# Mercy Medical Center
Trinity Health

# Community Health Needs Assessment

## JUNE 2019

# Community Health Needs Assessment 2019

*Prepared for*

## Mercy Medical Center
Trinity Health

Adopted by The Trinity Health Of New England Board, Mission Integration Committee: June 4, 2019

**Public Health Institute of Western Massachusetts**
**Collaborative for Educational Services**
**Franklin Regional Council of Governments**
**Pioneer Valley Planning Commission**

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

*Catalyst for Regional Progress*
**pvpc**

**Collaborative for Educational Services**
*Everyone is a learner*

**frcog**

# Consultant Team

## 1. Lead Consultant

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

## 2. 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.

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

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

# Table of Contents

# I.  Executive Summary

## 1.  Introduction and Methods

Founded in 1873, **Mercy Medical Center** has established itself as a provider of health care services within Western Massachusetts for over 145 years. In 2015, Mercy Medical Center and its affiliates became part of Trinity Health Of New England, an integrated health care delivery system that is a member of Trinity Health, Livonia, MI, one of the largest multi-institutional Catholic health care delivery systems in the nation. The local health system includes Mercy Medical Center, a 182 bed acute care hospital in Springfield; Providence Behavioral Health Hospital, located in Holyoke and licensed for 131 beds; Weldon Rehabilitation Hospital, a comprehensive hospital-based rehabilitation center on the campus of Mercy Medical Center; Brightside for Families and Children, an outpatient service offering counseling and family support programs; and two outpatient substance abuse treatment centers.

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Our Core Values:

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- Justice - We foster right relationships to promote the common good, including sustainability of Earth.
- Stewardship - We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
- Integrity - We are faithful to who we say we are.

Mercy Medical Center (referred to as Mercy) is a member of the **Coalition of Western MA Hospitals** ("the Coalition") a partnership between 8 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 worked in collaboration with the Coalition to conduct this assessment. The assessment was conducted to update the findings of

Mercy's 2016 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 Coalition engaged over 1,200 residents across the counties of Western Massachusetts in data collection and outreach about the CHNA.

The assessment focused on the Mercy Medical Center service area of Hampden County, the primary service area of the Mercy Medical Center.

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

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

The prioritized health needs identified in the 2019 CHNA include community level social and economic determinants that impact health, access and barriers to quality health care, and health conditions and behaviors. The assessment included analysis and synthesis of 1) a variety of social, economic and health data; 2) findings from recent Hampden County and regional assessment reports; 3) information from 10 focus groups and interviews with 44 key informants, plus 5 interviews with public health leaders, conducted for the 2019 CHNA; and 4) community input from 3 Community Conversations (two in English and one in Spanish) and 49 Community Chats. In total, almost 1,100 individuals across Hampden County were engaged in outreach and data collection.

**Vulnerable populations** were identified using a health equity framework with available data.

Knowing that health inequities exist for many communities of color in Hampden County, we focus on inequities among those who are Latino and Black because 1) they are the largest communities of color in Hampden County and 2) available data was limited for other racial and ethnic groups, such as Asian, Native American, and others. We use the terms White, Black, and Latino, recognizing that these terms do not always capture how every individual identifies themselves. For more information on the terminology of race and ethnicity as well as other definitions, please see the Glossary in Appendix II.

Information from this CHNA will be used to inform the updating of Mercy Medical Center's community health improvement plan (CHIP) and to inform the Coalition's regional efforts to improve health.

## 2. Findings

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

### a. 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 2016 CHNA and continue to impact the health of the population in Mercy's service area.  Social, economic, and community level needs identified in the 2019 CHNA include:

- **Housing needs** – Over one-third of residents experience *housing insecurity*, paying more than 30% of their income on housing. For a typical household people pay more than half of their income on housing plus transportation. Hampden County has the highest amount of homelessness in Western Massachusetts. *Poor housing conditions* also impact the health of residents.  Older housing combined with limited resources to maintain the housing leads to conditions that can affect asthma, other respiratory conditions and safety.

- **Built environment (Access to healthy food, transportation, and places to exercise) –** Decisions about how the infrastructure is developed impact *transportation choices* and *access to healthy food*, among other determinants. Nearly 14% of Hampden County residents and 23% of Springfield residents do not have personal transportation or rely on public transportation. Over 23% of Springfield residents travel by bus, and the Pioneer Valley Transit Authority raised rates and decreased service in 2018. Private sector and economic development investments have led to parts of Hampden County being considered *food deserts*, which are areas where low-income people have limited access to grocery stores. *Food insecurity* continues to 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.

- **Lack of resources to meet basic needs** – Many Hampden County residents struggle with insufficient financial means; 17% of Hampden County residents have incomes at *poverty levels* and the median household *income* is one-third lower than that of the state. Though *unemployment* rates have dropped, they continue to impact the county with rates of 8% unemployed.  Springfield's average hourly *wage* of $17.85 is far less than the estimated living wage of $27.29.

- **Educational attainment** - Lower levels of *education* contribute to unemployment, the ability to earn a livable wage, and many health outcomes. About 16% of Hampden County residents do not have a high school diploma (in Massachusetts, 10% do not) and only 27% of Hampden County residents have a bachelor's degree or higher (in MA, 42% do).

- **Violence and trauma** – Similar to the 2016 CHNA, *personal and community safety* were elevated as a concern in Hampden County. About 13% of all sexual assaults in the state were in Western MA, and Springfield Police found that 67% of all assault arrests in 2014 were domestic violence assaults. Crime rates are high, with violent crime rates in Hampden County almost 60% higher than that of the state and murder by guns in Springfield increasing by 20% between 2013 and 2017. Youth bullying was also identified as a concern in this assessment, particularly of children with disabilities and LGBTQ students.

- **The social environment is a key area where many in Hampden County face challenges**. In general, Hampden County is younger, more racially and ethnically diverse, with higher levels of disability that the state. Social isolation and experiences of interpersonal and structural racism create barriers to being able to access services and social determinants of good health. Additionally people spoke of the negative effect that social isolation has on health and the health value of being part of a community.

*"My mom was diagnosed with 3 – 6 months to live, and if it weren't for the Cancer Support Group, she wouldn't be alive. Support group makes her have hope and want to live."*
Focus Group Participant, Cancer Care Focus Group, Hampden County

- **Environmental exposures -** *Air pollution* impacts the health of Hampden County residents. Springfield experiences poor ambient air quality due to multiple mobile and point sources, with risk of cancer from breathing air toxins higher than 80% of the state. 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. Exposure to lead is also heightened in Springfield and Holyoke.

## b. Barriers to Accessing Quality Health Care

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

- **Insurance and health care related challenges.** The ability to navigate both what health insurance will cover and medical care systems was raised by multiple community stakeholders and interviewees. High costs of co-pays and deductibles, the difficulty of

knowing what is covered or not, constant changes in coverage, and barriers of bureaucracy were cited as examples.

- **Limited availability of providers** - Hampden County residents experience challenges accessing care due to the shortage of providers. Focus group participants reported using "Minute Clinic" because they could not get an appointment with their provider, providers not accepting new patients, and other barriers. Psychiatrists who can prescribe and dental providers were identified as in shortage. 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 and need for financial assistance -** Transportation arose as a barrier to care among interviewees in the 2016 CHNA, and it continues to be a major barrier to accessing care as one of the most frequently cited barriers in key informant interviews and focus groups for the 2019 CHNA. Poor access to transportation is a barrier to medical care, other appointments, picking up medication, work, and non-work activities. Also, the high costs of co-pays, deductibles, tests and medication are a barrier to quality health care, despite high rates of coverage by health insurance.

*"Transportation is a big issue. A lot of our patients financially aren't doing that great… and struggle to get to appointments so transportation is a big support service need."*
Key Informant Interviewee, Oncology Program Coordinator, Mercy Medical Center Hampden County

- **Need for culturally sensitive care** – Public health leaders, focus group participants, and other interviewees called for increased training, experience, and sensitivity for health care and social service providers to a variety of different cultures. Cultures of race and ethnicity as well as the cultures of people with mental health and substance use disorders, older adults, transgender patients, ex-offenders, people experiencing homelessness, and adults and children with disabilities were mentioned.

- **Lack of 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, a need to provide "warm handoffs" and better communications when a person is released from an institution such as jail, foster care, or a substance use treatment programs, and the need for hospitals to coordinate with community health centers should hospitalization take place.

- **Health literacy, language barriers –** The need for health information to be understandable and accessible was identified in this assessment.  Data from focus groups indicate the need for increased *health literacy*, including understanding health information, types of services and how to access them, and how to advocate for oneself

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA

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.

## 3.  Health Outcomes

- **Mental health and substance use disorders -** Substance use and mental health were identified as urgent health needs/problems impacting the area in virtually every type of stakeholder engagement in the 2019 CHNA. Hampden County has nearly double the rate of mental health hospitalizations as the state. Among 8th graders in Springfield, 10% of girls and 6% of boys had attempted suicide in 2017.  Substance use admissions to treatment programs have risen by 42% from 2012 to 2017 in Hampden County, with alcohol and heroin as the drivers of admissions. Opioid use disorder continues to be a public health crisis, with the number of opioid-related deaths in Hampden County increasing annually from 32 in 2000 to 113 in 2017. 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, the need for more treatment options and in particular treatment for people with co-morbidity.

*"There are not many dual programs. Many addicts have mental health issues as well, but programs usually do not treat both – just addiction – so they recover but it doesn't last and they go back in and out of rehab."*
Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

- **Chronic health conditions –** High rates of **obesity**, **cancer**, **diabetes**, **cardiovascular disease, asthma,** and associated morbidity previously identified as prioritized health needs in the 2016 CHNA continue to impact Hampden County residents. While rates of **cancer** are slightly lower than the state, cancer is the second leading cause of death in Hampden County. Heart disease is the leading cause of death.  An estimated 29% of adults in Hampden County are obese with 37% obese in Springfield. Four out of 5 adults over 65 have hypertension, a risk factor for cardiovascular disease. An estimated 11% of county residents have diabetes. Emergency Room use for asthma for adults is 78% higher than the state, pediatric asthma ranges from 10% of children in Westfield and West Springfield to up to 20% in the urban core cities of Hampden County.

- **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.

- **Infant and perinatal health -** Infant and perinatal health factors were identified as health needs in the 2016 CHNA and continue to impact Hampden County residents. Need for increased utilization of prenatal care and a decrease in smoking during pregnancy were identified. Disparities exist with whether a person has private or public insurance in prenatal care and birth outcomes. As a result, 8 -10% of Hampden County births are born preterm or low birth weight.

- **Sexual health -** While great strides have been made to reduce teen birth rates in Hampden County, they are still more than double that of the state. High rates of unsafe sexual behavior remain a need in Hampden County. Sexually transmitted infection (STI) rates continue to be high, with Hampden County *chlamydia, gonorrhea, syphilis* and *HIV* rates higher than that of the state. *Youth* are at particular risk for sexually transmitted infections, with rates of chlamydia, gonorrhea and syphilis between 70% higher to double that of the state among youth.

- **Alzheimer's disease.** Hampden County has higher rates of Alzheimer's disease than the state. Between 2010 and 2035, the percentage of people over age 60 is expected to increase from 20% to 28%.

## 4. Vulnerable Populations

Available data indicate that **children and youth**, **older adults**, and **Latinos** and **Blacks** experience disproportionately high rates of some *health conditions* or associated morbidities when compared to that of the general population in Hampden County. Children and youth 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 poor *mental health and substance use disorder* among **youth** and particularly **girls**, **LGBTQ** (lesbian, gay, bi-sexual, transgender, queer) youth, **older adults**, **Latinos**, **women**, **people reentering society after incarceration**, **people experiencing homelessness**, and those with **dual diagnoses** (mental health and substance use disorder).

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

*"Structures of power get in the way. It's not a lack of resources, it's isolation of systems… you have to be intentional to understand this, the way structures interact with each other."* Key Informant Interview, Public Health Official, Hampden County

# 5. Summary

The Mercy service area of Hampden County, MA continues to experience many of the same prioritized health needs identified in Mercy's 2016 CHNA. Social and economic challenges experienced by the population in the service area contribute to the high rates of chronic conditions and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health inequities observed among vulnerable populations, which include children, older adults, Latinos, Blacks, LGBTQ youth, people with low incomes, women, people with mental health and substance use disorders, people involved in the criminal legal system and those experiencing homelessness, and people living with disabilities. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The 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 health care system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. Chronic health conditions such as obesity, cancer, diabetes, cardiovascular disease, asthma were also prioritized.

# II. Introduction

## 1. About Mercy Medical Center

**Mercy Medical Center (referred to as Mercy) -** Founded in 1873, Mercy has established itself as a provider of health care services within Western Massachusetts for over 145 years. In 2015, Mercy Medical Center and its affiliates became part of Trinity Health Of New England, an integrated health care delivery system that is a member of Trinity Health, Livonia, MI, one of the largest multi-institutional Catholic health care delivery systems in the nation. The local health system includes Mercy Medical Center, a 182 bed acute care hospital in Springfield; Providence Behavioral Health Hospital, located in Holyoke and licensed for 131 beds; Weldon Rehabilitation Hospital, a comprehensive hospital-based rehabilitation center on the campus of Mercy Medical Center; Brightside for Families and Children, an outpatient service offering counseling and family support programs; and two outpatient substance abuse treatment centers.

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## 2. The Coalition of Western Massachusetts Hospitals

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

## 3. Community Health Needs Assessment (CHNA)

Improving health and equitable distribution of health outcomes across Western Massachusetts is a shared mission across the Coalition 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 2018-2019 to update their 2016 CHNAs. The PPACA requires tax-exempt hospitals and insurers to "conduct a Community Health Needs Assessment [CHNA] every three years and adopt an implementation strategy to meet the community health needs identified through such assessment." Integral to this needs assessment was the participation and support of community leaders and representatives who provided input through Regional Advisory Council participation, stakeholder interviews and focus groups, Community Conversations and Chats. Based on the findings of the CHNA and as required by the PPACA, the hospitals develop health improvement plans specific to their hospitals to address select prioritized needs. The CHNA data also informs County Health Improvement Plans (CHIPs) in all Coalition Counties.

# III. Methodology for 2019 CHNA
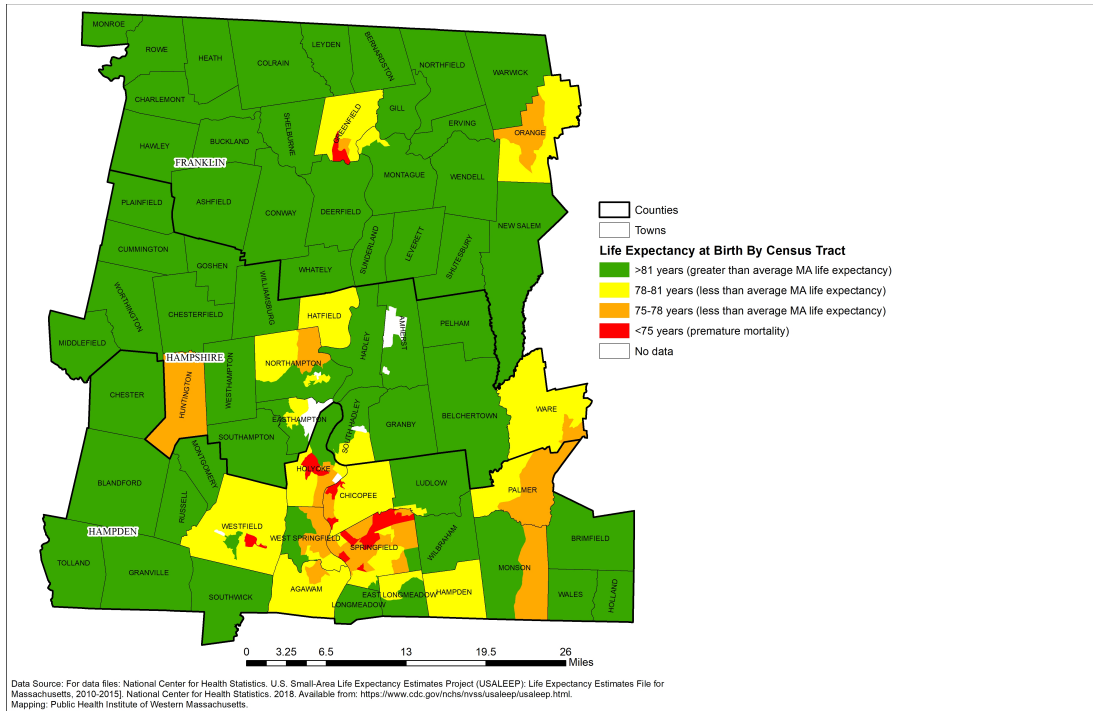
## 1. Equity as a Guiding Value

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

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

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

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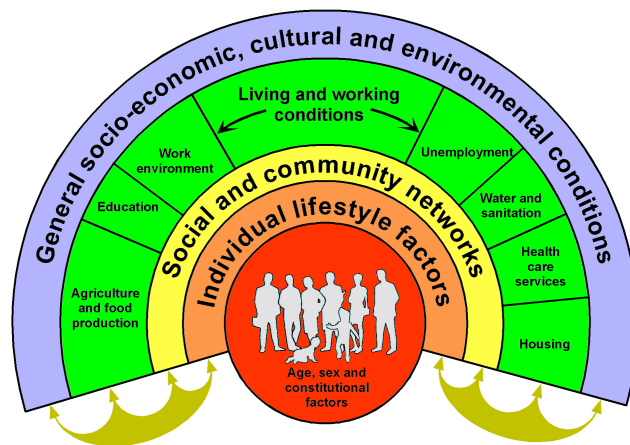


Data Source: For data files: National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates File for Massachusetts, 2010-2015]. National Center for Health Statistics. 2018. Available from: https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html.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

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

# 2. Social and Economic Determinant of Health Framework

Similar to the 2016 CHNA, this CHNA was conducted using a determinant of health framework recognizing that **social and economic environment contributes substantially to population health**. Research shows that that less than a third of our health is influenced by our genetics or biology.[1] Our health is largely determined by the social, economic, cultural, and physical environments that we live in and healthcare we receive (Figure 2).

Among modifiable factors that affect health, research shows that social and economic environments have the greatest impact. The County Health Rankings model (Figure 3), developed by the Robert Wood Johnson Foundation and the University of

**Figure 2. Determinants of Health**



Source: Dahlgren and Whitehead, 1993

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 3. County Health Rankings Model - Health Factors**
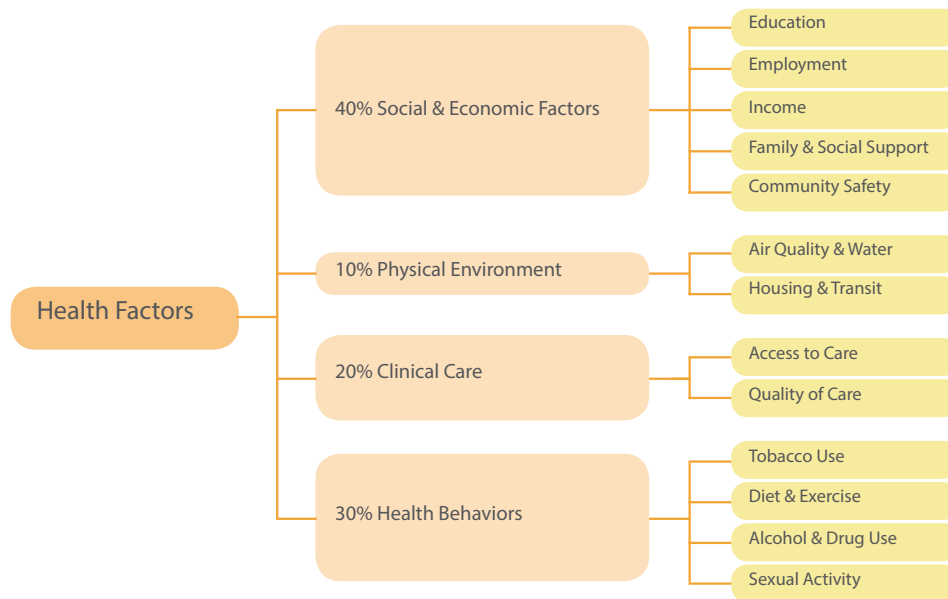


Since the 2016 CHNA, the Massachusetts D categories of determinants, which they refer to as health priorities: housing, employment, education, violence and trauma, the built environment, and the social environment.[3] (Figure 4) MDPH also has focus health issues: substance use, mental illness and health, and chronic disease. This CHNA is organized according to the MDPH categories and focus issues.

**Figure 4. MA Department of Public Health Priorities**



*Source: Massachusetts Department of Public Health, 2018*

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA

# 3. Assessment Methods

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

Assessment methods included: 1) analysis of social, economic, and health **quantitative data** from MA Department of Public Health, the U.S Census Bureau, the County Health Ranking Reports, the Massachusetts Healthy Aging Collaborative, Social Explorer, and a variety of other data sources; 2) analysis of findings from **12 focus groups, 55 interviews with key informants** (including with local and regional public health officials), **3 Community Conversations** and **49 Community Chats** conducted by the consultant team and the Regional Advisory Council (RAC) as part of this CHNA; and 3) review of existing assessment reports published since 2016 that were completed by community and regional agencies serving Hampden County. The assessment focused on county-level data and select community-level data as available. Given data constraints, the following communities were identified for the majority of the community level data analyses: Chicopee, Holyoke, Palmer, Springfield, West Springfield, and Westfield. Other communities were included as data was available and analysis indicated an identified health need for that community. Health Equity Workgroup members of the Regional Advisory Council identified that there are health needs specific to rural areas of Hampden County, however due to small numbers and lack of existing data, there is limited discussion of rural health issues in Hampden County.

To the extent possible given data and resource constraints, vulnerable populations were identified using qualitative and quantitative information. Qualitative data included focus group findings, interviews, input from our Regional Advisory Committee and Community Benefits Advisory Committees, and community outreach. We used quantitative data to identify vulnerable populations by disaggregating by race/ethnicity; age with a focus on children/youth and older adults; and LGBTQ (lesbian/gay/bi-sexual/transgender/queer) populations.

# 4. Prioritization Process

The 2019 used the 2016 CHNA priorities as a baseline with a goal of reprioritizing if quantitative and qualitative data, including community feedback, indicated changes. For the 2016 CHNA prioritization, health conditions were identified based on consideration of magnitude and severity of impacts, populations impacted, and rates compared to a referent (generally the state

rate). In the 2016 CHNA, prioritized health needs were those that had the greatest combined magnitude and severity or that disproportionately impacted vulnerable populations in the community.  Quantitative, qualitative, and expanded community engagement data confirms that priorities from 2016 continue in 2019.


# 5. Community and Stakeholder Engagement

The input of the community and other important regional stakeholders was prioritized by the Coalition as an important part of the CHNA process.  Below are the primary mechanisms for community and stakeholder engagement (see Appendix 1 for list of public health, community representatives and other stakeholders included in process).

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

- **Key informant interviews** and **focus groups** were conducted to gather information used to identify priority health needs and engage the community. Key informant interviews were conducted with health care providers, health care administrators, local and regional public health officials, and local leaders that represent the interests of the community or that serve medically underserved, low-income or populations of color in the service area. Interviews with local and regional public health officials identified priority health areas and community factors that contribute to health needs. Focus group participants included community organizational representatives, community members (low-income, people of color, and others), and other community stakeholders. Topics and populations included:  substance use, transgender health, older adults, youth, mental health, cancer care, gun violence, and rural food access. Key informant interviews and focus groups were conducted from February 2019 – March 2019. Focus groups and key informant interviews engaged about 210 people primarily in Hampden County but also across the

region; this CHNA also used qualitative data from other hospital service areas as appropriate.

- Baystate Health held 3 **Community Conversations** and approximately 46 **Community Chats** that were pertinent to Mercy's CHNA. Community Conversations were larger bi-directional information-sharing meetings conducted for each Baystate Hospital service area and one done in Spanish in Springfield. For Community Chats, RAC members brought information about the CHNA and gathered priorities in regular meetings of service providers, community-based organizations, and groups of staff and administration at hospitals. While these outreach efforts were spearheaded by Baystate Health, the engagement and findings benefitted all Coalition member hospitals/insurer. Conversations and Chats were held from January 2019 – April 2019 and engaged approximately 824 people in Hampden County.

- A **Community Forum** will be held upon completion of this report to share the findings. The Community Forum will include individuals representing the broad interests of the community, participants in the focus groups, interviews, Conversations, Chats, and community stakeholders representing medically underserved, low-income and populations of color.

*"We are too often talking about people, not with people. Community needs to be at the table, have their voices valued. They don't feel heard."*
Key Informant Interviewee, Public Health Official, Hampden County

# 6. Limitations and Information Gaps

Given the limitations of time, resources and available data, our analysis was not able to examine every health and community issue.  Much of the quantitative data gathered for this report was provided by the Massachusetts Department of Public Health (MDPH) as part of their efforts to provide data for community health needs assessments. Data and resource constraints at MDPH created challenges, although MDPH was very supportive in pulling together supplemental data. This experience will inform continued data collection efforts 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.

# 7. Hospital Service Area

The service area for Mercy includes all 23 communities within Hampden County (Table 1 and Figure 5), 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 communities exist to the east and west of this central core area. Many of these communities have populations under 20,000 people. 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.

**Figure 5. Mercy Medical Center Service Area**
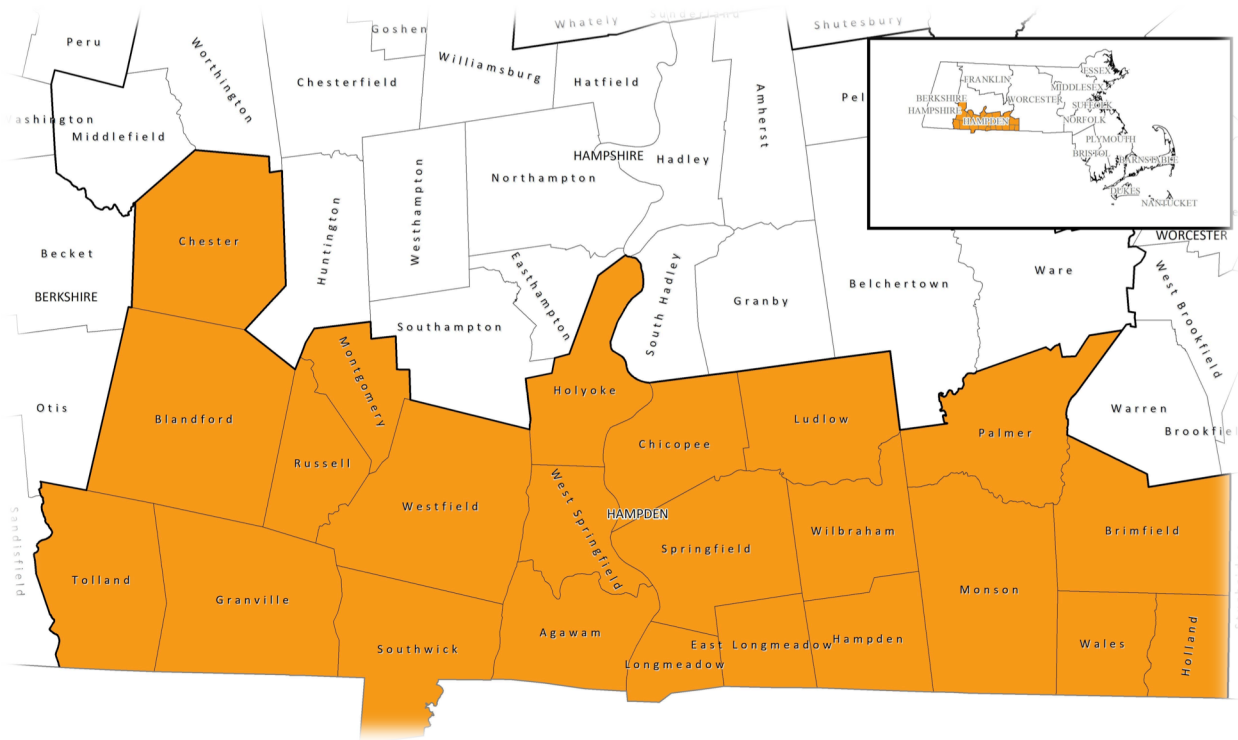


*Source: Public Health Institute of Western Massachusetts*

The service area has more racial and ethnic diversity than many other parts of Western Massachusetts (Table 2). County-wide, 24% of the population is Latino, 8% is Black and 2% is Asian (ACS, 2013-2017), though this diversity is not equally spread throughout the region and tends to be concentrated in the urban core. A substantial proportion of the county's population is from other countries. In 2017, 22% of the state's immigrants came to Western Massachusetts.[4] West Springfield has welcomed the highest proportion in Hampden County; 15% of the city's population are immigrants (US Census, ACS, 2013 – 2017)

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 $52,000 ($22,000 less than the state) and, the poverty rate is more than 60% higher than statewide, and the child poverty rate is an alarming 27% - more than 1 out of every 4 children in Hampden County is living in poverty (ACS, 2013-2017). Despite being at the core of the Knowledge Corridor region, only 27% of the population age 25 and over has a bachelor's degree, compared to 43% statewide. Unemployment is somewhat higher than the state average.

The median age for the service area is similar to that of Massachusetts, although in Springfield the median age is about 33 years of age compared to 39 in Hampden County. The population over 45 years old is growing as a percentage of the total population (Table 2). Between 2010 and 2035, the proportion of people over age 60 is projected to grow from 20% of the population to 28% in Hampden County, with the number of older adults increasing from approximately 92,000 in 2010 to an estimated 140,000 in 2035.[5]

In Hampden County 16% of the population has a disability compared to the state, where 12% do. In Springfield and Holyoke, disability rates are high at almost 20% and 17% respectively. In Hampden County, 11% of youth under 18 have disability (state – 7%). By race and ethnicity, 6% of White children have a disability, 10% of Latino children; and 6% of Black children.(ACS, 2013-2017)  People with disabilities tend to have higher rates of poverty and lower levels of education.  In Hampden County, poverty rates among those with a disability (27%) were more than double those among people without a disability (12%).  Similarly, 30% of the disabled population did not have a high school diploma compared to 11% among those without a disability (US Census, ACS, 2013-2017).

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

| Hampden County | 2017 Population Estimate |
|---|---|
| Agawam | 28,849 |
| Blandford | 1,260 |
| Brimfield | 3,745 |
| Chester | 1,380 |
| Chicopee | 55,515 |
| East Longmeadow | 16,291 |
| Granville | 1,624 |
| Hampden | 5,196 |
| Holland | 2,496 |
| Holyoke | 40,341 |
| Longmeadow | 15,864 |
| Ludlow | 21,502 |
| Monson | 8,836 |
| Montgomery | 864 |
| Palmer | 12,279 |
| Russell | 1,793 |
| Southwick | 9,758 |
| Springfield | 154,758 |
| Tolland | 500 |
| Wales | 1,892 |
| Westfield | 41,700 |
| West Springfield | 28,704 |
| Wilbraham | 14,671 |
| **Total Service Area** | **469,692** |

*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 | Springfield | MA |
|---|---|---|---|
| **Age** | | | |
| Median age (years) | 38.7 | 32.9 | 39.4 |
| >18 years | 22.1% | 25.7% | 20% |
| 18-64 | 62.1% | 62.3% | 64% |
| 65 and over | 15.7% | 12.0% | 16% |
| | | | |
| **Race and Ethnicity** | | | |
| Latino or Hispanic | 23.9% | 43.8% | 11.2% |
| Non-Latino or Hispanic | | | |
| White | 64.1% | 32.6% | 72.9% |
| Black or African American | 7.8% | 18.9% | 6.7% |
| American Indian and Alaska Native | 0.1% | 0.2% | 0.1% |
| Asian | 2.2% | 2.1% | 6.2% |
| Native Hawaiian and Other Pacific Islander | 0.0% | 0.0% | 0.0% |
| Some other race | 0.2% | 0.1% | 0.7% |
| Two or more races | 1.7% | 2.3% | 2.1% |
| | | | |
| **Language Spoken at Home (population over 5)** | | | |
| Speaks language other than English at home | 25.1% | 38.1% | 24% |
| | | | |
| **Educational Attainment** | | | |
| Population 25 years and over | | | |
| Less than high school graduate | 14.6% | 22.8% | 9% |
| High school graduate (includes equivalency) | 30.2% | 31.3% | 24% |
| Some college or associate's degree | 28.8% | 24.5% | 23% |
| Bachelor's degree or higher | 26.5% | 18.2% | 43% |
| | | | |
| **Income** | | | |
| Median household income | $52,205 | $37,118 | $74,167 |
| | | | |

*Source: U.S. Census, ACS, 2013-2017; for MA Census Reporter (https://censusreporter.org/profiles/04000US25-massachusetts/*

# IV. 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 the Mercy Medical Center are grouped into three categories: (I) social and economic determinants that impact health, (II) barriers to accessing quality health care, and (III) health conditions and behaviors.

## 1. Social and Economic Determinants that Impact Health

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

- **Housing Needs** – affordability, quality, stability, and tenure
- **Built Environment** – transportation, access to healthy food, and places to be active
- **Employment and Income** – poverty, living wages, unemployment, and workplace policies
- **Educational Needs** – educational attainment and systemic barriers to quality education
- **Violence and Trauma** – interpersonal and community violence and violence-related trauma
- **Social Environment** – social isolation, connection to community, and interpersonal, institutional, structural, and historical racism
- **Environmental Exposures** – air quality and lead exposures

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

### a.  Housing Needs

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

**Housing insecurity** 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. (U.S. Census Bureau, ACS, 2013-2017)(Figure 6).  For homeowners in Hampden County, 6.8% experienced being cost-burdened compared to 31% of renters. Housing cost burden is defined as more than 30% of income going towards housing. Lack of affordable housing can contribute to homelessness and housing instability, which leads to increased stress and can often force families to prioritize housing costs over factors that can influence health, such as purchasing healthy foods and medications.

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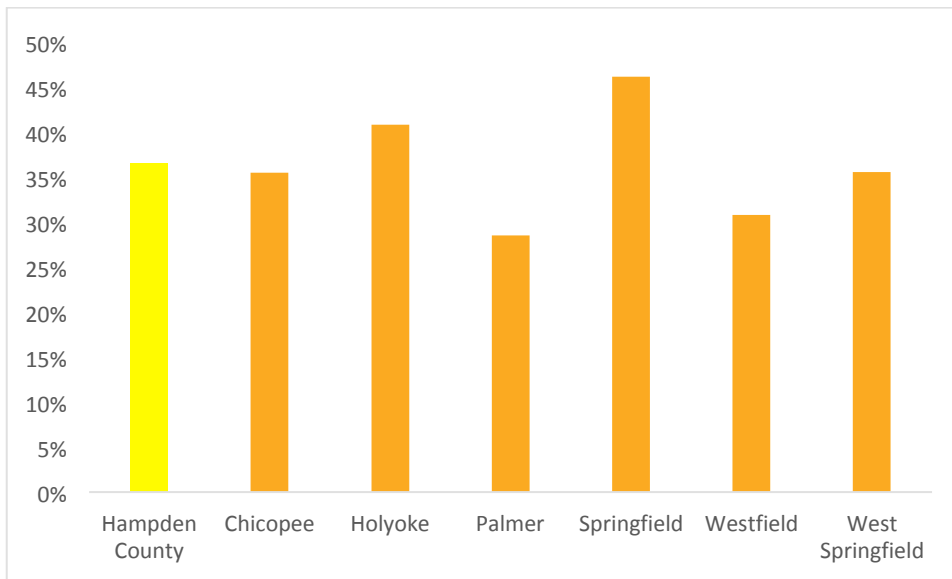


*Source: U.S. Census, ACS 2013 – 2017*

A more complete picture of affordability adds the cost of transportation. In Hampden County for a typical household income, people spend 52% of their income on housing and transportation costs combined. However, those with a lower household income spend 70% of their income on housing plus transportation.[6] In focus groups, people living with disabilities mentioned housing as the highest need, citing the difficulty of finding suitable housing for their needs. Older adults also felt that finding housing could be challenging due to affordability – adult living communities are plentiful but very expensive.

**Homelessness -** A "Point-in-Time" count done by the Western Massachusetts Network to Eliminate Homelessness found that there were almost 2,900 people homeless on one night in January 2018 in Western MA, of which 80% were in Hampden County. An estimated 20% were chronically homeless. When someone is chronically homeless, providing housing combined with social and health services is necessary. However, many people experiencing homelessness do not need housing but instead need social and health services, and an expedited pathway to these services. Approximately 55% of the homeless population is children under the age of 18. Of youth aged 18 – 24 who are unstably housed, more than half have been involved in the juvenile, foster, or jail systems. And more than 80% of mothers who are homeless are survivors of domestic violence.[7] In Springfield in 2017, almost 600 youth aged 18 – 24 stayed in emergency shelters in Hampden County.[8]

Key recommendations from focus groups and interviews to prevent homelessness are to
- Provide resources including more housing combined with supportive services, more rapid rehousing, and simply more affordable housing
- Target audiences include people who are leaving institutional settings (e.g., foster care, jail, hospital stays), those at risk of losing housing, people living with physical or psychological disabilities, and survivors of domestic violence.[8]

In a focus group with people experiencing homelessness, the most common health issue mentioned was not housing, but the need for treatment services for mental illness and substance use disorders. In a focus group with Recovery Coaches for people with substance use disorders, the first need mentioned was housing, particularly for women as well as for people with CORI issues.

*"You can't do treatment [for substance use disorder] without a place to live. You can't do it if you're living on the street."*
Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

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

**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, exposure to lead paint, asbestos, and lead pipes) that affect asthma, other respiratory illnesses, and child development. Housing conditions are important for the safety and accessibility of children, elderly or disabled populations. Hampden County has a large older housing stock with 32% of housing built before 1940. Springfield and Holyoke have a greater number of older

homes, with 41% and 48% of homes built before 1940, respectively (U.S. Census Bureau, ACS, 2014-2017). Data from the Be Healthy Partnership (BHP), an Accountable Care Organization (ACO) that includes five health centers serving Springfield Medicaid patients, 4% of respondents said their homes had bug infestation, 5% had mold or water leaks, 2% had inadequate heat, and 1% had inoperable oven or stove (BHP ACO, 2019).

**Housing tenure,** or whether someone owns or rents, is also a health issue. Home ownership can be a path to wealth and has the potential to be more stable than renting.[9] In Hampden County, 61% of people own their homes and 39% rent. Historically, redlining lending practices, racial discrimination related to mortgage acquisition in the GI bill, and higher incidence of predatory lending in communities of color have denied Black and Latino communities the ability to create stability and generational wealth via home ownership.[10,11] Reflecting inequitable policies and practices, only 39% of the Black population and 23% of the Latino population of Hampden County owns their home. Possibly mirroring the higher proportions of people of color and lower incomes in Springfield, 47% of Springfield residents own their own homes compared to the countywide proportion of 61% (U.S. Census, ACS, 2013-2017).

## b. Built Environment (Access to Healthy Food, Transportation, and Places to be Active)

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

**Transportation** arose as a barrier to care in the 2016 CHNA, and continues to be a major obstacle to good health (see Access section for more detail on Transportation as a barrier). Reliable transportation is a critical part of daily life, allowing individuals to go to work, travel to the grocery store, or get to medical appointments. However, nearly 23% of all Springfield households report not having any access to a vehicle, and 14% of Hampden County residents (US Census Bureau, ACS 2013-2017).

Unequal access to appropriate transportation options exacerbates racial and ethnic health disparities. Communities of color and those with lower incomes have less access to transportation options compared to majority white and higher income communities.[12,13] Public transportation plays a significant role in filling transportation needs for many of these households. Among Springfield residents lacking access to a vehicle, 23% report regularly using public transportation to travel to work, while 14% reported carpooling.[14] The Pioneer Valley Transit Authority (PVTA), which operates buses in Springfield and across Pioneer Valley, reports that the majority of PVTA customers – over 62% - are people of color. A 2017 equity analysis examining

proposed bus line service cuts and fare hikes concluded that the changes would have a negative impact on communities of color.[15]

*"Transportation, access to health care, ease of getting health care….We need to make it easy for people to make the decision to get care."*
Key Informant Interview, Community Health Center of Franklin County staff

**Food Access - Food insecurity**, or being without reliable access to sufficient affordable and nutritious food, continues to impact many Hampden County residents.  Eating nutritious food promotes overall health and helps manage many chronic health conditions. However, not all individuals and communities have equal access to healthy food. As can be seen in a map of food insecure census tracts in Hampden, Hampshire and Franklin counties (Figure 7), large portions of Springfield, and small parts of Chicopee, Holyoke, Palmer, West Springfield, and Westfield have rates of food insecurity greater than 15% (Figure 7).

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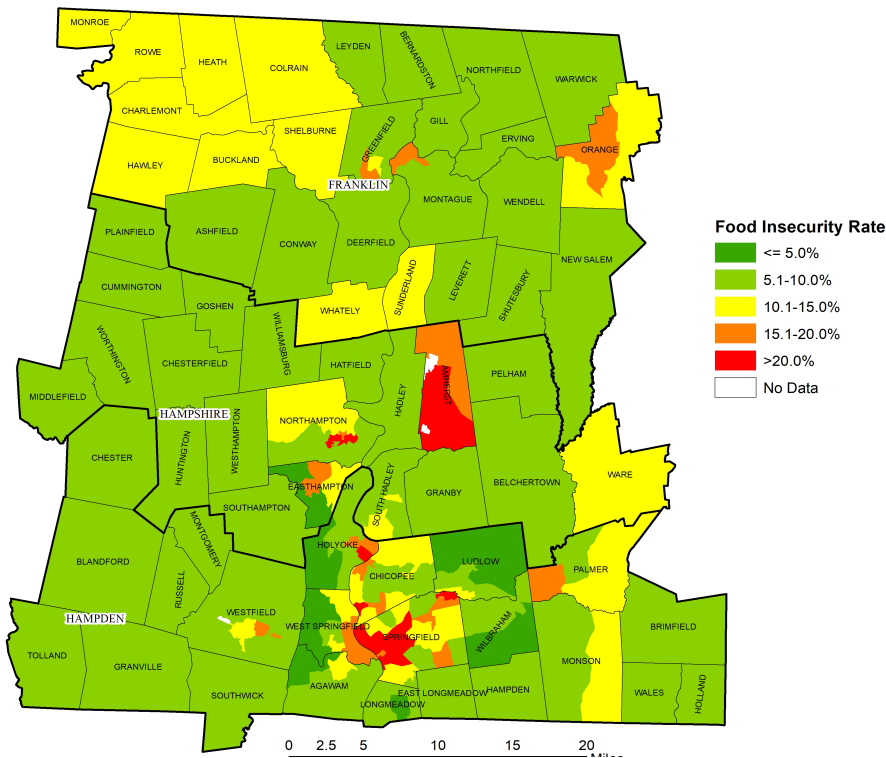


*Data source: Gundersen C Dewey A, Crumbaugh A, Kato M, Engelhard E. 2018. Map the Meal Gap 2018: A Report on the County and Congressional District Food Cost in the United States in 2016. Feeding America, 2018. Provided courtesy of the Food Bank of Western Massachusetts. Mapping: Public Health Institute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

Historical planning decisions created highways that split cities and separated white areas from black areas. One of many legacies has been that communities of color have worse access to grocery stores, more access to unhealthy fast foods, and more liquor retailers in their communities.[16] Additionally, marketing of fast food, junk food, sugary drinks, tobacco and alcohol more often targets communities of color.[17] Hampden County also has several **food deserts,** or areas where grocery stores and other options to purchase healthy foods are far away and difficult to access for people that either do not own a vehicle or live where public transportation is limited. People with lower incomes are more likely to live in food deserts. As identified in the 2016 CHNA, parts of Springfield, Holyoke, and surrounding communities have areas that the USDA has identified as food deserts (Figure 8).

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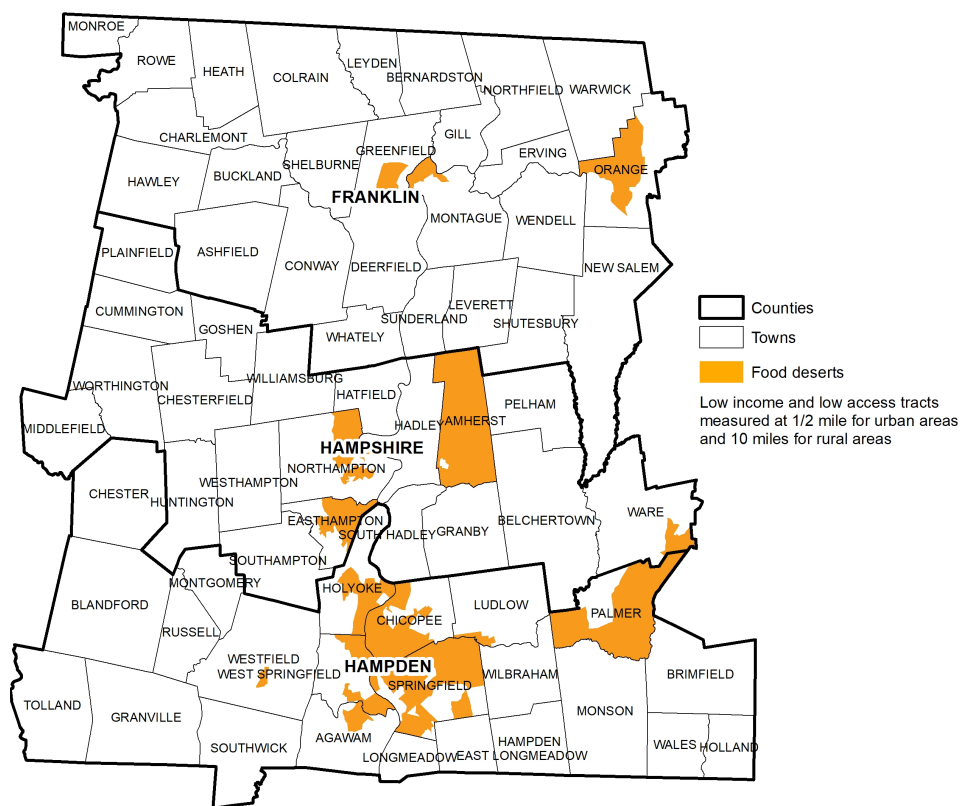


*Source:  USDA ERS Food Access Research Atlas – 2015; US Census Bureau's Cartographic Boundary Files; Mapping: Public Health Institute of Western MA. 3/21/2019.  USDA Food desert: at least 500 low-income people in a census tract live more than one mile away from a grocery store in urban areas and more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

**Access to opportunities for physical activity**. Having safe and accessible places to be physically active is a key resource for people's health. Approximately 12% of youth aged 13 – 16 in Springfield report felt they could not easily access opportunities to be physically active (Public Health Institute of Western MA, 2017 Youth Health Survey).

### c. Employment and Income

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

The median household income of $52,205 in Hampden County is one-third less that of the state. In Hampden County, the Census estimates that Black families make less than 70% that of White families and Latinos less than half (Table 3). The unemployment rate in Hampden County among the Black and Latino population is double that of the White population.

**Table 3. Socioeconomic Status Indicators**

|  | Hampden County | | | | MA* |
|---|---|---|---|---|---|
|  | Overall | White** | Black** | Latino |  |
| Median Household Income | $52,205 | $63,224 | $39,179 | $25,352 | $77,385 |
| Unemployment | 8% | 5.5% | 14% | 14% | 6% |
| Poverty | 17.2% | 8.1% | 21.6% | 39.8% | 10.5% |
| Child Poverty | 26.7% | N/A | N/A | N/A | 14.6% |
| No high school diploma | 14.6% | 9% | 16.9% | 34.5% | 10.5% |

*Sources: UC Census, ACS 2013-2017; poverty is 100% below federal poverty level; no high school diploma among adults age 25 and older; *US Census, Fact Finder, MA Profile; **Data for White residents is among those reporting non-Latino White. Contrary to previous years, recent census data does not separate people who identify as non-Hispanic Black or Hispanic Black. Therefore, these estimates cannot be compared to previous years.*

Just over 17% of county residents live in poverty, with rates of poverty over 21% of the population concentrated in areas of Springfield (28.6%) and Holyoke (28.7%) (Figure 10). An estimated 36% of county residents have incomes at or below 200% of the poverty level, which is a better indicator of people in need as the federal poverty level is extremely low and does not capture all of those who are economically struggling. The Springfield Be Healthy Partnership ACO found that 13% of their patient population had had a utility shut off in the past 12 months, 26% had often or sometimes had food run out by the end of the month, and 11% said they had trouble affording their children's basic needs (BHP, ACO, 2019).

**Figure 10. Hampden County Poverty Rates**
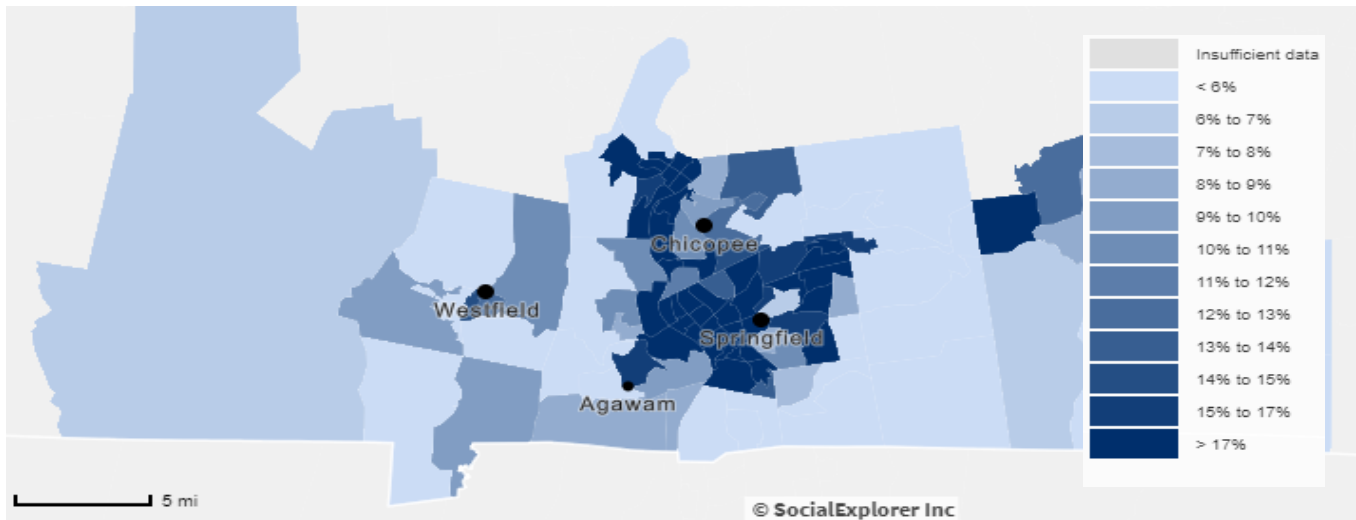


*Source: Social Explorer 2019, U.S. Census Bureau, 2013-2017; poverty is 100% below federal poverty level*

The Massachusetts Institute of Technology (MIT) estimates a Living Wage for different regions, based on typical expenses. In Hampden County for a family with one adult and one child, a Living Wage would be an hourly wage of $27.29.[18]  Using median household income for Hampden County and Springfield and dividing by the number of hours per year finds an average hourly wage is just over $25 in Hampden County and $17.85 in Springfield. Of note, using median household income is an imperfect proxy as there is the potential that more than one adult per household is bringing in a salary, but it is the only data point to provide a comparison. Current minimum wage in Massachusetts is $12/hour.

Across all Hampden County focus groups, Community Conversations, and Chats, poverty was identified as a factor that impacts overall health, access to health care, and access to program and services that promote health. In particular in Springfield, poverty was a factor called out by key informants and focus group participants as a major factor affecting involvement in gun violence.

Hiring and workplace discrimination affect people of color more frequently than white people.[19] Historically, laws passed during the 1990s "Tough on Crime" era decreased the ability of people who have been arrested, convicted, or incarcerated to find jobs. The National Inventory of Collateral Consequences documents tens of thousands of limitations placed on people who have been convicted[20] of which an inequitable proportion, are people of color due to discriminatory policies and practices.[21]

*"Health issues unique to people of color? It's harder to get hired."*
Focus Group Participant, Youth of Color focus group, Franklin County

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA

Workplace policies and practices can help or hinder well-being and health. Access to work-subsidized health care benefits, affordable childcare, sick and personal leave, a living wage, wellness programs, reasonable advance knowledge of scheduling, and workplace discrimination can impact direct health or illness as well as cause chronic stress.[22,23,24] Number of hours worked and predictability of scheduling are other employer practices that have a large health effect.[25]

Women, children and populations of color are disproportionately affected by poor socioeconomic status in Hampden County. Women in Hampden County earn 83 cents compared to every $1 earned by men, and women of color earn even lower proportions. Latinas earn 57 cents to white men's $1; Black women earn 71 cents. Women also participate in the workforce at lower rates than men in Hampden County (73% for women vs. 80% for men) and at lower rates than in the state (73% in Hampden County vs. 77% in MA).[26] Almost 60% of **children** living in Hampden County qualify for free or reduced lunch and 27% are in families with incomes below the poverty level (U.S. Census Bureau, ACS 2013-2017). With regard to race and ethnicity, median income levels are lower and unemployment and poverty rates are higher among **Latinos** and **Blacks** (U.S. Census Bureau, ACS 2013-2017). Hiring and workplace discrimination affects people of color more frequently than Whites.

### d. Educational Needs

**Educational attainment** is a community health need as it contributes longevity, availability of resources to meet basic needs, higher health literacy, and access to less physically dangerous jobs. Levels of education are strongly correlated with both employment status, the ability to earn a livable wage, and many health outcomes.[27] Approximately 16% of Hampden County residents age 25 and older do not have a high school diploma, compared to the Massachusetts rate of 10%. In the communities of Springfield, Chicopee, Holyoke, and Ludlow, over 20% of eligible individuals do not have a high school diploma. And while 42% of the population of Massachusetts has a bachelor's degree or higher, in Hampden County only 27% do, with even lower rates in Springfield (18%), Chicopee (17%), and Holyoke (24%) (U.S. Census, ACS, 2013-2017).

Communities of color face systemic barriers to education. Historically, slaves were not allowed to learn how to read or write, and Jim Crow laws required schools to be racially segregated.[28] Segregation of lower income students of color into underfunded schools continues today.[29] Additionally, differentially applied school discipline policies negatively affect students of color and disabled students, resulting in higher dropout rates and more involvement in the criminal justice system.[30]

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

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

*"In school, they don't teach you how to deal with emotional stress. You can end up being depressed about it."*
Focus Group Participant, Youth of Color focus group, Franklin County

Suggestions for how schools could help included:

- Training teachers and staff to be trauma-informed and have cultural humility
- Including Social Emotional Learning[31] in the curriculum
- Distributing information about developmental milestones to parents so they can detect disabilities early
- Incorporating restorative justice circles to deal with school discipline issues
- Hiring staff and teachers who have experience with the same types of neighborhood issues students face, such as gun violence
- Policy suggestions include passing statewide public school budget bills being considered in the legislature and incorporating restorative circles at all schools

## e. Violence and Trauma

**Interpersonal** and **collective** violence affects health directly, via death and injury, as well indirectly through the trauma that impacts mental health and healthy relationships.[32]

**Interpersonal violence** includes sexual and intimate partner violence, childhood physical and sexual abuse and neglect, and elder abuse and neglect. Western Massachusetts does not have any surveillance systems that measure incidence, prevalence, risk and protective factors, and related negative health outcomes associated with interpersonal violence (including intimate partner, dating, and sexual violence, violence against children, child exploitation). Data was gathered from subject matter experts across Western MA and the State (Department of Public Health and Executive Office of Public Safety and Security), in addition to publicly available statewide-level datasets and reports.

- **Sexual violence -** Of the over 2,900 Provider Sexual Crime Reports (PSCRs) submitted in 2017 and 2018, 13% were from assaults that reportedly occurred in Western MA, and only 57% were reported to the police. Of Western MA PSCRs, 55% (or 218) were in Hampden County. Females comprised 94% of victims/survivors, and one-third were youth under age 18.[33]

- **Intimate partner violence -** A 2014 criminal justice survey conducted by the city of Springfield found that of all assault arrests, 67% were for domestic violence offenses.[34] In 2018, nearly 6,900 restraining orders were filed in all of Western MA. The YWCA of Western MA in Hampden County fielded 5,116 calls to its Intimate Partner Violence (IPV) hotline; 94% were in English, 4% were in Spanish.[26]

- **Dating violence -** The Springfield 2017 Youth Health Survey found that 43% of students had experienced "aggressive behavior from their significant other," and 29% had experienced physical abuse from their significant other (Public Health Institute of Western MA, 2017 Youth Health Survey).

- **Child abuse and neglect** - In the Springfield Public Schools' 2017 Youth Health Survey, 8% of students reported that they had experienced physical abuse by someone in their family (PHIWM, 2017 Youth Health Survey). The MA Department of Children and Families (DCF) reports that in the last quarter of 2018 in Western MA, over 3,000 reports of child abuse or neglect were filed and screened in for investigation, and 42% of them were deemed true and in need of services.[35]

- **Elder abuse and neglect** - Nationally, 1 in 10 older adults reports some type of financial, emotional, physical, or sexual mistreatment or potential neglect in the prior year.[36] The Massachusetts Executive Office of Elder Affairs reported 9,800 confirmed abuse and neglect cases in 2017, nearly 40% more than in 2015.[37] In the Springfield Area Service Access Point, where reports would be filed, there were 2,438 intakes completed in 2018, up from 1,401 in 2014.[38]

- **Witnessing or experiencing any form of violence** contributes to many negative outcomes including mental illness, Post-traumatic stress disorder (PTSD), substance use disorder, aggressive behavior, poor school outcomes, and an elevated risk of criminal legal system involvement.[39] In the Springfield Public School 2017 Youth Health Survey, 12% of students reported that they had witnessed physical abuse. In focus groups and interviews on gun violence, young men and women discussed the anxiety, stress, grief, and sometimes numbness they have experienced.

*My son's father was shot at. It caused me to have PTSD, I see a therapist now. I have anxiety walking down the street. My son's father is gang affiliated and it makes me cry for him because I'm scared for him. What is he's [with the kids] and someone shoots?"*
Focus Group Participant, Gun Violence Focus Group, Hampden County

**Collective violence and trauma.** Lack of community safety was a prioritized health need in the 2016 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 much higher than that of the state. The rate of violent crime in Hampden County was 60% higher than the state

at 616 per 100,000 people compared to 384 in MA.[40] Property crime was similarly higher in the Springfield Metropolitan District than the state, at 2,171 vs. 1,437 per 100,000 people.[41]

- **Gun violence** - An analysis of gun violence done by the City of Springfield Police Department found that over a 5 year period (2013 – 2017), total incidents involving guns have decreased by 17%, with robbery with a gun decreasing the most (26%). However, murder with a gun increased by 20%. In all, total incidents with a gun went from 469 in 2013 to 345 in 2017.[42] Young men and women speaking in 2019 CHNA focus groups about gun violence in Springfield perceived that gun violence was omnipresent, guns are easy to get, and felt that change in the culture of gun use for people their age (18 – 25) was unlikely. Focus group participants and interviewees suggested starting at middle school age with interventions preventing or reducing gun violence. Ideas included the importance of mentors, youth programs [including sports] that kids want to participate in and are affordable, and improving school systems and law enforcement.

- **Bullying** - More than 1 out of every 5 students nationally reports being bullied, with girls, children with disabilities, and LGBTQ students at increased risk. In Western MA, more than one-quarter of female students report being bullied, which is 1.4 to 1.7 times higher than male students.[43] Findings from the Springfield Youth Health Survey (2017) indicate that 32% of Springfield 8th grade students were bullied in the past year (Public Health Institute of Western MA, 2017 Youth Health Survey).

  - Students with disabilities are 2 to 3 times more likely to be bullied than nondisabled students, and one study showed that 60% of students with disabilities report being bullied regularly compared with 25% of all students. Youth in special education were told not to tattle almost twice as often as youth not in special education.[44]

  - In the Springfield focus group, parents of youth with disabilities were passionate about the experiences of bullying their children had experienced, stating their children felt unsafe at school and the response of the authorities had not been adequate.

*"My son told me he was being assaulted in class and every day. They started a bullying investigation and before we could even submit his statement they closed the investigation with the finding that no bullying had happened, saying that 'none of the other students witnessed it'."* Focus Group Participant, Parent of a Child with Disabilities, Hampden County

## f. Social Environment

The social environment consists of the **demographics** of a region, including distribution of age, race, ethnicity, immigration status, and ability; **community-level factors** such as language

isolation, participation in democracy, social isolation or support, experiences of interpersonal discrimination; and the **policies and practices** of systems of government, cultural norms, and institutional racism, all of which impact people's health every day.

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

- Emotional implications of having a disability
- Decreased day services for people with mental health problems
- For older adults, limited availability of Meals on Wheels, limited Senior Centers hours and activities, and hearing, vision, and dental problems
- Linguistic isolation in Hampden County, with over 25% speaking a language other than English at home and 9% stating they speak English "less than very well." (ACS, 2013-2017)

*"Social connections and networks for social activities and support are as important as medical and mental health care. Older adults want to feel valued and involved in the community."*
Community Forum participant, Older Adults Community Forum, Hampshire County

**Being a connected part of a community is health-protective** - Participants of focus groups and interviews gave many examples: rural food pantry users stated that one always has something to eat if you get together with your neighbors; older adults who get support by frequenting Senior Centers; and parents of children with disabilities find connections with other parents helped them find resources. Public health leaders strongly advised health practitioners to become culturally sensitive and knowledgeable about different communities in order to be better health care practitioners.

*"My mom was diagnosed with 3 – 6 months to live, and if it weren't for the Cancer Support Group, she wouldn't be alive. Support group makes her have hope and want to live."*
Focus Group Participant, Cancer Care Focus Group, Hampden County

Experiences of **interpersonal racism, discrimination** and other forms of **exclusion** can serve to socially isolate people, and have consequences for mental and physical health.[45,46] Participants in focus groups and key informant interviews shared their experiences:

- Lack of sensitivity of transgender issues socially isolates transgender people who don't pass as the gender they identify with
- People with substance abuse and mental health disorders face discrimination in the medical system

- Rural populations feel that their priorities get "kicked down the road"
- Youth of color report being stereotyped by peers, teachers, and mention that "doctors shame and threaten parents that they should take better care of their kids." One young woman said, "A guy told me I was unattractive because I was black. It took a toll on me."
- Children with disabilities face a high rate of bullying in schools

**Policies and practices** of systems of government, cultural norms, and institutional racism impact people's health every day. The 2016 CHNA identified **institutional racism** as a driver of health inequities. Institutional racism is 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.[47] Practices of systems and institutions that result in racial inequities become the norm, are often codified by law or policy, and can manifest as inherited disadvantage.  These practice do not necessarily transpire at the individual level, but are embedded in our systems, regulations, and laws. Institutional racism is perpetuated by bureaucratic barriers and inaction in the face of need.[47] Structural racism is mutually reinforcing systems (criminal justice, poorly funded public schools, and housing policies, for example) that perpetuate discrimination in all areas of daily life and results in unequal distribution of social resources.[48] The policies and practices of systems and institutions are directly influenced by who has power and how they use it. Racially-motivated discrimination, whether conscious or built into the practices of systems, can lead to adverse health outcomes such as poor mental health, chronic stress, hypertension, and cardiovascular disease.[49,50,51]

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

- In schools, black children are more likely to be disciplined and experience unequal treatment in dress code violations

- Substance use disorder recovery coaches are not paid or have very low pay, there is very little training and no certification, which systematically marginalizes and devalues recovery services

- Marginalized youth don't often see teachers, counselors, community staff who look like them or have had the same kinds of experiences they have

- In focus groups and interviews about gun violence in Springfield, participants spoke of instances in which police came late to the scene of a fight or shooting, questioned/blamed witnesses instead of quickly pursuing people with guns, are not present in a helpful way in communities, and are generally seen as not doing enough in communities of color

- Emergency rooms practices that deny victims of gun violence visits by their loved ones, restrict number of visitors, and perceived lengthy response time by ambulances to gun violence victims

- Administrative level of health care does not feel friendly to transgender people. Forms and protocol disregards preferred names and gender identity, and asks patients to fill out forms with inscrutable questions about transgender status

*"Living in Holyoke or Springfield, you cannot ignore the racial difference. If you are a Hispanic parent, particularly if your English isn't what they think it should be, there is a huge gap and a much different response [to complaints of bullying of a disabled child].*
Focus Group Participant, Parent of Children with Disabilities Focus Group, Hampden County

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

Racial residential segregation is 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, jobs, quality housing, healthy food, and a number of other social determinants of health.[52] The University of Michigan's Center for Population Studies in 2013 ranked the Springfield Metropolitan Statistical Area (Hampden, Hampshire and Franklin counties) as the most segregated in the U.S. for Latinos, and 22nd in the country for Blacks.[53]

Mass incarceration and criminalization are examples of institutional racism that result in racial inequities at every stage of the criminal legal system, with health implications. In 2015 admissions to the Hampden County Jail were more than double the Massachusetts rate (458 in Hampden County compared to 216 people per 100,000 in MA). The average daily population in the jail was 1,428 people. Blacks and Latinos are jailed at disproportionately higher rates, comprising 60% of the jail's population compared to an estimated 32% in the county as a whole. Only 36% of the Hampden County jail population is White.[54] The incarceration of women in jails is on the rise, with Hampden County jail incarcerating 40% more women between 2011 and 2015.[55]

## g. Environmental Exposures

Air pollution impacts the health of Hampden County residents. Air pollution is associated with asthma, cardiovascular disease and other illnesses. Springfield in particular experiences poor ambient air quality due to development, zoning, and land use decisions which have located 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. Additionally, many cities in Hampden County are in a valley into which air pollution travels from other sources and

settles.  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 neighborhoods. In Springfield, the risk of cancer from breathing air toxins is higher than at least 80% of all of the rest of Massachusetts.[56] Air quality in Hampden County as a whole is slightly worse, with 8.8 micrograms of particulate matter 2.5 (PM2.5) in the air compared to the state at 8.657. Particulate matter is one form of air pollution known to impact asthma, heart disease, lung cancer, and premature mortality.[58]

**Exposure to lead** is a well-known health risk, connected to outcomes as varied as decreased academic achievement, IQ, and reduced growth in children and decreased kidney function, increased blood pressure and hypertension in adults.[59] Springfield had the highest risk score for blood lead poisoning in the state based on 2013-2017 elevated blood level incidence rates, poverty, and percent of households built before 1978.[60] In Springfield in 2017, 26 children (0.5% of children over 5) had blood lead levels that were considered lead poisoning (>10mcg/dL), and 183 children (3.6%) have >5mcg/dL. Holyoke was also identified as a high risk community for blood lead poisoning in MA, with 9 children identified as having lead poisoning.[61]

# 2. Barriers to Accessing Quality Health Care

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

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

## a. Insurance and health care related challenges

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

*"The whole system needs a group of people who know what's going on and know the system and can help people navigate it and coordinate all the different parts that affect a person."*
Focus Group participant, Substance Use Disorder Focus Group, Hampden County

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

- MassHealth reducing the number of hours they would provide for Personal Care Attendants
- Needing multiple different diagnoses so insurance would cover medical services and school-related resources for disabled children
- Providers not taking MassHealth
- Insurance companies changing their products

Patients and their families praised the navigation assistance at the Sister Caritas Cancer Center at Mercy Hospital. The Cancer Center has 2 dedicated Nurse Navigators, 2 social workers, and 1

patient advocate all dedicated to helping people find their way through insurance and care as well as supporting them emotionally.

## b.  Limited Availability of Providers

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

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

Population to provider ratios are one indicator of how many healthcare professionals there are in an area. Hampden County has 1400 people for every primary care physicians, compared with a ratio of 960:1 in Massachusetts. Hampden County has 1210 people for every dentist, compared to 990 in the state (County Health Rankings, 2019). Although there is greater access to mental health providers for Hampden County residents as compared to the state (120:1 vs. 180:1 in MA), focus group participants and key informant interviewees overwhelmingly reported a need for increased access to mental health and addiction services. Some specific mentions were for Medication Assisted Treatment (MAT), specialists such as neuropsychologists and physiatrists for children with disabilities, Ear Nose and Throat providers, rheumatologists, and oral surgeons.

*"We have a lot of therapists, but not enough psych prescribers."*
Key Informant Interviewee, Public Health Official, Franklin County

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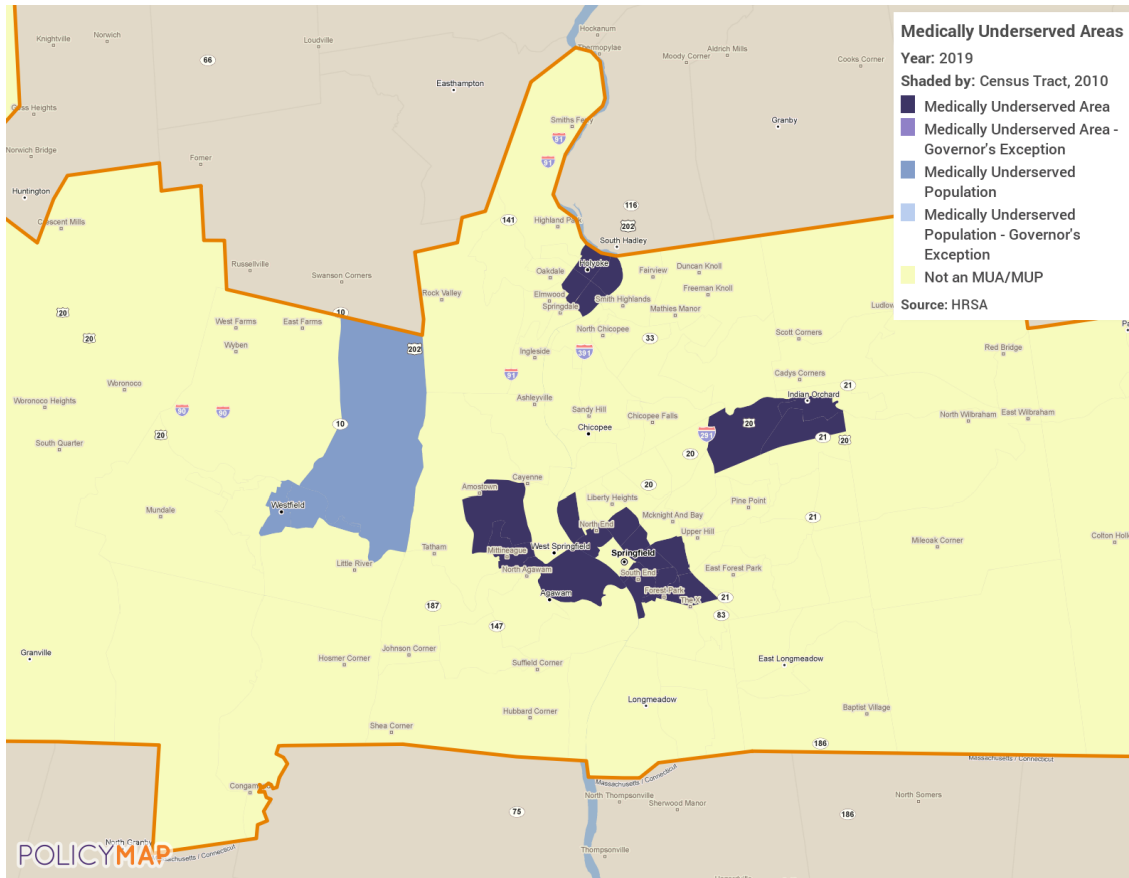


*Source: Community Commons, HRSA 2015*

## c. Need for Increased Culturally Sensitive Care

The need for culturally sensitive care remains a prioritized health need, as it was in the 2016 CHNA, with increased training in cultural humility needed as a means to deliver more culturally sensitive care. Cultural sensitivity refers to a commitment among health care and social service providers to self-reflection and evaluation in order to reduce the power imbalance between patients and providers, and to the development of care partnerships that are based on mutual respect and equality.[10]

Results from 2019 CHNA interviews with public health leaders and focus groups identified cultural differences between the community and providers and implicit bias as a barrier to health. They called for an assessment of where and when this happens; increased training, experience, and sensitivity for health care providers to a variety of different cultures; and accountability for cultural insensitivity and bias. 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, people with mental health or substance use

issues, the aging population, transgender, non-binary, and gender non-conforming, adults and children with disabilities. The need for providers competent in racial and cultural issues was also raised.

*"We need providers who look like and are from the community, who understand the culture. We need education for providers, a sense of what the community is. Some doctors are very conscious, but providers need to be immersed in the community, know how to navigate it."*
Key Informant Interviewee, Public Health Official, Hampden County

### d. Need for Transportation and Financial Assistance

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

Transportation is a particularly difficult issue for children and adults living with disabilities, older adults, low income populations, and cancer patients. People in focus groups mentioned challenges due to lack of transportation in getting to medical appointments, the food pantry, places for disabled children to exercise, the grocery store, and the pharmacy. In the BHP ACO data from Springfield Medicaid recipients, 17% said that lack of transportation had kept them from getting to medical appointments or getting medication. Survey respondents had gotten to their medical appointment the day of the survey by vehicle (55%), public transportation (9%), walk or bicycle (5%), with the rest not answering. (BHP ACO, 2019) Focus group participants had many creative ideas, ranging from expanding existing PVTA bus service; increasing eligibility for vans that are Americans with Disabilities Act (ADA) compliant; telehealth; more transportation vouchers (Uber, taxis, bus passes); mobile health vans that go to people to do lab draws and fill prescriptions; pharmacies that deliver; and EMS doing wellness checks.

*"Transportation is a big issue. A lot of our patients financially aren't doing that great, so transportation is a big issue. We would love to have a shuttle or better taxi service, make sure the taxi voucher program through our Patient Fund is still running. A lot of patients struggle to get to appointments so transportation is a big support service need."*
Key Informant Interviewee, Oncology Program Coordinator, Hampden County

Financial assistance was also identified as a need. Despite high rates of coverage by health insurance, the cost of health care co-pays, deductibles, tests, and medication is a barrier for many to having optimal health. Beyond the costs of portions of health care that insurance doesn't cover, additional costs include programs, equipment, physical activities, and alternative therapies such as acupuncture that are typically not covered by insurance but are suggested by medical providers and help patients. A public health leader noted, for example, an increase in demand for free immunizations because people cannot afford co-pays. The high cost of home

care for people with disabilities impacts the quality and quantity of those services. Older adults can fall into a gap where they are too young or have too much money to qualify for services they need, yet cannot afford expensive services. Financial counseling that hospitals offer is helpful but there are not enough counselors to serve the need.

*"It would be good to have dedicated financial counseling in the Cancer Center. Patients and families have support from social workers if they need help with insurance, but having someone in the Cancer Center to think through the cost of their treatment – which can be huge – would be helpful. They can access the financial counseling for all of Mercy, but it would be good to have someone dedicated."*
Key Informant Interviewee, Oncology Program Coordinator, Hampden County

### e. Lack of Care Coordination

Lack of care coordination is a prioritized community health need, as it was in the 2016 CHNA. Care coordination refers to the coordination of patient care, including the exchange of information between all parties involved in patient care (AHRQ, 2007). In the 2019 CHNA, informants went beyond simply identifying that providers need to coordinate individuals' care. Several called for "one-stop shopping," "consolidation of services that already exist", and reduction of the duplication of services, suggestions that were also made in the 2016 CHNA.

Focus group participants and interviewees identified important areas where care provided by multiple providers continues to be uncoordinated and results in challenges. Examples include: lack of follow up when a person is discharged from a mental health treatment program, substance use disorder program, or jail; lack of coordination among agencies that provide support services for transgender clients, need for survivor planning for people after cancer as they separate from the health care industry, need to integrate mental health and substance use disorder services with primary care, and need for transitions, communication, and "warm handoffs" from jail to the community for a population that has a high rate of trauma and more needs.

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

## f. Health Literacy and Language Barriers

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

**Health literacy** is the capacity for an individual to find, "communicate, process, and understand basic health information and services to make appropriate health decisions."[9] Data from focus groups illustrate the need for increased access to information about providers, services, resources, how to advocate for themselves and their families, and health education. The Be Healthy Partnership ACO found that 48% of patients said they need help with reading medical materials always, often, or sometimes, and 13% self-identified their ability to read at all as poor. (BHP ACO, 2019) Several focus groups pointed to the need to have all information in one place. In focus groups for transgender, non-binary, and gender non-conforming people as well as parents of children with disabilities, participants mentioned needing a hub of information for their specific needs that all in their communities know is the place to go for information, even if just an on-line resource. One person noted that they had three separately compiled documents with resources for transgendered people, and how helpful it would be if everything were in one spot. While a support group is not a replacement for an institution or organization providing needed information, participants in the Cancer Support Group identified how vital the role the group played in teaching members self-advocacy, providing information about various resources, and health education.

Providers also spoke of health education needs, including increasing parents' knowledge of typical developmental milestones so they can identify if their child is delayed, and increasing knowledge of resources available to children with disabilities.

**Language barriers** can create multiple challenges for both patients and health care providers and was previously identified as a need. Increasing availability of interpreters as well as translation of health material are specific actions that health care institutions can help to address this barrier. Another Hampden County-based medical center - Baystate Medical Center - had almost 217,000 interpreter service requests in 2018 out of almost 1.3 million inpatient and outpatient encounters, meaning that about 17% of encounters required interpreter services.[62] This data is not available for Mercy but demonstrates need in the Springfield area.

Baystate Medical Center held a Community Conversation in Spanish in Springfield. Turnout was high, and Latino participants were appreciative of the rare attempt to hear their needs. Regional Advisory Committee members identified a need to integrate the perspective of people who speak other languages as well. There is a need for bilingual providers, translators, and health materials translated in a wider range of languages. The refugee and immigrant populations in Hampden County makes for an increasingly diverse linguistic population. In Hampden County, a quarter of the population speaks a language other than English at home, and 9% of Hampden County households are linguistically isolated (U.S. Census, ACS 2013-2017).  Linguistic isolation

is defined by the U.S. Census Bureau as a household in which all members older than age 14 speak a non-English language and have difficulty with English.  Cities with the largest proportion of linguistically isolated households in Hampden County are Springfield (14%) and Holyoke (17%) (US Census, ACS 2013-2017).

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA

# 3. Health Conditions and Behaviors

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

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


## a. Mental Health and Substance Use

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

- More treatment options, including Medication Assisted Treatment (MAT), long term care options, treatment beds external to the criminal justice system, and treatment for people with dual diagnoses
- Increased education across all sectors to reduce the stigma associated with mental health and substance abuse
- More sober and transitional housing for people with mental health issues, those dually diagnosed, and for those leaving institutions (incarceration, foster care, etc)
- Increased integration between the treatment of mental health and substance use disorders
- Recognition of the impact of mental health conditions and substance abuse on families

*"I really wish we had a better program to treat not just cancer, but the mental side of the diagnosis. When people hear the 'C' word, it's a really scary thing and people don't often know how to handle or understand the diagnosis and everything it means for them."*
Key Informant Interviewee, Thoracic Surgery Nurse Navigator, Hampden County

## Mental Health

Though mental health is commonly thought of as the absence of mental illness, mental well-being extends beyond the presence or absence of mental disorders. The World Health Organization defines mental health as the "state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[16] Only an estimated 17% of U.S adults are "in a state of optimal mental health."[17] More than one out of four adults nationally live with a mental health disorder in any given year, and 46% will have a mental health disorder over the course of their lifetime.[63] Mental health is an indicator of health itself, but also contributes to physical health and inequities.

In Springfield adults, 17% report poor mental health on 14 days or more a month.[64] In Hampden County, people report 4.5 mentally unhealthy days in the last 30 days, comparable to the statewide number of day of 4 (County Health Rankings, 2019). Hampden County has nearly double the rate of mental health hospitalizations (1,550 per 100,000) as the state wide rate (854)(Figure 13). Latinos experience drastically higher hospitalization rates (2,345 per 100,000) than the county average (Figure 14).

Depression is the most common type of mental illness, and it affects more than 26% of U.S adults.[17] Estimates sugggest that by 2020, depression will be the 2nd leading cause of disability worldwide, and children are particularly vulnerable.[17] Substance use disorder often co-occurs with mental illness and impacts physical health as well.

*"Anxiety and depression have increased. It seems like everyone has some psychiatric diagnosis that needs managing."*
Key Informant Interviewee, Community Health Center staff, Franklin County

**Suicide** is higher in specific populations. According to MDPH, across the state 74% of intentional deaths in 2016 were suicide (n = 638), at a rate of 9.4 per 100,000. Of those 77% were men, and the highest rate is in Whites at 11 per 100,000, then Blacks at 9 and Latinos at 4 per 100,000.[65] No local data is available.

**Figure 13. Mental Health Disorder Hospitalization Rates for Select Hampden County Communities**



Chart showing Mental Health Disorder Hospitalization Rates:
- Chicopee: 2008
- Holyoke: 1665
- Ludlow: 2384
- Palmer: 1509
- Springfield: 1512
- Westfield: 1745
- West Springfield: 839
- Hampden County: 1550
- Massachusetts: 854
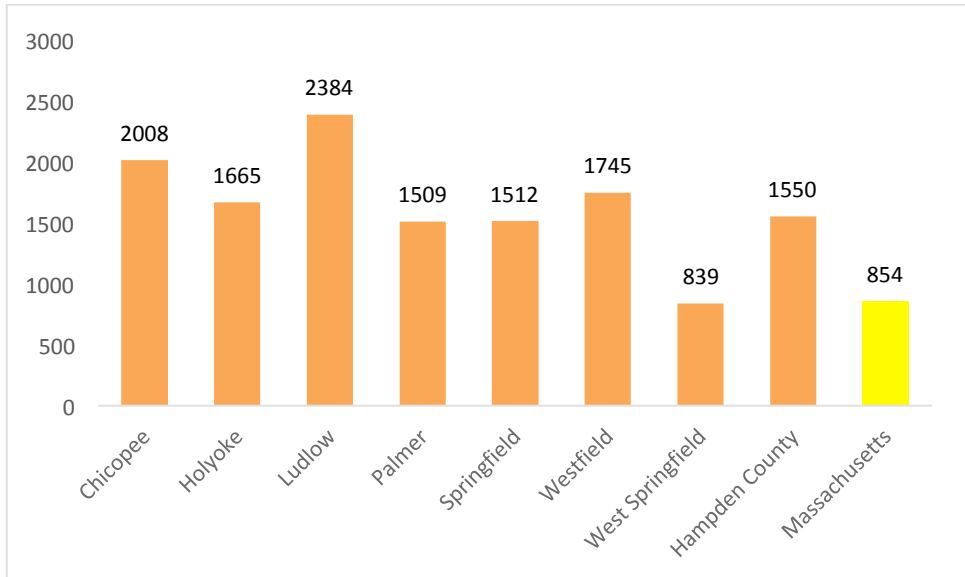
*Source: MDPH, 2012 – 2015. Age-adjusted per 100,000*

**Figure 14. Mental Health Disorder Hospitalization Rate by Race, Hampden County and Massachusetts**



Chart showing Mental Health Disorder Hospitalization Rate by Race:
- Total: 1550
- White: 1384
- Black: 1422
- Latino: 2345

State Rate 854

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

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA
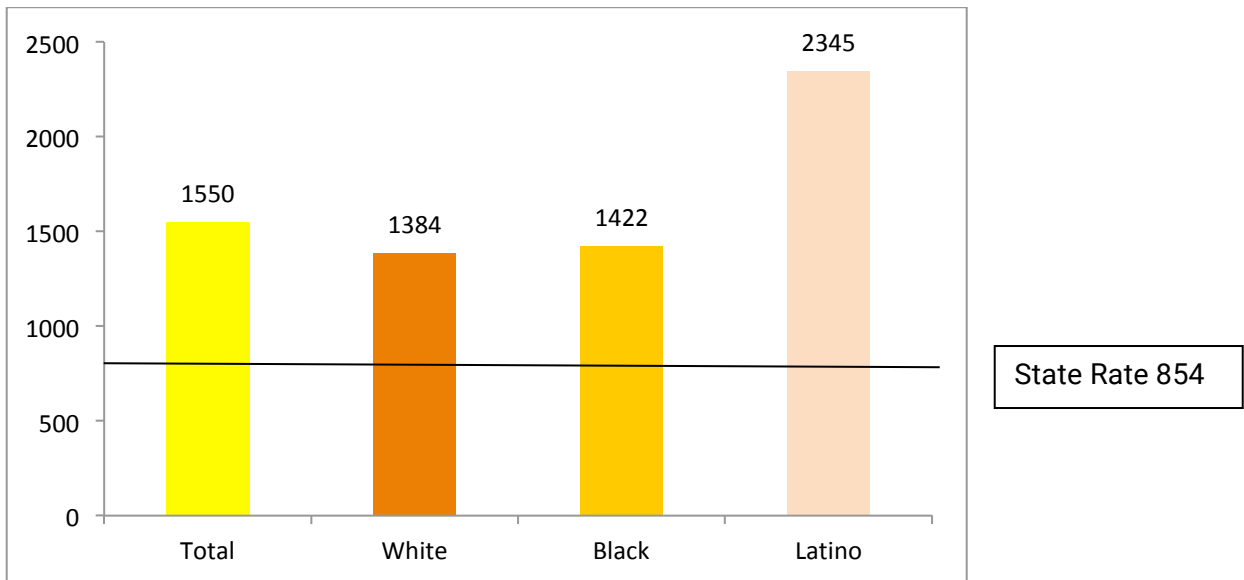
**Vulnerable Populations**

- **Youth** are disproportionately impacted with mental health issues. Data from the 2017 Springfield Youth Health Survey indicated that 31% of Springfield 8th graders "felt so sad or hopeless that they stopped doing their usual activities."[66] This is a 3% decrease from 2015, but still 50% higher than statewide.
- In the 2017 Prevention Needs Assessment Survey in the Springfield Public Schools, 44% of students reported experiencing depressive symptoms.[67] Among 8th graders in Springfield, 14% had considered suicide and 8% had attempted suicide in the previous year. Rates were higher among females; 10% of girls and 6% of boys had attempted suicide in the year prior to the survey, and 26% of girls and 20% of boys engaged in self-harm.[68]
- **LGBTQ** youth are also disproportionately impacted with 61% of LGBTQ 10th and 12th grade students responding to the 2017 Springfield Youth Risk Behavior Survey reporting feeling sad or hopeless two weeks or more, an increase of 5% since the 2015 survey. One in five report that they tried to commit suicide in the past year and 38% had engaged in self-harm.[69]
- Out of all Massachusetts communities statewide, nine of the ten communities with the highest rates of mental health-related hospital admissions among **women** were in Western MA. About 56% of **girls** in Springfield schools are at high risk for depression compared to 32% for boys.[26]
- About 1 out of 3 **older adults** experience depression in select communities in Hampden County. Several communities report higher rates of depression than the state rate of 32%, including Holyoke (36%), Springfield (35%), and Chicopee (33%). However, West Springfield (31%), Ludlow (30%) and Westfield (29%) rates are lower.[70]
- **Latinos** experienced high hospitalization rates for mental disorders with rates 70% greater than Whites and over 50% greater than Hampden County rates overall. These disparities have worsened since the 2016 CHNA.
- The Substance Abuse and Mental Health Services Agency (SAMHSA) estimates that 26% of **people who experience homelessness** have a severe mental illness and 35% have chronic substance use issues.[71]

*"There is too much of a separation in treatment between physical and mental health."*
Focus Group Participant, Patients Living with Disabilities, Hampden County

**Substance Use**

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

- An estimated 18% of Hampden County residents smoke tobacco as compared to 14% statewide (County Health Rankings, 2019). Smoking in Hampden County decreased by 3% from the 2016 CHNA. In Springfield, 24% of residents smoke tobacco.[72]

- Seven percent of 8<sup>th</sup> graders in Springfield reported drinking alcohol and using marijuana in the last 30 days (PHIWM, 2017 Youth Health Survey). In key informant interviews, health care providers noted vaping and marijuana use among youth as a rising concern since the legalization of marijuana in Massachusetts.
- A national study found that vaping has doubled in high school youth between 2017 and 2018, from 11% to 21%.[73] In Springfield, 19% of students report trying vaping, and 4% stated they had vaped in the last month (PHIWM, 2017 Youth Health Survey).
- Among adults over age 65 in Massachusetts, 7% report substance use. Proportions in Hampden County towns are generally higher, with Springfield reporting 9%, West Springfield 8%, Holyoke 10%, Chicopee 8%, and Palmer 7%.[70] Communities with lower proportions than the state average include Ludlow and Westfield.

*"Some high schoolers with learning disabilities can have lots of trouble with anxiety, take drugs to help with the anxiety. We're not picking up on this fast enough to stop the drug use."*
Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

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

- In Hampden County, Emergency Room (ER) visits for substance use rose from a rate in 2012 of 223 ER visits per 100,000 to 266 in 2014. The rate in 2014 is similar to the rate in Massachusetts overall (251) (Figure 15).
- Rates are elevated among select communities: Holyoke (402), Palmer (377), and Westfield (350) had higher rates of ER use for substance use disorders. Springfield was only slightly higher (285) (MDPH, 2014).
- Data disaggregated by race/ethnicity was unavailable.

*"The newspaper put a person's photo on the front page for possession charge – not dealing or anything serious. We don't treat people with diabetes or other diseases that way."*
Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

Substance use admissions to treatment programs have increased over time. Total admissions in Hampden County have risen by 42% from 2012 to 2017, from 8,047 in 2012 to 11,394 in 2017 (Figure 16). Admissions for heroin and alcohol drive admissions, with heroin increasing over time. Crack/cocaine, marijuana and other opioids account for under 10% each (Figure 17).

**Figure 15. Substance Use Disorder Emergency Room Visits, Hampden County and Massachusetts**
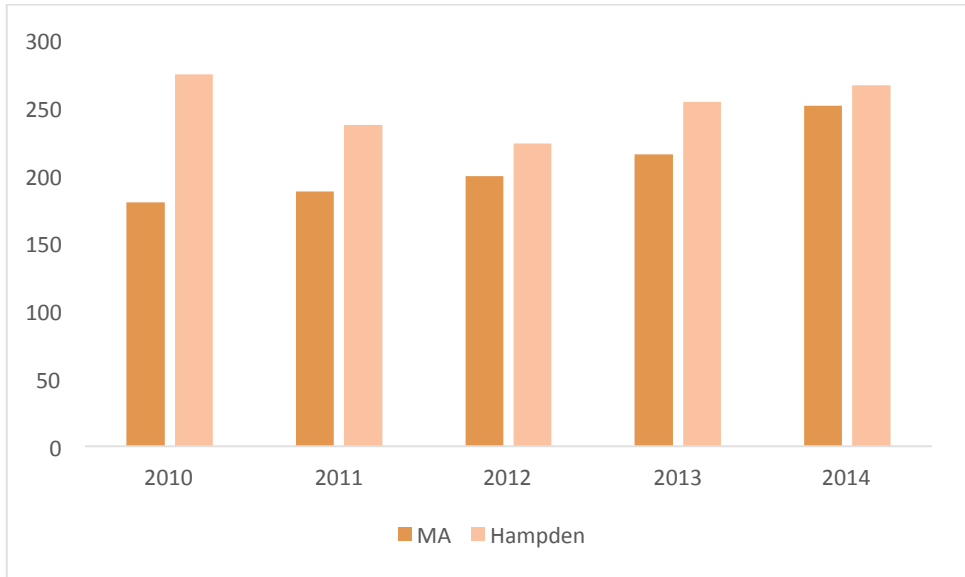


*Source:  MDPH, 2010 – 2014. Age-adjusted per 100,000*

**Figure 16. Substance Use Admissions to Treatment Programs in Hampden County, 2010 – 2017**
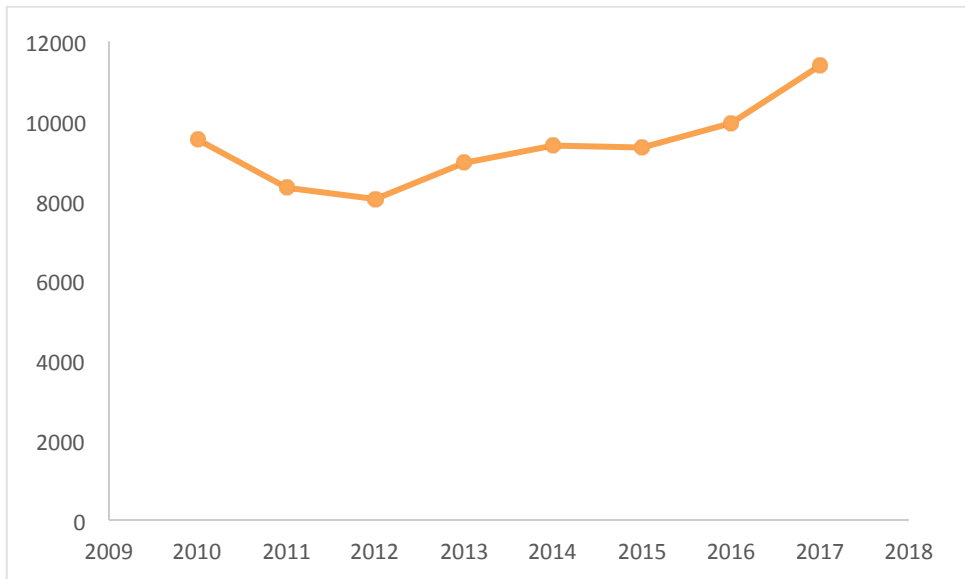


*Source: Massachusetts Department of Public Health. Bureau of Substance Addiction Services. 2018. Geographic Fact Sheets FY 2017, Admission Statistics by County. Available at https://www.mass.gov/lists/substance-abuse-treatment-admissions-statistics#geographic-based-admissions-statistics-*

**Figure 17. Substance Use Admissions to Treatment Programs in Hampden County by Primary Drug of Admission, 2010 – 2017**
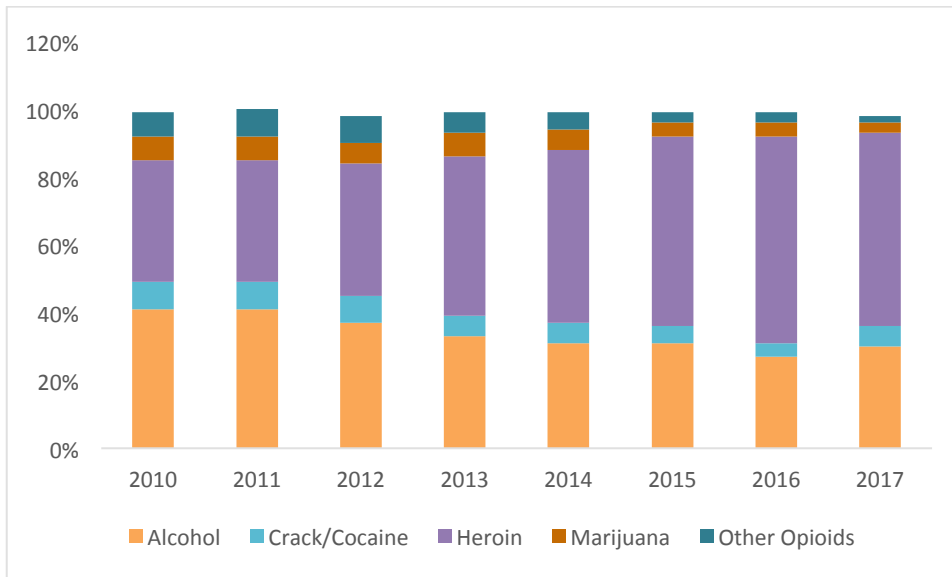


*Source: Massachusetts Department of Public Health. Bureau of Substance Addiction Services. 2018. Geographic Fact Sheets FY 2017, Admission Statistics by County. Available at https://www.mass.gov/lists/substance-abuse-treatment-admissions-statistics#geographic-based-admissions-statistics-*

**Opioid use disorder** continues to be a public health crisis in Massachusetts and across the country. In Massachusetts, the number of opioid-related deaths in 2014 represents a 65% increase from 2012.[19] Between 2016 to 2017 there was a 4% decrease in the number of opioid-related deaths in Massachusetts, however in the prior year there had been a 28% increase. In 89% of deaths from opioids, fentanyl was present.[74]

- In Hampden County, the number of opioid-related deaths has increased annually, from 32 in 2000, trending upward until 2017, with 113 deaths.[75] The 2016 CHNA reported lower opioid overdose hospitalization rates in Hampden County than the state (80 vs. 104 per 100,000).
- An analysis of opioid overdoses from 2016 and 2017 shows that Springfield, Chicopee, and Holyoke are the areas with higher amounts in Western MA (Figure 18).
- According to provisional data from the Pioneer Valley Opioid Data Committee (PVODC), approximately 50% of overdoses in Hampden County went to Baystate Medical Center, with about 20% going to Mercy Medical Center, about 20% to Holyoke Medical Center, less than 10% to Baystate Noble, and Baystate Wing (PVODC, 2019).
- Increased use of harm reduction approaches, such as Narcan, reduces morbidity and mortality of opioid overdose.[76] Additionally, stakeholders called for increased access to long-term treatment programs; more provider and patient education to reduce stigma

and as a means to get people the care they need; and more support for youth, particularly those with histories of trauma.

**Figure 18. Opioid Overdose Incidents Density, Hampden County, 2016-2017**
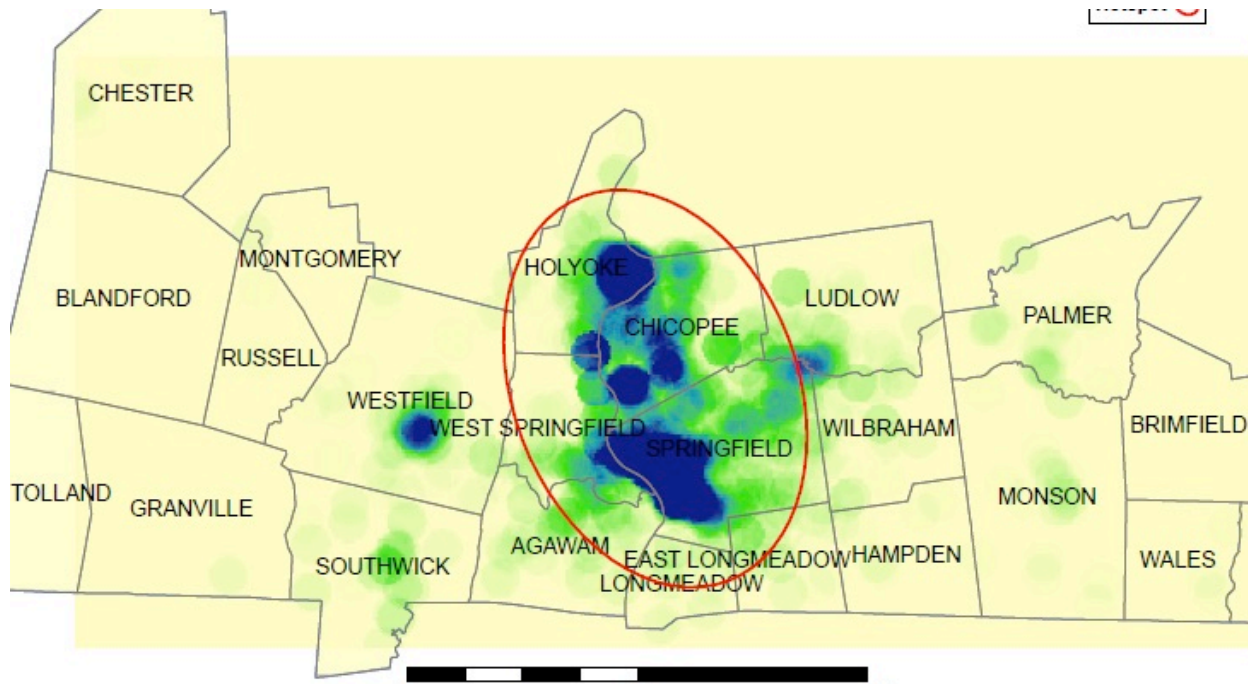


*Source: Pioneer Valley Opioid Data Committee, 2019*

## 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 8th 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, Case Mix Data, 2012-2015).
- In Hampden County communities **older adults** have higher proportions of some form of substance use disorder than statewide, as stated above.
- **People reentering society after incarceration**, particularly if their incarceration was related to drugs in any way. Studies consistently show high risk of overdose in the first two weeks after reentry.[77]
- **People who have dual diagnoses.** People who have both mental health and substance use disorders face greater challenges accessing services, according to focus group participants and interviewees.

*"There are not many dual programs. Many addicts have mental health issues as well, but programs usually do not treat both – just addiction – so they recover but it doesn't last and they go back in and out of rehab."*
Focus Group Participant, Substance Use Disorder Focus Group, Hampden County

## b. Chronic Health Conditions

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

### Obesity

In Hampden County 29% of adults are obese compared to the Massachusetts rate of 24% (County Health Rankings, 2019). In Springfield, 37% of the population is obese.[78] Obesity is a national epidemic and contributes to chronic illnesses such as cancer, heart disease, and diabetes. Obesity can impact overall feelings of wellness and mental health status. A healthy diet and physical activity play an important role in achieving and maintaining a healthy weight.

Though childhood obesity rates have been falling nationally and within some communities in the region over the last few years, it remains concerning. In the 2014 – 2015 school year, obesity rates were over 20% in Springfield, Palmer, Chicopee, West Springfield, and Holyoke schools.[79] County-level childhood obesity data is not available.

In the Springfield Public Schools in 2017, 17% of students are overweight with 26% having a Body Mass Index signifying obesity. This proportion is similar for White, Black and Latino students.[80]

### Cardiovascular Disease (CVD)

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

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA

- Holyoke and Springfield have the highest rates of cardiovascular disease hospitalization in Hampden County, both of which are almost 70% higher than the state. Springfield, Westfield, Palmer and Ludlow have higher rates of stroke hospitalization (Figure 19).
- Hypertension (high blood pressure) affects about 4 out of 5 adults over age 65 in Hampden County, slightly higher than the statewide proportion, and coronary heart disease affects about 40% of older adults, with slightly higher proportions in Holyoke, Chicopee, and West Springfield. [70]
- CVD hospitalization rates for the Latino population are almost double that of Whites, and about 65% higher for Blacks (Figure 20).

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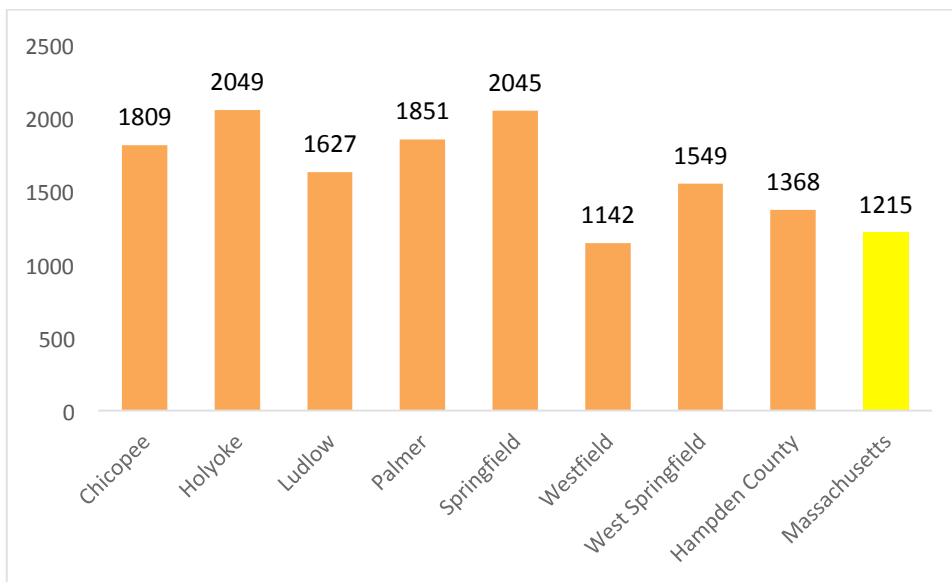


*Source: MDPH, 2014. Age-adjusted per 100,000*

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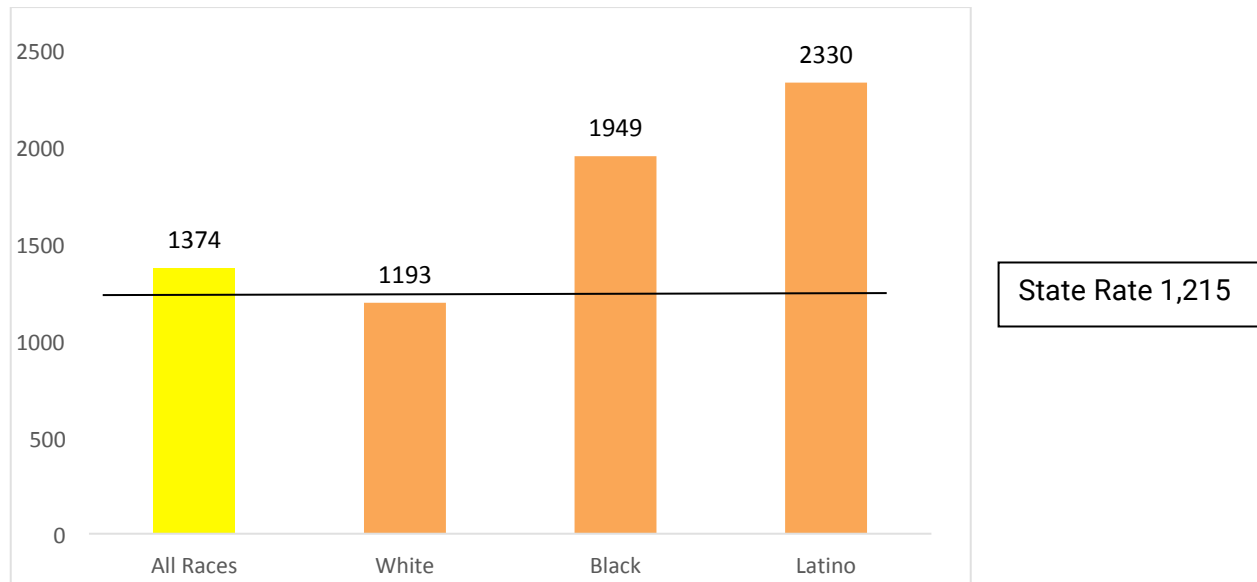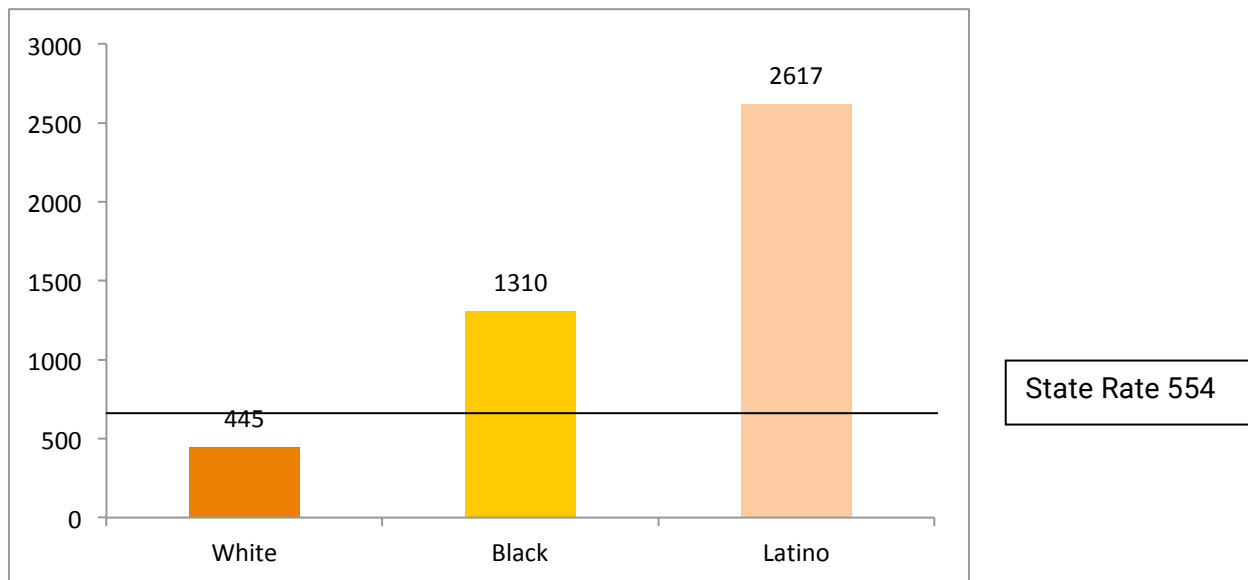


Source: MDPH, 2012 – 2015. Age-adjusted per 100,000

## Vulnerable Populations

- **Older adults** experience higher rates of CVD: for example, about four-fifths of people over age 65 have hypertension, which is reflective of the high rates in the state overall (76%).[70]
- **Latinos and Blacks** had stroke and heart disease hospitalization rates much higher than Whites.

## Diabetes

An estimated 11% of Hampden County residents have **diabetes**, which is greater than the state rate of 9% (County Health Rankings, 2019). The vast majority of diabetes is Type 2 diabetes, which is one of the leading causes of death and disability in the U.S. and a strong risk factor for cardiovascular disease. The CDC estimates that 9% of people in the U.S have diabetes, of which 24% are undiagnosed.[81] Pre-diabetes is when a person has high blood sugar levels that are not high enough for a diagnosis of diabetes. An estimated 15-30% of people with pre-diabetes will develop Type 2 diabetes within 5 years.[13]

Diabetes hospitalization rates are a measure of severe morbidity due to diabetes. Springfield, Holyoke and Chicopee have high diabetes hospitalization rates (281, 253, and 233 per 100,000 people) that are double or nearly double the statewide rate. (Figure 21). Older adults experience

a high prevalence of diabetes. The percentage of adults over age 65 who have diabetes is high in Springfield (41%), Holyoke (37%), and Chicopee (35%) as compared to the state rate of 32%.[70]

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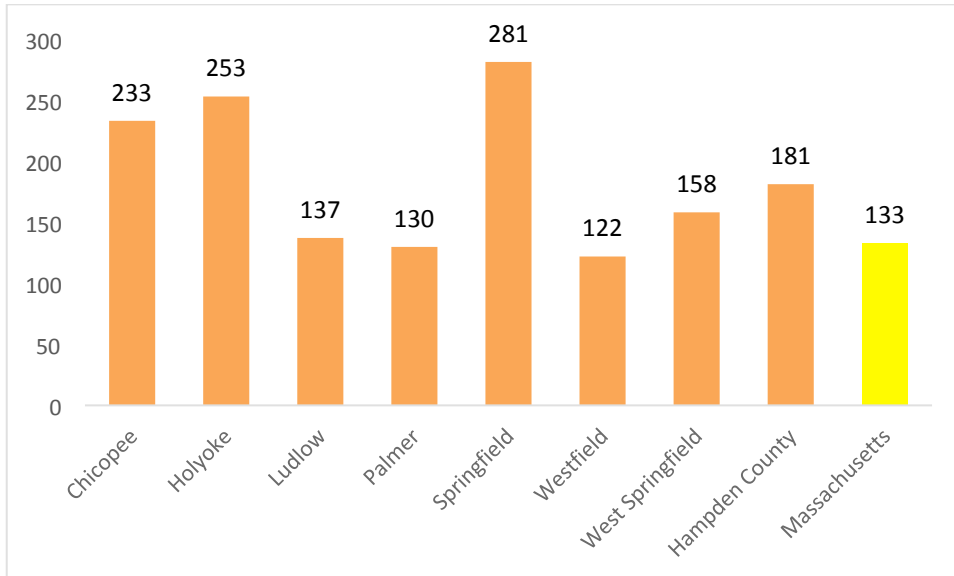


*Source: MDPH, 2012 – 2015. Age-adjusted per 100,000*

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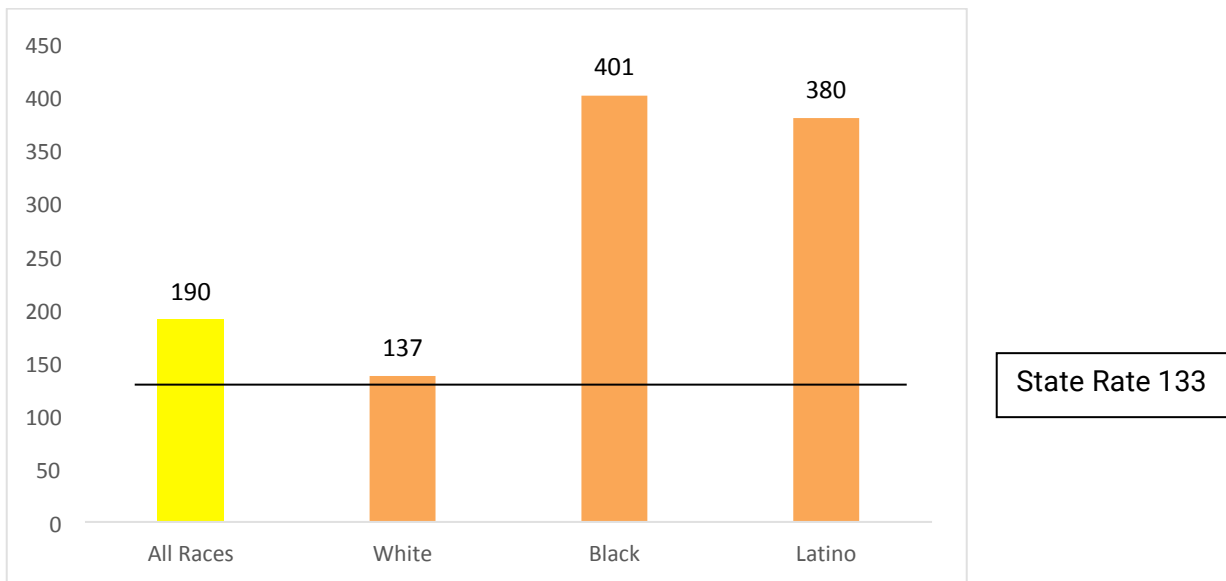


*Source: MDPH, 2012 – 2015. Age-adjusted per 100,000*

## Vulnerable Populations

- **Older adults** in select communities in Hampden County experience higher rates of diabetes than the state. Nearly 2 out of 5 older adults have diabetes, as cited above.
- **Latinos** and **Blacks** in Hampden County experienced about 3 times the rates of diabetes hospitalizations (380 and 401 per 100,000 people, respectively) compared to Whites and the statewide rate which are the same (137) (MDPH, Case Mix Data, 2012-2015).

## Asthma

**Asthma** impacts many Hampden County residents. 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. The Springfield Metropolitan District was identified as the most challenging place to live in the U.S. with asthma, according to the Asthma and Allergy Foundation's 2018 Asthma Capital rankings. The rankings are based on prevalence of asthma, emergency room visits, mortality, and presence of risk factors.[82]

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



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

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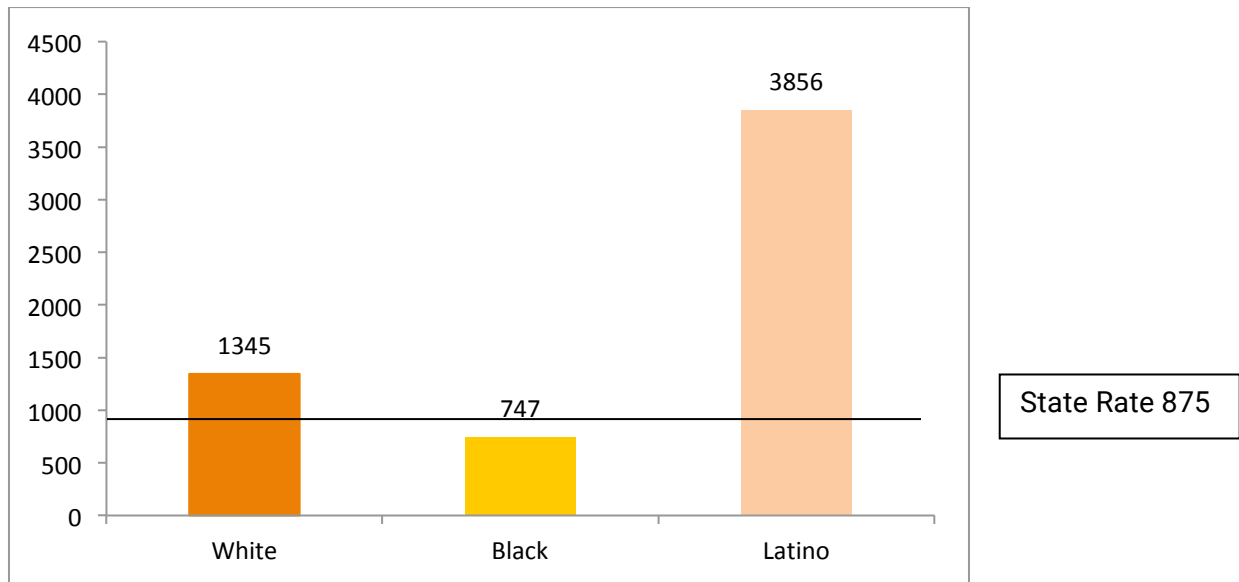


*Source: MDPH, 2012-2015. Age-adjusted per 100,000*

Emergency room visit rates are 78% higher than statewide rates (Figure 23), and rates are highest among Springfield and Holyoke residents (MDPH, Case Mix Data, 2014). Childhood asthma prevalence ranges from 10% in Westfield and West Springfield to up to 20% in the urban core (Table 4). About 1 in 4 older adults in Hampden County cities have asthma.[70]

**Table 4. Childhood and Older Adult Asthma Prevalence in Select Hampden County Communities**

|  | Childhood | Adults > Age 65 |
|---|---|---|
| Chicopee | 18% | 26% |
| Holyoke | 20% | 27% |
| Springfield | 17% | 24% |
| Westfield | 10% | 22% |
| West Springfield | 10% | 22% |
| Massachusetts | 12% | 15% |

*Sources: Massachusetts Healthy Aging Collaborative, CMS 2014, 2015; MDPH Environmental Public Health Tracking 2016-2017*

**Vulnerable Populations**

- **Children and older adults** are vulnerable populations for asthma. Figure 25 shows that rates for both children and adults are highest in Holyoke out of the select communities researched. As in the 2016 CHNA, children are hospitalized in Hampden County at lower rates than the state (140 in Hampden County compared to 186 per 100,000 in MA) but

go to the Emergency Room at 80% higher rates than the state (1,548 vs. 857)(MDPH, 2014).

- **Latinos** in Hampden County experience large asthma-related disparities, with hospitalization rates 6 times that of Whites in Hampden County and more than 4 times that of the state hospitalization rate overall (Figure 23).
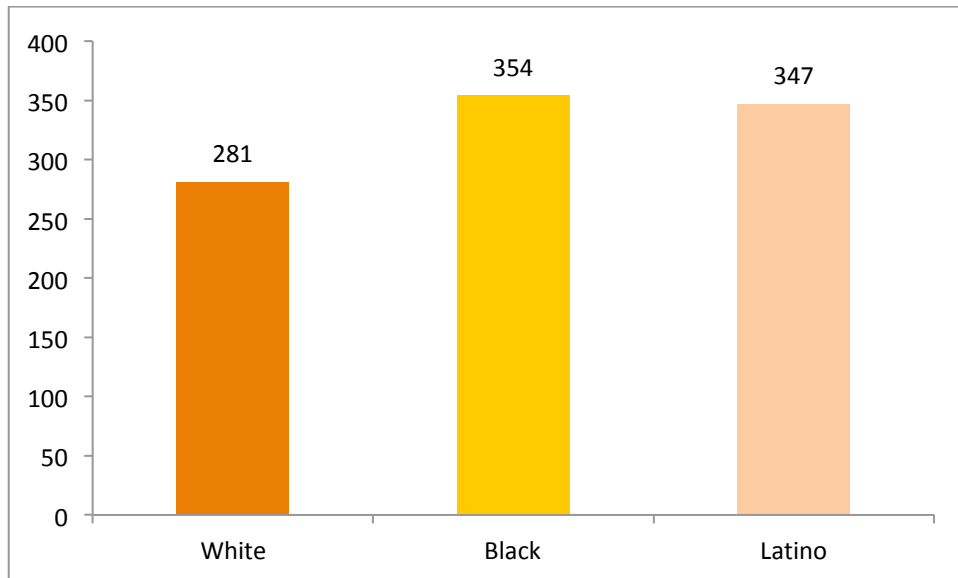
## Cancer

Cancer is the second leading cause of death in Hampden County.[83] Hampden County's rate of hospitalization for cancer is a bit lower than the state (305 per 100,000 in Hampden County compared to 338)(MDPH, 2014). Holyoke, West Springfield, and Springfield have slightly higher rates of cancer hospitalization compared to the statewide rate. Cancer hospitalization rates are 26% higher in Blacks and 23% higher in Latinos than Whites in Hampden County (Figure 26).

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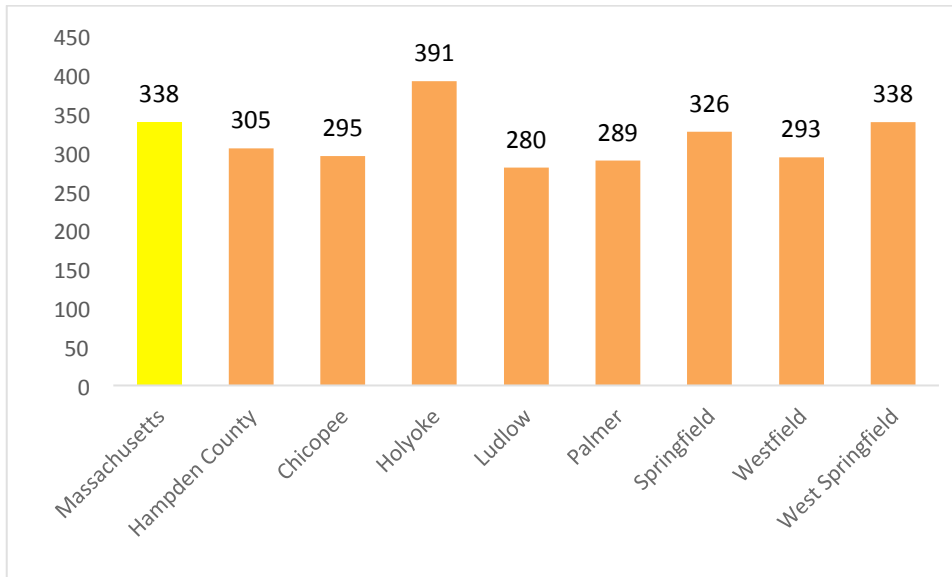


*Source:  MDPH, 2012 – 2015. Age-adjusted per 100,000*

**Figure 26. Cancer Hospitalization Rate, Hampden County, by Race/Ethnicity**

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

In Massachusetts from 2011 to 2015, the incidence rate of cancer decreased.[84] The Hampden County cancer incidence, or rate of people who have cancer, is 442 cases per 100,000 people, lower than the Massachusetts rate of 467.[85]  However, the population of Hampden County, like across the country, is aging, which will lead to an increase in number of people seeking treatment for cancer.

Statewide, the most prevalent forms of cancer for men are prostate (23%), bronchus/lung (14%), colon/rectum (8%), and urinary/bladder (8%). For women, the most prevalent forms are breast (30%), bronchus/lung (14%), colon/rectum (8%), and uterine (7%). Cancer of the bronchus/lung accounted for approximately 27% of all cancer deaths from 2011 – 2015 statewide.[86]

Key informant interviewees providing cancer treatment services at Mercy's Cancer Center and a focus group with cancer patients, survivors, and their families identified areas where Mercy excels and areas of need for the Cancer Center.

Areas where Mercy excels include:

- Rapid follow up with patients
- Getting people into treatment and surgery quickly
- Doctors and other providers who take extra care on behalf of patients
- Support from the Cancer Support group
- Assistance from nurse navigators and social workers

Areas of need for the Cancer Center include:

- Cancer survivorship support
- Programs for mental health support needed for those with a cancer diagnosis
- Cancer support for children and youth who have cancer
- Clinical trials so patients do not need to travel to Boston for some newer treatments
- Transportation and financial support for patients

Additionally, cancer providers had ideas about prevention and policy that could impact cancer incidence:

- Expansion of the mobile CT scan program
- Support for the HPV vaccination outreach, education, and screening
- Advocacy so the U.S. Preventative Services Task Force incorporates lung cancer screening into doctors' computer programs so they are prompted to ask about risk factors
- Expansion of criteria for lung cancer screening so that insurance companies cover the cost for more populations

### Need for Increased Physical Activity and Healthy Diet

Increasing physical activity and consuming more fresh fruits and vegetables is another identified need in Hampden County. Healthy eating and physical exercise are important habits to create and keep to prevent poor health outcomes such as cardiovascular disease, diabetes, dementia, and depression, to name a few.[87] Community level access to affordable healthy food and safe places to be active, as described in the Social Determinants of Health section, as well as individual knowledge and behaviors affect these rates.

Among Massachusetts residents in the CDC's BRFSS 2013 survey, only 11% of respondents met the vegetable consumption recommendation and 14% met the fruit consumption recommendations. In general, women, Latinos, and people with higher income are those who are more likely to meet recommended intake levels.[88] Students in Springfield report low levels of vegetable consumption, with about two-thirds of Black and Latino students and more than half of White students responding that they had eaten either one or no vegetables in the day prior to the survey (Figure 27). Rates of eating fruit or drinking fruit juice were higher, with a majority of Black (59%) and Latino (64%) students having two or more servings of fruit juice or eating fruit in the prior day (Springfield Youth Health Survey, 2017).

**Figure 27. Percent of 8th Graders Who Ate Vegetables One Time or Less in the Prior Day, Springfield**
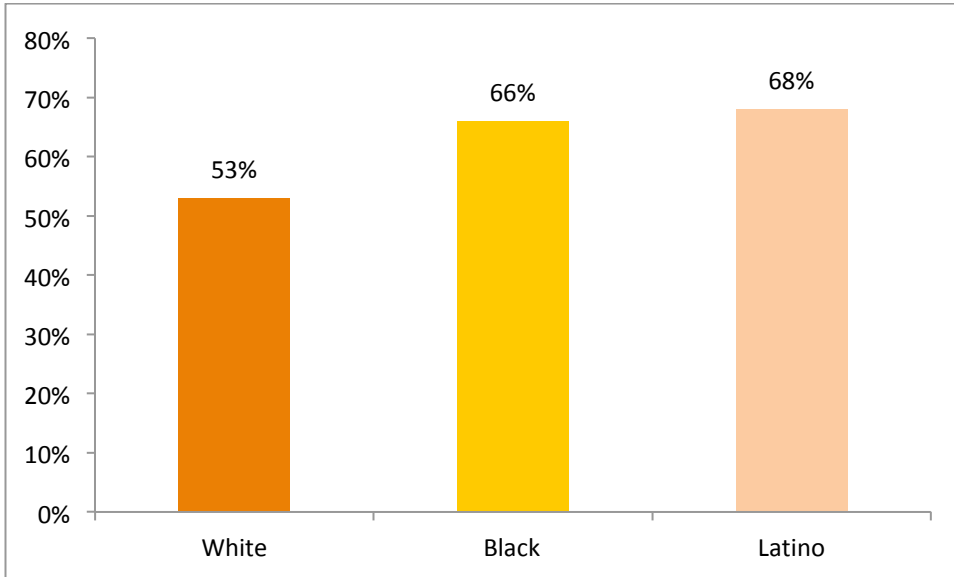
In Hampden County, 1 of 4 residents over age 20 reports getting no leisure-time physical activity in the past month, slightly higher than the state rate of 22%.[89] In Springfield, 35% of adults aged 18 and over report no physical activity.[90] Most Springfield teens reported that they are active for 60 minutes with 68% reporting physical activity at least 3 days a week. Still, one-third report little activity with 14% reporting no physical activity (Figure 28).

**Figure 28. Number of Days Physically Active for 60 Minutes or More - 8th Graders, Springfield**
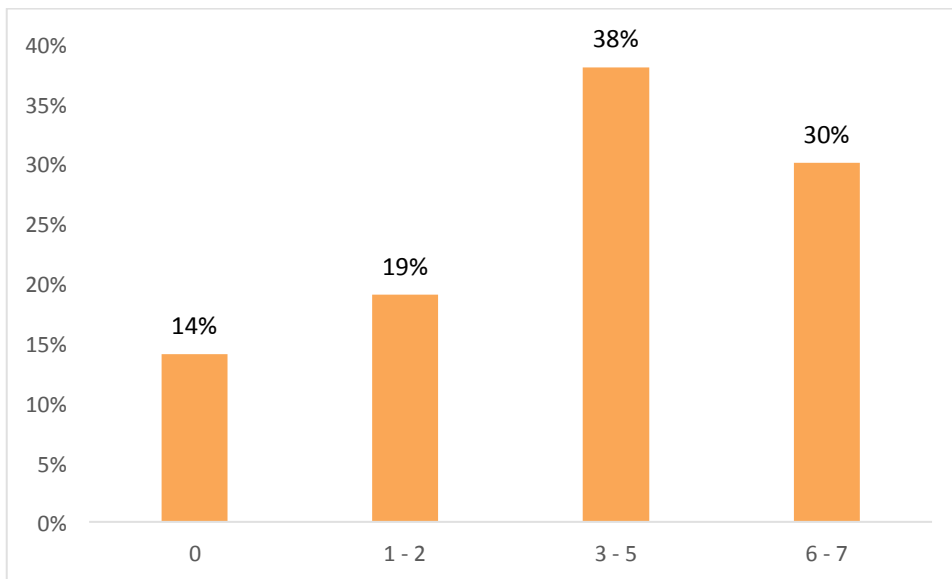
The need for increased youth programming and access to places that encourage physical activity was cited by individuals across several focus groups and interviews conducted for this

CHNA, and particularly sports and after school programming that are affordable to those with low incomes.  With regard to preventing or reducing gun violence, young people, parents, staff from community organizations and law enforcement all discussed the importance of sports as one form of activity that is attractive to youth and helps keep them from violence. Parents of children with disabilities spoke about the importance of being able to access places where their children can exercise, such as the pool and the Be Fit program at Shriners Hospital for Children.

## c. Infant and Perinatal Health

Infant and perinatal health risk factors continue to impact Hampden County residents, causing poor maternal and infant outcomes.  Preterm birth (<37 weeks gestation) and low birth weight (about 5.5 pounds) are among the leading causes of infant mortality and morbidity in the U.S., and can lead to health complications throughout the life span. Early entry to prenatal care and adequate prenatal care are crucial components of health care for pregnant women that directly impact birth outcomes, including preterm birth, low birth weight, and infant mortality (infant death before age 1). Smoking during pregnancy is a risk factor that increases the risk for pregnancy complications and affects fetal development.[21]

In Hampden County, 10% of births were born preterm birth (PTB) and 8% were born low birth weight (LBW). In Hampden County, the highest rates of low birth weight and preterm birth among select communities are in Springfield and Holyoke (MDPH, 2016).  When examining by race/ethnicity, Black women in Hampden County experience the highest rates of low birth weight, at a rate double that of White women (Figure 29). Rates of preterm birth were also higher among Black and Latina women compared to White women. Rates are also high among teens, with an estimated 13% giving birth to low birth weight babies and 12% having preterm births (MDPH, Birth Outcomes Data, 2016).

**Figure 29. Birth Outcomes by Race/Ethnicity, Hampden County**
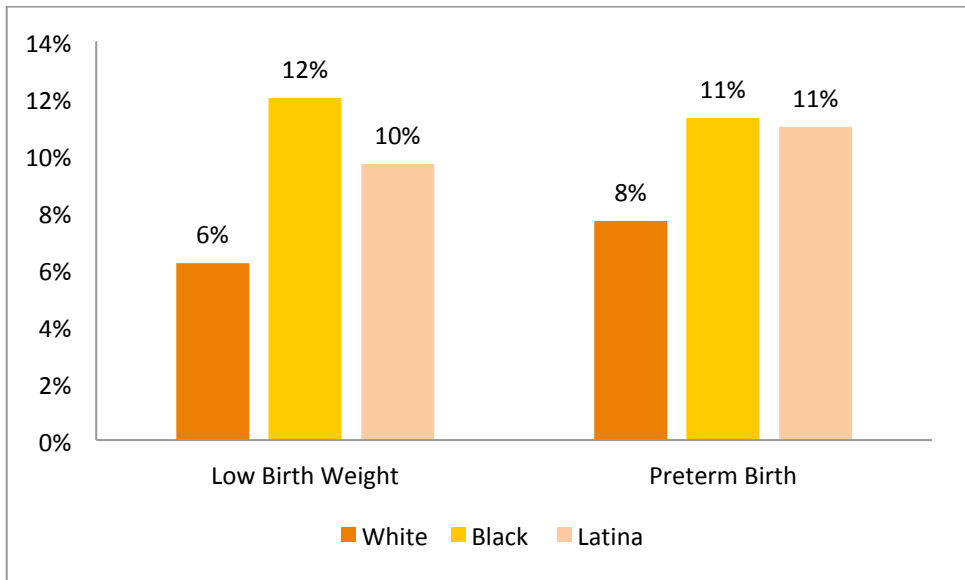
Source: MDPH, 2016.

An estimated 19% of women did not receive adequate **prenatal care** in Hampden County. National guidelines suggest that women receive routine checkups once a month for weeks 4 through 28 of pregnancy, twice a month during weeks 28 through 36, and weekly from weeks 36 to birth. The Adequacy of Prenatal Care Utilization Index (APNCU) measures utilization of prenatal care based on the time when care is initiated and frequency of care received. While adequacy of prenatal care rates are comparable to the state in general, prenatal care varies by race/ethnicity. Black women in Hampden County experience higher rates of inadequate prenatal care compared to White women (27% vs. 16%)(Figure 30). Studies suggest that racial and ethnic disparities in receiving adequate prenatal care are linked to systemic injustices facing many individuals of color, including practitioners stereotyping women of color when providing care, and unequal education opportunities.[91] Teens also had high rates of less than adequate prenatal care (27%) (MDPH, 2016).

While lower than the 2016 CHNA, currently 7% of women report smoking during pregnancy in Hampden County, (Table 5). When examining by race/ethnicity, rates were highest among White women (10%), as compared to Black women or Latinas (Figure 30).

**Table 5. Less than Adequate Prenatal Care and Smoking During Pregnancy, Hampden County and Select Communities**

**2019 Community Health Needs Assessment: Mercy Medical Center**
Public Health Institute of Western MA

| | Less than Adequate Prenatal Care | Smoked During Pregnancy |
|---|---|---|
| Chicopee | 19% | 8% |
| Holyoke | 20% | 8% |
| Palmer | 16% | 13% |
| Springfield | 21% | 7% |
| Westfield | 17% | 9% |
| West Springfield | 18% | 5% |
| Hampden County | 19% | 7% |
| Massachusetts | 18% | 5% |

*Source: MDPH, 2016. Age-adjusted per 100,000*

**Figure 30. Less than Adequate Prenatal Care and Smoking during Pregnancy, By Race/Ethnicity, Hampden County**
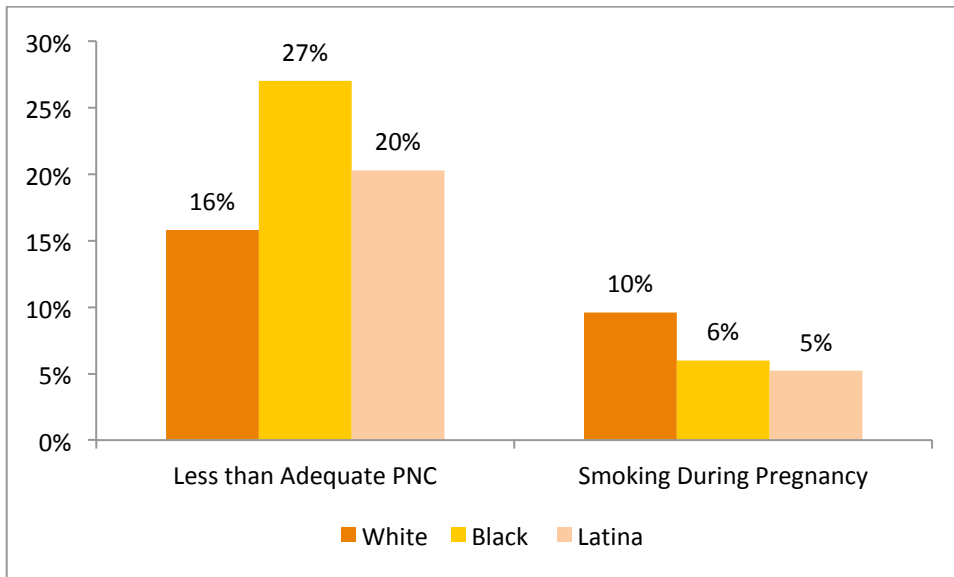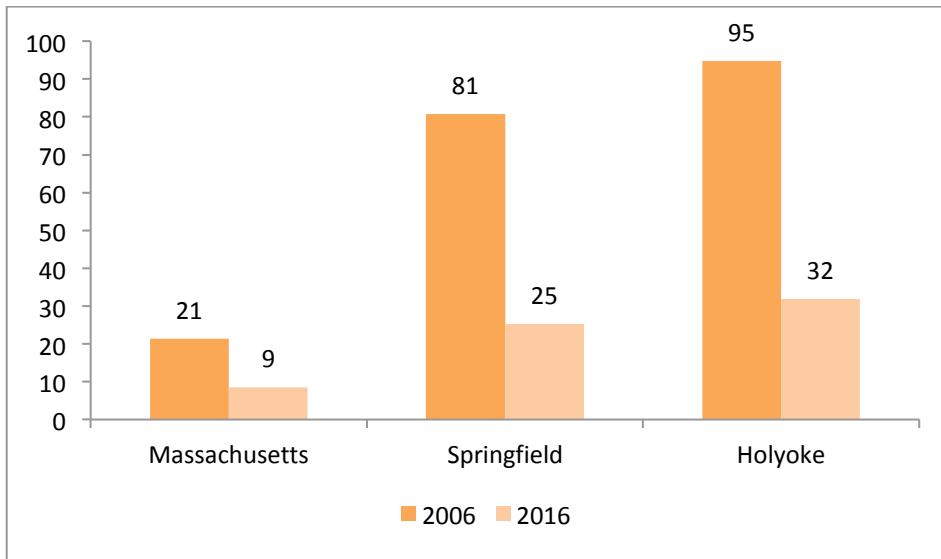


*Source: MDPH, 2016.*

**Vulnerable populations**

- Outcomes by **race/ethnicity** illustrate drastic disparities in Hampden County; Black rates of low birth weight are double that of Whites (12% compared to 6.2%) and Latina rates are more than 50% higher (9.7%). Black and Latina preterm births are almost 50% higher than that of Whites (MDPH, Birth Outcomes Data, 2016).
- Blacks and Latinas in Hampden County have lower rates of smoking during pregnancy than Whites, but higher rates of receiving less than adequate prenatal care.
- Being a pregnant **teenager** impacts birth outcomes, with teen moms having much lower rates of adequate prenatal care.
- **Income** also makes a difference. With the proxy being type of insurance, we see that only 9% of those with private insurance were without adequate prenatal care, compared to 16% of those with public insurance. Women with private insurance have lower rates of poor birth outcomes than those with public insurance (low birth weight babies 6% private compared to 10% public; preterm births 8% private compared to 11% public) (MDPH, Birth Outcomes Data, 2016).

## d. Sexual Health

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 almost double that of the state (17 vs. 9 per 1,000) with high rates in Springfield (25 per 1,000) and Holyoke (32 per 1,000). (MDPH, 2016) [92] From 2006, teen birth rates in Springfield dropped significantly from 81 to 25 per 1,000 females age 15 - 19), and in Holyoke by an even greater amount (from 95 to 32). Massachusetts' rate dropped significantly - from 21 to 9 - in the same time period (Figure 31).

**Figure 31. Teen Birth Rates in MA, Springfield, and Holyoke**

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Source: MDPH, 2006 and 2016. Rates are per 1,000 females age 15 – 19.

**Figure 32. Teen Birth Rates in Hampden County by Race/Ethnicity, 2012-2016**
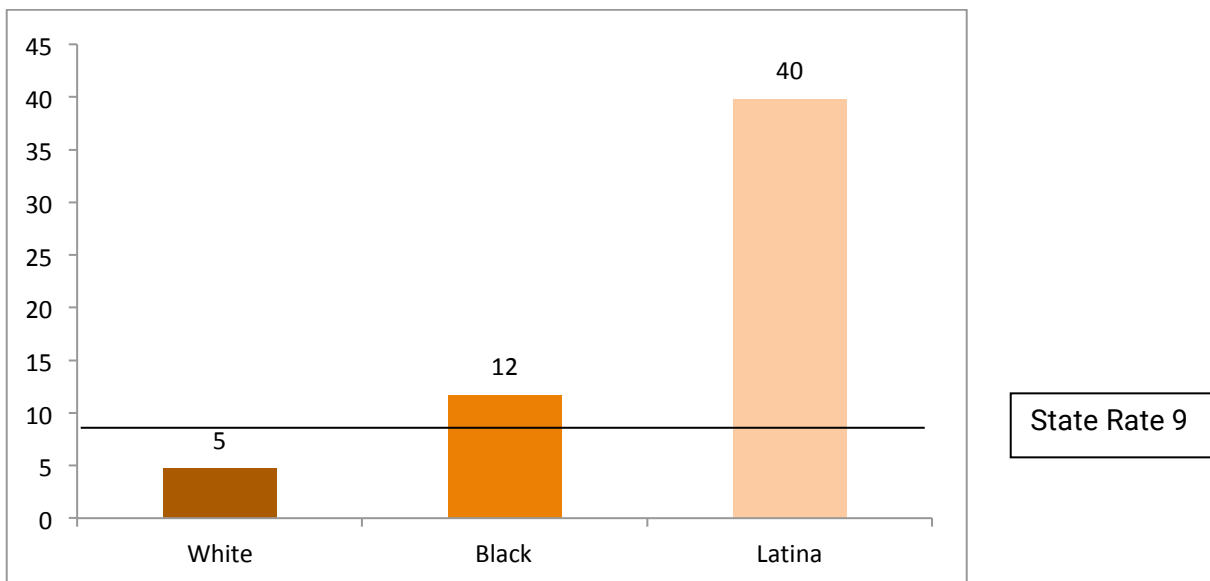


Source: MDPH, 2012- 2016. Rates are per 1,000 females age 15 – 19.

## Sexually Transmitted Infections

**Chlamydia** rates are elevated in Hampden County with rates of newly diagnosed chlamydia cases 22% higher than the state (481 in Hampden County compared to 395 per 100,000 in the state) (County Health Rankings, 2019). Springfield has the fifth highest chlamydia incidence rate

in Massachusetts (827 per 100,000 compared to statewide rate of 388) and the fourth highest gonorrhea incidence rate in Massachusetts (174 per 100,000 compared to statewide rate of 69).[93]

From 2015 to 2017, Hampden County had 150 cases of HIV diagnosed (122 in men and 28 in women). Seven of those were between the ages of 15 and 19. Because the numbers were so low, it was not possible to get a racial breakdown of HIV diagnosis.

**Table 6. Age-Specific Rates of Sexually Transmitted Infections, 15 – 19 year olds**

|  | Chlamydia | Gonorrhea | Syphilis |
|---|---|---|---|
| Massachusetts | 1,290 | 102 | 5 |
| Hampden County | 2,200 | 226 | 9 |

*Source: MDPH, 2015 – 2017. Rate calculated using Census ACS 2013 – 2017 estimates. Rates are per 100,000*

**Vulnerable Populations**

- Hampden County **youth** have STI rates between 70% higher to almost double the state rate (Table 6).
- Chlamydia and gonorrhea rates are double or more in teenage girls than boys (chlamydia – 3,410 for girls compared to 1,041 for boys per 100,000; gonorrhea – 299 for girls compared to 157 for boys per 100,000). Syphilis is higher in teenage boys (11 per 100,000 for boys compared to a number suppressed because it was too small to report for girls)(MDPH, Infectious Disease, 2015-2017, rate calculated using Census ACS 2013-2017 estimates).
- Teen pregnancy rates are particularly high among **Latinas** with a rate of 40 per 1,000 young Latina women aged 15-19 in Hampden County compared to a rate of 5 in White women (Figure 32).

### e. Alzheimer's disease and Dementia

Approximately 1 in every 10 people over age 65 has some form of Alzheimer's dementia.[94] The proportion of those living with Alzheimer's disease in almost all of the larger cities of Hampden County is larger than that of Massachusetts. Springfield (17%), Holyoke (19%), West Springfield (16%) and Palmer (15%) all are above the Massachusetts rate of 14%.[95]

# 4. Vulnerable Populations of Concern

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

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

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

# 5. Geographic Areas of Concern

Springfield, Holyoke and occasionally Chicopee 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. These communities include the largest proportions of residents of color, so health inequities experienced by these communities contribute to the many racial and ethnic disparities observed in Hampden County.

# V. Community & Hospital Resources to Address Identified Needs

## Lack of resources to meet basic needs

**Mercy Financial Assistance & Counseling:** In the spirit of our mission to serve together as a compassionate and transforming healing presence within our communities, Mercy is committed to providing healthcare services to all patients based on medical necessity. For patients who require financial assistance or who experience temporary financial hardship, Mercy offers financial support, including short-term and long-term payment arrangements, and discounted care. Financial counselors are available to work with patients in completing financial assistance applications to determine what financial assistance is available. This includes assessing eligibility for Medicaid and Health Insurance Exchange plans.

http://www.mercycares.com/billing

## Safety

**Mercy Driver Advisement Program:** If there are concerns about an individual's ability to drive due to age or disability, Mercy has developed a coordinated program to objectively assess a person's ability to drive safely. Our program evaluates: Vision and perception, physical status, mobility, reaction time, traffic sign/situation identification and interpretation, cognition, including problem-solving, attention and memory and the use of/need for adaptive equipment. The Driving Advisement Program begins with a clinical evaluation completed by a licensed occupational therapist. Then, we'll discuss the results and appropriate recommendations with you and your doctor.

http://www.mercycares.com/driver-advisement

## Obesity

**Mercy Nutrition Services:** In taking your first step to life-long healthy eating, sometimes knowing what to eat seems complicated. You know you are "supposed" to eat healthy, but what does that really mean? And how do you make that fit into your life? Our outpatient dietician is available for individualized nutrition counseling sessions for people looking to improve their

nutrition and health.  Meet with the dietician and let them get to know you, your life, your health issues and your goals. You will walk out the door with a personalized eating plan that can be put in place right away.

http://www.mercycares.com/nutrition

**Mercy Weight Loss Solutions:**  We offer two proven methods for weight management that can be tailored to your unique health needs and lifestyle. And unlike many other weight-loss programs, Mercy's has a bariatric surgeon oversee your care from the outset, even if you're not having surgery – ensuring a high level of expert, personalized attention.  We offer two approaches to weight management: Nutrition – Real-world guidance for lifelong healthy habits; and Weight-Loss (bariatric) surgery – Proven surgical options to treat obesity when diet and exercise alone don't work.  We also hold periodic free seminars about the current options for weight management and surgery.

http://www.mercycares.com/weight-loss

## Mental Health

**Mercy Behavioral Health Care:** As the largest provider of behavioral health services in western Massachusetts, 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

## Smoking Cessation

**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 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

## Opioids & Other Substances

**Mercy Opioid (Methadone Maintenance) Treatment Program:** The mission of the Opioid Treatment Program (also called the methadone maintenance program or MMTP) is 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

## Cancer

**Mercy Cancer Care:**  At Mercy's Sister Caritas Cancer Center, we are continually looking to provide patient-centered and personalized treatment. From the time of diagnosis, throughout therapy, and through survivorship and rehabilitation, we have developed programs and services for both patients and their families.  Our respected team of cancer specialists, oncology nurses, social workers, therapists, dietitians, chaplains and other support staff provide a full range: Medical Oncology, Radiation Oncology, Surgical Oncology, Breast Care Center, Lung Cancer Program, Clinical Trials, Cancer Survivorship Program, Cancer Rehabilitation, Patient Navigation Program, Counseling and other support services.

http://www.mercycares.com/cancer

## 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 Childbirth Education class; the Mommy & Me support and educational group; 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, an Expectant Mothers' Breastfeeding Class, and convenient access to breast pumps, nursing bras and breastfeeding accessories.

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 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

# VI. Input and Actions Taken on Previous CHNA

## 1. Community Input on Previous 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/chna). They are posted for easy access and we include contact information for questions or comments. The links on our website also include our federal IRS 990 tax return and an overview of Community Benefit at Mercy. We have verified and confirmed that we have not received any written comments since posting the last CHNA and Implementation Strategy.

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

The CHNA conducted in 2016 identified three significant categories of health needs within the Mercy Medical Center community. Those needs were then prioritized based on the magnitude and severity of impact of the identified need, the populations impacted, and the rates of those needs compared to referent (generally the state) statistics. Two categories of significant health needs, Mercy's implementation strategies to address those needs, and impacts of those strategies are:

### a. Access and Barriers to Quality Health Care:

A: Hampden County residents experience challenges accessing care due to the shortage of providers. 54% of county residents live in a healthcare professional shortage area. Western Massachusetts hospitals have high rates of individuals who frequent the emergency rooms more than four times in a two year period. Patients report that access to the emergency room assists in their medical care and consistent primary care access is sometimes unattainable.

*Mercy's objective: Improve health services and outcomes of individuals by promoting primary care and reducing Emergency Department frequentation through enrollment of individuals in the High End Utilizer (HEU) program.*

*Mercy promoted health insurance to Emergency Department (ED) visitors, promoted Primary Care Provider (PCP) use to ED visitors, assisted with PCP enrollment for the High End Utilizer participants along with hands on case management services including assistance with transportation, healthcare access and social service referrals. The impact was better case management, better emergency situation prevention and a lower rate of ED frequentation by the HEU participants.*

B: The need for health information to be understandable and accessible was identified in the CHNA. 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.

*Mercy's objective: Improve health literacy along with access to cervical cancer screenings and mammograms for homeless women.*

*Mercy helped homeless women who participate in women's health screenings to include cervical cancer and mammography screenings, tracked the number of verified records of homeless women for cervical screening records and mammograms, and offered women's health educational programs for the homeless female population. The impact was increased awareness among homeless women about cervical cancer and breast cancer, an increase in the use of health services, and a decreased rate of missed appointments and screenings for the homeless women cohort.*

## b. Health Conditions and Behaviors:

C: Mental health was identified as one of the top three urgent health needs/problems impacting the area. An estimated 15.9% of Hampden County residents reported having poor mental health 15 days or more in a month. ER visit rates for mental disorders in Hampden County in 2016 were 24% higher than that of the state with particularly high rates in Holyoke and Springfield.

*Mercy's Objective: Improve the mental health education and awareness of Hampden County residents.*

*Mercy's involvement in the regional Mental Health First Aid (MHFA) training program helped to increase mental health literacy and management among MHFA community participants. Mercy provided train-the-trainer MHFA classes, participated in the overall promotion of the countywide MHFA program, and provided conference meeting space and resources for the community training sessions. The impact was a reduction in the stigma of seeking help in mental health and raising awareness about mental health for the participants in the MHFA program.*

# VII. Summary

The Mercy service area of Hampden County, MA continues to experience many of the same prioritized health needs identified in Mercy's 2016 CHNA. Social and economic challenges experienced by the population in the service area contribute to the high rates of chronic conditions and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health inequities observed among vulnerable populations, including children; older adults; Latinos; Blacks; LGBTQI+ youth; people with low incomes; women; people with mental health and substance use disorders; people involved in the criminal legal system; people experiencing homelessness; and people living with disabilities. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The 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 health care system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. Also prioritized are chronic health outcomes, such as cardiovascular disease, asthma, cancer, and diabetes among others.

# CONTACT INFORMATION

For questions or comments regarding the Community Health Needs Assessment, please contact:

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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.

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# Community Health Needs Assessment 2019

# Mercy Medical Center

*Appendices*

# Appendix I. Stakeholders Engaged in the 2019 CHNA Process

## Regional Advisory Committee (RAC)

| Name (Last, First) | Title | Organization | Organization Serves Broad Interests of Community | Organization Serves Low-Income, Minority, & Medically Underserved Populations | State, Local, Tribal, Regional, or Other Health Department Staff |
|---|---|---|---|---|---|
| Bankert, Sarah | Program Manager, Healthy Hampshire | Collaborative for Educational Services | X | X | |
| Bruno, Kathleen* | Health Management Program Manager | Health New England | X | X | |
| Cardillo, Beth | Executive Director | Armbrook Village | X | X | |
| Darling, Ann | Director of Planning and Resource Development | Community Action Pioneer Valley | X | X | |
| Douglas, Henry Jr. | Recruitment & Retention Specialist | Men of Color Health Awareness (MOCHA), MLK Family Services | X | X | |
| Fallon, Sean* | Manager of Community Benefits and Health | Mercy Medical Center; Trinity Health of New England | X | X | |
| Frutkin, Jim | Senior Vice President Business IFU | ServiceNet; Western MA Veterans Outreach | X | X | |
| Golden, Annamarie* | Director, Community Relations | Baystate Health | X | X | |
| Goldman, Doron | Freelance baseball researcher/historian | Cooley Dickinson Hospital Patient Family Advisory Council | X | X | |

| | | | | | |
|---|---|---|---|---|---|
| Gonzalez, Brittney* | Community Benefits Specialist | Baystate Health | X | X | |
| Gorton, George* | Director of Research, Planning & Business Development | Shriners Hospital for Children - Springfield | X | X | |
| Harris, Aumani | Project Manager | Springfield Department of Health & Human Services | X | X | X |
| Harness, Jeff* | Director, Community Health and Government Relations | Cooley Dickinson Health Care | X | X | |
| Kaufmann, Sally* | Director, Post Acute Business Integration and Development | Baystate Health | X | X | |
| Knapik, Michael* | Vice President, Government and Community Relations | Baystate Health | X | X | |
| Lake, Eliza | Chief Executive Officer | Hilltown Community Health Center | X | X | |
| Lamas, Kelly | Project Coordinator | Baystate Springfield Educational Partnership | X | X | |
| Landrau, Madeline | Senior Relationship Manager | Mass Mutual | X | | |
| Lee, Jennifer | Systems Advocate | Stavros Center for Independent Living | X | x | |
| Lopez, Luz | Executive Director | Metrocare of Springfield | X | X | |
| Patrissi, JAC | Director of Domestic Violence & PATCH Services | Behavioral Health Network, Inc. | X | X | |
| Perez-McAdoo, Sarah | Board of Health Member | East Longmeadow Board of Health | X | X | X |
| Pluguez- | President | National Association of | X | X | |

| | | | | | |
|---|---|---|---|---|---|
| Moldavskiy, Melissa | | Hispanic Nurses of Western MA | | | |
| Puleo, Elaine | Community Member | Town of Shutesbury Baystate Franklin Medical Center Community Action Council | X | | |
| Reed-McNally, Maureen | Director | Mass Mutual | X | | |
| Robinson, Frank* | Vice President, Public Health | Baystate Health | X | X | |
| Rosenthal, Sarah* | Administrative Coordinator | Shriners Hospital for Children - Springfield | X | X | |
| Silverman, Risa | Outreach Director | Western MA Health Equity Network, University of Massachusetts - Amherst School of Public Health & Health Sciences | X | X | |
| Stevens, David P. | Executive Director | Massachusetts Councils on Aging | X | X | |
| Walker, Phoebe | Director of Community Services | Franklin Regional Council of Governments | X | X | |
| Wilson, Gloria M. | ACO Care Manager MSC, RN | Western MA Black Nurses Association | X | X | |

*Coalition of Western Massachusetts Hospitals/Insurer member

# Focus Group Participants

Findings from five focus groups conducted in Hampden County and 7 focus groups from other Western Massachusetts counties informed this CHNA. In total, 14 focus groups were conducted for the full Coalition CHNA effort, and unique perspectives that were appropriate to this CHNA from different geographic areas informed this CHNA. Each focus group had a specific topic, and participants represented a range of age, gender, and race/ethnicity.  Focus groups included:

<u>Hampden County</u>

***Shriners Hospitals for Children – Springfield:  Parents of Children with Neuromuscular Diseases***
- 11 participants
- 10 women and 1 man
- All participants were parents of children ages 5 – 18
- Two participants required Spanish translation, provided by a fellow participant

***Mercy Medical Center:  Cancer Support Group Participants***
- 10 participants
- 5 women and 5 men
- 6 people were between the ages of 51 to 70; 1 person was under 50, 1 person was between 71 – 80, and two people were over 80
- All 10 people identified as White

***Baystate Medical Center:  Men Exposed to Gun Violence in Springfield***
- 10 participants; all male
- All between the ages of 18 - 25
- 3 identified as Black, 5 as Latino

***Baystate Medical Center:  Women Exposed to Gun Violence in Springfield***
- 8 participants; all female
- All between the ages of 18 - 25
- Half identified as Black, half as Latino

***Baystate Noble Hospital:  Service Providers and Family Members of People with Substance Use Disorder***
- 8 participants
- 5 women and 3 men
- 6 were over age 40; 2 were between 20 - 40
- 6 people were White and 2 were Latino

<u>Hampshire County</u>

***Cooley Dickinson Hospital:  Community forum with Older Adults - Northampton***
- 47 participants
- Mostly women
- All participants were older adults, mostly age 60+

- Roughly 90% White, 10% People of Color

***Cooley Dickinson Hospital:  Community forum with Older Adults - Amherst***
- 40 participants
- Mostly women
- All participants were older adults, mostly age 60+
- Roughly 90% White, 10% People of Color

***Baystate Wing:  Young Adults (Ware)***
- 6 participants – all were students in an adult learning program for GED/HiSET and career planning
- 2 women and 4 men
- All participants were under age 25
- 3 participants were White, 3 were People of Color

***Baystate Wing:  Young Adults (Palmer)***
- 4 participants
- 3 women and 1 man
- All participants were under age 25
- 3 participants were White, 1 was a person of color

<u>Franklin County</u>

***Baystate Franklin Medical Center:  People Experiencing Homelessness***
- 9 participants
- 4 women and 5 men
- 3 age 31 – 40; 4 age 41 – 50; 1 age 51 - 60
- 7 White, 1 Black Latina, 1 American Indian

***Baystate Franklin Medical Center:  People Who Use a Rural Food Pantry***
- 13 participants
- 10 women and 3 men
- 1 age 22 – 30; 1 age 31 – 40; 2 age 41 – 50; 5 age 51-6-; 3 age 61 – 70; 1 age 71 - 80
- 10 White; 2 American Indian; 1 Bi-Racial (White/American Indian)

***Baystate Franklin Medical Center:  Youth of Color***
- 11 participants
- 5 women, 4 men, 2 no gender selected
- 10 under 18 years; 1 age 18 - 21
- 5 Latinx; 2 Black; 2 Asian; 2 Bi-Racial (Black/American Indian and Asian/Other)

***Baystate Franklin Medical Center:  People who are Transgender, Non-Binary, and/or Gender Non-Conforming***
- 5 participants
- People identified as unmanifested genderless/manifested female, transgender (1); female, male, & nonbinary, prefer not to say whether transgender (1); male, transgender (1); nonbinary transgender (2)

- 4 age 22 – 30; 1 51 - 60
- 4 White, 1 Semitic

<u>Hampden, Hampshire, Franklin, Berkshire, and Worcester Counties</u>

***Health New England:  Adults Living with Disabilities***
- 7 participants who were patients or clients of Caring Health Center
- 4 women, 3 men
- All people of color
- All spoke English

# Key Informant Interviewees

Findings from interviews with 50 individuals conducted in Hampden County and from other Western Massachusetts counties informed this CHNA. Interviewees from Hampden County (n=16) were the primary data sources, however unique perspectives that were appropriate to this CHNA from different geographic areas also informed this CHNA. Key informants were health care providers, health care administrators, local and regional public health officials, local leaders that represent the interests of the community or serve people who are medically underserved, have low incomes, or are people of color.  Key informants were:

| Name (Last, First) | Title | Organization | Organization Serves Broad Interests of Community | Organization Serves Low-Income, Minority, & Medically Underserved Populations | State, Local, Tribal, Regional, or Other Health Department Staff |
|---|---|---|---|---|---|
| *Shriners Hospitals for Children - Springfield* | | | | | |
| Adamopolous, Ava | Program Director | Boys and Girls Club of Springfield | X | X | |
| Bakowski, Lisa | Principal | Edward P. Boland School, Springfield | X | X | |
| Kaplan, Lawrence | Developmental Pediatrician | Shriners Hospitals for Children - Springfield | | X | |
| Phillips, Kelly | Founder and Director | KP Fit | | X | |
| *Mercy Medical Center* | | | | | |
| LeBlanc, Ashley | Nurse Navigator | Thoracic Surgery – Mercy Hospital Cancer Center | | X | |
| Nash, Shirin | Pathologist and Cancer Committee Outreach Coordinator | Mercy Medical Center's Cancer Center | | X | |
| Velis, Stephanie | Oncology Program Coordinator | Mercy Medical Center's Cancer Center | | X | |
| *Baystate Medical Center* | | | | | |

| Berkowitz-Gosselin, Leah | LICSW, Clinical Social Worker | Family Advocacy Center's Homicide Bereavement Program | | X | |
|---|---|---|---|---|---|
| Caisse, Edward III | High Risk Reentry Program Coordinator | Hampden County Sheriff's Department | | X | |
| Gonzalez, Joesiah | Director of Youth Services | New North Citizen's Council | | X | |
| Judd, Christine | Director | Roca Springfield and Holyoke | | X | |
| Wheeler, Felicia | Mother and advocate | | | | |
| **_Baystate Noble Hospital_** | | | | | |
| Evans, Rose | Vice President of Operations | Behavioral Health Network | | X | |
| Rai, Chitra | Senior Case Manager | Ascentria | | X | |
| Savery, Kim | Case Manager | Hilltown Community Health Center | X | X | |
| Sitler, Kathey | Director | Drug Task Force | X | | |
| **_Baystate Wing Hospital (Eastern Region)_** | | | | | |
| Patrissi, JAC | Director of Domestic Violence Services | Valley Human Services | X | X | |
| | | | | | |
| **_Cooley Dickinson Hospital_** | | | | | |
| Nurse care managers, social workers, project specialist, director of clinical operations | 7 Integrated Care Management Program Staff | Cooley Dickinson Physician Hospital Organization | X | X | |
| Tartakov, Carlie | Community member, retired | | | | |
| **_Baystate Franklin Medical Center_** | | | | | |
| Pascucci, Cheryl | Family Nurse Practitioner | Baystate Franklin Community Hospital | | X | |

| Name | Title | Organization | | | |
|---|---|---|---|---|---|
| | | Acceleration, Revitalization & Transformation Program (CHART) | | | |
| Calabrese, Jessica<br>Carey, Cameron<br>Ewart, Jared<br>Hamilton, Wes<br>Heidenreich, Maria<br>Hoynnoski, Arley<br>Jacobson, Allie<br>Luippold, Susan<br>Petrie, Maegan<br>Sayer, Ed<br>Van der Velden, Allison<br>Welenc, Susan | Chief Operating Officer<br>Development Director<br>Accountant<br>Chief Information Officer<br>Medical Director<br>Chief Financial Officer<br>Information Officer<br>Human Resources<br>Accountant<br>Chief Executive Officer<br>Dental Director<br><br>Population Health | Community Health Center of Franklin County | X | X | |
| Bowman, Sue<br>Kiener, Andrea<br>Stephens, Kate | Retired from ministry<br>Rabbi<br>Pastor | Interfaith Council<br>Temple Israel<br>Interfaith Council | X | | |
| Avery, Jennifer<br>Brzezinski, Jen<br>Chartrand, Ken<br>Laurel, Charles<br>Margosian, Alex<br>Mercado, Reuben<br>Neubauer, Deb<br>Pliskin, Ariel<br>Schwartz, Levin | Reentry Caseworker<br>Reentry Caseworker<br>Reentry Coordinator<br>Clinician<br>LICSW Clinician<br>Reentry Caseworker<br>Clinician<br>Clinical Intern<br>Director, Clinical and Reentry Services | Franklin County Sheriff's Department | | X | |
| *Health New England* | | | | | |
| Brooks, Shane | Vice President, Intellectual and Disability Services | Center for Human Development | | X | |
| Keough, Jill | Executive Director | Greater Springfield Senior Services | | X | |

| Lee, Jennifer | Systems Advocate | Stavros | | X | |
| Torres, Orlando | Physician | Baystate Medical Center | X | X | |
| *Public Health Personnel* | | | | | |
| Caulton-Harris, Helen | Commissioner of Public Health | City of Springfield, Public Health Department | | | X |
| Cluff, Ben | Veterans' Services Coordinator | MA Department of Public Health, Bureau of Substance Use Services | | | X |
| Federman, Julie | Health Director | Town of Amherst | | | X |
| Hyry-Dermith, Dalila | Supervisor | MA Department of Public Health, Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit | | | X |
| Walker, Phoebe | Director of Community Services | Franklin Regional Council of Governments | | | X |

## Community Chats

Regional Advisory Committee (RAC) members and Baystate Health Community Benefits Advisory Committee members identified existing community or provider meetings to bring information about the CHNA and gather priorities.  Findings informed prioritization of CHNA health needs.

| Organization (60) | Population | Location | # of Participants (total: 838) |
|---|---|---|---|
| **Hampden County (46)** <br> **N = 729** | | | |
| Baystate Noble Healthcare Professionals | Health Care Professionals | Westfield | 30 |
| Community Benefits Advisory Council Baystate Medical Center | Community Leaders | Springfield | 15 |
| Patient Family Advisory Council Baystate Medical Center | Youth Patients | Springfield | 5 |
| Patient Family Advisory Council Baystate Medical Center | Community Members | Springfield | 5 |
| Armbrook Village | Older Adult Community Members | Westfield | 27 |
| Healthy Hill Initiative, Seniors | Older Adult Community Members | Springfield | 10 |
| Alzheimer's Support Group | Caretakers and Alzheimer's Patients | Westfield | 6 |
| Baystate Medical Center – Team Member Engagement Council | Health Care Professionals | Springfield | 8 |

| | | | |
|---|---|---|---|
| Baystate Wing-Team Member Engagement Council | Health Care Professionals | Palmer | 11 |
| Project Coach | Youth | Springfield | 27 |
| Springfield Dept Health & Human Services | Municipal Staff | Springfield | 35 |
| Hampden County Health Coalition | Non-Profit Staff | Springfield | 16 |
| Westfield Residents with Mild Cognitive Impairment | Community Members with Mild Cognitive Impairment | Westfield | 10 |
| Maternal and Child Health Commission | Non-Profit Staff | Springfield | 13 |
| Shriners Medical Home Meeting | Health Care Professionals | Springfield | 40 |
| Mental Health Association | Non-Profit Staff | Springfield | 40 |
| Unity of Pioneer Valley | Transgender Adults | Springfield | 9 |
| Square One | Non-Profit Staff | Springfield | 18 |
| Baystate Wing Leadership Council | Health Professionals | Palmer | 30 |
| Baystate Financial Counselors | Health Care Professionals | Springfield | 16 |
| C3 Mason Square | Community Members | Springfield | 18 |
| Baystate Noble Community Care Team Meeting | Non-Profit Staff | Westfield | 15 |

| | | | |
|---|---|---|---|
| ACO Patient Family Advisory Council | Community Members | Springfield | 14 |
| Girls Inc – Holyoke | Youth Community Members | Holyoke | 8 |
| C3 South End | Community Members | Springfield | 19 |
| Kamp for Kids, Behavior Services | Adults with Disabilities | Westfield | 14 |
| Square One, Young Children's Council | Community Members-Parents | Springfield | 7 |
| Jewish Family Services | Non-Profit Staff | Springfield | 28 |
| Out Now Youth | LGBT Youth | Springfield | 8 |
| Baystate Community Faculty | Health Care Professionals | Springfield | 11 |
| Boys and Girls Club | Youth Community Members | Westfield | 10 |
| Girls Inc –Springfield | Youth Community Members | Springfield | 13 |
| Interfaith Council | Faith Leaders | Springfield | 11 |
| Mason Square CAB | Community Members | Springfield | 12 |
| The Carson Center | Non-Profit Staff | Westfield | 18 |
| Parent Villages | Community Members- Parents | Springfield | 18 |

| | | | |
|---|---|---|---|
| Mass in Motion | Municipal Staff | Palmer | 7 |
| Baystate Noble Patient Family Advisory Council | Health Care Professionals | Westfield | 5 |
| Dean High School | Youth Community Members | Holyoke | 22 |
| Morgan School | Non-Profit Staff | Holyoke | 19 |
| Gandará | Community Members | Springfield | 13 |
| BSEP Career Interdisciplinary Course | Youth Community Members | Springfield | 19 |
| Westfield Senior Center | Older Adults | Westfield | 13 |
| Falcetti Towers | Community Members | Holyoke | 9 |
| Holyoke Community College Health Worker Class | Health Care Professionals | Holyoke | 16 |
| Community Benefits Advisory Council Baystate Noble | Community Leaders | Westfield | 11 |
| **Hampshire County (10)** **N = 77** | | | |
| Community Benefits Advisory Council Baystate Wing | Community Leaders | Ware | 15 |
| Hampshire Regional YMCA | Non-Profit Staff | Northampton | 7 |
| Ware Senior Center | Older Adult Community Member | Ware | 8 |

| | | | |
|---|---|---|---|
| Common Goals –E2E | Non-Profit Staff | Ware | 9 |
| Hillside/Highland Community Center | Community Members | Ware | 6 |
| Healing Alliance Support Group | Community Members | Ware | 5 |
| Treehouse Community | Non-Profit Staff | Easthampton | 6 |
| Treehouse Community - Youth | Youth Community Members | Easthampton | 8 |
| UMass Public Health Graduate Students | UMass Graduate Students | Amherst | 5 |
| It Takes a Village | Community Members | Cummington | 8 |
| **Franklin County (2)** **N = 12** | | | |
| Baystate Franklin Medical Center Social Workers | Social Workers | Greenfield | 9 |
| Baystate Franklin Medical Center Emergency Department | Emergency Department Staff | Greenfield | 3 |
| **Worcester County (2)** **N = 20** | | | |
| North Quabbin Recovery Center | Community Members | Athol | 8 |
| N. Quabbin Children's Health and Wellness System of Care | Community Members | Athol | 12 |

# Community Conversations

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

*Baystate Medical Center:  At Martin Luther King Jr. Family and Community Services in Mason Square in Springfield*
- 45 participants
- Wide range of ages
- Women and men participated
- Primarily African-American

*Baystate Medical Center:  Spanish-speaking Conversation, at Riverview Senior Center in Springfield*
- 40 participants
- Majority older adults
- Men and women participated
- Primarily Latino/Hispanic

*Baystate Noble Hospital:  At Westfield Senior Center*
- 10 participants, primarily from Westfield area
- Women and men participated
- All participants were age 40 and up
- Most were White

*Baystate Wing:  At Education to Employment site of Holyoke Community College in Ware*
- 8 participants
- All women, from Ware and the surrounding area)
- All White

*Baystate Franklin Medical Center:  At John Olver Transit Center in Greenfield*
- 40 people from across Franklin County and the North Quabbin region

## Appendix II.  Glossary of Terms

- **Built Environment** – man-made structures, features, and facilities viewed collectively as an environment in which people live, work, pray, and play. The built environment includes not only the structures but the planning process wherein decisions are made.
- **Community** – can be defined in many ways, but for the purposes of the CHNA we are defining it as anyone outside of the Western MA Coalition of Hospitals/Insurer, which could be community organizations, community representatives, local businesses, public health departments, community health centers, and other community representatives.
- **Community Benefits (hospitals) –** Services, initiatives, and activities provided by nonprofit hospitals that address the cause and impact of health-related needs and work to improve health in the communities they serve.
    - o **Community Health Needs Assessment (CHNA) and Implementation Plan** – an assessment of the needs in a defined community. A CHNA and a hospital implementation plan is required by the Internal Revenue Service in order for nonprofit hospitals/insurers to maintain their nonprofit status. The implementation plan uses the results of the CHNA to prioritize investments and services of the hospital or insurer's community benefits strategy.
- **Community Health Improvement Plan (CHIP)** – long-term, systematic county-wide plans to improve population health. Hospitals likely participate, but the CHIPs are not defined by hospital service areas and typically engage a broad network of stakeholders. CHIPs prioritize strategies to improve health and collaborate with organizations and individuals in counties to move strategies forward.
- **Cultural humility** – An approach to engagement across differences that acknowledges systems of oppression and embodies the following key practices: (1) a lifelong commitment to self-evaluation and self-critique, (2) a desire to fix power imbalances where none ought to exist, and (3) aspiring to develop partnerships with people and groups who advocate for others on a systemic level.
- **Data Collection**
    - o **Quantitative data** – information about quantities; information that can be measured and written down with numbers (e.g., height, rates of physical activity, number of people incarcerated). You can apply arithmetic or statistical manipulation to the numbers.
    - o **Qualitative data** – information about qualities; information that cannot usually be measured (e.g., softness of your skin, perception of safety); examples include themes focus group and key informant interview data.
    - o **Primary data** – collected by the researcher her/himself for a specific purpose (e.g., surveys, focus groups, interviews that are completed for the CHNA).
    - o **Secondary data** – data that has been collected by someone else for some other purpose, but is being used by the researcher for another purpose (e.g., rates of disease compiled by the MA Dept. of Public Health).
- **Determination of Need (DoN) application** – proposals by hospitals for substantial capital expenditures, changes in services, changes in licensure and transfer of ownership by hospitals must be reviewed and approved by the Massachusetts Dept. of Public Health. The goal of the DoN process is to promote population health and increased public health value by guiding hospitals to focus on the social determinants of health with a proportion of funds allocated for the proposed changes.

- **Ethnicity** – shared cultural practices, perspectives, and distinctions that set apart one group of people from another; a shared cultural heritage.
- **Food insecure** – lacking reliable access to sufficient quantity of affordable, nutritious food.
- **Health** – a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO).
- **Health equity** – the highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition (WHO)
  - Health equity is concerned with creating better opportunities for health and gives special attention to the needs of those at the greatest risk for poor health
  - Health equity is when everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.
- **Housing insecurity** – the lack of security about housing that is the result of high housing costs relative to income, poor housing quality, unstable neighborhoods, overcrowding, and/or homelessness. A common measure of housing insecurity is paying more than 30% of income toward rent or mortgage.
- **LBGTQ+** — lesbian, bisexual, gay, transgender, queer or questioning, and all other people who identify within this community.
  - **Transgender** —refers to anyone whose gender identity does not align with their assigned sex and gender at birth.
  - **Non-Binary** —people whose gender is not male or female.
  - **Gender-Nonconforming** — a person who is, or is perceived to have gender characteristics that do not conform to the traditional or society expectations.
- **Race** – groups of people who have differences and similarities in biological traits deemed by society to be socially significant, meaning that people treat other people differently because of them, e.g., differences eye color have not been treated as socially significant but differences in skin color have. Race is a socially created construct as opposed to true categorization.
  - **Black** – we use the term "Black" instead of African American in this report in reference to the many cultures with darker skin, noting that not all people who identify as Black descend from Africa.
  - **Latino/a** – we use the term "Latino or Latina" in this report in reference to the many cultures who identify as Latin or Spanish-speaking. We chose to use Latino/a instead of Hispanic or Latinx, noting that there is a current discussion on how people identify. Latinx is a gender-neutral term, a non-binary alternative to Latino/a.
- **Social determinants of health** – the social, economic, and physical conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels. (WHO)
- **Social justice** – justice in terms of the distribution of wealth, opportunities, and privileges within a society.

# Appendix III.  Focus Group Summaries

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

**Focus Group Report: Gun Violence and Youth: Young Men**

**Primary Hospital/Insurer:**  Baystate Medical Center
**Topic of Focus Group:**  Gun violence and youth: Young men
**Date of Focus Group:** 2/19/2019
**Facilitator:**  Kim Gilhuly
**Note Taker:**  Tenzin Tsepal

**Executive Summary**

A.  Participant Demographics:
- Ten men participated.
- All participants were between the ages of 18 and 30. Three were aged 18 to 21, and five were aged 22 to 30.
- Five men were African American/Black, and five were Hispanic/Latino.

B.  Areas of Consensus:
- See below table: Question 2 - Causes of gun violence in Springfield.

C.  Areas of Disagreement:
- Some believe cops are corrupt and don't respond; others believe cops are there and running into the bullets.
- Some believe the media truthfully covers shootings in Springfield; others do not believe this.

D.  Recommendations:
- Provide more mentoring and job programs.
- Make sure youth have something to do other than getting involved in a life of guns.
- Gun control actions, like increasing sentencing and making it harder to get guns can help.
- Improving school systems, so that students who are failing are supported more.
- Encouraging youth to create their own positive rap music that doesn't focus on gangs and guns and violence may also help.

E.  Quotes:
- "It affects you badly. You just spoke to that person and then an hour or a day later you find out your friend was shot. Most of the time, we are going to keep living, and that's the hard part."
- "It is very scary and not funny. It is heartbreaking to realize people you know are not alive. "

- "My man got shot in the spine and paralyzed very recently and the kid who shot him was 15. These kids are young and they learn from media, propaganda, rap music." Then another person said, "No they learn from people around them."
- "Around the block, people get shot and stand there and it's a very natural and everyday thing, "
- "There are 3 reasons why people get a gun: for protection, to make money (robbing) and the scariest reason is just to have it - people have guns just to have a gun."
- "Give children some admirers and leaders."
- "Open more centers for kids to join."
- "I don't like that people died for no reason - [just because of] gangs and violence."

**Key Issues**

| Question | Synthesis of Responses |
|---|---|
| 1. What is gun violence? | Gun violence includes shooting, gun powder, shells, bullet holes, loss of friends and family, suicide, gangs. |
| 2. Causes of gun violence in Springfield? | <ul><li>Guns are omnipresent and really easy to get. People are exposed to them at an early age. They are just part of life in Springfield.</li><li>Rap music is a bad influence on the uptake of gangs, guns, and violence.</li><li>Gun violence causes many types of serious mental health issues.</li><li>There are a lot of reasons why people resort to shooting (e.g., territories, gangs, fights over women, domestic violence, suicide), but the fact that everyone has a gun means that they resort to gun violence as the response.</li><li>There has been an uptick in gun violence since 2014, when someone named Caleb was killed, resulting in a lot of retribution shootings and killings.</li></ul> |
| 3. How does gun violence affect you and people in general? | The effects mentioned by participants included:<ul><li>Mental health effects (e.g., grief, sadness, insomnia, stress, heartbreak from others' deaths)</li><li>Hypervigilance, paranoia, panic, fear</li><li>Anger</li><li>Trying to be more peaceful</li></ul> |
| 4. How old were you when you first saw guns? | Most participants said they didn't remember a time when they weren't exposed to guns in the neighborhood. Some said they were exposed to guns as early as age 3 or 5. One participant said "I picked up a gun off the ground at age 5." People also talked about knowing how to recognize when someone has a gun – in the way |

| | they walk, their demeanor of thinking they can do anything, or acting like they are trying to hide something (a gun) when police are around. |
|---|---|
| 5. How does the community respond to gun violence (neighborhood, law enforcement, media)? | In neighborhoods, mostly people mind their own business and don't want to get involved or be investigated themselves. Others mentioned "Street Watch", "Neighborhood Watches", and an app that people can use to alert others when they hear gunshots.<br><br>Regarding law enforcement, participants' reactions were mixed. At first everyone said that cops don't respond and are corrupt. Then someone said (and several others agreed) that cops are in fact responding, and that not all cops are bad, and we call them when we need help.<br><br>Regarding the media, some participants said the media doesn't report gun violence, and others said the media does report on gun violence, though sometimes the media gets it wrong. |
| 6. Your ideas for how to reduce gun violence in Springfield | Early in the focus group, most people felt that there was no way to curb gun violence, that nothing can be done about it - it is just the way it is. Then participants started to come up with ideas, such as mentoring, which can provide children with leaders that they can admire, and having teachers that really care about individual kids and get involved with them. Job programs, certification programs, community centers, and organizations like Roca can provide things for young people to do and be involved in that don't involve guns and violence. Participants also said that increasing gun control, making it harder for people to get guns, and increasing the amount of time people serve if arrested for having a gun could help reduce gun violence. |
| 7. How can "systems" prevent gun violence? | These answers were subsumed into Question 6. |
| 8. How easy is it to get guns in Springfield? | Participants thought it was incredibly easy to get guns. "You can buy guns easily anywhere and you don't have to have a license." |

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

**Focus Group Report: Gun Violence and Youth: Young Women**

**Primary Hospital/Insurer:** Baystate Medical Center
**Topic of Focus Group:** Gun violence and youth: Young women
**Date of Focus Group:** 2/28/2019
**Facilitator:** Kim Gilhuly
**Note Taker:** Nikki Burnett

**Executive Summary**

A. Participant Demographics:
- Eight women participated.
- Five women were Hispanic/Latino, and the other three were African American/Black.
- Six participants were between the ages of 22 and 30, one was between the ages of 18 and 21, and one was under the age of 18.

B. Areas of Consensus:
- Guns are omnipresent and really easy to get
- There are a lot of reasons why people resort to shooting - gangs, jealousy or drama, to look cool or prove themselves, peer pressure, lack of parents in their lives.
- Gun violence causes many types of serious mental health issues, notably PTSD, anxiety, fear.
- There's no hope to reduce or prevent gun violence in young adults, you have to intervene with middle school-aged children or younger.
- After school activities have to be affordable. Otherwise, many parents and children can't make use of them

C. Areas of Disagreement:
- Whether there are any police who respond appropriately to gun violence
- Most of the women said they are fearful of gun violence, but some said that they aren't and that you just react in the moment.

D. Key Recommendations:
Young people at risk for gun violence would benefit from:

- After school activities, programs, job opportunities, more programs like Roca
- Teachers and program staff that have lived through the same kinds problems youth face so they are relatable
- Gun violence curriculum at schools
- Police getting more involved in high violence communities and getting to know people, not just putting them in jail

     ○ Museum or a program through Baystate Medical Center (BMC) showing actual gun trauma and the impacts of using guns

    E. Quotes:
- ○ "My son's father was shot at. It caused me to have PTSD, I see a therapist now. I have anxiety walking down the street. My son's father is gang affiliated and it makes me cry for him because I'm scared for him. What if I am walking with him and our kids and someone shoots?"
- ○ "I don't like guns because of my experience in elementary school. I have flashbacks and anxiety because I witnessed my little cousin get shot in face at the playground in elementary school by a child her age."
- ○ "My first friend got shot in middle school."
- ○ "If they [police] would come faster, lives could be saved."
- ○ "Nothing will help prevent gun violence unless the whole world wants to stop."
- ○ "Kids look for love and acceptance in the street because they don't have it at home."
- ○ "Cops should be more involved with the community instead of trying to lock everybody up."

**Key Issues**

| Question | Synthesis of Responses |
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| 1. What is gun violence? | Participants defined gun violence as a situation with a gun or a hammer. |
| 2. Causes of gun violence in Springfield? | Participants said the main cause of gun violence was gangs. People use guns when fighting with each other, for retaliation, and when a fight escalates - from a fist fight to using guns. Other causes include:<br><br>● Drama caused by jealousy, drama around baby mamas<br>● Thinking gun use is "normal" because they grow up around guns<br>● Feeling scared and feeling like they need a gun for protection. Scared people are more likely to shoot and not think about the consequences.<br>● Peer pressure and thinking gun use is cool.<br>● Having a gun even though they don't know how to shoot<br>● Young guys in gangs showing off guns to kids they want to recruit<br>● People on the sidelines of a fight pushing the fighters to shoot each other<br>● Not feeling loved at home by parents and finding their family on the street |

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| 3. How does gun violence affect you and people in general? | Effects include:<br><br>● PTSD, anxiety, hypervigilance, other mental health effects<br>● Fear - some participants said they weren't scared and that you just react in the moment, but many said they were scared for their children and their children's fathers<br>● Knowing that gun violence is real. One participant said her cousin died, and that she saw the bullets on the street. It all happened and she just reacted however she did, but later thought "I could have died". |
| 4. How old were you when you first saw guns? | Some participants said that guns have been around all of their lives. Some said guns were around when they were eight years old or when they were sixth graders. The participants generally agreed that guns are usually introduced to kids by middle school, when they are recruited into gangs. They felt that middle school is the time to intervene, or even before. |
| 5. How does the community respond to gun violence (neighborhood, law enforcement, media)? | ● Neighborhoods: People don't "band together". Mostly they keep to themselves so they don't have someone going after them. "Snitches get stitches. We learned this in elementary school."<br>● Law Enforcement: Usually law enforcement is not helpful. They "start shooting first", and they shoot either because they see a gun and are scared or because they can. Sometimes cops are helpful, but they aren't doing enough - they don't respond fast enough, or they help only when they want to. There have been several incidents when cops let people fight for a while and *then* break it up.<br>● Media: Lots of people get their news on social media. Some of this news is true, and some is not. Social media often reports news about gun violence quicker than the news media. "Facebook lets us know what's really happening."<br>● Hospitals: EMTs take too long to get to the scene when there are fights or gunshots. |
| 6. Your ideas for how to reduce gun violence in Springfield | Ideas for reducing gun violence included:<br><br>● Programs (like Roca), sports, activities, and afterschool programs, which can keep people off the streets. But these activities have to be affordable in order to be helpful.<br>● Jobs and opportunities<br>● Cops being more involved in the community. Cops in Holyoke are a good example because they go to neighborhoods where there are guns and gangs and hand out flyers, sign people up for programs, and talk with people and get to know them.<br><br>Many participants mentioned barriers to reducing gun violence. When asked this focus group question, participants' first response was that nothing can be done. But when the focus group facilitator |

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| | said "You said kids are exposed in middle school – should something be done then?", participants had ideas (listed above). Some participants felt that mediation is not helpful. Some were concerned about vetting staff for activities. One person pointed out a boxing coach who was later found to be molesting boys. |
| 7. How can "systems" prevent gun violence? | Participants named some issues with school prevention efforts.<br><br>● Metal detectors at schools reduce some risk of gun violence, but they are inadequate, people can get around them, and they are not enforced enough.<br>● Teachers don't pay attention to their students.<br>● Teachers have not had the experiences that the students are having in their neighborhoods, so how can they understand? Teachers judge their students and don't know how to handle them or react.<br><br>Suggestions for prevention at schools included:<br><br>● Training teachers and program staff in how to deal with trauma and people who have been through trauma<br>● Having gun violence be part of the curriculum<br><br>Recommendations for prevention in community based programs included:<br><br>● Hiring staff who have had experience in the neighborhood (like Roca), so that they know what people are going through and can relate to them.<br>● Funding more programs, sports opportunities, and jobs<br><br>A recommendation for prevention in hospitals was that hospitals could have a program like Scared Straight, where they hand out flyers or show young kids the reality of gun violence, with pictures of gun trauma.<br><br>A recommendation for prevention through law enforcement in Springfield was to use the model in Holyoke, where the cops are really involved. They are out on the worst streets, talking with people at a table, handing out flyers for programs kids can go to. |
| 8. How easy is it to get guns in Springfield? | Very easy. "I can call up somebody right now and get one." |

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

**Focus Group Report: Substance Use**

**Primary Hospital/Insurer:** Baystate Noble
**Topic of Focus Group:** Substance use
**Date of Focus Group:** 3/11/2019
**Facilitator:** Gail Gramarossa
**Note Taker:** Karen Auerbach

**Executive Summary**

A. Participant Demographics:
   ○ middle-aged adults with substance use issues, or with adult children with substance use issues
   ○ 8 people
   ○ 5 women, 3 men
   ○ 6 people were white, 2 were Hispanic
   ○ 6 people seemed to be over age 45, and 2 seemed to be in their early 30's
   ○ 1 man who was Hispanic and in his early 30's did not talk at all
B. Areas of Consensus:
   ○ People who are receiving treatment for substance use disorders need housing for treatment to be effective, but it is often very difficult for them to get affordable housing.
   ○ Not having adequate transportation from a treatment/recovery center to home or work can be a big barrier to receiving effective treatment.
   ○ There aren't enough beds in hospitals and inpatient substance use treatment centers. Even if someone does get a bed, the length of stay is very short.
   ○ There is stigma around receiving addiction support, so typically people who live in Westfield go outside Westfield for addiction treatment and recovery, and people who live outside Westfield go to Westfield for these services.
   ○ There is typically little to no follow-up for people who are discharged from medically assisted treatment programs.
   ○ Grandparents who are raising grandchildren because their children are addicts need more support.
C. Key Recommendations:
   ○ There should be more recovery options, like sober houses and recovery coaches, in Westfield.
   ○ Addiction treatment and recovery programs should include mental health services and support because most people who are addicted to drugs also have mental health issues, which if untreated can lead to relapse.
   ○ There need to be therapists in Westfield who are trained in addiction. There aren't any currently.

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

I. **Key Issues**

| Question | Synthesis of Responses |
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| 1. What are the most serious barriers or service gaps that consumers face in accessing mental health and substance use care? | • There are very few beds in hospitals and other inpatient substance use treatment centers that are available when they are needed (without a long wait time) for people without private insurance. Even if someone does get a bed, the length of stay is very short.<br>• There aren't enough options in Westfield for post-inpatient treatment and recovery. There are options in Holyoke and Springfield, but these places may be too far away from Westfield (especially if people don't have adequate access to transportation) to be realistic options. As a result, it can be difficult for parents who live in Westfield to support their children's recovery in Holyoke or Springfield.<br>• People who need or are receiving treatment for a substance use disorder need a place to live for treatment to be effective, but it's often very difficult for people in treatment to find and get affordable housing, especially people with CORI issues. Background checks and credit checks that are done when people apply for housing can be a barrier.<br>• Inadequate transportation to or from treatment and recovery locations to home, family, or work can also be a big barrier to recovery.<br>• Judges may not understand the substance use treatment and recovery process. People who are convicted of drug offenses and are in drug treatment don't get access to methadone or suboxone when in pretrial. If they go to jail or the street, they also won't get access to this treatment.<br>     • Judges and others may not understand what drug addiction is. One judge said an addicted person can't be addicted if he's working full time and has a car and place to live. Another didn't believe someone's son who was a great athlete with an injury could be addicted to heroin. Some believe that if a drug is a prescription drug, there can't be addiction.<br>• Probation should be integrated with the legal system and hospitals, but it is not. Recovering addicts on probation are made to jump through hoops, like call in every day or go to court by 4 pm even if they have no transportation. There should be a |

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| | separate probation for drug issues - currently they're all for crime.<br>● Most addicts have mental health issues as well, but typically addiction treatment and recovery programs only address addiction issues. As a result, recovery may not last very long.<br>● Most clinics help with addiction and provide counseling and women's support groups, but they don't provide the other services and support that people in recovery need to become financially self sufficient, be better parents, and so on.<br>● There are no therapists in Westfield who are trained in treating addiction. Patients are usually just treated by interns at the hospital who are in training. But these interns typically leave for other, better paying jobs when they're done with their internships.<br>● The whole system needs a a group of people who know what's going on and understand the system who can help people seeking or receiving treatment to navigate it and coordinate all the different parts. |
| 2. Are there specific vulnerable populations that you are most concerned about in relation to addiction and substance use? Who are they and why? | ● It's hard to help high schoolers deal with anxiety and depression with meds effectively, so they often turn to drugs.<br>● Some high schoolers with learning disabilities can have lots of trouble with anxiety, and take drugs to help with the anxiety. |
| 3. What about mental health care and substance use/addiction care for people who have young children? What are the major needs and issues for those age groups? | ● Getting affordable housing can be very difficult for mothers in recovery whose children were taken away from them. They often can not get their children back without having housing, but may need to have their children living with them to obtain affordable housing.<br>● Often grandparents are raising their grandchildren because their children are addicted to drugs or are in treatment and recovery. There is not enough support for these grandparents to raise their grandchildren and deal with their children's addiction and recovery.<br>● Some addiction recovery support groups don't allow children to be present or don't provide child care, so some parents can't attend these support groups.<br>● Because most state services can only be accessed in Springfield (like applying for MassHealth), it can be very hard for grandparents to access these services for their grandchildren. |
| 4. Are there enough providers who can prescribe Medication Assisted Treatment (MAT) | ● There are two providers for medically-assisted recovery in Westfield– 1 doctor who can prescribe suboxone and one methadone recovery center.<br>● There is a lot of stigma around receiving this treatment, so |

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| such as suboxone? Is there a methadone clinic in Westfield? If not, should there be? | people who live in Westfield tend to get MAT outside of Westfield (like Riverbend and Clean Slate), and people who get MAT in Westfield tend to live elsewhere. There is community pushback and stigma against having more services available in Westfield.<br>● The protocol for MAT is often not effective, especially when therapy is not provided at the same time, which can lead patients to relapse.<br>● When most people are discharged from an MAT program at a hospital or clinic, they are itching to get out and don't use other services available to continue their recovery, and often relapse. There is typically no follow-up 24-48 hours after discharge.<br>　● One place had a grant for 2 years to follow-up with people who were discharged. After they lost grant funding, follow-up was just a phone call. People were just cut off after discharge.<br>　● Sometimes the police were sent to find people after they were discharged from Noble hospital, but there wasn't enough money and training to support police to keep doing that. |
| 5. What about long-term substance use and recovery care needs? What are the needs for such services? | ● Recovery coaches can help people recover from having a substance use disorder, but there are very few recovery coaches in Massachusetts. Gandara, the Behavioral Health Network, and Caring Center provide recovery coach training. People with lived experiences, who have overcome their mental health or addiction issues, can be effective coaches and help addicts throughout their recovery process/ They can help with the spiritual and emotional aspects of recovery and can being there every step of the way for a recovering addict. But there isn't much training for them, they're not paid very much, and may not paid if they don't meet some requirements (like meeting with a client 5 times or more in a month). |
| 6. In relation to opioid use, what are the most pressing issues and needs around prevention, intervention and access to care? How about overdose issues such as prevention and who carries Narcan? | ● The Westfield task force can't do a Narcan training. Only the police can, so they have done a couple trainings. But this isn't enough.<br>● The police force is having some issues with getting Narcan – sometimes it's because of unions, and sometimes police officers don't want to carry Narcan. Sometimes officers get ill from fentanyl and need treatment. |
| 7. What is happening in this | ● There is proper education for HIV and free condoms are |

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| area related to substance use prevention? Should there be more prevention efforts and what would that look like? | available everywhere. But there isn't very much around drug use. One program is just starting in Westfield for 6$^{th}$, 8$^{th}$, and 10$^{th}$ graders, which will integrate drug addiction education. |
| 8. How do substance use disorders and addiction impact overall community health and stability? | <ul><li>The police force often have to diagnose and place people with addiction issues, but they're not trained and equipped to handle things like this.</li><li>The Westfield community seems economically and socially divided by neighborhoods. People think drug problems exist in other neighborhoods, but not theirs.</li><li>There is a huge impact of young adults dying from overdoses on other young adults and their families, and the community in general. Grief is often not recognized or dealt with. "It's like a lost generation." There is sadness and weariness in the community as a result. There is an impact on businesses, faith leaders, and family owned funeral homes as well.</li></ul> |

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

**Primary Hospital/Insurer:** Baystate Franklin Medical Center
**Topic of Focus Group:** Transgender, non-binary, and gender nonconforming (GNC) people
**Date of Focus Group:** 2/19/2019
**Facilitator:** Kat Allen
**Note Taker:** Jeanette Voas

## Executive Summary

A. Participant Demographics:
   - 5 participants
   - 4 participants were between the ages of 22 and 30. 1 was between the ages of 51 - 60
   - 4 were White, 1 was non-Hispanic/Latinx Semitic
   - 1 Unmanifested genderless, manifested female, transgender; 1 Female, male, & nonbinary, prefer not to say whether transgender; 1 Male, transgender; 2 Nonbinary transgender
B. Areas of Consensus:
   - "Transgender, non-binary, and gender nonconforming" works as an acceptable set of labels. There are many other culturally specific identities like "two-spirit." [In this report "trans" – the word the participants used most often – is used as short hand to cover a range of identities.]
   - The health care system needs to be more trans-friendly and trans-knowledgeable at all levels. There are a few good PCPs that trans/GNC people go to, but not enough, and sometimes other providers use the fact that someone else is trans-friendly as an excuse to *not* need to become more informed. And most specialists do not have the needed sensitivity and knowledge.
   - There are not enough behavioral health care providers who are transgender (the ideal situation) or trans-friendly and trans-competent.
   - Medical providers should be expected to meet a higher bar for trans-competence than the general public does. Patients should not need to be in the position of educating their medical providers.
   - The administrative level of health care does not feel trans-friendly, e.g. forms and protocol disregarding information provided about preferred names, asking patients to fill out forms with inscrutable questions about transgender status.
   - The lack of coordination among agencies can make it difficult to find trans-friendly care and services.
   - There's a general lack of sensitivity in the community, which can be socially isolating, especially for transgender people who don't "pass."
   - All of the participants agreed that they felt uncomfortable or afraid going to any of the gyms in town.

C. Areas of Disagreement:

D. Recommendations:
- Recruit trans-friendly and trans-knowledgeable providers (including and especially behavioral health specialists), and providers who are themselves transgender. Involve trans people in the hiring/interviewing process.
- Train everyone in the hospital or medical practice in trans issues to build competence throughout the organization.
- Provide training to community organizations to make them trans-friendly and motivate them to involve transgender people. Gyms are a good place to start.
- Create a single LGBTQIA+ hub that people know about and can go to for information about providers, resources, events, etc. (Cooley Dickinson just hired someone for a similar role.)

E. Quotes:
- "I need Baystate to understand that people are falling through the cracks. We're *not* healthy, we're *not* doing great, we're suicidal, struggling to maintain employment and paying all the bills, so it's so difficult to do self-care. There's a lot of personal responsibility on me taking care of myself, but also I need those resources to be there and available and accessible, and to be treated like a human being."
- "I have never been in a gym where I have not felt terrified 100% of the time I was there. I just want to exercise!"
- "I can't go to the gym and do the things I want to do, be with people in that setting, and maybe develop a friendship. I can't have that because I don't think they're ready for it. And specifically in my case, it's because I do not pass."
- "Not passing is a huge barrier to everything."
- "When I feel like I am expressing myself in a way that's true to myself, most people in society don't know how to read that or be with it."
- "There's this idea that you're moving from one side of the binary to the other, you're in transition, and you're always trying to get somewhere. I'm non-binary but that doesn't mean I'm trying to find a means to an end. I hope that health care can get used to the idea of people just being people and identifying as themselves without having to reach some gender identity. This idea that people have to look at you and have to diagnose you as something is really frustrating."
- "Even the hormones they put trans people on were usually designed for cis people. So much of what happens with trans people, there's no research, there's no knowledge."
- "Before coming here I went to Fenway Health in Boston, which is specifically for LGBTQIA+ community. Here I feel like providers lack interest in becoming well-read and accepting and caring. It feels like they're doing it because they're being mandated to, or because people are reacting against the things that they're not doing."
- "I swear medical school steals people's souls. Every time I deal with a medical assistant or nurse practitioner, they're so great…doctors terrify me."
- "I seek out only trans-friendly physicians. I go to people I trust."

- "*If* they're taking new patients."
- "There's no network. Coming here and finding a therapist who's trans-friendly… In Boston, there's a network you can go to and there's actual information about the providers and what their experiences are with trans people. Here I have no idea."
- "Resources are so fragmented. I've seen at least 3 separately compiled documents made by different groups that list all the trans-friendly providers in the area, with 90% overlap, but people at 3 different organizations had to painstakingly put these together separately and then give them to like the 5 people they interact with."
- "In this area, people think, 'everyone's queer,' so we don't need queer-specific resources, we don't need a LGBT center like Fenway."
- "Some weeks what I do to stay healthy is I eat well and I exercise and some weeks what I do to stay healthy is I eat McDonalds and I sleep for 15 hours and I try again the next week. I don't want a health care system that's going to shame me because I have to do that sometimes."

**Key Issues**

| Question | Synthesis of Responses |
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| **1. Obstacles to being healthy** | Lack of awareness, sensitivity, and competence around trans issues in the health care system<br><br>• Providers need to be better educated about trans issues. Otherwise the burden falls on the patients to teach the providers.<br>• Ideally, there would be good providers who are themselves transgender. Second choice: loving, caring providers who have the knowledge and understanding.<br>• There are not enough mental health providers who are transgender themselves or trans-friendly and trans-competent. And mental health support is a big need for trans people.<br>• It's difficult to seek behavioral health. 5 years ago I knew I'd be approached a certain way, asked to do certain tests. Now I get a lot of apologies. It's just too much.<br>• Some providers lack sensitivity, and others will say, "I treat transgender people like everyone else." But there are extra issues with being transgender. The providers need to be knowledgeable about that.<br>• There are a few providers who are known to be trans-friendly, and everyone goes to them. Because those few providers are out there, other providers, especially specialists, seem to feel they don't need to become trans-knowledgeable themselves.<br>• I have health issues that have nothing to do with being trans, but when I go to a specialist, all they want to know is whether I'm on testosterone.<br>• The administrative level needs training as well. They're the first line. They don't use your preferred name and they give you |

| | forms with questions that are not helpful and hard to answer. Lack of sensitivity in the community, no welcome feeling |
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| | • The gyms in town do not feel welcoming. Fear that someone will freak out in the locker room and call 911. Gyms aren't ready for us. "I have never been in a gym when I have not felt terrified." |
| | Social isolation if you don't fit in |
| | • If you don't pass, you're a provoker. Not passing is a huge barrier to everything. There are lots of nonpassing transgender women who don't leave the house.<br>• People don't see us as we are. |
| | Capitalism! |
| | • We live in a system that funnels power and wealth to people who don't tend to be transgender or care about transgender people. |
| **2. Health challenges unique to transgender people & how well are they being addressed** | • Not enough research on health issues for transgender people.<br> ○ What are long-term effects of hormones?<br> ○ What about interaction of hormones and other medications?<br> ○ How best to deal with other health issues that are different for transgender people?<br> ○ It's like we're being experimented on.<br>• There are not many providers who are themselves transgender. Getting into those fields can be hostile to transgender people.<br>• A lot of trans-specific health care happens to people before they're 18, when they can't speak or decide for themselves.<br> ○ One participant reported medical abuse as a child, including having medications and treatments that weren't explained to them, perhaps because of their gender nonconformity.<br>• I worry that if you have a history in the mental health system, as many transgender people have, that can affect how you're treated in the medical system. You say something's going on and they say, "It's just in your head."<br>• Trans people don't all want the same things, the same combination of hormones & surgery.<br> ○ One participant said: Insurance has had restrictive rules, e.g. you can't get top surgery unless you're on hormones<br> ○ Another said: rules have changed in MA, so that's no longer the case<br> ○ Another said: providers need to be able to educate patients about things like that<br>• At times, there have been shortages of HRT meds and I have been unable to get them at the pharmacy. It's awful. |
| **3. Where do you get medical care & do you get the** | • CHC, Baystate, VMG, CSO, alternative providers<br>• Mix of satisfaction with providers: I'm comfortable, I'm ready to move, I don't talk with my doc about anything |

| care you need? | • Dental is awesome at CHC!<br>• Bad experiences:<br>   o Hole in the system: I hit my head at work, I have symptoms that prevent me from working, but I don't have a diagnosis and without a diagnosis, I can't get disability or any kind of assistance.<br>   o In CT, when I was suicidal I was admitted to hospital into awful conditions, with people freaking out all around and guards. There was no trans support, no recognition. You've got to make accommodations and be trans knowledgeable. I was ready for help and that's how I got treated.<br>   o I've been in Baystate psych ward. They're not trans knowledgeable. And the reason why is that they send trans people up to Brattleboro Retreat, but that unit is poorly resourced, as compared to other units. |
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| **4. Local resources that have helped you be healthier** | • (Long silence before anyone answered)<br>• Recovery Learning Center, for community and mental health support |
| **5. What else/what other services would be helpful?** | • A central go-to place for trans people to find out where to get trans - friendly services. An LGBTQI+ resource center. A hub that people know about, one entry point.<br>   o There's word of mouth, and everyone says to go to the same provider and that provider is booked solid<br>   o For someone new in town, it's hard to navigate<br>• When people go into crisis here, they often get sent to respite. But respite sucks for trans people. Their policies make no sense, so they usually don't accept trans people. Trans people who could be in a less locked-down situation end up getting pushed into the hospital.<br>• Opportunities for improving health & talks about health resources that don't all go back to exercise and eating well. Some of us can't exercise, and the healthy food is the most expensive food. |
| **6. What do you do to stay healthy?** | • Exercise, take care of yourself be fit & active, mentally healthy and happy<br>• Dance, as often as possible<br>• I need Baystate to understand that people are falling through the cracks.<br>• Marijuana has been helpful. Looking for Increased accessibility and lower price. |
| **7. Recommendations from one participant who wrote up her** | • Remove gender-specific signage<br>• Stockpile and make available HRT meds when supplies become low<br>• Set a gift fund for transgender surgical procedures for those who cannot afford them.<br>• Hire health care providers—especially mental health providers—who |

| thoughts for us | are themselves trans or GNC<br>• Recruit medical professionals with specific training with trans people.<br>• Conduct mandatory training of all health care employees for trans-friendly environment<br>• Involve trans people in provider hiring & interviewing process<br>• Get involved in retraining influential people and the community at large to create a more inclusive environment |
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**Coalition of Western Massachusetts Hospitals
2019 Community Health Needs Assessment**

**Focus Group Report: Youth of Color**

**Primary Hospital/Insurer:**  Baystate Franklin Medical Center
**Topic of Focus Group:**  Youth of Color
**Date of Focus Group:** 2/19/2019
**Facilitator:**  Kat Allen
**Note Taker:**  Jeanette Voas

**Executive Summary**

  A.  Participant Demographics: 8 participants
   - 5 women, 3 men
   - 6 people seemed to be over age 45, and 2 seemed to be in their early 30's
   - 6 people were white, 2 were Hispanic

  B.  Areas of Consensus:
   - Life is stressful, with multiple demands of school, homework, chores at home, and for many, work.
   - School can be a stressful environment, with social expectations, cliques, unnecessary drama, and a school environment that doesn't help young people deal with the emotions and the stress.
   - The students said they see a lot of anxiety, eating disorders, depression among their peers.
   - They report instances of being stereotyped by their peers, being treated unfairly at school because of race, or being less likely to be hired because of race.
   - Young people need a place to hang out that's not school.

  C.  Key Recommendations:
   - Support social emotional learning in schools
   - Work to destigmatize mental health issues
   - Provide lots of support for students transferring into a school
   - Train students and staff in diversity/cultural humility for students and staff
   - Continue support for programs like CAYP Shout Out group.
   - Consistently and fairly apply school discipline policies and school dress code across gender, race, ethnicity, class, and appearance.
   - Incidents of teachers and school staff not respecting students' physical space (i.e. in dress code violations) are not uncommon and should be avoided.
   - Community activities and resources such as "lightskating" and a skate park and greater access to the YMCA would provide healthy ways for youth to feel more connected and engaged.

  D.  Quotes:

"School's supposed to be a learning environment, but it stresses you out. There's not enough time to socialize, time to learn social skills."

"There aren't enough hours in the day to get everything done in a way that's acceptable to your peers and your parents."

"When I get angry, I don't show my emotions for nothing. People can use it against you. I feel bottled up by too much emotion. Sometimes I don't pay attention because I'm so stressed, it slows me down."

"It's not good for your body to be so stressed out. You get panic attacks, anxiety. We see lots of it. I know so many people at school who have eating disorders or anxiety."

"If you transfer in to our school, it's not easy to integrate in. Everyone stays with their own friend group."

"Teachers care about the work, not the student – well, not every teacher. I can stay after to talk about school work, but I can't stay after to talk with a teacher about emotional problems."

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

"There's a lot of stigma against mental health. I know a girl who's depressed and her friends told her, 'I don't get it, just be happy.' She's afraid to go to therapy because people don't understand."

**Key Issues**

| Question | Synthesis of Responses |
|---|---|
| Things that get in the way of being healthy | • Financial issues<br>    o Expense of health insurance and health care<br>    o Some people don't have enough money to go to the doctor and doctors shame and threaten parents that they should take better care of their kids.<br>    o It's too expensive to go to the Y or to have exercise equipment<br>• Family has moved a lot, and that makes it hard to be healthy. You have to adjust to everything, to new schools.<br>• No rides; it takes a long time to get places<br>• Lack of a healthy social environment in school<br>    o It's hard to transfer into a new school and fit in<br>    o peer pressure to spend money and have certain clothes, shoes, technology. It makes people stressed out.<br>• Stressors |

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| | <ul><li>    ○  People compare their body types to others. I know a lot of people with eating disorders.<br>    ○  School + work + homework + chores + sports is exhausting. It's hard to stay awake during the day.<br>    ○  We see lots of anxiety, panic attacks, depression</li><li>JUULing, including in school</li><li>Some parents are against vaccination; kids can't decide on their own to get vaccinated</li></ul> |
| 2. Health issues unique to young people of color? | <ul><li>It's harder to get hired.</li><li>There are social expectations – people expect you to be something you're not, and that adds to stress.</li><li>Because of Asian stereotype, everyone wants to be in a group with me and make me do all the work.</li><li>People get labeled for how they look or act.</li><li>People get called messed up names.</li><li>There's drama that's unnecessary and so common.</li><li>There's unequal treatment, for example in dress code violations. It doesn't happen to white girls like it does to me.</li></ul> |
| 3. How well are those challenges addressed | <ul><li>Some teachers care about school work, not about the students.</li><li>We complain, for example about school food, and nothing is done about it.</li><li>Teachers can be disrespectful, for example, yanking off a hood instead of asking you to take it off.</li></ul> |
| 4. Discrimination that impacts health | <ul><li>A guy told me I was unattractive because I'm black. It took a toll on me.</li><li>I keep my emotions bottled up.</li><li>In school they don't teach you how to deal with emotional stress. You can end up being depressed about it.</li><li>There's a stigma against mental health. Someone might not go to therapy because people don't understand.</li></ul> |
| 5. Local resources that contribute to health | <ul><li>CAYP, Family Center.</li><li>The Shout Out advisor bought me a planner and helped me plan.</li><li>Therapy</li><li>Friends can be therapists, too</li><li>Family members</li><li>It's good to have someone you can trust</li><li>Being alone</li></ul> |

| 6. What else is needed | <ul><li>A place for youth to go hang out<ul><li>Friday night "Lightskating" with lights and DJ was good, but they don't do it anymore</li><li>Skatepark is gone and Turners is so far</li><li>Boredom makes kids do crazy things</li></ul></li><li>Transportation – Leyden Woods is so far from everything</li></ul> |
| --- | --- |
| 7. How do you stay healthy | <ul><li>Sports</li><li>Spending time alone</li><li>Hike to Sachem's Head – it's so peaceful</li><li>Dance when I clean</li><li>Go to the Y</li><li>Have pets</li></ul> |

**2019 Community Health Needs Assessment Focus Group Report**
**ServiceNet Wells Street Shelter in Greenfield, Jan 23, 2019**

**Primary Hospital/Insurer:** Baystate Franklin Medical Center
**Topic of Focus Group:** People living unsheltered in Greenfield, MA
**Date of Focus Group:** 1/23/2019
**Facilitator:** Kat Allen
**Note Taker:** Jeanette Voas

**Executive Summary**

A. Participant Demographics: 9 participants
   - 4 women, 5 men
   - 7 non-Hispanic white, 1 black Latina, 1 American Indian
   - 3 age 31-40; 4 age 41-50; 1 age 51-60
B. Areas of Consensus:
   - Shortage of mental health/substance use care
   - Problems with coordination of care and continuity of care
   - There's a shortage of shelter space and a need for warm places to go during the day
   - Transportation can be a barrier to accessing services; lack of transportation on evenings & weekends
   - Shelter residents have good access to healthy food
C. Key Recommendations:
   - Identify warm places to be during the day, with volunteer opportunities for shelter residents
   - Weekend bus service is needed
   - More shelter beds are needed
   - Increased access to MAT is needed
D. Quotes:
   - "There's not enough follow up to mental health and substance use care. When you're discharged from a program, it's hard to get the meds you need."
   - "Trying to get a provider and get prescriptions after you've been discharged from a program is a huge challenge."
   - "There's a stigma about being homeless. They assume we're just trying to get a free ride. I don't have a home, no car. Sometimes you have to rely on people in the community."
   - "There are plenty of meals. Food is not hard to find, if you can get there."
   - "FRTA promises new bus stops, and then cuts back. There's no weekend or evening bus. This town needs weekend bus service."

**Key Issues**

| Question | Synthesis of Responses |
|---|---|
| 1. biggest things that make it hard for you to be as healthy as you would like to be | o Inadequate mental health care, especially for those with dual diagnoses.<br>   • Not enough beds<br>   • Not enough capacity at Greenfield methadone clinic<br>   • Nursing homes don't take people on methadone<br>   • Not enough follow up, continuity of care when you leave a program<br>   • It's taken a long time to get an accurate diagnosis<br>   • DMH beds for respite are taken up by people who don't want to be there and aren't taking advantage of services; and there are others who need higher level of care<br>o People with substance use disorders and mental health diagnoses are not listened to and face discrimination in medical system.<br>   • Longs waits for appointments, can't get in to see my own doctor, communication problems with provider organizations |
| 2. services currently available to people experiencing homeless in Franklin County | o In Greenfield, excellent resources for a small town.<br>o We need more shelters.<br>o Here it's a transportation issue.<br>   • Sometimes you have to travel a ways for care (e.g. to methadone clinic in Springfield)<br>   • If you're in any kind of treatment you can get a free bus pass.<br>   • Greenfield needs weekend and evening bus service.<br>o We have to leave the shelter at 8:00am and there's nowhere to go.<br>o Breakfast and lunch at Salvation Army & you can shower there.<br>o Plenty of meals offered – if you can get there |
| 3. Barriers for people experiencing homelessness to accessing these services | o Transportation<br>   • no weekend service<br>   • If you don't have a stable address, you don't get PT1 (transportation voucher)<br>o Have to be sober to access many services<br>o Long waits to get into shelters |

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| 4. What else is needed to help people experiencing homelessness be healthier | o Warm places to be during the day<br>o Productive things to do during the day<br>    • We could volunteer to help out, to make things<br>    • Keep old buildings and let the homeless people who want to better themselves get to work on them |
| 5. Source/availability of medical care | o Have used many medical resources in town – Baystate, Valley Medical, CHCFC, Health Care for the Homeless (Springfield) – and have moved among them<br>o Have had both positive and negative experiences with medical system<br>o Are able to get preventive care if they choose to<br>o Limited availability of dental care – only a certain number of patients on certain days |
| 6. Measures to stay as healthy as you can while experiencing homelessness | o Eat healthy food<br>    • Ready availability of food<br>    • Plenty of fruits and vegetables<br>    • A lot of options at shelter; can cook own food<br>    • Shout out to Stone Soup!<br>o Rest<br>o Walk<br>o Garlic/herbs/other personal remedies and habits |

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

**Primary Hospital/Insurer:** Baystate Franklin Medical Center
**Topic of Focus Group:** Users of a Rural Food Pantry
**Date of Focus Group:** 1/31/2019
**Facilitator:** Kat Allen
**Note Taker:** Jeanette Voas

**Executive Summary**

A. Participant Demographics: 13 participants
   - 10 women, 3 men
   - 10 non-Hispanic white; 2 American Indian; 1 white/American Indian
   - 1 age 22-30; 1 age 31-40; 2 age 41-50; 5 age 51-60; 3 age 61-70; 1 age 71-80
B. Areas of Consensus:
   - Transportation is the #1 issue
   - Shortage of good primary care physicians, mental health providers, and participants often have to go to Springfield for specialists.
   - Insurance doesn't cover things the participants feel they need, and trying to get referrals or deal with insurance is frustrating.
   - Social networks among neighbors are recognized as an asset.
   - Pretty good access to healthy food; participants said the Charlemont Federated Church food pantry was the best. HIP at farmers' markets is a plus.
C. Key Recommendations:
   - Satellite or mobile clinics would be very useful for rural residents.
   - Telehealth and telemental health services would be very useful
   - Pharmacy delivery services (which used to exist) would be very useful
   - A clothing closet (perhaps mobile, perhaps paired with other mobile services) would be very useful
   - Expand community health nursing programs
D. Quotes:
   - "Some places you get frowned on because you get food stamps whether you live in the hilltowns or in the city."
   - "If you get together with your neighbors, you will always have something to eat."
   - "Transportation is the ultimate question. It's a big trip to Greenfield. You ask the neighbors, 'Who's going in today?'"
   - "What is needed? *Anything* mobile."
   - "Because our population is small, our priorities get kicked down the road."

**Key Issues**

| Question | Synthesis of Responses |
|---|---|
| 1. Biggest things that make it hard for you to be as healthy as you would like to be | o Transportation!<br>    • Bus comes through 2-3 times a day. Some people can't get down to the bus. If you go into Greenfield you have to wait around to catch a bus back.<br>    • People can get PT-1, but people not on MassHealth need rides, too.<br>o Shortage of primary care physicians, not enough mental health care, providers not accepting new patients. No ENT, No rheumatology. You get sent to Springfield.<br>o Referrals get complicated confusing. You get frustrated and you go without care. |
| 2. Sources of food, and access to healthy food | o Charlemont Fed Church Food Pantry is the best. Difference of opinion about others (from "food pantries and offerings are good" to "they ask you lots of questions and the food is not very good.")<br>o Farmers' markets and HIP are good. Several in the group had used HIP; not everyone knew about it. |
| 3. What you do if you run out of food | o Go hunting<br>o Turn to family and neighbors ("Stone Soup") |
| 4. Source and adequacy of medical care | o Various, mostly in Greenfield, including Valley Medical, CHCFC, Franklin Adult Medical, Shelburne Family Practice, CHD, and Minute Clinic (participant says she has been unable to get her own doc)<br>o Had to go to Orange for dental care because it's easier to get in there<br>o Medication can be hard to get; insurance doesn't cover supplements and some tests we need<br>o Walk-in clinics at the church are helpful |
| 5. Transportation | o The ultimate question!<br>o There's a bus in the morning, and 11:20, and then you're stuck all day.<br>o I've hitchhiked.<br>o People who have bicycles use them |
| 6. Missing services, other things that would help | o Sidewalks. To get to the bus I have to walk ¼ mile in the road.<br>o The town plans a bicycle trail and sidewalks, with construction to begin in the spring.<br>o Even two more buses would help.<br>o A rural clinic for all the towns around here.<br>o Anything mobile, e.g. a mobile unit from Baystate or CHCFC that would do lab draws, prescriptions. |

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| | <ul><li>Pharmacies that deliver up here.</li><li>Ambulance could take people to appointments when it's not on call.</li><li>Telehealth</li><li>Group exercise classes</li><li>Clothing closet (there's one in Colrain at First Baptist)</li></ul> |
| 7. What you do to stay healthy, despite the challenges | <ul><li>I don't smoke or drink</li><li>I go to bed at a reasonable hour</li><li>I walk my dog</li><li>I garden</li><li>We have a strong social network</li></ul> |

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

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

**Primary Hospital/Insurer:** Cooley Dickinson Health Care, but the focus group results are applicable to:
  - Baystate Franklin Medical Center
  - Possibly Baystate Eastern Region for rural similarities
  - Health New England for needs of older adult members across western Massachusetts

**Topic of Focus Group:** Older Adults
**Date of Focus Group:** February 26, 2019 in Northampton and March 4, 2019 in Amherst
**Facilitator:** Jeff Harness
**Note Taker:** Gail Gramarossa

## Executive Summary

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

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

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

- Primary care and behavioral health care need to be more integrated and providers need to communicate with each other more consistently
- Need more deliberate and direct outreach to older adults, rather than waiting for them to come to you as health care providers

D. Quotes:
- "We are not our mothers – our health and social needs are very different from our parents' generation."
- "We want to make new 'families' and create our own supportive communities, especially if our children/grandchildren live far away from us"
- "We need help to manage the mental aspects of having a chronic disease such as stress, depression, and anxiety"
- "Our needs really vary by decade – what I need in my 60s may not be what I need in my 70s or 80s or 90s, so tailor services to my changing needs"
- "Be sure that providers and patients are 'tapping the resources', for example, the Diabetes Education Center at CDH. Many primary care doctors do not refer to the Center; I learned so much from the Step Up program and was able to avoid going on medication for 15 years based on diet and exercise. Diabetes is an illness that people feel guilty about, they feel they brought it on themselves, but I have learned to manage it well. No primary care doc can give me what I received from the Center"

E. Was there anything that could be relevant to another hospital service area? If so, which geographic area and describe:
- This information could be useful for other hospitals that serve a suburban and rural community with many retirees and older adults. This audience was also fairly well-educated and aware of services in the region.

**Key Issues:**

| Question | Synthesis of Responses |
|---|---|
| 1. What makes life fulfilling as you grow older? What is important to aging successfully? | <ul><li>Social connections and people you can call upon for help</li><li>Feeling valued and involved</li><li>Sense of safety and capacity to get health care when you need it</li><li>Quality of life, control over your life, having a say in your life</li></ul> |
| 2. What supports and services do you or other older adults in our community need to support good health? Where are there gaps in services, and how do these gaps impact older adults? Think about older adults with limited | <ul><li>Transportation</li><li>Affordable housing, down-sized and smaller</li><li>Provider with expertise in elder care issues/needs</li><li>Financial advice and information to avoid financial "scams"</li><li>Home-based services</li><li>Day programs for frail elders</li><li>Care coordination services to integrate care more seamlessly</li></ul> |

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| English, or who are people of color, or live in a rural area, identify as LGBTQ, or from other underrepresented groups. | |
| 3. Most older adults in our community have at least 1 chronic or serious illness.  What helps older adults manage chronic disease? | ● Behavioral health support to manage the psychological impact/stress and anxiety of having a chronic disease<br>● Help with managing and following a medication regimen<br>● Case management services<br>● Pharmacy home delivery<br>● Help with navigating insurance and Medicare issues<br>● More follow-up and "check-ins" from my primary care provider<br>● Health education for managing chronic illness provided in a non-hospital setting<br>● Be sure that providers and patients are aware of and referred to key health education and support programs that help with managing chronic disease such as the Diabetes Education Center at CDH; too many primary care doctors do not refer to the Center or other similar supports<br>● It is important for CDH to let the community know about all of the resources that are available to help older adults manage chronic illnesses<br>● Primary care needs to be better integrated with the other resources within the community<br>● For someone who is not able to get themselves there, perhaps a coach or someone to help people get to outside resources<br>● Could each office have 1 nurse who works specifically on integrating the office with other resources in the area? They could work with primary care around how to link the patients with those resources, using resources guides and websites about local services<br>● CDH should make sure that their primary care doctors/office staff are fully knowledgeable about what is out there in terms of other local resources and support services to manage chronic illness |
| 4. What would you like to see in your community that would make it a better place for older adults to live? | ● More support for "aging in place"<br>● Better sidewalks and recreation areas<br>● Home visiting<br>● More entertainment and social activities |
| 5. *Optional if time allows:* Do you have adequate | ● Need more elder-friendly psychiatric services with expertise in older adults' needs, but it's hard to find a good therapist |

| access to health care services, including mental health care? Is it working for you? Is it easy to get a qualified provider? | ● There are insurance barriers to ongoing care<br>● When you are new to the area, hard to find a primary care provider, need a navigator |
|---|---|

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

**Focus Group Report**

**Primary Hospital/Insurer:** Health New England
**Topic of Focus Group:** Experience with healthcare and basic needs for disabled adults
**Date of Focus Group:** 3/5/2019
**Facilitator:** Gail Gramarossa
**Note Taker:** Caitlin Marquis

**Executive Summary**

A. Participant Demographics:
   ○ 7 participants who were patients or clients of Caring Health Center
   ○ 4 women, 3 men
   ○ All people of color
   ○ All spoke English
B. Areas of Consensus:
   ○ Caring Health Center provides several services to help patients understand and carry out the roles they play in maintaining their own health, such as cooking classes, exercise classes, crocheting circles, etc.
   ○ MassHealth provided transportation is unreliable and drivers tend to be disrespectful or apathetic toward patients. A great deal of the conversation was dedicated to this topic.
   ○ Supplemental and emergency food resources are inadequate and difficult to access. SNAP benefits awarded sometimes do not feel worth the invasive application process, and food pantries in Springfield can be chaotic and difficult to make use of without transportation home from the pantries. The latter problem is exacerbated by poorly maintained housing with elevators in disrepair.
   ○ Participants had experienced instances of both targeted and structural racism that discouraged them from using emergency and support services.

- For a variety of reasons, accessing services to address basic needs can be a highly stressful experience that causes participants to question whether accessing those services is worth the stress.
- The healthcare system comes across to many of the participants as hasty, uncoordinated, and emotionally apathetic. There were accounts of pharmacists, doctors, and homecare providers all lacking the time and information required to help patients understand and receive the care they need.

C. Recommendations:
- Doctors, nurses, or staff in the doctor's office should do the work of arranging transportation and billing MassHealth
- Eliminate Yellow Cab as a Provider Requested Transportation (PT-1) provider
- Instead of trying to arrange a pick-up time with transportation ahead of time, patients should be able to call transportation when they are done with their appointments (however, doing this now gets the transportation providers off schedule)
- Drivers should escort patients from their doors to the van to ensure their safety
- Drivers should be trained to treat people with respect, empathy, and concern
- Make grocery carts available in housing developments to help people go get food and carry it home
- Records should be centralized with the primary care provider and easy for other doctors and specialists to access on demand
- Update the phone lines so that patients can actually reach someone
- Follow up on complaints that are filed about things like unreliable transportation
- Politicians should be coming to cities and knocking on the doors of people who use all these services to talk to them about their experiences
- Look to states that are doing a good job of delivering healthcare as an example for what we should be doing in Massachusetts
- Cultural education for people in the medical field

D. Quotes:
- Transportation:
  - "She waited for an hour and it was like 0 degrees outside and she was waiting and we wasn't gonna leave her so we ended up waiting with her, but god forbid if she was by herself. You're relying on someone to give you a ride and then you call but nobody answers so what do you do? Do you wait around or do you leave?"
  - "I've watched [name redacted] stand out there four two hours waiting for a driver, and then the driver comes up with only attitude. My brother, that woman lives all the way out in Timbuktu. She travels out here on a bus sometimes, and then to leave her here to have her family come all the way out here to drive her home--ridiculous. Nevermind she has emotional issues. We all have emotional issues."
  - "In 2015, I got sick and went to Baystate. 9:30 at night, no bus to come back from Baystate to King Street, snow to my knee. I walked from Baystate to King Street [about 3 miles], snow to my knee. Nobody at the hospital asked 'how are you getting home?'"
- Food

- - - "I did the groceries but the elevator wasn't working and I live on the fourth floor. I went in one trip with all my groceries and when I got to the last floor, I had a heart attack. I stood there; nobody was around. So, I said, 'I have to bring this home,' so I crawled over, and brought my groceries to the house… The elevator was out for like two weeks."
    - "If you're going in to apply [for SNAP], it's because you need it. So, if I'm telling you I'm coming here and I'm degrading myself, giving you all my business, and then you want to tell me 'okay, we can only give you $15,' I'm like 'uh, what is $15 gonna do?' You'd be lucky if you can get some eggs, some milk, some bread and that's it."
  - Health care
    - "I watched a video on Facebook… saying that there is a separation of how black people are treated in emergency rooms versus other nationalities of people… I have noticed myself, whether it's Baystate, Mercy, Noble, or any other hospital, when I [a black man] have an issue, I have to wait an hour or two just to get a doctor to come see me, and then for somebody to tell me, 'Oh, we don't have enough doctors,' that makes no sense to me. You're a hospital. Baystate is one of the top five hospitals in America. You have a helipad, and you're telling me there's not enough doctors in here?"
    - "My biggest issue is respect. I feel like a paycheck; I don't feel like a person. I feel like a docket number; I don't feel like a person. You don't even know my name."

**Key Issues**

| Question | Synthesis of Responses |
|---|---|
| 1. How do you see your own role in taking care of your health? What do you see as your responsibilities to help yourself stay healthy? | <ul><li>Eating healthy</li><li>Exercising</li><li>Getting out and socializing with others</li><li>Taking advantage of the cooking, exercise, crocheting, etc. classes offered by Caring Health Center</li><li>Being an advocate for myself--actively participating in activities and my primary care</li><li>Understanding the choices I have, speaking up when I don't want something, and getting help somewhere else when I need it</li><li>Working with an advocate provided by the healthcare system</li><li>Calling my care coordinator when I need something</li></ul> |
| 2. Let's talk about some day-to-day issues that can affect health. Are there services to meet basic needs such as food, housing, and transportation | <ul><li>Having to make repeated calls to schedule transportation for regularly scheduled appointments</li><li>Elderly people and people with limited mental capacity have to call back to arrange transportation over and over again, and this can create serious consequences for someone who needs urgent or steady care</li></ul> |

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| that you have had trouble accessing or getting enrolled into? What has been your experience trying to use such services? Do you feel that you are aware of the wide range of such services that you could use and be eligible for? What services would you like to know more about? | <ul><li>Transportation works well less than half the time</li><li>Worrying about transportation being reliable for family members or loved ones</li><li>Sometimes rides don't show up for people who scheduled them and those people don't have anyone else to call for rides, and there is no number to call if the ride doesn't show up</li><li>The people who come to pick up patients are rude, disrespectful, and treat people very poorly. They don't talk to or treat the people they are picking up as if they know they are physically and/or mentally disabled.</li><li>There is a lack of empathy and understanding among drivers of all types of transportation.</li><li>When Yellow Cab is called for transportation, they don't call the riders and sometimes they leave if the rider is not looking in the right place for them and doesn't come out in time. Yellow Cab gets paid regardless of whether they actually pick up a patient or not.</li></ul> |
| 3. Which of the basic needs we talked about - food, housing, and transportation, for example - pose the greatest problem for you? What happens when you can't get access to food, housing or transportation? What are some of the social, emotional, mental, physical or financial impacts? | <ul><li>Transportation is among the top five hardest basic needs to access</li><li>If walking or taking the bus is an option, that is preferable to the provider-scheduled transportation</li><li>When scheduling transportation, providers ask if people have mobility impairments, but then drivers say that it is not their job to accommodate those mobility impairments.</li><li>The transportation providers don't answer the phone at busy times</li><li>Even if it is not a problem to walk to pantries, it is a challenge to walk home with all the groceries. There used to be workers who would help with this at Caring Health Center, but they shut that program down.</li><li>SNAP benefits are not enough to sustain someone with all the nutrients they need for a whole month</li><li>Some buildings don't have elevators and people have to carry loads of groceries from the food pantries up the stairs</li><li>The DTA requires a ton of information in order to just get someone $15 a month in SNAP benefits, causing clients to wonder if it's worth it</li><li>The SNAP benefits the DTA gives out have gone down, but the cost of food has gone up</li><li>The lines at food pantries are aggressive and cause participants to question whether it is worth it to go to food pantries</li><li>The wait at a pantry can be as long as two hours and some pantries have let certain people jump the line</li><li>One participant experienced another pantry-goer making degrading comments about Puerto Ricans</li></ul> |
| 4. What has been your | <ul><li>Hospitals engage in practices that appear racist to one of the</li></ul> |

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| experience when you try get health care? What has worked well? What has not worked well or has been a real problem in getting the health care you need? | participants<br>● Emergency rooms say that they don't have enough doctors to treat all the patients in the emergency room<br>● Emergency rooms don't have the specialists or equipment needed to test people for all the issues they come in with<br>● It is very expensive to have even a short visit with an emergency room doctor<br>● Doctors in emergency rooms and specialists aren't getting records from primary care providers with enough timeliness to have a complete understanding of a patient's health issues within a visit<br>● Doctors prescribe medications that have side effects that force patients to choose between the lesser of two evils, and patients may not have the capacity or resources to treat the side effects as a separate issue. Doctors don't take the time to determine if patients might be susceptible to the side effects. |
| 5. What happens when you are not able to get the health care that you need? What are some of the social, emotional, mental, physical or financial impacts? | This question was not explicitly asked or answered. |
| 6. How does managing your disability fit into the overall picture of trying to get health care services when you need them? What would help your living with a disability? | This question was not explicitly asked or answered. |
| 7. When you get health care services, how much do you think the doctors, nurse, therapists or other healthcare providers really understand what you experience from your disability? How would you rate them in terms of that understanding? | ● Caring Health Center understands mental disabilities but only provides limited care on the physical disability side<br>● Doctors only treat patients for one issue at a time and don't take a holistic view of dealing with physical disabilities<br>● Doctors don't always treat patients with respect and empathy, and don't take the time required to get to know patients' names or really understand their issues<br>● Caring Health Center has too many clients and makes patients feel like they are just getting dealt with as quickly as possible<br>● There is too much of a separation in treatment between physical and mental health<br>● The pharmacy isn't giving out enough doses of insulin to get one participant through more than two or three days |
| 8. Let's talk about home care services. What has | ● The doctor asks at every visit if patients need care at home<br>● Help with eating and cooking more nutritiously |

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| worked well in any home care services you have had? What has not worked well? What do you see as lacking in home care services? What would make home care services better? | ● Providing an in-home nutritionist<br>● Better background checks and oversight for home care providers<br>● Home care providers aren't necessarily always doing the work they are getting paid to do<br>● Aligning diagnoses for home care because the doctors and the home care providers don't always agree that home care is required<br>● Home care available around the clock for surgery recovery |
| 9. Is there anything else you think we need to know about what it is like living with a disability? What would help? Everyone go around and say one thing that we maybe haven't said yet. | ● Better housing<br>● Getting a call from my doctor to check-in every six months or so<br>● Nothing, everything is good<br>● More accessible housing for a wheelchair or for other disabilities<br>● Assisted living for people with disabilities<br>● Empathy, less focus on statistics and working "by-the-book"<br>● Individualized care<br>● For doctors to make sure that patients are okay when they are leaving, and then conduct a follow-up call to make sure patients have what they need<br>● Doctors being on time and taking more time with patients<br>● Doctors getting to know patients on a personal level<br>● More coordination between emergency care and primary care<br>● Reducing the wait time between emergency room visits and follow-up treatment<br>● Getting enough doses of insulin from the pharmacy to get through more than a few days before coming back |

<u>**Focus Group Report**</u>

**Primary Hospital/Insurer:** Mercy Medical Center
**Topic of Focus Group:** Cancer
**Date of Focus Group:** 3/4/2019
**Facilitator:** Kim Gilhuly
**Note Taker:** Eve Sullivan

**Executive Summary**

A. **Participant Demographics:**
   ○ 10 participants - 5 women and 5 men; all white.
   ○ 1 person was aged 41 – 50, 3 people were aged 51 – 60, 3 people were aged 61-70, 1 person was aged 71 – 80, and 2 people were over age 80.
   ○ All participants were White
B. **Areas of Consensus:**
   ○ Mercy's Cancer Support Group has been an incredible and vital source of assistance, advocacy, support and love for people in treatment, their caregivers, and after cancer. People were effusive about the Support Group and most were long-time participants.
   ○ The position of Nurse Navigator or Social Worker to help people and families navigate the cancer care, medical, support services, and insurance systems is incredibly important.
   ○ People appreciated doctors and other staff who are dedicated, seem to go the extra mile, and are truly caring. The cancer care at Mercy was very appreciated.
   ○ Impacts of cancer are grief, the difficulty of dealing with uncertainty, whole-family impacts (ranging from family members not wanting to talk about it to divorce), and the ongoing nature of cancer – "it never ends".
C. **Key Recommendations:**
   ○ Need a Children/Youth Cancer Support group for children or grandchildren of people who have cancer.
   ○ Make sure other hospitals (such as Baystate) have Cancer Support Groups that meet every week and are for all cancer types.
   ○ Make sure other hospitals (such as Baystate) have a nurse or social worker navigator to help patients and their families navigate the medical, support services, and insurance systems.
   ○ Assistance and guidance and support is especially needed in times when a patient is near death but it's not entirely clear. If some kind of person or program could be created for those patients and those times, it would be helpful.

- All patients who have completed treatment for cancer should leave with a Survivor Care Plan

**D. Quotes:**
- "These support groups (cancer support and grief) have made a huge difference for me, learning to be a self-advocate, becoming more informed as patients and family member."
- "My mom was diagnosed with 3-6 months to live, and I think if she were in a Pancreatic support group, she wouldn't be alive. Support group makes her have hope and want to live."
- "The devotion of the staff here is one of the most loving and embracing care environments I have ever encountered. I felt when I was a patient here that I had extended family."
- "My doctor stretched to try to get my husband into a trial; he did what he had to do. It was too late for my husband but I recognize that the doctor tried."
- "When my mom had cancer it was worse than having cancer myself."
- "That feeling (*survivor's guilt*) is real."
- "No one else understands. That's why the Support Group is so important."
- "Last year my insurance changed. Now I have a high deductible, but the hospital helped me through a social worker. So I experience no barriers with the hospital."

**Key Issues**

| Question | Synthesis of Responses |
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| 1. Strengths of Mercy's cancer treatment and support | ● Every single person mentioned the cancer support group, and couldn't say enough about it. They liked that it was a single group for people with any kind of cancer, rather than type-specific support groups. They also liked that the group meets once a week (instead of once a month or less frequently). <br> ● Having all services and treatment in one place. "I had to leapfrog from one place to another before but now it is much nicer to have all care together." <br> ● Devotion, kindness, and commitment from all staff (doctors, nurses, navigators, etc.). There were several stories of incredible devotion and follow up by doctors and other staff. <br> ● Having a nurse navigator or social worker to help coordinate care, navigate insurance, and advocate for you and your family. <br> ● One person called out the importance of the spiritual aspect of Mercy as a Catholic hospital. |
| 2. Suggestions/ recommendations | ● Doctors and staff on the care team need to educate all cancer patients that the support group exists. <br> ● Other hospitals should have Cancer Support Groups modeled after Mercy's. <br> ● The nurse navigator position is key to being able to navigate your services and get the services and treatment you need. One |

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| | person mentioned that Baystate doesn't have this position. ● Wish there was a Cancer Support group for children and youth. ● Help and guidance in those times when it's not clear what to do because it seems like the end (see Question 4). |
| 3. Impacts of going through cancer | ● Not knowing how much to tell children, and seeing the impact on children and younger family members. ● Cancer affects everyone in the family. ● Sometimes cancer tears families apart due to grief and reactions to grief. Some never get through their grief. ● Some family members just will not talk about the cancer. ● There is survivor's guilt. ● Cancer is frightening. ● The ongoing nature of cancer, that it often returns, and the uncertainty can wear on people. "Cancer never ends". ● One couple didn't have kids because of the cancer. ● One person mentioned losing their job because of the cancer, and ending up divorced. |
| 4. Barriers to treatment or support servicers | ● Navigating the medical and insurance system can be a challenge ● High deductibles and copays, but there are individuals (social workers, pharmacists) that can help get these costs down ● One heartfelt barrier people mentioned is that it's difficult to know what to do when the outcome is unclear – mentioned by a couple of people about when is best to end treatment, start hospice, give up hope for healing. A guide around that uncertainty would be helpful. |
| 5. Have you seen inequities in treatment by race, sex, income, sexual preference, or other? | ● Participants had not experienced inequity. They hypothesized that people might experience "barriers" (not inequities) due to financial issues, bad insurance mostly. But several with public insurance felt that they were treated well at Mercy. |
| 6. Policy or practice suggestions that Mercy could support to decrease risk of cancer | ● Laws, regulations, and more education about e-cigarettes and the risks of smoking in general ● One person was against regulation and in favor of education ● Practice suggestion: Hospital should make sure every patient has a survivor care plan when they are through with their treatment. Now when people are done they are just sent out on their own to "deal". Everyone should have something written down about what to do after they are no longer receiving treatment, whether it's a pamphlet, a business card with a phone number, or something else. This plan would be something that patients could also take to any future doctor they need to see as part of their history. |

**Coalition of Western Massachusetts Hospitals**
**Community Health Needs Assessment**

**Focus Group Report**

**Primary Hospital/Insurer:** Shriners Hospital for Children - Springfield
**Topic of Focus Group:** Parents of Children with Neuromuscular Diseases
**Date of Focus Group:** 1/30/2019
**Facilitator:** Gail Grammarossa
**Note Taker:** Caitlin Marquis

**Executive Summary**

A. Participant Demographics: 11 participants who were parents of children in the BFit program, a power-based exercise program designed to aid children with neuromuscular diseases.
   ○ 10 women, 1 man.
   ○ All participants were parents of children ages 5 - 18.
   ○ At least two participants required Spanish translation, which was provided by a fellow participant.
B. Areas of Consensus:
   ● When children of the parents in the group are the targets of bullying, school authorities do not respond in a satisfactory way that includes repercussions for the bullies or safeguards for the bullied children.
   ● It is hard to find the necessary doctors, specialists, urgent care, and consistent care in Western Massachusetts. Parents sometimes have to find the time and resources to go to Boston in order to get the care their children need.
   ● Many challenges that the parents in the group reported revolve around navigating insurance coverage and other spheres in which their children needed to qualify for treatment or support. For example, sometimes the diagnosis that merits insurance coverage for treatment is not the same diagnosis that merits support in school.
   ● It is important to be connected to other parents of children with disabilities in order to find out about helpful resources and programs for the children.
   ● The BFit program has helped both children--by empowering them to engage in socialization and physical activity--and parents, by giving them a sphere in which to connect with one another about challenges and resources.
C. Recommendations:
   ○ Leverage gatherings of parents: Parents named several programs and services that support children with neuromuscular differences, including the BFit program, and each of these is an opportunity to catch parents while they are waiting for their children to complete a class or session. These opportunities could be leveraged to check in with parents about their support needs, share information

about available programs and resources, and encourage parents to support and network with one another.
- Find funding for the 4C program or a similar intervention: The Collaborative Consultative Care Coordination Program was a federally funded program that provided teams of professionals to support pediatric patients who required many different specialists and types of support. Federal funding for the program was cut, but parents in the group remarked on how helpful the program was for navigating a complicated landscape of providers and services.
- Increase support for children with disabilities in schools: Many parents felt that schools were not sufficiently acting on their responsibility to support children with disabilities. Areas where schools were perceived to be falling short include:
  - i. Swift and satisfactory response to bullying incidents where children with disabilities are the targets.
  - ii. Providing therapies and supports that were perceived by parents to be necessary to their children's success, but that insurance companies will not cover because they expect schools to provide them.
  - iii. Creating accurate assessments that would qualify students for services that the parents perceived to be necessary for their children's success.
  - iv. Advocating for students with disabilities.
- Expand the umbrella of children who qualify for the BFit program: Many parents noted how essential the BFit program was to their children's physical and social success, but some parents noted that they had to fight or have advocates fight to get their kids into the program because their children did not technically qualify.
- Streamline diagnoses: Create broader categories of diagnoses to increase access to services without having to have kids misdiagnosed. Provide consistency in support for the same diagnosis across healthcare and school environments.
- Consolidate information about support for children with disabilities: Make information about specialists more readily available and easy to access, particularly by empowering specialists and healthcare providers with knowledge about other specialists in the area. Make information about physical activity opportunities available at Shriners and other healthcare providers' offices.
- Employ adult and therapeutic mentors, psychologists, therapists, etc. to help kids cope with bullying.
- Use advocacy groups, such as the Special Education Parent Advisory Council (SEPAC or SpedPAC), as a vehicle to identify issues that many students with disabilities are facing and elevate them to the attention of higher authorities in the school department.
- Make exercise and durable equipment more available and affordable for increasing physical activity opportunities and capacity in the home.

D. Quotes:
- Bullying:

- [Translating for Spanish speaker] "When [some kids at school] poured juice on her daughter she went to the school department and put in a complaint. They told her that they cannot move her from that school because it has to be three incidents back-to back… When she brought it to the attention of the principal in [the middle school].. they just moved her into another school in the same building as where the bullying was occurring."
- "My son...told me… he was being assaulted... in every class and every day…. They started a bullying investigation and they asked me for his statement and we wrote out the statement, but before I could drop off his statement they closed the investigation and they told me that they didn't find that any bullying had happened.  When I asked them how they could conclude the investigation without my son's statement, they said they just used some information that I mentioned in an email. They said that none of the students witnessed it."
- "Living in Holyoke or Springfield, you cannot ignore the racial difference… If you are a Hispanic parent, particularly if your English isn't what they think it should be, there is a huge gap and a much different response. There is also a large group of kids who are labeled special ed who are really just English Language Learners"

  ○ Access to specialty medical services:
  - "My daughter was seeing a physiatrist in West Springfield who was great... but then she left the practice and was no help in terms of telling us where to go next. She suggested that we try Boston… I did try Boston, but it was a 3-month process to even get her in there. We finally got her in there and I like it, but four or five times a year, we're driving to Boston, and she's four, so it's not fun."
  - "Some of the specialists that we do see… they're not helpful in expediting the process or making referrals, or sending her where she needs to go…. That information is not out there."
  - "My daughter's doctor in Boston told me she needed therapies for two years… I have so much difficulty, struggle, and pressure on me, on my husband, on my family…. Every night I have to cry. I went to Baystate [for my daughter's recommended treatment] and after a while they said that the insurance wouldn't cover it, and I had to call many people and after a gap [in her treatment] they sent me to [another hospital], and then after a while, they told me the insurance wouldn't pay again. Then, finally, they sent me here to Shriners and the same thing happened. I said 'no! I am done with this. My daughter needs these therapies. When she is making gains and progress, why do you want to stop it?'... This is the end of her therapies now, and again, I'm scared they are going to put gaps in between. This is my nightmare I have every day."

  ○ Physical Activity Opportunities:
  - "BFit has helped my daughter from being the most uncoordinated kid to being able to ride a bike last year."
  - "[My son's high school] just started Special Olympics two years ago and [my son] was afraid to do it, but we have a competition in two weeks and

*[my son] is doing real good… he was literally afraid to walk off the bus [before] because he was afraid people were going to make fun of him."*
- *"I asked one of the physical therapists for swimming opportunities for my daughter because swimming is very good for relieving neuromuscular pain and she said we used to have [a pool] at Shriners but they closed it for financial reasons, and I would like them to open it again because a pool is actually a treatment for our children."*

**Key Issues**

| Question | Synthesis of Responses |
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| 1. What do you know about the frequency or type of bullying that occurs towards youth with disabilities in the local schools? | ● A bully hit one woman's son the morning of the focus group<br>● One woman's daughter had juice poured on her, had insults written on her shirt, and had other students tell her that kids were only friends with her because they felt bad for her<br>● One woman's son told her that kids were taking opportunities when the teachers weren't looking to hit him in every class, and it was happening every day<br>● One woman said that she homeschools because one of her kids is terrified that he would be bullied if he went to school outside the home<br>● One woman said that her son was lucky and hadn't experienced any bullying at his current school, but that she took him out of his elementary school because how poor the school condition was |
| 2. When you or someone else reports the bullying to the school, how do they respond? | ● The school called the mother and asked her to take her son to the ER<br>● The school gave the bully a verbal warning<br>● The school said they cannot move the child who was bullied to another school because that would require three incidents back-to-back<br>● The school moved the child to another school, but in the same building as the school where the bullying occurred<br>● The school said they conducted an investigation but didn't collect a statement from the bullied child and said that they concluded the investigation and didn't find any bullying because there were no witnesses<br>● The school said that, in order to determine bullying had occurred, incidents had to be ongoing and repetitive over the course of 3-4 weeks<br>● The school has repeatedly ruled incidents "not bullying" for a variety of reasons |
| Is their response effective? | ● One woman reported that the school discourages bullying by asking students to be careful because they might hurt her son; no other effective responses were reported |
| 3. If your child has been | ● Recruiting a mentor through a family member who works on a |

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| bullied, what strategies do you use with your child to help them cope with and respond to the bullying? | military base<br>● Therapeutic mentorship<br>● In-home therapy<br>● Outpatient therapy<br>● Working with Special Education Parent Advisory Council (SPEDPAC) to get the attention of school authorities<br>● Seeing a therapist and psychologist |
| Are they effective? | ● This question was not specifically answered, but one woman was successful in reaching school authorities through SPEDPAC |
| 4. How does bullying affect the physical and mental health of youth with disabilities? | ● One child has gotten very tough and tried to hurt other kids before they could hurt her because she is constantly being hurt. She is seeing a therapist and a psychologist.<br>● Feeling unsafe<br>● Feeling terrified of potential bullying |
| 5. Where do you receive help obtaining specialty medical services (Shriners, other organizations, other hospitals)? | ● Referrals from other specialists<br>● Formerly, the 4C program<br>● Shriners |
| What services do you access while at the hospital? | ● BFit<br>● Physical therapy<br>● Diagnoses for services and treatment outside of the hospital<br>● Neurological/psychological evaluation and testing<br>● Bike camp |
| What services do you access while at school, if applicable? | ● Occupational Therapy<br>● Physical Therapy<br>● Speech Therapy<br>● Neurological/psychological evaluation and testing |
| What services do you access in the community? | ● This question was only answered with regards to services that support physical activity. See question 8. |
| 6. What specialty care services does your child need, that you lack access to (at Shriners or in the area)? | ● Physiatrists<br>● Child psychiatrists<br>● Neuropsychologists |
| What is not offered here in Western MA? | ● Physiatrists |
| 7. What are some of the barriers you face in obtaining access to the | ● Lack or dearth of certain specialists in Western MA<br>● Treatments not recognized or covered by insurance<br>● Insurance won't cover services that they pay the schools to |

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| types of specialty medical services that your child needs? (awareness, availability/waitlists, insurance/cost, travel, etc) | provide, but the school won't qualify the students for the services because they're not "bad enough" <br> ● Insurance companies refusing to pay for services that the school is supposed to pay for, but doesn't <br> ● Lack of readily available information about who providers are and where to find them <br> ● Failure to diagnose children in ways that qualify them for the services they need <br> ● Long waitlists <br> ● Deciding which diagnosis to pursue in order to get necessary services <br> ● Highly specific diagnostic categories that block patients from qualifying for necessary services |
| **8**. Where do you receive help with your child's access to physical activity opportunities  (Shriners, other organizations, other hospitals)? | ● BFit <br> ● BFit cycling club <br> ● The Kehila Program at the Springfield Jewish Community Center <br> ● Whole Children <br> ● Ultimate Sports Program, particularly rock climbing <br> ● Children's Miracle Network <br> ● Project Splash swim lessons at Mount Holyoke College <br> ● Spedchildmass.com has a listing of programs <br> ● Miracle League adaptive baseball <br> ● Special Olympics <br> ● Hippotherapy (horseback riding) <br> ● Easter Seals <br> ● Facebook groups for parents of children with disabilities <br> ● Center for Human Development <br> ● Willpower Foundation to help pay for programs <br> ● getATstuff.com [currently inactive] <br> ● Our Lady of Guadalupe CYO Basketball for ages K - 2 <br> ● Family Scouts <br> ● Federation for Children with Special Needs listserve <br> ● Family TIES of Massachusetts |
| Which organizations do you access for services? | ● Shriners <br> ● Springfield Jewish Community Center <br> ● Whole Children <br> ● Ultimate Sports Program <br> ● Children's Miracle Network <br> ● Baystate Hospital <br> ● Mount Holyoke College <br> ● Miracle League <br> ● Special Olympics <br> ● Easter Seals <br> ● Department of Developmental Services <br> ● Center for Human Development <br> ● Federation for Children with Special Needs |

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| 9. 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)? | ● Help with renting or buying indoor exercise equipment<br>● The opportunity to exchange information and resources with other parents of children with disabilities |
| What is not offered here in western MA? | ● This question was not specifically answered |
| 10. 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.) | ● Cost of programs or equipment<br>● Not knowing about the opportunities<br>● Some volunteer-run recreational and physical activity opportunities will not accept children with disabilities because volunteers are not willing to take them on (cub scouts, youth sports leagues, etc.) |
| 11. 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? | ● A swimming pool at Shriners<br>● A list of physical activity resources, at Shriners or at primary care doctors' offices<br>● Encourage the sharing of information and resources among parents of children in BFit and other similar programs |
| Speaking generally, and thinking back over our discussion so far, what is the most important service you need for your child? | ● Therapies--speech, OT, and PT<br>● Neuropsychologists<br>● Consistency of services<br>● Access<br>● Continuum of care<br>● Continuous therapies<br>● Fun physical therapy like the BFit program<br>● Easier access to durable equipment--fixing used equipment and getting it into the marketplace (insurance sometimes won't cover this equipment and it can be expensive)<br>● The right placement in school (this was said twice)<br>● A ramp for the home because some homes will not qualify for this<br>● Attentive housing management that will ensure ongoing ADA accessibility<br>● Lists of services that the child may qualify for other than BFit and Shriners services<br>● More advocates for kids with disabilities in schools<br>● Continuation of Applied Behavioral Analysis services |
| Is there anything you would like Shriners to know about | ● It would be helpful to get grants for parents of children with |

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| your needs around any of these issues? | disabilities to take classes at community colleges and educate themselves about how to take care of their children at home<br>● Schools seem to be using the excuse that there are a lot of kids fighting for services and this is why they will not give kids the services they need<br>● Because of several fires in public housing, the housing authority is addressing the needs of those who were affected by the fires before the needs of those with disabilities |

# Appendix IV.  Key Informant Interview Summaries

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

**Key Informant Interview Report**

**Hospital/Insurer:**  Baystate Medical Center
**Interviewer:** Kim Gilhuly
**Interview Format:** Phone and in-person interviews, about 1 hour in length.

**Participants:**
- Christine Judd, Director, Roca Springfield and Holyoke
- Ed Caisse, Hampden County Sheriff's Department, High Risk Reentry
- Felicia Wheeler, Springfield mother whose son was murdered by gun violence
- Josiah Gonzalez, Director of Youth Services, New North Citizens' Council
- Leah Berkowitz-Gosselin, Family Advocacy Center's Homicide Bereavement Program

| Question | Synthesis of Responses |
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| 1. What are the causes of gun violence in Springfield for young men? | Poverty creates toxic and chronic stress, the need to fulfill basic needs, and lack of opportunity in these neighborhoods for jobs and positive activities. Trauma that young men have witnessed their whole lives in the home or on the streets can lead to grief from losing people and anger, bitterness, aggression, and impulsivity. Another cause is not having positive caring adults in their lives that young men can connect to and feel safe with. Examples include the lack of two parent homes, missing fathers and male role models, and mothers who are not great parents or are severely impacted by poverty, drugs, and/or incarceration, which can make raising children challenging. In addition, in many cases everyone in the neighborhood is involved in gangs or other lifestyles that include guns. In such neighborhoods, having to pull the trigger to save face is the norm. <br><br> Other causes include: <br><br> • Feeling like life has no value or hope, which makes it easy to pull the trigger <br> • Incredibly easy access to guns <br> • Schools that are underperforming and contribute to the devaluing of people in the neighborhood <br> • The lack of trauma-informed practices by institutional actors like police and schools |
| 2. What could have been put in place to divert them from pulling the trigger? | All interviewees mentioned identifying the young people who are highly at risk and impacted by gun violence early to prevent them from using guns. They also said mentioned: <br><br> • Mentors in combination with mental health providers and other |

| | wraparound services |
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| | ● Getting youth connected to activities that line up with their interests, which will connect them to positive, caring adults |
| | ● Psychoeducation about brain science and trauma |
| | ● A public health campaign to the general public and community about the impacts of trauma |
| | ● Treatment of students with gun trauma and grief with lenience in school rather than suspensions |
| | ● Support for young people who are trying to make a fresh start instead of putting more barriers in their way |
| | ● More preventive programs for fourth and fifth graders, rather than reactive programs for older kids who are involved in gun violence |
| 3. What are the impacts of gun violence in a person's life? | Interviewees mentioned the following possible impacts:<br><br>● A young person's mindset could be locked into a certain way of viewing the world (e.g., as a place where gun violence is normal)<br>● Trauma, toxic stress, fear, anxiety, hypervigilance, being stuck in a fight/flight/freeze mode<br>● Impulsivity, being overly reactive, and not knowing how to deal with your emotions<br>● Poor physical health (e.g., heart disease, diabetes) as a result of ongoing cortisol release due to stress and fear<br>● The need to dominate, be powerful, and influence others<br>● Low levels of successful at school, work, in their daily routines<br>● Death<br>● Traumatic grief that impacts the whole family, community, and a person's ability to parent<br>● Risk to other family members |
| 4. Programs in Springfield that have done a good job at preventing or reducing gun violence | Interviewees mentioned the following programs:<br><br>● Roca, which works with the highest risk youth, offers psychoeducation on the effect of trauma and on brain science, and uses cognitive behavioral therapy to help young men and women pause, not be impulsive, and deal with their emotions<br>● The Shannon Community Safety Initiative, which funds programs such as the YMCA, the Dunbar Community Center, the Boys and Girls Club, and Acorn, which create safe spaces for youth<br>● After Incarceration Support Services runs a mentorship program for young adults aged 17 to 24.<br>● The High Risk Reentry Program at Hampden County Sheriff's Department<br>● The Safe and Successful Youth Initiative<br>● Winter and summer basketball leagues that are part of Holyoke Safe Neighborhoods Initiative<br>● The New North Citizens' Council<br>● The Youth Advisory Council at the Department for Youth Services (DYS), which offers youth a stipend for sitting on the council and completing a community service activity once a month<br>● Restorative Justice Circles, which are used at Roca and Holyoke High School |

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| | ● The Western Massachusetts Violence Prevention Coalition<br>● The Homicide Bereavement Program's "Standing Together" event, which honors the lives of people who have died from gun violence<br>● The Mass Mentoring Partnership, which trains basketball coaches and volunteers to identify youth who have experienced trauma and to work with them |
| 5. How could these good programs that currently exist be improved? | Programs funded by the Shannon Community Safety Initiative provide safe haven for youth, but they should focus more on the root issues of gun violence, connecting people to benefits, and helping young people get jobs. These programs should also have a therapist on staff to help students dealing with issues related to gun violence. After school activities like football and basketball are expensive and should be subsidized so more students can participate. Springfield programs listed above, such as Roca and the Dunbar Community Center, could serve as probation options, rather than sending youth to detention programs. Legislators and representatives from the police, schools, and community service organizations who are missing from the Western MA Violence Prevention coalition should be included. |
| 6. General ideas for how to reduce/prevent gun violence | Interviewees gave a number of ideas, including:<br><br>● Identifying youth early who need prevention or intervention<br>● Mentoring, which can help support and encourage youth to make different choices<br>● The creation of more programs for 13 to 16 year olds, who are the most vulnerable to gangs and drugs<br>● Keeping youth in programs even if they age out<br>● Funding at community centers for activities that are not sports, like dance, singing, and art<br>● Teaching social-emotional skills in the course of all activities<br>● Dealing with the underground market where guns are sold because it is more problematic than the legal market<br>● Making sure all agencies and nonprofits that work with young people are linking them up to basic needs, like clothing, housing, and employment.<br>● Job training<br>● Creating a bridge organization around gun violence that would link judges in juvenile courts to youth mental health counseling and the provision of basic needs<br>● Having more mental health counselors who are from similar racial and ethnic backgrounds as the youth they help<br>● Having ex-gang members and others who have left a life of gun violence serve as support, role models, and consultants to youth<br>● Building support systems for youth and their families that include case managers, mentors, and other support professionals and services<br>● A pilot program with 10 to 20 youth aged 17 to 24 who have been involved in gangs and gun violence. Youth would go to Baystate Medical Center (BMC) three days a week for 12 months for job |

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| | readiness training and mentorship. They get a certificate, help with getting their driver's license and registering a car, help with getting a job, and $1,000 once they complete the program. |
| 7. Resources and ideas from other places | Interviewees mentioned the following three resources:<br><br>● Prevention Institute: UNITY Roadmap, Imperative Side of Safety, THRIVE tool for health and resilience in vulnerable communities<br>● The book *Murder is No Accident – Understanding and Preventing Youth Violence in America* by Deborah Prothrow-Stith<br>● Child College Savings Accounts, which are used in Oklahoma, Cleveland, San Francisco and possibly all over California. The city or state or county opens an account with seed money for each kindergartener. Evidence shows this gives kids hope and they have better educational attainment and social emotional learning. |
| 8. What can systems do? | Regarding legislation or practice/policy change, interviewees offered the following ideas:<br><br>● The crime bill of 2018 raised the age of juvenile jurisdiction and reduced the amount of time before you can seal your juvenile record. This is good because if you seal your record you can move forward, get your driver's license. Young people should know about this law and seek to seal their records.<br>● Legislators could come to Roca and speak to youth<br>● Gun control legislation could create red flags for people with mental illnesses so they can't purchase a gun, impose stricter penalties for people who do not lock up their gun, and impose longer jail sentences if people are caught with a stolen gun.<br>● Appoint officials who are thinking about reducing gun violence from a public health lens to relevant positions of power.<br>● Create more funding for surveillance, like cameras where ShotSpotter goes off that can take pictures of guns being fired.<br><br>Ideas for schools included:<br><br>● Do more restorative justice circles at high schools beyond Holyoke High School. Roca trains people to lead restorative justice circles.<br>● Train teachers about warning signs. If a kid is acting out, something might be going on for them at home. Teachers need to have relationships with kids so they know what's going on.<br>● Have counselors at schools to help kids grieve.<br>● Don't suspend kids if they are having a bad day.<br><br>Ideas for what the police and the courts can do included:<br><br>● Community Care Cooperative (C3) is great, and helps the community know the police and feel comfortable calling them. Get the word out so more people participate in C3.<br>● Hub & COR are system-wide approaches to deal with violence, substance use disorders, and other issues.  All providers (such as the |

| | school, BMC, the Behavioral Health Network, Roca) come together and conference with each youth. If any of them have noticed something going on with that person, they all respond immediately with extra support.<br>● Deal with racist practices at the police department<br>● Promote and support the new Young Adult Court that Roca is planning, which includes pretrial and post-conviction, where the sentence would be to go to Roca.<br><br>Suggestions for community centers included:<br><br>● Create more community centers and fund the ones that already exist to do more, make accessibility easier for kids and parents, and decrease the barriers to using these programs like fees.<br>● Externally evaluate these programs so that western Massachusetts knows what works best out of everything they are doing and what is not useful.<br><br>Suggestions for what hospitals and EMTs can do included:<br><br>● Figure out how to work in collaboration with Roca staff so they can visit and get in touch with people who are in the hospital due to gun violence and stop retaliation. HIPAA is an obstacle.<br>● Ambulances take a long time to respond to incidents of gun violence, so help them to respond more quickly.<br>● Treat victims of gun violence and their families the same way you would treat anyone suffering from trauma or heart disease – with respect and support, privacy in a consultation room instead of the public area, and encourage the support of a large family or neighborhood rather than punishing them. |
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| 9. Role of families in preventing gun violence | Parents need to get involved in their children's lives and act like parents rather than friends. They should not be too scared to confront their children if they find drugs or a gun in their room, but rather should have information about how to handle such a situation. Families also need to support youth who are trying to embrace non-violence. In addition, programs must develop relationships with parents and families, like inviting them to sports activities, family nights, and back to school events. |
| 10. Who needs to be at the table advocating for changes in our systems in order to reduce gun violence? | Community members who have been impacted by gun violence should help advocate for system change. They can share their experiences to make gun violence real for those who haven't experienced it. Others who should be more involved in advocacy for system change include:<br><br>● Criminal justice systems, such as the District Attorney, police commissioner, police chief of Holyoke, chief of probation, public defenders, DYS, juvenile court system, and Hampden County Corrections<br>● Schools, social service agencies, youth organizations, and the faith |

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| | community<br>● Baystate Health<br>● Legislators and people with power who come to the funerals |
| 11. What are barriers to making these changes? | The barriers described by interviewees included:<br><br>● Politics<br>● Limited resources<br>● Lack of trust within agencies<br>● Lack of trust by the community<br>● Racism – even though talking about racism can be a barrier, there is a lot of inherent racism<br>● Not enough mental health counselors who look like the youth they assist<br>● The lack of an umbrella organization that brings all agencies and support professionals and the community together to address and help those at risk<br>● Support professionals who are jaded by their jobs, such as an older police officer who doesn't want to change their methods |

**Quotes:**

- "To ask them to do anything but survive would be ludicrous."
- "It's all trauma."
- "Many youth, in these environments feel as though … life has no value, not theirs or the lives of others.  Those types of feelings make it easy for someone to pull a trigger or become addicted to alcohol or drugs."
- "Some impulsive decisions have come from immediate high stress  situations or anger that they have not learned to control or deal with."
- "It's great to take a youth that was on the wrong roads and get him on the right road, but we should be equally excited about preventing the next generation of youth from going down the wrong roads to begin with."
- "A lot of people fail to realize that the lifestyle they live is for so many different reasons - but it's grievance, anger, bitterness, for losing people they love."
- "Impulsivity – people don't take time to problem-solve, and when they have a gun they use it."
- "[The youth involved in gun violence] don't trust systems because systems haven't helped them."
- "People grow up on a certain street, with a certain clique, and it's just their neighborhood, not a 'gang'. When someone gets shot, they say it's 'gang related' and that out the sympathy the kid.  It's racist because when a white person gets stabbed or shot, that's not what they say.
- "When my son was murdered, they showed his juvie picture. They never came to my house and asked for a picture where he played sports. Every season he played basketball and football. But they just used the juvie picture."
- They have a grant to help pay for funeral if a person is shot. "They have a whole fund for death. But not for living."
- "It's time to move beyond focus groups and study sessions."
- "The biggest impact [of gun violence to an individual and a community] is a mindset impact, locking someone into a way to view the world at a young age."

**Coalition of Western Massachusetts Hospitals**

**2019 Community Health Needs Assessment**

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Noble (Substance Abuse)
**Interviewer:** Catherine Brooks
**Interview Format:** Phone interviews, approximately 45 minutes - 1 hour in length.

**Participants:**

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

| Question | Synthesis of Responses |
|---|---|
| 1. What are the 3 most urgent substance use-related issues or needs for adults in your community/service area? | The needs noted included:<br><br>● Lack of access to methadone and other medication-assisted treatment (MAT)<br>● Affordable housing and transportation<br>● Access to child care during treatment hours<br>● A detox facility in Westfield<br>● A step-down program<br>● Substance abuse programming and education<br><br>Chitra Rai reported that there is some alcohol abuse in the refugee community, but it is rare and he does not usually deal with substance abuse issues. |
| 2. What substance use issues have emerged and/or dramatically increased in prevalence in the last 1-2 years? | New issues are related to ongoing opioid epidemic. These include a new unwillingness to engage in or continue with treatment, and overdoses from fentanyl or carfentanil. Suboxone has also become a commodity with a street value. Vaping has also become a big problem for people of all ages. |
| 3. What specific service gaps or barriers to accessing substance use treatment are you most concerned about? For whom are these treatment services most critical? | Kathleen Sitler reported an overall lack of facilities, while Rose Evans believes that there is sufficient capacity for acute detox but not for the longer-term management of addiction. This includes stabilization and recovery services and sober housing. Both women noted the issue of stigma around drug addiction and how it prevents people from learning about and seeking access to services.<br><br>Other barriers include the need for child care and transportation in order to access services. |

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

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

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

**Coalition of Western Massachusetts Hospitals**

**2019 Community Health Needs Assessment**

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Noble (Food Insecurity)
**Interviewer:** Catherine Brooks
**Interview Format:** Phone interviews, approximately 45 minutes - 1 hour in length.

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

| Question | Synthesis of Responses |
|---|---|
| 1. Where do most people in the area get most of their food? | Closer in to Westfield, most people go to large grocery stores such as Price-Rite, Big Y, Wal-Mart, Costco. There are also some convenience stores. Further out in the Hilltowns, the people who have access to transportation go to the big stores once or twice per week. People without transportation in the Hilltowns rely on small general stores. There are also food pantries that distribute food once per week. There are a few farm stands but this is not a significant source of food for residents. There are no Community-Supported Agriculture (CSA) programs, large-scale farm stands, or community gardens. |
| 2. What barriers do people face when accessing food resources? | Transportation is a major barrier. Food supports are also insufficient - Supplemental Nutrition Assistance Program (SNAP) funding is low and the income threshold to qualify for services is low. There is also a lack of information about healthy food and where to get it. For recent immigrants, language is a barrier and also different customs and systems around food access and preparation that are difficult to implement here. |
| 3. What makes it easier for people to get healthy foods? What makes it harder to get healthy foods? | Easier: <br><br>● A few summers ago, there was a CSA in Huntington <br>● SNAP recipients get Healthy Incentive Program (HIP) funding to spend at farmers markets <br>● There are plans to have a mobile food market in the Hilltowns <br>● For Ascentria clients, case managers help them connect with resources <br><br>Harder: <br>● Lack of transportation to large markets <br>● Small general stores don't have refrigeration, capacity to store fresh produce |

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| | ● Prices at farmers markets and small stores are high<br>● Lack of knowledge about healthy foods, particularly among recent immigrants<br>● Case management at Ascentria is time-limited |
| 4. What portion of your community takes advantage of free food distributions or meals? Are there people who are food insecure but don't take advantage of free food distribution/meals? If so, why don't they utilize these services? | Among recent immigrants, many receive SNAP benefits for the first year and then get jobs. School-age children receive subsidized breakfast and lunch, and the schools in Westfield have food pantries. In the Hilltowns, there is a significant portion that is eligible but not participating. There is stigma involved, and in two separate cases the religious affiliation of the provider caused reluctance to participate. Sometimes people will bring food or gift cards to the Hilltown Community Health Center (HCHC) to distribute to clients, but this is sporadic and HCHC is not able to store perishable food. As noted earlier, transportation is a barrier here as well. |
| 5. Are there local policies or ordinances that affect the community's food security? | There are barriers to having community gardens in the Hilltowns. There had been one in in Russell, but it wasn't well-maintained and the landowner didn't want it to continue. Many planning boards have adopted policies against community gardens. Some towns also have business districts which are very small, and food stores cannot locate outside of these districts. |
| 6. Are there sufficient resources available to meet the needs of people who need emergency or supplemental food? | In Westfield, there are resources, but people lack knowledge of how to access them and in some cases, transportation. In the Hilltowns, there are limited resources. There are a lot of small initiatives going on, but no large organized service providers. Most communities have someone who is willing to help out, but you have to know who to call. |
| 7. What kind of structural and social changes are needed to tackle health inequities around food security? | Needs mentioned included:<br><br>● Widespread availability of information about healthy foods<br>● Better methods of access, delivery, distribution of healthy foods<br>● Stability for farmers<br>● An understanding of how isolation affects food access<br>● Access to healthy food in satellite centers<br>● Linkage of people in need with social services |
| 8. Is there anything else you would like to share about food insecurity in the Baystate Noble service area region? | There are several food access groups and initiatives all working in the same area - can Baystate Noble help get them together and coordinate their efforts? |

**Quotes:**

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

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

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate East
**Interviewer:** Karen Auerbach
**Interview Format:** Phone interview, approximately 45 minutes in length.

**Participant:** JAC Patrissi, Director of Domestic Violence Services at Valley Human Services, Member of Ware Domestic Violence Task Force

| Question | Synthesis of Responses |
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| 1. What are the biggest problems or challenges the young adults you work with are trying to deal with on a daily basis? What do they do to overcome those problems or challenges? | One problem that young adults face is domestic violence in intimate relationships. This area (Quaboag Hills) has the highest rates per capita of domestic violence, ACEs, childhood abuse and neglect. When abused or neglected children get older, they may enter into abusive relationships and/or use substances to help regulate their difficult emotions.<br><br>Teen pregnancy rates in this area are decreasing, but young adults can have problems if they get pregnant at age 20, especially if they haven't finished their education. Many have trouble finding a way to support themselves, getting a job with high enough wages, and getting a car or another means of adequate transportation to get to their job. Some young adults are caring for sick parents or siblings and don't receive enough support for this.<br><br>All of these issues can make parenting more difficult. But this age group is actually really good at putting their kids' needs first. They walk to where help is. They have a lot of ingenuity, perseverance to keep going. |
| 2. What gets in the way of young adults getting good jobs with good pay and benefits? | It's very difficult for young people to get jobs with high enough wages and benefits to support themselves sufficiently. They may not know or have the skills needed for a job, like self-regulation, problem solving, being clear about one's role, getting to work on time every day, not using a cell phone at work, and others. These expectations may be unrealistic if a young person is taking care of sick or dependent family members or don't have reliable transportation.<br><br>It's also difficult for young people to get a good job if they don't know what their options are, what the available opportunities are, and what they might be good at. |
| 3. What do you see among young adults in terms of getting enough food and healthy food? What does that look like for them? | There are food banks and fresh produce available, but young people or their parents may not get to these places or may throw out food if they don't know what to do with it. BIg Y has the freshest food, but it's expensive and a bit far away. Young people without much money will spend it on salty, oily snacks that make them happy. |

| | They also may not know how to cook, and may only have or be comfortable with a microwave oven. |
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| 4. How about housing options for independent living? What do you see in terms of challenges and successes in getting a safe place to live? | The housing options are very expensive, even the ones that are old and in bad condition. Subsidized housing is clumped together, not spread out in different communities, so the people in their neighborhood are all stressed out. There are lots of sex offenders in the area, lots of drug dealing, but it's the "most affordable" in the area. It can be unsafe and too isolating to be in independent living. <br><br> Young people often don't know how to get housing. They tend to not have the necessary skills and knowledge. |
| 5. How about transportation and ways to get to work, school, appointments, shopping? What do you see as the biggest transportation problems for young adults? What resources do they use to get to where they need to be? | Young people in Quaboag Hills can use the Connector, which offers 800-900 rides a month, but it's often hard for them to get a ride on it to where they need to go. The Connector is not good for small rural living because it can take a very long time to get to where you want to go, even if the bus goes there. <br><br> Not many people own cars because insurance and gas are expensive. There is no train stop or other way to get to Boston from the Quaboag Hills area. <br><br> Because Quaboag Hills is in the middle of a few counties, and people rarely know which county it's part of, few counties provide services for people who live in this area. |
| 6. How about health care? What helps young adults get the health care they need? What gets in the way of getting the health care that they or their family needs? For those of your clients/participants with children, what makes getting health care for them easier or harder? | Barriers to young adults receiving adequate health care include a lack of transportation, not knowing how to navigate health insurance systems and manage their insurance (letters, bills, statements, etc.), and limited access to health care providers and services (including dentists and ob/gyn services). The local hospital in Ware currently serves outpatients only, so people have to go to Palmer or other towns for inpatient care. Young people don't typically go to Springfield or Northampton for care because they're too far away. |
| 7. When you think of the young adults you work with, how many of them are struggling with issues related to alcohol or other drug use either themselves or in their families? What would make it easier for young adults to deal with alcohol or drug problems for themselves or their families? | Virtually all of the young adults JAC works with deal with substance use issues - either their own or their families' issues. Marijuana and vaping shops are opening nearby. Young adults need the connection, social connection, and social support, but there's no way for them to get this without a community center or other gathering place, so they get it through marijuana and drug use, and through going to marijuana and vaping shops and meeting up with other people. <br><br> In Belchertown and Palmer, there are programs that bring families together and destigmatize the problem, but these are far from Quaboag Hills. Locally, there are 12 step programs, but they aren't successful for everyone. There aren't programs that are aimed at the whole family, which are needed. The programs in Belchertown, Palmer, and Ware are underfunded. |

| 8. What else should we know about what young adults in the Quaboag Hills region need to be healthy? | Young people need positive places to go and gather. They need people to help them know what's coming in their future, and help prepare them for it and for a positive path in life. They don't need people who say "that's not my job". |

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

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center
**Interviewer:** Ilana Gerjuoy, with Jeanette Voas taking notes
**Interview Format:** In person interview, 1.25 hours

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

| Question | Synthesis of Responses |
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| What are the 3 most urgent health needs/problems in your community/service area? | The CHART Program worked with the highest utilizers of ED & inpatient services. For these patients (n=543), primary issues were *pain*, *suffering\**, and *substance use disorder*. 55% of this population had SUD dx, and those who did not typically had severe mental illness or were chronic disease/end of life cases.<br><br>\*Suffering can include psychological distress, SUD and withdrawal, trauma, and troubles related to SDOH. |
| What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area? | • SUD is escalating, particularly in rural areas.<br>• Our health care system is too medicine- and procedure-based. There's very little attention to self-care or instilling hope. |
| What specific vulnerable populations are you most concerned about? | • People who have pain and don't have a plan.<br>• People who are suffering with mental illness.<br>• People who are dually eligible for Medicare & Medicaid but are under age 65 are a very high risk population. |
| What specific gaps to health care are you most concerned about? For whom are these most | • Fee for service and medical models are not equipped to deal with the enormity of people's problems. Clinicians' "person-centered care" shouldn't be |

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| critical? | disease-specific; what's missing is attention to whatever the person says they need.<br>• There's a lack of integration of medicine, behavioral health and social services. |
| What specific barriers to health care are you most concerned about? For whom are these most critical? | • The way health care is paid for (before transition to ACO model).<br>• Lack of capacity of clinicians to spend time with people. |
| What does the available data NOT show about health needs and gaps, meaning, what's missing? | • We need a team to work with high-needs population under age 65 who are dually eligible for Medicare & MassHealth. We don't have a good way of working with this population here. The North Quabbin is completely left out.<br>• There are successful models in Springfield. In rural areas, we need to collaborate to make it work. |
| What are the opportunities for better prevention to keep people you serve out of the hospital? In addition to more funding, what other resources do you need to better address emerging or increasing health concerns? | • Community Health Workers trained for person-centered care, including helping patients develop their own action plans, build their confidence, advocate for themselves. (WRAP – Wellness Recovery Action Plan is a model.)<br>• Telemedicine<br>• Integrated teams, with outside agency (e.g. CSO, DMH) real time access to someone in the hospital for communication when a client comes into the ER/hospital.<br>• CHWs fare better as part of a team. When they're in it by themselves they burn out quickly and there is high turnover. |
| Externally, what do you wish you could refer people to? | Police are being trained to recognize individuals experiencing a mental health crisis or in withdrawal, but there is no place for police to call in or drop people off other than the ED for overnight & weekends. |
| How would you recommend that the western Massachusetts Hospital Coalition work in closer partnership with local and regional public health organizations after | Commonwealth Care Alliance (OneCare for <65) is the model with teams providing and coordinating a full spectrum of health services. The patient experience is enhanced and the cost of care goes down. |

| the CHNA is completed? | |
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| What specific ways can such a partnership be supported and sustained? | Follow the money. We need to partner with the entity that is financially responsible for the outcomes of the human being. The ACO needs to step up. |
| Other | CHART data shows reductions in ER visits and inpatient admissions over the (short) span of the program. |

Quotes:

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

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

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center
**Interviewer:** Kat Allen, with Jeanette Voas taking notes
**Interview Format:** In person interview, 1 hour

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

| Question | Synthesis of Responses |
|---|---|
| 1. 3 most urgent health needs/problems | <ul><li>Homelessness</li><li>Access issues (including # providers, transportation, social determinants, expenses), e.g. for oral health – urgency because of lack of access</li><li>Behavioral health; too few psych prescribers, so primary care providers end up prescribing outside their comfort zones</li><li>Shortage of dental specialists, so dental providers work outside their comfort zones</li></ul> |
| 2. Health issues that have emerged and/or dramatically increased in prevalence in the last 1-2 years | <ul><li>Opioid crisis isn't new but it's gotten more visible in past couple of years</li><li>Anxiety and depression – everyone has some psych dx that needs managing</li><li>Obesity continues to mount, and that causes other health problems</li><li>New dx of PTSD including from dysfunctional families. We may be identifying it more than before. People see a behaviorist and things start to come out.</li></ul> |
| 3. Specific vulnerable populations of concern | <ul><li>Migrant seasonal agricultural workers (we take care of about 300 – there are close to 2000 in FC) with usual problems plus language, cultural barriers, insurance. They are unfamiliar with our system & don't advocate for themselves. CHC doesn't have enough bilingual staff</li><li>Pediatric population:<ul><li>More kids with anxiety, OCD, ADD</li><li>When our dental providers see kids, they're often well down the path of oral disease</li><li>Behavioral health issues affect school</li></ul></li></ul> |

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| | attendance, health regimes & take a toll on families<br>• LGBTQ – we're trying to get better at providing services for them<br>• Elderly – we don't tend to their needs specifically, e.g. no fall risk screening |
| 4. Gaps to health care of most concern | • Transportation<br>• Gaps in reimbursement structure, e.g. telehealth, community health workers<br>• When people shift to high deductible plans, docs will wait until the end of the year to see them when deductible is paid<br>• Lack of coordinated care (primary care, oral health, behavioral health) |
| 5. Barriers | • Transportation<br>• Language<br>• Psychiatric services<br>• Housing<br>• Food insecurity – has gotten worse<br>• Poverty<br>• Illiteracy |
| 6. What's missing that we're not seeing in the data | • Just starting to capture social determinants<br>• We have data on those who are using the system; we don't know about those who are not. |
| 7. Opportunities for prevention to keep people out of hospital | • Transitions of care: we contact discharged patient within 48 hours and follow up on meds, questions, services, appointments. It's reimbursed through CMS (Ctrs for Medicare & Medicaid Services) if patient not readmitted within 30 days.<br>• Complex case management is not reimbursable or sustainable<br>• Work on getting patient buy-in, holding patients accountable, responsible for self-care<br>• More oral health providers and space where people can get regular restorative care. ER visits for dental issues are a waste of $$. |
| 8. What's needed apart from more funding | • Access to healthy food<br>• Healthy social support systems to address loneliness, isolation, lack of transportation<br>• Places to congregate<br>• Exercise opportunities and associated social connections<br>• More community health workers |
| 9. Resources to refer people to from the CHC | • Dental specialists (oral surgeons, periodontists, orthodontists). We have regional shortages, and it's even worse in the public service sector.<br>• Groups for social support, weight loss, etc<br>• Psychiatry for ongoing care |

| 10. Recommendations for connections between hospitals and public health | • This is important. Now we have a Balkanization of health services.<br>• Hospitals can:<br>  o Attract and recruit specialists<br>  o Fund common electronic health record<br>  o Provide clearinghouse for best practices<br>  o Legal services to help people navigate issues, e.g. with landlords |
|---|---|
| 11. How to support such a partnership | • Subscription. CHCFC would be ready to pay into a menu of services. |
| 12. Other | • It's shocking how weak the connection is between the hospital and the CHCFC.<br>• More than 80% of our patients are below 200% poverty. There needs to be a lot more cooperation. CHC has the most comprehensive picture of the low income population.<br>• It's a struggle to recruit and staff the health center. Loan reimbursement can help attract doctors, but not nurses, dental assistants, etc. What can we do to make this a destination career? |

**Quotes:**

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

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

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center
**Interviewer:** Kat Allen, with Jeanette Voas taking notes
**Interview Format:** In person interview, 1 hour

**Participants:** Andrea Kiener, Temple Israel; Kate Stephens, Interfaith Council of FC/pastor; Sue Bowman, Interfaith Council, retired from ministry

| Question | Synthesis of Responses |
|---|---|
| 1. Most urgent health issues | <ul><li>Housing, homelessness</li><li>Isolation</li><li>Stressed out families: income insecure, parenting at a young age, parenting without good modeling or skills</li><li>The growing gap between the rich and poor, and associated nexus of interrelated problems</li><li>Issues like addiction and homelessness are symptoms of untreated trauma, efforts to self-medicate</li></ul> |
| 2. Issues that are new or increasing | <ul><li>Addiction isn't new, but now the substances we hear about are opioids</li><li>Homelessness has caught our attention because of encampment on the common</li><li>Greater awareness of racism</li><li>A general despair, background pain because of polarized politics, climate change and lack of problem solving.</li></ul> |
| 3. Specific populations of concern | <ul><li>Homeless</li><li>People who have been incarcerated</li><li>People with substance use disorders</li></ul> |
| 4. Gaps in health care of concern | <ul><li>Mental health care</li><li>Dental care</li><li>Equal access to quality care</li></ul> |
| 5. Barriers to health care | <ul><li>Money!</li><li>Broken health care system; those who most need stable services are the least likely to get them</li><li>Patchwork of services; need one-stop shopping for services</li><li>Failure to think and act like a community, care for the community as a whole</li></ul> |
| 6. What's missing from the data or the conversation that we should pay | <ul><li>Isolation, despair</li><li>Plight of sex offenders who have no way out of their situation</li></ul> |

| attention to | • People with CORIs – it's hard for them to reconnect |
|---|---|
| 7. Better prevention to keep people out of the hospital | • Upset about Baystate decision to locate mental health all in one place. We want to keep care local.<br>• Do things to build relationships, keep social connections strong, build social infrastructure, like the library<br>• Finding ways to engage people so they feel needed, have responsibilities, have roles.<br>    o How about turning empty store fronts on Main St into crafting centers – "Sit and Knit."<br>    o Rehab empty housing<br>• Educate community about people transitioning from jail to community, e.g. landlords about accepting people with CORIs |
| 8. What else is needed | • Shelters<br>• Transportation<br>• Community dialogue, opportunities to meet people in the community who are different from us in age, class, life experience<br>• "Social Infrastructure" including libraries, community gathering places and events |
| 9. Resources to refer people to | • Mental health counselors, free behavioral health care and support groups<br>• Better information about services available (one-stop shopping) |
| 10. Partnership between hospital and community | • Hospital can act as convener, can train about services and resources available<br>• Would like to see hospital participate in jail to community transitions group |
| 11. Anything else | • When groups get together to discuss issues, it's important that people with lived experience with those issues participate |

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

**Key Informant Interview Report**

**Hospital/Insurer:** Baystate Franklin Medical Center
**Interviewer:** Kat Allen, with Jeanette Voas taking notes
**Interview Format:** In person interview, 1.25 hours

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

| Question | Synthesis of Responses |
|---|---|
| 1. 3 most urgent health needs | • Livable wages/Housing<br>    o Housing with support for mental health challenges<br>    o Housing for people with mental health issues *and* sex offense charges or arson in their histories.<br>    o Greenfield has about 200 homeless people; many are formerly incarcerated<br>    o Many leave here and end up couch surfing in environments that aren't safe<br>• Residential treatment, particularly for dual diagnosis (which is true of most of our clients here).<br>    o To get into a dual diagnosis program you have to be suicidal. People may have to lie to get in.<br>    o And there are guys in East Spoke who have a plan to kill themselves, but when their insurance hits a limit, they're out of the program.<br>    o Or any violent behavior can get them dismissed from East Spoke.<br>• Case workers and coordination of services in the community<br>    o We have 3 reentry caseworkers here and hundreds of clients who have left the jail<br>    o Many services do not communicate with one another<br>    o Points of transition are when things fall apart the most. There are disconnects between services and levels of care.<br>    o Barriers to successful reentry are huge for clients with mental health, substance issues and trauma history. |

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| | ▪ It's hard for them to engage in any community apart from the one that landed them in jail in the first place<br>▪ Or some have no family, no friends<br>▪ It's hard when they have to go to new providers to retell their story and ask for services.<br>• Trauma, retraumatization, passed through generations |
| 2. Emergent issues, increased problems | • Commercial sex trade has come onto our radar since we started housing women.<br>   ○ It's a huge issue in our community, and there are no resources out here for it.<br>   ○ Many have been exploited & experienced trauma as a result<br>   ○ On release, that's how they know how to make money, and it leads back to substance use for coping<br>• Proliferation of MAT services<br>   ○ While intended as a harm reduction measure, it doesn't always function that way.<br>   ○ In the jail, we have clinical services, intense therapy to go with the MAT, when clients get out, if they're on MAT, they're more likely to decline services. MAT alone isn't working.<br>   ○ It's problematic that they can be on Suboxone and not be required to be clean on anything else. People are using the Suboxone not as prescribed or selling it and using other substances.<br>   ○ We've had some success with Vivitrol. |
| 3. Specific vulnerable populations you're worried about | • Anyone incarcerated<br>• Homeless and everyone connected to them<br>• Sex offenders<br>• People with mental health, substance use, complex trauma issues who don't have natural supports of family and friends<br>   ○ Their connections are to professionals, and those are vulnerable to funding shifts & staff turnover.<br>• Young people<br>   ○ They need to develop skills for emotional regulation, impulse control.<br>   ○ How can you expect them to grow up differently if they're not taught how to deal with adversity, how to deal with emotions |
| 4. Specific gaps to health care you are most | • Transitions, hand offs<br>   ○ A client might have a few days in Eastspoke, |

| concerned about | then respite, then back to homelessness.<br>○ Handoffs from the jail to the community. Clients get intense support here, and they don't get that on the outside.<br>○ We have a Nurturing program and family-focused programming, but we don't know who's providing services to the family. We don't know what context our clients are returning to.<br>○ One barrier to warm handoffs is that outside therapists cannot bill for treating people in jail. Inreach could help.<br>• People are free to NOT show up for services.<br>○ How many follow thru with reentry plans and resources, and for those who don't, why not?<br>○ Because our clients suffer from chronic anxiety, depression and trauma, it's hard for them to follow up, and we should start from the assumption that they're not going to go.<br>○ Agencies should share data so clients don't have to retell their stories multiple times. We don't need to ask so many questions at intake.<br>○ Gaps in insurance – restrictions on what's available to whom, for how long<br>• Effective contingency programs for MAT.<br>• Lack of options for people who have mental health needs and CORIs.<br>○ They're high need, not best served in jail, but there's no place for them to go. So they come here.<br>• Clinicians to do ride-alongs with police to use discretion to help keep people out of the criminal justice system<br>• Community case workers who are not tied to a particular agency, so clients aren't cut off when they're no longer connected to the agency |
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| 5. What's missing, what important things are not showing up in the data | • Generational legacies<br>○ Children are removed from parents who can't take care of them, but what's the long-term success of foster care?<br>• What happens to clients who haven't been able to complete treatment because of insurance?<br>○ For example, they go into intensive treatment to normalize the situation, but may have to leave when they don't feel they're ready. |
| 6. What else is needed to better address health | • We're pruning the tree, not going for the cause in the roots.<br>• The skewed distribution of wealth has put us in this |

| issues | position. |
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| | • Our system of judgment and punishment is proven not to work. We need to unravel this narrative and orient ourselves towards a more scientifically valid perspective. |
| | • We have a DBT program here, and it applies to teaching skills to clients and to staff, to structuring the environment to make it conducive to this work, and to generalizing skills to clients' natural environments. It's a strategy for applying what you learn in different environments. |
| 7. What do you wish you could refer people to outside the jail? | • Housing, housing, housing. |
| | • There's hardly any sober housing in the western region. |
| | • The GAAMHA House in Greenfield, with 6 beds for women (no children) is a model. It's where I would want to refer my clients who don't need constant supervision. For those without supports, it's like a family. But it can accommodate only 6! |
| | • More community reentry caseworkers. |
| | • Adult leisure services |
| |     o provide outdoor experiences, music, theater, something to engage in creatively |
| |     o no cost/inexpensive outlets for leisure |
| |     o community center with safe environment |
| |     o being bored is a trigger |
| |     o DMH invested in a Club House model in Boston. It's a turned-up community center, with prosocial stuff, voc rehab, meals. You go and you're participating in community. |
| 8. Partnerships between hospital and public health organizations? | • Let's sit down and talk about how we can work together, including Mayor's office, DA, probation. We need to talk the same language and share the same vision. |
| | • Baystate plans to relocate behavioral health to one place. How will the hospital help people to relocate back to their own communities? |
| | • With hospitalization, the emphasis is on stabilization (with drugs so patients don't kill themselves) and release. How can we make subsequent services more available? |
| 9. What else? | • We need collaboration across agencies not just at administrative level but among people on the ground working with clients. |
| | • Instead of implementing a program and thinking it's done, we need long-term planning and ongoing implementation. |
| | • Here at the jail, we have latitude to experiment, to see what works and what doesn't. We've focused on |

| | transitions, specific needs, and reinforcement throughout the system. |
| | • When we look at vulnerable groups, we mustn't get sucked into silos – physical health, mental health, co-occurring, homeless, etc) |

**Quotes:**

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

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

**Key Informant Interview Report**


**Hospital/Insurer:** Cooley Dickinson Health Care
**Interviewer:** Catherine Brooks
**Interview Format:** One group interview (7 participants), approximately 60 minutes, with the Cooley Dickinson Physician Hospital Organization (CDPHO) integrated care management program staff. One 45-minute telephone interview.

**Participants:**
- Group interview: nurse care managers, social workers, project specialist, and the director of clinical operations
- Carlie Tartakov, professor emerita, University of Massachusetts


| Question | Synthesis of Responses |
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| 1. What makes life fulfilling as you grow older? What supports exist in our community to help older adults find joy and meaning in their lives? | People noted the following ways in which life remains fulfilling for older adults:<br><br>- Interaction with others and with the community<br>- Making a contribution to the community<br>- Being able to continue to live independently and access needed services<br>- Participating in social and cultural activities<br><br>Supports mentioned included:<br><br>- Senior centers<br>- College and university lifelong learning programs<br>- Transportation provided through some senior centers<br>- Aging Services Access Points (ASAPs)<br>- The Hilltown Elder Network<br>- The Food Bank of Western Massachusetts<br>- The MassHealth Frail Elder Waiver Program |
| 2. What supports and services do older adults in our community need to support good health? Where are there gaps in services, and how do these gaps impact older adults? Think about older adults with limited English, | Supports and services needed by older adults include transportation, help with medicine, help with household tasks, healthy food, and opportunities for exercise.<br><br>Gaps include a lack of people who provide support services, and a lack of people of color providing these services.<br><br>When service providers do not reflect the demographics of their clientele, they don't understand their specific cultural needs, and it is difficult for people receiving services to feel comfortable with them. In addition, people who do not speak English or Spanish sometimes have |

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| or who are people of color, or live in a rural area, identify as LGBTQ, or from other underrepresented groups. | trouble accessing services, because of a lack of translated materials or people who can interpret for them. Immigrants may have limited health insurance coverage that does not allow them to access non-emergency services.<br><br>Transportation was mentioned repeatedly as a significant gap in services. In some communities, there are vans run by senior centers, but even there people usually have to schedule their transportation in advance and they may not be able to make multiple stops. In more rural areas, transportation may not be available at all. |
| 3. Older adults can feel isolated, lonely, or depressed. How does the community help older adults with these feelings? What are the barriers, if any, to receiving or accessing help with mental or emotional health? | Many elders have experienced loss as people close to them die. They also may perceive their neighborhoods changing around them and feel unable to connect with the people around them. Some also do not want to participate in senior center activities; they see the senior centers as cliquish or otherwise not suiting their needs. The issues older adults experience with hearing, vision, or eating (dental needs) can also lead to isolation.<br><br>An additional problem is that people of color sometimes come from communities that encourage them to be outwardly strong and not ask for help. They might also lack trust in service providers who do not reflect their cultural heritage.<br><br>Senior centers attempt to address these needs, but they are only able to reach the people who are willing to engage with their services, and they have limited budgets. Some communities have strong support networks, but this is highly variable among towns and neighborhoods. There are some library programs and "meet-ups," but these are limited. |
| 4. What supports and services do elders in our community need but have a hard time accessing? What are the barriers they face? (Probe for housing, transportation, ability to afford prescriptions, and healthy food.) | As noted above, transportation is a necessary support but is sometimes difficult to access. Eligibility is limited and the service must be scheduled in advance. Some older adults need services but do not qualify based on their age or income levels. |
| 5. What needs do elders have for social services? (Probe: Food Pantry, Weatherization and Heating Assistance, Exercise classes, Help with bills, | Some needed social services noted included:<br><br>● Behavioral health counseling<br>● Assistance with medication<br>● Subsidized or free heating, food, and housing<br>● Personal care<br>● Housekeeping |

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| Help with taxes, Home Health Care, Housekeeping Support) What are the barriers they face in accessing these services? | The primary barrier faced in accessing needed services is financial. ASAPs provide home-based care and other services on a sliding scale, but this can still be expensive. There are many living communities for older adults that provide services, but they also are expensive. People have to spend down all of their assets before they can qualify for support.<br><br>Other barriers include the logistics of having to interview home health care providers, and a lack of knowledge about available resources. Some people think that Medicare will pay for nursing homes and any other needed services, which is not the case. |
| 6. What would you like to see in your community that would make it a better place for older adults to live? | Needs mentioned included transportation, affordable housing, walkable sidewalks, a nearby grocery store, and someone to provide the services noted above. People also noted the need to listen to elders, treat them with respect, and honor their stories. There needs to be positive, proactive outreach, and maybe a rebranding of senior centers, with access to different services and providing more of a connection to the community.<br><br>In addition, Cooley Dickinson Health Care is no longer providing home draw services, which makes it difficult for some seniors to keep up with their health. There is a need to make this and other home-based medical services available to seniors. |
| 7. Which skilled nursing facilities do you work with most frequently and are there any systems concerns – communication, hand-offs, medical records, medications, etc. | The CDPHO staff reported that they work with three different skilled nursing facilities, and have not encountered any systems concerns. |

**Quotes:**

- "The general attitude toward elders in our society is a problem. They are not just people to be cared for."
- "The hospital sees episodes of care, but doesn't see the full picture"

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

**Key Informant Interview Report**

**Hospital/Insurer:** Health New England
**Interviewer:** Karen Auerbach
**Interview Format:** Phone interviews, approximately 45 minutes in length.

**Participants:**
- Jennifer Lee, Systems Advocate, Stavros
- Jill Keough, Executive Director, Greater Springfield Senior Services
- Orlando Torres, physician, Baystate Medical Center
- Shane Brooks, VP Intellectual and Disability Services, Center for Human Development (CHD)

| Question | Synthesis of Responses |
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| 1. What do you see as the priority needs for food, housing, and transportation among clients with disabilities?  Do you feel that clients/consumers are aware of the wide range of services they are eligible for? | The most commonly mentioned issue was housing, mentioned by all four interviewees. Three of the four interviewees said for people with disabilities, getting subsidized housing was difficult because of the long wait lists. In particular, it is difficult for them to get subsidized housing if they: have more needs, need handicapped- accessible housing, or need a second bedroom for a partner or caregiver.<br><br>All interviewees said transportation was critical as well, as it is needed for people with disabilities to get to medical appointments, the pharmacy, the grocery store, to meet and socialize with friends, and more.  The difficulties with having access to adequate transportation include (1) its availability, affordability, and accessibility if it's not provided by an insurance provider, (2) if people needing transport live in rural areas or far from a bus line, (3) its lack of flexibility for including short stops to pick up medications or milk on the way home.<br><br>Several mentioned food access as also difficult for many people with disabilities. For some, the amount of food allotted through SNAP and similar programs is inadequate. It is difficult for those with mobility issues to have meals delivered to their homes as most meal delivery services are for those ages 60 or above. It is also very difficult for people under age 60 to navigate the programs and procedures for getting assistance with food |

| | access without an advocate. |
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| | Most of the interviewees said that people with disabilities typically are not aware of all of the services they are eligible for because (1) these services tend to change frequently, and (2) advocates are typically needed to help people determine which services they qualify for and help them access these services. |
| 2. Which of the basic needs - food, housing, or transportation, for example - pose the greatest challenges for people living with disabilities? What are some of the social, emotional, physical or financial impacts of these unmet needs? | Three of the four interviewees said housing, transportation, and food access all pose equally great challenges to people with disabilities. The fourth interviewee said housing was more challenging than the others because there are mechanisms to help with access to food and transportation. However, another interviewee said food access was very challenging for people with disabilities because they need transportation to get food, as meal delivery is typically only available for the elderly.<br><br>Having inadequate access to all three basic needs can impact social, emotional, physical, and financial well-being. For instance, if a physically-handicapped person can't obtain handicapped-accessible housing, or can't bathe properly, their mental health will suffer.<br><br>In addition, inadequate access to transportation can lead to social isolation. Inadequate access to all the different types of food a person needs can lead to health problems. |
| 3. What has been your experience when people with disabilities try to access health care? What has worked well? What has not worked well or has been a real problem in getting the health care they need? | Challenges to people with disabilities in getting health care mentioned by the four people interviewed include: (1) getting a medical appointment to deal with an urgent issue quickly and setting up transportation to the appointment in a short amount of time, (2) getting health services or navigating changes to health plans without an advocate or health care coordinator, (3) getting treated by medical providers who are knowledgeable of and comfortable with people with disabilities, (4) getting access to specialized care, and (5) experiencing psychiatric hospitalizations. |
| 4. What happens when clients with disabilities are not able to get the health care that they need? What are some of the social, emotional, physical or | Impacts from not getting adequate health care include: (1) social isolation, (2) stress and anxiety, (3) financial impacts from being unable to work, (4) increased cost for transportation if a medical appointment runs long, and (5) poorer health from inadequate food access or from transportation difficulties. |

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| financial impacts? | |
| 5. How well do providers - doctors, nurses, therapists or other healthcare providers - really understand what is experienced by a person living with a disability? How would you rate providers in terms of that understanding? | The interviewees seemed to believe that healthcare providers, and especially physicians, have only a moderate level of understanding of the experiences of people with disabilities and how to treat them. Providers are likely to be less effective in treating patients with disabilities if they are: (1) younger, (2) less experienced as a provider or in dealing with people with disabilities, (3) have not worked with a particular patient with a disability before, or (4) have only a very short length of time (for example, 12 minutes) to spend with a patient. |
| 6. What service gaps exist in home care services for persons with disabilities? What would make home care services better? | Several people interviewed said that the high cost of home care services for people with disabilities impact the quality and quantity of these services. Issues that affect the quality of care that personal care aides (PCAs) provide to people with disabilities include: (1) MassHealth is reducing the number of hours that PCAs can work, (2) they are often are not paid well, (3) some do not receive sufficient training, (4) the increasing amount and complexity of paperwork can reduce the amount of time PCAs can spend with patients, and (5) there are often high turnover rates among PCAs, which can affect patients' continuity of care. Case managers typically have very high caseloads, which can lead to high turnover or movement from one position to another. In addition, Orlando Torres said that people with disabilities often receive care from relatives, and Jennifer Lee referenced the PCA program at Stavros (see quotes, below). |
| 7. Is there anything else you think we need to know about what people with disabilities need to be healthy? | Shane Brooks said that well-trained, empathetic, professional staff and health care providers that would treat people with disabilities as they would the regular population would help these patients be healthier. Jennifer Lee mentioned the emotional implications of having a disability (see quote, below) and also said there is a need for improvements to architectural and walking barriers and housing to better accommodate people with physical disabilities. Furthermore, she said that people with various disabilities can have a hard time in hospitals (like operating tv and bed controls if their arms or hands are impaired), and may not have the level of care in hospitals that they need (for example, being turned frequently, having their pillows fluffed when needed because PCAs don't get paid when their client is in the hospital, and nurses or other staff may not do this for the patient, so patients may need longer to recover. |

**Quotes:**

- "Emotionally, [getting access to adequate housing] can take a toll on folks - wondering if they have a roof over their head, especially if they have children, and especially if the kids have disabilities. This can make it difficult for people with disabilities to accept help - because of the stigma of needing help. So it's important to make it seem like the help they are getting is part of a long term plan that will make them self-sufficient in the future." Shane Brooks
- "In terms of scientific advances, opportunities for treatment are good. But understanding people with disabilities as people and not as diagnoses is not great. For example, if a person is a paraplegic, providers start out talking about what they can't do, rather than talk about what they can do, and connect them to communities of people with disabilities to help them navigate their new lives. There needs to be more done on part of providers in helping people understand living with a disability can be okay, not terrible. If providers tell people what possibilities exist now in life as a disabled person at the beginning rather than focusing on what they lost or can't do, the person may have a better recovery" Jennifer Lee
- "Relatives help, help pay, but getting help from relatives doesn't really work. Relatives get paid to take care of the patient, but may not help or help adequately, and sometimes the patient cooks for or helps out the relative." Orlando Torres
- "The PCA program is having more options for people to be able to find qualified PCAs, is making sure home care services are really structured around what the consumers want and need, and is helping them advocate for what they need in a home care situation." Jennifer Lee
- "The emotional implications of having a disability leads to feeling lonely and isolated. Social opportunities helps them learn from each other, share ideas about services that exist." Jennifer Lee

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

**Key Informant Interview Report**

**Hospital/Insurer:** Mercy Hospital
**Interviewer:** Kim Gilhuly
**Interview Format:** Phone interviews, from 30 – 45 minutes in length.

**Participants:**
- Dr. Shirin Nash, pathologist, physician liaison with community, Cancer Committee outreach coordinator.
- Ashley LeBlanc, thoracic surgery nurse navigator. Provides education and helps people with expectations and navigating through cancer, the hospital system, and can get people connected
- Stephanie Velis, oncology program coordinator.

| Question | Synthesis of Responses |
|---|---|
| 1. Strengths of Mercy's Cancer care and support services. | • Get patients in very quickly – important for the stage of cancer and getting treatment. Much quicker in comparison to other places.<br>• Very committed, responsive, and talented doctors and staff<br>• Treat all kinds of cancer – breast, colorectal, prostate, other – but specialty is lung cancer – have specialized surgeons and services.<br>• Have a robust support team – 2 nurse navigators, 2 social workers and 1 patient advocate dedicated to the Cancer Center. Have amazing spiritual counseling.<br>• Also have lung cancer screening program – the earlier you detect the better the outcomes are.<br>• Have an amazing Cancer Support group.<br>• We have a Patient Fund here that people contribute to. |
| 2. Services and supports that you wish Mercy had. | • Better programs to treat the psychological side of things. "The C word is a really scary thing."<br>• Services to help people feel emotionally well, such as massage, reidi, pet therapy, acupuncture, meditation, hypnosis. Classes in how to do make-up, moisturizer to use for your skin, sleeping changes. "Things that help people feel their best when they are feeling their worst." Almost impossible to get reimbursed for these things.<br>• Clinical trials – have to send to Boston or Hartford.<br>• Cancer survivorship support – more people are surviving (great!) but need guidance, support, mental health services during survivorship<br>• Education for patients – what is cancer, how do you |

| | |
|---|---|
| | access care, etc.<br>• Smoking cessation for oncology patients (not just lung cancer) |
| 3. Barriers people face that it would be helpful to address (or address more) | • Transportation – shuttle, better taxi service, make sure taxi voucher program through the Patient Fund is still running, that cancer patients are accessing Mercy Hospital uber services, even some sort of valet parking services and help getting exhausted and nauseous patients through the parking lot and the hospital.<br>• Co-pay assistance – can be very large and we don't have assistance<br>• Financial counseling – have support from social workers if people need help w/ their insurance companies, but having someone in the Cancer Center to think through the cost of their treatment (which can be huge) would be helpful. Can access financial counseling for all of Mercy, but would be good to have in Cancer Center.<br>• Bilingual assistance<br>• Mental health needs<br>• More community outreach so people know about the Cancer Center. We have amazing services here and many people don't even know we're here. |
| 4. Models for care in other places that would be good at Mercy | • Genetic counseling and genetic lab services to enable targeted therapies (if a tumor has a specific genetic makeup there may be specific drugs). Must have ability to identify the problem, counsel, provide therapy for that problem, and then counsel families as to what it might mean for them.<br>• Breast cancer screening that is more immediately responsive. Would mean having a standby radiologist do a "wet read", if something is suspicious get immediate same-day appointment for ultrasound or biopsy. Now Mercy has a primary care model, PCP order mammogram, it's read in a day or so, results back to PCP. It's just slower. Our breast cancer screening to treatment should mirror how fast and responsive our lung cancer screening to treatment is.<br>• Palliative care team inside the Cancer Center. Mercy has a palliative care service just for inpatient, we would like to have an outpatient service. We have a pharmacist pain specialist we can access, but would be good to have palliative care at the Cancer Center. |
| 5. Impacts of cancer diagnosis | • Devastating.<br>• Scary, anxiety-provoking, general emotional distress.<br>• Impacts not just the person with cancer but caregivers<br>• People need to know – I have cancer, what does it mean for me, my family, will I work again. It would be great if we could explain to every cancer patient their prognosis, therapy, how to survive cancer. Just not sure if any of |

| | our first line clinicians, primary care docs, have the time. |
|---|---|
| 6. Cancer prevention efforts that Mercy is doing | • Lung cancer screening at the hospital. If you can identify lung cancer early on, you can treat it early and prognosis is much better.<br>• We did one free lung cancer screening day last year and will do one this year.<br>• Did some work through Transforming Communities Initiative educating adolescents about the harms of smoking<br>• Helped pass Tobacco 21 in Springfield and the state. Some of those same youth in the education sessions were able to talk to legislators.<br>• Work with Tobacco Free Springfield – meet to see who is selling tobacco to whom.<br>• Education about cervical cancer screening for Healthcare for the Homeless. |
| 7. Cancer prevention efforts that would be good to do | • Continue lung cancer screening<br>• Mobile CT scan so lung cancer screening didn't NEED to be done at the hospital.<br>• HPV vaccination outreach and education – the Cancer Committee is planning on doing some of this in the coming year.<br>• Do HPV screening event and a prevention/education program. |
| 8. Policy or practice change that Mercy could support that would decrease risk of or reduce cancer (like Mercy supported Tobacco 21 law last year) | • Lung cancer is the deadliest cancer (only about 17% of people are alive 5 years after diagnosis). Outcomes are much better if caught earlier.<br>• Push the U.S. Preventative Services Task Force to incorporate lung cancer screening into doctors' computer programs so they are prompted to ask patients if they fit the criteria.<br>• Insurance companies should expand the criteria for lung cancer screening – it is very narrow now (age 55 – 77, former smokers within 15 years, family hx) and many more people would benefit.<br>• Expand awareness in1) health care community and 2) general public of importance of lung cancer screening.<br>• Address the barrier that regulatory and compliance puts on hospitals setting up ancillary services (massage, meditation, acupuncture, etc). Now it's very hard to bring in outside services because of laws and rules that implicate that hospitals are trying to coerce patients to come.<br>• Resources for HPV education and screening. |

| 9. Have you witnessed any inequities in cancer treatment or services by race, income, gender, sexual preference, or in any other way? | • No. |
|---|---|
| 10. Anything else? | • Would like to see cancer rates for different types of cancer in the hospital service area incorporated into the CHNA.<br>• Mercy does some amazing stuff, would be great if the larger community knew about it.  Healthcare for the Homeless, community work through Transforming Communities Initiative, other. This all should be publicized!<br>• Heresy, but would be great if we could have ONE cancer center in the Springfield area and everyone get treated there rather than duplicating services. Not sure everyone would agree. |

**Quotes:**

- The Mercy Hospital Caritas Cancer Center is "not just competent cancer care but compassionate cancer care."
- "We get patients in very quickly, and are very responsive to patients. Doctors and the whole team are very available. We get patients in appointments in 24 – 48 hours; other facilities might not even answer the call in that amount of time.  Mercy tracks patients from our lung cancer screening; where other hospitals' time between initial scan and surgery is 4 – 6 months, our is less than 30 days."
- "The "C" word is a really scary thing, and people don't often know how to handle or understand the diagnosis or what it means for them. Support systems, how are people going to get the kids on the bus. I wish we had a program to assist this side – it's usually simple things."
- The survival rate for lung cancer is lower than any other cancer. Only 17% - 18% are living 5 years after their diagnosis, compared to breast cancer where 90% are. That's why screening and immediate treatment are so important.
- "People in the world don't understand that HPV vaccination is prevention – of cervical, penile, others cancers, and if you can vaccinate kids while they are still developing you can be protected for life. But there is this strange thought out there that having child vaccinated at 10 or 11 will make them promiscuous.  My subcommittee [of Mercy's Cancer Committee] is going to find ways to talk to parents about this."

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

**Key Informant Interview Report**

**Hospital/Insurer:** Shriners Hospital
**Interviewer:** Catherine Brooks
**Interview Format:** Phone interviews, approximately 30 minutes - 1 hour in length.

**Participants:**
- Ava Adamopolous, Program Director, Boys and Girls Club of Springfield
- Kelly Phillips, Founder and Director, KP Fit
- Lawrence Kaplan, Developmental Pediatrician, Shriners Hospitals for Children
- Lisa Bakowski, Principal, Edward P. Boland School, Springfield

| Question | Synthesis of Responses |
|---|---|
| 1. What specialty medical services for children are needed that are not offered in western Massachusetts? | There is a lack of pediatric subspecialties - neurology, neuropsychology, neurosurgery neurodevelopmental pediatrics. There are also no autism clinics. Western Massachusetts needs occupational therapy that is appropriate for children with sensory issues. There are very few providers - it's a chronic problem; it's very difficult to attract people to work in the Springfield area. |
| 2. What barriers do families face in obtaining access to specialty medical services for their children in western Massachusetts (i.e., awareness, availability/wait lists, insurance/cost, transportation, distance to travel)? | The major issue is access, waitlists - there is a waitlist of over a year for Dr. Kaplan's program. There is also lack of awareness among parents about what services are available, and what developmental delays look like. Many parents don't understand the system, how to use it, or how to get the care their children need. |
| 3. Do you have ideas for ways that Shriners or other hospitals could be helpful to families with a child with disabilities around access to specialty medical services? If so, what are they? | Dr. Kaplan is working collaboratively with Northampton Area Pediatrics, based on Collaborative Office Rounds. He is in direct communication with care providers and has the opportunity to follow up on referrals. This could also be done with Holyoke Pediatrics - they are interested in starting the process.

Shriners offers Be Fit, a new cerebral palsy clinic. Shriners could do something similar for children with behavioral issues, pairing children with tutors/mentors, using the Basketball Hall of Fame resources for rewards.

Shriners could offer educational materials aimed at parents, such as descriptions of the typical ranges of development, a list of what resources there are for children not meeting these targets, |

| | descriptions of how to access these resources. This could be disseminated through schools. |
|---|---|
| | In an ideal world, Shriners and other hospitals would provide a crisis response team, evaluate a child who needs help, and connect them with services. |
| 4. What types of supports or resources do families and children with disabilities need to gain greater access to physical activity opportunities? What is not offered here in western Massachusetts? | Services in western Massachusetts are very limited - it's especially difficult to find services for children with autism. We need access to swimming pools for swimming lessons and hubbard tanks for warm water therapy. There is no gym at Shriners. We need more opportunities for kids in wheelchairs to be mobile. |
| 5. What are some of the barriers that families face in obtaining access to physical activity opportunities for their children with disabilities? (e.g., equipment, accessibility, awareness, availability/ waitlists, insurance/cost, travel, etc.) | The biggest barrier is lack of information about what is out there. Other issues include cost (insurance does not usually cover these types of opportunities), transportation, the need for venues that won't provide sensory overload, and the need for venues that are barrier free. |
| 6. Do you have ideas for ways that Shriners or other hospitals could be helpful around access to physical activity opportunities for children with disabilities? If so, what are they? | Someone needs to put together information about what is available and distribute it to families and schools. This has been done in Connecticut and could be done here - someone needs to keep on top of this information, make sure the programs are effective, and make sure the information gets out to families (could be distributed through schools). There are a lot of grassroots organizations out there, but no one is gathering all of the information. This could be a task, not for Shriners Hospital, but for the local Shriners members and women's auxiliary members in the area. They are willing to roll up their sleeves and get to work, looking for projects. The hospital could disseminate the information they collect. |
| | Shriners also has vans that can support transportation to programs. Shriners could also partner with community organizations, churches with space, YMCA, colleges, to offer programs throughout the city. People are more likely to go to programs if they are nearby. |
| 7. What do you know about the frequency or type of bullying that occurs | It's definitely a big issue. There are estimates that 70% of children with disabilities are bullied at school. It's usually verbal abuse, taunting, and staring. Schools can combat this with integrating |

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|---|---|
| towards youth with disabilities in the local schools? | children, lunch groups, model play. |
| 8. How does bullying affect the physical and mental health of youth with disabilities? In what ways does bullying impact them differently than youth without disabilities? | Bullying diminishes self-confidence, which is already low for these children - they cower down, withdraw. They sometimes exhibit selective mutism. It can lead to physical issues - for example, a child who won't use a walker for fear of being singled out could fall more often and get hurt. The impact varies - some students aren't aware of it, because their disability impedes their perception, but others range the gamut from being bothered by it to being acutely aware. It makes their disability even more traumatic for them. It can be hard to know what is bothering them and how to address it. |
| 9. What types of bullying prevention education would be helpful for children with disabilities and their families? Who do you think should do it? | Kids get a lot of general, schoolwide messages, but they don't internalize them. There needs to be more of a connection. Kids need to express how the bullying makes them feel, in encounter groups mediated by adults, or the parents of bullied children could do this. Maybe bring bullies and victims together to work on projects, again with adult supervision.

Difference of opinion over doing it in school vs. in outside groups. One respondent thinks that kids are more receptive to messages that they get in fun, social settings. Another talked about the need to do it in school so that they don't have to transfer skills learned in an outside setting to the school setting. |
| 10. If resources were available to spend on initiatives that might address the problem of bullying and children with disabilities, what types of things do you think should be done? What should we consider… educational programs, public campaigns to promote inclusion/integration and acceptance? Who should we target for these initiatives… the individuals with disabilities themselves, families, caregivers, schools… etc.? | Exercise programs that are adapted for people with disabilities - builds self-confidence, self-worth, makes them less vulnerable to bullying. Currently there is a lack of quality fitness programs for people with disabilities - a lot of the organized activities for them are around food.

It's best to start with young children, and use school settings to build awareness, provide information. You can use spaces and events where parents and families gather. It's important to start in elementary school - begin the work of building decent people who appreciate each other. |
| 11. Is there anything we haven't discussed that | There should be an educational health collaborative, modeled after the program in Connecticut, established here - it brings people |

| you'd like to mention before we finish the interview? | together, and provides momentum and continuity for goals. Professionals need to underscore the importance of using schools as a conduit for providing information to families. |
|---|---|

**Quotes:**

- "The clock is ticking . . . we're missing opportunities to provide services to these kids" Lisa Bakowski
- "A good part of disabilities care isn't medical care" Larry Kaplan
- "Shriners can be a hub for information" Kelly Phillips
- "People with disabilities are perfect victims for bullying and abuse" Kelly Phillips
- "If kids are uncomfortable or if something is unfamiliar, they make light of it" Ava Adamopolous

NOTE: Kelly Phillips mentioned that her church, St. Paul Lutheran in East Longmeadow, would be interested in partnering with Shriners to offer space for programs for children with disabilities. Anne Strickert is the pastor.

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

**Public Health Interview Summary Report**

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

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

| Question | Synthesis of Responses |
|---|---|
| 1. What local policies and social conditions predispose people in your community/ service area to good health and mental wellness? | Some of the conditions and policies mentioned included schools, education around prevention issues, nutrition, and health. In more rural areas, there are farms that have farm stands and Community Supported Agriculture programs, and institutional support for local healthy food. In urban areas, there is good access to services. The hospitals do a good job with outreach to communities in general and to people of color. Communities in this area are attuned to wellness and health in implementing policies throughout local government. |
| 1a. Are there groups of people who benefit from these policies/social conditions more than others? | The people who benefit most are white people and people with higher levels of education. The system is oriented toward prevention, so people who are able to hear and incorporate that message are better served. Implementation takes more time and money than prevention does. There is a lack of cultural competence in provider community - it is difficult for people of color to access mental health supports from people who understand their culture. |
| 2. What kind of structural and social changes are needed to tackle health inequities in your community/service area? | There is a need to integrate services that are provided from different organizations. We need an integrated approach to health care, removing structures that get in the way of collaboration. Physician training should include racial equity, family-centered care. We need a graduated income tax, and greater investment in education, child care, transportation, and community health workers. We need one-stop shopping with health care services under one roof. We need cultural humility, diversified offices and staff, public schools with staff who look like the students. |
| 3. What are the 3 most urgent health needs/problems in your service area? | The issues most frequently named were mental health, substance use, obesity, chronic diseases. |

| | |
|---|---|
| 4. In the last 1-2 years what health issues have emerged or increased dramatically in prevalence in your area? What evidence or data do you have to illustrate this increase? | Public health officials in Hampshire and Franklin counties mentioned tick-borne diseases. These are tracked through the University of Massachusetts, which tracks ticks sent in for testing, and through the Massachusetts Virtual Epidemiologic Network, which tracks diagnoses. Other health issues mentioned include pertussis being spread through unvaccinated people, and influenza. Health departments are facing bigger issues, such as mental health, substance use, and opioids, but these have been around longer. |
| 5. What gaps in services exist in addressing these needs? What are barriers to filling these gaps? | We need a coordinated system of roles, the widespread use of Community Health Workers, and recovery coaches. Public health professionals need to be out in the community, and value community voices. We need a centralized public health system - some small towns do not have services. We need better transportation in rural areas - I would love it if hospitals would buy vans. Emergency Medical Technicians can provide wellness checks and preventive services. This would be especially important for mental health - there are not enough providers, people have to travel to find them. We need more racial and cultural competence, especially for mental health providers. The current education system for health providers lacks this. |
| 6. In addition to more funding, what resources do you need to better address these emerging or increasing health concerns? | We need policy changes at the state level - established minimal expectations for public health services at the town level. We need a good public health response and resources around marijuana legalization. We need culturally sensitive practices in health care, which includes providers who look like and are from the community, who understand the culture, and who understand the history of racism. Hospitals need to develop a transportation infrastructure, and to develop the workforce to provide mobile health care (Boston is making a start with this). There needs to be outreach to mental health patients and an increase in prescribers for mental health issues, especially those who accept MassHealth health insurance. |
| 7. What specific vulnerable populations are you most concerned about? And why? | Populations mentioned included:<br>• People with mental health issues<br>• People coming out of jail<br>• African-Americans<br>• Transgender population<br>• Isolated elders<br>• New Americans, from specific communities that lack established outreach<br>• Homeless<br>• Residents of rural communities<br>• Inner city residents<br>All of these communities lack resources, access, culturally sensitive providers. |
| 8. Externally, what resources/services do you wish people in your area had access to? | Resources and services mentioned included:<br>• Transportation<br>• Better pain management services (Stanford has a course about creative, non-medical approaches to pain |

| | management) |
| --- | --- |
| | • Housing for people coming out of jail<br>• Supports for new Americans<br>• Funding for social determinants of health<br>• Workforce issues - recruiting and retaining physicians<br>• Drop-in day services for people with mental health issues and people experiencing homelessness<br>• Easy to navigate public health insurance accepted by most providers |
| 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? | Hospitals are the big organization in any partnership. They need to step back and not always take a leadership role, let smaller community-based organizations lead at times. There is a need to clarify roles and responsibilities within partnerships.<br><br>Some suggestions for what hospitals can do include:<br>• Working with public health nurses on readmission prevention and discharge planning<br>• Partnering with local health departments for workshops on pain management<br>• Putting pressure on the state to provide public health, put political power behind the need for a better system<br>• Providing Community Health Needs Assessment data for their communities to local health agents<br>• Providing forums for community people to come together and talk<br>• Supporting partnerships between public health nurses and community liaisons from hospitals. Jeff Harness does this very well, but he is one person<br>Sustainability suggestions include:<br>• Using community benefits funding to support and sustain the partnership<br>• Working from a project list to sustain momentum<br>• The Massachusetts Department of Public Health can provide financial support for forums |
| 10. What issues do you see emerging in the next 5 years? | Issues mentioned included:<br>• The opioid crisis will keep evolving, with new types of drugs<br>• The warming climate will lead to an increase in tick-borne diseases, mold, respiratory ailments<br>• Youth marijuana and vaping<br>• Pertussis<br>• Child and maternal health<br>• Obesity<br>• Aging population, especially veterans<br>• The rising cost of health insurance<br>• The immigrant community being afraid to access health insurance and health services<br>• Autism spectrum disorders |

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

# Appendix V.  Community Conversation Summaries

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

<u>**Community Conversation Summary Report**</u>

**Primary Hospital/Insurer:**  Baystate Medical Center
**Topic of Focus Group:**  Health needs and social determinants of health/ Spanish
**Date of Focus Group:** 2/08/2019
**Facilitator:**  Melissa Pluguez-Moldavskiy NAHN-WMass
**Note Taker:**  Brittney Gonzalez
**Location:** Riverview Senior Center, Springfield, MA

**Executive Summary**

A. **Participant Demographics:**
   - 45 people
   - Brightwood neighborhood/ Clyde St in Springfield
   - Primarily Hispanic/Latino attendees
   - Majority elderly and mixed gender

B. **Areas of Agreement (top health needs and related issues):**
   - Transportation: length wait times, delayed arrival or none at all causing missed appointments
   - Access in Spanish to services
   - Nutrition services in spanish, diabetic education
   - Food insecurity
   - Day resources for the elderly

C. **Recommendations:**
   - Need more dialogue and mutual conversation with health care providers, phone resources available in spanish in the offices.
   - Need more resources to address social needs in a culturally competent manner for the spanish community. Senior Centers are a good resource for resources, but underlying social/economic needs require more attention.
   - Need more community involvement
   - Stay focused on key needs
   - Need more time to talk and to talk more frequently, not just every 3 years, include more spanish speaking communities.
   - Want to know more about when the report and CHNA findings will be available - what will be done with this information to make improvements?
   - Do more advertising for future meetings to get more people

**D. Participant Quotes:**
   - "Transportation: Hospitals don't provide enough, Public is cheaper but riskier."
   - "Education is not culturally sensitive; diet medical, lack of cultural knowledge in the medical community."
   - "Advisar de resources que hay para la comunidad hispana (advertise about resources available to the hispanic community)"

**Key Issues**

| Question | Synthesis of Table Discussions |
|---|---|
| 1. What are the top 3 most pressing health needs in your community? | <ul><li>Transportation</li><li>Culturally competent care with spanish speaking translators</li><li>Food Securities</li></ul> |
| 2. Who is disproportionately impacted by these problems? How? | <ul><li>People without transportation</li><li>Non-English speaking</li><li>Undereducated</li><li>Speakers of other languages</li><li>Homeless/at risk for homelessness</li><li>People living with substance use disorders</li><li>Older adults</li></ul><br>These groups lack access to services, encounter stigmas that pose barriers to getting services, lack the means to get to and from appointments, do not understand how to navigate through the health care system, are just trying to survive "day-to-day", amd tend to feel that health care is not necessarily a top priority. |
| 3. Who do you think is being missed in the CHNA process? | <ul><li>Media</li><li>Elderly/older adults</li><li>Barber shops and beauty salons</li><li>Men</li><li>Government officials</li><li>Grandparents who are raising their grandchildren</li><li>Youth and young adults</li><li>Single parents</li><li>Clergy</li></ul> |

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

<u>**Community Conversation Summary Report**</u>

**Primary Hospital/Insurer:** Baystate Health - Noble Hospital
**Topic of Focus Group:** Health needs and social determinants of health
**Date of Focus Group:** 2/20/2019
**Facilitator:** Gail Gramarossa
**Note Taker:** Eve Sullivan
**Location:** Westfield Senior Center

**Executive Summary**

    A.  Participant Demographics (# people, geographic area):
- 10 people, primarily Westfield residents
- Most were white
- Men and women participated
- All participants were ages 40 and up

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

- Built environment
- Financial health
- Education

**Key Issues**

| Question | Synthesis of Table Discussions |
|---|---|
| 1. What are the top 3 most pressing health needs in your community? | <ul><li>When transportation is difficult, people can't go to medical appointments, grocery shopping, the pharmacy</li><li>When there is a crisis, or when a person has a substance use disorder, the person is likely to have very limited access to care because of an insufficient number of beds.</li><li>There is a lack of training and education for people in the medical professions to work with people with intellectual or other disabilities. The creation of a greater network of peer support or coaches could help with this.</li><li>The availability and quality of affordable housing is an issue. People need enough money to pay first and last month's rent and a security deposit in addition to monthly rent. But having this money may make a person ineligible for MassHealth.</li><li>Poor sidewalk quality can affect children, people in wheelchairs, people with disabilities, and the elderly.</li></ul> |

| | |
|---|---|
| | <ul><li>Poor water quality has long term effects for everyone.</li><li>Noise pollution from the airport can affect people's quality of sleep and ability to relax, and their pets' well-being.</li><li>Other issues include:<ul><li>Shortage of medical professionals, especially those who take Medicaid</li><li>Getting the right cane or other device</li><li>Affordability of care</li><li>Lack of food security</li><li>Homelessness</li></ul></li></ul> |
| 2. How do these health needs disproportionately affect the most vulnerable people and communities? | <ul><li>People from different cultures and people with disabilities may not be treated appropriately by medical professionals.</li><li>Cultural differences can also affect people's willingness to access health care, their understanding of treatment, and their understanding of what treatment and services are available.</li><li>Stigma around medical marijuana can affect people's access and use of this type of treatment.</li><li>People with financial hardships often need help with transportation to access health care.</li></ul> |
| 3. Who do you think is being missed in the CHNA process? Who should we reach out to and invite to become more involved? | <ul><li>Immigrant and refugee groups</li><li>People who are homeless</li><li>People who are disabled</li><li>The elderly</li><li>People of color and other minorities</li><li>People who use community health clinics to access health care</li></ul> |

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

<u>**Community Conversation Summary Report**</u>

**Primary Hospital/Insurer:**  Baystate Medical Center
**Topic of Focus Group:**  Health needs and social determinants of health/ Spanish
**Date of Focus Group:** 2/08/2019
**Facilitator:**  Melissa Pluguez-Moldavskiy NAHN-WMass
**Note Taker:**  Brittney Gonzalez
**Location:** Riverview Senior Center, Springfield, MA

**Executive Summary**

    A. **Participant Demographics:**
- About 40 participants
- Brightwood neighborhood/ Clyde St in Springfield
- Primarily Hispanic/Latino attendees
- Majority elderly and mixed gender

    B. **Areas of Agreement (top health needs and related issues):**
- Transportation: length wait times, delayed arrival or none at all causing missed appointments
- Access in Spanish to services
- Nutrition services in Spanish, diabetes education
- Food insecurity
- Day resources for the elderly

    C. **Recommendations:**
- Need more dialogue and mutual conversation with health care providers, phone resources available in Spanish in the offices.
- Need more resources to address social needs in a culturally competent manner for the Spanish community. Senior Centers are a good resource for resources, but underlying social/economic needs require more attention.
- Need more community involvement
- Stay focused on key needs
- Need more time to talk and to talk more frequently, not just every 3 years, include more Spanish speaking communities.
- Want to know more about when the report and CHNA findings will be available - what will be done with this information to make improvements?
- Do more advertising for future meetings to get more people

    D. **Participant Quotes:**

- ○ "Transportation: Hospitals don't provide enough, Public is cheaper but riskier."
- ○ "Education is not culturally sensitive; diet medical, lack of cultural knowledge in the medical community."
- ○ "Advisar de resource que hay para la comunidad Hispana (advertise about resources available to the Hispanic community)"

**Key Issues**

| Question | Synthesis of Table Discussions |
|---|---|
| 1. What are the top 3 most pressing health needs in your community? | ● Transportation<br>● Culturally competent care with Spanish speaking translators<br>● Food Securities |
| 2. Who is disproportionately impacted by these problems? How? | ● People without transportation<br>● Non-English speaking<br>● Undereducated<br>● Elderly<br>● Those with mental health needs<br><br>These groups lack access to services, encounter stigmas that pose barriers to getting services, lack the means to get to and from appointments, do not understand how to navigate through the health care system, are just trying to survive "day-to-day", and tend to feel that health care is not necessarily a top priority. |
| 3. Who do you think is being missed in the CHNA process? | ● Media<br>● Younger individuals<br>● Representatives of those with disabilities<br>● Physicians<br>● Single parents<br>● Clergy<br>● Someone to discuss pharm/med prices |

# Appendix VI.  Community Chat Summary

**Community and Stakeholder Engagement**

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

**Methodology**

From January 2019 to April 2019, the RAC held 60 Chats throughout Hampden (46), Hampshire (10), Franklin (2), and Worcester (2) counties. The Chats were a convenience sample selected by Baystate Health through the input of RAC members, Community Benefits Advisory Council (CBAC) members, and through leveraging existing community relationships. Participation snowballed throughout the process with the assistance of Chat participants suggesting other community groups to include in the process. In total, the RAC reached 838 people through these Chats. Figure 1 shows the role participants identified with during the Chats.
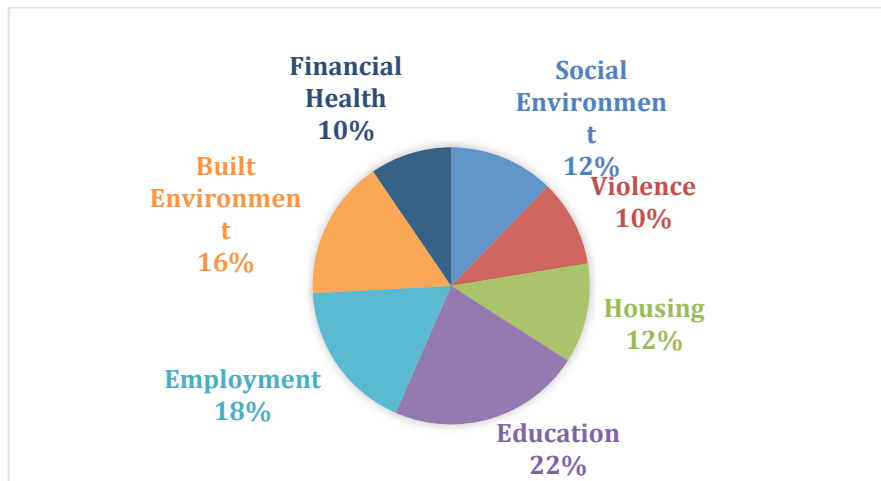
Figure 1:  Chat Participants

| | |
|---|---|
| Nonprofit Staff | 23% |
| Health Care Professionals | 21% |
| Community Member | 19% |
| Youth | 13% |
| Older Adult | 8% |
| Municipal Staff | 5% |
| Community Leader | 5% |
| Individual with Disabilities | 3% |
| Transgender and LGBTQ+ | 2% |
| Faith Leader | 1% |

**Health Needs, Issues and Concerns:**

 In 42 of the 60 Chats conducted, participants were given two sticker dots and asked to mark on a poster what they believed were the two most pressing health issues in their communities. Facilitators presented options organized by the Massachusetts Department of Public Health Social Determinants of Health Framework, which included: social environment, violence, education, employment, housing, built environment, financial health, as well as more specific subsets of each topic listed. Figure 2 lists how Chat participants voted.

Figure 2: Social Determinants of Health Priorities 2019



**Priorities from Chat Participants**

**Education:** Education was the top priority of Chat participants throughout Western Massachusetts. Resources and opportunities for education were identified as the most pressing issues, followed by social and psychological education, and knowledge and behavior. A lack of health literacy was a common issue for communities as well. Participants identified limited knowledge of available services, and the need for a reference list of all available services and resources within their communities.

**Employment:** Employment was also identified as a top priority in Western Massachusetts. Within the category of employment, Chat participants specifically elevated the issue of income and poverty over some of the other options, such as benefits and resources, employer policies, and physical workspace.

**Built Environment:** Built environment top priorities included transportation, health care access, and food access, respectively. Many chat participants reported living in transportation deserts or reported inadequate transportation services. Participants also mentioned a lack of sidewalks and sidewalk upkeep. Community members reported issues such as food deserts, unaffordable healthy food, lack of fast-food zoning laws, and stigma around food pantries as challenges. Additionally, lack of health care access was indicated in many Chats. This includes: inability to pay for services, difficulty navigating healthcare and health insurance systems, long wait times in the ER and to see a health care specialist, and limited service providers. Overwhelmingly, participants reported a lack of mental health and substance use disorder treatment as an issue.

**Social Environment:** The social environment encompasses factors as such language isolation, racism, poverty, gender discrimination, immigration status, ageism and more. Through the chats, challenges with the social environment were found at the individual, community and societal (systems and policies) level. Increased cultural humility among providers, as well as a need for bilingual providers were areas where participants identified needs. Institutionalized racism was consistently mentioned as a significant contributor to poor health in Western

Massachusetts. Community members also identified a lack of community engagement and specifically requested more after-school programs and mentoring programs for youth.

**Housing:** Participants named homelessness as the top issue within the housing category, with some participants also reporting housing stability and quality as an area of concern. Chat participants specified that affordable housing was low quality and aging, but also limited, leading to long waitlists.

**Financial Health:** Financial health is built through having access to safe, high-quality financial products and services that help people save, spend, borrow, and plan. Financial health not only improves a person's life today, but it also creates opportunity for their future generations. Overall, Chat participants reported financial health as a general problem.

**Violence:** Violence was most frequently reported as a problem at the interpersonal level (such as domestic violence, bullying, and homicide). Self-directed violence, including self-harm and suicide, was also reported as a community concern.

### Vulnerable Populations

Commonly cited vulnerable populations and common challenges include:

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

### Community Assets

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

### Limitations and Recommendations

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

capture the demographic make-up of the Chat participants, and begin the Chats earlier in the CHNA process to better guide CHNA priorities.