to integrate</li> <li>● Not sure if bullying is an issue - students in their teens are less likely to talk to their parents about this.</li> <li>● Perception is that there is not active bullying, but exclusion and passive bullying. Students won’t interact with special needs students.</li> </ul>
<p><b>9. Have you received help advocating with the school for your child’s inclusion from Shriners or from other organizations? If so, who has helped you and what has this looked like?</b></p>	<p>Most parents reported that they haven’t received help from anyone concerning issues in the schools. There has been help from the schools with transporting children to therapy.</p>
<p><b>10. Is there a need for more education/advocacy around how well schools integrate your child and other children facing health challenges? Do you have suggestions about this?</b></p>	<p>Parents suggested that there needs to be more assistance and education within the school systems as to how to integrate children with special needs into the school setting - not just in terms of academic achievement, but also socially. Parents have tried to advocate for this, but they feel that the schools are not listening to them. They would like someone else to help advocate on their behalf with schools.</p> <p>Several parents reported that they have filled out all the appropriate paperwork to get their children what they need, but the schools have not taken action on beginning this work. They wondered if Shriners could help them find advocates who would go into the schools and push for getting these programs started.</p>

Question	Synthesis of Responses
<p><b>11. Speaking generally, and thinking back over our discussion so far, what is the most important service you need for your child?</b></p>	<p>The most important service cited by various parents included:</p> <ul style="list-style-type: none"> <li>● More opportunities for physical therapy and physical activity</li> <li>● A nutritionist and evaluation for child</li> <li>● More motivation and physical activity for children (child has not been to necessary therapy in a year because “plan” ran out)</li> <li>● Help getting child into a smaller class</li> <li>● More assistance in education settings (getting access to sensory therapy)</li> <li>● More intense &amp; motivational physical therapy (one on one therapy??)</li> <li>● Occupational therapy (in general) <ul style="list-style-type: none"> <li>○ School therapist cancelled the child’s services because “he learned as much as he could”, same happened with the school’s physical therapist</li> <li>○ Parent asked for speech therapy from Shriners but was told it wouldn’t be available through their facilities. She brought the child to another location for physical therapy, but couldn’t find anyone to provide occupational therapy.</li> </ul> </li> </ul>
<p><b>12. What local policies and social conditions predispose people in your community/service area to good health and mental wellness? Are there groups of people who benefit from these policies/social conditions more than others?</b></p>	<p>All respondents agreed that the region provides excellent health services, but many talked about the difficulty some populations have in accessing them. Lack of transportation is a major issue for some groups of people throughout the service area.</p> <p>Respondents from Hampden county had difficulty naming local policies and service conditions other than health care institutions that promote health and wellness. One mentioned Mass Health as expanding access to most people. In Franklin and Hampshire counties, respondents named access to fresh local food, compliance policies around tobacco and alcohol, town-based programs such as senior centers, Mass in Motion, public transportation, and access to mental health providers as predisposing people toward good health.</p>

Question	Synthesis of Responses
<p><b>13. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</b></p>	<p>Again, the most frequently mentioned issue is lack of transportation. Other changes that would help improve inequities included:</p> <ul style="list-style-type: none"> <li>● Help families understand what resources are available to them</li> <li>● Follow through beyond initial outreach</li> <li>● Workforce development</li> <li>● Affordable/improved housing</li> <li>● Continuity of care around addiction treatment</li> <li>● Healthy markets</li> <li>● Workplace wellness programs</li> <li>● Education around harm associated with marijuana</li> <li>● Coordination of care/avoiding readmission</li> </ul>
<p><b>14. What are the 3 most urgent health needs/problems in your service area?</b></p>	<p>This list shows the issues named and the number of people who named each one:</p> <ul style="list-style-type: none"> <li>● Substance abuse/addiction/treatment (5)</li> <li>● Mental health (3)</li> <li>● Poverty (2)</li> <li>● Communicable diseases (2)</li> <li>● Obesity (1)</li> <li>● Diabetes (1)</li> <li>● Teen pregnancy (1)</li> <li>● Lack of prevention services in schools (1)</li> <li>● Smoking (1)</li> <li>● Lack of youth engagement (1)</li> <li>● Perception of city as drug-friendly (1)</li> <li>● Chronic diseases (1)</li> <li>● Need to improve workforce development in health care (1)</li> </ul>
<p><b>15. What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area? What evidence/data do you have to illustrate this increase?</b></p>	<p>Every respondent mentioned substance abuse as an emerging issue, with four specifically referencing opioids. Other issues, each noted by one respondent, were:</p> <ul style="list-style-type: none"> <li>● Mental health</li> <li>● Pertussis</li> <li>● Lyme disease</li> <li>● Obesity</li> <li>● Sexually transmitted diseases</li> </ul>
<p><b>16. What gaps in services exist in addressing these needs? What are barriers to filling these gaps?</b></p>	<p>Some respondents spoke of gaps around connecting people with services - the services exist, but people are not aware of them or unable to reach them because of barriers including lack of transportation, waiting lists, cultural and language differences between the community and providers, and lack of information about what is available.</p> <p>Other gaps included lack of services for substance abuse, the lack of coordination among agencies doing similar work, lack of comprehensive prevention work in some schools, lack of mental health providers, lack of access to exercise and healthy food. Barriers cited included lack of funds, lack of time for coordination and planning, and lack of consensus in the community about the importance of the issues.</p>



Question	Synthesis of Responses
<p><b>17. In addition to more funding, what resources do you need to better address these emerging or increasing health concerns?</b></p>	<p>Several respondents mentioned the need for increased coordination and communication among hospitals concerning the services that are available and what is needed (one person noted that the CHNA is a good start). Other needed resources that respondent noted were:</p> <ul style="list-style-type: none"> <li>● Support for families as they navigate the healthcare system</li> <li>● Better transportation, either public or provided by hospitals</li> <li>● Better-trained, more diverse health care staff</li> </ul>
<p><b>18. What specific vulnerable populations are you most concerned about? And why?</b></p>	<p>Three respondents mentioned the elderly, and two each mentioned mentally ill people, homeless people, and low-income people. Reasons given usually addressed these populations' lack of access to services that meet their needs. These are populations which are less able to advocate for themselves and find help.</p>
<p><b>19. Externally, what resources or services do you wish people in your area had access to?</b></p>	<p>These responses varied, but three respondents mentioned better transportation options. Other resources and services mentioned included:</p> <ul style="list-style-type: none"> <li>● Mental health care</li> <li>● Better care coordination</li> <li>● More workforce development</li> <li>● Partnerships or services around improving air quality (high asthma rates)</li> <li>● More money for community outreach</li> <li>● Universal child care/after school care</li> <li>● Support groups and behavioral interventions</li> <li>● Access to healthy food</li> </ul>



Question	Synthesis of Responses
<p><b>20. How would you recommend that your local hospitals/insurers and/or Western Massachusetts Hospital Coalition 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>Respondents often did not have a clear idea of what this could look like. Two respondents addressed community benefit programs and expressed an interest in or questions about how these programs relate to coalition-building, particularly with regard to hospitals acquired by Baystate. Both said it was unclear what these programs look like in their communities.</p> <p>One respondent spoke of the need for greater coordination among and also within hospitals, including sharing information on individual patients (within the hospital) and letting people know what is available in the community. Hospitals could also work together to identify and fill local service gaps.</p> <p>Some specific suggestions included involving hospitals in community discussions around:</p> <ul style="list-style-type: none"> <li>● where people who been treated for overdoses can go after release from the hospital</li> <li>● reducing re-admissions</li> <li>● workplace health screenings</li> </ul> <p>Ideas around sustaining and supporting this collaboration included:</p> <ul style="list-style-type: none"> <li>● Regular meetings</li> <li>● Open forums to discuss issues and problems</li> <li>● Discussion of what resources are available</li> <li>● Funds are available as part of capitation - hospitals are changing the kind of work that they do, supporting efforts to keep people out of hospitals</li> <li>● Developing a common vision for improving health</li> <li>● Making it an ongoing effort with partners who are engaged with the process</li> </ul>
<p><b>21. Is there anything else you would like to share?</b></p>	<p>Only one person took the opportunity to add to the conversation. She suggested that more efforts need to be placed on prevention programs, and suggested that hospitals partner with the YMCA or other organizations to offer vacation and afterschool programs for youth. This would motivate young people to exercise and also keep them out of trouble.</p>

# Key Informant Interviews Report: Mercy Medical Center

## Dates

February 9 - March 1, 2016

## Interview Format

Phone interviews, approximately 1 hour in length.

## Participants

- Dr. Andrew Balder; Director of the Mason Square Neighborhood Health Center and Health Care for the Homeless
- Dr. Maria Russo-Appel; Chief Medical Officer of Providence Behavioral Health Hospital (PBHH)
- Dr. Robert Roose; Chief Medical Officer of Addiction Services for the Sisters of Providence Health System and member of the Governor’s Task Force on Opioid Abuse
- Dr. Louis Durkin; Director of Emergency Medicine at Mercy Medical Center

Question	Synthesis of Responses
<p><b>1. What are the 3 most urgent health needs/problems in your service area?</b></p>	<ul style="list-style-type: none"> <li>• addiction, especially opioid addiction in relation to pain management issues</li> <li>• untreated mental health needs such as depression and anxiety</li> <li>• overlay of poverty, poor housing, lack of 'living wage' employment and other social determinants of health that contribute to poor health</li> </ul>
<p><b>2. What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area? What evidence/data do you have to illustrate this increase?</b></p>	<ul style="list-style-type: none"> <li>• the opioid abuse crisis has shed more light on underlying fragmented systems of care and the mechanisms to pay for it</li> <li>• lack of access to care for substance abuse treatment is now more pressing with increased demand</li> <li>• ‘silos’ of care where co-location of services is not true integration</li> <li>• lack of beds for longer-term treatment options for mental health and addictions</li> </ul>
<p><b>3. What specific vulnerable populations are you most concerned about? And why?</b></p>	<ul style="list-style-type: none"> <li>• Elders with co-morbid mental health and medical care needs</li> <li>• Homeless person and families</li> <li>• Homeless alcoholic and addicted patients</li> <li>• Young parents with limited resources</li> <li>• “Working poor” who do not have health insurance, can’t afford self-pay; in most cases, self-pay means no pay</li> </ul>

Question	Synthesis of Responses
<p>4. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</p>	<ul style="list-style-type: none"> <li>• need to significantly improve housing stock and options for affordable housing</li> <li>• need employment at living wages</li> <li>• need better and more accessible transportation</li> <li>• medical care that is not "silo'd" based on condition or payer</li> <li>• overcome underlying racism and other discrimination</li> <li>• eliminate the prior approval process for an in-patient MH or SA bed</li> </ul>
<p>5. What are the most serious gaps and needs for Mental Health (MH) services?</p>	<ul style="list-style-type: none"> <li>• need longer-term behavioral health care at the community level working in collaboration and as part of a truly integrated medical care team</li> <li>• lack of adequate in-patient and out-patient mental health and substance use care services drives people to use the Emergency department</li> <li>• lack of psychiatrists on the region; (also a national level problem)</li> </ul>
<p>6. What about long-term Mental Health care? What are those needs and who is most vulnerable?</p>	<ul style="list-style-type: none"> <li>• need more sober living and long-term care options for people in recovery from addictions</li> <li>• fragmented care is nothing new but it is most problematic for mental health patients whose cognition and executive functioning are compromised by the disease</li> </ul>
<p>7. What are the needs for bilingual Mental Health care capacity, especially psychiatrists?</p>	<ul style="list-style-type: none"> <li>• systems can often adequately address needs for bilingual services and translation with frontline staff and patient navigators, but recruiting bilingual mental health clinicians and psychiatrists is a huge challenge</li> </ul>
<p>8. What are the most pressing issues around access to care for detox, long-term treatment, criminalization, and stigma, especially in light of growing opioid abuse?</p>	<ul style="list-style-type: none"> <li>• lack of access to beds in timely fashion</li> <li>• detox is not a treatment</li> <li>• lack of resources drive people to use ED for pathway into the system</li> <li>• not enough long-term SA care resources as part of comprehensive systems of recovery</li> <li>• many still believe that addiction is a volitional choice</li> </ul>
<p>9. What about substance use disorder prevention? What is needed and what is working?</p>	<ul style="list-style-type: none"> <li>• more evidence- based programs in schools at much earlier ages</li> <li>• more training for prescribers and medical care professionals in training</li> <li>• media campaigns to broadly educate the public and work to reduce stigma and shame associated with substance use</li> </ul>
<p>10. What do you think community leaders think about the philosophy of harm reduction for addiction including Narcan and needle exchange?</p>	<ul style="list-style-type: none"> <li>• medical care professionals have seen the value of harm reduction for quite some time, but community leaders and officials have been less quick to adopt;</li> <li>• the opioid crisis may spur action on harm reduction approaches such as needle exchange and "safe rooms" for users to prevent overdose</li> </ul>
<p>11. How does the integration of primary care and MH care</p>	<ul style="list-style-type: none"> <li>• it must be deeper integration with shared access to EHRs and other practical aspects where the team is fully</li> </ul>

Question	Synthesis of Responses
(with primary care providers prescribing psych meds) work for providers? What are the up-sides and down-sides of this?	<p>functioning together;</p> <ul style="list-style-type: none"> <li>• co-location is not integration and the paradigm of what constitutes full integration must shift to be shared system of care for all complements and phases of treatment</li> <li>• should be seamless to patients</li> <li>• integrating primary care with behavioral health provides for a more holistic approach</li> </ul>
12. Where do you think the uninsured ‘pockets’ of patients are – the patients that don’t show up in overall stats about how the percentage of insured populations is near 100%?	<ul style="list-style-type: none"> <li>• Geriatric patients who are “Medicaid Pending” are not being placed in long-term care facilities; there can be a wait for up to 3 months and up to 10 years for out-of state patients</li> <li>• Some insured patients are not able to comply with communications for renewing submitting paperwork/forms and then lose insurance coverage; suffer from recurring gaps in health insurance coverage</li> </ul>
13. How would you recommend that your local hospitals/insurers and the Western Massachusetts Hospital Coalition 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?	<ul style="list-style-type: none"> <li>• more data sharing across in-house departments and across hospitals and community providers throughout the region</li> <li>• more frequent case conferences about ‘high utilizer’ patients who are seen in EDs in region</li> <li>• need more collaboration and information-sharing about ways to serve new ethnic/cultural communities that are growing in Western Mass</li> <li>• collaboration and advocacy on larger social issues that impact health such as economic development; child-rearing supports; life cycle planning for individuals and communities; environmental justice issues</li> </ul>

**Quotes:**

- “Mental health and substance use are overlapping; we should not look at them as separate”
- “I see us being 3 generations into addiction with heroin – how do we get grandma into treatment and stop parents from giving drugs to their children to begin to break the intergenerational cycle?”
- “We need relationships with new communities and their health beliefs and ways to adapt our systems for mutual understanding about their cultures”
- “I want hospitals and other community partners to support an environment where our patients can be the healthiest family possible”

# Key Informant Interview Report: Public Health Personnel

## Dates

January 2nd - February 1st, 2016

## Interview Format

Phone interviews, approximately 45 minutes in length.

## Participants

- Helen Caulton Harris, Commissioner of Public Health, City of Springfield
- Soloe Dennis, Western Region Director, Massachusetts Department of Public Health (MDPH)
- Dalila Hyry-Dermith, Supervisor, and Luz Eneida Garcia, Care Coordinator, MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit
- Judy Metcalf, Director, Quabbin Health District
- Merridith O’Leary, Director, Northampton Health Department
- Lisa Steinbock, Public Health Nurse, City of Chicopee
- Phoebe Walker, Director of Community Services, and Lisa White, Public Health Nurse, 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? Are there groups of people who benefit from these policies/social conditions more than others?</b></p>	<p>All respondents agreed that the region provides excellent health services, but many talked about the difficulty some populations have in accessing them. Lack of transportation is a major issue for some groups of people throughout the service area.</p> <p>Respondents from Hampden county had difficulty naming local policies and service conditions other than health care institutions that promote health and wellness. One mentioned Mass Health as expanding access to most people. In Franklin and Hampshire counties, respondents named access to fresh local food, compliance policies around tobacco and alcohol, town-based programs such as senior centers, Mass in Motion, public transportation, and access to mental health providers as predisposing people toward good health.</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>Again, the most frequently mentioned issue is lack of transportation. Other changes that would help improve inequities included:</p> <ul style="list-style-type: none"> <li>● Help families understand what resources are available to them</li> <li>● Follow through beyond initial outreach</li> <li>● Workforce development</li> <li>● Affordable/improved housing</li> <li>● Continuity of care around addiction treatment</li> <li>● Healthy markets</li> <li>● Workplace wellness programs</li> <li>● Education around harm associated with marijuana</li> <li>● Coordination of care/avoiding readmission</li> </ul>

Question	Synthesis of Responses
<p><b>3. What are the 3 most urgent health needs/problems in your service area?</b></p>	<p>This list shows the issues named and the number of people who named each one:</p> <ul style="list-style-type: none"> <li>● Substance abuse/addiction/treatment (5)</li> <li>● Mental health (3)</li> <li>● Poverty (2)</li> <li>● Communicable diseases (2)</li> <li>● Obesity (1)</li> <li>● Diabetes (1)</li> <li>● Teen pregnancy (1)</li> <li>● Lack of prevention services in schools (1)</li> <li>● Smoking (1)</li> <li>● Lack of youth engagement (1)</li> <li>● Perception of city as drug-friendly (1)</li> <li>● Chronic diseases (1)</li> <li>● Need to improve workforce development in health care (1)</li> </ul>
<p><b>4. What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area? What evidence/data do you have to illustrate this increase?</b></p>	<p>Every respondent mentioned substance abuse as an emerging issue, with four specifically referencing opioids. Other issues, each noted by one respondent, were:</p> <ul style="list-style-type: none"> <li>● Mental health</li> <li>● Pertussis</li> <li>● Lyme disease</li> <li>● Obesity</li> <li>● Sexually transmitted diseases</li> </ul>
<p><b>5. What gaps in services exist in addressing these needs? What are barriers to filling these gaps?</b></p>	<p>Some respondents spoke of gaps around connecting people with services - the services exist, but people are not aware of them or unable to reach them because of barriers including lack of transportation, waiting lists, cultural and language differences between the community and providers, and lack of information about what is available.</p> <p>Other gaps included lack of services for substance abuse, the lack of coordination among agencies doing similar work, lack of comprehensive prevention work in some schools, lack of mental health providers, lack of access to exercise and healthy food. Barriers cited included lack of funds, lack of time for coordination and planning, and lack of consensus in the community about the importance of the issues.</p>
<p><b>6. In addition to more funding, what resources do you need to better address these emerging or increasing health concerns?</b></p>	<p>Several respondents mentioned the need for increased coordination and communication among hospitals concerning the services that are available and what is needed (one person noted that the CHNA is a good start).</p> <p>Other needed resources that respondent noted were:</p> <ul style="list-style-type: none"> <li>● Support for families as they navigate the healthcare system</li> <li>● Better transportation, either public or provided by hospitals</li> <li>● Better-trained, more diverse health care staff</li> </ul>



Question	Synthesis of Responses
<p><b>7. What specific vulnerable populations are you most concerned about? And why?</b></p>	<p>Three respondents mentioned the elderly, and two each mentioned mentally ill people, homeless people, and low-income people. Reasons given usually addressed these populations' lack of access to services that meet their needs. These are populations which are less able to advocate for themselves and find help.</p>
<p><b>8. Externally, what resources or services do you wish people in your area had access to?</b></p>	<p>These responses varied, but three respondents mentioned better transportation options. Other resources and services mentioned included:</p> <ul style="list-style-type: none"> <li>● Mental health care</li> <li>● Better care coordination</li> <li>● More workforce development</li> <li>● Partnerships or services around improving air quality (high asthma rates)</li> <li>● More money for community outreach</li> <li>● Universal child care/after school care</li> <li>● Support groups and behavioral interventions</li> <li>● Access to healthy food</li> </ul>
<p><b>9. How would you recommend that your local hospitals/insurers and/or Western Massachusetts Hospital Coalition 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>Respondents often did not have a clear idea of what this could look like. Two respondents addressed community benefit programs and expressed an interest in or questions about how these programs relate to coalition-building, particularly with regard to hospitals acquired by Baystate. Both said it was unclear what these programs look like in their communities. One respondent spoke of the need for greater coordination among and also within hospitals, including sharing information on individual patients (within the hospital) and letting people know what is available in the community. Hospitals could also work together to identify and fill local service gaps. Some specific suggestions included involving hospitals in community discussions around:</p> <ul style="list-style-type: none"> <li>● where people who been treated for overdoses can go after release from the hospital</li> <li>● reducing re-admissions</li> <li>● workplace health screenings</li> </ul> <p>Ideas around sustaining and supporting this collaboration included:</p> <ul style="list-style-type: none"> <li>● Regular meetings</li> <li>● Open forums to discuss issues and problems</li> <li>● Discussion of what resources are available</li> <li>● Funds are available as part of capitation - hospitals are changing the kind of work that they do, supporting efforts to keep people out of hospitals</li> <li>● Developing a common vision for improving health</li> <li>● Making it an ongoing effort with partners who are engaged with the process</li> </ul>

Question	Synthesis of Responses
<p><b>10. Is there anything else you would like to share?</b></p>	<p>Only one person took the opportunity to add to the conversation. She suggested that more efforts need to be placed on prevention programs, and suggested that hospitals partner with the YMCA or other organizations to offer vacation and afterschool programs for youth. This would motivate young people to exercise and also keep them out of trouble.</p>



# Key Informant Interviews Report: Baystate Medical Center

## Dates

February 19 - March 8, 2016

## Interview Format

Phone interviews, approximately 30-45 minutes in length.

## Participants

- Dr. Evan Benjamin, Chief Quality Officer & Sr. VP, Quality & Population Health
- Dr. Stephen Boos, Medical Director, Family Advocacy Ctr., Baystate Health
- Joni Beck Brewer, Vice President, Parent Services, Square One
- Dr. Joeli Hettler, Chief, Pediatric Emergency Medicine
- Yolanda Johnson, Executive Officer for Student Services, Springfield Public Schools
- Dr. Niels Rathlev, Chair, Emergency Medicine
- Nancy Shendell-Falik, President, Baystate Medical Center & Sr. VP, Hospital Operations, Baystate Health

Question	Synthesis of Responses
<p><b>1. What are the three (3) most emergent and/or urgent health issues facing Baystate Medical Center (BMC), Springfield Public Schools (SPS), and/or its community/service area?</b></p>	<p>The most common response, noted by five people, was drug abuse and particularly opioids. Diabetes and behavioral health issues were each cited by three people, and two each cited asthma and violence.</p>
<p><b>2. What additional resources (internal and external) are needed to better address these emerging/urgent health issues?</b></p>	<p>Several respondents spoke of the need for accessible, high-quality behavioral health services, and not just limited to those with serious mental illnesses. Without access and transportation, people in need of behavioral health services can wind up in the emergency department, where they face long waits for placement and strain the ED resources. One respondent noted that greater prevention efforts are needed - that so much time and energy is spent treating problems, when supporting people early on will lead to fewer problems. Another supported this, saying that parents need to be engaged and supported with positive parenting practices, and early childhood education and care needs to provide enriching experiences.</p> <p>There is also a need for patients to be supported after they leave the hospital, with step-down or partial hospitalization programs. Lack of transportation for follow-up visits is a related issue.</p>

Question	Synthesis of Responses
<p><b>3. Are there vulnerable populations about whom you are particularly concerned? Please describe.</b></p>	<p>These responses varied by respondent and included:</p> <ul style="list-style-type: none"> <li>● The frail elderly</li> <li>● The dual-eligible (disabled and poor, eligible for Medicaid and Medicare)</li> <li>● Teenagers involved with sex trafficking (this was also mentioned as an issue by a different respondent later in the interview)</li> <li>● The African-American population</li> <li>● Young men who are not engaged with the health care system</li> <li>● Children of preschool age who are not enrolled in preschool</li> <li>● Older teens who drop out of school</li> </ul>
<p><b>4. What gaps in services do these vulnerable populations face?</b></p>	<p>Responses to this were similar to that of Question 2, and included:</p> <ul style="list-style-type: none"> <li>● Need for more in-house social support services related to navigating the medical care system and following up on treatment (noted by two respondents)</li> <li>● Lack of adequate behavioral health services, including both mental health and substance abuse treatment options (noted by two respondents)</li> <li>● A lack of public transportation</li> <li>● More activities for older teens to engage them with school</li> </ul>
<p><b>5. Does BMC have a prevention strategy to keep vulnerable populations out of the hospital? If yes, describe how the strategy presents in practices and operations. If not, why?</b></p>	<p>Some Baystate employees were not aware of a comprehensive strategy and did not feel they could comment on it. Those who did cited:</p> <ul style="list-style-type: none"> <li>● Three community health centers, which do outreach and offer preventive as well as acute care</li> <li>● The infectious diseases division, which offers care management for people living with HIV</li> <li>● Involvement of their Trauma Services department with local police and public safety officials</li> <li>● Task forces around addiction in various parts of the community</li> <li>● The Family Advocacy Center, dealing with issues of abuse and child protection.</li> <li>● Project Launch, which brings in behavioral health screening and services.</li> </ul>

Question	Synthesis of Responses
<p><b>6. How does BMC/SPS define health equity? Describe how BMC is addressing health inequities.</b></p>	<p>The consensus among BMC stakeholders is that the hospital cares for everyone as best they can, regardless of income, insurance, race, ethnicity, or other variables. There is tracking data that would indicate if certain sub-populations were not getting equal levels of care, and the data indicate that this is not a problem.</p> <p>One respondent cited the Jail Health program, which connects doctors with inmates while they are in prison. The inmates see the same doctor throughout their incarceration and then continue the relationship after they are released, at the community health centers.</p> <p>A community member said that the perception in the community is that Baystate serves those who come to them, but does not do outreach. This person is aware of the Family Advocacy Center, but says that this organization does outreach to other organizations and not to individuals.</p> <p>Another Baystate stakeholder said, “No money, no mission.” While there are structures in place, such as the community health centers, that could support health equity, as funding is tightened they are not prioritized.</p> <p>At Springfield Public Schools, this is primarily the work of the nursing supervisor. Ms. Johnson was not familiar with the details of her work.</p>
<p><b>7. Describe the top urgent health determinants of school success in the SPS for the general population. Do these vary by educational level (elementary, middle and high school)? If so, how?</b></p> <p><b>Are there programs and services being offered by SPS to address these health determinants? If so, please describe. What effect, if any, have these programs and services had on these determinants?</b></p>	<p>Ms. Johnson noted that physical and behavioral health issues can both cause kids to miss school and to fall behind in their learning. When home environments lack the capacity to respond to health needs and crises, this also impacts learning. She noted that there is a need for children and families to establish better strategies to cope with life’s stressors, so that the children are able to attend school and engage in learning when they are there. She also spoke of the need for quality health insurance, so they can take advantage of existing health care opportunities.</p> <p>She did not address the question about programs and services directly, but spoke to the importance of the schools broadening their perspectives on what learning can look like, and their understanding of how to engage them in learning. This includes not assuming students are not learning simply because they are not sitting properly in their seats.</p>

Question	Synthesis of Responses
<p><b>8. Problems exist with current social welfare and public policies, including institutional racism, that predispose people in our community to poor health. Does Baystate/SPS have internal policies/programs in place to address these problems? Do you have suggestions for solutions to address these problems in the Baystate/SPS community?</b></p>	<p>These responses varied greatly, and focused more on suggestions than on existing policies and programs. A Baystate stakeholder did note that the hospital has applied for grants to fund asthma prevention programs, and Ms. Johnson noted several programs including:</p> <ul style="list-style-type: none"> <li>● City Connects</li> <li>● A school-based counselor who connects families with services in the community</li> <li>● A school-based clinic</li> <li>● Partnerships with Department of Children and Families (DCF) and Department of Youth Services (DYS)</li> <li>● Collaboration with the courthouse around juvenile issues.</li> </ul> <p>Suggestions for solutions included:</p> <ul style="list-style-type: none"> <li>● Doing an internal assessment of who gets investigated for child abuse (noted by two respondents)</li> <li>● Recognizing that this work requires partnerships with organizations outside of the hospital system</li> <li>● Public investment in private determinants of health</li> <li>● Figuring out how to overcome internalized racism in institutions, and the mistrust this engenders in the community</li> <li>● Partnerships with local housing authorities to promote the use of clinics, or perhaps mobile health care units, rather than the Emergency Department for primary care</li> </ul>
<p><b>9. How do you recommend that BMC/SPS and/or the Coalition of Western MA Hospitals work in closer partnership with local and regional municipal public health entities following the completion of the CHNA? Describe specific ways such a partnership can be supported and sustained.</b></p>	<p>Respondents spoke generally about the importance of collaboration and aligning the work that each hospital does, in order to have more impact in an era of declining resources. Reducing readmissions was named as a basic goal that hospitals could work together to support. Another was providing mental health counseling in emergency departments, along with links to service providers. One respondent noted that what is needed is a consistent, causative model that will direct money to addressing root causes of poor health, perhaps by focusing on early childhood issues and preventive care.</p>

Question	Synthesis of Responses
<p><b>10. Is there anything else you would like to share? Perhaps the one thing you were waiting for us to ask (or dreading that we would ask) and we did not ask.</b></p>	<p>One doctor noted that the ED is overused by parents who need to get a (required) note allowing their sick children to return to school. PCPs sometimes require an appointment before they will verify that the child is well, and parents don't want to do this. This overburdens the ED, not only with providing the service but also with all the documentation involved.</p> <p>Another noted that Baystate is an ACO (Accountable Care Organization), which moves beyond fee-per-service to include taking care of the population overall and rewarding for high achievement. The problem is that this will result in reduced payments to some doctors, especially in specialty fields, and the medical education model with its high debt loads. For that reason, the AMA is not likely to support this model.</p>

**Quotes:**

- “The state of behavioral health care in America is abysmal.”
- “Specifically at Baystate, the social work department needs to be doubled, or even tripled.”
- “America’s health care system is wonderful, but it’s all on the back end, and it’s expensive. In other countries, for every dollar they spend on health care, they spend \$2 on the social determinants of health. In the US, we spend 60 cents.”
- “We’re at 30,000 feet right now - if a decision (about working in closer partnership) is made and committed to, we’re going to have to come down and start working, having more conversations.”

# Key Informant Interview Report: Holyoke Medical Center

## Dates

February 25 - 29, 2016

## Interview Format

Phone interviews, approximately 1 hour in length.

## Participants

1. Melissa Perry, Director of Behavioral Health
2. Laura O'Connor, Social Worker in Oncology
3. Chereilyn Roberts, Director of Discharge Transitions
4. Eva Cavanaugh, Nursing Director of Emergency Department

Question	Synthesis of Responses
<p><b>1. What are the 3 most urgent health needs/problems in your service area?</b></p>	<ul style="list-style-type: none"> <li>▪ patients with co-morbidities of diabetes, mental health and substance use needs</li> <li>▪ access to mental health care providers</li> <li>▪ lack of education about acute and chronic diseases</li> <li>▪ opioid abuse issues are big challenge, even though Holyoke has dealt with drug abuse for some time</li> </ul>
<p><b>2. What specific vulnerable populations are you most concerned about? And why?</b></p>	<ul style="list-style-type: none"> <li>▪ smokers with COPD</li> <li>▪ chronically mentally ill and homeless persons dually diagnosed with mental health and substance use disorders</li> <li>▪ children and elders who are subjected to abuse and neglect from family or caregivers</li> <li>▪ elders with dementia and other chronic health issues such as diabetes, COPD and cancer</li> </ul>
<p><b>3. What are the most serious barriers or service gaps that consumers face in accessing health care, including mental health and substance use care?</b></p>	<ul style="list-style-type: none"> <li>▪ lack of transportation</li> <li>▪ lack of health insurance, especially those who are 'on and off' insurance when they do not comply with requirements to renew or update information to avoid gaps in coverage</li> <li>▪ lack of timely appointments for primary care</li> </ul>
<p><b>4. What about mental health care and substance use/addiction care for adolescents and young adults? What are the major needs and issues for such care?</b></p>	<ul style="list-style-type: none"> <li>▪ need detox and children's psych unit for young drug users; waiting lists are too long to access local treatment programs</li> <li>▪ need more consistent follow-up care procedures after a Mental Health or Substance Abuse crisis with younger patients</li> </ul>

Question	Synthesis of Responses
<p>5. What are the community’s needs for bilingual mental health/substance use care capacity? Are there other languages needed in addition to Spanish?</p>	<ul style="list-style-type: none"> <li>▪ need more bilingual providers and interpreters in Spanish, Russian, Polish, Cambodian, and Vietnamese</li> </ul>
<p>6. What are the major needs, service gaps or barriers 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?</p>	<ul style="list-style-type: none"> <li>▪ Expand social work services for high users of the ED with mental health and substance abuse diagnoses, but need more funds for an on-campus clinic to target such users</li> <li>▪ Need more communications and care planning with community agencies and partners who are treating the same patients we see in our ED</li> <li>▪ Certain payers will only pay for certain services for younger patients with mental health and substance use needs</li> </ul>
<p>7. In light of the opioid use epidemic, what are the most pressing issues and needs around access to care, prevention, and intervention?</p>	<ul style="list-style-type: none"> <li>▪ Implement more harm reduction and overdose prevention efforts including use of Narcan, training staff and community members in how to obtain it and use it</li> <li>▪ Hospital wants to work more closely with community providers such as police and EMS to reduce risks of overdose and overdose deaths</li> <li>▪ Look at more innovative harm reduction approaches such as ‘safer injection sites’ as other hospitals are exploring</li> <li>▪ Conduct more outreach to identify opioid users, homeless users, and younger users to support a pathway to treatment and harm reduction services</li> </ul>
<p>8. What do you think community leaders think about the philosophy of harm reduction for addiction including the use of Narcan and needle exchange?</p>	<ul style="list-style-type: none"> <li>▪ Most health professionals strongly support it but local officials can be mixed on support;</li> <li>▪ Provide more education about cost-effectiveness and benefits of harm reduction</li> </ul>
<p>9. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</p>	<ul style="list-style-type: none"> <li>▪ Work to address poverty and lack of educational and employment opportunities</li> <li>▪ Support improved schools</li> <li>▪ Support improved access to affordable and safe housing</li> <li>▪ More information sharing between providers, but HIPPA and other structures can be a barrier to fuller inter-agency communications</li> <li>▪ Challenge payers to cover more services and to provide a longer-term duration of coverage for services, especially mental health and substance abuse treatment</li> </ul>

Question	Synthesis of Responses
<p><b>10. How would you recommend that your local hospital and the Western Massachusetts Hospital Coalition work in closer partnership with local and regional municipal public health entities and other community partners after the CHNA is completed? What specific ways can such partnerships be supported and sustained?</b></p>	<ul style="list-style-type: none"> <li>▪ Hospital can serve as entity to convene and coordinate health improvement initiatives and planning, but HMC needs grant funds to support this; continue to work with existing efforts like the Prevention and Wellness Trust Fund project</li> <li>▪ Forge closer partnerships with police, schools, community-based agencies to address stigma of mental health and substance use disorders</li> <li>▪ Hospital staff can become more active members of local coalitions and Task Forces to address opioid crisis</li> <li>▪ Focus less on competition between hospitals and more on regional cooperation</li> </ul>

**Quotes:**

- “We desperately need a homeless shelter right in Holyoke”
- “We want to more readily walk the path of harm reduction in this opioid crisis”
- “Children under the age of 14 with serious mental health and substance abuse issues have no place to go locally; many parents can’t work if their child needs treatment in a program that is so far away”
- “Hispanic clinicians are like gold and I know we struggle to recruit and retain them”



## **Appendix III: Data Tables**

**Hospitalizations and Emergency Room Visits among Select Communities  
in Hampden County, 2012**

**Hospitalization Rates and Pediatric Asthma ER Visit Rates for Select  
Hampden County Communities by Race/Ethnicity, 2012**

**Behavioral Risk Factor Surveillance System (BRFSS) Prevalence Estimates  
for Health Behaviors and Conditions among Select Communities in  
Hampden County**

## Hospitalizations and Emergency Room Visits among Select Communities in Hampden County, 2012

Geography	Hospitalizations							ER Visits			
	Cerebrovascular Disease	Coronary Heart Disease	Diabetes	Asthma	Asthma - pediatric	Mental Disorders	Substance Use	Asthma	Asthma-pediatric	Mental Disorders	Substance Use
Chicopee	246.5	302.0	196.3	179.7	162.2	1519.6	800.43	944.1	1914.1	2782.2	1005.13
Holyoke	282.4	405.3	268.7	347.7	245.2	2302.7	1127.58	2028.2	3012.6	4261.5	1559.27
Palmer	268.1	269.0	98.7	96.7	NA	2011.3	751.21	932.7	1047.4	2787.6	829.75
Springfield	291.0	264.1	247.6	242.3	181.0	1894.8	801.37	1483.0	2245.6	4143.3	1614.2
West Springfield	210.6	229.3	125.8	137.5	NA	1542.8	889.84	702.7	982.8	2346.9	811.51
Westfield	223.9	264.0	128.0	95.7	NA	1463.0	579.01	849.2	952.1	2221.3	665.77
HAMPDEN COUNTY	242.7	268.0	177.4	166.8	143.2	1516.9	691.85	1027.6	1579.9	2850.4	1019.12
MA	219.5	264.5	133.7	132.7	206.1	845.5	362.39	571.9	865.7	2304.4	986.52

\*MDPH, MassCHIP, 2012; rates are per 100,000 and are age-adjusted except for pediatric age-specific rates for age 0-14

## Hospitalization Rates and Pediatric Asthma ER Visit Rates for Select Hampden County Communities by Race/Ethnicity, 2012

Geography	Race / Latino Ethnicity	Hospitalizations						ER Visits
		Substance Use Related	Cerebro-vascular Disease	Coronary Heart Disease	Diabetes	Mental Disorders	Asthma	Pediatric Asthma
Chicopee	White	807.2	227.5	287.1	151.2	1432.2	139.4	1079.3
Chicopee	Black	NA	NA	NA	602.2	1435.0	NA	NA
Chicopee	Latino	891.3	656.3	432.3	609.6	2005.0	392.1	3455.9
Chicopee	Asian / Pacific Islander	NA	NA	NA	NA	NA	NA	NA
Holyoke	White	1008.1	222.8	320.2	134.8	1916.9	109.8	1375.3
Holyoke	Black	NA	NA	NA	NA	2285.9	NA	NA
Holyoke	Latino	1204.8	462.6	586.4	443.8	2563.9	686.4	3240.3
Holyoke	Asian / Pacific Islander	NA	NA	NA	NA	2798.6	NA	NA
Palmer	White	728.8	258.8	248.9	85.9	2018.6	100.9	868.2
Palmer	Black	NA	NA	NA	NA	NA	NA	NA
Palmer	Latino	NA	NA	NA	NA	NA	NA	NA
Palmer	Asian / Pacific Islander	NA	NA	NA	NA	NA	NA	NA
Springfield	White	944.8	233.9	276.2	169.0	1945.4	110.2	1074.3
Springfield	Black	438.6	381.6	150.2	312.9	1344.1	172.9	1653.5
Springfield	Latino	884.0	366.5	321.6	347.0	2248.0	552.0	2916.2
Springfield	Asian / Pacific Islander	NA	NA	638.3	NA	NA	NA	NA
West Springfield	White	981.2	201.6	229.8	108.8	1599.4	130.5	542.5
West Springfield	Black	NA	NA	NA	NA	NA	NA	NA
West Springfield	Latino	1508.1	NA	NA	NA	2120.2	NA	2141.9
West Springfield	Asian / Pacific Islander	NA	NA	NA	NA	NA	NA	NA

## Hospitalization Rates and Pediatric Asthma ER Visit Rates for Select Hampden County Communities by Race/Ethnicity, 2012

Geography	Race / Latino Ethnicity	Hospitalizations						ER Visits
		Substance Use Related	Cerebrovascular Disease	Coronary Heart Disease	Diabetes	Mental Disorders	Asthma	Pediatric Asthma
Westfield	White	566.8	208.7	241.4	115.9	1415.3	77.6	818.3
Westfield	Black	NA	NA	NA	NA	1921.2	NA	NA
Westfield	Latino	769.6	NA	681.9	NA	1983.4	NA	1579.0
Westfield	Asian / Pacific Islander	NA	NA	NA	NA	NA	NA	NA
Hampden County	White	675.5	212.7	249.7	126.4	1353.2	93.6	654.9
Hampden County	Black	443.1	386.5	165.2	326.5	1354.0	178.3	1715.8
Hampden County	Latino	922.1	396.4	397.6	386.6	2237.4	543.9	2903.6
Hampden County	Asian / Pacific Islander	114.9	NA	272.6	NA	292.3	NA	NA
Massachusetts Total	White	392.6	208.2	257.9	115.9	861.2	101.0	527.3
Massachusetts Total	Black	260.2	309.5	244.4	320.2	816.7	276.3	1804.5
Massachusetts Total	Latino	317.8	246.7	290.5	222.8	860.6	294.6	1643.0
Massachusetts Total	Asian / Pacific Islander	39.8	149.7	137.0	43.1	164.9	69.7	376.7

\*NA - data suppressed because of low counts

## Behavioral Risk Factor Surveillance System (BRFSS) Prevalence Estimates for Health Behaviors and Conditions among Select Communities in Hampden County

Geography	Obese*	Over-weight or Obese	Heart Disease**	Stroke	Heart Attack or MI*	Diabetes*	Pre-diabetes*	Poor Mental Health (15+ days)	Current Smoker	Binge Drinker
Chicopee	***	***	7.0	2.3	5.6	***	6.7	***	***	***
Holyoke	***	***	8.3	3.7	3.6	***	8.5	***	***	***
Palmer	***	***	6.7	2.3	4.2	***	6.9	***	***	***
Springfield	31.7	***	6.4	2.6	4.3	11.7	8.9	17.0	21.3	***
West Springfield	***	***	6.2	2.7	3.9	8.3	7.2	***	***	***
Westfield	***	***	5.1	2.1	3.7	***	6.1	***	***	***
HAMPDEN COUNTY	28.8	64.7	7.8	3.4	5.1	13.2	7.6	15.9	21.5	16.1
MA	23.6	59.0	6.1	2.4	4.0	9.0	7.3	11.1	16.1	18.7

county and state estimates are direct estimates 2012-2014

\*SAE 2012-2014

\*\*SAE 2011, 2012, 2014

\*\*\* estimate unavailable due to small sample size or confidence limits that are too wide and do not meet reporting requirements

## **Appendix IV: Community and Hospital Resources to Address Identified Needs**

### *Lack of Resources to Meet Basic Needs*

- **Baystate Financial Assistance & Counseling:** Baystate Health provides financial counseling services to inpatient and outpatient individuals who are unable to pay their estimated care prior to treatments or who have large existing balances. This assistance includes linking patients to available funding sources such as Medicaid and Medicare and determining whether they are eligible for Health Safety Net or Baystate's Financial Assistance Program. <https://www.baystatehealth.org/~media/files/brochures/financial%20assistance%20brochure%20english.pdf>

### *Safety*

- **Safe Kids of Western Massachusetts:** Safe Kids of Western MA strives to prevent accidental childhood injuries and death through public awareness, safety education and distribution of safety devices. <https://www.safekids.org/coalition/safe-kids-western-massachusetts>
- **Baystate Trauma and Injury Prevention (TIP):** Trauma centers have an important role in reducing the impact of injury by participating in prevention efforts. Examples of our programs include; Brains at Risk, The Balancing Act, Drowsy Driving Campaign, Gun Buy Back Program, Governor Patrick's Safe and Successful Youth Initiative.  
Ida Konderwicz RN, BSN,CEN, Department of Surgery, Pediatric Trauma/Injury Prevention Coordinator, [Ida.Konderwicz@baystatehealth.org](mailto:Ida.Konderwicz@baystatehealth.org)

### *Limited Availability of Providers*

- **Baystate Community Health Centers:** Located in Springfield's low-income neighborhoods that have both HPSA and MUA/MUP designation, BMC health centers are primary care first-contact sites for thousands of underserved, low-income people. <https://www.baystatehealth.org/locations/mason-square-neighborhood-health-center>  
<https://www.baystatehealth.org/locations/high-street-health-center>  
<https://www.baystatehealth.org/locations/brightwood-health-center-centro-de-salud>
- **Baystate Springfield Educational Program:** Baystate Springfield Educational Partnership (BSEP) provides career pathway programming to Springfield high school students with an expressed interest in the health care professions. <https://www.baystatehealth.org/about-us/community-programs/education-training/bsep>

### *Lack of Care Coordination*

- **Community Provider Integration Programs:** The Community Provider Program Manager at Baystate Health, an APRN, develops purposeful, innovative, health care frameworks that build institutional continuity and support capacity building infrastructure for healthier communities.

### *Health Literacy*

- **Consumer Health Library:** The Consumer Health Library was established by Baystate Health to offer free library resources and services to patients and their families. <https://www.baystatehealth.org/patients/support/consumer-health-library>

### *Obesity*

- **Mercy Weight Loss Solutions:** The Mercy Weight Loss group offers proven methods for weight management that can be tailored to individuals' unique health needs and lifestyle. Free monthly seminars and online information resources are offered. Certified nutritionists are available to teach how to choose and prepare real food, and our exercise physiologists can work one-on-one to help folks start and maintain a program of regular physical activity. <http://www.mercycares.com/weight-loss>
- **Caring Health Center's Wellness Center:** The CHC Wellness Center, located in Springfield, provides free group-based exercise, nutrition education, and chronic disease self-management services on site. All CHC patients, staff, and residents of Springfield can participate. <http://caringhealth.org/chcwellnessctr.html>
- **Live Well Springfield:** LWS is a community-based coalition of over 20 organizations working to improve health equity in Springfield through improved access to healthy eating and active living opportunities. <http://www.livewellspringfield.org/>
- **MIGHTY (Moving, Improving and Gaining Health Together at the Y):** MIGHTY is a pediatric obesity treatment program for ages 5-21 years old held at the Springfield YMCA and includes 14 - 2 hour sessions which include physical activity, nutrition and behavior modification. <https://www.baystatehealth.org/services/pediatrics/specialties/weight-management-program>

### *Cardiovascular Disease*

- **Mercy Medical Center's Cardiology Services:** Mercy's cardiovascular team offers one-stop access to an exceptional depth and breadth of experts who can offer the latest medical information on a wide range of heart conditions. Advice, diagnostics, and treatment options are available on a variety of issues including coronary artery disease (CAD), heart rhythm disorders (arrhythmias) and heart failure. <http://www.mercycares.com/cardiology>

### *Diabetes*

- **Diabetes Education Center:** Mercy brings the latest in diabetes self-management education to the residents of western Massachusetts by providing information, classes and support groups. The program is recognized by the American Diabetes Association and meets the National Standards of Excellence in diabetes education. <http://www.mercycares.com/diabetes>
- **Diabetes Exercise Program:** Mercy offers an individualized, structured exercise program just for people with diabetes. Classes meet three times a week for eight weeks at a small gym on the Mercy Medical Center campus, and last about one hour. <http://www.mercycares.com/diabetes-exercise-program>



## Asthma

- **Mercy Asthma Information Resources:** As a part of Mercy's Healthy Balance Health & Wellness programs, we provide an extensive online library of information on asthma which even includes video content. The medical info includes, among many details, asthma causes, symptoms, testing, treatment and prevention strategies. <http://www.mercycares.com/healthinformation>
- **Pioneer Valley Asthma Coalition:** PVAC is a community partnership that works to improve the quality of life for individuals, families and communities affected by asthma. [www.pvasthmacoalition.org](http://www.pvasthmacoalition.org)
- **Springfield Healthy Home Collaborative:** SHHC is a city-wide collaboration of community partners and stakeholders from multiple sectors, who have joined together to begin to address the health issues faced by residents due to poor housing conditions, including asthma. Their website links to resources and programs to mitigate asthma triggers in the home. <http://springfieldhealthyhomes.org/asthma-triggers/>

## Nutrition

- **Mercy Nutrition Services:** Mercy offers a comprehensive array of services not only for our patients, but also for the general public. Besides extensive online resources and information, Mercy has registered dietetic staff that are available for individual and group nutrition counseling sessions to help people improve their nutrition and overall health. <http://www.mercycares.com/nutrition>
- **Caring Health Center's Teaching Kitchen:** The Caring Health Center in Springfield has a teaching kitchen for nutrition education.
- **Brown Bag-Food for Elders Program:** The 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. <https://www.foodbankwma.org/get-help/brown-bag-food-for-elders/>
- **Live Well Springfield:** LWS is a community-based coalition of over 20 organizations working to improve health equity in Springfield through improved access to healthy eating and active living opportunities. <http://www.livewellspringfield.org/>

## Physical Activity

- **Physical Therapy Services:** Mercy Physical Therapy Department staff bring a tremendous depth of experience along with knowledge of today's most effective exercise techniques. Besides offering information and resources, our staff can work one-on-one with individuals to develop a plan tailored to their health needs. With coaching and education, activities as varied as stretching, core strengthening, walking and strength training can be implemented to help improve or restore physical function and fitness levels. <http://www.mercycares.com/physical-therapy>
- **Caring Health Center's Wellness Center:** The CHC Wellness Center, located in Springfield, provides free group-based exercise, nutrition education, and chronic disease self-management services on site. <http://caringhealth.org/chcwellnessctr.html>

- **Dunbar Community Center:** At the Dunbar Y Family & Community Center, located at 33 Oak Street in Springfield, families enjoy everything from martial arts, fitness sessions and dance classes, to after-school care, summer camp, senior health initiatives and mentoring opportunities for both youth and adults. <http://www.springfieldy.org/family-centers/dunbar-y-family-community-center/>
- **Shriners Hospital for Children-Springfield** offers specialty programs to promote physical activity including, but not limited to:
  - *BFit Power-based Exercise Program:* This is an individually-mentored exercise program for children with physical disabilities focusing on fast movements to build strength, power, and coordination. BFit integrates socialization with area college students as personal coaches, expert supervision by staff from Shriners Hospitals for Children, music for motivation and energy, and a wide variety of group and individual exercises.
    - Community partners
      - American International College
      - Springfield College
      - University of Hartford
      - University of Massachusetts
      - Western New England University
  - *BFit Summer Cycling Program:* This is an individually-mentored cycling program to introduce children with physical disabilities to the sport of cycling focusing on safety, skill development, and fitness. The BFit cycling program integrates socialization with area college students as personal coaches, expert supervision by staff from Shriners Hospitals for Children, music for motivation and energy, and a wide variety of group and individual exercises.
    - Community partners
      - American International College
      - Springfield College
      - University of Hartford
      - University of Massachusetts
      - Western New England University
  - *MyPAR Golf and Games Program:* Participants ages 8 to 18 explore the sport of golf through fun and interactive games including putting, chipping, pitching, and full swing. Participation in a sport helps children and adolescents develop strong interpersonal, self-management, communication, socialization, goal setting, and resilience skills. The MyPAR Golf and Games program will provide participants with the opportunity to learn a new sport, practice important life skills and engage in fun activities with new friends.
    - Community Partners
      - Springfield College
  - *Shriners Hospitals for Children Walk for Love*
    - This is a 3 mile walk and Barbeque offered free of charge to community members each fall to enjoy the fall foliage and build community spirit.

- **Live Well Springfield:** LWS is a community-based coalition of over 20 organizations working to improve health equity in Springfield through improved access to healthy eating and active living opportunities. Their website includes a listing of fitness venues and resources. <http://www.livewellspringfield.org/>

### *Mental Health*

- **Mercy Behavioral Health Care:** Mercy Behavioral Health Care offers streamlined access to an entire continuum of high-quality inpatient and outpatient care, information, support groups and education for people of all ages, from children and adolescents to adults and seniors. Areas of expertise include: Mercy Recovery Services for various treatment options, Child and Adolescent Psychiatric Care which includes services for families, Adult Psychiatric Care and even Geriatric Psychiatric Care. <http://www.mercycares.com/behavioral-health>
- **Baystate Family Advocacy Center:** The Baystate Family Advocacy Center provides assessment, treatment and crisis support to child abuse victims and their non-offending caretakers affected by child abuse, domestic violence and homicide in western Massachusetts. <https://www.baystatehealth.org/services/pediatrics/family-support-services/family-advocacy-center>
- **Gandara Center's Outpatient Mental Health Services:** Gandara's outpatient mental health clinic in Springfield provides a range of traditional mental health outpatient services, including programs for individuals with a long-standing history of psychiatric or substance abuse disorders. <https://gandaracenter.org/counseling-therapeutic-services/#outpatient-mental-health>
- **Gandara Center's Outreach Programs for Youth:** The Gandara Center provides in-home therapy as well as in-home behavioral health services for youth. <https://gandaracenter.org/child-adolescent-family-services/#in-home-therapy-services> and <https://gandaracenter.org/child-adolescent-family-services/#in-home-behavioral-services>
- **Behavioral Health Network's Outpatient Services:** Through 6 licensed clinics, BHN provides services to chronically mentally ill adults, seriously emotionally disturbed children, adolescents, and families. <http://bhninc.org/content/outpatient>
- **Transgender Support Group:** In partnership with UNITY of Pioneer Valley, this support group is a peer lead and psychosocial support group for Transgender individuals, their allies and all GLBTs. <https://groups.yahoo.com/neo/groups/unity-of-the-pioneer-valley/info>

### *Substance Use*

#### *Tobacco*

- **Mercy Smoking Cessation Programs:** If a smoker wants to quit the habit, Mercy offers multiple ways to help. Tobacco cessation strategies, resources, education and a wide variety of treatment options are offered. Smoking cessation aides are also available at the Mercy Medical Center Community Pharmacy. <http://www.mercycares.com/need-help-quitting-smoking> <http://www.mercycares.com/mercy-rx>
- **Mercy Lung Cancer Screening Program:** For current or former smokers, Mercy Medical Center offers a comprehensive lung cancer screening program that can potentially save lives. The

screening program provides education and resources while also offering coordinated care from the initial CT scan through the rest of the process including image interpretation, evaluation and the options for treatment. <http://www.mercycares.com/lung-cancer-screening-program>

- **Caring Health Center's Tobacco Treatment Services:** CHC offers individual, group counseling, and pharmacological treatment. <http://caringhealth.org/tobaccotreatmentservices.html>

### *Opioids & Other Substances*

- **Mercy Opioid Treatment Program:** Mercy's Opioid Treatment Program (also called the Methadone Maintenance Treatment Program or MMTP) is available to provide high-quality, evidence-based medication-assisted treatment for opiate addiction in a non-judgmental, recovery-oriented, individualized manner in order to improve the lives of those we serve, their families, and the community. Education on addiction and treatment options along with individual and group counseling by clinicians is offered. <http://www.mercycares.com/methadone-maintenance-treatment-program>
- **Mercy Addiction Programs & Services:** Substance abuse counseling and education for individuals, families and groups is available for people who are addicted to drugs and/or alcohol. Services include the Pathways Intensive Program, which is structured for anyone who is suffering from the negative consequences of substance abuse or chemical dependency, and the Driver Alcohol Education program. <http://www.mercycares.com/outpatient-programs>
- **Gandara Center's Addiction Services:** The Gandara Center provides a variety of substance abuse services including outpatient treatment services and a structured "partial hospitalization" program. <https://gandaracenter.org/counseling-therapeutic-services/#outpatient-addiction-recovery-services>
- **Behavioral Health Network's Addiction Services:** BHN provides comprehensive addiction services including detox, post-detox residential series, long-term residential, day treatment programs, and outpatient services. <http://bhninc.org/content/addiction-services>
- **Gandara Center's Recovery Supportive Housing:** The Supportive Housing Programs work in collaboration with HAP Housing, area recovery homes, and shelters to provide safe, sober, and affordable bilingual housing options to individuals and families in recovery. Location in Holyoke for women and in Springfield for men. <https://gandaracenter.org/adult-services/#recovery-supportive-housing>
- **Hope for Holyoke Recovery Support Center:** Free services including peer-to-peer support groups, relapse preventions and tobacco cessation support groups, social events, job readiness activities, advocacy, and recovery coaching. Participants must be 18 years of age or older. Located at 100 Suffolk Street, Holyoke, MA 01040. Contact: 413-561-1021, <https://gandaracenter.org/hope-for-holyoke/#HFH>
- **Needle Exchange Program:** Tapestry Health has a needle exchange program in Holyoke and Northampton, where they provide sterile needles to injection drug users, trainings on Naloxone, education and counseling. <http://www.tapestryhealth.org/index.php/services/prevention/needle-exchange>
- **Stop Access Drug-Free Communities Springfield:** This city-wide coalition, coordinated by the Gandara Center, works to prevent and reduce underage drinking and marijuana use in the

Mason Square, South End, and Forest Park neighborhoods of Springfield.  
<https://gandaracenter.org/child-adolescent-family-services/#stop-access>

- **Springfield Coalition for Opioid Overdose Prevention:** S.C.O.O.P. is a coalition in Springfield whose mission is to train, educate, advocate, and provide support and resources to all who are affected by opiate abuse and overdoses. <http://www.springfield-ma.gov/hhs/index.php?id=scoop-about>

#### *Prenatal and Perinatal Care*

- **Mercy Childbirth and Parenting Education:** The Mercy Family Life Center for Maternity offers extensive education and support resources for the community. Numerous options include a weekly Childbirth Education Class, a two-weekend Childbirth Education “Express” Class, a Big Brother/Big Sister Class to prepare siblings for the arrival of their family's baby and a Baby Boot Camp for expectant mothers and partners to learn newborn care.  
<http://www.mercycares.com/childbirth-education>
- **Mercy Breastfeeding Center:** Mercy offers one of the most extensive breastfeeding (lactation) support programs in the region. Breastfeeding education, resources and support services include: free lactation consultations, a free Breastfeeding Support Line, a monthly Expectant Mothers’ Breastfeeding Class, and the Baby Café which is a free drop-in center offering professional breastfeeding support for pregnant and breastfeeding mothers in a relaxed and fun café-style atmosphere where they can enjoy refreshments and meet other mothers.  
<http://www.mercycares.com/breastfeeding-center>

#### *Teen Pregnancy and Parenting*

- **Mercy Pregnancy Care:** Mercy offers special teen pregnancy care, including referrals to the Massachusetts Healthy Families program that offers first-time parents ages 20 and under the information and support they need to raise healthy, happy and safe kids, and a biweekly teen moms group. Numerous services and education include: Free pregnancy testing with no appointment necessary, Routine Prenatal Care, Post-Partum care and care for High Risk pregnancies. <http://www.mercycares.com/pregnancy-care>
- **Springfield Pregnant & Parenting Teen Program:** The Springfield Pregnant and Parenting Teen Project (SPPTP) is a network of Springfield based service providers established by the YEAH! Network and coordinated through Partners for a Healthier Community to deliver comprehensive, integrated services that address the broad needs of pregnant and parenting teens, aged 12-24. <http://www.partnersforahealthiercommunity.org/springfield-pregnant-parenting-teen-program>
- **Young Parent Support (YPS) Young Fathers Program:** Martin Luther King Jr. Family Services provides services to young fathers between the ages of 15-24.  
<http://www.mlkjrfamilyservices.org/child-parent-services.html>

#### *Sexually Transmitted Infections (HIV/AIDS, Chlamydia)*

- **Mercy HIV/AIDS and Chlamydia Information Resources:** Along with Mercy Medical's clinical staff providing education, counseling and treatment of sexually transmitted infections, our Healthy Balance Health & Wellness program offers an extensive online library. Medical information on sexually transmitted diseases including HIV/AIDS and Chlamydia is detailed

listing causes, symptoms, testing, treatment, prognosis and prevention strategies.  
<http://www.mercycares.com/healthinformation>

- **Gandara Center’s Project Health- Case Management for People with HIV/AIDS:** Medical case management for HIV positive clients in the Springfield area. Staff are fluent in Spanish and their strength is in working with Spanish speaking clients, although services are open to everyone. Clients of any age may receive services. Case management assists clients to access medical, mental health and substance abuse services and to maintain a positive lifestyle despite being HIV+ or having AIDS. Eligibility: Must be HIV positive or living with AIDS. Open Referral: community service agency or self-referred. Located at 85 St. George Road Springfield, MA, 01104. Contact: 413-732-2120, <https://gandaracenter.org/adult-services/#project-health>

## CONTACT INFORMATION

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An electronic version of this Community Health Needs Assessment is publically available at <http://www.mercycares.com/chna> and print versions are available upon request.