

2019 Community Health Needs Assessment

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



**PUBLIC HEALTH INSTITUTE
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Acknowledgments

We would like to thank the members of the 2019 Community Health Needs Assessment Regional Advisory Council who represented community interests:

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Consultant Team

Lead Consultant

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

Consultants

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

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

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

Table of Contents

Acknowledgments.....	1
Consultant Team	2
I. Executive Summary.....	5
II. Introduction	14
1. About Baystate Wing Hospital.....	14
2. Coalition of Western Massachusetts Hospitals/Insurer	15
3. Community Health Needs Assessment (CHNA)	15
III. Methodology for the 2019 CHNA	16
1. Equity as a Guiding Value.....	16
2. Social and Economic Determinants of Health Framework	18
3. Assessment Methods.....	20
4. Prioritization Process	21
5. Community and Stakeholder Engagement.....	21
6. Limitations and Information Gaps	23
7. Hospital Service Area	24
IV. Prioritized Health Needs of The Community	28
1. Social and Economic Determinants That Impact Health	28
A. Social Environment.....	28
B. Housing Needs.....	31
C. Lack of Access To Transportation, Healthy Food, and Places To Be Active	33
D. Lack of Resources To Meet Basic Needs	36
E. Need For Financial Health	38
F. Violence and Trauma	40
2. Barriers To Accessing Quality Health Care	42
A. Insurance and Health Care Related Challenges	42
B. Limited Availability of Providers.....	43
C. Need For Cultural Humility.....	45
D. Need For Transportation.....	45
E. Lack of Care Coordination	46
F. Health Literacy And Language Barriers.....	47

3. Health Conditions and Behaviors.....	49
A. Mental Health and Substance Use	49
B. Chronic Health Conditions.....	57
C. Infant and Perinatal Health	64
D. Alzheimer’s Disease and Dementia.....	67
4. Priority Populations of Concern	68
5. Geographic Areas of Concern.....	69
V. Community and Hospital Resources To Address Needs	70
VI. Input and Actions Taken Since Previous CHNA.....	77
1. Community Input on Previous CHNA and Implementation Strategy	77
2. Impact of Actions Taken By Hospital Since Last CHNA	77
VII. Summary	84
VIII. References	85
IX. Appendices.....	A-1

I. Executive Summary

Introduction and Methods

Baystate Wing Hospital (Baystate Wing) is a 74-bed facility located in Palmer, Massachusetts helping people in a service area that includes three counties – Hampden, Hampshire, and Worcester. The hospital services approximately 120,000 residents in seventeen towns, with over half of this population living in Belchertown, Ludlow, Palmer, Wilbraham, and Ware. We offer a broad range of medical, surgical, and psychiatric services. Our expanded Emergency Department (ED) provides comprehensive emergency services for adults and children around the clock. The emergency department includes a six-bed critical care unit and is a primary stroke center designated by the Massachusetts Department of Public Health (MDPH). Our hospital offers comprehensive, personalized, and high-quality inpatient and outpatient behavioral health and addiction treatment services through the Griswold Behavioral Health Center and the Center for Geriatric Psychiatry.

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

Baystate Wing is a member of the **Coalition of Western Massachusetts Hospitals/Insurer** (Coalition), a partnership among eight non-profit hospitals 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 triennial **community health needs assessments** (CHNAs) and address regional needs. Baystate Wing worked in collaboration with the Coalition to conduct this assessment and update findings of the Baystate Wing 2016 CHNA.

The goals of the 2019 CHNA were to:

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

The assessment focused on the **primary geographic service area of Baystate Wing**. Numerous small, rural towns make up the service area (Belchertown, Brimfield, Brookfield, East Brookfield, Hampden, Hardwick, Holland, Ludlow, Monson, New Braintree, North Brookfield, Palmer, Spencer, Wales, Ware, Warren, West Brookfield, and Wilbraham), which crosses three County lines in Hampden, Hampshire, and Worcester Counties.

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

When identifying the areas that can be addressed to improve the health of the population, the assessment used the 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, Hampshire, and Worcester county reports and regional assessment reports; 3) information from two focus groups and seven key informant interviews, including interviews with public health leaders, conducted for the 2019 CHNA; and 4) community input from one Community Conversation and seven Community Chats. In total, about 100 individuals across Hampden, Hampshire, and Worcester counties were engaged in outreach and data collection.

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

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

Findings

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

COMMUNITY LEVEL SOCIAL AND ECONOMIC DETERMINANTS THAT IMPACT HEALTH

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

- **Social environment** - includes relationships between people, connectedness to community, and broader societal values and norms. Different people may experience different health outcomes as a result of inequities in social environments. People in focus groups and key informant interviews spoke of the negative effect that social isolation has on health and the health value of being part of a community. While the region is not very diverse by race and ethnicity, experiences of interpersonal and structural discrimination as well as social exclusion can create barriers to being able to access services and social determinants of good health.
- **Housing needs** - about one-third of residents in Hampshire and Worcester Counties experience housing insecurity, paying more than 30% of their income on housing; in Hampden County 37% are housing insecure. In a typical Baystate Wing service area household people pay more than half of their income on housing plus transportation; in households with lower incomes use up to two-thirds of their income on housing plus transportation. Hampden County, which is about 60% of Baystate Wing's service area, has the highest amount of homelessness in western Massachusetts. Poor housing conditions also impacts the health of residents. Older housing combined with limited resources to maintain the housing leads to conditions that can affect asthma, other respiratory conditions and safety.
- **Lack of access to transportation and healthy food** - regional public health officials interviewed for the 2019 CHNA continue to identify increased transportation options as an overall community need for the region. While improvements have been made with a region-wide van service, the Quaboag Connector, there are still transportation barriers for many individuals. Nearly 6% of the service area residents do not have a car and have very poor ability to provide their own transportation. Individuals who do not own a vehicle face difficulties accessing educational and employment options or participating in community-based programs that promote health, such as exercise and nutrition programs, or other activities that promote social connection. Food insecurity continues to impact the ability of many Baystate Wing service area residents to access healthy food. Portions of Ludlow, Monson, and Ware have food insecurity rates over 15%. In addition, part of Palmer is considered a food desert, which is an area where people with low-incomes have limited access to grocery stores.

- **Lack of resources to meet basic needs** - many Baystate Wing service area residents struggle with poverty and low levels of income. Parts of Ware, Palmer, and Ludlow have poverty rates greater than 15%. In Warren, nearly 40% of the population lives in households at or below 200% of the federal poverty level, a measure which offer a better glimpse of individuals who are low-income and may lack resources to meet basic needs. Lower levels of education, concentrated in Ludlow, Palmer, and Ware, contribute to unemployment and the ability to earn a livable wage. Only 31% of service area residents have a bachelor’s degree or higher (in Massachusetts, 42% do). Nearly 6% of the service area population is unemployed.
- **Violence and trauma** - key informant interviews and community members continue to identify domestic violence as a priority concern in the Baystate Wing service area. High rates of domestic violence were observed in Ware and Palmer. Domestic Violence Advocates serving the Quabog Hills region serve approximately 580 survivors of domestic and sexual violence and their children per year. At 21%, Ware's per capita restraining order rate is twice that of the other six towns served by the Eastern Hampshire District Court (Hadley, Belchertown, Granby, Amherst, Pelham, and South Hadley). The impacts of domestic violence reach far beyond the person who is being abused. Children who are exposed to violence in the home are predisposed to many social and physical problems.

“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. 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.”

Key Informant Interview, Hampshire County

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, especially young adults in two focus groups. 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. For young adults, navigating the systems are so overwhelming that they often just forgo health care and wait until they need urgent or emergency room care.

- **Limited availability of providers** - focus group participants and key informant interviews overwhelmingly reported a need for increased access to mental health and addiction services for acute, maintenance, and long-term care. The need for increased access to dental care was also identified by Baystate Wing young adult focus group participants as an important health need. In particular, a shortage of providers that accept adult MassHealth was identified as well as insufficient dental service coverage for adults with MassHealth insurance.
- **Need for cultural humility** - public health leaders, focus group participants, and other interviewees called for increased training, experience, and sensitivity for health care and social service providers to a variety of different cultures. Cultures of race and ethnicity as well as the cultures of people with mental health and substance use disorders, older adults, transgender patients, ex-offenders, people experiencing homelessness, and adults and children with disabilities were mentioned.
- **Lack of transportation** - transportation arose as a barrier to care among interviewees in the 2016 CHNA, and it 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.
- **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 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 and for materials at reading levels that match the needs of patients with less education and lower reading abilities.

“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 healthcare 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.”

Key Informant Interviewee, Hampshire County

HEALTH OUTCOMES

- **Mental health and substance use disorders** - substance use and mental health were identified as the most urgent health needs/problems impacting the area, as identified in local and regional interviews and focus groups and survey data of school districts in the Baystate Wing service area under the auspices of the Quaboag Hills Drug Free Communities project. Substance use disorders, specifically opioid use, were of particular concern. Opioid use disorder, which has been declared a public health emergency in Massachusetts, is impacting residents with high opioid related hospitalization rates in Ware and Palmer. Tobacco use remains high with an estimated 16-21% of adults that smoke. The rates of youth vaping nicotine-based products is a major concern; over 25% of 12th grade students in the Quaboag Hills region say that they vaped in the past 30 days. There was overwhelming consensus among focus group participants and health care providers about the need for increased education across all sectors to reduce the stigma associated with mental health and substance use, as well as the need for expanded treatment options, particularly 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

“There are significant problems with substance use among our peers, I've seen many friends die from overdoses...we are hiding our pain with drugs.”

Young Adult Focus Group Participant, Ware Adult Literacy Program, Hampshire 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 Baystate Wing service area residents in 2019. While rates of cancer are slightly lower than the state, cancer is the leading cause of death in the towns of Belchertown and Palmer; heart disease is the leading cause of death in Ware and Ludlow. In Hampshire County, the leading cause of death is heart disease; in Worcester County the leading

cause of death is cancer. An estimated 29% of adults in Hampden County are obese, 21% in Hampshire County are obese, and 26% in Worcester County are obese. Four out of 5 adults over 65 have hypertension, a risk factor for cardiovascular disease. An estimated 11% of Hampden county residents have diabetes; in Palmer 35% of adults over age 66 have diabetes; in Ludlow 33% over age 66 have diabetes; in Belchertown, 32% have diabetes; and in Ware 36% of older adults over age 66 have diabetes. In Wing’s service area, pediatric asthma ranges from 10% of children in Palmer to 16% of children in Ware.

- **Physical activity and nutrition** - the need for increased physical activity and consumption of fresh fruits and vegetables was identified among residents. Low rates of physical activity and healthy eating contribute to high rates of chronic disease and also impact mental health. Data from the Pioneer Valley Planning Commission's "Mass in Motion" program in Palmer (addressing healthy eating and physical activity) shows that most significant barrier to adequately feeding their families the way survey respondents want to is money; financial barriers to accessing healthy food are particularly high in the villages of Three Rivers (37%) and Bondsville (36%).

"I just snack all day – eat pizza, get food from gas stations, I have food at my job, but it is very expensive, I live on energy drinks and coffee."

Young Adult Focus Group Participant; Ware Adult Literacy Center, Hampshire County

- **Infant and perinatal health** - infant and perinatal health factors were identified as health needs in the 2016 CHNA and continue to impact residents. Need for increased utilization of prenatal care and a decrease in smoking during pregnancy were identified. Rates of smoking during pregnancy in the towns of Ware and Palmer are significantly above the statewide rate. Disparities exist with whether a person has private or public insurance in prenatal care and birth outcomes. As a result, 5-7% of Baystate Wing service area births are born preterm or low birth weight.
- **Alzheimer’s disease** - Palmer has slightly higher rates of Alzheimer’s disease (15%) among those over age 65 than the state (14%). Belchertown (13%) and Ware (11%) have rates of Alzheimer’s disease slightly lower than statewide rates, but also concerning. By 2035, the percentage of people over the age of 60 is expected to increase to 28% in Hampden County and to 32% in Hampshire County. Advancing age is a risk factor for Alzheimer’s disease.

PRIORITY POPULATIONS

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

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

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

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

Key Informant Interview, Public Health Official

Summary

The Baystate Wing service area, which includes parts of Hampden, Hampshire, and Worcester Counties, continues to experience many of the same prioritized health needs identified in Baystate Wing's 2016 CHNA. Social and economic challenges experienced by some members of the population in the service area contribute to the high rates of chronic conditions and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health disparities observed among priority populations, which include youth, young adults ages 19 to 25, older adults, GLBQ+ youth, transgender individuals, Latinos and blacks, 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, including children. Individuals who are homeless, low-income, living in poverty or in domestic violence situations were also identified as priority populations. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The Baystate Wing service area population continues to experience a number of barriers that make it difficult to access affordable, quality care; several of which are related to the social and economic conditions in the community, and others which relate to the healthcare system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. Progress has been made to address some of the prioritized social and health needs previously identified, such as transportation, substance use, and domestic violence; however, rates remain high and work needs to be continued.

II. Introduction

About Baystate Wing Hospital

Baystate Wing Hospital (Baystate Wing) is a 74-bed facility located in Palmer, Massachusetts helping people in a service area that includes three counties – Worcester, Hampden and Hampshire. The hospital serves approximately 120,000 residents in seventeen towns, with over half this population living in Belchertown, Ludlow, Palmer, Wilbraham and Ware. Our expanded, Emergency Department (emergency department) provides 24-hour comprehensive emergency services for adults and children. The emergency department includes a six-bed critical care unit and is a primary stroke center designated by the MDPH. Baystate Wing and its team of 500 dedicated employees provide comprehensive, personalized, and high-quality inpatient and outpatient behavioral health and addiction treatment services through the Griswold Behavioral Health Center and the Center for Geriatric Psychiatry. Baystate Wing's five medical centers, located in Belchertown, Ludlow, Monson, Palmer, and Wilbraham, offer outpatient services and primary care provided by physicians who specialize in adult family medicine, internal medicine, geriatric medicine and pediatric medicine. A satellite facility, Baystate Mary Lane Outpatient Center (Baystate Mary Lane) offers 24-hour emergency services, and outpatient medical, surgical, ancillary, and cancer care.

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

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

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

Coalition of Western Massachusetts Hospitals/Insurer

Baystate Wing is a member of the **Coalition of Western Massachusetts Hospitals/Insurer** (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 (a member of Trinity Health – New England), Shriners Hospitals for Children – Springfield, and Health New England, a local health insurer whose service areas covers the four counties of western Massachusetts. The Coalition formed in 2012 to bring hospitals within western Massachusetts together to share resources and work in partnership to conduct their triennial **community health needs assessments** (CHNAs) and address regional needs.

Community Health Needs Assessment (CHNA)

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

Integral to this needs assessment was the participation and support of community leaders and representatives who provided input through participation in the **CHNA Regional Advisory Council** (RAC), and the **Baystate Wing Community Benefits Advisory Council** (CBAC), stakeholder interviews, focus groups, a Community Conversation, and Community Chats (more detail on these elements of the process in Section 5 below on Community and Stakeholder Engagement). Special thanks to the Baystate Wing CBAC members who participated in the RAC: Gail Gramarossa of Collaborative for Educational Services and the Town of Ware, and JAC Patrissi of Behavioral Health Network.

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

III. Methodology for the 2019 CHNA

1. Equity as a Guiding Value

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

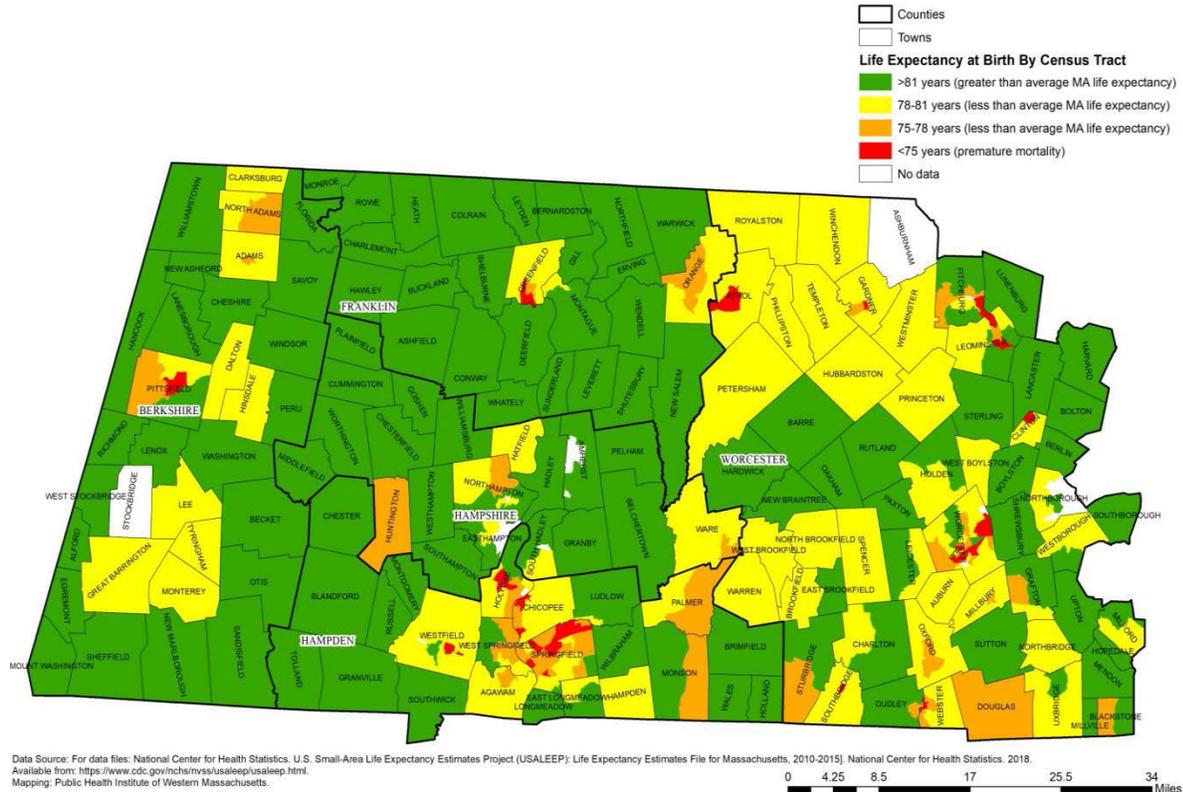
The Coalition and the CHNA RAC created a proposition that the CHNA reflect values of health equity, cultural humility, and social justice within a framework of social determinants of health. As part of this, the CHNA process was conducted with an inclusive, community-engaged process that strove for 1)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

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

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

Opportunities to lead a long and healthy life vary dramatically by neighborhood. Life expectancy in Massachusetts overall is 81 years (80.7), the sixth highest in the nation; however there are large differences depending on where you live. Some areas of western Massachusetts 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, and lower educational attainment, lack health insurance, and have more nonwhite residents among other measures.² Inequity impacts health. For example, 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

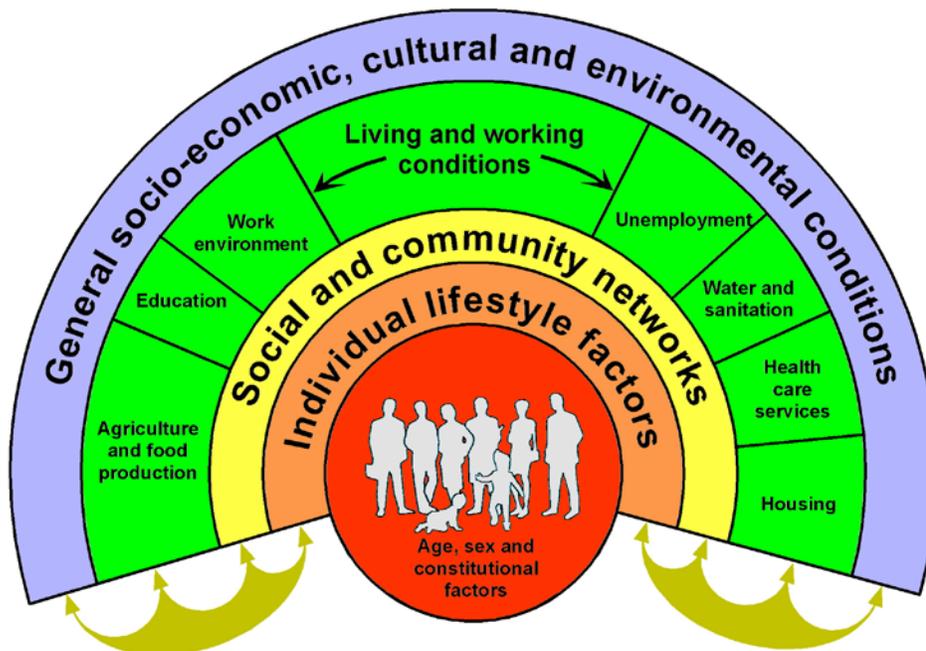


Source: National Center for Health Statistics, Life Expectancy for Massachusetts 2010-2015

2. Social and Economic Determinants of Health Framework

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

Figure 2. Determinants of Health



Source: Dahlgren and Whitehead, 1993

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

Figure 3. County Health Rankings Model - Health Factors

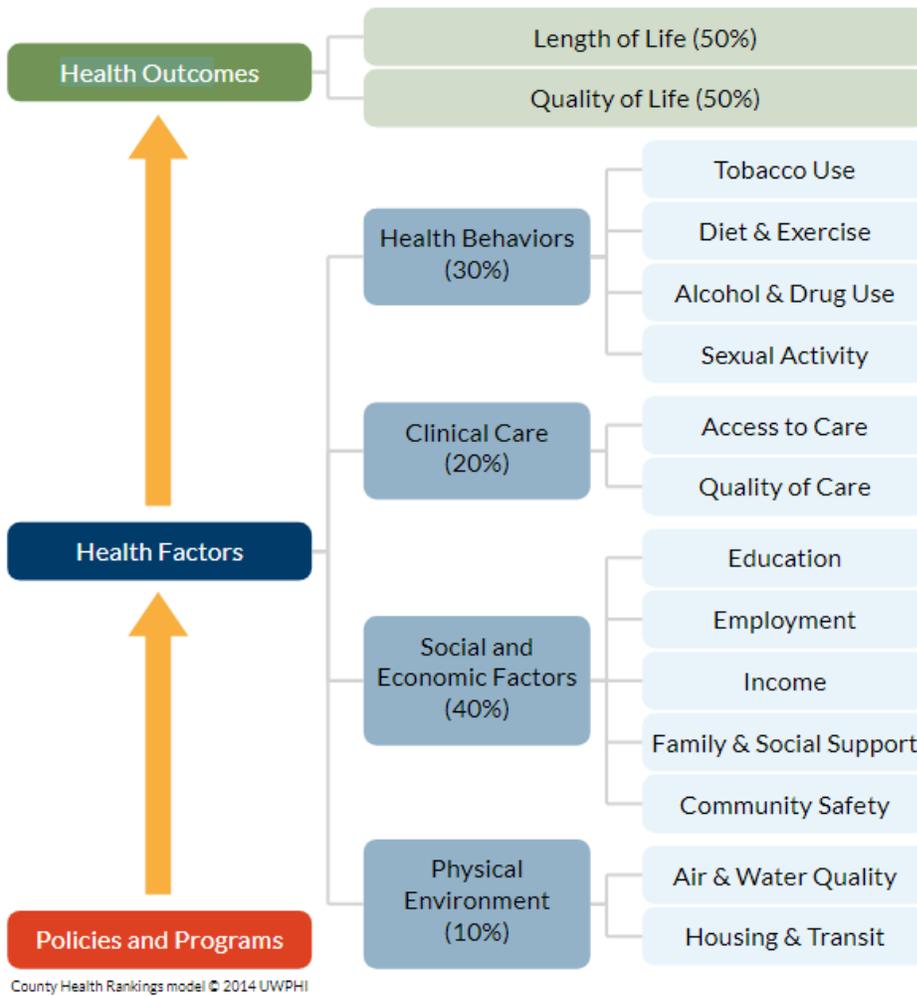


Figure 4. Massachusetts Department of Public Health Priorities

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



3. Assessment Methods

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

Assessment methods included: 1) analysis of social, economic, and health quantitative data from the MDPH, the U.S. Census Bureau, the County Health Ranking Reports, the Massachusetts Healthy Aging Collaborative, Social Explorer, and a variety of other data sources; 2) analysis of findings from two focus groups, seven interviews with key informants (including five with local and regional public health officials), one Community Conversation and seven Community Chats conducted by the consultant team and the RAC as part of this CHNA; 3) the experiences of community members who gave input in focus groups or key informant interviews in other regions, which were often considered relevant to this service area and were included; and 4) 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 RAC identified that there are health needs specific to rural areas of Hampden County, however due to small numbers and lack of existing data, there is limited discussion of rural health issues in Hampden County.

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

Some of the data sources supplied data in rates (e.g., rates per 100,000 of the population), including the main source of data for health outcomes, the MDPH. Creating rates allows us to compare outcomes from geographies that might be drastically different in size, such as the state of Massachusetts and the town of Palmer. If all we could report was the number of people hospitalized, for instance, it would not be possible to compare how Palmer is doing compared to the state. For example, if 286 people in a town of 12,000 were hospitalized in one-year for cardiovascular disease, the rate is 1,852 per 100,000. If over 92,000 people across the approximately 6.9 million people in the state of Massachusetts were

hospitalized for the same thing in one-year, the rate is 1,216 per 100,000. Thus, we can see that the town of Palmer had a much higher rate of hospitalization even though they had far fewer people hospitalized.

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 priority populations in the community. Quantitative, qualitative, and expanded community engagement data confirms that priorities from 2016 continue in 2019.

5. Community and Stakeholder Engagement

The input of the community and other important regional stakeholders was prioritized by the Coalition as an important part of the CHNA process. In the region, the Coalition engaged almost 1,100 people in the 2019 CHNAs. Below are the primary mechanisms for community and stakeholder engagement, and the number engaged for the Baystate Wing CHNA. See Appendix 1 for a list of public health, community representatives, and other stakeholders included in the 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 through June 2019.
- **Key informant interviews** and **focus groups** were conducted to gather information used to identify priority health needs and engage the community. Key informant interviews were

conducted with health care providers, health care administrators, local and regional public health officials, and local leaders that represent the interests of the community or that serve medically underserved, low-income or populations of color in the service area. Interviews with local and regional public health officials identified priority health areas and community factors that contribute to health needs. Focus group participants included community 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 through March 2019. Focus groups and key informant interviews engaged people in Hampshire and Hampden counties and across the region; this CHNA also used qualitative data from other hospital service areas as appropriate.

- Baystate Wing held **one Community Conversation** and seven **Community Chats** that were pertinent to Baystate Wing’s service area and CHNA. Community Conversations were larger bi-directional information-sharing meetings conducted for each Baystate Hospital service area and one done in Spanish in Springfield. For Community Chats, RAC members brought information about the CHNA and gathered priorities in regular meetings of service providers, community-based organizations, and hospital clinical staff and administrators. While these outreach efforts were spearheaded by Baystate Health, the engagement and findings benefitted all Coalition member hospitals/insurer. Conversations and Chats were held from January 2019 through April 2019.
- A **Community Forum** was held on June 17, 2019 upon completion of this report to share the findings. The Community Forum included individuals representing the broad interests of the community, participants in the focus groups, interviews, Conversations, Chats, and community stakeholders representing medically underserved, low-income and populations of color.

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

Key Informant Interviewee, Public Health Official, Hampden County

6. Limitations and Information Gaps

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

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

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

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

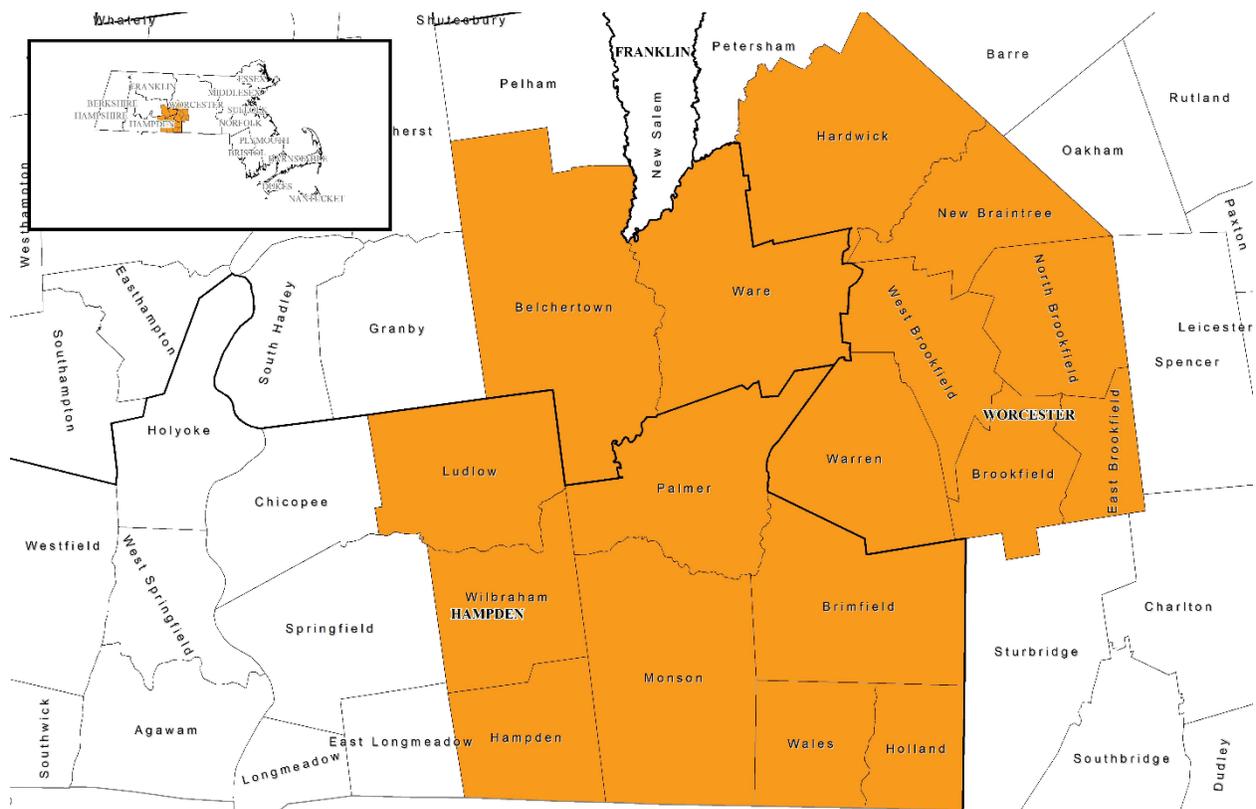
Ideally, we would disaggregate data for a better understanding of people who identify with different races and ethnicities, yet this data is often not available, or is based on estimates that come with a large margin of error. Beyond broad categories, we recognize that there are differences among those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

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

7. Hospital Service Area

The Baystate Wing service area overlaps to great degree the region that is also known as the Quaboag Hills. The region is 90 miles west of Boston, 30 miles northeast of Springfield and 30 miles west of Worcester, representing 17 communities in a 440-square mile region in west-central Massachusetts with a total population of 122,033. Numerous small, rural towns make up the region (Belchertown, Brimfield, Brookfield, East Brookfield, Hampden, Hardwick, Holland, Ludlow, Monson, New Braintree, North Brookfield, Palmer, Spencer, Wales, Ware, Warren, West Brookfield, and Wilbraham) which crosses three County lines (Hampden, Hampshire, and Worcester Counties) (Figure 5). The towns are comprised of densely populated former mill villages surrounded by rural areas and developing commuter neighborhoods.

Figure 5. Baystate Wing Service Area



Source: Public Health Institute of Western Massachusetts

Thirteen of the 17 towns have populations of less than 10,000 people living in them, and all 17 towns meet the state definition of “rural”, defined as “a municipality in which there are fewer than 500 people per square mile.”⁵ Transportation is extremely limited. Demographically, the service area is overwhelmingly white (more than 96%) with 2% Latino and less than 1% black or Asian. However recent trends show growing numbers of new immigrants and Spanish-speaking residents. For example, the town of Ware and the Quaboag Regional Schools each have a student body that is 6% Latino and Palmer students are 8% Latino.

The region has been characterized by chronic high unemployment, historically 1 to 2 points above the state average. Education levels in the Quaboag Hills are significantly lower than the average in Massachusetts. In the 2018 Robert Wood Johnson Foundation County Health Rankings, Hampden County ranks last (14th of 14 counties); Worcester County ranks 9th, and Hampshire County ranks 5th. Economically, the region has been hard-hit by lost manufacturing jobs and recession. In four of the six school districts, over 33% of students are eligible for reduced price/free lunch. An average of 8% of families lives below the poverty level; in Ware, Warren, and Hardwick, over 20% of families live in poverty. The Worcester Community Action Council, Inc.’s Community Action Plan 2015-2017 ranked the town of Hardwick as one of the five towns in Worcester County with the highest individual, childhood and family poverty rates. Many families living in poverty are headed by single females.⁶ The town of Ware (pop. 9,872) serves as the region’s economic and service “hub” with the broadest network of commercial entities, service providers, employers, and health care providers.

In Hampden County, 16% of the population has a disability compared to the state prevalence of 12%. In Hampshire County, 10% of the population has a disability. Disability prevalence in Ware and Palmer is higher than the state at 16% and 17%, respectively. 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 (U.S. Census Bureau, ACS, 2013-2017).

Table 1. Municipal Communities in Baystate Wing Service Area

Service Area Town	2017 Population Estimate
Hampden County	58% of the service area
Brimfield	3,724
Hampden	5,193
Holland	2,510
Ludlow	21,331
Monson	8,803
Palmer	12,237
Wales	2,009
Wilbraham	14,553
Hampshire County	20% of the service area
Belchertown	14,906
Ware	9,863
Worcester County	22% of the service area
Barre	5,491
Brookfield	3,406
Hardwick	3,024
New Braintree	1,247
North Brookfield	4,760
Warren	5,199
West Brookfield	3,777
Total Service Area	122,033

Source: Population Division, U.S. Census Bureau

Table 2. Sociodemographic Characteristics of selected towns in the Baystate Wing Service Area

Sociodemographic Characteristics	Baystate Wing Service Area	Ware	Palmer	Massachusetts
Age				
Median age (years)	44.9	41.7	43.1	39.4
>18 years	20%	20%	18%	20%
18-64	62%	62%	64%	64%
65 and over	17%	17%	18%	16%
Race and Ethnicity				
Latino or Hispanic	4%	6%	4%	11.2%
Non-Latino or Hispanic				
White	92%	96%	95%	73%
Black or African American	1%	1%	2%	7%
American Indian and Alaska Native	0%	0.1%	0%	0.1%
Asian	1%	0.5%	0.3%	6%
Native Hawaiian and Other Pacific Islander	0%	0%	0%	0%
Some other race	0.1%	0.1%	0.3%	0.7%
Two or more races	2%	3%	3%	2%
Language Spoken at Home (population over 5)				
Speaks language other than English at home	4%	5%	4%	24%
Educational Attainment (population 25 years and over)				
Less than high school graduate	9%	8%	8%	9%
High school graduate (includes equivalency)	32%	43%	34%	24%
Some college or associate's degree	28%	27%	33%	23%
Bachelor's degree or higher	19%	22%	27%	43%
Income				
Median household income	\$73,092	\$50,016	\$57,022	\$74,167

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

IV. Prioritized Health Needs of the Community

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

1. Social and Economic Determinants that Impact Health

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

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

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

A. SOCIAL ENVIRONMENT

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

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

- emotional implications of having a disability
- 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

“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 felt supported by frequenting Senior Centers; and parents of children with disabilities who found connections with other parents and who also helped them find resources. Public health leaders strongly advised health practitioners to practice cultural humility and knowledgeable about different communities in order to be better health care practitioners.

Experiences of interpersonal racism, discrimination and other forms of exclusion can serve to socially isolate people, and have consequences for mental and physical health.^{7,8} Participants in focus groups and key informant interviews shared their experiences:

- lack of sensitivity of transgender issues socially isolates transgender people who don't pass as the gender they identify as
- people with substance abuse and mental health disorders face discrimination in the medical system
- rural populations feel that their priorities get “kicked down the road”
- youth of color report being stereotyped by peers, teachers, and mention that “doctors shame and threaten parents that they should take better care of their kids.” One young woman said, “A guy told me I was unattractive because I was black. It took a toll on me.”
- children with disabilities face a high rate of bullying in schools

Policies and practices of systems of government, cultural norms, and institutional discrimination impact people's health every day. The 2016 CHNA identified institutional racism as a driver of health inequities. In the 2019 CHNA, **institutional and systemic racism** continue as major sources of health inequities.

Institutional racism is racial inequities, created by policies and practices of an institution, in access to goods, services, and opportunities such as quality education, housing, employment opportunities, medical care and facilities, and a healthy physical environment.⁹ **Systemic or structural racism** extends beyond one institution. Policies and practices of systems and institutions that result in racial inequities and other forms of discrimination become the norm, are often codified by law or policy, and can manifest as inherited disadvantage. These practices do not necessarily transpire at the individual level, but are embedded in our systems, regulations, and laws. Institutional racism is perpetuated by bureaucratic barriers and inaction in the face of need.⁹ 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.¹⁰ The policies and practices of systems and institutions are directly influenced by who has power and how they use it. Racially-motivated and other forms of discrimination, whether conscious or built into the practices of systems, can lead to adverse health outcomes such as poor mental health, chronic stress, hypertension, and cardiovascular disease.^{11, 12, 13, 14, 15}

While the black, Latino, and Asian populations are a small proportion of the Wing service area, it is important to recognize the disproportionate burden people of color face with regard to the social determinants of health. We heard about examples of institutionalized discrimination from focus groups and interviews in many Coalition CHNA service areas. These included unequal discipline for black children compared to children of other races in public schools, police response to gun violence, and health care administrative practices that marginalize transgender people.

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.¹⁶ The University of Michigan's Center for Population Studies in 2013 ranked the Springfield Metropolitan Statistical Area (MSA) as the most segregated in the U.S. for Latinos, and 22nd in the country for blacks.¹⁷ The Springfield MSA includes Hampden, Hampshire, and Franklin counties. The MSA consists of the urban centers of Springfield, Chicopee and Holyoke (in Hampden County), cities that are the area's historic population centers. The MSA also includes the smaller towns in more rural Hampshire and Franklin Counties. Across the MSA, racial residential segregation manifests in racial segregation in neighborhoods in the urban core, and also shows up in the many surrounding smaller communities, which are majority white.

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. Admissions in the Hampden, Hampshire, and Worcester County Houses of Correction were highly disproportionate by race, with blacks and Latinos jailed between three and almost eight times the rate of whites.¹⁸ The incarceration of

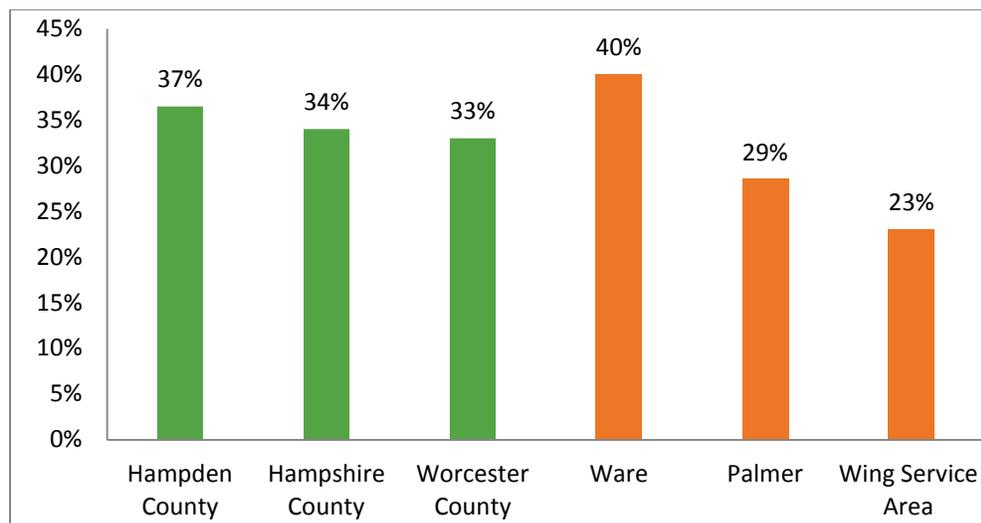
women in jails is on the rise, for example with Hampden County jail incarcerating 40% more women between 2011 and 2015.¹⁹

B. HOUSING NEEDS

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

Housing insecurity continues to impact Baystate Wing service area residents. Over a third of the population in Hampden, Hampshire, and Worcester Counties is housing cost burdened (U.S. Census Bureau, ACS, 2013-2017) (Figure 6). In Ware, over 40% of the population is housing cost burdened. 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. Homelessness and housing instability 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, Hampshire & Worcester Counties and Select Communities in Baystate Wing Service Area



Source: U.S. Census Bureau, ACS, 2013-2017

A more complete picture of affordability adds the cost of transportation. For a typical household income, people in Palmer spend 55% of their income on housing and transportation costs combined. However, those with a lower household income in Palmer spend 66% of their income on housing plus transportation.²⁰ In Ware, lower-income residents spend 59% of their income on combined housing and transportation costs. 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 Massachusetts, of which 80% were in Hampden County. An estimated 20% were chronically homeless. When someone is chronically homeless, providing housing combined with social and health services is necessary. Many people experiencing homelessness housing, social and health services, and an expedited pathway to these services. Approximately 55% of the homeless population are 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.²¹ Key recommendations from focus groups and interviews to prevent homelessness are to:

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

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 are 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. Palmer has older housing stock with 35% of housing built before 1940; Ware has 33% of its housing stock built before 1940. Less than 1% of housing stock in Ware or Palmer is new, built after

2014. In the Wing service area, the median year when residential structures were built is 1968 (U.S. Census Bureau, ACS, 2013-2017).

“It is very hard to find safe, affordable housing.....I worry that the housing is old and not safe, there’s a risk of fires and other hazards.... factory housing has not been renovated enough or recently enough.”

Young Adult Focus Group Participant, Palmer Public Library

C. LACK OF ACCESS TO TRANSPORTATION, HEALTHY FOOD, AND PLACES TO BE ACTIVE

In the MDPH social determinants of health framework, transportation, healthy food access, and places for physical activity are categorized as the “built environment.” There is a vast research base demonstrating that decisions about how the world around us is constructed can impact health behaviors, i.e. our “built environment.” Transportation systems and choices, access to food, community spaces, retail, and institutions all serve to help or harm.

As in the 2016 CHNA, **transportation** continues to be a prioritized need, with nearly every focus group and set of key informants mentioning transportation as a need. It is seen as a significant barrier to care in 2019 and continues to be a major obstacle to good health (see Barriers section for more detail on Transportation as a barrier to quality health care). Reliable transportation is a critical part of daily life, allowing individuals to go to work, travel to the grocery store, or get to medical appointments. In a rural area such as the Baystate Wing service area, transportation is a significant challenge. Nearly 6% of all households in the Baystate Wing service area report not having any access to a vehicle (U.S. Census Bureau, ACS, 2013-2017).

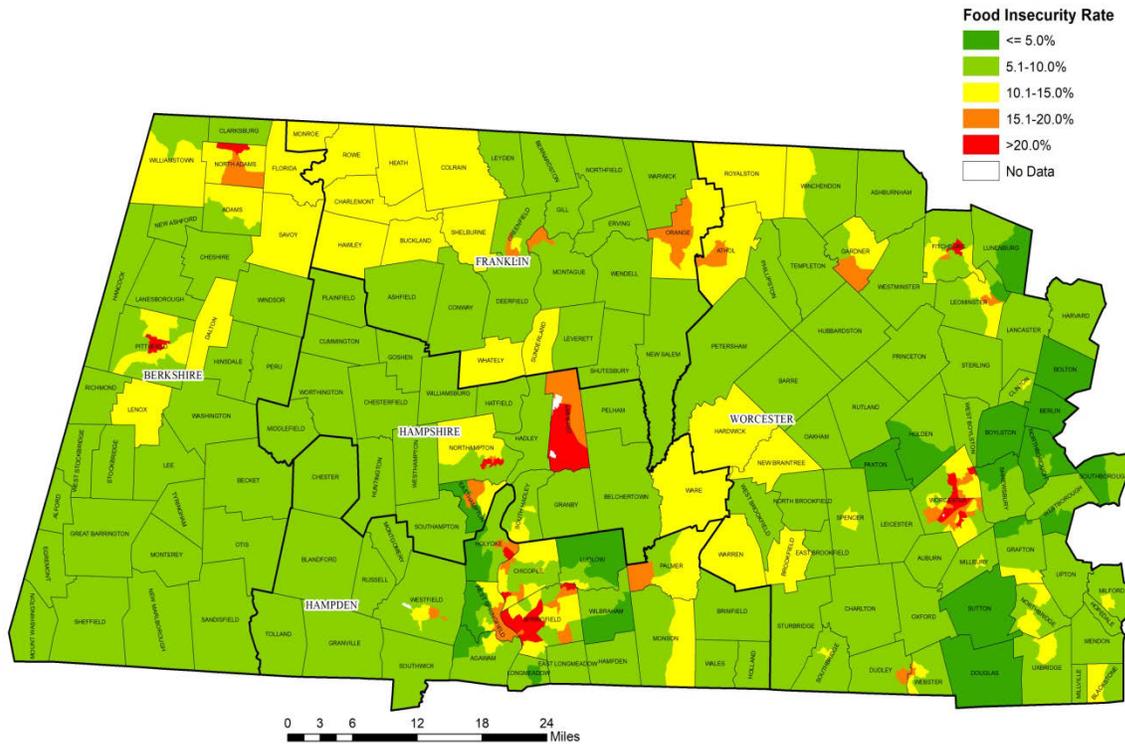
Unequal access to appropriate transportation options exacerbates racial and ethnic health disparities. Communities of color and those with lower incomes have less access to transportation options compared to majority white and higher income communities.^{22,23} Public transportation plays a significant role in filling transportation needs for many of these households. The Pioneer Valley Transit Authority (PVRTA), which operates buses across Pioneer Valley, reports that the majority of PVRTA 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.²⁴

“I’m still relying on parents and friends for car rides.... and I walk where and when I can, it helps that I live near the center of town.....when feasible, I share a car with friends, but some of my friends are just too scared to drive.”

Young Adult Focus Group Participant, Palmer Public Library

Food Access - food insecurity, or not having reliable access to sufficient affordable and nutritious food, continues to be a prioritized health need impacting many Baystate Wing Service area residents in 2019. 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. In portions of Palmer, Ware, Monson, and Brimfield between 10% to over 15% of households are at risk for food insecurity (Figure 7).

Figure 7. Percent Food Insecure Berkshire, Hampden, Hampshire, Franklin & Worcester Counties



Data Source: Food Insecurity Rates from Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County 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 Massachusetts.

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 areas 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.²⁵ In addition, marketing of fast food, junk food, sugary drinks, tobacco, and alcohol more often targets communities of color.²⁶ 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, most of Palmer and a small part of Ware are areas that the USDA has identified as food deserts (Figure 8).

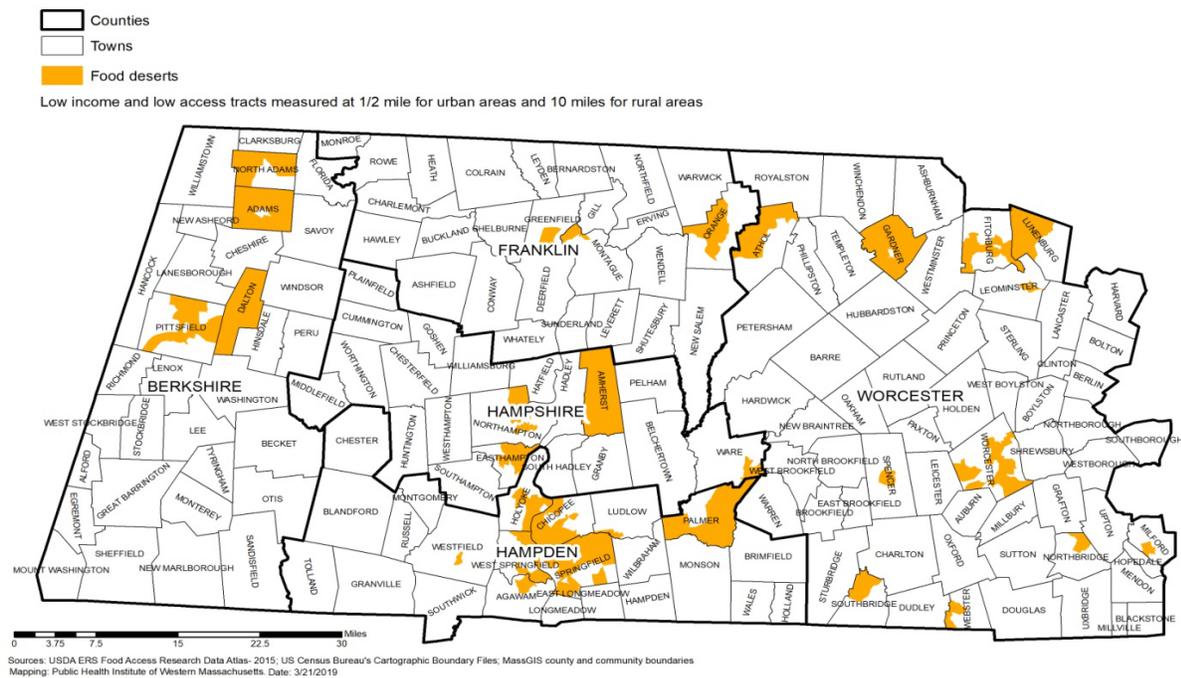
“Junk food is cheaper and easier than healthy food....it’s hard to walk back and forth to the grocery store with heavy bags and kids”

Young Adult Focus Group Participant, Ware Adult Literacy Program

“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.”

Key Informant Interview, Baystate Wing Service Area

Figure 8. USDA Food Atlas Food Desert Areas in Hampden, Hampshire, Franklin & Worcester County



Source: USDA ERS Food Access Research Atlas – 2015; U.S. 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. The 2015 Bikeability Assessment conducted by the Pioneer Valley Planning Commission (PVPC) for the Palmer “Mass in Motion” program noted that many of Palmer’s main streets and thoroughfares are very difficult to navigate on a bicycle and that walking poses risks on street where pedestrian walkways are not clearly marked. The “Mass in Motion” assessment recommended that the town conduct a parking utilization study, remove unnecessary parking spaces to reallocate roadway space for bicycle/pedestrian accommodations, consider narrowing space for parking, and add bike lanes where appropriate.²⁷

D. LACK OF RESOURCES TO MEET BASIC NEEDS

Many residents in the Baystate Wing service area struggle with a lack of resources to meet basic needs. The connection of poor health with poverty, low levels of income, and access to fewer resources is well established. People who have 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. People of color have higher rates of poverty and lower levels of income than whites.

The median household income of \$73,092 in the Baystate Wing service area is below the statewide median income. Unemployment for the Baystate Wing service area is similar to that of the state – about 6%. The unemployment rate from the U.S. Census Bureau for blacks is listed at only about 1%, which is a lower rate of unemployment than the service area level. However the poverty rate among black residents is quite a bit higher – about 20% compared to about 8% for the service area as a whole. It is possible that the black unemployment rate is skewed due to low numbers of blacks in the region. The number should be interpreted with caution based on trends across the region, which consistently show higher levels of unemployment among blacks and Latinos. Latino unemployment in the Baystate Wing service area is 33% higher than the white population in the Baystate Wing service area (Table 3).

Table 3. Socioeconomic Status Indicators

	Baystate Wing Service Area				Massachusetts*
	Overall	White**	Black**	Latino	
Median Household Income	\$73,092	\$73,823	\$63,478	\$57,259	\$77,385
Unemployment	5.8%	5.6%	0.9%	9.3%	6%
Poverty	7.5%	6.9%	19.6%	14.5%	10.5%

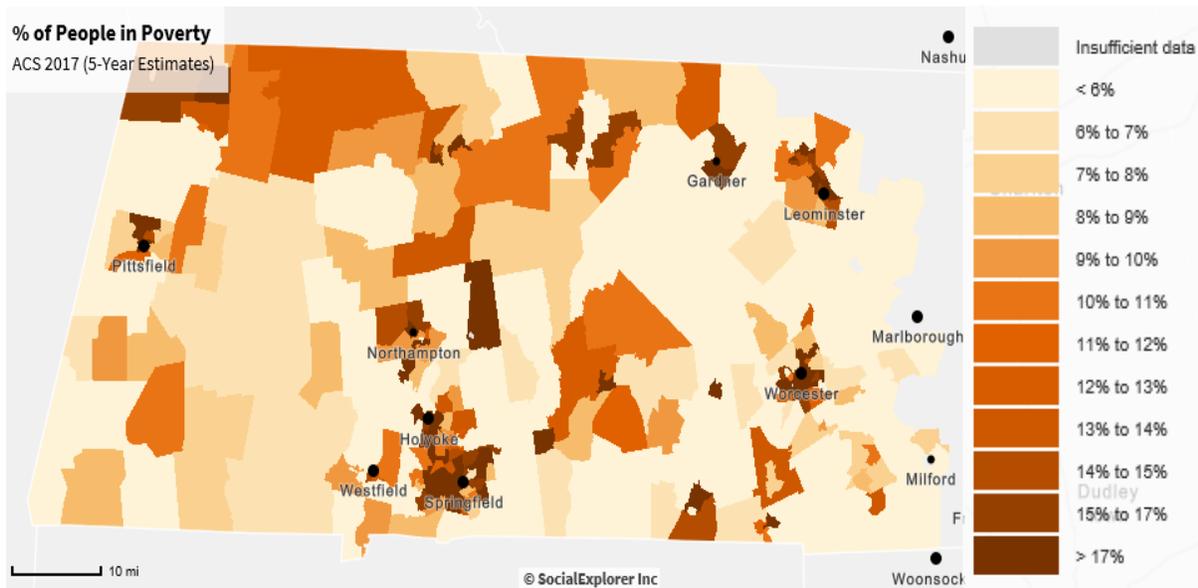
Sources: U.S. Census Bureau, ACS 2013-2017; poverty is 100% below federal poverty level; no high school diploma among adults age 25 and older

*U.S. Census Bureau, 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

While 8% of the overall service area residents live in poverty, there are marked differences for people of color. Blacks have almost 20% poverty rate and Latinos almost 15% (Table 3). An estimated 20% of the service area 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 does not capture all of those who are economically struggling (U.S. Census Bureau, ACS, 2013-2017). Higher pockets of poverty tend to cluster in the urban areas of Springfield, Holyoke, and Worcester, but there are pockets of high poverty in the Wing service area, generally represented between Springfield and Worcester on the map below (Figure 9). Across all of the 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.

Figure 9: Service Area Poverty Rates



Hiring and workplace discrimination affect people of color more frequently than white people.²⁸ 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,²⁹ of which an inequitable proportion are people of color due to discriminatory policies and practices.³⁰

“Health issues unique to people of color? It’s harder to get hired.”

Focus Group Participant, Youth Of Color Focus Group, Franklin County

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.^{31,32,33} Number of hours worked and predictability of scheduling are other employer practices that have a large health effect.³⁴

Women, children and populations of color are disproportionately affected by poor socioeconomic status. Women in Hampden County earn 83 cents compared to every \$1.00 earned by men. Women of color earn even lower proportions with Latinas earning 57 cents and black women 71 cents to white men’s \$1.00.³⁵ Almost 42% of children in Palmer and 51% of children living in Ware qualify for free or reduced lunch.³⁶ With regard to race and ethnicity, median income levels are lower and poverty rates are higher among Latinos and blacks in the Baystate Wing service area. (U.S. Census Bureau, ACS, 2013-2017). Hiring and workplace discrimination affects people of color more frequently than whites.

Educational attainment contributes to 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.³⁷ Education levels in the Baystate Wing service area are lower than Massachusetts' levels. Where 37% of Massachusetts residents have college degrees, within the Quaboag Hills region the average is 27% (U.S. Census Bureau, ACS, 2013-2017).

"I was trying to go to work and school, but I just couldn't focus on both at the same time and did not get what I needed out of either work or school."

Young Adult Focus Group Participant, Palmer Public Library

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.³⁸ Segregation of lower income students of color into underfunded schools continues today.³⁹ In addition, differentially applied school discipline policies negatively affect students of color and disabled students, resulting in higher dropout rates and more involvement in the criminal justice system.⁴⁰

Suggestions for how schools could help included:

- training teachers and staff to be trauma-informed and have cultural humility
- including Social Emotional Learning⁴¹ 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. NEED FOR FINANCIAL HEALTH

Financial health is a measure of how one's financial and economic resources are able to support their physical, mental, and social well-being.⁴² Financial resources that impact health include: amount of savings, money set aside for retirement, and proportion of income spent on daily living, among others. Financial health describes how well a person's finances support their ability to be healthy every day and in the future. In 2019, Baystate Wing has included financial health as a prioritized community health need.

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

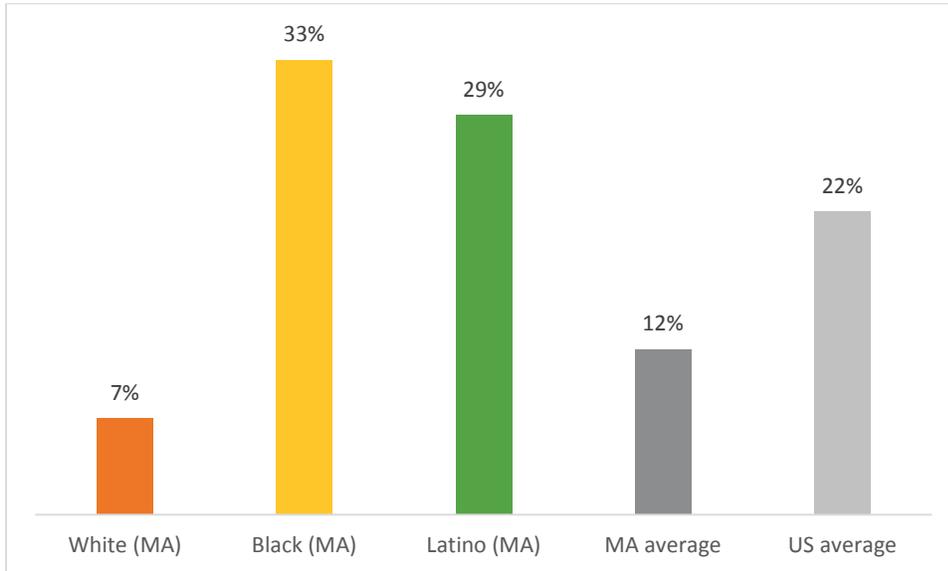
Savings - saving money can help with financial security and can provide a safety net in case of an emergency. In 2016, the median amount of savings in the United States was \$7,000. The median is often used to describe savings because it is a more accurate approximation of what most Americans have saved since the average (mean) is heavily skewed by high-income outliers. Women have a much lower median savings of \$2,500 compared to \$9,200 for men. In addition, blacks and Latinos have an average savings account balance of \$1,500, which is substantially lower than that of whites (\$9,700).⁴³

Homeownership - for many, the primary way to build wealth is through homeownership. Homeownership can be a path to wealth and has the potential to be more stable than renting.⁴⁴ In the Baystate Wing service area overall, 80% of people own their homes and 20% rent (U.S. Census Bureau, ACS, 2013-2017). Historically, redlining lending practices, racial discrimination related to mortgage acquisition in the GI bill, and higher incidence of predatory lending in communities of color have denied black and Latino communities the ability to create stability and generational wealth via home ownership.^{45,46} Reflecting inequitable policies and practices, only 39% of the black population and 23% of the Latino population of Hampden County owns their home. Reflecting inequitable policies and practices, in the Wing service area 80% of whites are home owners; 59% of blacks are homeowners; and 40% of Latinos are home owners (U.S. Census Bureau, ACS, 2013-2017).

Financial literacy - having the skills and knowledge to manage personal finances so that a person can fulfill their goals.⁴⁷ It includes the knowledge to understand financial choices and the ability to make informed judgments and take effective actions, such as planning for the future, spending wisely, saving for retirement, paying for a child's education, and managing challenges associated with life events like a job loss. For example, individuals need to understand how to balance a checkbook, comprehend personal income taxes, and understand the concept of budgeting in order to make wise decisions with money.⁴⁸

The National Center for Education Statistics measures financial literacy. The Program for International Student Assessment (PISA) rates students on a scale, with the top level (level 5) defined as students understanding a wide range of financial concepts. Lower levels of financial literacy show some baseline level of understanding of the difference between needs and wants and being able to make decisions on everyday spending. Students at lower levels can apply basic numerical operations (addition, subtraction, or multiplication) but not create percentages, use budgets, or make longer term financial decisions taking into account the impact on their financial health.⁴⁹ There is no local data available in Hampden County, but in Massachusetts, 12% of students nearing the end of the mandatory schooling (generally about 15 years old) scored at the lowest level of financial literacy. By race and ethnicity, however, only 7% of whites in Massachusetts scored that low, while almost one-third of blacks and over one-fourth of Latinos did (Figure 10).

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



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

F. 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.⁵⁰

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 Massachusetts 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 Massachusetts, and only 57% were reported to the police. Of western Massachusetts PSCRs, 55% (or 218) were in Hampden County and 18% (70) were in Hampshire County. Females comprised 94% of victims/survivors, and one-third were youth under age 18.⁵¹
- **Dating violence** - in the 2017 Quaboag Hills Prevention Needs Assessment Survey (PNAS) 17% of middle and high school students said they had a friend who had been abused by a dating partner; 9% had had been forced to engage in sexual activity when they did not want to.⁵²

- **Domestic and sexual violence** - domestic violence advocates in the Baystate Wing service area serve approximately 580 survivors of domestic and sexual violence and their children per year. At 21%, Ware's per capita restraining order rate is twice that of the other six towns served by the Eastern Hampshire District Court (Hadley, Belchertown, Granby, Amherst, Pelham, and South Hadley). This rate has remained steady for 18 years of collaborative community work by the members of the Ware River Valley Domestic Violence Task Force.⁵³ The physical and mental health impact of domestic and sexual violence costs the healthcare system more than \$8.3 billion per year.⁵⁴ Because of low vehicle ownership rate, lack of public transportation, and limited social services, survivors of domestic violence in Ware turn to one of the few tools available to them: advocacy services and restraining orders.

"This is one of the only public health issues where there is an active agent—the abuser—whose focus is to ensure that the survivor patients do not disclose and do not get help. People who perpetrate domestic and sexual violence overestimate the degree to which others agree with their violent and abusive value system, so when health systems make public and explicit declarations that domestic and sexual violence are priority health concerns, they help disempower the perpetrator."

Key Informant Interviewee, Domestic Violence Advocate, Baystate Wing Service Area

- **Child abuse and neglect** - Massachusetts Department of Children and Families (DCF) reports that in the last quarter of 2018 in western Massachusetts, over 3,000 reports of child abuse or neglect were filed and screened in for investigation, and 42% of them were deemed true and in need of services.⁵⁵
- **Elder abuse and neglect** - nationally, 1 in 10 older adults report some type of financial, emotional, physical, or sexual mistreatment or potential neglect in the prior year.⁵⁶ The Massachusetts Executive Office of Elder Affairs reported 9,800 confirmed abuse and neglect cases in 2017, nearly 40% more than in 2015.⁵⁷ In the Springfield Area Service Access Point, there were 2,438 intakes completed in 2018, up from 1,401 in 2014. In the Florence Area Service Access Point, there were 770 intakes in 2018, up from 526 in 2014.⁵⁸
- **Bullying** - more than 1 out of every 5 students nationally reports being bullied, with girls, children with disabilities, and GLBQ+ and transgender students at increased risk. Considering data from Berkshire, Hampden, and Hampshire counties and Springfield, more than one-quarter of female students report being bullied, which is 1.4 to 1.7 times higher than male students.⁵⁹ Findings from the 2017 Quaboag Hills Prevention Needs Assessment Survey indicate that 34% of 8th grade students were bullied in the past year.⁶⁰ 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. The study also found that youth in special education were told not to tattle almost twice as often as youth not in special education.⁶¹

2. Barriers to Accessing Quality Health Care

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

- insurance and health care related challenges
- limited availability of providers
- need for increased cultural humility
- need for transportation
- lack of care coordination
- health literacy and language barriers

A. INSURANCE AND HEALTH CARE RELATED CHALLENGES

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

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

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

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

- 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

“How do we get coverage when we are not on our parents’ plans..... I know many young people my age who get and keep a job they hate just to be eligible to get health insurance.”

Young Adult Focus Group Participant, Palmer Public Library

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

“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.”

Key Informant Interview, Ware, Hampshire County

B. LIMITED AVAILABILITY OF PROVIDERS

Baystate Wing service area 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; 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. In general, the Baystate Wing service area has fewer providers when compared to the state; in Table 4, red font identifies the areas where the number of people per 1 provider are lower than the state rate.

Table 4. Population to Provider Ratios, Hampden, Hampshire, and Worcester Counties

	Population to Primary Care Providers	Population to Dentists	Population to Mental Health Providers
Hampden County	1400:1	1210:1	120:1
Hampshire County	730:1	1410:1	120:1
Worcester County	1000:1	1370:1	220:1
Massachusetts	990:1	990:1	180:1

Source: County Health Rankings, 2019

Although there is greater access to mental health providers for Hampden and Hampshire County residents as compared to the state, focus group participants and key informant interviewees overwhelmingly reported a need for:

- increased access to mental health and addiction services, with specific mentions of need for Medication Assisted Treatment (MAT) and psychiatrists who can prescribe medication
- neuropsychologists and psychiatrists for children with disabilities
- a variety of other specialists including Ear, Nose, and Throat providers, rheumatologists, and oral surgeons

Focus groups and key informant interviews for the western Massachusetts region also identified a lack of dental care providers, of psychiatrists who can prescribe medication for mental illness, and of specialists serving people with disabilities, and in particular these types of specialty providers who accept MassHealth. A 2014 MDPH survey found that less than half of dentists accept patients on MassHealth. The Massachusetts Office of Rural Health tracks health in six clusters of rural towns across the state, including the Hilltowns. Less than 2% of the state’s dentists practice in these rural areas, and they tend to be older (and closer to retirement) than dentists who practice in urban or suburban areas. Sixty-one percent of dentists in the rural clusters are age 55 or older, compared to 39% of dentists statewide.⁶²

“I don’t go to my primary health care.... I just use 911 or go to the emergency room when I have a problem....we’re young, so I don’t think we need doctors that much.”

Young Adult Focus Group Participant, Ware Adult Literacy Project

“We have a lot of therapists, but not enough psych prescribers.”

Key Informant Interviewee, Public Health Official, Franklin County

C. NEED FOR CULTURAL HUMILITY

The need for cultural humility among healthcare and social service providers remains a prioritized health need, as it was in the 2016 CHNA. Training in cultural humility is one strategy to deliver more culturally sensitive care. Cultural humility refers to a commitment among health care and social service providers to self-reflection and evaluation in order to reduce the power imbalance between patients and providers, and to the development of care partnerships that are based on mutual respect and equality.⁶³

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

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

Focus group participants noted that cultural humility is not limited to a racial or ethnic culture, but also includes care for stigmatized groups, such as ex-offenders, homeless individuals, and 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

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

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

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

“Young people in Quaboag Hills can use the Quaboag Connector van service, 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..... 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.”

Key Informant Interview, Ware, Hampshire County

“Because the Quaboag Hills is in the middle of a few counties, and people rarely know which county it is part of, few counties provide services for people who live in this area.”

Key Informant Interview, Ware, Hampshire County

E. LACK OF CARE COORDINATION

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

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

- lack of follow up when a person is discharged from a mental health treatment program, substance use disorder program, or jail
- lack of coordination among agencies that provide support services for transgender clients
- lack of coordination between the emergency department and primary care
- need for survivor planning for people after cancer as they separate from the health care industry

- need to integrate mental health and substance use disorder services with primary care
- need for transitions, communication, and “warm handoffs” from jail to the community for a population that has a high rate of trauma and more needs

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

Regional Advisory Committee member

F. HEALTH LITERACY AND LANGUAGE BARRIERS

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

Health literacy is the capacity for an individual to find, “communicate, process, and understand basic health information and services to make appropriate health decisions.”⁶⁵ 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 (BHP) 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.

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. At Baystate Medical Center in Springfield, about 17% of inpatient and outpatient encounters required interpreter services; at Baystate Noble Hospital, 2.3% required interpretation services, and at Baystate Franklin Medical Center, less than 2% did.^{66,67,68} The data was unavailable for Baystate Wing.

The issue is relevant both in the doctor’s office and in the community. Patients need to understand what their providers tell them about their health, be able to give informed consent and manage medications and home care appropriately. That said, on average, Americans spend one hour a year in the doctor’s

office or a hospital, and they access the majority of health information in their homes and communities.⁶⁹ Health care providers and community organizations should be mindful that while the vast majority of the area’s adult population has a high school degree and more than half have studied in college, some patients will not have had that level of education. Seven percent of Franklin County residents are not high school graduates and 2% have less than a 9th grade education.

In the Baystate Wing service area, about 8% of the population speaks a language other than English at home and 3% speak English “less than very well.” 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. Baystate Medical Center held a Community Conversation in Spanish in Springfield. Participants noted a need for bilingual providers, translators, interpreters, and health materials translated in a wider range of languages. The refugee and immigrant populations in Hampden County make for an increasingly diverse linguistic population.

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 Baystate Medical Center. Based on our analysis, the priority health conditions and behaviors are the following:

- Mental health and substance use - use of alcohol, tobacco (especially during pregnancy), marijuana, and opioids
- Chronic health conditions - obesity, heart disease, hypertension, diabetes, asthma, cancer, and the need for increased physical activity and healthy diet
- Infant and perinatal health - utilization of prenatal care, smoking during pregnancy, low birth weight, and preterm birth
- Alzheimer’s disease and dementia

A. MENTAL HEALTH AND SUBSTANCE USE

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

- more treatment options, including Medication Assisted Treatment (MAT), long term care options, treatment beds external to the criminal justice system, and treatment for people with dual diagnoses
- increased education across all sectors to reduce the stigma associated with mental health and substance 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

“There is still a huge amount of stigma with seeking help for mental health needs; PTSD and trauma are not recognized and talked about as much as they should be.”

Young Adult Focus Group Participant, Palmer Public Library

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.”⁷⁰ Only an estimated 17% of U.S adults are “in a state of optimal mental health.”⁷¹ 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.⁷² Mental health is an indicator of health itself, but also contributes to physical health and inequities.

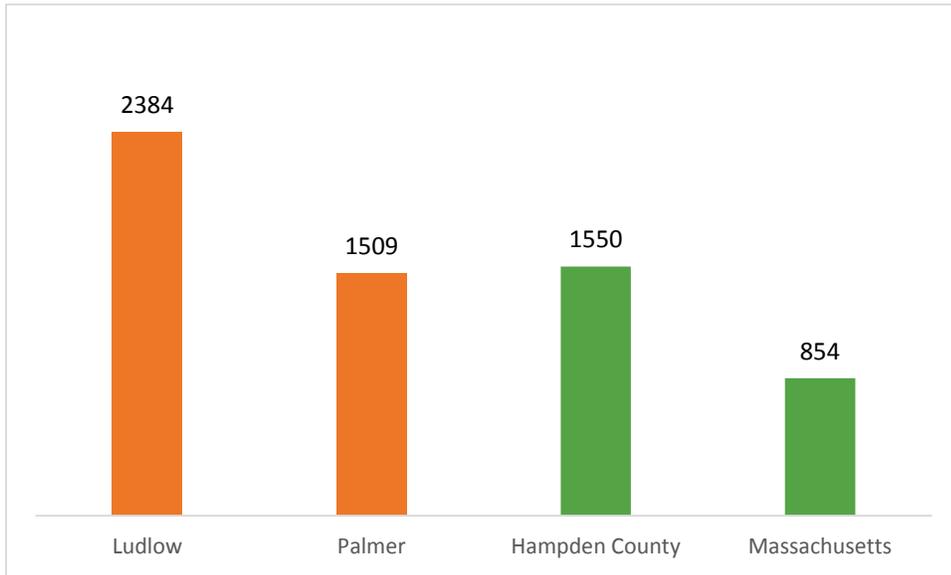
Palmer has more than double the rate of mental health hospitalizations (1,744 per 100,000) as the state-wide rate (854 per 100,000) (Figure 11). Ware has a rate 70% higher than the statewide rate for mental health hospitalizations. The towns of Ludlow (839 per 100,000) and Belchertown (747 per 100,000) are below the statewide rate. Mental health disorder hospitalization by race, with Latinos and blacks typically hospitalized at higher rates than whites (Figure 12). One caveat to note is that the Baystate Wing service area does not contain some of the larger cities that are included in a county-level estimate, so this finding should be interpreted with caution.

Depression is the most common type of mental illness, and it affects about 27% of adults.⁷³ Depression is the leading cause of disability worldwide.⁷⁴ Suicide has risen 27% from 2005 to 2015 in Massachusetts,⁷⁵ and the rate in Hampden County is higher than the Massachusetts rate (29 per 100,000 compared to 26).⁷⁶ 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.”

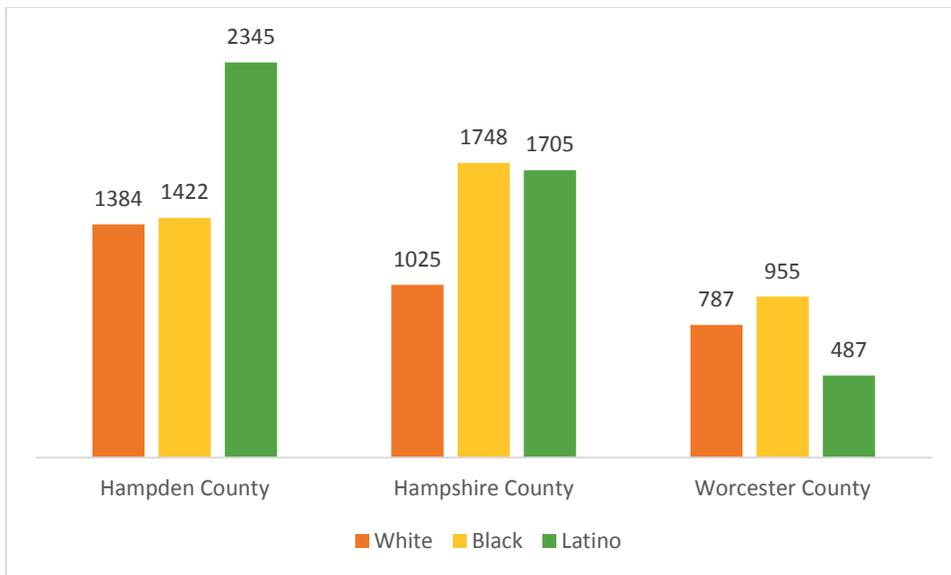
Key Informant Interviewee, Community Health Center Staff, Franklin County

Figure 11. Mental Health Disorder Hospitalization Rates for Select Communities



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

Figure 12. Mental Health Disorder Hospitalization Rates by Race and County



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

Priority Populations

- Youth data from the 2017 Quaboag Hills Prevention Needs Assessment Survey (PNAS) indicated that 34% of 8th, 10th, and 12th grade students said they “have felt depressed or sad MOST days, even if you felt okay sometimes in the past 12 months.” Almost 28% of students said that “sometimes I think that life is not worth it.”⁷⁷
- GLBQ+ and transgender youth are also disproportionately impacted. While no data specific to the Baystate Wing service area was available, given that area youth surveys all find a high risk for GLBQ+ and transgender youth, we conclude the same is true for Baystate Wing. We found that 61% of GLBQ+ and transgender 10th and 12th grade students responding to the 2017 Springfield Youth Risk Behavior Survey reporting feeling sad or hopeless two weeks or more, one in five report that they tried to commit suicide in the past year and 38% had engaged in self-harm.⁷⁸ In Franklin County in 2018, 72% of GLBQ+ and transgender youth had the risk factor “Depressive Symptoms”, compared to 41% of their heterosexual peers.⁷⁹ Nationally, teen suicide risk for GLBQ+ and transgender youth is higher than straight youth.⁸⁰
- Out of all Massachusetts communities statewide, nine of the ten communities with the highest rates of mental health-related hospital admissions among women were in western Massachusetts.
- About 30% of older adults experience depression in Ludlow, Belchertown, Palmer and Ware.⁸¹
- 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.⁸²

“There is too much of a separation in treatment between physical and mental health.”

Focus Group Participant, Patients Living with Disabilities, Hampden County

“Young adults don’t know where and how to find help for depression and anxiety; there are resources at the library, but we need more information on social media and online resources where young people typically look for information.”

Young Adult Focus Group Participant, Palmer Public Library

Substance Use

High rates of substance use continue to be a prioritized health need for the Baystate Wing service area.

- Several towns in the Baystate Wing service area have high rates of adult cigarette smoking including, East Brookfield (18%), Monson (17%), Palmer (22%), and Ware (27%).⁸³
- Palmer and Ware have significantly high rates of smoking during pregnancy; the Palmer rate is 191% higher than the statewide rate (20% vs. 7%) and the Ware rate is 251% higher than the statewide rate (27% vs. 7%) (MDPH, 2016).
- Ten percent of 8th graders in the Quaboag Hills reported drinking alcohol in the last 30 days. Thirty-one percent of 10th graders and 47 % of 12th graders reported using alcohol in the past 30 days.⁸⁴
- Eight percent of 8th graders, 26% of 10th graders, and 34% of 12th graders reported using marijuana in the past 30 days.⁸⁵
- Ten percent of 8th graders, 20% of 10th graders, and 28% of 12th graders in the Quaboag Hills reported using vaping/e-cigarette devices in the past 30 days. All of these local rates are higher than national levels as measured by the Monitoring the Future (MTF) study.⁸⁶
- In local and region-wide 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%.⁸⁷

"Virtually all of the young adults I work 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."

Key Informant Interviewee, Ware

"Most of us are dealing with trauma that leads to substance use....."

Young Adult Focus Group Participant, Ware Adult Literacy Center

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.

Palmer and Ware had higher rates of emergency department use for substance use disorders (377 and 401 per 100,000, respectively) compared to Hampden and Worcester County rates (266 and 307 per 100,000, respectively), and compared to Massachusetts (251) (Figure 13).

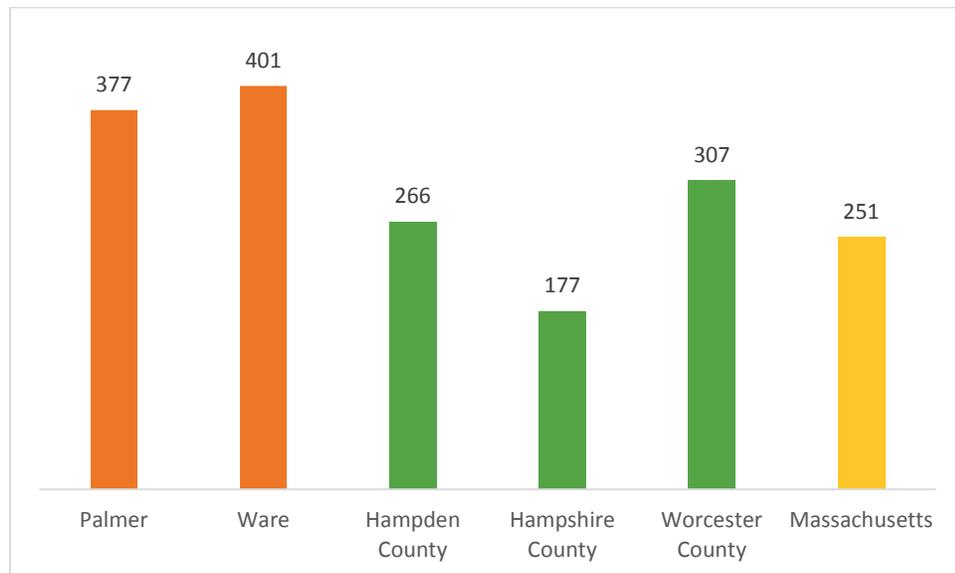
Data disaggregated by race/ethnicity was unavailable.

Among adults over age 65 in Massachusetts, 7% report having substance use disorders. The proportion in Ware is higher at 9%; Belchertown (6.7%) and Palmer (6.8%) are similar to the statewide rate.⁷¹

“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

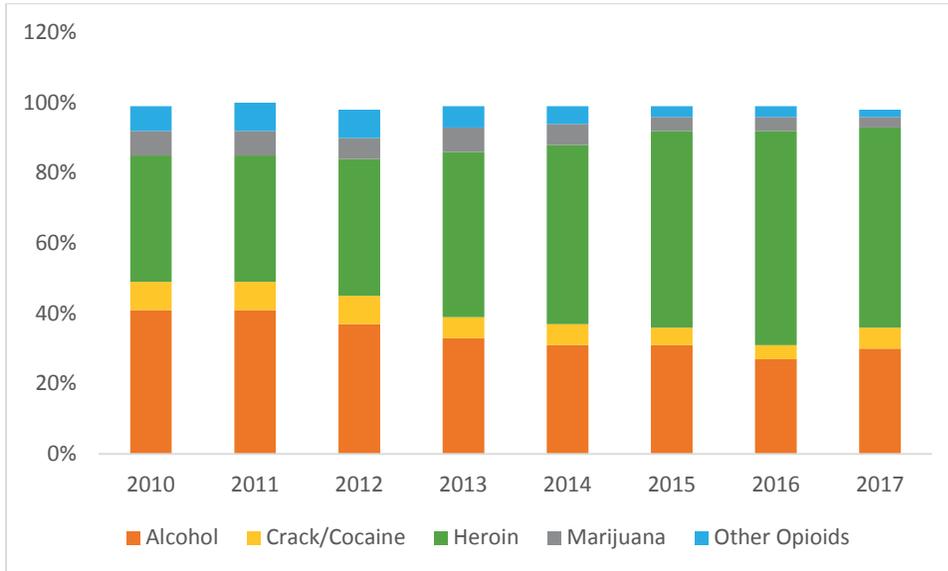
Substance use admissions to treatment programs have increased over time. From 2012 to 2017, total admissions in Hampden County have risen by 42%, in Hampshire County by 30%, and in Worcester County by 20%.⁸⁸ Heroin and alcohol are the primary drugs that drive admissions, with heroin increasing over time. Crack/cocaine, marijuana, and other opioids account for fewer than 10% each (Figure 14). While Figure 14 shows Hampden County, which comprises over 50% of Baystate Wing’s service area, Hampshire and Worcester counties have similar proportions.⁸⁹

Figure 13. Substance Use Disorder Emergency Department Visits for Select Communities and Counties



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

Figure 14. Substance Use Admissions to Treatment Programs in Hampden County by Primary Drug of Admission, 2010 – 2017



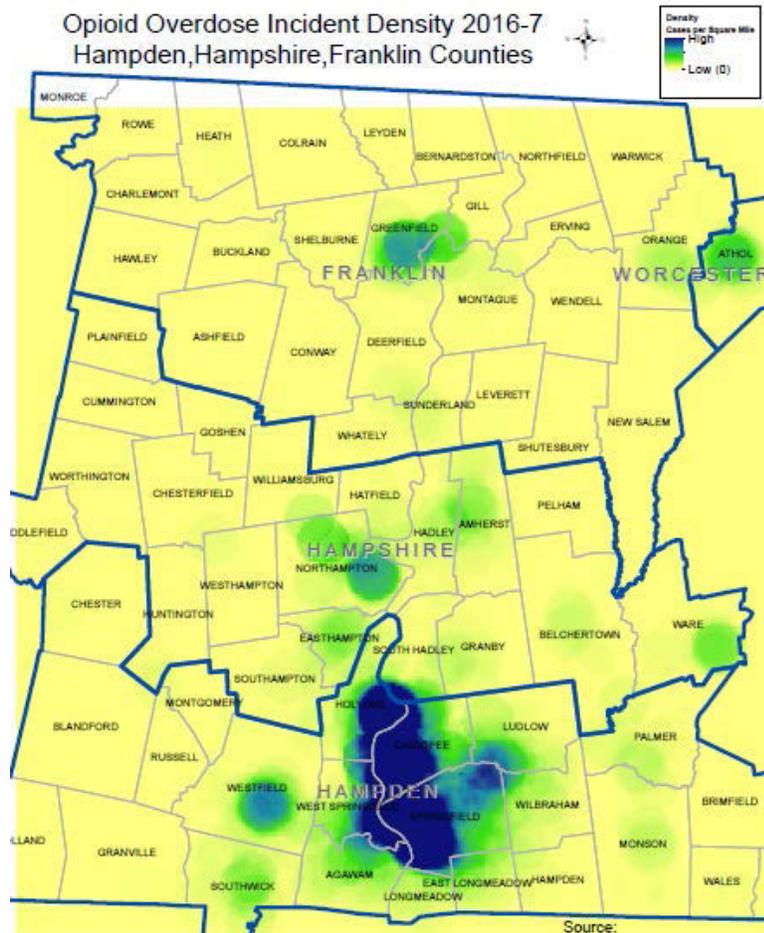
Source: MDPH. Bureau of Substance Addiction Services. 2018. Geographic Fact Sheets FY 2017, Admission Statistics by County

Opioid use disorder continues to be a public health crisis in Massachusetts and across the country. In Massachusetts, the number of opioid-related deaths in 2014 represents a 65% increase from 2012.⁹⁰ 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.⁹¹

- From 2016-2018 the town of Palmer had a non-fatal opioid overdose rate of 6.3 per 1,000 population and the town of Ware had a rate of 8.5 per 1,000 population.⁹²
- In the Baystate Wing service area, understaffed small town Emergency Medical Services (EMS) are regularly dealing with opioid overdose calls. From 2017-2018, the number of calls increased in the towns of Belchertown, Hardwick, Ludlow, Palmer, and Ware. From 2017-2018, Palmer saw a 36% increase in EMS calls for opioid-related incidences. In 2018, across Massachusetts, the greatest number of suspected opioid-related overdoses treated by EMS is among males aged 25-34, accounting for 25% of opioid-related overdose incidents with a known age and gender.⁹³
- Increased use of harm reduction approaches, such as Narcan, reduces morbidity and mortality of opioid overdose.⁹⁴ In addition, stakeholders called for increased access to long-term treatment programs; more provider and patient education to reduce stigma and as a means to get people the care they need; and more support for youth, particularly those with histories of trauma.

- Based on the Massachusetts Ambulance Trips Information System, the major hotspots of incidents of opioid overdose where ambulances responded are Springfield, Holyoke, and Chicopee. However, data also shows smaller hot spots in Ludlow, Ware, Palmer, and Belchertown (Figure 15).

Figure 15. Opioid Overdose Incidents Density, Hampden, Hampshire & Franklin Counties, 2016-2017



Source: Pioneer Valley Opioid Data Committee, 2019

Priority Populations

- Youth substance use and abuse can affect the social, emotional, and physical well-being of youth and lead to lifelong substance dependence problems. As described above, an estimated 10% of 8th graders drink alcohol and 8% use marijuana in the Baystate Wing service area.
- While data specific to the Baystate Wing area was unavailable, Latinos and blacks in other regions experienced substance use emergency department visit rates substantially higher than that of whites (MDPH, 2012-2015).
- Older adults in Belchertown (7%), Palmer (7%), and Ware (9%) have some form of substance use disorder.⁹⁵
- 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.⁹⁶
- 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

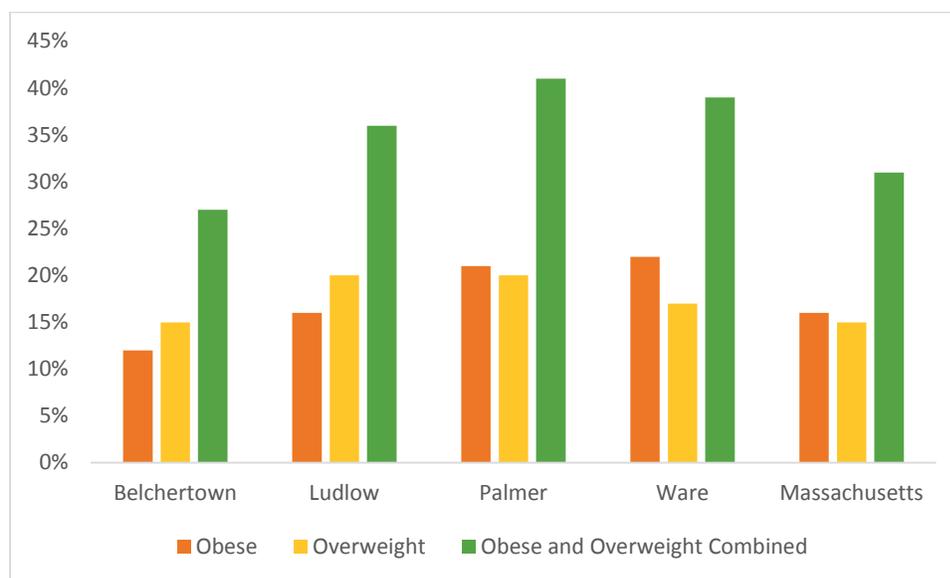
Chronic health conditions continue to remain an area of prioritized health need for Baystate Wing service area residents. Residents continue to experience high rates of chronic health conditions and associated morbidity, particularly for obesity, diabetes, cardiovascular disease, cancer and asthma. A chronic health condition is one that persists over time and typically can be controlled but not cured. According to the Center for Disease Control (CDC), chronic disease is the leading cause of death and disability in the U.S. By 2020 it is estimated that 81 million Americans will have multiple chronic conditions.⁹⁷ A healthy diet and physical activity play an important role in preventing and managing chronic diseases.

Obesity

In Hampshire County one out of every five adults are obese. In Worcester (27%) and Hampden (29%) counties, even higher proportions of the population are obese.⁹⁸ Obesity puts individuals at higher risk for chronic illnesses such as cancer, high blood pressure, heart disease, stroke, sleep apnea, and diabetes.⁹⁹ Obesity can impact overall feelings of wellness and mental health status. A healthy diet and physical activity play an important role in achieving and maintaining a healthy weight.

Though childhood obesity rates have been falling nationally and within some communities in the region over the last few years, it remains concerning. Children develop lifelong dietary and physical activity habits in their early years, and children who are obese are more likely to continue to be obese adults in addition to having adult risk factors that are more severe.¹⁰⁰ In the 2014 – 2015 school year, the proportion of children in Ludlow (16%), Palmer (21%), and Ware (22%) who were obese is similar to or higher than the state as a whole (16%). When combining the proportion of children who are overweight to those that are obese, a high proportion emerges – up to 41% of children in Palmer are either overweight or obese (Figure 16).¹⁰¹

Figure 16. Percentage of Childhood Obesity and Overweight in Select Communities



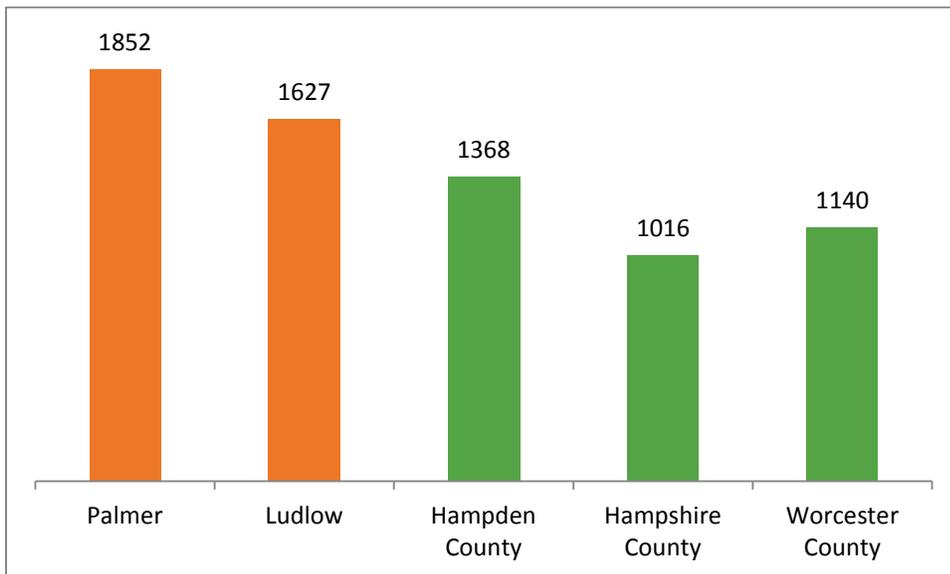
Source: MDPH, 2017. Results from the Body Mass Index Screening in Massachusetts Public School Districts, 2015

Cardiovascular Disease (CVD)

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

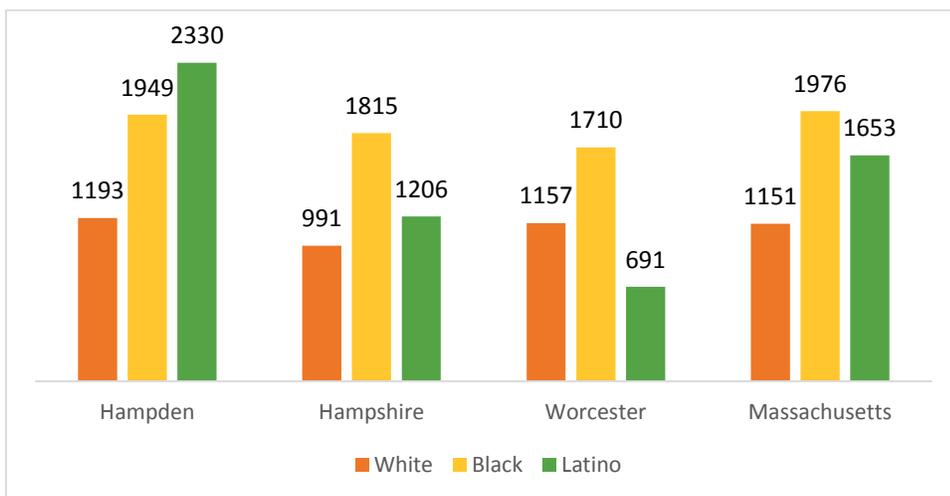
- Palmer and Ludlow have higher rates of cardiovascular disease hospitalization as compared to rates county-wide for all three counties in the Baystate Wing service area (Figure 17).
- Hypertension (high blood pressure) affects more than 3 out of 4 older adults in Ware (81%), Belchertown (76%), Palmer (81%), and Ludlow (79%) (Massachusetts – 76%). Ischemic heart disease affects more than 40% of older adults in Palmer and Ware.¹⁰²
- CVD hospitalization rates in Hampden County for the Latino population were almost double that of whites. The CVD hospitalization rate for blacks was 63% higher for blacks (Figure 18).

Figure 17. Cardiovascular Disease Hospitalization Rates Counties and Select Communities



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

Figure 18. Cardiovascular Disease Hospitalization Rates by Race and by County



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

Priority Populations

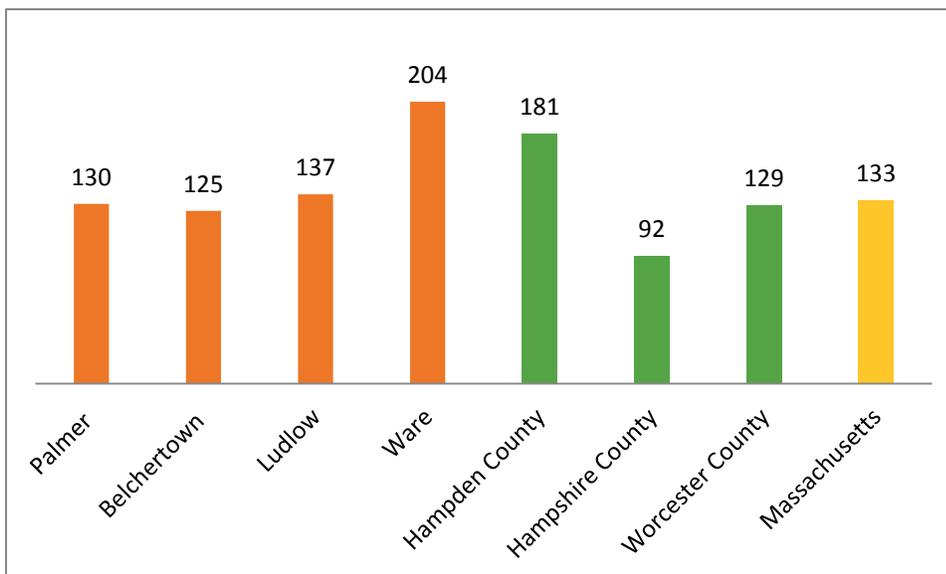
- Older adults – ischemic heart disease affects about 40% of older adults, with slightly higher proportions in Worcester, Holyoke, Ware, and Shrewsbury (between 48% and 44%). Hypertension affects over three-quarters of older adults.¹⁰³
- Latinos and blacks had heart disease hospitalization rates much higher than whites (Figure 18).

Diabetes

As in 2016, diabetes continues to be a prioritized health need in the Baystate Wing service area. The vast majority of people suffering from diabetes have 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.¹⁰⁴ Pre-diabetes is when a person has high blood sugar levels that are not high enough for a diagnosis of diabetes. An estimated 15-30% of people with pre-diabetes will develop Type 2 diabetes within five years.¹⁰⁵

Diabetes hospitalization rates are a measure of severe morbidity due to diabetes. Ludlow and Ware have higher diabetes hospitalization rates (137 and 204 per 100,000 population, respectively) than statewide rate of 133 per 100,000 (Figure 19). One-third of older adults are living with diabetes in Belchertown, Ludlow, Palmer, and Ware.¹⁰⁶

Figure 19. Diabetes Hospitalization Rates Counties, State and Select Communities

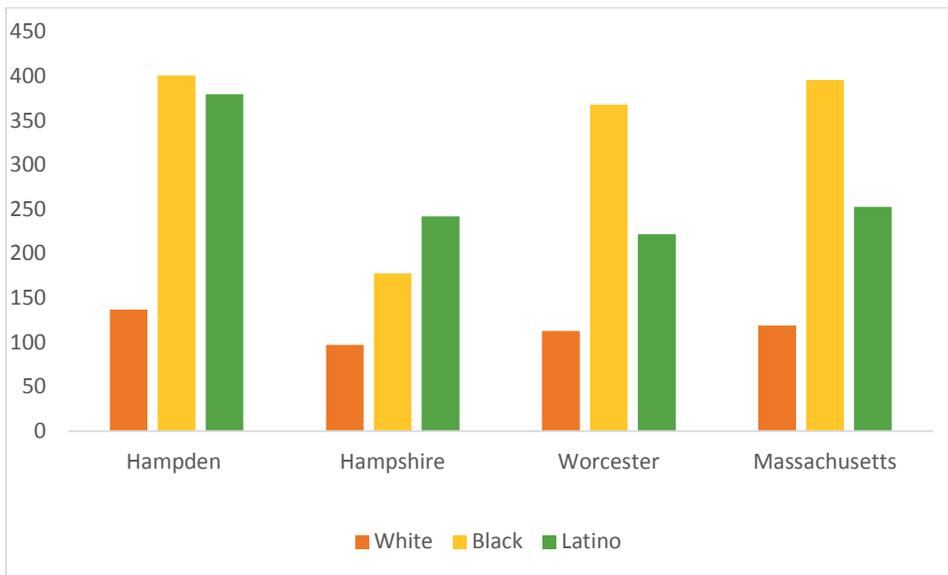


Source: MDPH, 2012 – 2015. Age-adjusted per 100,000

Priority Populations

- Older adults experience high rates of diabetes. Approximately one out of three older adults in select communities in Baystate Wing’s service area have diabetes.¹⁰⁷
- Latinos and blacks in Hampden County experienced about three times the rates of diabetes hospitalizations (380 and 401 per 100,000 people, respectively) compared to whites (137). Diabetes hospitalization rates are also higher for blacks and Latinos in Hampshire and Worcester counties (Figure 20).

Figure 20. Diabetes Hospitalization Rates by Race by County



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

Asthma

Asthma impacts many Baystate Wing service area residents. The Springfield Metropolitan District, which includes Hampden and Hampshire counties, 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.¹⁰⁸ 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.

Asthma affects the health and quality of life of children and adults. Asthma is the most common chronic disease in children, and is a driver of emergency room use for children.¹⁰⁹ Asthma also affects the

physical, social, and emotional lives of children.¹¹⁰ Between 9% and 16% of children in the Baystate Wing service area have asthma (Table 5).

Older adults in Hampshire County also have a need for asthma services. While across Massachusetts, 15% of those over age 65 have asthma, Belchertown (16%), Palmer (16%), and Ludlow (16%) have similar or slightly higher rates of asthma.¹¹¹

Table 5. Childhood and Older Adult Asthma Prevalence in Select Communities

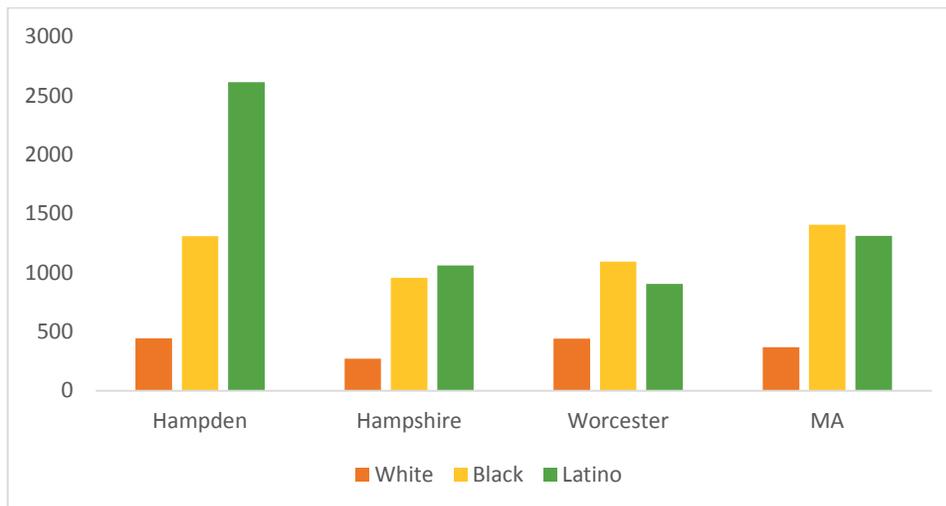
	Childhood	Adults > Age 65
Belchertown	9%	16%
Ludlow	12%	15%
Palmer	10%	16%
Ware	16%	13%
Hampshire County	14%	NA
Worcester County	12%	NA
Hampden County	15%	NA
Massachusetts	12%	15%

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

Priority Populations

- Children and older adults in Palmer and Ware are priority populations for asthma.
- Latinos and blacks across the Baystate Wing service area, but particularly in Hampden County experience large asthma-related disparities, had hospitalization rates six times that of whites in Hampden County and more than four times that of the state hospitalization rate overall (Figure 21).

Figure 21. Emergency Department Visit Rates by Race for Asthma by Race and County



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

Cancer

Cancer was the leading cause of death in Massachusetts and in Worcester County, and was the second leading cause of death in Hampden and Hampshire counties in 2016.¹¹² Advancing age is the most important risk factor for cancer, and the proportion of the population over age 60 in Hampden County is projected to increase from 20% in 2010 to 28% in 2035. In Hampshire County the proportion is projected to grow even more, from 19% to 32%.¹¹³ While cancer hospitalization rates for the towns of Belchertown, Ludlow, Palmer, and Ware are similar to or lower than the statewide rate of 338 per 100,000, rates for blacks and Latinos were nearly double the rate of whites in Hampden County (MDPH, 2012-2015).

Statewide, the most prevalent forms of cancer for men are prostate (23%), bronchus/lung (14%), colon/rectum (8%), and urinary/bladder (8%). For women, the most prevalent forms are breast (30%), bronchus/lung (14%), colon/rectum (8%), and uterine (7%). Cancer of the bronchus/lung accounted for approximately 27% of all cancer deaths from 2011-2015 statewide.¹¹⁴

Need for Increased Physical Activity and Healthy Diet

Increasing physical activity and consuming more fresh fruits and vegetables is another identified need in the Baystate Wing service area. This is particularly true in Palmer, where a state-funded “Mass in Motion” program works to increase physical activity and improve access to healthy food. Healthy eating and physical exercise are important habits to create to prevent poor health outcomes such as cardiovascular disease, diabetes, dementia, and depression, to name a few.¹¹⁵ 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.

“It’s easier to get liquor than to get healthy food in town.”
Young Adult Focus Group Participant, Ware Adult Learning Center

Among Massachusetts residents in the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) 2013 survey, only 11% of respondents met the vegetable consumption recommendation and 14% met the fruit consumption recommendations. In general, women, Latinos, and people with higher income are more likely to meet recommended intake levels.¹¹⁶

In Hampden County, 1 of 4 residents over age 18 reports getting no leisure-time physical activity in the past month, slightly higher than the state rate of 22%.¹¹⁷ In Hampshire and Worcester counties, 16% and 21% of adults respectively report no leisure-time physical activity.¹¹⁸ In addition, the CDC found that only 29.5% of Massachusetts adults met the recommended levels of physical activity set forth in the 2008 U.S. Department of Health and Human Services (HHS) physical activity guidelines.¹¹⁹ The guidelines recommend that adults engage in at least 150 minutes of moderate physical activity per week, or 75

minutes per week of vigorous physical activity, as well as muscle-strengthening activities two-days per week or more. Though the percentage of adults meeting these needs is slightly higher than that of the country as a whole, the low percentage of adults meeting these guidelines indicates an area of continued need. These rates are affected by the availability of affordable healthy food and safe places to be active as well as individual knowledge and behaviors.

According to survey responses in the 2015 “Mass in Motion” Palmer Food Assessment Survey, respondents in all three villages purchase fresh fruits and vegetables every week, and many purchase whole grains, low-fat dairy, and lean meats regularly. Survey respondents in Bondsville and Depot Village are most likely to purchase fresh fruit and vegetables each week, with 81% of those in Bondsville doing so and 76% (fruit) and 81% (veggies) in Depot Village doing so. Residents in all four villages tend to grow some of their own food, possibly making eating healthy more affordable.¹²⁰

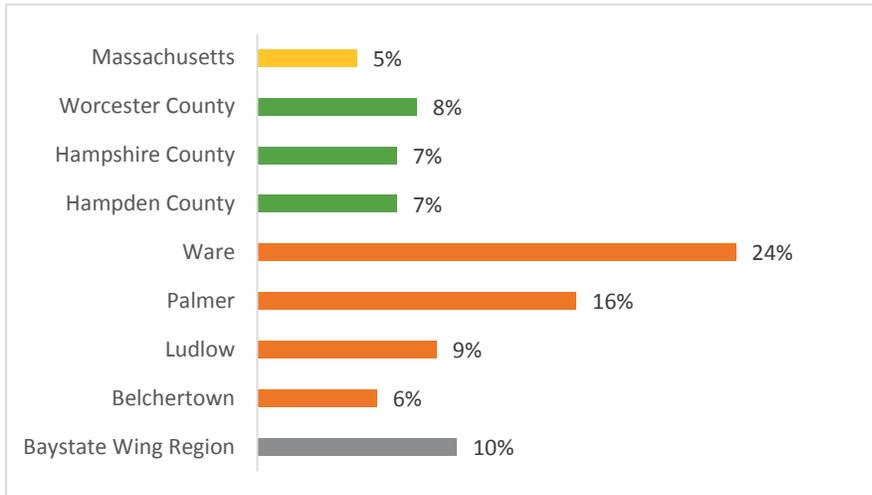
The need for increased youth programming and access to places that encourage physical activity was cited by individuals across several focus groups and interviews conducted for this CHNA and particularly sports and after school programming that are affordable to those with low-incomes. Parents of children 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, and young adults in Springfield talked about the importance of affordable sports programs as a deterrent to gun violence.

C. INFANT AND PERINATAL HEALTH

Early entry to prenatal care and adequate prenatal care are crucial components of health care for pregnant women that impact birth outcomes, including preterm birth, low birth weight, and infant mortality (infant death before age 1). 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. Smoking during pregnancy is a risk factor that increases the risk for pregnancy complications, poor birth outcomes, and affects fetal development.¹²¹

All of the selected communities studied have higher rates of smoking during pregnancy than the state, with the towns of Ware and Palmer having notably high rates of smoking during pregnancy (24% and 16%, respectively). The Baystate Wing service area as a whole has double the rate of smoking during pregnancy as the state (Figure 22). Women of color tend to have lower rates of smoking during pregnancy (Figure 24).

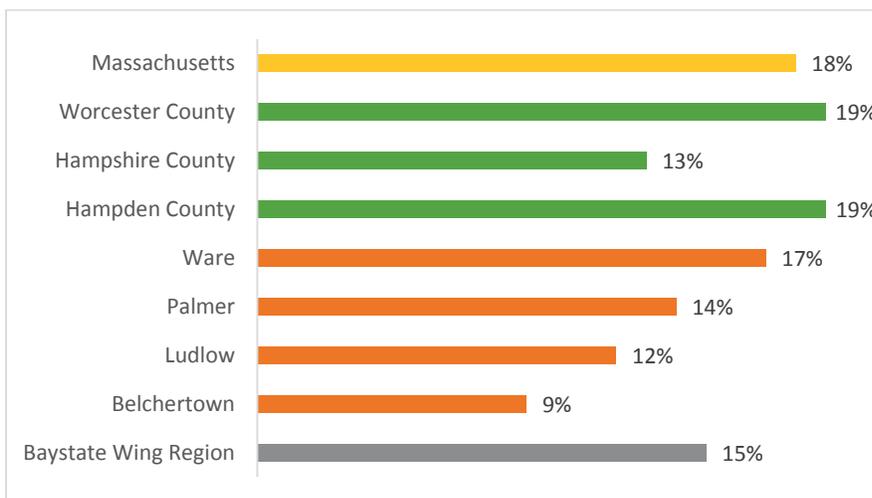
Figure 22. Smoking During Pregnancy, Baystate Wing Region



Source: MDPH, 2016. Rates are age adjusted and per 100,000

Between 9% and 17% of select communities in the Baystate Wing service area do not receive adequate prenatal care (Figure 23). National guidelines suggest that adequate pre-natal care is defined as women receiving 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 the rate of 15% of the Baystate Wing service area not receiving adequate prenatal care is lower than the state rate of 18%, it remains concerning that for the region as a whole, more than one out of ten women are not receiving adequate prenatal care (Figure 23). Teens also had high rates of less than adequate prenatal care in the Baystate Wing service area (30%) (MDPH, 2016).

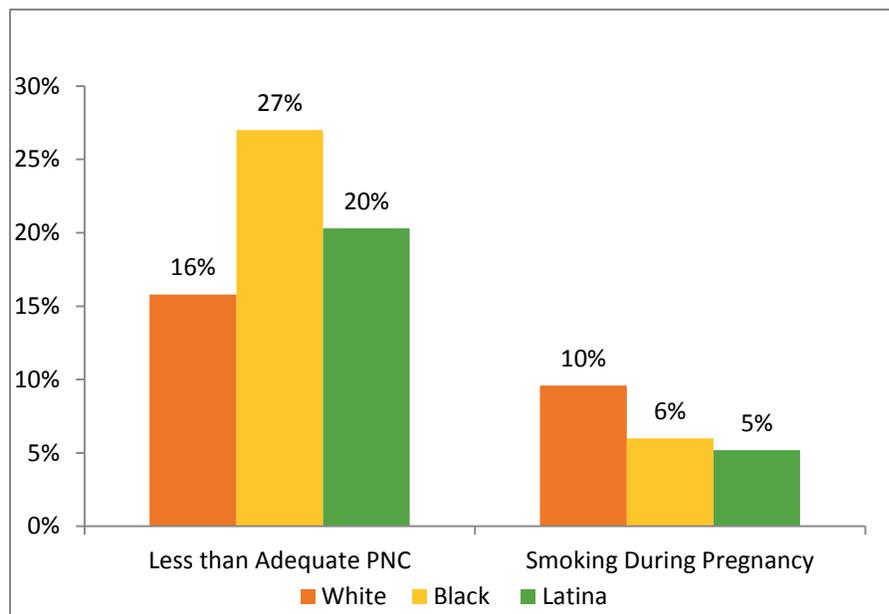
Figure 23. Less than Adequate Prenatal Care, Baystate Wing Region



Source: MDPH, 2016. Rates are age adjusted and per 100,000

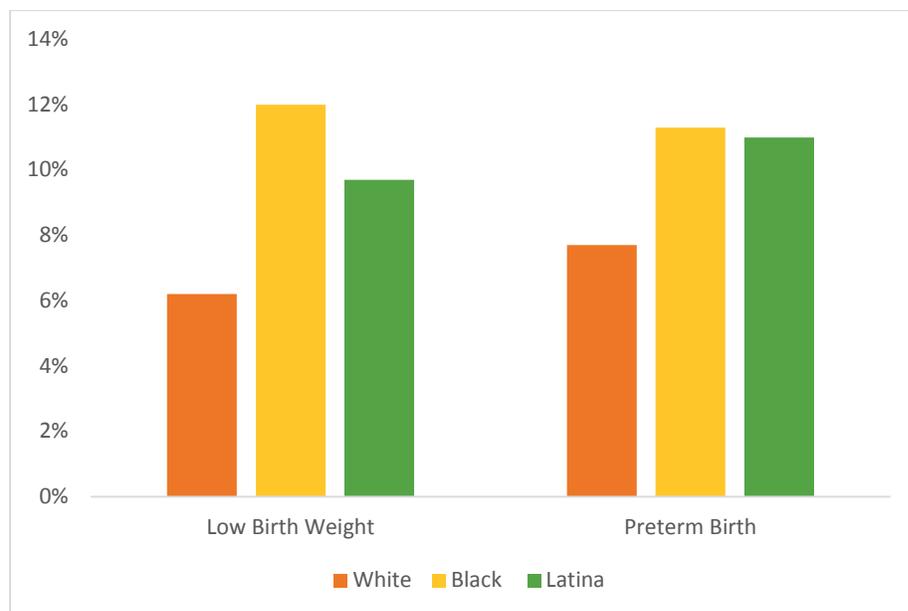
Prenatal care varies by race/ethnicity. While rates disaggregated by race were not available for the Baystate Wing service area specifically, we see on a county level rates in Hampden County reflect inequitable access. While 16% of white women in Hampden County did not receive adequate prenatal care, rates are higher among black women (27%) and Latinas (20%) (Figure 24). This is of great concern as poor birth outcomes continue to plague communities of color, with higher rates of low birth weight and preterm birth in blacks and Latinas (Figure 25). While rates in Hampden County include Springfield and Holyoke – cities that are not part of the Wing service area, poor birth outcomes exist in communities of color across the nation. 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.¹²²

Figure 24. Less than Adequate Prenatal Care and Smoking during Pregnancy, By Race/Ethnicity, Hampden County



Source: MDPH, 2016. Rates are age adjusted and per 100,000

Figure 25. Birth Outcomes by Race/Ethnicity, Hampden County



Source: MDPH, 2016. Rates are age adjusted and per 100,000

Priority populations

- Outcomes by race/ethnicity illustrate drastic disparities across statewide data; black rates of low birth weight are double that of whites (12% compared to 6%) and Latina rates are more than 50% higher (10%). Black and Latina preterm births are almost 50% higher than that of whites (MDPH, 2016).
- Being a pregnant teenager impacts birth outcomes, with teen moms having much lower rates of adequate prenatal care. In the Baystate Wing service area, 30% of pregnancies born to teen mothers age 15-19 had less than adequate prenatal care (MDPH, 2016).
- Income also makes a difference. With the proxy being type of insurance, we see that only 10% of those with private insurance in the Baystate Wing service area were without adequate prenatal care, compared to 22% of those with public insurance. In the Baystate Wing service area, the communities with lower median incomes – Palmer and Ware – had higher rates of less than adequate prenatal care and significantly higher rates of smoking during pregnancy (MDPH, 2016).

D. ALZHEIMER’S DISEASE AND DEMENTIA

Approximately 1 in every 10 people over age 65 has some form of Alzheimer’s or dementia, as do over one-third of those over age 85.¹²³ The proportion of those living with Alzheimer’s disease in the Baystate

Wing service area ranges from 11% in Ware to 15% in Palmer among select communities (in Massachusetts, 14% have Alzheimer's Disease).¹²⁴ Between 2010 and 2035, the proportion of people age 60 and over in the four western Massachusetts counties and Worcester County is projected to grow between 8% (Hampden County) up to 13% (Hampshire County).¹²⁵ As the older adult population grows, more people will be impacted by this debilitating condition.

The Alzheimer's Association notes that between 2000 and 2017, the number of deaths from Alzheimer's disease has increased 145%.¹²⁶ The disease places a high toll on the health care system, as well as on caregivers, who are mostly family members. Compared with caregivers of people without dementia, twice as many caregivers of those with dementia indicate substantial emotional, financial, and physical difficulties.¹²⁷

4. Priority Populations of Concern

Available data indicate that children and youth, young adults under age 25, older adults, Latinos, and blacks experience disproportionately high rates of some health conditions when compared to that of the general population. Children experienced high rates of asthma and obesity. 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 disorders, data indicate increased risk for youth for depression, substance use, and suicide. In particular, girls have higher rates of some types of substance use and GLBQ+ and transgender youth have particularly high rates of depression and suicide. Older adults are at risk for substance use disorder. 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 populations experience a host of inequities, including poverty, unemployment, income, educational attainment, interpersonal and institutional racism, affordable and safe housing, and access to transportation and to healthy food. Youth were identified as at risk with regard to childhood poverty, 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

In the Baystate Wing service area, many of the smaller, rural communities do not have sufficient numbers of cases of chronic diseases and other conditions to be available for analysis. The MDPH does not publish cases or rates of certain health conditions or illnesses when there are a small number in a given town. This varies based on dataset and health conditions. For example, for birth data, the number must be 5 or more; for other data, cases must number more than 11.

In the Baystate Wing service area, the towns of Ware and Palmer 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, such as lower household incomes and lower educational attainment levels. While the region served by Baystate Wing is overwhelmingly white, these two 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 the service area.

V. Community and Hospital Resources to Address Needs

Hospital Resources		
Organization Name	Description of Services Provided	Contact/Website
Baystate Behavioral Health	Continuum of high-quality inpatient and outpatient care, information, support groups and education. Child and Adolescent Psychiatric Care, services for families, Adult Psychiatric Care and Geriatric Psychiatric Care.	https://www.baystatehealth.org/services/behavioral-health
Baystate Community Health Link	CHL is a leading community-based provider of health care services in Central Massachusetts, including services for: Mental health, Substance abuse, Rehabilitation, Homeless individuals and families.	https://www.baystatehealth.org/about-us/community-programs/health-initiatives/community-health-link
Baystate Health Support Groups	Support groups that cover topics related to weight loss and stroke.	https://www.baystatehealth.org/patients/support
Baystate Mary Lane OB/GYN	Baystate Medical Practices - Mary Lane OB/GYN welcomes women of all ages. Whether patients are considering having a baby, need gynecological care, are going through menopause, or are due for preventative care, providers offer an exceptional level of care.	https://www.baystatehealth.org/locations/outpatient-center-ware/ob-gyn
Baystate Neighbors Program	Baystate Health provides employees with financial assistance to purchase homes in Springfield, Greenfield, Westfield, Palmer, and Ware.	http://springfieldnhs.org/employer-assisted-program
Comprehensive Adult Weight Management Program	Proven methods for weight management tailored to individuals' unique health needs and lifestyle.	https://www.baystatehealth.org/services/weight-management
Diabetes Self-Management Program	Complete range of services for the evaluation, treatment, and management of diabetes. Goal is to help adult patients and their families learn to manage their diabetes and live full and productive lives.	https://www.baystatehealth.org/services/diabetes-endocrinology
Griswold Behavioral Health Center	A service of Baystate Wing offers patients and loved ones comprehensive mental health, behavioral medicine, and employee assistance programs including outpatient mental health and addiction recovery services.	https://www.baystatehealth.org/locations/behavioral-health-griswold-center
Heart & Vascular Care Services	Comprehensive diagnostics and treatment options for coronary artery disease (CAD), heart rhythm disorders (arrhythmias) heart failure; cardiac surgeries for adults and children; cardiology clinical trials.	https://www.baystatehealth.org/services/heart-vascular
Patient Family Advisory	The Baystate Health Patient & Family Advisory Council	https://www.baystatehealth.org

Hospital Resources

Organization Name	Description of Services Provided	Contact/Website
Councils	(PFAC) is made up of a diverse group of patients, family members, and community members who represent the 'collective voice of our patients and families'.	h.org/about-us/community-programs/health-initiatives/patient-family-advisory-council
Physical Therapy Services	Information, resources, coaching and education, stretching, core strengthening, walking, and strength training to improve or restore physical function and fitness levels.	https://www.baystatehealth.org/services/rehabilitation

Community Resources

Organization Name	Description of Services Provided	Website Address
Behavioral Health Network <i>Addiction Services</i> <i>Outpatient Services</i>	A regional provider of comprehensive behavioral health services for adults, children and families with life challenges due to mental illness, substance abuse or intellectual and developmental disabilities.	http://bhninc.org/
Belchertown Family Center	Provides the community with early childhood enrichment in a safe environment that allows children to develop socially, emotionally, intellectually and physically through learning activities and play.	https://www.belchertown.org/residents/family_center/index.php
Center for Human Development (CHD)	One of the largest social service organizations in western Massachusetts, delivering a broad array of critical services with proven effectiveness, integrity and compassion	https://chd.org/
Clean Slate Outpatient Addiction Medicine	The Ware, Massachusetts CleanSlate drug treatment center treats patients with dignity, compassion and respect. We offer rehabilitation for drug addictions like opioids and alcohol and accept Medicare, Medicaid and commercial insurance as well.	https://www.cleanslatecenters.com/ware-ma
Community Action! of Hampshire County	Federally designated Community Action Agencies serving low-income individuals and families.	http://www.communityaction.us/index.html
Drug Addiction Recovery Team (DART)	A collaborative effort with Hampshire County HOPE. Members are patrol officers who volunteer to be part of this program in addition to their regular patrol duties. DART officers review log activities and identify people who have engaged in high risk behavior as a result of narcotics addiction, work to meet with the person, offer resources, and may even transport a person to a local treatment facility.	http://www.townofware.com/news_detail_T2_R284.php
Eagle Hill School	Educates students identified with learning (dis)abilities by providing an intimate and encouraging community that honors the individual, values learning diversity, and cultivates international mindedness	https://www.eaglehill.school/
Education to Employment (E2E)	A collaboration between HCC and Quaboag Valley Community Development Corporation, the Center offers non-credit classes in hospitality and culinary arts. The expectation is that course offerings will expand to include manufacturing and health careers. Credit & non-credit HCC courses; EMS training; workforce development; training and resume writing	https://www.qvcdc.org/education.html
Hardwick Youth Center and Commission	The Youth Center and Commission is open to all residents of Hardwick, Gilbertville, Old Furnace, and Wheelwright.	https://www.townofhardwick.com/YouthCommission.html
Healthy Hampshire	Community-based coalitions to improve health equity in Ware and Palmer through improved access to healthy eating and active living.	http://www.northamptonma.gov/1482/Healthy-Hampshire

Community Resources

Organization Name	Description of Services Provided	Website Address
Mass In Motion-Palmer	Promotes healthy behavior, increase in access to healthy food, and moves the communities toward a health-in-all-policies approach through modifications to both the regulatory and built environment. Pioneer Valley Planning Commission is the coordinator.	http://www.pvpc.org/projects/mass-motion
Palmer Council on Aging/Senior Center	Identifies the total needs of the senior population, to promote and encourage new and existing activities, to provide services and education to enhance the quality of life for elders and to assist elders to age with dignity and independence.	https://www.townofpalmer.com/coa
Palmer Domestic Violence Task Force	The mission of the Palmer Domestic Violence Task Force Group is to eradicate Domestic Violence in Palmer. Group meets monthly and welcomes new members.	https://www.townofpalmer.com/domesticviolence
Pioneer Valley Asthma Coalition	Community partnership that works to improve the quality of life for individuals, families and communities affected by asthma.	www.pvasthmacoalition.org
Pioneer Valley Planning Commission <i>Hardwick Community Development Program</i>	The Hardwick Community Development program funds housing rehabilitation, senior weekend meals program, environmental hazards study, The Literacy Project, PATCH Program, and Domestic Violence Task Force Program.	http://www.pvpc.org/Hardwick
Pioneer Valley Transit Authority (PVTA)	A federal, state, and locally funded transit system. It is the largest regional transit authority in Massachusetts with 186 buses, 132 vans, and 24 participating member communities.	http://www.pvta.com/
Quabbin Reservoir	An unfiltered water supply for the community and space for recreation.	https://www.mass.gov/locations/quabbin-reservoir
Quaboag Connector	A transportation system that services Belchertown, Brookfield, East Brookfield, Hardwick, Monson, Palmer, Ware, Warren, West Brookfield. Rides relating to work, job training programs, and other job-related destination take priority.	https://www.rideconnector.org/
Quaboag Hills Community Coalition <i>Substance Use Alliance</i>	Made up of members and agencies who work for the people of the Quaboag Hills region in western Massachusetts to help them access resources to solve basic problems: food, shelter, transportation, childcare, health care, substance use treatment, support and information. Regional coalition that works to prevent and reduce substance use in the 15 towns of the Quaboag Hills	http://qhcc.weebly.com/
Quaboag Valley Community Development Corporation (CDC)	A member-based, non-profit organization committed to economic development and helping small businesses grow and prosper.	https://www.qvcdc.org/

Community Resources

Organization Name	Description of Services Provided	Website Address
Scantic Valley YMCA Tri-Community YMCA	Fitness sessions, swimming, dance classes, after-school care, summer camp, senior health initiatives and mentoring opportunities.	http://www.springfielddy.org/family-centers/scantic-valley-y-family-center/ http://www.tricomcommunitymca.org/
South Middlesex Opportunity Council	Improve the quality of life of low-income and disadvantaged individuals and families by advocating for their needs and rights; providing services; educating the community; building a community of support; participating in coalitions with other advocates and searching for new resources and partnerships. <i>Greater Worcester Housing Connection: provides housing and supportive services to homeless and formerly homeless individuals towards the community goal of ending homelessness.</i>	http://www.smoc.org/services-alphabetical-listing.php http://www.smoc.org/greater-worcester-housing-connection.php
Tapestry Health: Needle Exchange Program	Needle exchange programs in Holyoke and Northampton, sterile needles to injection drug users, trainings on Naloxone, education and counseling	http://www.tapestryhealth.org/index.php/services/prevention/needle-exchange
Food Bank of Western Massachusetts: Mobile Food Pantry Brown Bag-Food for Elders Program	Our Mobile Food Bank delivers a truck full of free fresh and non-perishable groceries from our warehouse directly to a community site for immediate distribution to residents. The program reaches under-served populations throughout western Massachusetts that don't have access to healthy foods, including families, seniors and children. Provides a free bag of healthy groceries to eligible seniors once a month at local senior centers and community organizations.	https://www.foodbankwma.org/get-help/mobile-food-bank/ https://www.foodbankwma.org/get-help/brown-bag-food-for-elders/
Top Floor Learning	Promote and provide personalized tutoring services in basic literacy skills and to sponsor a dynamic, comprehensive program of life-long learning opportunities for adults.	https://www.facebook.com/topfloorlearningpalmer/info/?entry_point=page_nav_about_item&tab=overview
Trinity Church Jubilee Diaper Program	This Ministry provides 25 diapers and 1 package of wipes once a month at no cost to low-income families living in Ware, and families in the surrounding area experiencing an emergency situation. 121 families were served in 2018.	https://trinityware3n1.org/?page_id=48
Valley Human Services/Carson Center Behavioral Health Network	Provides services to chronically mentally ill adults, seriously emotionally disturbed children, adolescents, and families; substance use disorder treatment; domestic violence services; traumatic brain injury services; child care and summer camps Batterer's Intervention Program at Carson Center /	http://www.carsoncenter.org/ http://www.carsoncenter.org/programs/domesticviolence/

Community Resources

Organization Name	Description of Services Provided	Website Address
	Domestic Violence Advocacy, Support and Safe House Program / Ware & Palmer Domestic Violence Task Forces	
Valley Opportunity Council: Fuel Assistance	Fuel Assistance (also known as the Low-income Home Energy Assistance Program) helps eligible households challenged by the high cost of home heating fuel pay a portion of their winter heating bills.	https://www.valleyopp.com/energy-assistance/fuel-assistance
"Van Go" Van Services	Service the transportation needs of seniors and disabled residents within the Ware Town limits, mostly with rides to medical appointments, food or local shopping, social services and trips to the Senior Center.	http://warema.virtualtownhall.net/Pages/WareMA_COA/Transportation
Ware Adult Education Center/ The Literacy Project	Provides free adult education classes at 3 levels: basic literacy, pre GED, through GED. Provides access to post-secondary education and job training skills.	http://www.literacyproject.org/
Ware Family Center	For families with children ages 0-5 in Ware and the surrounding towns. Helps our families find resources to make it through trying times-bringing home a new baby, identifying high-quality child care and pre-schools, managing unexpected financial hardships, and other problems that affect them at home.	https://www.facebook.com/WareFamilyCenter/
Ware River Valley Domestic Violence Task Force	The Task Force currently serves Ware, Warren and Hardwick. The mission of the Task Force is to prevent, and respond to, domestic violence in these towns. Their goals are to: 1) ensure that victims and survivors have access to necessary services; 2) educate the community about healthy relationships, domestic violence and about resources available to victims and survivors; 3) train local professionals to respond effectively to domestic violence and; 4) teach young people about healthy dating and dating violence prevention.	https://www.waredvtaskforce.org/
Ware Senior Center and Council on Aging	It is the mission of the Ware Senior Center and Council on Aging to identify the total needs of the community's older adult population, to link services to those needs, and to improve the quality of life for our seniors. WSS/COA provides a one-stop resource center for social services, van services, daily lunch, exercise classes, library, and other social and arts activities.	http://www.townofware.com/departments/council_on_aging/index.php
Way Finders	Confronts homelessness head on in communities throughout western Massachusetts. Develops targeted services that help people lift themselves up and out of homelessness with a focus on Housing, Real Estate, Employment Support and Community Services.	https://www.wayfindersma.org/welcome-way-finders
Worcester Community Action Council, Inc. for towns in Worcester County	Federally designated Community Action Agencies serving low-income individuals and families.	http://www.wcac.net/
Worcester County Food	Collects and inspects perishable and non-perishable food	http://foodbank.org/

Community Resources

Organization Name	Description of Services Provided	Website Address
Bank	and distributes it through a network of 131 Partner Agencies in all 60 cities and towns of Worcester County.	
Worcester Regional Transit Authority	A regional transit system that services the City of Worcester and the surrounding 36 communities in the Central Massachusetts area.	http://www.therta.com/
Workshop 13	Non-profit cultural arts and learning center in Ware. Offers classes and workshops in fine arts and crafting, photography, ceramic arts and personal growth.	http://qhma.com/list/member/workshop13-ware-6969

VI. Input and Actions Taken Since Previous CHNA

1. Community Input on Previous CHNA and Implementation Strategy

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

2. Impact of Actions Taken by Hospital Since Last CHNA

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

COMMUNITY LEVEL SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

Brown Bag Food for Elders - more than ever, older members of our communities are living on limited, fixed incomes and are struggling to meet their basic needs. Rising costs in healthcare, food, and expenses associated with helping to raise children and grandchildren make seniors especially vulnerable when balancing their budgets each month. The Brown Bag Food for Elders helps to meet the needs by providing income qualified senior citizens with monthly supplemental bags of food. All types of food are included, from canned goods, pasta, and produce when available. Through the efforts of the Baystate Eastern Region Community Benefits Advisory Council (CBAC) and Country Bank, Baystate Mary Lane has been able to bring the Brown Bag Program, sponsored by the Food Bank of Western Massachusetts to seniors in Ware for over two years. Starting in 2015, through the efforts of the team, the Food Bank now delivers food directly to the Ware Senior Center, providing supplemental food monthly to over 130 low-income seniors in Ware.

Mobile Food Pantry - as a result of collaborative work between the Baystate Eastern Region CBAC and the Quaboag Hills Community Coalition, the Food Bank of Western Massachusetts established a mobile food pantry to come to Ware once a month. The mobile food pantry is a way to expand the reach of the regional Food Bank, to provide healthy food that may not be available from other sources, and provide a more comfortable community-based way to accessing food. The mobile pantry program consists of a refrigerated truck coming from the Food Bank with 6 or more fresh items (primarily produce) to be directly distributed to families in Ware. The mobile pantry will be positioned at the Highland/Hillside

village parking lot in Ware – where over 200 low-income families currently reside. Members of the CBAC and hospital staff have agreed to be the site supervisors responsible for monitoring and documenting activities and clients at the mobile pantry and serving as a liaison between the Food Bank and mobile pantry site. Hospital staff members volunteer at this monthly program to extend the reach of the hospital by providing access to programs and services, WIC services, Fuel Assistance, and SNAP. Outreach efforts at the Mobile Pantry lead by the Community Action enrollment coordinator for the Head Start Program in Ware continue to result in class rooms being filled. Prior to this effort, enrollment in Ware was very low. The Mobile Pantry comes to Hillside Village the third Tuesday of every month.

Ware River Valley Domestic Violence Task Force was awarded funding for Phase III of the initial BMLH Domestic and Sexual Violence Screening and Response Project funded in 2016. In Phase I, screening questions and practices were analyzed and evaluated, and all nurses were surveyed with an on-line survey on their experience and needs with regard to screening. National consensus guidelines on screening were reviewed, and a consultant from Newton Wellesley Hospital visited Baystate Mary Lane to assist with recommendations. A new protocol for screening was also developed. In Phase II, new screening protocols were implemented. The Emergency Department will use the same screening questions they use now, but where and how questions are asked will be changed to increase privacy in general, and allow patients to ask for complete privacy which is not generally available now. Nurses who screen will be trained and will practice screening so their comfort level increases. Patients will also be given a health safety card when they are treated. In Phase III this project was extended to Palmer Wing Hospital, new and expanded training was offered on building skills to respond effectively to domestic violence and on understanding when and if to file child abuse reports when children witness violence. In addition, BHN hired a new hospital based domestic violence advocate to work in partnership with this effort and to provide critical on-site response to domestic violence for Mary Lane and Palmer Wing Hospital, both in the Emergency Department and for In Patient Services.

BARRIERS TO ACCESSING QUALITY HEALTH CARE

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

Baystate Financial Assistance Program - Baystate Health is committed to ensuring that the community has access to quality health care services provided with fairness and respect and without regard to a patients’ ability to pay. Baystate hospitals’ not only offers free and reduced cost care to the financially

needy as required by law, but has also voluntarily established discount and financial assistance programs that provide additional free and reduced cost care to additional patients residing within the communities served by the hospitals. Baystate hospitals also make payment plans available based on household size and income.

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

Population-based Urban and Rural Community Health (PURCH) - an innovative, four-year track of UMMS-Baystate in Springfield, Massachusetts. The medical education of PURCH students emphasizes population health and patient-centered, community-based care in high need, low resourced, distressed urban and rural communities of western Massachusetts. The PURCH Longitudinal Community Health Education (LCHE) experience complements and augments the biomedical education of medical students in the PURCH Track. The LCHE provides students with immersive community health education opportunities, focused on determinants of health, health disparities and health equity. Through these experiences, students begin to understand the factors which impact quality patient care and population health outcomes. In the fall of 2018 a group of PURCH medical students participated in a PURCH Clerkship with the Quaboag Connector in which they learned about transportation as a social determinant of health in the rural town of Ware. This unique learning experience was presented at the MassDOT Innovation Conference in 2019 and has opened the door the working with the Quaboag Connector and MassDOT to engage medical students in the development of evidence based strategies and advocacy to improve rural transportation in Ware and eight nearby communities. The Population Health Clerkship experience with the Quaboag Connector will evolve into a longitudinal educational opportunity for students who participate in the new interprofessional Health Equity Incubator at UMMS-Baystate. Medical students will learn and participate in the process of exploring and implementing a model for rural health transportation that will be able to address the health needs of community residents in the towns served by the Quaboag Connector.

Quaboag Connector - as a vital resource for the region consistently supported by Baystate Wing. In 2018, QVDC was awarded a second \$30,000 grant to support the Quaboag Connector, a transportation service for transport to and from work and the Work Force Training program in Ware offered by Holyoke Community College (HCC). In addition to providing transportation to employment and the college site, community members also have access to the Connector for transportation to and from medical visits and cultural activities. The Quaboag Connector has grown from providing 2 rides in the last week of January 2017 to 1,009 rides in the month of May 2019. In 2017 there were 5,720 rides provided. In 2018, there were 8,871 rides provided. There have been 5,241 rides provided through the end of June

2019. The funding from Baystate provides a portion of the matching funds required by a Community Transit Grant. These funds support the daily operations of the Quaboag Connector. This service provides a lifeline to residents needing transportation to medical appointments, employment, education, and access to healthy foods and other necessities.

HEALTH CONDITIONS AND BEHAVIORS

Diabetes Support Group - Baystate Mary Lane offered a diabetes support group for individuals and families, giving them opportunities to gain the insight and knowledge needed to best address and manage their chronic condition.

Free Blood Pressure Checks - the Emergency Department at Baystate Mary Lane continues welcoming the community to their department daily between the hours of 6:00 and 9:00 am, seven days a week for blood pressure checks at no cost, no appointment is necessary. Knowing that over 40% of strokes could be prevented if high blood pressure was controlled, Mary Lane Emergency Department staff continues to engage with community members, encouraging them to know their blood pressure as an effort to address this statistic. In addition to conducting blood pressure assessments, the team is prepared to share education on blood pressure screening, follow up, free blood pressure monitoring cards and information for patients as requested.

The **Quaboag Hills Community Coalition (QHCC)** was awarded funding to address the high rates of alcohol and drug use in the Quaboag Hills region by helping communities build the infrastructure necessary for effective and enduring substance use prevention, treatment and recovery services across the region. The grant funds supported coordination to engage the membership of its sub-group, the Quaboag Hills Substance Use Task Force (QHCC SUFT – now known as the Quaboag Hills Substance Use Alliance, QHSUA). The Baystate Wing funding supported training in the Strategic Prevention Framework (SPF) planning and implementation processes, as well as interim substance use education/training, prevention, and/or intervention activities to be carried out by the QHSUA in response to the current public health crisis. SPF is built on evidence-based theory and practices and the knowledge that effective prevention and intervention programs must engage individuals, families, and entire communities.

Baystate Mary Lane and Baystate Wing continue to play an active role in the Quaboag Hills Community Coalition (QHCC), the Quaboag Hills Substance Use Alliance (QHSUA) and the Hampshire Heroin Opiate Prevention and Education (HOPE) Coalition. Members of the QHSUA and Baystate Wing serve on the Advisory Committees, Steering Committees and are actively involved in decision-making. The hospital has co-sponsored the printing and distribution of the QHSUA Resource Guide and Emergency Resource Cards, and educational materials throughout the region. In addition, the hospital joined the QHSUA in sponsoring Nasal Narcan training and providing Nasal Narcan to area school nurses, and to those at greatest risk of overdosing. The hospital also joined the QHSUA to hold annual Community Dinners to discuss and address addiction issues in the region, over 200 legislative and local leaders, police, EMS providers and community members have attended these events since 2016. Baystate Wing and Mary

Lane provided outreach and support for the nationally recognized, evidence-based *Youth Mental Health First Aid* trainings at their sites. Over 50 people were trained as "First Aiders" to recognize and address mental health needs in youth under age 18.

The hospital has been an integral partner to QHSUA by providing meeting space and training and communications to local and regional medical care providers including SCOPE of Pain trainings for prescribers. To help the QHSUA expand and sustain its work, the hospital has been instrumental in supporting Task Force applications for multi-year funding including the federal Drug Free Communities Support Program grant, funding from the Greater Worcester Community Foundation and the Community Foundation of Western Massachusetts and from the Public Health Services Commissioned Officers Foundation (PHS COF). Baystate Wing was instrumental in helping the QHSUA secure a Medical Advisor and to apply to the Commonwealth for approval to be a Narcan trainer and distributor of Narcan kits to community groups. Baystate Wing and Mary Lane and its Community Benefits Advisory Council continued to foster community partnerships and awarded grant funding to select partners through a request for proposal process to further address behavioral health/substance use needs identified in the 2016 community health needs assessment.

COMMUNITY BENEFITS ADVISORY COUNCIL INVESTMENTS

The Baystate Wing CBAC has continued to meet monthly on the second Friday of every month since the 2016 CHNA iteration. The CBAC is co-chaired by Michelle Holmgren, Manager of Public Affairs and Community Relations at Baystate Mary Lane and Baystate Wing, and Gail Gramarossa, Evaluation and Technical Assistance Specialist at Collaborative for Educational Services. The CBAC currently consists of about 30 members who represent a mix of both internal Baystate employees and external community stakeholders. Since 2016, the CBAC has strategically invested in local initiatives to continue meeting the community's identified needs through its grant awards. The following is a short list of investments made over the last three years:

Franklin Hampshire Youth Employment Fund (Greater Ware) - the Franklin Hampshire Regional Employment Board, Inc. was funded to help set up a Youth Employment Fund for greater Ware as the culminating project in a three-year USDOL Summer Jobs & Beyond initiative. Designated Youth Employment Funds, managed by the Quaboag CDC, will go to direct support of youth employment - gas cards, work clothes, credential fees; or underwriting the wage of a youth to gain short term work experience in a sector of interest. The FHWB has used its Youth Employment Fund to help youth without access to other resources or a mentor in their life to make a connection in the community on a career path of interest. This new fund will allow the FHWB to work with people in the Ware community to do the same for greater Ware youth. The flexibility of the fund will allow the Fiscal Sponsor at QV CDC in conferral with the FHWB to respond to youth needs in the form and at the time they arise.

Quaboag Valley Community Development Corporation (QV CDC) - in addition to providing funding for the Quaboag Connector, QV CDC was also awarded grant funds towards its Tutoring program at E2E. The

funds will be used to pay qualified tutors for math, reading, writing and language skills to local residents seeking to upgrade their skills for educational or job related needs, or self-esteem. These services are free for residents from Low-to Moderate Income households and on a sliding fee scale for individuals that are more affluent. Both one-to-one and group sessions are available. This initiative will primarily benefit families of limited means in our region by providing an accessible source of help for students needing extra assistance with academic work, students needing to brush up or improve their skills for placements in a credit bearing class vs. a remedial class, workers needing to upgrade their skills for job requirements, parents wanting to be able to provide help with homework, people seeking to improve their skills to address the tasks of everyday life, and people for whom English is not their first language. It will be located at E2E in downtown Ware to be easily accessible for residents of Ware and the surrounding towns.

Top Floor Learning (TFL) - awarded grant funding to continue their mission to provide adult literacy and education services for people living in the Pioneer Valley and the Quaboag Hills Region. TFL provide all levels of English language instruction from Beginner to Advanced, high school and college tutoring, high school equivalency preparation, basic skills development for the workplace, job search assistance, resume building, employer/employee communications skills, and specialized test preparation. TFL predominantly serves low and moderate-income members of the population but we strive on assisting ALL in need of increasing/improving their education.

Trinity Church Jubilee Diaper Ministry - provides 25 diapers and 1 package of wipes once a month at no cost to low-income families living in Ware, and families in the surrounding area experiencing an emergency situation. 121 families were served in 2018. The CBAC grant funds were awarded to increase capacity of their donations and were put towards programmatic support of the "Keeping Baby Safe" and Safe Sitter classes for youth, also offered at no cost to Ware residents.

Ware Public School Fire Science Class (2018) - the program led by Ware Fire Department Acting Chief Edward Wloch will assist students in reaching their goal of providing Emergency Medical Service (EMS) care in the region by enrolling in an EMT-B course at the Holyoke Community College E2E Satellite Facility in Ware. The Financial Literacy Program done in collaboration with Country Bank will help these high school students plan and save for the EMT-B course. The Baystate Wing grant is a matching grant that will cover half the cost of the course and text books, with the students investing the balance.

Ware Public Schools Certified Nurse Assistant (CNA) Training Program - Ware Public School has partnered with Holyoke Community College and Baystate Wing to offer a Certified Nurses Training Program as part of the Ware High School curriculum. The training program will provide students with over 260 hours of classroom instruction and 48 hours of clinical training. In addition to providing financial support to begin the CNA training program, Baystate Mary Lane/Baystate Wing hospital has donated the equipment required for the practical training including hospital beds, bedside tables, commodes a wheelchair and much more. Certifications of the course will include Nursing Assistant/Home Health Aide, CPR/First Aide, and Healthcare Interactive for Basic and Advanced Dementia Care as well as information about additional health related career pathways and assistance

with job placement. This initiative helps to fill a critical need for expanding the number of certified CNAs in the Baystate Wing service area, especially as more assisted living facilities are built in the region; it also supports expansion of future nursing staff and trained workers in the health care field.

VII. Summary

The Baystate Wing service area, which includes parts of Hampden, Hampshire, and Worcester Counties, continues to experience many of the same prioritized health needs identified in the 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 disparities observed among priority populations, which include youth, older adults, and Latinos. Individuals who are homeless, low-income, or living in poverty were also identified as priority populations. Additional data is needed to better understand the needs of these populations in order to reduce inequities. The Baystate Wing service area population continues to experience a number of barriers that make it difficult to access affordable, quality care, some of which are related to the social and economic conditions in the community, and others which relate to the healthcare system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. The opioid crisis and other drug use, such as rising rates of youth vaping, and consistent rates of adult alcohol use have emerged as top issues impacting the health of the community. Domestic violence and its impact on individuals, families, and entire communities remain significant public health and social concerns. Progress has been made to address some of the prioritized health needs previously identified, such as childhood obesity and food insecurity; however, rates remain high and work needs to be continued.

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IX. Appendices

- Appendix I. Stakeholders Engaged in the 2019 CHNA Process
- Appendix II. Glossary
- Appendix III. Focus Group Summaries
- Appendix IV. Key Informant Interview Summaries
- Appendix V. Community Conversation Summaries
- Appendix VI. Community Chat Summary

Appendix I. Stakeholders Engaged in the 2019 CHNA Process

Regional Advisory Committee (RAC)

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

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
Landrau, Madeline	Senior Relationship Manager	Mass Mutual	X		
Lee, Jennifer	Systems Advocate	Stavros Center for Independent Living	X	X	
Lopez, Luz	Executive Director	Metrocare of Springfield	X	X	
Patrissi, JAC	Director of Domestic Violence & PATCH Services	Behavioral Health Network, Inc.	X	X	
Perez-McAdoo, Sarah	Board of Health Member	East Longmeadow Board of Health	X	X	X
Pluguez-Moldavskiy, Melissa	President	National Association of Hispanic Nurses of Western Massachusetts	X	X	
Puleo, Elaine	Community Member	Town of Shutesbury Baystate Franklin Medical Center Community Action Council	X		
Reed-McNally, Maureen	Director	Mass Mutual	X		
Robinson, Frank*	Vice President, Public Health	Baystate Health	X	X	
Rosenthal, Sarah*	Administrative Coordinator	Shriners Hospital for Children - Springfield	X	X	
Silverman, Risa	Outreach Director	Western MA Health Equity Network, University of Massachusetts - Amherst School of Public Health & Health Sciences	X	X	
Stevens, David P.	Executive Director	Massachusetts Councils on Aging	X	X	
Walker, Phoebe	Director of Community Services	Franklin Regional Council of Governments	X	X	
Wilson, Gloria M.	ACO Care Manager MSC, RN	Western Massachusetts Black Nurses Association	X	X	

*Coalition of Western Massachusetts Hospitals/Insurer member

Focus Group Participants

Findings from the following focus groups conducted informed this CHNA and unique perspectives that were appropriate to this CHNA from different geographic areas also informed this CHNA. Each focus group had a specific topic, and participants represented a range of age, gender, and race/ethnicity. Focus groups included:

Hampden County

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

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

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

Hampshire County

Baystate Wing Hospital: 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 Hospital: 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

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

Franklin County

Baystate Franklin Medical Center: Youth of Color

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

Key Informant Interviewees

Findings from interviews with the following individuals informed this CHNA. Interviewees from the Baystate Wing Hospital service area were the primary data sources; however, unique perspectives that were appropriate to this CHNA from different geographic areas also informed this CHNA. Key informants were health care providers, health care administrators, local and regional public health officials, and local leaders that represent the interests of the community or serve people who are medically underserved, have low incomes, or are people of color. Key informants were:

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low-Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
<i>Baystate Wing Hospital (Eastern Region)</i>					
Patrissi, JAC	Director of Domestic Violence Services	Valley Human Services	X	X	
<i>Baystate Franklin Medical Center</i>					
Calabrese, Jessica	Chief Operating Officer	Community Health Center of Franklin County	X	X	
Carey, Cameron	Development Director	Community Health Center of Franklin County	X	X	
Ewart, Jared	Accountant	Community Health Center of Franklin County	X	X	
Hamilton, Wes	Chief Information Officer	Community Health Center of Franklin County	X	X	
Heidenreich, Maria	Medical Director	Community Health Center of Franklin County	X	X	
Hoynoski, Arley	Chief Financial Officer	Community Health Center of Franklin County	X	X	
Jacobson,	Information	Community Health	X	X	

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low-Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
Allie	Officer	Center of Franklin County			
Luippold, Susan	Human Resources	Community Health Center of Franklin County	X	X	
Petrie, Maegan	Accountant	Community Health Center of Franklin County	X	X	
Sayer, Ed	Chief Executive Officer	Community Health Center of Franklin County	X	X	
Van der Velden, Allison	Dental Director	Community Health Center of Franklin County	X	X	
Welenc, Susan	Population Health	Community Health Center of Franklin County	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
Hry- 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 (59)	Population	Location	# of Participants (total: 846)
Hampden County (47) N = 759			
Alzheimer's Support Group	Caretakers and Alzheimer's Patients	Westfield	6
Armbrook Village	Older Adult Community Members	Westfield	27
Baystate Health Financial Counselors	Health Care Professionals	Springfield	16
Baystate Medical Center Adult Patient Family Advisory Council	Youth Patients	Springfield	5
Baystate Medical Center Community Benefits Advisory Council	Community Leaders	Springfield	15
Baystate Medical Center Pediatric Patient Family Advisory Council	Community Members	Springfield	5
Baystate Medical Center Team Member Engagement Council	Health Care Professionals	Springfield	8
Baystate Noble Hospital Community Benefits Advisory Council	Community Leaders	Westfield	11
Baystate Noble Hospital Community Care Team Meeting	Non-Profit Staff	Westfield	15
Baystate Noble Hospital Healthcare Professionals	Health Care Professionals	Westfield	30

Organization (59)	Population	Location	# of Participants (total: 846)
Baystate Noble Hospital Patient Family Advisory Council	Health Care Professionals	Westfield	5
Baystate Springfield Educational Partnership (BSEP) Career Interdisciplinary Course	Youth Community Members	Springfield	19
Baystate Wing Hospital Leadership Council	Health Professionals	Palmer	30
Baystate Wing Hospital Team Member Engagement Council	Health Care Professionals	Palmer	11
BeHealthy Partnership (ACO) Patient Family Advisory Council	Community Members	Springfield	14
Boys and Girls Club of Greater Westfield	Youth Community Members	Westfield	10
C3 Mason Square	Community Members	Springfield	18
C3 South End	Community Members	Springfield	19
Dean High School	Youth Community Members	Holyoke	22
Falcetti Towers	Community Members	Holyoke	9
Gándara	Community Members	Springfield	13
Girls Inc. - Holyoke	Youth Community Members	Holyoke	8
Girls Inc. - Springfield	Youth Community Members	Springfield	13
Hampden County Health Coalition	Non-Profit Staff	Springfield	16
Healthy Hill Initiative, Seniors	Older Adult Community Members	Springfield	10

Organization (59)	Population	Location	# of Participants (total: 846)
Holyoke Community College Community Health Worker Class	Health Care Professionals	Holyoke	16
Interfaith Council	Faith Leaders	Springfield	11
Jewish Family Services	Non-Profit Staff	Springfield	28
Kamp for Kids, Behavior Services	Adults with Disabilities	Westfield	14
Mason Square CAB	Community Members	Springfield	12
Mass in Motion	Municipal Staff	Palmer	7
Maternal and Child Health Commission	Non-Profit Staff	Springfield	13
Mental Health Association	Non-Profit Staff	Springfield	40
Morgan School	Non-Profit Staff	Holyoke	19
Out Now Youth	GLBQ+ and Transgender Youth	Springfield	8
Parent Villages	Community Members-Parents	Springfield	18
Pastors Council of Greater Springfield	Faith Leaders	Springfield	30
Project Coach	Youth	Springfield	27
Shriners Medical Home Meeting	Health Care Professionals	Springfield	40
Springfield Dept. Health & Human Services	Municipal Staff	Springfield	35
Square One	Non-Profit Staff	Springfield	18
Square One, Young Children's	Community Members-	Springfield	7

Organization (59)	Population	Location	# of Participants (total: 846)
Council	Parents		
The Carson Center	Non-Profit Staff	Westfield	18
UMMS-Baystate Community Faculty	Health Care Professionals	Springfield	11
Hampshire County (10) N = 77			
Baystate Wing Hospital Community Benefits Advisory Council	Community Leaders	Ware	15
Common Goals – E2E	Non-Profit Staff	Ware	9
Hampshire Regional YMCA	Non-Profit Staff	Northampton	7
Healing Alliance Support Group	Community Members	Ware	5
Hillside/Highland Community Center	Community Members	Ware	6
It Takes a Village	Community Members	Cummington	8
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
Ware Senior Center	Older Adult Community Member	Ware	8
Worcester County (2) N = 20			
North Quabbin Children’s Health and Wellness System of Care	Community Members	Athol	12
North Quabbin Recovery Center	Community Members	Athol	8

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 black

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 Wing Hospital: At Education to Employment site of Holyoke Community College in Ware

- 8 participants
- All women, from Ware and the surrounding area
- All white

Appendix II. Glossary of Terms

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

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

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

Appendix III. Focus Group Summaries

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

Focus Group Report: Substance Use

Primary Hospital/Insurer: Baystate Noble Hospital

Topic of Focus Group: Substance use

Date of Focus Group: 3/11/2019

Facilitator: Gail Gramarossa

Note Taker: Karen Auerbach

Executive Summary

A. Participant Demographics:

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

B. Areas of Consensus:

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

C. Key Recommendations:

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

D. Quotes:

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

Key Issues

Question	Synthesis of Responses
<p>1. What are the most serious barriers or service gaps that consumers face in accessing mental health and substance use care?</p>	<ul style="list-style-type: none"> ● 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. ● 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. ● 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. ● Inadequate transportation to or from treatment and recovery locations to home, family, or work can also be a big barrier to recovery. ● 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. ● 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

Question	Synthesis of Responses
	<p>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.</p> <ul style="list-style-type: none"> ● Probation should be integrated with the legal system and hospitals, but it is not. Recovering addicts on probation are made to jump through hoops, like call in every day or go to court by 4 pm even if they have no transportation. There should be a separate probation for drug issues - currently they're all for crime. ● 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. ● 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. ● 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. ● The whole system needs a group of people who know what's going on and understand the system who can help people seeking or receiving treatment to navigate it and coordinate all the different parts.
<p>2. Are there specific vulnerable populations that you are most concerned about in relation to addiction and substance use? Who are they and why?</p>	<ul style="list-style-type: none"> ● It's hard to help high schoolers deal with anxiety and depression with meds effectively, so they often turn to drugs. ● Some high schoolers with learning disabilities can have lots of trouble with anxiety, and take drugs to help with the anxiety.
<p>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?</p>	<ul style="list-style-type: none"> ● Getting affordable housing can be very difficult for mothers in recovery whose children were taken away from them. They often cannot get their children back without having housing, but may need to have their children living with them to obtain affordable housing. ● 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. ● 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. ● 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.

Question	Synthesis of Responses
<p>4. Are there enough providers who can prescribe Medication Assisted Treatment (MAT) such as suboxone? Is there a methadone clinic in Westfield? If not, should there be?</p>	<ul style="list-style-type: none"> ● There are two providers for medically-assisted recovery in Westfield— 1 doctor who can prescribe suboxone and one methadone recovery center. ● There is a lot of stigma around receiving this treatment, so people who live in Westfield tend to get MAT outside of Westfield (like Riverbend and Clean Slate), and people who get MAT in Westfield tend to live elsewhere. There is community pushback and stigma against having more services available in Westfield. ● The protocol for MAT is often not effective, especially when therapy is not provided at the same time, which can lead patients to relapse. ● 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. ● One place had a grant for two years to follow-up with people who were discharged. After they lost grant funding, follow-up was just a phone call. People were just cut off after discharge. ● 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.
<p>5. What about long-term substance use and recovery care needs? What are the needs for such services?</p>	<ul style="list-style-type: none"> ● Recovery coaches can help people recover from having a substance use disorder, but there are very few recovery coaches in Massachusetts. Gándara, the Behavioral Health Network, and Caring Center provide recovery coach training. People with lived experiences, who have overcome their mental health or addiction issues, can be effective coaches and help addicts throughout their recovery process. They can help with the spiritual and emotional aspects of recovery and can be there every step of the way for a recovering addict. But there isn't much training for them, they're not paid very much, and may not get paid if they don't meet some requirements (like meeting with a client 5 times or more in a month).
<p>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?</p>	<ul style="list-style-type: none"> ● 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. ● 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.

Question	Synthesis of Responses
<p>7. What is happening in this area related to substance use prevention? Should there be more prevention efforts and what would that look like?</p>	<ul style="list-style-type: none"> ● There is proper education for HIV and free condoms are available everywhere. But there isn't very much around drug use. One program is just starting in Westfield for 6th, 8th, and 10th graders, which will integrate drug addiction education.
<p>8. How do substance use disorders and addiction impact overall community health and stability?</p>	<ul style="list-style-type: none"> ● 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. ● The Westfield community seems economically and socially divided by neighborhoods. People think drug problems exist in other neighborhoods, but not theirs. ● 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.

**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: Eight participants
 - Five women, three men
 - Six people seemed to be over age 45, and two seemed to be in their early 30's
 - Six people were white, two were Latino

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

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

D. Quotes:

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

Key Issues

Question	Synthesis of Responses
<p>1. Things that get in the way of being healthy</p>	<ul style="list-style-type: none"> ● Financial issues <ul style="list-style-type: none"> ○ Expense of health insurance and health care ○ 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. ○ It’s too expensive to go to the Y or to have exercise equipment ● Family has moved a lot, and that makes it hard to be healthy. You have to adjust to everything, to new schools. ● No rides; it takes a long time to get places ● Lack of a healthy social environment in school <ul style="list-style-type: none"> ○ It’s hard to transfer into a new school and fit in ○ Peer pressure to spend money and have certain clothes, shoes, technology. It makes people stressed out. ● Stressors <ul style="list-style-type: none"> ○ People compare their body types to others. I know a lot of people with eating disorders. ○ School + work + homework + chores + sports is exhausting. It’s hard to stay awake during the day. ○ We see lots of anxiety, panic attacks, depression ● JUULing, including in school

Question	Synthesis of Responses
	<ul style="list-style-type: none"> Some parents are against vaccination; kids can't decide on their own to get vaccinated
<p>2. Health issues unique to young people of color?</p>	<ul style="list-style-type: none"> It's harder to get hired. There are social expectations – people expect you to be something you're not, and that adds to stress. Because of Asian stereotype, everyone wants to be in a group with me and make me do all the work. People get labeled for how they look or act. People get called messed up names. There's drama that's unnecessary and so common. There's unequal treatment, for example in dress code violations. It doesn't happen to white girls like it does to me.
<p>3. How well are those challenges addressed</p>	<ul style="list-style-type: none"> Some teachers care about school work, not about the students. We complain, for example about school food, and nothing is done about it. Teachers can be disrespectful, for example, yanking off a hood instead of asking you to take it off.
<p>4. Discrimination that impacts health</p>	<ul style="list-style-type: none"> A guy told me I was unattractive because I'm black. It took a toll on me. I keep my emotions bottled up. In school they don't teach you how to deal with emotional stress. You can end up being depressed about it. There's a stigma against mental health. Someone might not go to therapy because people don't understand.
<p>5. Local resources that contribute to health</p>	<ul style="list-style-type: none"> CAYP, Family Center. The Shout Out advisor bought me a planner and helped me plan. Therapy Friends can be therapists, too Family members It's good to have someone you can trust Being alone
<p>6. What else is needed</p>	<ul style="list-style-type: none"> A place for youth to go hang out <ul style="list-style-type: none"> Friday night "Lightskating" with lights and DJ was good, but they don't do it anymore Skatepark is gone and Turners is so far Boredom makes kids do crazy things Transportation – Leyden Woods is so far from everything

Question	Synthesis of Responses
7. How do you stay healthy	<ul style="list-style-type: none">• Sports• Spending time alone• Hike to Sachem's Head – it's so peaceful• Dance when I clean• Go to the Y• Have pets

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

Focus Group Report (based on 2 Community Forums)

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

- Baystate Franklin Medical Center
- Possibly Baystate 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
<p>1. What makes life fulfilling as you grow older? What is important to aging successfully?</p>	<ul style="list-style-type: none"> ● Social connections and people you can call upon for help ● Feeling valued and involved ● Sense of safety and capacity to get health care when you need it ● Quality of life, control over your life, having a say in your life
<p>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</p>	<ul style="list-style-type: none"> ● Transportation ● Affordable housing, down-sized and smaller ● Provider with expertise in elder care issues/needs ● Financial advice and information to avoid financial “scams” ● Home-based services ● Day programs for frail elders

Question	Synthesis of Responses
<p>how do these gaps impact older adults? Think about older adults with limited English, or who are people of color, or live in a rural area, identify as GLBQ+, transgender, or from other underrepresented groups.</p>	<ul style="list-style-type: none"> • Care coordination services to integrate care more seamlessly
<p>3. Most older adults in our community have at least one chronic or serious illness. What helps older adults manage chronic disease?</p>	<ul style="list-style-type: none"> • Behavioral health support to manage the psychological impact/stress and anxiety of having a chronic disease • Help with managing and following a medication regimen • Case management services • Pharmacy home delivery • Help with navigating insurance and Medicare issues • More follow-up and “check-ins” from my primary care provider • Health education for managing chronic illness provided in a non-hospital setting • 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 • 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 • Primary care needs to be better integrated with the other resources within the community • For someone who is not able to get themselves there, perhaps a coach or someone to help people get to outside resources • 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 • 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
<p>4. What would you like to see in your community that would make it a better place for older adults to live?</p>	<ul style="list-style-type: none"> • More support for “aging in place” • Better sidewalks and recreation areas • Home visiting • More entertainment and social activities

Question	Synthesis of Responses
<p>5. <i>Optional if time allows:</i> Do you have adequate access to health care services, including mental health care? Is it working for you? Is it easy to get a qualified provider?</p>	<ul style="list-style-type: none"> • Need more elder-friendly psychiatric services with expertise in older adults' needs, but it's hard to find a good therapist • There are insurance barriers to ongoing care • When you are new to the area, hard to find a primary care provider, need a navigator

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

Focus Group Report: Parents of Children with Neuromuscular Diseases

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 Gramarossa

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.
- Ten women, one 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:
 - Swift and satisfactory response to bullying incidents where children with disabilities are the targets.
 - 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.
 - Creating accurate assessments that would qualify students for services that the parents perceived to be necessary for their children's success.
 - 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.

E. 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 psychiatrist 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
<p>1. What do you know about the frequency or type of bullying that occurs towards youth with disabilities in the local schools?</p>	<ul style="list-style-type: none"> ● A bully hit one woman’s son the morning of the focus group ● 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 ● 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 ● 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 ● 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
<p>2. When you or someone else reports the bullying to the school, how do they respond?</p>	<ul style="list-style-type: none"> ● The school called the mother and asked her to take her son to the emergency department ● The school gave the bully a verbal warning ● The school said they cannot move the child who was bullied to another school because that would require three incidents back-to-back ● The school moved the child to another school, but in the same building as the school where the bullying occurred ● 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 ● 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 ● The school has repeatedly ruled incidents “not bullying” for a variety of reasons

Question	Synthesis of Responses
2a. Is their response effective?	<ul style="list-style-type: none"> ● 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 bullied, what strategies do you use with your child to help them cope with and respond to the bullying?	<ul style="list-style-type: none"> ● Recruiting a mentor through a family member who works on a military base ● Therapeutic mentorship ● In-home therapy ● Outpatient therapy ● Working with Special Education Parent Advisory Council (SPEDPAC) to get the attention of school authorities ● Seeing a therapist and psychologist
3a. Are they effective?	<ul style="list-style-type: none"> ● 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?	<ul style="list-style-type: none"> ● 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. ● Feeling unsafe ● Feeling terrified of potential bullying
5. Where do you receive help obtaining specialty medical services (Shriners, other organizations, other hospitals)?	<ul style="list-style-type: none"> ● Referrals from other specialists ● Formerly, the 4C program ● Shriners
5a. What services do you access while at the hospital?	<ul style="list-style-type: none"> ● BFit ● Physical therapy ● Diagnoses for services and treatment outside of the hospital ● Neurological/psychological evaluation and testing ● Bike camp
5b. What services do you access while at school, if applicable?	<ul style="list-style-type: none"> ● Occupational Therapy ● Physical Therapy ● Speech Therapy ● Neurological/psychological evaluation and testing
5c. What services do you access in the community?	<p>This question was only answered with regards to services that support physical activity. See question 8.</p>
6. What specialty care services does your child need, that you lack access to (at Shriners or in the area)?	<ul style="list-style-type: none"> ● Psychiatrists ● Child psychiatrists ● Neuropsychologists

Question	Synthesis of Responses
6a. What is not offered here in western MA?	<ul style="list-style-type: none"> ● Psychiatrists
7. What are some of the barriers you face in obtaining access to the types of specialty medical services that your child needs? (awareness, availability/waitlists, insurance/cost, travel, etc.)	<ul style="list-style-type: none"> ● Lack or dearth of certain specialists in Western MA ● Treatments not recognized or covered by insurance ● Insurance won't cover services that they pay the schools to provide, but the school won't qualify the students for the services because they're not "bad enough" ● Insurance companies refusing to pay for services that the school is supposed to pay for, but doesn't ● Lack of readily available information about who providers are and where to find them ● Failure to diagnose children in ways that qualify them for the services they need ● Long waitlists ● Deciding which diagnosis to pursue in order to get necessary services ● 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)?	<ul style="list-style-type: none"> ● BFit ● BFit cycling club ● The Kehila Program at the Springfield Jewish Community Center ● Whole Children ● Ultimate Sports Program, particularly rock climbing ● Children's Miracle Network ● Project Splash swim lessons at Mount Holyoke College ● Spedchildmass.com has a listing of programs ● Miracle League adaptive baseball ● Special Olympics ● Hippotherapy (horseback riding) ● Easter Seals ● Facebook groups for parents of children with disabilities ● Center for Human Development ● Willpower Foundation to help pay for programs ● getATstuff.com [currently inactive] ● Our Lady of Guadalupe CYO Basketball for ages K - 2 ● Family Scouts ● Federation for Children with Special Needs listserv ● Family TIES of Massachusetts
8a. Which organizations do you access for services?	<ul style="list-style-type: none"> ● Shriners ● Springfield Jewish Community Center ● Whole Children ● Ultimate Sports Program ● Children's Miracle Network

Question	Synthesis of Responses
	<ul style="list-style-type: none"> ● Baystate Hospital ● Mount Holyoke College ● Miracle League ● Special Olympics ● Easter Seals ● Department of Developmental Services ● Center for Human Development ● Federation for Children with Special Needs
<p>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)?</p>	<ul style="list-style-type: none"> ● Help with renting or buying indoor exercise equipment ● The opportunity to exchange information and resources with other parents of children with disabilities
<p>9a. What is not offered here in western MA?</p>	<p>This question was not specifically answered</p>
<p>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.)</p>	<ul style="list-style-type: none"> ● Cost of programs or equipment ● Not knowing about the opportunities ● 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.)
<p>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?</p>	<ul style="list-style-type: none"> ● A swimming pool at Shriners ● A list of physical activity resources, at Shriners or at primary care doctors' offices ● Encourage the sharing of information and resources among parents of children in BFit and other similar programs
<p>11a. Speaking generally, and thinking back over our discussion so far, what is the most important service you need for your child?</p>	<ul style="list-style-type: none"> ● Therapies--speech, OT, and PT ● Neuropsychologists ● Consistency of services ● Access ● Continuum of care ● Continuous therapies ● Fun physical therapy like the BFit program ● Easier access to durable equipment--fixing used equipment and

Question	Synthesis of Responses
	<p>getting it into the marketplace (insurance sometimes won't cover this equipment and it can be expensive)</p> <ul style="list-style-type: none"> ● The right placement in school (this was said twice) ● A ramp for the home because some homes will not qualify for this ● Attentive housing management that will ensure ongoing ADA accessibility ● Lists of services that the child may qualify for other than BFit and Shriners services ● More advocates for kids with disabilities in schools ● Continuation of Applied Behavioral Analysis services
<p>11b. Is there anything you would like Shriners to know about your needs around any of these issues?</p>	<ul style="list-style-type: none"> ● It would be helpful to get grants for parents of children with disabilities to take classes at community colleges and educate themselves about how to take care of their children at home ● 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 ● 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

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

Focus Group Report: Young Adults

Primary Hospital/Insurer: Baystate Eastern Region (Wing Hospital and Mary Lane Outpatient Center)

Topic of Focus Group: Young adults

Date of Focus Group: 3/6/2019 at the Ware Adult Learning Center

Facilitator: Rebecca Mazur

Note Taker: Gail Gramarossa

Executive Summary

A. Participant Demographics:

- Six participants - four men and two women
- All were young adults under age 25, and students in an adult learning program for GED/HiSET and career planning
- Three participants were white, and three were People of Color

B. Areas of Consensus:

- Transportation remains a huge barrier to getting to work, school, and other activities, especially if you have kids.
- There are too few social or entertainment opportunities for young adults that do not involve alcohol or drugs.
- Relationships between young adults and police are not good in Ware.
- There are too few job opportunities that pay good salaries with benefits.
- Affordable and safe housing is very hard to find, especially if you have a criminal record or a bad credit record.
- Have to travel to larger cities like Springfield to get services, and that is often impossible without transportation or support from friends or family.
- Hard to afford and find nutritious food; hard to get to the grocery store and back with bags and kids.

C. Key Recommendations:

Young adults need:

- Help with learning more practical skills such as budgeting and work-related training that helps them get a good job
- Dental care providers that take MassHealth
- More affordable and safe housing
- More social activities that are substance free and supportive of recovery

D. Quotes:

- "Very hard to take leadership or be involved in the town when you have a record; many of my peers have a juvenile record and it is a real obstacle to my future and my goals – can't do military, housing, etc., with a record"
- "I think that Ware is a lost cause – it has been since the 1940's and it's not getting any better"
- "The local police are not an asset – they are working for the community, but they can also be on 'power-trips'".
- "I just snack all day – eat pizza, food from gas stations, I have food at my job, but it is very expensive, I live on energy drinks and coffee".

E. Was there anything that could be relevant to another hospital service area? If so, which geographic area and describe:

- May be applicable to other hospitals/insurer serving a rural, lower-income young adult population such as Baystate Franklin Medical Center or Health New England

Key Issues

Question	Synthesis of Responses
1. What do you see among young adults your age as the biggest problems or challenges they face on a daily basis? How do they try to overcome those problems or challenges?	<ul style="list-style-type: none"> ● No sleep from combining work, school, and family ● Police problems ● Bad school experiences ● Budgeting/financial information and how to manage money
2. What are the biggest challenges with trying to get work that you enjoy?	<ul style="list-style-type: none"> ● Not sure what type of work I enjoy ● No place to get trained or start from the ground up ● Need college ● Need money for college or training programs ● Transportation is a huge barrier – young people can't afford cars
3. What gets in the way of getting good jobs with good pay and benefits? What about school or other types of training that can help you get good jobs?	<ul style="list-style-type: none"> ● Cost of training schools ● Have to travel too far to attend training schools or programs
4. Let's talk about some other basic needs that we all have - what do you see among young adults your age in terms getting enough food and healthy food? What does	<ul style="list-style-type: none"> ● No Spanish food here in town, I have to go to Springfield for that ● Junk food is cheaper than healthy food ● Hard to walk to grocery store with bags and kids ● Mostly shop at Wal-Mart and Big Y ● Eat a lot at gas stations and convenience stores

Question	Synthesis of Responses
<p>that look like for you and your peers? Where do you get food?</p>	
<p>5. How about housing and the kinds of options there are for living on your own? How easy or hard it is to get a safe place to live? What makes it easier or harder to find an affordable and safe place to live in this area?</p>	<ul style="list-style-type: none"> ● It's impossible to find safe, affordable housing. You have to have good credit record, no criminal record, no record of evictions. ● Landlords charge extra for pets ● Help from the Department of Transitional Assistance is not enough to cover costs ● Some landlords do not allow kids
<p>6. How about transportation and ways to get to work, school, appointments, shopping, or to just get around this area? What are the biggest transportation problems for adults your age? What resources do you use to get to where you need to go?</p>	<ul style="list-style-type: none"> ● The Quaboag Connector is good, but it should cover more hours in the evening and on weekends ● I just walk as I feel safer doing that than Uber. I don't trust buses when I have my 2 kids. ● Parents or friends drive me around when I need a ride ● Saving money for a car is very hard ● No PVTa regular schedules and routes ● Hitch rides with co-workers
<p>7. How about health care? What helps you get the health care you need when you need it, and what gets in the way of getting the health care that you or your family needs? For those of you with children, what makes getting health care for them easier or harder?</p>	<ul style="list-style-type: none"> ● Have to go out of town for dental care as no providers take MassHealth. Then have to deal with travel and transportation problems. ● Do not go to my primary health care, just use 911 or emergency department when I have a problem ● "We're young, so I don't think we need doctors that much"
<p>8. What about mental health, like depression or anxiety? Do people your age know where to get help for mental health issues? Do they get help? If not, why not?</p>	<ul style="list-style-type: none"> ● Care is really hard to find for mental health and substance use needs ● In-patient care feels like a jail – it's too crowded and scary ● Need more therapy and counseling programs for younger adults
<p>9. When you think of the young adults you know, how many of them are struggling with issues related to alcohol</p>	<ul style="list-style-type: none"> ● There are significant problems with substance use among our peers. We've seen many friends die from overdoses. "We are hiding our pain with drugs." ● There is over-prescribing of pain medications after surgery and

Question	Synthesis of Responses
<p>or other drug use either themselves or in their families? What would make it easier for adults your age to deal with alcohol or drug problems for themselves or their families?</p>	<p>heroin is cheap</p> <ul style="list-style-type: none"> ● Need more help from people with "real-life" experience and less judging by family and friends ● Small town life has stigma and everyone knows your business, so it's hard to get help locally ● Offer more sober activities and drug-free social events ● Most of us are dealing with trauma that leads to substance use
<p>10. What else should we know about what you need to be healthy in this area?</p>	<ul style="list-style-type: none"> ● We need more Wi-Fi access and help with computers ● Need more retail stores like clothing stores ● "It's easier to get liquor than to get healthy food in town" ● More digital bulletin boards about activities and events ● More apps, text messages, and phone communications to reach young adults ● Need clean water more consistently ● We need more of a community and connectedness

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

Focus Group Report: Young Adults

Primary Hospital/Insurer: Baystate Eastern Region (Wing Hospital and Mary Lane Outpatient Center)

Topic of Focus Group: Young adults

Date of Focus Group: 3/19/2019 at the Palmer Public Library

Facilitator: Karen Auerbach

Note Taker: Gail Gramarossa

Executive Summary

A. Participant Demographics:

- Four participants – one man and three women
- All were young adults under age 25
- Three participants were white, and one was a Person of Color

B. Areas of Consensus:

- Transportation remains a huge barrier to getting to work, school, and other activities
- It is almost impossible to afford to go to college; loan payments are too hard to make
- Stress among young adults is very high; depression and anxiety about the future are also very prevalent
- Affordable and safe housing is very hard to find; have to have several roommates to afford an apartment in the area and need to be near stores, bus stops
- Healthy food is expensive and most of us don't know how to cook
- We worry about what happens when we come off of our parents' health insurance – makes us keep a job just for the benefits, even if we don't like the job

C. Key Recommendations:

Young adults need:

- More affordable and safe housing
- Affordable options for going to college and/or training schools on the pathway to better jobs and longer-term careers

D. Quotes:

- "I think that most young people are just an 'organized mess', at least I know I am"
- "I was trying to go to work and school, but I just couldn't focus on both at the same time and did not get what I needed out of either work or school"
- "What I need to get a good job are schooling, connections and a good reputation – it's all in who you know"
- "I have to feel comfortable with the people I work with – it's hard when a supervisor you like moves on"
- "Medications are not covered under my parents' health insurance, so I skip my autism meds sometimes"

- E. Was there anything that could be relevant to another hospital service area? If so, which geographic area and describe:
- May be applicable to other hospitals/insurer serving a rural, lower-income young adult population such as Baystate Franklin Medical Center or Health New England

Key Issues

Question	Synthesis of Responses
1. What do you see among young adults your age as the biggest problems or challenges they face on a daily basis? How do they try to overcome those problems or challenges?	<ul style="list-style-type: none"> ● Depression and anxiety ● Lack of confidence in what we are doing ● Costs of college are too high; looking for and obtaining scholarships is a challenge ● Trying to combine work and school simultaneously
2. What are the biggest challenges with trying to get work that you enjoy?	<ul style="list-style-type: none"> ● Not sure what type of work I enjoy ● Need college; need money for college or training programs ● Transportation is a huge barrier ● Disabilities and learning disabilities make it harder to find work
3. What gets in the way of getting good jobs with good pay and benefits? What about school or other types of training that can help you get good jobs?	<ul style="list-style-type: none"> ● Employers want more credentials and experience ● Discrimination against people with learning disabilities or other types of disabilities ● May not have the right “connections” with key people
4. Let’s talk about some other basic needs that we all have - what do you see among young adults your age in terms getting enough food and healthy food? What does that look like for you and your peers? Where do you get food?	<ul style="list-style-type: none"> ● Healthy food is expensive ● Some people have social anxiety and eating out is challenging ● Food allergies make it hard to participate in free meals or lunches at the library or other places ● Most young people do not know how to cook for themselves; they still rely on family for meals
5. How about housing and the kinds of options there are for living on your own? How easy or hard it is to get a safe place to live? What makes it easier or harder to find an	<ul style="list-style-type: none"> ● It very hard to find safe, affordable housing ● Worry that the housing is old and not safe, risk of fires and other hazards; factory housing has not been renovated enough or recently enough ● Most young adults needs to share a place with roommates and that brings its own challenges

Question	Synthesis of Responses
affordable and safe place to live in this area?	<ul style="list-style-type: none"> • Need to have places on bus lines near stores and services
6. How about transportation and ways to get to work, school, appointments, shopping, or to just get around this area? What are the biggest transportation problems for adults your age? What resources do you use to get to where you need to go?	<ul style="list-style-type: none"> • Still relying on parents and friends for car rides • Walking where and when I can, helps that I live near the center of town • When feasible, share a car with friends • Some friends are too scared to drive
7. How about health care? What helps you get the health care you need when you need it, and what gets in the way of getting the health care that you or your family needs? For those of you with children, what makes getting health care for them easier or harder?	<ul style="list-style-type: none"> • Most are on parents' health insurance, but worry about what will happen when they age out of that option; how do we get coverage when we are not on our parents' plans? • Young adults may get and keep a job just to be eligible to get employer-based health insurance • Not sure I trust doctors; "if I am not dying, I won't go to an MD" • Some local doctors are not taking new patients
8. What about mental health, like depression or anxiety? Do people your age know where to get help for mental health issues? Do they get help? If not, why not?	<ul style="list-style-type: none"> • Depression is very common among their peers • Young adults may not know where and how to seek help; there are resources at the library, but need more information on social media and online resources where young people typically look for information • Still a huge amount of stigma with seeking help for mental health needs; PTSD and trauma are not recognized as much as they should be • Hard to find a clinician that you like, trust and can be totally open with; transitions and changes in mental health care providers are hard and make treatment less effective • If I have no insurance, seems like I would not easily get care or at all
9. When you think of the young adults you know, 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 adults your age to	<ul style="list-style-type: none"> • Family members are frequently using substances; peers have experience with family alcohol and drug use • Lots of young adults using JUULs and other vaping products • Use JUULs with marijuana as well as nicotine • If you are underage, not hard to find people to buy alcohol, vaping or marijuana products for you • Young adults think they can 'party' hard and can handle it • For some, it is social activity and fun to use a lot of alcohol and other

Question	Synthesis of Responses
deal with alcohol or drug problems for themselves or their families?	drugs <ul style="list-style-type: none">• Much more prevention and education programs are needed; many youth and young adults in Palmer are using substances• Many young adults need help with family issues as well as peer issues

Appendix IV. Key Informant Interview Summaries

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

Key Informant Interview Report

Hospital/Insurer: Baystate Franklin Medical Center

Interviewer: Kat Allen, with Jeanette Voas taking notes

Interview Format: In person interview, 1 hour

Participants: Community Health Center of Franklin County Leadership Team of:

- Ed Sayer (CEO)
- Jared Ewart (Accountant)
- Arcey Hoynoski (CFO)
- Maria Heidenreich (Medical Director)
- Cameron Carey (Development Director)
- Maegan Petrie (Accountant)
- Allison van der Velden (Dental Director)
- Allie Jacobson (Information)
- Jessica Calabrese (COO)
- Susan Welenc (Population Health)
- Susan Luippold (Human Resources)
- Wes Hamilton (CIO)

Question	Synthesis of Responses
<p>1. Three most urgent health needs/problems</p>	<ul style="list-style-type: none"> • Homelessness • Access issues (including # providers, transportation, social determinants, expenses), e.g. for oral health – urgency because of lack of access • Behavioral health; too few psych prescribers, so primary care providers end up prescribing outside their comfort zones • Shortage of dental specialists, so dental providers work outside their comfort zones
<p>2. Health issues that have emerged and/or dramatically increased in prevalence in the last 1-2 years</p>	<ul style="list-style-type: none"> • Opioid crisis isn't new but it's gotten more visible in past couple of years • Anxiety and depression – everyone has some psych diagnosis that needs managing • Obesity continues to mount, and that causes other health problems

Question	Synthesis of Responses
	<ul style="list-style-type: none"> • New diagnoses of PTSD including from dysfunctional families. We may be identifying it more than before. People see a behaviorist and things start to come out.
3. Specific vulnerable populations of concern	<ul style="list-style-type: none"> • Migrant seasonal agricultural workers (we take care of about 300 – there are close to 2,000 in FC) with usual problems plus language, cultural barriers, insurance. They are unfamiliar with our system & don't advocate for themselves. CHC doesn't have enough bilingual staff • Pediatric population: <ul style="list-style-type: none"> ○ More kids with anxiety, OCD, ADD ○ When our dental providers see kids, they're often well down the path of oral disease ○ Behavioral health issues affect school attendance, health regimes & take a toll on families • GLBQ+ and transgender – we're trying to get better at providing services for them • Elderly – we don't tend to their needs specifically, e.g. no fall risk screening
4. Gaps to health care of most concern	<ul style="list-style-type: none"> • Transportation • Gaps in reimbursement structure, e.g. telehealth, community health workers • When people shift to high deductible plans, docs will wait until the end of the year to see them when deductible is paid • Lack of coordinated care (primary care, oral health, behavioral health)
5. Barriers	<ul style="list-style-type: none"> • Transportation • Language • Psychiatric services • Housing • Food insecurity – has gotten worse • Poverty • Illiteracy
6. What's missing that we're not seeing in the data	<ul style="list-style-type: none"> • Just starting to capture social determinants • We have data on those who are using the system; we don't know about those who are not.

Question	Synthesis of Responses
7. Opportunities for prevention to keep people out of hospital	<ul style="list-style-type: none"> ● Transitions of care: we contact discharged patient within 48 hours and follow up on meds, questions, services, appointments. It's reimbursed through CMS (Centers for Medicare & Medicaid Services) if patient not readmitted within 30 days. ● Complex case management is not reimbursable or sustainable ● Work on getting patient buy-in, holding patients accountable, responsible for self-care ● More oral health providers and space where people can get regular restorative care. emergency department visits for dental issues are a waste of \$\$.
8. What's needed apart from more funding	<ul style="list-style-type: none"> ● Access to healthy food ● Healthy social support systems to address loneliness, isolation, lack of transportation ● Places to congregate ● Exercise opportunities and associated social connections ● More community health workers
9. Resources to refer people to from the CHC	<ul style="list-style-type: none"> ● Dental specialists (oral surgeons, periodontists, orthodontists). We have regional shortages, and it's even worse in the public service sector. ● Groups for social support, weight loss, etc. ● Psychiatry for ongoing care
10. Recommendations for connections between hospitals and public health	<ul style="list-style-type: none"> ● This is important. Now we have a Balkanization of health services. ● Hospitals can: <ul style="list-style-type: none"> ○ Attract and recruit specialists ○ Fund common electronic health record ○ Provide clearinghouse for best practices ○ Legal services to help people navigate issues, e.g. with landlords
11. How to support such a partnership	<ul style="list-style-type: none"> ● Subscription. CHCFC would be ready to pay into a menu of services.
12. Other	<ul style="list-style-type: none"> ● It's shocking how weak the connection is between the hospital and the CHCFC. ● 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. ● It's a struggle to recruit and staff the health center. Loan

Question	Synthesis of Responses
	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/Insurer
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
<p>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?</p>	<p>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.</p> <p>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.</p> <p>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.</p>
<p>2. What gets in the way of young adults getting good jobs with good pay and benefits?</p>	<p>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.</p> <p>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.</p>
<p>3. What do you see among young adults in terms of getting enough food and</p>	<p>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</p>

Question	Synthesis of Responses
healthy food? What does that look like for them?	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.
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?	<p>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.</p> <p>Young people often don't know how to get housing. They tend to not have the necessary skills and knowledge.</p>
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?	<p>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.</p> <p>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.</p> <p>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.</p>
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	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

Question	Synthesis of Responses
<p>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?</p>	<p>through marijuana and drug use, and through going to marijuana and vaping shops and meeting up with other people.</p> <p>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.</p>
<p>8. What else should we know about what young adults in the Quaboag Hills region need to be healthy?</p>	<p>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".</p>

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

Public Health Interview Summary Report

Interviewer: Catherine Brooks

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

Participants:

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

Question	Synthesis of Responses
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	The issues most frequently named were mental health, substance use, obesity, chronic diseases.

Question	Synthesis of Responses
service area?	
<p>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?</p>	<p>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.</p>
<p>5. What gaps in services exist in addressing these needs? What are barriers to filling these gaps?</p>	<p>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.</p>
<p>6. In addition to more funding, what resources do you need to better address these emerging or increasing health concerns?</p>	<p>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.</p>
<p>7. What specific vulnerable populations are you most concerned about? And why?</p>	<p>Populations mentioned included:</p> <ul style="list-style-type: none"> ● People with mental health issues ● People coming out of jail ● African-Americans ● Transgender population ● Isolated elders ● New Americans, from specific communities that lack established outreach ● Homeless ● Residents of rural communities

Question	Synthesis of Responses
	<ul style="list-style-type: none"> • Inner city residents <p>All of these communities lack resources, access, culturally sensitive providers.</p>
<p>8. Externally, what resources/services do you wish people in your area had access to?</p>	<p>Resources and services mentioned included:</p> <ul style="list-style-type: none"> • Transportation • Better pain management services (Stanford has a course about creative, non-medical approaches to pain management) • Housing for people coming out of jail • Supports for new Americans • Funding for social determinants of health • Workforce issues - recruiting and retaining physicians • Drop-in day services for people with mental health issues and people experiencing homelessness • Easy-to-navigate public health insurance accepted by most providers
<p>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?</p>	<p>Hospitals are the big organization in any partnership. They need to step back and not always take a leadership role, let smaller community-based organizations lead at times. There is a need to clarify roles and responsibilities within partnerships.</p> <p>Some suggestions for what hospitals can do include:</p> <ul style="list-style-type: none"> • Working with public health nurses on readmission prevention and discharge planning • Partnering with local health departments for workshops on pain management • Putting pressure on the state to provide public health, put political power behind the need for a better system • Providing Community Health Needs Assessment data for their communities to local health agents • Providing forums for community people to come together and talk • Supporting partnerships between public health nurses and community liaisons from hospitals. Jeff Harness does this very well, but he is one person <p>Sustainability suggestions include:</p> <ul style="list-style-type: none"> • Using community benefits funding to support and sustain the partnership • Working from a project list to sustain momentum • The Massachusetts Department of Public Health can provide financial support for forums
<p>10. What issues do you see</p>	<p>Issues mentioned included:</p>

Question	Synthesis of Responses
<p>emerging in the next 5 years?</p>	<ul style="list-style-type: none"> ● The opioid crisis will keep evolving, with new types of drugs ● The warming climate will lead to an increase in tick-borne diseases, mold, respiratory ailments ● Youth marijuana and vaping ● Pertussis ● Child and maternal health ● Obesity ● Aging population, especially veterans ● The rising cost of health insurance ● The immigrant community being afraid to access health insurance and health services ● 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/Insurer 2019 Community Health Needs Assessment

Community Conversation Summary Report

Primary Hospital/Insurer: Baystate Wing Hospital

Topic of Focus Group: Health and social determinant of health needs

Date of Focus Group: 2/28/2019

Facilitator: Gail Gramarossa

Location: Education to Employment (E2E) site of Holyoke Community College in Ware, MA

Executive Summary

- A. Participant Demographics:
 - Eight participants
 - From Ware and the surrounding area
 - white
 - Women

- B. Areas of Agreement (top health needs and social determinants of health):
 - Vaping among teens
 - Substance Use
 - Mental Health
 - Transportation; especially for evenings and weekend shift work
 - Access to healthy, affordable food
 - Safe, affordable housing for young adults and young parents
 - Stable jobs with good wages and benefits to secure sufficient income

- C. Recommendations:
 - Need more options for transportation and affordable, safe housing
 - More services for young adults and young parents, especially those in recovery or trying to get life 'on track' after leaving high school before graduating
 - Need more parent education; young parents may have experienced family trauma and need support to learn parenting skills themselves
 - Need more training for young adults in basic life skills such as cooking, banking, laundry, employment-seeking, looking for housing, budgeting, etc.

- D. Participant Quotes:
 - "Young people have anxiety and depression, so they often medicate themselves with alcohol and drugs."

- “We need more parent education – most of my clients did not have good parenting themselves, so they don’t have that to draw upon when they are parenting their own kids.”
- “Transportation needs in this rural area are still a major concern.”
- “We have an issue with transportation justice – poorer residents still have barriers to getting transportation.”

Question	Synthesis of Table Discussions
1. What are the top three most pressing health needs in your community?	<ul style="list-style-type: none"> ● Substance use, especially vaping among teens and young adults ● Transportation; still a huge issue in a rural region, even with major improvement in past few years with the establishment of the Quaboag Connector van services ● Mental health; especially anxiety and depression among youth and young adults
2. Who is disproportionately impacted by these problems? How?	<ul style="list-style-type: none"> ● Teens ● Young adults ● People in domestic violence situations ● Isolated elders and others in small, rural towns ● Young mothers, especially single mothers
3. Who do you think is being missed in the CHNA process?	<ul style="list-style-type: none"> ● School counselors ● Rural populations ● Speakers of other languages ● Young parents ● People with experiences with the Department of Children and Families and/or foster care; they do not trust any organizations or institutions in the system, so are less likely to participate in community assessments

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

Community Conversation Summary Report

Primary Hospital/Insurer: Baystate Medical Center

Topic of Focus Group: Health needs and social determinants of health/ Spanish

Date of Focus Group: 2/8/2019

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 Street 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 recursos que hay para la comunidad hispana (advertise about resources available to the Latino community)”

Question	Synthesis of Table Discussions
<p>1. What are the top 3 most pressing health needs in your community?</p>	<ul style="list-style-type: none"> ● Transportation ● Culturally competent care with Spanish speaking translators ● Food Securities
<p>2. Who is disproportionately impacted by these problems? How?</p>	<ul style="list-style-type: none"> ● People without transportation ● Non-English speaking ● Undereducated ● Speakers of other languages ● Homeless/at risk for homelessness ● People living with substance use disorders ● Older adults <p>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.</p>
<p>3. Who do you think is being missed in the CHNA process?</p>	<ul style="list-style-type: none"> ● Media ● Elderly/older adults ● Barber shops and beauty salons ● Men ● Government officials ● Grandparents who are raising their grandchildren ● Youth and young adults ● Single parents ● Clergy

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

Community Conversation Summary Report

Primary Hospital/Insurer: Baystate Medical Center

Topic of Focus Group: Health needs and social determinants of health

Date of Focus Group: 2/21/2019

Facilitator: Jenise Katalina

Note Taker: Gail Gramarossa

Location: Martin Luther King Jr. Family & Community Services, Springfield, MA

A. Participant Demographics:

- 45 people
- Mason Square neighborhood in Springfield
- Primarily African-American attendees
- Wide range of ages and mixed gender

B. Areas of Agreement (top health needs and related issues):

- Mental health issues
- Gun violence
- Transportation needs, especially door-to-door services for elders and young parents with children
- Food insecurity
- Obesity

C. Recommendations:

- Need more dialogue and mutual conversation with health care providers, law enforcement and people directly affected by gun violence to get at solutions at the neighborhood level
- Need more resources to address social needs in the urban Mason Square area. The clinic is a good resource for health care, 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
- 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
- Need bigger room

D. Participant Quotes:

- “Depression is a huge problem, but we don't talk about it.”

- “Guns and bullets don’t fly in places where there is a lot of money - they fly where there is not enough money.”
- “The system keeps people in poverty.”

Question	Synthesis of Table Discussions
1. What are the top 3 most pressing health needs in your community?	<ul style="list-style-type: none"> ● Mental health ● Food security/access to healthy food ● Gun violence
2. Who is disproportionately impacted by these problems? How?	<ul style="list-style-type: none"> ● People without transportation ● Uninsured/underinsured ● Undereducated ● Speakers of other languages ● Homeless/at risk for homelessness ● People living with substance use disorders ● Older adults <p>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.</p>
3. Who do you think is being missed in the CHNA process?	<ul style="list-style-type: none"> ● Media ● Elderly/older adults ● Barber shops and beauty salons ● Men ● Government officials ● Grandparents who are raising their grandchildren ● Youth and young adults ● Single parents ● Clergy

Appendix VI. Community Chat Summary

Community and Stakeholder Engagement

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

Methodology

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

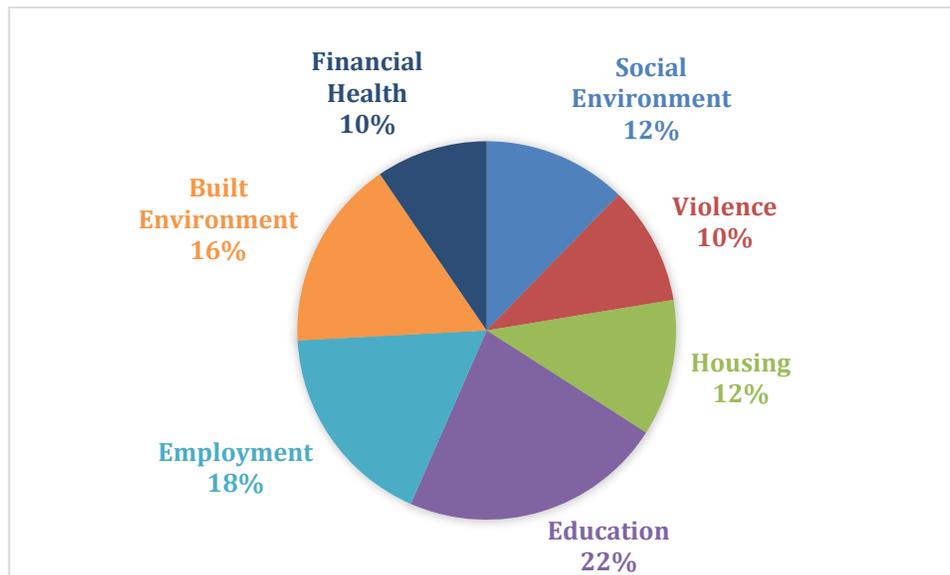
Figure 1: Chat Participants

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

Health Needs, Issues, and Concerns

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

Figure 2: Social Determinants of Health Priorities 2019



Priorities from Chat Participants

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

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

Priority Populations

Commonly cited priority populations and common challenges include:

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

Community Assets

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

Limitations and Recommendations

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

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