

2019 Community Health Needs Assessment

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



**PUBLIC HEALTH INSTITUTE
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PARTNERS FOR HEALTH EQUITY



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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- **Ann Darling**, Community Action Pioneer Valley
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Consultant Team

Lead Consultant

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

Consultants

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

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

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

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I. Executive Summary

Introduction and Method

Baystate Medical Center (Baystate Medical) is a 724-bed academic medical center based in Springfield, Massachusetts. Baystate Medical is home to western New England's only tertiary care referral medical center, Level I Trauma Center and Level II Pediatric Trauma Center, and neonatal and pediatric intensive care units. The medical center also includes Baystate Children's Hospital and the Wesson Women and Infants' Unit, and is the regional campus of the University of Massachusetts Medical School - Baystate. Baystate Medical is also the community's major referral hospital, providing the highest level of care for conditions such as cancer, acute, and chronic cardiovascular illness, nervous system illness, digestive illness, and other diseases that affect the major organs of the body.

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

Baystate Medical is a member of the **Coalition of Western Massachusetts Hospitals/Insurer** (Coalition) a partnership between eight non-profit hospitals, clinics, and insurers in the region. The Coalition formed in 2012 to bring hospitals in western Massachusetts together to share resources and work in partnership to conduct their triennial **community health needs assessments** (CHNAs) and address regional needs. Baystate Medical worked in collaboration with the Coalition to conduct this assessment and update the findings of the Baystate Medical 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 Medical's Community Benefits Strategic Implementation Plan (SIP) development efforts

The assessment focused on **Hampden County**, the **primary geographic service area of Baystate Medical**. The Coalition engaged over 1,200 residents across the counties of western Massachusetts in data collection and outreach about the CHNA.

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, and systemic racism - and their consequences, such as unequal access to jobs, education, housing, safe environments, and health care.

When identifying the areas that can be addressed to improve the health of the population, the assessment used the Massachusetts Department of Public Health's (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 (DoN) processes when hospitals make capital improvements and allocate funds for community benefits.

The **prioritized health needs** identified in the 2019 CHNA include community level social and economic determinants that impact health, access and barriers to quality health care, and health conditions and behaviors. The assessment included analysis and synthesis of 1) a variety of social, economic, and health data; 2) findings from recent Hampden County and regional assessment reports; 3) information from 12 focus groups and interviews with 50 key informants, plus five interviews with public health leaders, conducted for the 2019 CHNA; and 4) community input from three Community Conversations (two in English and one in Spanish) and 38 Community Chats. In total, almost 1,100 individuals across Hampden County 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 in Hampden County, we focus on inequities among those who are Latino and black because 1) they are the largest communities of color in Hampden County and 2) available data was limited for other racial and ethnic groups, such as Asian, Native American, and others. We use the terms white, black, and Latino, recognizing that these terms do not always capture how every individual identifies themselves. For more information on the terminology of race and ethnicity as well as other definitions, please see the Glossary in Appendix II.

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

Findings

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

COMMUNITY LEVEL SOCIAL AND ECONOMIC DETERMINANTS THAT IMPACT HEALTH

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

- **Social environment** - a key area where many in Hampden County face challenges – In general, Hampden County is younger, more racially and ethnically diverse, and has higher levels of disability than the state. Experiences of interpersonal and structural racism as well as social isolation create barriers to being able to access services and social determinants of good health. In addition, people spoke of the negative effect that social isolation has on health and the health value of being part of a community.
- **Housing needs** - over one-third of residents experience housing insecurity, paying more than 30% of their income on housing. For a typical household, people pay more than half of their income on housing plus transportation. Hampden County has the highest amount of homelessness in western Massachusetts. Poor housing conditions also impact the health of residents. Older housing combined with limited resources to maintain the housing leads to conditions that can affect asthma, other respiratory conditions, and safety.
- **Access to transportation, healthy food, and places to exercise** - decisions about how the infrastructure is developed impact transportation choices and access to healthy food, among other determinants. Nearly 14% of Hampden County residents and 23% of Springfield residents do not have personal transportation or rely on public transportation. Over 23% of Springfield residents travel by bus, and the Pioneer Valley Transit Authority raised rates and decreased service in 2018. Private sector and economic development investments have led to parts of Hampden County being considered food deserts, which are areas where low-income people have limited access to grocery stores. Hampden County residents experience limited access to healthy foods. Springfield, Holyoke, and Chicopee in particular have high rates of food insecurity experienced by over 20% of residents in some areas of these communities.
- **Lack of resources to meet basic needs** - many Hampden County residents struggle with insufficient financial means; 17% of Hampden County residents have incomes at poverty levels and the median household income is one-third lower than that of the state. Though unemployment rates have dropped, they continue to impact the county with rates of up to 8%. Springfield's average hourly wage of \$17.85 is far less than the estimated living wage of \$27.29.

- **Educational attainment** - lower levels of education contribute to unemployment, the ability to earn a livable wage, and many health outcomes. About 16% of Hampden County residents do not have a high school diploma (10% do not in Massachusetts overall) and only 27% of Hampden County residents have a bachelor's degree or higher (in Massachusetts, 42% do).
- **Violence** - similar to the 2016 CHNA, personal and community safety were elevated as a concern in Hampden County. About 13% of all sexual assaults in the state occurred in western Massachusetts, and Springfield Police found that 67% of all assault arrests in 2014 were domestic violence assaults. Crime rates are high, with violent crime rates in Hampden County almost 60% higher than that of the state, and murder by guns in Springfield increasing by 20% between 2013 and 2017. Youth bullying was also identified as a concern in this assessment, particularly of children with disabilities, and GLBQ+ (gay, lesbian, bi-sexual, queer, questioning) and transgender students.

"It affects you badly. You just spoke to that person and then an hour or a day later you find out your friend was shot. Most of the time, we are going to keep living, and that's the hard part."

Focus Group Participant, Focus Group about Gun Violence, Hampden County

- **Environmental exposures** - air pollution impacts the health of Hampden County residents. Springfield experiences poor ambient air quality due to multiple mobile and point sources, making the risk of cancer from breathing air toxins 80% higher than that of the state. Air pollution impacts the morbidity of several chronic diseases that have a high prevalence in Hampden County, including asthma, cardiovascular disease, and diabetes, which recent studies have suggested is associated with air quality. Exposure to lead is also heightened in Springfield and Holyoke.

BARRIERS TO ACCESSING QUALITY HEALTH CARE

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

- **Insurance and health care related challenges** - the ability to navigate both what health insurance will cover and medical care systems was raised by multiple community stakeholders and interviewees. Despite high rates of health insurance coverage, people cited high costs of co-pays, deductibles, tests, and medications as barriers. The difficulty of knowing what is covered or not, constant changes in coverage, and barriers of bureaucracy were also mentioned as examples.
- **Limited availability of providers** - Hampden County residents experience challenges accessing care due to the shortage of providers. Focus group participants reported using "Minute Clinic" because they could not get an appointment with their provider, providers were not accepting

new patients, and other barriers. Psychiatrists who can prescribe and dental providers were identified as in shortage. Focus group participants and key informant interviewees overwhelmingly reported a need for increased access for both mental health and addiction services for acute, maintenance, and long-term care.

“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

- **Need for culturally sensitive care** - public health leaders, focus group participants, and other interviewees called for increased training, experience, and sensitivity for health care and social service providers to a variety of different cultures. Cultures of race and ethnicity as well as the cultures of people with mental health and substance use disorders, older adults, transgender patients, ex-offenders, people experiencing homelessness, and adults and children with disabilities were mentioned.
- **Lack of transportation** - transportation arose as a barrier to care among interviewees in the 2016 CHNA, and it was one of the most frequently cited barriers to accessing care in key informant interviews and focus groups for the 2019 CHNA. Poor access to transportation is a barrier to medical care, other appointments, picking up medication, work, and non-work activities.
- **Lack of care coordination** - increased care coordination continues to be a need in the community. Areas identified in focus groups 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 communication when a person is released from an institution such as jail, foster care, or substance use treatment programs, and the need for hospitals to coordinate with community health centers should hospitalization take place.
- **Health literacy, language barriers** - the need for health information to be understandable and accessible was identified in this assessment. Data from focus groups indicates the need for increased health literacy, including understanding health information, types of services and how to access them, and how to advocate for oneself in the healthcare system. The need for provider education about how to communicate with patients about medical information also arose. Focus group participants and key informant interviewees noted the need for more bilingual providers, translators, and health materials translated into a wider range of languages.

HEALTH OUTCOMES

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

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

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

- **Chronic health conditions** - high rates of obesity, cancer, diabetes, cardiovascular disease (CVD), asthma, chronic obstructive pulmonary disease (COPD), and associated morbidity previously identified as prioritized health needs in the 2016 CHNA continue to impact Hampden County residents. Heart disease is the leading cause of death, with cancer the second leading cause. An estimated 29% of adults in Hampden County are obese with 37% obese in Springfield. Four out of five adults over 65 have hypertension, a risk factor for cardiovascular disease. An estimated 11% of county residents have diabetes. Emergency department use due to asthma for adults is 78% higher than the state. Pediatric asthma ranges from 10% of children in Westfield and West Springfield to up to 20% in the urban core cities of Hampden County.
- **Physical activity and nutrition** - the need for increased physical activity and consumption of fresh fruits and vegetables was identified among Hampden County residents. Low rates of physical activity and healthy eating contribute to high rates of chronic disease and also impact mental health.
- **Infant and perinatal health** - infant and perinatal health factors were identified as health needs in the 2016 CHNA and continue to impact Hampden County residents. Need for increased utilization of prenatal care and a decrease in smoking during pregnancy were identified. Disparities in prenatal care and birth outcomes are correlated with whether a person has private or public insurance. Many of these factors contribute to the 8-10% rate of babies born preterm or low birth weight in Hampden County.

- **Sexual health** - while great strides have been made to reduce the teen birth rate in Hampden County, it is still more than double that of the state. Reducing high rates of unsafe sexual behavior remains a need in Hampden County. Sexually transmitted infection (STI) rates continue to be high, with Hampden County chlamydia, gonorrhea, syphilis, and HIV rates higher than that of the state. Youth are at particular risk for sexually transmitted infections.
- **Alzheimer's disease** - Hampden County has higher rates of Alzheimer's disease than the state. By 2035, the percentage of people over the age of 60 is expected to increase to 28% in Hampden County.

PRIORITY POPULATIONS

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

Data also indicated increased risk for poor mental health and substance use disorder among youth and particularly girls, GLBQ+ youth, transgender youth, older adults, Latinos, women, people reentering society after incarceration, people experiencing homelessness, veterans, and those with dual diagnoses (mental health and substance use disorder).

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

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

Key Informant Interview, Public Health Official, Hampden County

Summary

Hampden County continues to experience many of the same prioritized health needs identified in Baystate Medical's 2016 CHNA. Social and economic challenges experienced by the population in the service area contribute to the high rates of chronic and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health inequities observed among priority populations, which include children, older adults, Latinos, blacks, GLBQ+ and transgender youth, people with low-incomes, women, people with mental health and substance use disorders, people involved in the criminal legal system and those experiencing homelessness, and people living with disabilities. Additional data is needed to better understand the needs of these populations in order to reduce inequities.

The Baystate Medical service area population continues to experience a number of barriers that make it difficult to access affordable, quality care, some of which are related to the social and economic conditions in the community, and others which relate to the health care system. Mental health and substance use disorders were consistently identified as top health conditions impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. Chronic health conditions such as obesity, cancer, diabetes, cardiovascular disease, and asthma were also prioritized.

II. Introduction

1. About Baystate Medical Center

Baystate Medical Center (Baystate Medical) is a 724-bed academic medical center based in Springfield, Massachusetts. Baystate Medical is home to western New England's only tertiary care referral medical center, Level I Trauma Center and Level II Pediatric Trauma Center, and neonatal and pediatric intensive care units. The medical center also includes Baystate Children's Hospital and the Wesson Women and Infants' Unit, and is the regional campus of the University of Massachusetts Medical School - Baystate. Baystate Medical has over 1,100 medical staff physicians, 10 residency training programs, and 536 volunteers who have given over 47,000 hours of their time. Baystate Medical is the community's major referral hospital, providing the highest level of care for conditions such as cancer, acute and chronic cardiovascular illness, nervous system illness, digestive illness, and other diseases that affect the major organ systems of the body.

Baystate Medical is part of **Baystate Health**, a not-for-profit, multi-institutional, integrated health care organization which includes the following: Baystate Medical Center, Baystate Franklin Medical Center, Baystate Wing Hospital (and Baystate Mary Lane Outpatient Center), Baystate Noble Hospital, Baystate Medical Practices, Baystate Home Health, and Baystate Health Foundation.

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

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

2. Coalition of Western Massachusetts Hospitals/Insurer

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

3. Community Health Needs Assessment (CHNA)

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

Integral to this needs assessment was the participation and support of community leaders and representatives who provided input through the **CHNA Regional Advisory Council (RAC)** and the **Baystate Medical 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 Medical CBAC members who participated in the RAC: Jennifer Lee of Stavros Center for Independent Living and Luz Lopez of MetroCare of Springfield.

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

III. Methodology for the 2019 CHNA

1. Equity as a Guiding Value

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

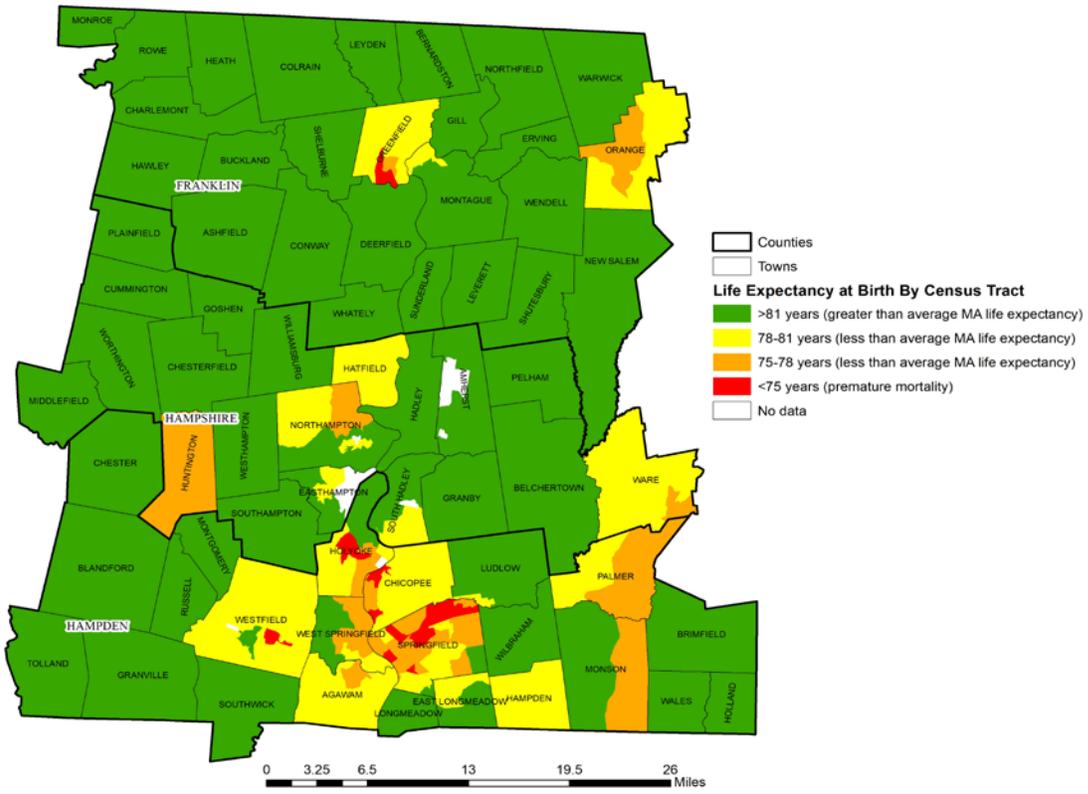
The Coalition and the CHNA RAC created a proposition that the CHNA reflect values of health equity, cultural humility, and social justice within a framework of social determinants of health. As part of this, the CHNA was conducted with an inclusive, community-engaged process that strove for 1) a transparent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

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

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

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

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



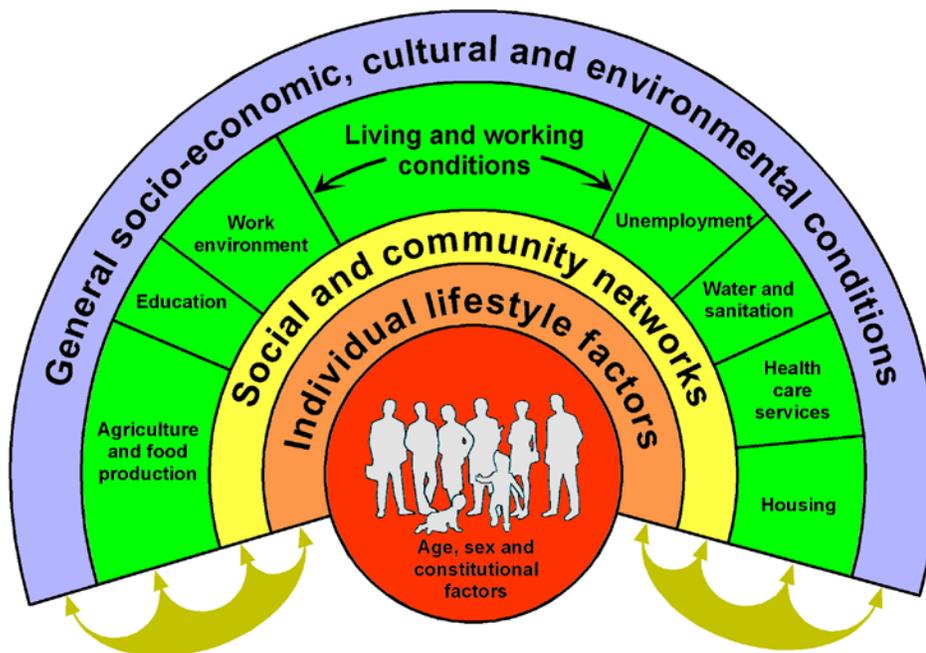
Data Source: For data files: National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP); Life Expectancy Estimates File for Massachusetts, 2010-2015). National Center for Health Statistics. 2018. Available from: <https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html>.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

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

2. Social and Economic Determinants of Health Framework

Similar to the 2016 CHNA, this CHNA was conducted using a determinant of health framework recognizing that social and economic environments contribute substantially to population health. Research shows that genetics or biology account for less than a third of health status.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).

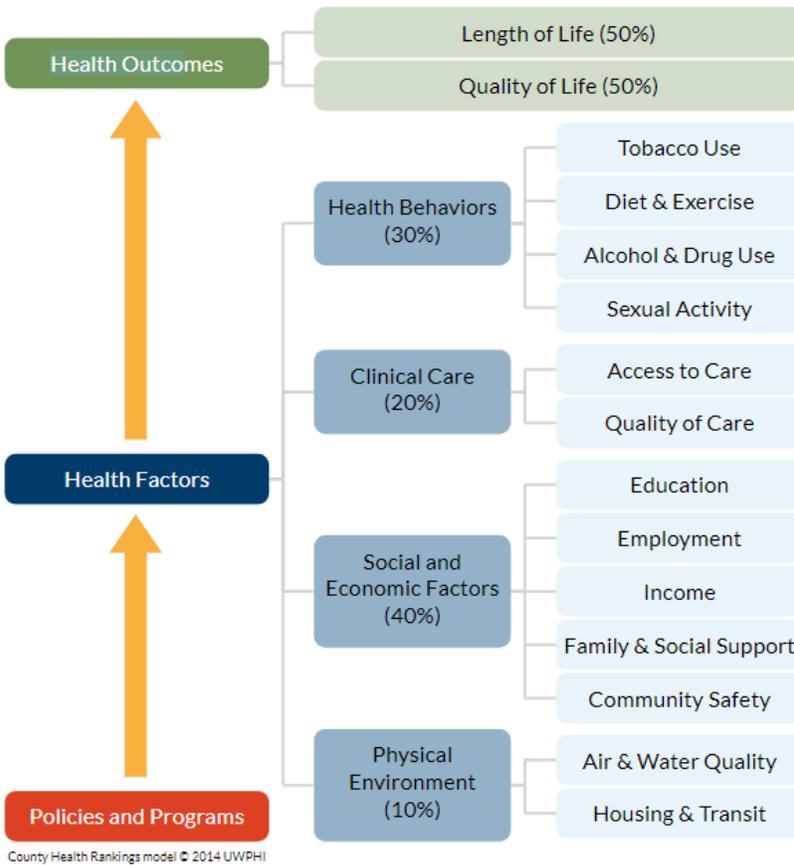
Figure 2. Determinants of Health



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



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.

Figure 4. Massachusetts Department of Public Health Priorities



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 12 focus groups, 55 interviews with key informants (including with local and regional public health officials), three Community Conversations, and 38 Community Chats conducted by the consultant team and the RAC as part of this CHNA (occasionally the experiences of community members who gave input in focus groups or key informant interviews in other regions were considered relevant to this service area and was included); and 3) review of existing assessment reports published since 2016 that were completed by community and regional agencies serving Hampden County. The assessment focused on county-level data and select community-level data as available. Given data constraints, the following communities were identified for the majority of the community level data analyses: Chicopee, Holyoke, Palmer, Springfield, West Springfield, and Westfield. Other communities were included as data was available and analysis indicated an identified health need for that community. Health Equity Workgroup members of the 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 or population, e.g., the state of Massachusetts and the town of Palmer. If all we could report was the number of people hospitalized, for example, it would not be possible to compare how Palmer is doing compared to the state. 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 2016 CHNA priorities were used as a baseline for the 2019 assessment, with a goal of reprioritizing if quantitative and qualitative data, including community feedback, indicated changes. For the 2016 CHNA prioritization, health conditions were identified based on consideration of magnitude and severity of impacts, populations impacted, and rates compared to a referent (generally the state rate). In the 2016 CHNA, prioritized health needs were those that had the greatest combined magnitude and severity or that disproportionately impacted priority populations in the community. Quantitative, qualitative, and expanded community engagement data confirms that priorities from 2016 continue in 2019.

5. Community and Stakeholder Engagement

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

- The **CHNA RAC** included representatives from each Coalition member hospital/insurer as well as public health and community stakeholders from each hospital service area. Stakeholders on the RAC 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 represent the broad interests of the community. The Coalition conducted a stakeholder analysis to ensure geographic, sector (e.g. schools, community service organizations, healthcare providers, public health, and housing), and racial/ethnic diversity of RAC. The RAC met in workgroups (Data and Reports, Engagement and Dissemination, and Health Equity) to guide the consultants in the process of conducting the CHNA, and prioritize community health needs, CHNA findings, and dissemination of information. Assessment methods and findings were modified based on the Steering Committee feedback. The RAC consisted of 31 people, including 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 organization representatives, community members (low-income, people of color, and others), and other community stakeholders. Topics and populations included: substance use, transgender health, older adults, youth, mental health, cancer care, gun violence, and rural food access. Key informant interviews and focus groups were conducted from February 2019 through March 2019. Focus groups and key informant interviews engaged people primarily in Hampden County but also across the region. This CHNA also used qualitative data from other hospital service areas as appropriate.

- Baystate Health held three **Community Conversations** and approximately 38 **Community Chats** that were pertinent to Baystate Medical’s CHNA. Community Conversations were larger bi-directional information-sharing meetings conducted for each Baystate Hospital service area and one done in Spanish in Springfield. For Community Chats, RAC members brought information about the CHNA and gathered priorities in regular meetings of service providers, community-based organizations, and hospital clinical staff and administrators. While these outreach efforts were spearheaded by Baystate Health, the engagement and findings benefitted all Coalition member hospitals/insurer. Conversations and Chats were held from January 2019 through April 2019 and engaged approximately 824 people in Hampden County.
- Three **Community Forums** were held upon completion of this report to share the findings. One Forum was held in English and two in Spanish with approximately 100 individuals representing the broad interests of the community; participants in the focus groups, interviews, Conversations, and 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.

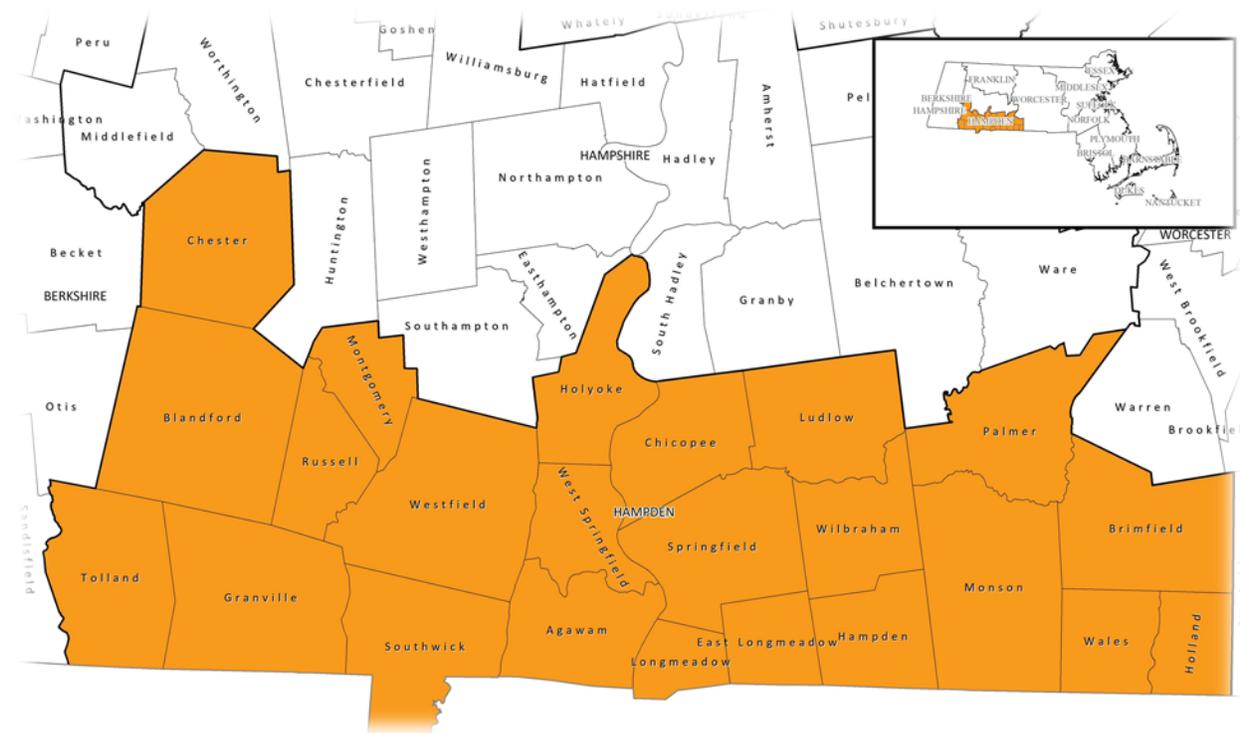
Ideally, we would disaggregate data for a better understanding of people who identify with different races and ethnicities, yet this data is often not available, or is based on estimates that come with a large margin of error. Beyond broad categories, we recognize that there are differences among those 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 an urban or rural community 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 Holyoke and Springfield, but also for Chicopee, Ludlow, Palmer, Westfield, and West Springfield as available.

7. Hospital Service Area

The service area for Baystate Medical includes all 23 communities within Hampden County (Table 1 and Figure 5), including the third largest city in Massachusetts – Springfield (population over 150,000). Three adjacent cities (Holyoke, Chicopee, and West Springfield) create a densely-populated urban core that includes over half of the population of the service area (270,000 people), and 91% of Hampden County is classified as urban (US Census, 2013-2017). Smaller communities exist to the east and west of this central core area. Many of these communities have populations under 20,000 people. The Pioneer Valley Transit Authority, the second largest public transit system in the state, serves 11 communities in the service area, and connects suburban areas to the core cities and services.

Figure 5. Baystate Medical Service Area



Source: Public Health Institute of Western Massachusetts

The service area has more racial and ethnic diversity than many other parts of western Massachusetts (Table 2). County-wide, 24% of the population is Latino, 8% is black, and 2% is Asian (ACS, 2013-2017), though this diversity is not equally spread throughout the region and tends to be concentrated in the urban core.

A substantial proportion of the county's population is from other countries. In 2017, 22% of the state's immigrants came to western Massachusetts.⁵ West Springfield has welcomed the highest proportion in Hampden County; 15% of the city's population are foreign-born (US Census, ACS, 2013-2017). The current political climate has exacerbated threats to immigrant health related to the behavioral, cultural, and structural systems that determine individual health decision on a daily basis.⁶ According to the MDPH, in the past 5 calendar years (2014-2018), there were 2,314 refugees with health assessments in western Massachusetts.⁷ This assessment is the first medical screening provided to refugees; it is their gateway into the medical system.

Economically, the Baystate Medical service area is home to many of the largest employers in the region as well as numerous colleges and universities, and provides a strong economic engine for the broader region. The largest industries and employers include health care, service, and wholesale trade and manufacturing. At the same time, the county struggles with higher rates of unemployment and poverty, lower household incomes, and lower rates of educational attainment (Table 2). The median household income in the service area is about \$52,000 (\$22,000 less than the state). The poverty rate is more than 60% higher than statewide, and the child poverty rate is an alarming 27%, with more than one out of every four children in Hampden County living in poverty (ACS, 2013-2017). Despite being at the core of the Knowledge Corridor region, only 27% of the population age 25 and over has a bachelor's degree, compared to 43% statewide. Unemployment is somewhat higher than the state average.

The median age for the service area is similar to that of Massachusetts, although in Springfield the median age is about 33 years of age compared to 39 in Hampden County. The population over 45 years old is growing as a percentage of the total population (Table 2). To give a sense of the change in service needs necessary, by 2035, the proportion of people over the age of 60 is projected to grow from 20% of the population to 28% in Hampden County, with the number of older adults increasing from approximately 92,000 in 2010 to an estimated 140,000 in 2035.⁸

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

Table 1. Municipal Communities in Baystate Medical Center Service Area

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

Source: Population Division, U.S. Census Bureau

Table 2. Sociodemographic Characteristics of Baystate Medical Service Area

Sociodemographic Characteristic	Hampden County	Springfield	MA
Age			
Median age (years)	39	33	39
>18 years	22%	26%	20%
18-64	62%	62%	64%
65 and over	16%	12%	16%
Race and Ethnicity			
Latino or Hispanic	24%	44%	11%
Non-Latino or Hispanic			
White	64%	33%	73%
black or African American	8%	19%	7%
American Indian and Alaska Native	0.1%	0.2%	0.1%
Asian	2.2%	2.1%	6.2%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%
Some other race	0.2%	0.1%	0.7%
Two or more races	1.7%	2.3%	2.1%
Language Spoken at Home (population over 5)			
Speaks language other than English at home	25%	38%	24%
Educational Attainment			
Population 25 years and over			
Less than high school graduate	15%	23%	9%
High school graduate (includes equivalency)	30%	31%	24%
Some college or associate's degree	29%	25%	23%
Bachelor's degree or higher	27%	18%	43%
Income			
Median household income	\$52,205	\$37,118	\$74,167

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

IV. Prioritized Health Needs of the Community

The following are the prioritized health needs identified for Baystate Medical's service area, Hampden County. The prioritized health needs of the community served by Baystate Medical 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 Medical's service area are:

- Social environment - social isolation, connection to community, and interpersonal, institutional, structural, and historical racism and other forms of 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, and workplace policies
- Need for financial health - saving, homeownership, and financial literacy
- Educational needs - educational attainment and systemic barriers to quality education
- Violence and trauma - interpersonal and community violence and violence-related trauma
- Environmental exposures - air quality and lead exposures

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 Medical'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 and structural racism and other oppressions, all of which impact people's health every day. The social environment - and specifically social isolation and institutional racism and other forms of discrimination - 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 racism and oppression. Social isolation and participation in communities arose during focus groups and interviews for the CHNA. Factors mentioned that can lead to social isolation are:

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

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

Community Forum Participant, Older Adults Community Forum, Coalition Hospital

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

- rural food pantry users stated that one always has something to eat if you get together with your neighbors
- older adults who get support by frequenting senior centers
- parents of children with disabilities, cancer support group participants, and transgender individuals find that connections with others helped them find resources
- people living with cancer and their caregivers supporting each other in a cancer support group

Public health leaders strongly advised health practitioners to become culturally sensitive 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.^{9,10} 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.¹¹ 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.¹¹ 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.¹² 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.^{13, 14, 15, 16, 17}

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

- in schools, black children are routinely more likely to be disciplined and experience unequal treatment in dress code and other violations
- the home care industry does not pay personal care attendants well, does not always thoroughly train them, and does not guarantee reliable hours. The devaluing of this position leads to inconsistent care for older adults, those with disabilities, and people recovering from illnesses
- marginalized youth don't often see teachers, counselors, or community staff who look like them or have had the same kinds of experiences they have. Without a concerted focus on recruiting, hiring, and training staff of color or from local neighborhoods, the ability for youth to trust and accept adults as mentees is hampered

- in focus groups and interviews about gun violence in Springfield, participants spoke of instances in which police came late to the scene of a fight or shooting, questioned or even blamed witnesses instead of quickly pursuing people with guns, and are seen mostly in the community to arrest and incarcerate people instead of having a helpful, partnering presence
- emergency department practices that deny victims of gun violence visits by their loved ones, restrict number of visitors, and perceived lengthy response time by ambulances to gun violence victims
- administrative level of health care does not feel friendly to transgender people. Forms and protocol disregards preferred names and gender identity, and asks patients to fill out forms with inscrutable questions about transgender status

“Living in Holyoke or Springfield, you cannot ignore the racial difference. If you are a Hispanic parent, particularly if your English isn’t what they think it should be, there is a huge gap and a much different response [to complaints of bullying of a disabled child].”

Focus Group Participant, Parent of Children with Disabilities Focus Group, Hampden County

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

Racial residential segregation is one of the most significant forms of institutional racism with detrimental impacts on health. This segregation limits opportunity environments and embeds communities with structural barriers that directly impact access to quality education, jobs, quality housing, healthy food, and a number of other social determinants of health.¹⁸ The University of Michigan’s Center for Population Studies in 2013 ranked the Springfield Metropolitan Statistical Area (Hampden, Hampshire, and Franklin counties) as the most segregated in the U.S. for Latinos, and 22nd in the country for blacks.¹⁹

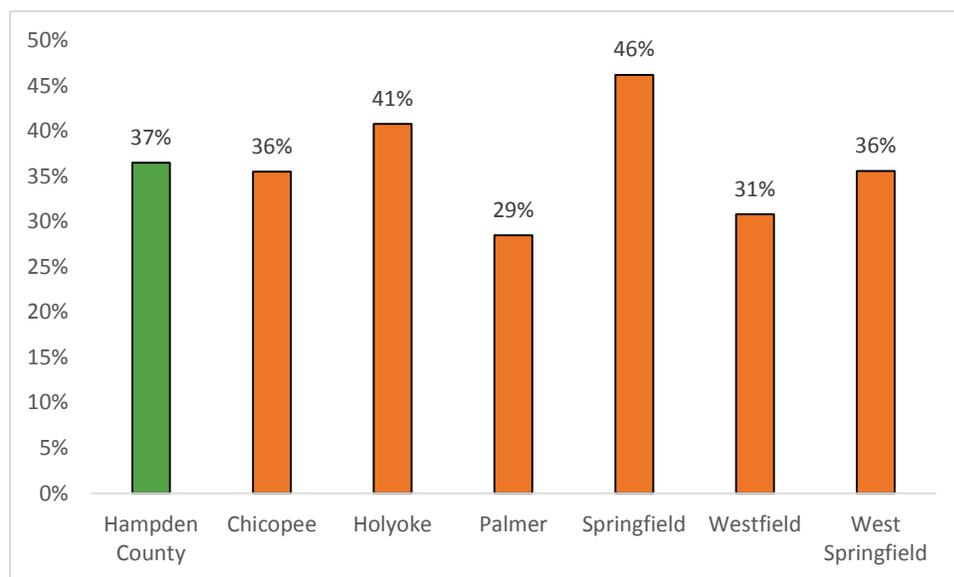
Mass incarceration and criminalization are examples of institutional racism that result in racial inequities at every stage of the criminal legal system, with health implications. In 2015 admissions to the Hampden County Jail were more than double the Massachusetts rate (458 in Hampden County compared to 216 people per 100,000 in Massachusetts). The average daily population in the jail was 1,428 people. Blacks and Latinos are jailed at disproportionately higher rates, comprising 60% of the jail’s population compared to an estimated 32% in the county as a whole. Only 36% of the Hampden County jail population is white. The incarceration of women in jails is on the rise, with Hampden County jail incarcerating 84% more women between 2011 and 2015.²⁰

B. HOUSING NEEDS

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

Housing insecurity continues to impact Hampden County residents. Over a third of the population in Baystate Medical’s service area is housing cost burdened, with rates close to 50% in Springfield (U.S. Census Bureau, ACS, 2013-2017)(Figure 6). For homeowners in Hampden County, 7% experienced being cost-burdened compared to 31% of renters. Housing cost burden is defined as more than 30% of income going towards housing. Lack of affordable housing can contribute to homelessness and housing instability, which leads to increased stress and can often force families to prioritize housing costs over factors that can influence health, such as purchasing healthy foods and medications.

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



Source: U.S. Census, ACS 2013 – 2017

A more complete picture of affordability adds the cost of transportation. In Hampden County for a typical household income, people spend 52% of their income on housing and transportation costs combined. However, those with a lower household income spend 70% of their income on housing plus transportation.²¹ 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 need housing, social and health services, and an expedited pathway to these services. Approximately 55% of the homeless population is children under the age of 18. Of youth aged 18 – 24 who are unstably housed, more than half have been involved in the juvenile, foster, or jail systems. And more than 80% of mothers who are homeless are survivors of domestic violence.²² In Springfield in 2017, almost 600 youth aged 18 – 24 stayed in emergency shelters in Hampden County.²³

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

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

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

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

Poor housing conditions also impact the health of residents. Older housing combined with limited resources for maintenance can lead to problems (e.g. exposure to mold, pests/rodents, lead paint, asbestos, and lead pipes) that affect asthma, other respiratory illnesses, and child development. Housing conditions are important for safety and accessibility for children, elderly or disabled populations. Hampden County has a large older housing stock with 32% of housing built before 1940. Springfield and Holyoke have a greater number of older homes, with 41% and 48% of homes built before 1940,

respectively (U.S. Census Bureau, 2014-2017). In data from the Be Healthy Partnership (BHP), an Accountable Care Organization (ACO) that includes five health centers serving Springfield Medicaid patients, 4% of respondents said their homes had bug infestation, 5% had mold or water leaks, 2% had inadequate heat, and 1% had inoperable oven or stove.²⁴

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

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

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

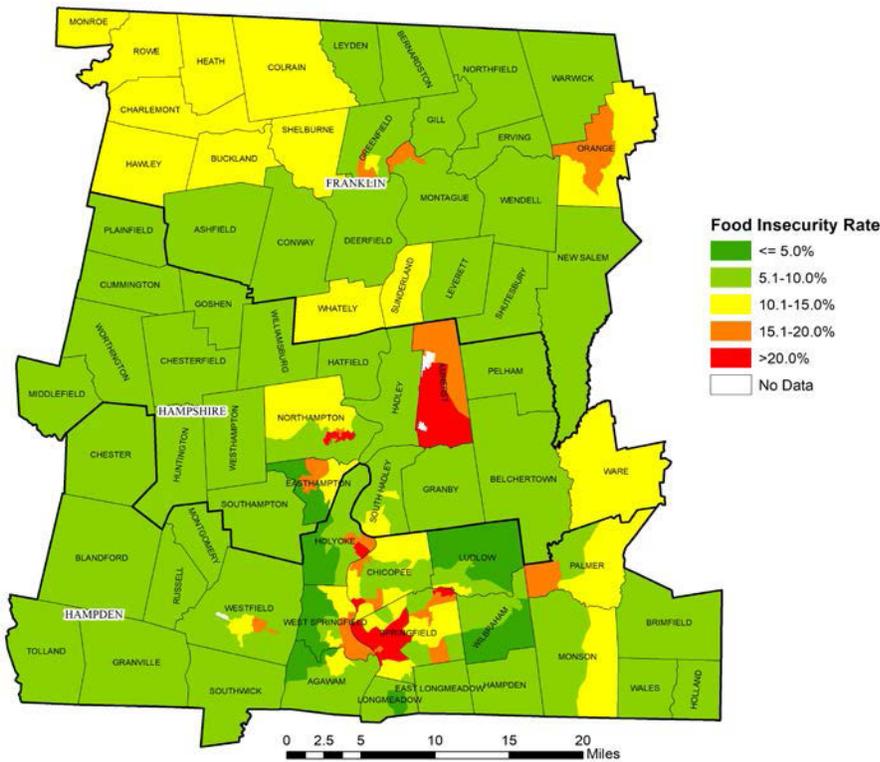
Unequal access to appropriate transportation options exacerbates racial and ethnic health disparities. Communities of color and those with lower incomes have less access to transportation options compared to majority white and higher income communities.^{25,26} Public transportation plays a significant role in filling transportation needs for many of these households. Among Springfield residents lacking access to a vehicle, 23% report regularly using public transportation to travel to work, while 14% reported carpooling.²⁷ The Pioneer Valley Transit Authority which operates buses in Springfield and across the Pioneer Valley, reports that the majority of its customers – over 62% – are people of color. A 2017 equity analysis examining proposed bus line service cuts and fare hikes concluded that the changes would have a negative impact on communities of color.²⁸

“I’ve watched [name redacted] stand out there for two hours waiting for a driver, and then the driver comes up with only attitude.”

Focus Group Participant, Focus Group about Health Needs for People with Disabilities, Hampden County

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

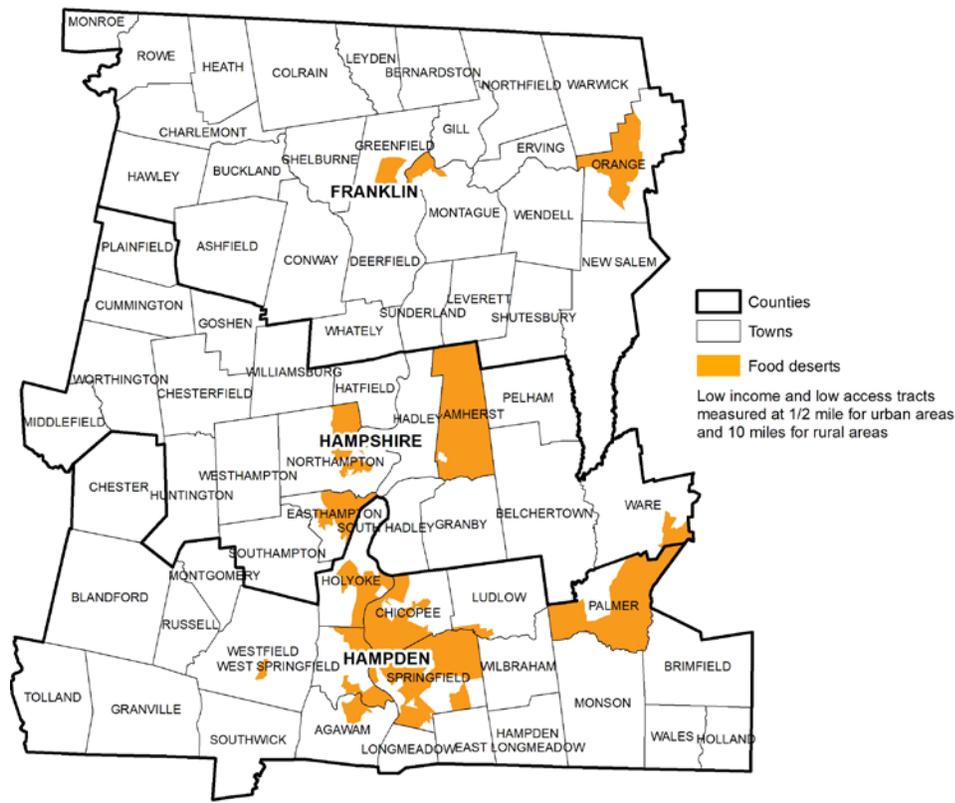
Figure 7. Percent Food Insecure Hampden, Hampshire, and Franklin Counties



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

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

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



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

Access to opportunities for physical activity - having safe and accessible places to be physically active is a key resource for people’s health. Approximately 12% of youth aged 13 – 16 in Springfield reported feeling that they could not easily access opportunities to be physically active.³¹

D. LACK OF RESOURCES TO MEET BASIC NEEDS

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

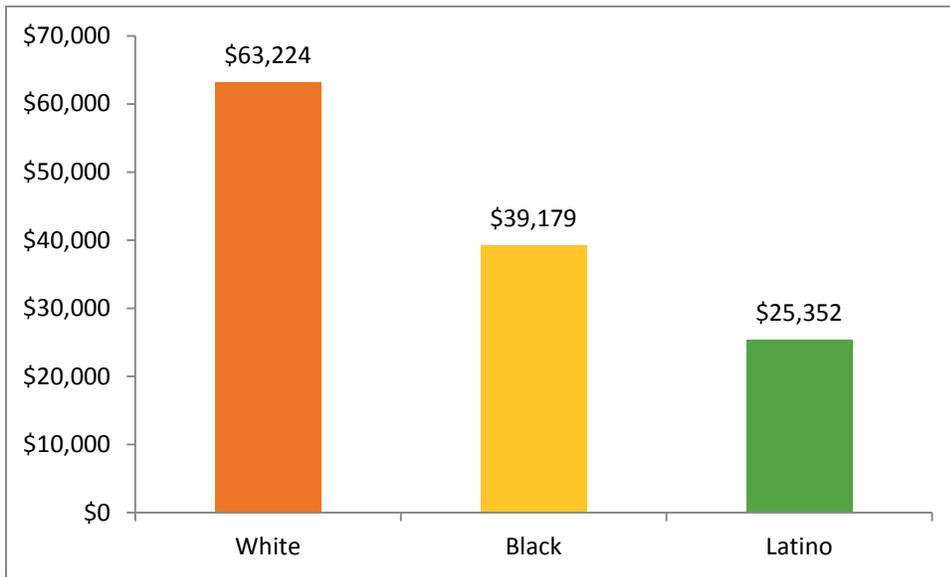
The median household income of \$52,205 in Hampden County is one-third less than that of the state. In Hampden County, the Census estimates that black families make less than 70% and Latinos make less than half the income of white families (Figure 9). The unemployment rate in Hampden County among the black and Latino population is double that of the white population.

Table 3. Socioeconomic Status Indicators

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

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

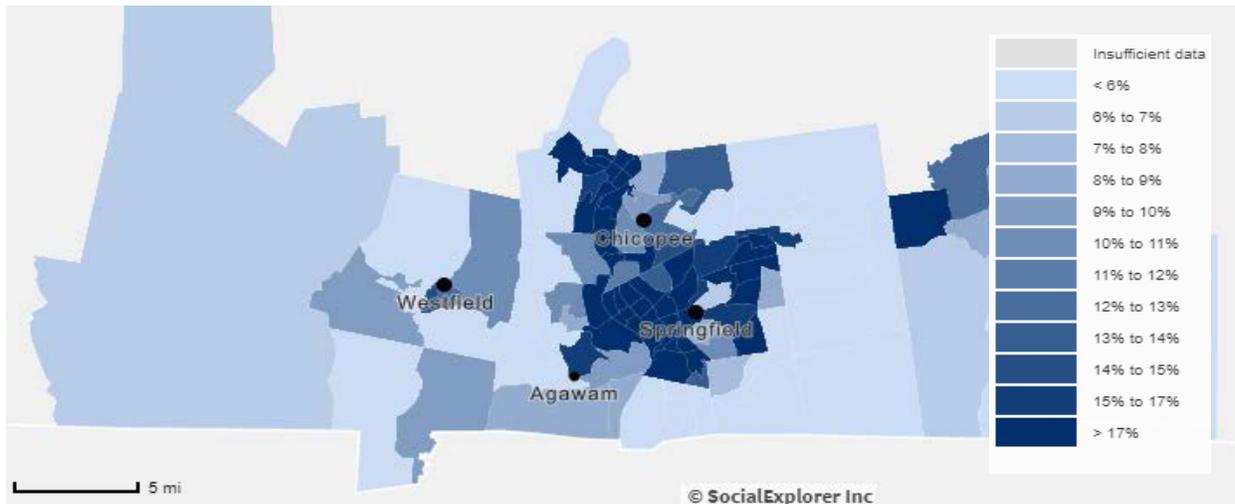
Figure 9. Median Household Income, By Race/Ethnicity, Hampden County



Source: US Census, ACS 2013-2017

Just over 17% of county residents live in poverty, with rates of poverty over 21% of the population concentrated in areas of Springfield (28.6%) and Holyoke (28.7%) (Figure 10). An estimated 36% of county residents have incomes at or below 200% of the poverty level, which is a better indicator of people in need as the federal poverty level is extremely low and does not capture all of those who are economically struggling. The Springfield Be Healthy Partnership ACO found that 13% of their patient population had a utility shut off in the past 12 months, 26% had often or sometimes had food run out by the end of the month, and 11% said they had trouble affording their children’s basic needs.³²

Figure 10. Hampden County Poverty Rates



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

The Massachusetts Institute of Technology (MIT) estimates a living wage for different regions, based on typical expenses. In Hampden County for a family with one adult and one child, a living wage would be an hourly wage of \$27.29.³³ Using median household income for Hampden County and Springfield and dividing by the number of hours per year finds an average hourly wage is just over \$25.00 in Hampden County and \$17.85 in Springfield. Using median household income is an imperfect proxy as there is the potential that more than one adult per household is bringing in a salary, but it is the only data point to provide a comparison. The current minimum wage in Massachusetts is \$12.00 per hour.

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

“Guns and bullets don’t fly in places where there is a lot of money – they fly where there is not enough money.”

Community Conversation Participant, Baystate Medical Community Conversation

Hiring and workplace discrimination affects people of color more frequently than white people.³⁴ 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,³⁵ of which an inequitable proportion are people of color due to discriminatory policies and practices.³⁶

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.^{37,38,39} Number of hours worked and predictability of scheduling are other employer practices that have a large health effect.⁴⁰

Women, children, and populations of color are disproportionately affected by poor socioeconomic status in Hampden County. Women in Hampden County earn 83 cents compared to every \$1.00 earned by men, and women of color earn even lower proportions; 57 cents for Latinas, and 71 cents for black women.⁴¹ Almost 60% of children living in Hampden County qualify for free or reduced lunch and 27% are in families with incomes below the poverty level (U.S. Census Bureau, ACS 2013-2017). With regard to race and ethnicity, median income levels are lower and unemployment and poverty rates are higher among Latinos and blacks (U.S. Census Bureau, ACS 2013-2017). Hiring and workplace discrimination affects people of color more frequently than whites.

E. NEED FOR FINANCIAL HEALTH

Financial health is a measure of how one's financial and economic resources are able to support their physical, mental, and social well-being.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 Medical 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

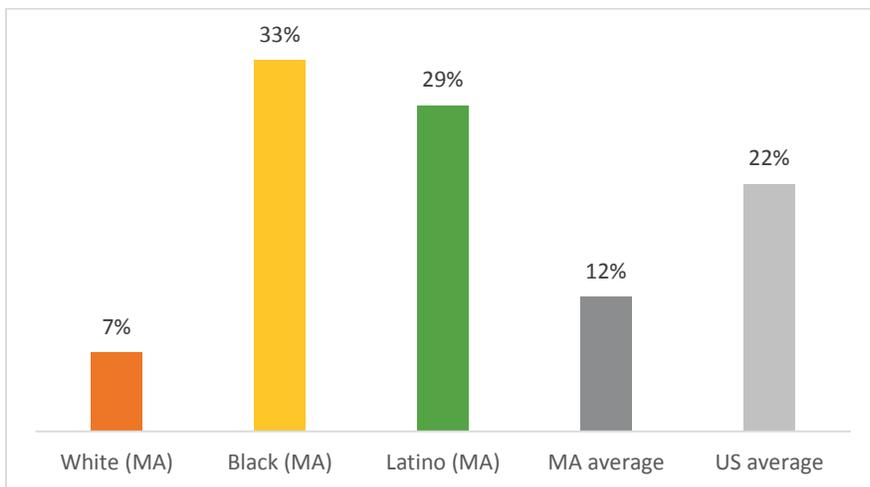
Homeownership - for many, the primary way to build wealth is through homeownership. Homeownership can be a path to wealth and has the potential to be more stable than renting.⁴⁴ In Hampden County, 61% of people own their homes and 39% rent. Historically, redlining lending practices, racial discrimination related to mortgage acquisition in the GI bill, and higher incidence of predatory lending in communities of color have denied black and Latino communities the ability to create stability and generational wealth via home ownership.^{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. Possibly mirroring the higher proportions of people of color and lower incomes in

Springfield, 47% of Springfield residents own their own homes compared to the countywide proportion of 61% (U.S. Census, ACS, 2013-2017).

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 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 11).

Figure 11. Percent of Students Scoring at the Lowest Level of Proficiency in Massachusetts, by Race/Ethnicity



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

F. EDUCATIONAL NEEDS

Educational attainment is a prioritized community health need as it contributes longevity, availability of resources to meet basic needs, higher health literacy, and access to less physically dangerous jobs. Levels of education are strongly correlated with employment status, the ability to earn a livable wage, and many health outcomes.⁵⁰ Approximately 16% of Hampden County residents age 25 and older do not have a high school diploma, compared to the Massachusetts rate of 10%. In the communities of Springfield, Chicopee, Holyoke, and Ludlow, over 20% of eligible individuals do not have a high school diploma. And while 42% of the population of Massachusetts has a bachelor’s degree or higher, in Hampden County only 27% do, with even lower rates in Springfield (18%), Chicopee (17%), and Holyoke (24%) (U.S. Census, ACS, 2013-2017).

Communities of color face systemic barriers to education. Historically, people who were enslaved were not allowed to learn how to read or write, and Jim Crow laws required schools to be racially segregated.⁵¹ Segregation of lower income students of color into underfunded schools continues today.⁵² 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.⁵³

In focus groups and key informant interviews, schools were called out in many ways as being a key social determinant of health. Comments included the importance of the school environment as well as how school systems could be a powerful partner to improve health. Participants raised elements of the school environment such as bullying. Youth of color talked about the stress of school requirements on top of work or other tasks; having experienced racism in schools; and the need for teachers and staff to recognize trauma in students’ behaviors, particularly when students have experienced violence.

“In school, they don’t teach you how to deal with emotional stress. You can end up being depressed about it.”

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

Suggestions for how schools could help included:

- training teachers and staff to be trauma-informed and have cultural humility
- including Social Emotional Learning⁵⁴ in the curriculum
- distributing information about developmental milestones to parents so they can detect disabilities early
- incorporating restorative justice circles to deal with school discipline issues
- hiring staff and teachers who have experience with the same types of neighborhood issues students face, such as gun violence
- policy suggestions include passing statewide public school budget bills being considered in the legislature

G. VIOLENCE

Interpersonal and collective violence affects health directly, via death and injury, as well as indirectly through the trauma that impacts mental health and healthy relationships.⁵⁵

Interpersonal violence includes sexual and intimate partner violence, childhood physical and sexual abuse and neglect, and elder abuse and neglect. Western Massachusetts does not have any surveillance systems that measure incidence, prevalence, risk and protective factors, and related negative health outcomes associated with interpersonal violence (including intimate partner, dating, and sexual violence, violence against children, and child exploitation). Data was gathered from subject matter experts across western Massachusetts and the MDPH 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. Females comprised 94% of victims/survivors, and one-third were youth under the age of 18.⁵⁶
- **Intimate partner violence** - a 2014 criminal justice survey conducted by the city of Springfield found that of all assault arrests, 67% were for domestic violence offenses.⁵⁷ In 2018, nearly 6,900 restraining orders were filed in all of western Massachusetts. The YWCA of Western Massachusetts in Hampden County fielded 5,116 calls to its Intimate Partner Violence (IPV) hotline; 94% were in English, 4% were in Spanish.⁵⁸
- **Dating violence** - the Springfield 2017 Youth Health Survey found that 43% of students had experienced “aggressive behavior from their significant other” and 29% had experienced physical abuse from their significant other.⁵⁹
- **Child abuse and neglect** - in the Springfield Public Schools’ 2017 Youth Health Survey, 8% of students reported that they had experienced physical abuse by someone in their family.⁶⁰ The Massachusetts Department of Children and Families (DCF) reports that in the last quarter of 2018 in western Massachusetts, over 3,000 reports of child abuse or neglect were filed and screened for investigation and 42% of them were deemed true and in need of services.⁶¹
- **Elder abuse and neglect** - nationally, 1 in 10 older adults reported some type of financial, emotional, physical, or sexual mistreatment or potential neglect in the prior year.⁶² The Massachusetts Executive Office of Elder Affairs reported 9,800 confirmed abuse and neglect cases in 2017, nearly 40% more than in 2015.⁶³ In the Springfield Area Service Access Point - where reports would be filed - there were 2,438 intakes completed in 2018, up from 1,401 in 2014.⁶⁴

“My son’s father was shot at. It caused me to have PTSD, I see a therapist now. I have anxiety walking down the street. My son’s father is gang affiliated and it makes me cry for him because I’m scared for him. What if he’s [with the kids] and someone shoots?”

Focus Group Participant, Gun Violence Focus Group, Hampden County

- **Collective violence** - lack of community safety was a prioritized health need in the 2016 CHNA and continues to impact Hampden County residents. A safe community is one that is free from violence and danger. It is a place where people do not have to consider whether they will be safe or not when deciding where and when they will go outside of their homes. Crime rates are high, with violent crime rates in Hampden County much higher than that of the state. The rate of violent crime in Hampden County was 60% higher than the state at 616 per 100,000 people compared to 384 in Massachusetts.⁶⁵ Property crime was similarly higher in the Springfield Metropolitan District than the state, at 2,171 vs. 1,437 per 100,000 people.⁶⁶
- **Gun violence** - an analysis of gun violence done by the City of Springfield Police Department found that total incidents involving guns have decreased by 17% over a 5 year period (2013 – 2017), with robbery with a gun decreasing the most (26%). However, murder with a gun increased by 20%. In all, total incidents with a gun went from 469 in 2013 to 345 in 2017.⁶⁷ Young men and women speaking in 2019 CHNA focus groups about gun violence in Springfield perceived that gun violence was omnipresent and that guns are easy to get. In addition, they felt that change in the culture of gun use for people their age (18 – 25) was unlikely. Focus group participants and interviewees suggested starting with interventions preventing or reducing gun violence at middle school age. Priority ideas included expanding the use of mentors, creating more youth programs, including sports, that kids want to participate in and that are affordable, and improving school systems and law enforcement (Table 4).

“It affects you badly. You just spoke to that person and then an hour or a day later you find out your friend was shot. Most of the time, we are going to keep living, and that’s the hard part.”

Focus Group Participant, Focus Group about Gun Violence, Hampden County

- **Bullying** - more than one in five students nationally reports being bullied, with girls, children with disabilities, and GLBQ+ and transgender students at increased risk. In Berkshire, Hampden, and Hampshire counties and the city of Springfield, more than one-quarter of female students report being bullied, which is 1.4 to 1.7 times higher than male students.⁶⁸ Findings from the 2017 Springfield Youth Health Survey indicate that 32% of Springfield 8th grade students were bullied in the past year.⁶⁹ Students with disabilities are 2 to 3 times more likely to be bullied than nondisabled students, and one study showed that 60% of students with disabilities report being bullied regularly compared with 25% of all students. Youth in special education were told not to tattle almost twice as often as youth not in special education.⁷⁰

Table 4. Focus group and key informant interview findings on origins, harms, and solutions to gun violence in Springfield

	Focus Group Participants <i>20 men and women aged 17 - 26</i>	Key Informant Interviewees <i>5 content experts with direct experience with gun violence or who provide services to people who have experienced gun violence</i>
Origins of or contributors to gun violence	<ul style="list-style-type: none"> • territory, money, retaliation, miscommunication • drama – jealousy, envy, cheating • ease of accessing guns • protection • peer pressure, think it’s cool • not a lot of good role models and/or don’t feel loved at home • culture – “that’s how it is in Springfield” 	<ul style="list-style-type: none"> • poverty • toxic stress • witnessing family and community trauma • lack of positive caring adults in youth’s lives • lack of hope; feeling like life has no value • underperforming schools
Harms of gun violence	<ul style="list-style-type: none"> • grief, sadness, heartbreak • panic, paranoia, fear, “on alert” • anger and desire to retaliate • insomnia • post-traumatic stress disorder 	<ul style="list-style-type: none"> • death and injury • trauma and anxiety • impulsiveness • stress reaction (cortisol release) that can lead to poor physical health • puts family members at risk
Recommendations to decrease or prevent gun violence	<ul style="list-style-type: none"> • mentors and caring adults involved in kids’ lives • youth program (sports but also other programs) • programs must be affordable • jobs • police getting involved in the community instead of just sending everyone to jail • teachers, school staff, and program staff that know how to handle kids after someone in their life has died from gun violence • schools could do a history project • gun control efforts 	<ul style="list-style-type: none"> • mentors • wraparound services • connecting youth to activities they like • connecting youth to positive adults • public education about brain science and trauma • preventative programs starting in 4th grade • cognitive behavioral therapy • don’t bump youth out of programming at different ages • deal with the underground market where guns are being moved • ensure schools and police are trauma-informed • hire people who used to be involved in gun violence but are no longer to work with youth in order to show youth a path out • healing activities like “standing together” events honoring people who have died

H. ENVIRONMENTAL EXPOSURES

Air pollution impacts the health of Hampden County residents. Air pollution is associated with asthma, cardiovascular disease, and other illnesses. Springfield in particular experiences poor ambient air quality due to development, zoning, and land use decisions which have located multiple mobile and point sources including a large inter-state highway, several state highways, and railroad lines running through the city and directly through its neighborhoods. In addition, many cities in Hampden County are in a valley into which air pollution travels from other sources and settles. Exposure to near roadway air pollution has a particularly detrimental impact on health with the highway and heavily trafficked roadways running through or adjacent to neighborhoods. In Springfield, the risk of cancer from breathing air toxins is higher than at least 80% of all of the rest of Massachusetts.⁷¹

Exposure to lead is a well-known health risk, connected to outcomes as varied as decreased academic achievement, IQ, and growth in children; and increased blood pressure, hypertension, and decreased kidney function in adults.⁷² Springfield had the highest risk score for blood lead poisoning in the state based on 2013-2017 elevated blood level incidence rates, poverty, and the percentage of households built before 1978.⁷³ In Springfield in 2017, 26 children (0.5% of children over 5) had blood lead levels that were considered lead poisoning (>10mcg/dL), and 183 children (3.6%) have >5mcg/dL. Holyoke was also identified as a high risk community for blood lead poisoning in Massachusetts, with nine children identified as having lead poisoning.⁷⁴

2. Barriers to Accessing Quality Health Care

The following prioritized barriers to accessing health care were identified as needs in Baystate Medical'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 culturally sensitive care
- need for transportation and financial assistance
- lack of care coordination
- health literacy and language barriers

A. INSURANCE AND HEALTH CARE RELATED CHALLENGES

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

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

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

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

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

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

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

B. LIMITED AVAILABILITY OF PROVIDERS

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

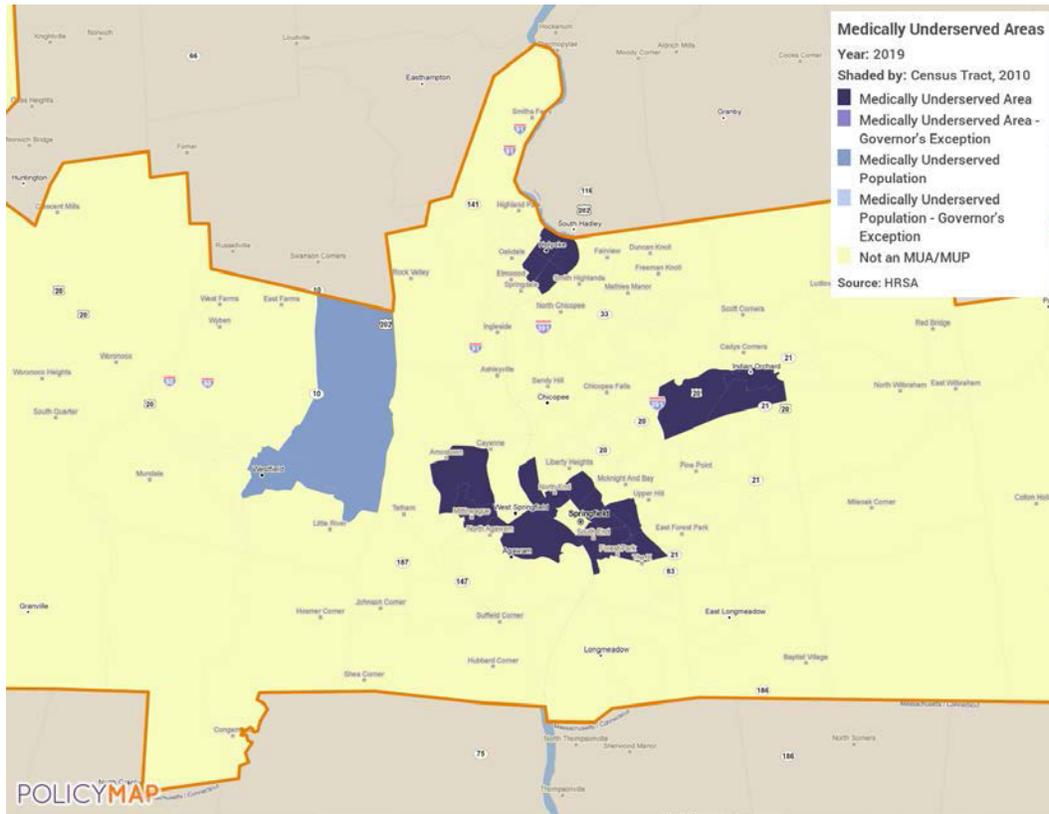
Focus group participants report long wait times; use of "Minute Clinic" because they cannot get in to see their own doctor; providers not accepting new patients; a wait time of 4 – 6 months between initial scan of lung cancer and surgery; a wait of a month to get replacement dentures; and other constraints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

Population to provider ratios are one indicator of how many healthcare professionals there are in an area. Hampden County has 1,400 people for every primary care physician, compared with a ratio of 960:1 in Massachusetts. Hampden County has 1,210 people for every dentist, compared to 990 in the state.⁷⁵ Although there is greater access to mental health providers for Hampden County residents as compared to the state (120:1 versus 180:1 in Massachusetts), focus group participants and key informant interviewees overwhelmingly reported:

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

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

Figure 12. Medically Underserved Areas/Populations in Hampden County



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

C. NEED FOR CULTURALLY SENSITIVE CARE

The need for culturally sensitive care 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 sensitivity refers to a commitment among health care and social service providers to self-reflection and evaluation in order to reduce the power imbalance between patients and providers, and to the development of care partnerships that are based on mutual respect and equality.⁷⁶

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 insensitivity and bias

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

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

Key Informant Interviewee, Public Health Official, Hampden County

D. NEED FOR TRANSPORTATION

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

Transportation is a particularly difficult issue for children and adults living with disabilities, older adults, low-income populations, and cancer patients. People in focus groups mentioned challenges due to lack of transportation in getting to medical appointments, the food pantry, places for disabled children to exercise, the grocery store, and the pharmacy. In the BHP ACO data from Springfield Medicaid recipients, 17% said that lack of transportation had kept them from getting to medical appointments or getting medication. Survey respondents had gotten to their medical appointment the day of the survey by vehicle (55%), public transportation (9%), and walking or bicycling (5%), with the rest not answering.⁷⁷ 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

“Transportation is a big issue. A lot of our patients financially aren’t doing that great, so transportation is a big issue. We would love to have a shuttle or better taxi service, make sure the taxi voucher program through our Patient Fund is still running. A lot of patients struggle to get to appointments so transportation is a big support service need.”

Key Informant Interviewee, Oncology Program Coordinator, Hampden County

E. LACK OF CARE COORDINATION

Lack of care coordination is a prioritized community health need, as it was in the 2016 CHNA. Care coordination refers to the coordination of patient care, including the exchange of information between all parties involved in patient care.⁷⁸ 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.”⁷⁹ Data from focus groups illustrates the need for increased access to information about providers, services, resources, how to advocate for themselves and their families, and health education. The Be Healthy Partnership ACO found that 48% of patients said they need help with reading medical materials always, often, or sometimes, and 13% self-identified their ability to read at all as poor.⁷⁹ 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 it’s 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 as vital the role the group played in teaching members self-advocacy, providing information about various resources, and health education.

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

Language barriers can create multiple challenges for both patients and health care providers and was previously identified as a need. Increasing the availability of interpreters and translated health materials are specific actions that health care institutions can take to help to address this barrier. Baystate Medical had almost 217,000 interpreter service requests in 2018 out of almost 1.3 million inpatient and outpatient encounters, meaning that about 17% of encounters required interpreter services.⁸⁰

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

3. Health Conditions and Behaviors

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

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

A. MENTAL HEALTH AND SUBSTANCE USE

Substance use and mental health were among the top urgent health needs/problems impacting the area based on focus groups, interviews with public health official, content experts, 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

Mental Health

Though mental health is commonly thought of as the absence of mental illness, mental well-being extends beyond the presence or absence of mental disorders. The World Health Organization defines mental health as the “state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”¹⁶ Only an estimated 17% of U.S adults are “in a state of optimal mental health.”¹⁷ More than one out of four adults nationally lives with a mental health disorder in any given year, and 46% will have a mental health disorder over the course of their lifetime.⁸¹ Mental health is an indicator of health itself, but also contributes to physical health and inequities.

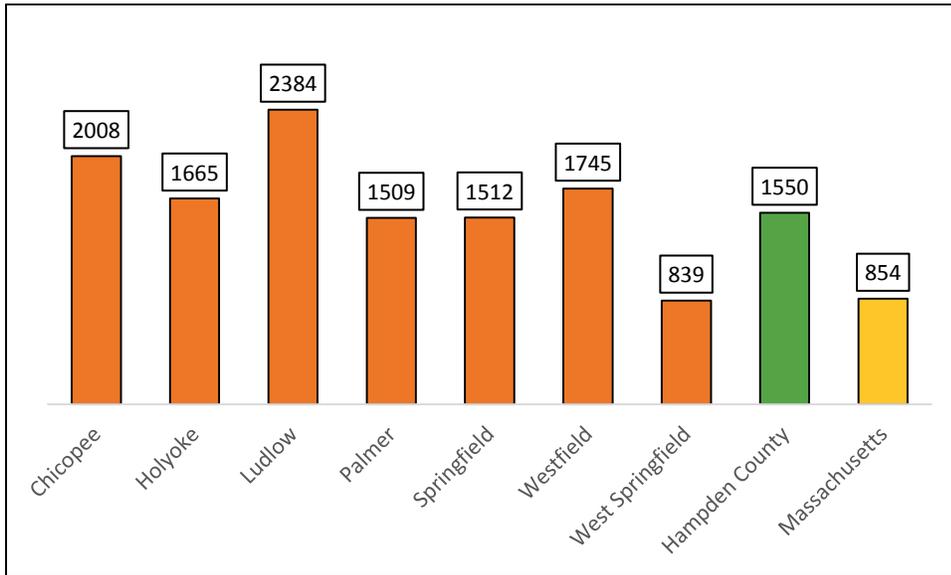
Of Springfield adults, 17% report poor mental health on 14 days or more a month.⁸² In Hampden County, people report 4.5 mentally unhealthy days in the last 30 days, comparable to the statewide rate of 4 unhealthy days.⁸³ Hampden County has nearly double the rate of mental health hospitalizations (1,550 per 100,000) as the state wide rate (854)(Figure 13). Latinos experience drastically higher hospitalization rates (2,345 per 100,000) than the county average (Figure 14).

Depression is the most common type of mental illness, and it affects more than 26% of U.S adults.⁸⁴ Depression is the leading cause of disability worldwide.⁸⁵ Suicide has risen 27% from 2005 to 2015 in Massachusetts,⁸⁶ and the rate in Hampden County is higher than the Massachusetts rate (29 per 100,000 compared to 26).⁸⁷ Substance use disorder often co-occurs with mental illness and impacts physical health as well.

Witnessing or experiencing any form of violence contributes to many negative outcomes including mental illness, post-traumatic stress disorder (PTSD), substance use disorder, aggressive behavior, poor school outcomes, and an elevated risk of criminal legal system involvement.⁸⁸ In the Springfield Public School 2017 Youth Health Survey, 12% of students reported that they had witnessed physical abuse. In focus groups and interviews on gun violence, young men and women discussed the anxiety, stress, grief, and sometimes numbness they have experienced.

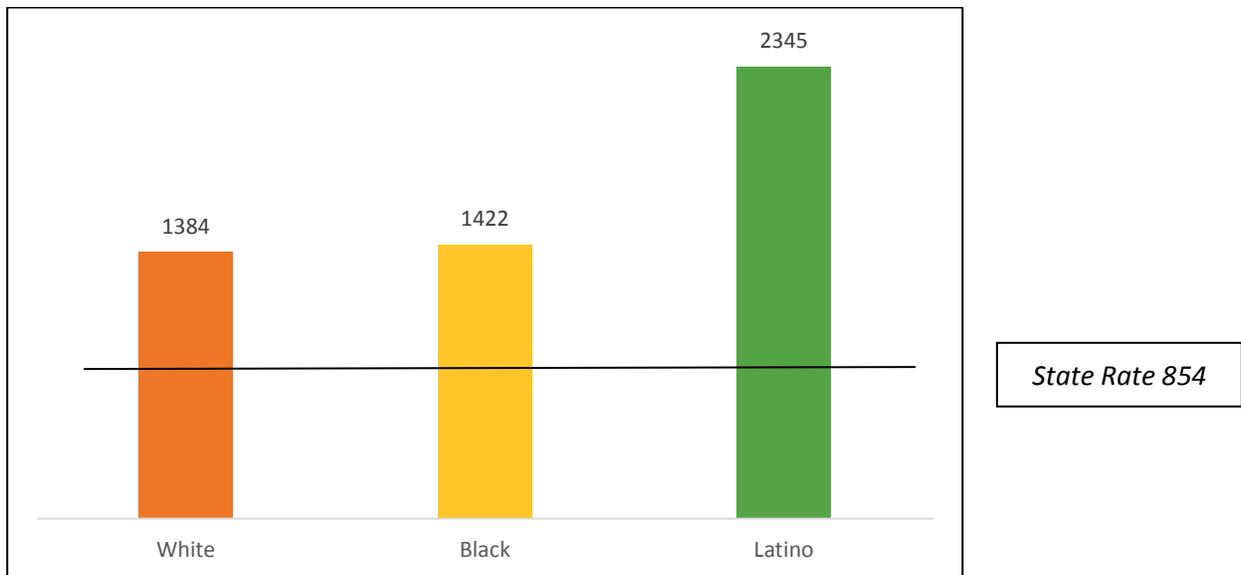
“Many youth in these environments feel as though life has no value, not theirs or the lives of others. Those types of feelings make it easy for someone to pull a trigger or become addicted to alcohol or drugs.”
Key Informant Interviewee, Hampden County Sheriff’s Office, Hampden County

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



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

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



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

Priority Populations

- Youth are disproportionately impacted by mental health issues. Data from the 2017 Springfield Youth Health Survey indicated that 31% of Springfield 8th graders “felt so sad or hopeless that they stopped doing their usual activities.”⁸⁹ Among 8th graders in Springfield, 14% had considered suicide and 8% had attempted suicide in the previous year. Rates were higher among females; 10% of girls and 6% of boys had attempted suicide in the year prior to the survey, and 26% of girls and 20% of boys engaged in self-harm.⁹⁰
- GLBQ+ and transgender youth are also disproportionately impacted with 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, an increase of 5% since the 2015 survey. One in five report that they tried to commit suicide in the past year and 38% had engaged in self-harm.⁹¹
- 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 56% of girls in Springfield schools are at high risk for depression compared to 32% for boys.⁹²
- About one in three older adults experience depression in select communities in Hampden County. Several communities report higher rates of depression than the state rate of 32%, including Holyoke (36%), Springfield (35%), and Chicopee (33%). However, West Springfield (31%), Ludlow (30%) and Westfield (29%) rates are lower.⁹³
- Latinos experienced high hospitalization rates for mental disorders with rates 70% greater than whites and over 50% greater than Hampden County rates overall. These disparities have worsened since the 2016 CHNA (Figure 14).
- 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.⁹⁴

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

Focus Group Participant, Patients Living with Disabilities, Hampden County

Substance Use

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

- An estimated 18% of Hampden County residents smoke tobacco as compared to 14% statewide. In Springfield, 24% of residents smoke tobacco.⁹⁵

- Seven percent of 8th graders in Springfield reported drinking alcohol and using marijuana in the last 30 days.⁹⁶ In key informant interviews, health care providers noted vaping and marijuana use among youth as a rising concern since the legalization of marijuana in Massachusetts.
- A national study found that vaping has doubled in high school youth between 2017 and 2018, from 11% to 21%.⁹⁷ In Springfield, 19% of students report trying vaping, and 4% stated they had vaped in the last month.⁹⁸
- Among adults over the age of 65 in Massachusetts, 7% report substance use. Proportions in Hampden County towns are generally higher, with Springfield reporting 9%, West Springfield 8%, Holyoke 10%, Chicopee 8%, and Palmer 7%.⁹³ Communities with lower proportions than the state average include Ludlow and Westfield.

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

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

Substance use disorders 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 substance use disorders include genetics, age at first exposure, and a history of trauma.

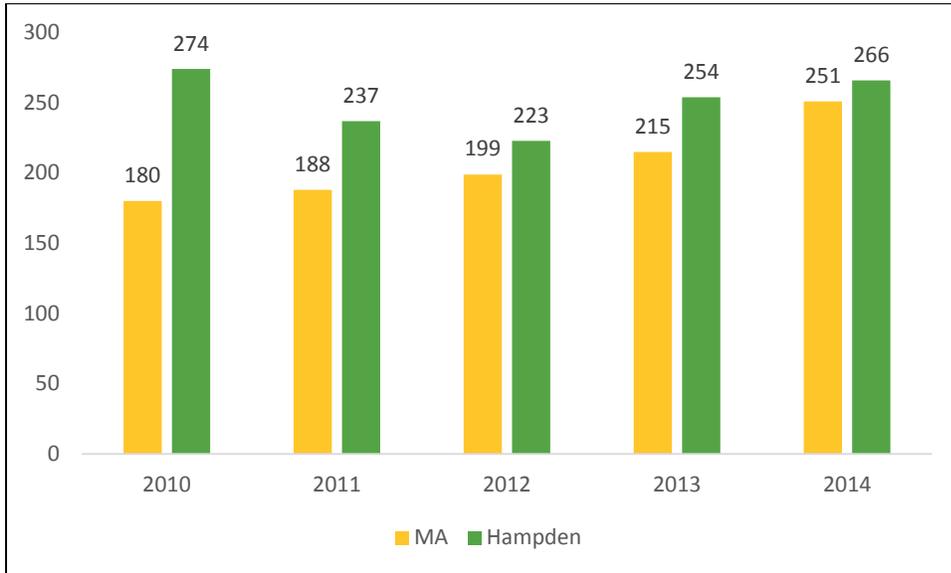
In Hampden County, emergency department visits for substance use rose from a rate in 2012 of 223 emergency department visits per 100,000 to 266 in 2014. The rate in 2014 is similar to the rate in Massachusetts overall (251) (Figure 15). Rates are elevated among select communities: Holyoke (402), Palmer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

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

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

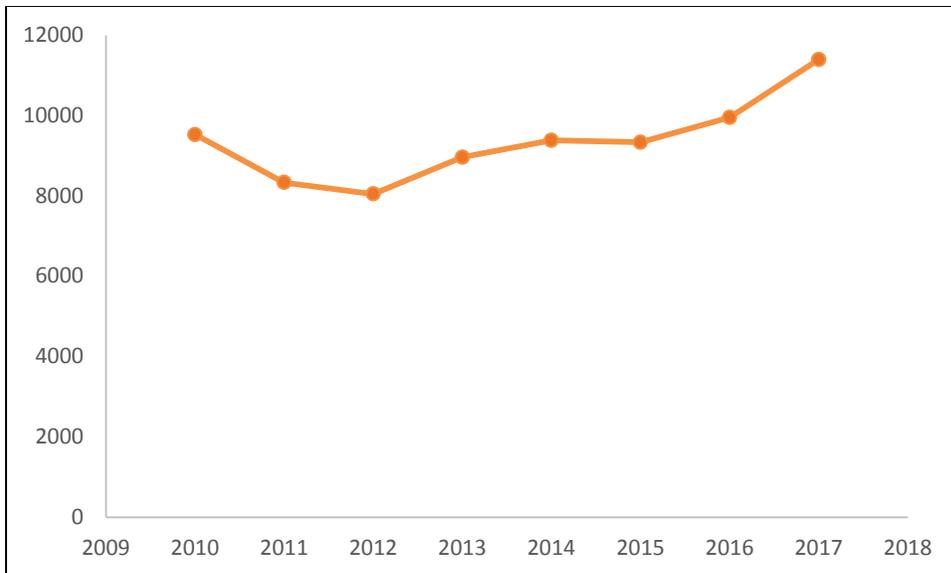
Substance use admissions to treatment programs have increased over time. Total admissions in Hampden County have risen by 42% from 2012 to 2017, from 8,047 in 2012 to 11,394 in 2017 (Figure 16). Admissions for heroin and alcohol drive admissions, with heroin increasing over time. Crack/cocaine, marijuana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

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



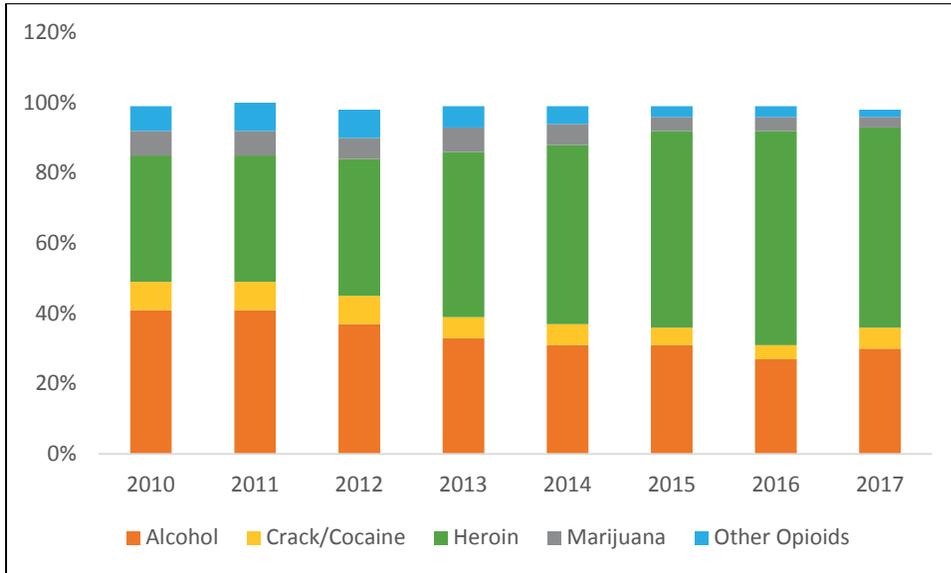
Source: MDPH, 2010 – 2014. Age-adjusted per 100,000

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



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

Figure 17. 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 2012.⁹⁹ 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.¹⁰⁰

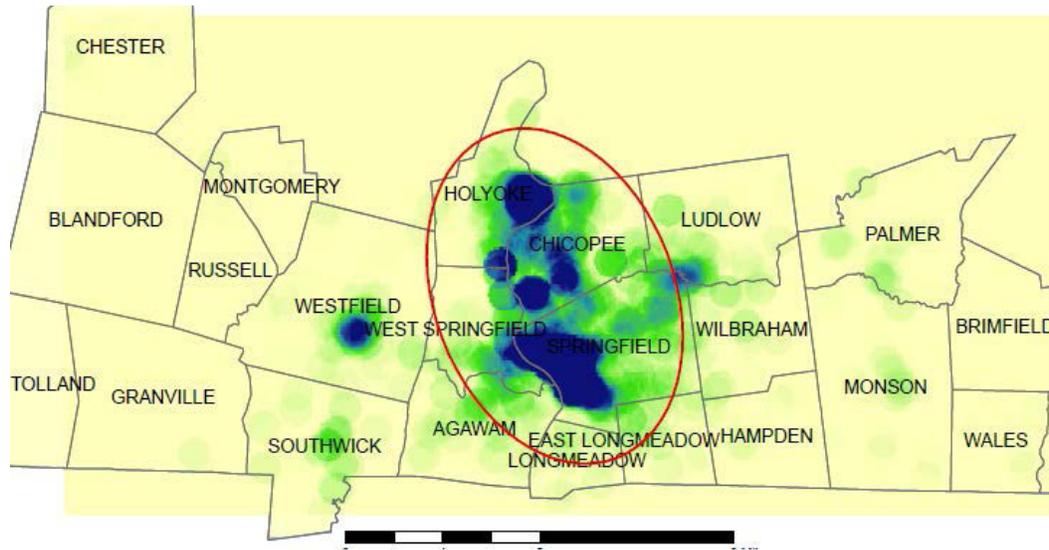
In Hampden County, the number of opioid-related deaths has increased annually, from 32 in 2000, trending upward until 2017, with 113 deaths.¹⁰¹ The 2016 CHNA reported lower opioid overdose hospitalization rates in Hampden County than the state (80 vs. 104 per 100,000).

An analysis of opioid overdoses from 2016 and 2017 shows that Springfield, Chicopee, and Holyoke are the areas with higher amounts in western Massachusetts (Figure 18).

According to provisional data from the Pioneer Valley Opioid Data Committee (PVODC), approximately 50% of overdoses in Hampden County went to Baystate Medical, with about 20% going to Mercy Medical Center, about 20% to Holyoke Medical Center, less than 10% to Baystate Noble and Baystate Wing.¹⁰²

Increased use of harm reduction approaches, such as Narcan, reduces morbidity and mortality of opioid overdose.¹⁰³ In addition, stakeholders called for increased access to long-term treatment programs; more provider and patient education to reduce stigma and as a means to get people the care they need; and more support for youth, particularly those with histories of trauma.

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



Source: Pioneer Valley Opioid Data Committee, 2019

Priority Populations

Youth substance use and abuse can affect the social, emotional, and physical well-being of youth and lead to lifelong substance dependence problems. As described above, an estimated 16% of 8th graders drink alcohol and 12% use marijuana in Springfield.

Latinos experienced high substance use emergency department visit rates at a rate double that of whites in Hampden County (MDPH, Case Mix Data, 2012-2015).

In Hampden County communities older adults have higher proportions of some form of substance use disorder than statewide, as stated above.

People reentering society after incarceration, particularly if their incarceration was related to drugs in any way. Studies consistently show high risk of overdose in the first two weeks after reentry.¹⁰⁴

People who have dual diagnoses. People who have both mental health and substance use disorders face greater challenges accessing services, according to focus group participants and interviewees.

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

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

B. CHRONIC HEALTH CONDITIONS

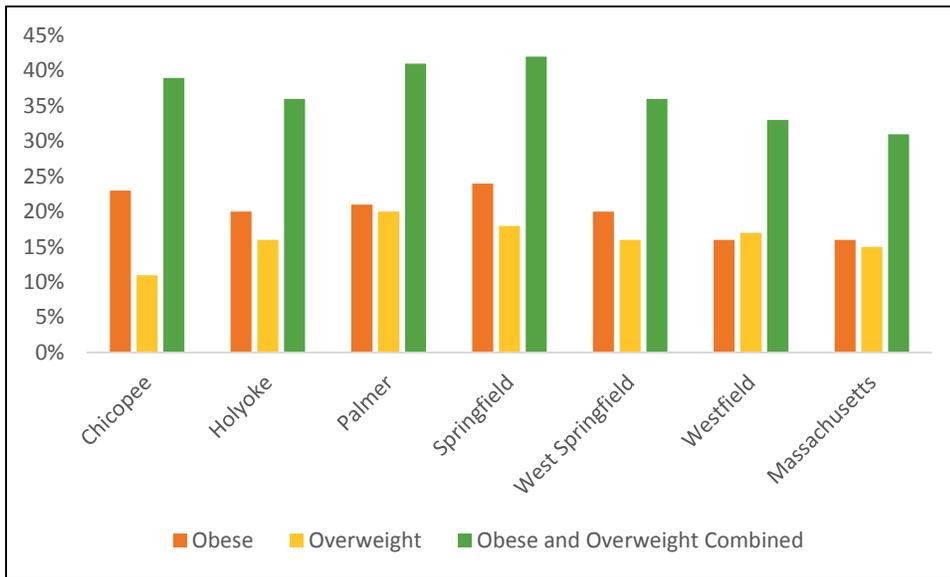
Chronic health conditions continue to remain an area of prioritized health need for Hampden County residents. Residents continue to experience high rates of chronic health conditions and associated morbidity, particularly for obesity, diabetes, cardiovascular disease, cancer, and asthma. A chronic health condition is one that persists over time and typically can be controlled but not cured. According to the Center for Disease Control (CDC), chronic disease is the leading cause of death and disability in the U.S. By 2020 it is estimated that 81 million Americans will have multiple chronic conditions.¹⁰⁵ A healthy diet and physical activity play an important role in preventing and managing chronic diseases.

Obesity

In Hampden County 29% of adults are obese compared to the Massachusetts rate of 24%.¹⁰⁶ In Springfield, 37% of the population is obese.¹⁰⁷ Obesity is a national epidemic and contributes to chronic illnesses such as cancer, heart disease, and diabetes. Obesity can impact overall feelings of wellness and mental health status. A healthy diet and physical activity play an important role in achieving and maintaining a healthy weight.

Though childhood obesity rates have been falling nationally and within some communities in the region over the last few years, it remains concerning. Children develop lifelong dietary and physical activity habits in their early years, and children who are obese are more likely to continue to be obese adults in addition to having adult risk factors that are more severe.^{108, 109} In the 2014 – 2015 school year, the proportion of children in Chicopee (23%), Holyoke (20%), Palmer (21%), Springfield (41%), 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 19).¹¹⁰ County-level obesity rates are not available.

Figure 19. 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

In the Springfield Public Schools in 2017, 17% of students were overweight with 26% having a Body Mass Index signifying obesity. This proportion is similar for white, black, and Latino students.¹¹¹

Cardiovascular Disease (CVD)

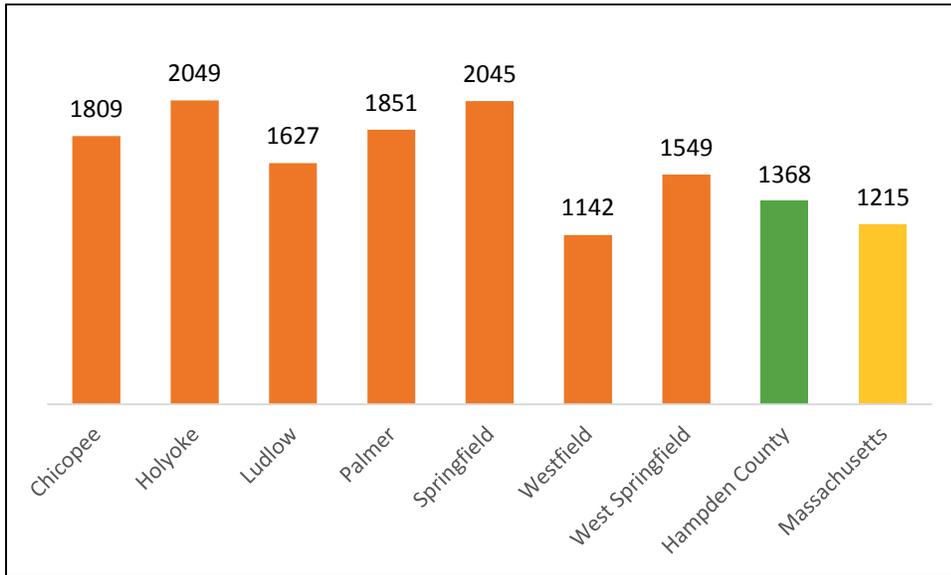
Cardiovascular disease (CVD) includes diseases that affect the heart and blood vessels, including coronary heart disease, angina (chest pain), hypertension, heart attack (myocardial infarction), and stroke. Heart disease is the leading cause of death in Hampden County (MDPH, Massachusetts Deaths 2016).

Holyoke and Springfield have the highest rates of cardiovascular disease hospitalization in Hampden County, both of which are almost 70% higher than the state (Figure 20). Springfield, Westfield, Palmer, and Ludlow have higher rates of stroke hospitalization (MDPH, 2014).

CVD hospitalization rates in Hampden County for the Latino population are almost double that of whites. The CVD hospitalization rate is about 63% higher for blacks (Figure 21).

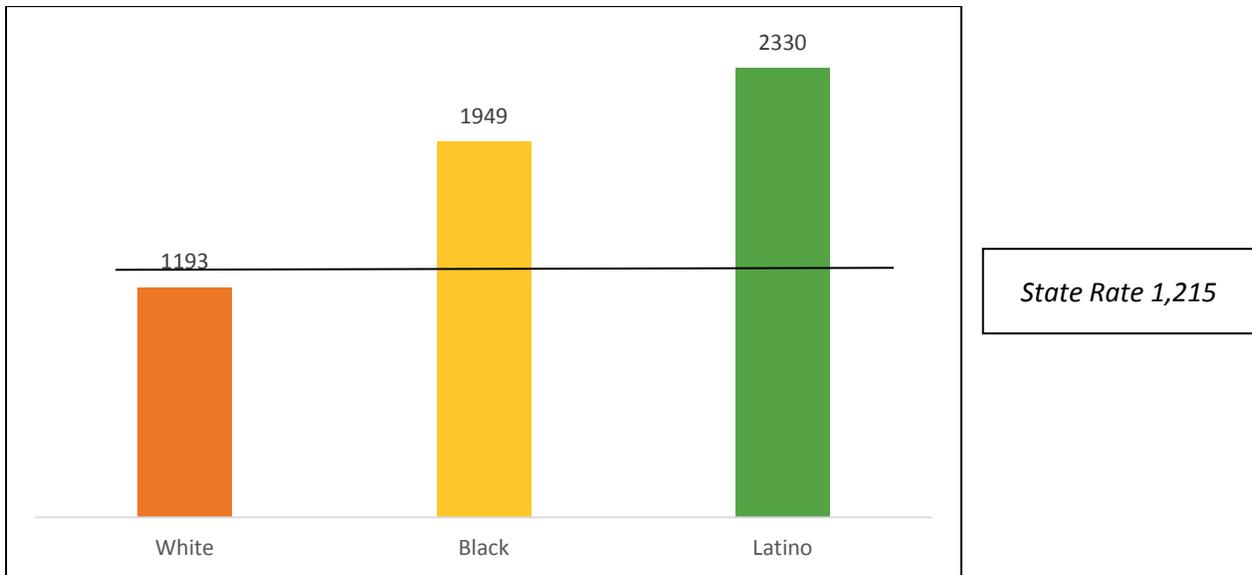
Hypertension (high blood pressure) affects about four in five adults over the age of 65 in Hampden County, slightly higher than the statewide proportion, and coronary heart disease affects about 40% of older adults, with slightly higher proportions in Holyoke, Chicopee, and West Springfield. 93

Figure 20. Cardiovascular Disease Hospitalization Rates, Hampden County and Select Communities



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

Figure 21. Cardiovascular Disease Hospitalization Rates by Race in Hampden County



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

Priority Populations

Older adults experience higher rates of CVD: for example, about four of every five people over the age of 65 have hypertension, which is reflective of the high rates in the state overall (76%).⁹³

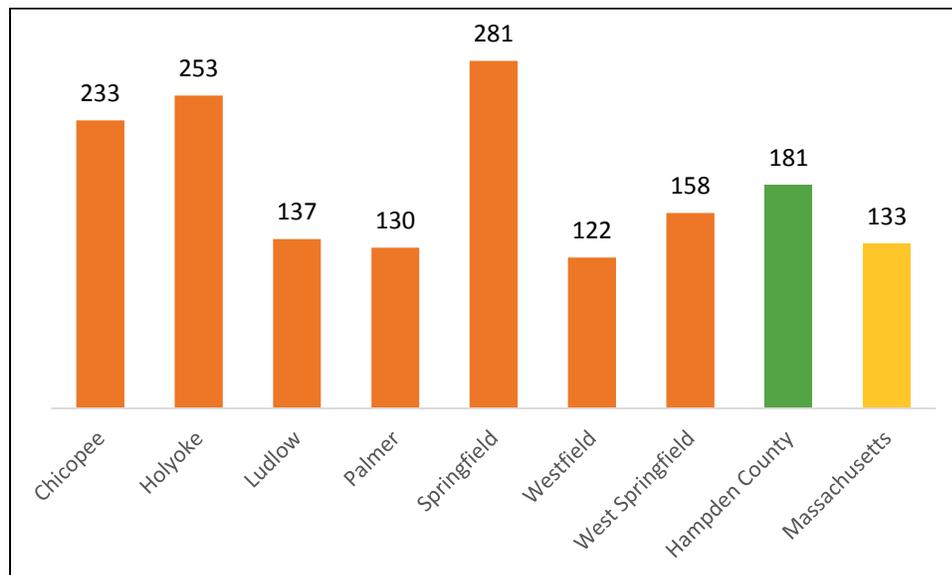
Latinos and blacks had stroke and heart disease hospitalization rates much higher than whites.

Diabetes

An estimated 11% of Hampden County residents have diabetes, which is greater than the state rate of 9%.¹¹² The vast majority is Type 2 diabetes, which is one of the leading causes of death and disability in the U.S. and a strong risk factor for cardiovascular disease. The CDC estimates that 9% of people in the U.S. have diabetes, of which 24% are undiagnosed.¹¹³ Pre-diabetes is when a person has high blood sugar levels that are not high enough for a diagnosis of diabetes. An estimated 15-30% of people with pre-diabetes will develop Type 2 diabetes within 5 years.¹¹⁴

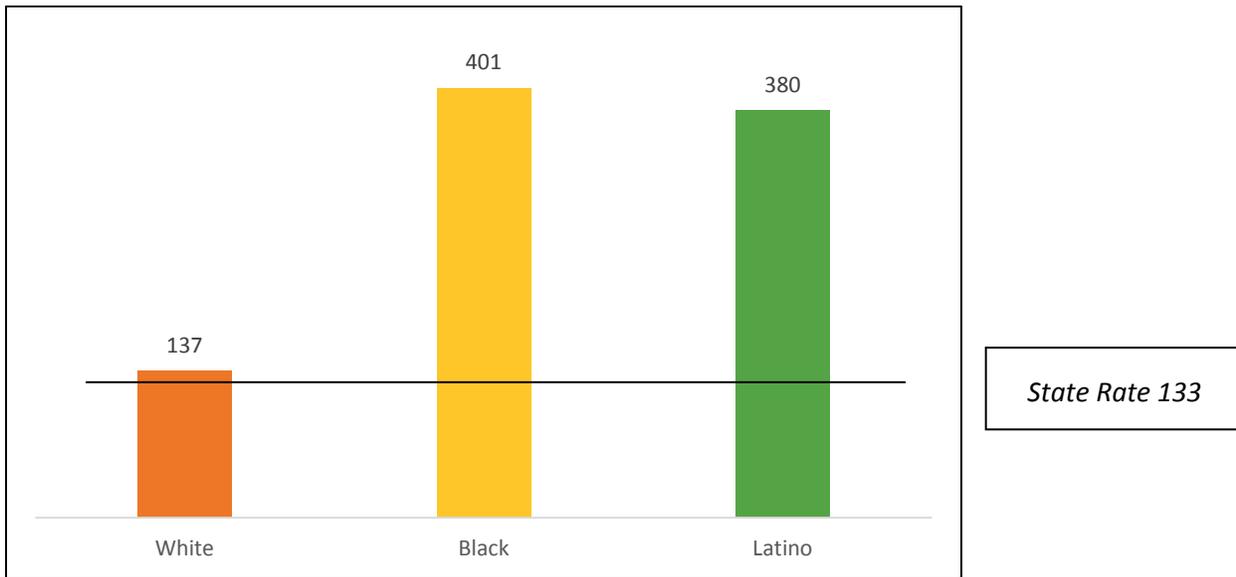
Diabetes hospitalization rates are a measure of severe morbidity due to diabetes. Springfield, Holyoke, and Chicopee have diabetes hospitalization rates (281, 253, and 233 per 100,000 people) that are double or nearly double the statewide rate (Figure 22). Older adults experience a high prevalence of diabetes. The percentage of adults over the age of 65 who have diabetes is high in Springfield (41%), Holyoke (37%), and Chicopee (35%) as compared to the state rate of 32%.⁹³

Figure 22. Diabetes Hospitalization Rates, Hampden County and Select Communities



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

Figure 23. Diabetes Hospitalization Rates by Race in Hampden County



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

Priority Populations

Older adults in select communities in Hampden County experience higher rates of diabetes than the state. Nearly 2 out of 5 older adults have diabetes, as cited above.

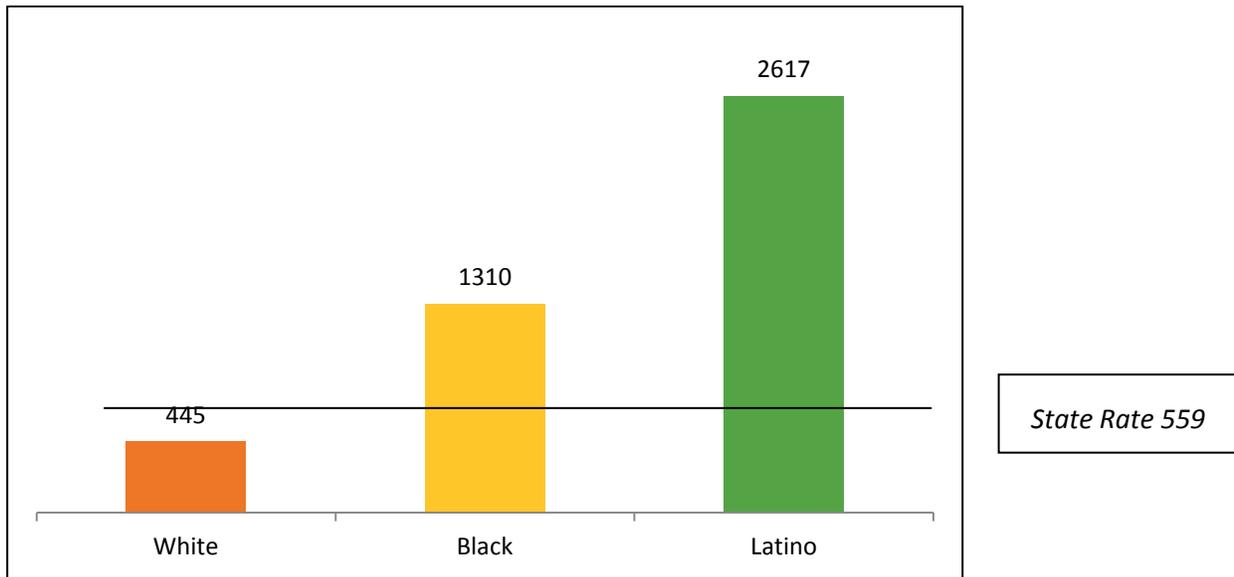
Latinos and blacks in Hampden County experienced about 3 times the rates of diabetes hospitalizations (380 and 401 per 100,000 people, respectively) compared to whites and the statewide rate which are similar to each other (137 and 133, respectively) (Figure 23).

Asthma and Chronic Obstructive Pulmonary Disease (COPD)

Asthma impacts many Hampden County residents. Asthma was elevated as a priority health need in the 2016 CHNA and continues to be a need. The Springfield Metropolitan District was identified as the most challenging place to live with asthma in the U.S., according to the Asthma and Allergy Foundation’s 2018 Asthma Capital rankings. The rankings are based on prevalence of asthma, emergency department visits, mortality, and presence of risk factors.¹¹⁵ Asthma is a common chronic respiratory disease that affects the health and quality of life of children and adults. Asthma can be impacted by different factors in the environment, including cigarette smoke, second hand smoke, air pollution, pollen levels, mold, dust, and other household contaminants or exposures.

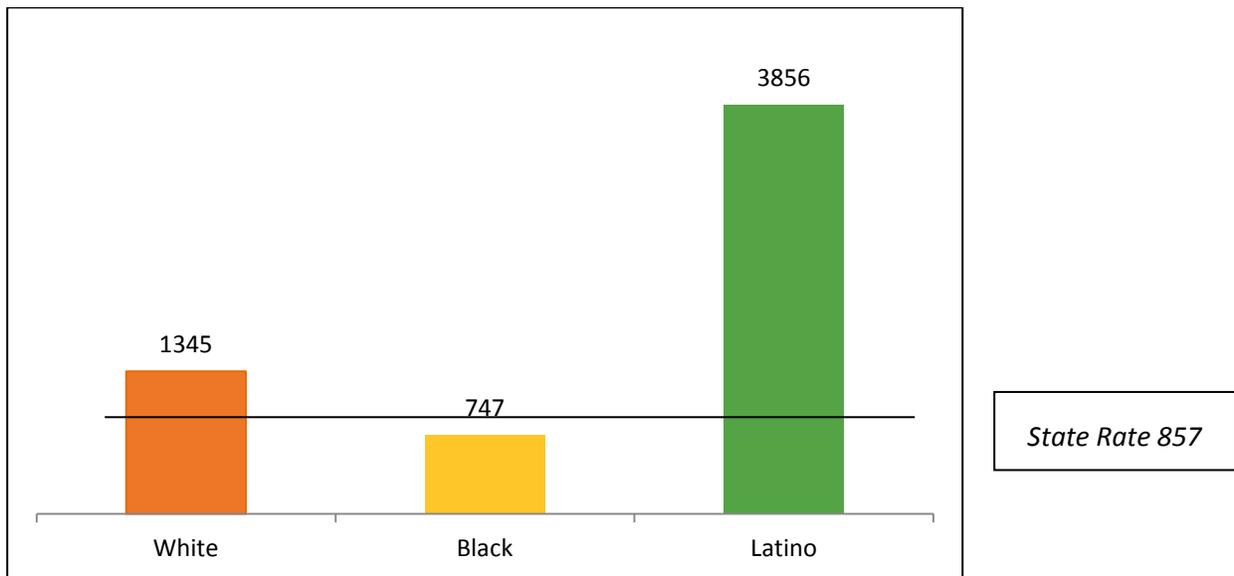
Asthma affects the health and quality of life of children and adults. Asthma is the most common chronic disease in children, and is a driver of emergency department use for children.¹¹⁶ Asthma also affects the physical, social, and emotional lives of children.¹¹⁷

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



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

Figure 25. Emergency Department Visit Rates by Race for Pediatric Asthma, Hampden County



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

Emergency department visit rates are 78% higher in Hampden County than statewide (Figure 24), and rates are highest among Springfield and Holyoke residents (MDPH, 2014). Childhood asthma prevalence ranges from 10% in Westfield and West Springfield to up to 20% in the urban core (Table 5). About one in four older adults in Hampden County cities have asthma.⁹³

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

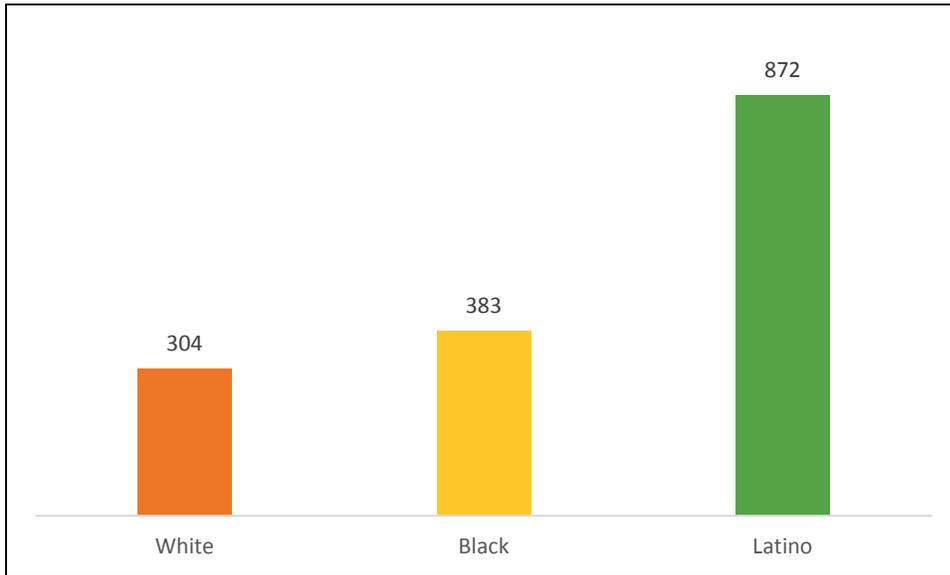
	Childhood	Adults > Age 65
Chicopee	18%	26%
Holyoke	20%	27%
Springfield	17%	24%
Westfield	10%	22%
West Springfield	10%	22%
Massachusetts	12%	15%

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

Chronic Obstructive Pulmonary Disease (COPD) is chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. More familiar terms such as chronic bronchitis and emphysema are no longer used but are included within COPD. COPD impacts many Baystate Medical service area residents. Long-term exposure to lung irritants that damage the lungs and airways is usually the cause of COPD, which can include tobacco use or secondhand exposure, air pollution, and chemical fumes or dusts from the environment or workplace.

Hampden County has a COPD hospitalization rate (389 per 100,000) 22% higher than that of the state (318 per 100,000). Latinos in Hampden County have almost triple the rate of hospitalizations compared to whites. Blacks also have a higher rate than whites (Figure 26).

Figure 26. COPD Hospitalizations by Race/Ethnicity, Hampden County



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

Priority Populations

Children and older adults are priority populations for asthma. Rates for both children and adults are highest in Holyoke out of the select communities researched (Table 5). As in the 2016 CHNA, children are hospitalized in Hampden County at lower rates than the state (140 in Hampden County compared to 186 per 100,000 in Massachusetts) but go to the emergency department at 80% higher rates than the state (1,548 vs. 857)(MDPH, 2014). Latinos in Hampden County continue to experience large asthma- and COPD-related disparities. Asthma hospitalization rates among Latinos are 6 times that of whites in Hampden County and more than 4 times that of the state hospitalization rate overall for asthma (Figure 24). COPD hospitalization rates for Latinos are nearly 3 times the rate for whites (Figure 26).

Cancer

Cancer is the second leading cause of death in Hampden County.¹¹⁸ Advancing age is the most important risk factor for cancer, and the proportion of the population over the age of 60 in Hampden County will increase from 20% in 2010 to 28% in 2035.¹¹⁹ While Hampden County's rate of hospitalization for cancer is 10% lower than that of the state (305 per 100,000 in Hampden County compared to 338 statewide) (MDPH, 2014), the age-adjusted rate of death from cancer is higher (171 per 100,000 compared to 160).¹²⁰ Holyoke, West Springfield, and Springfield have slightly higher rates of cancer hospitalization compared to the statewide rate. Cancer hospitalization rates are higher in blacks and Latinos than whites (MDPH, 2012 – 2015).

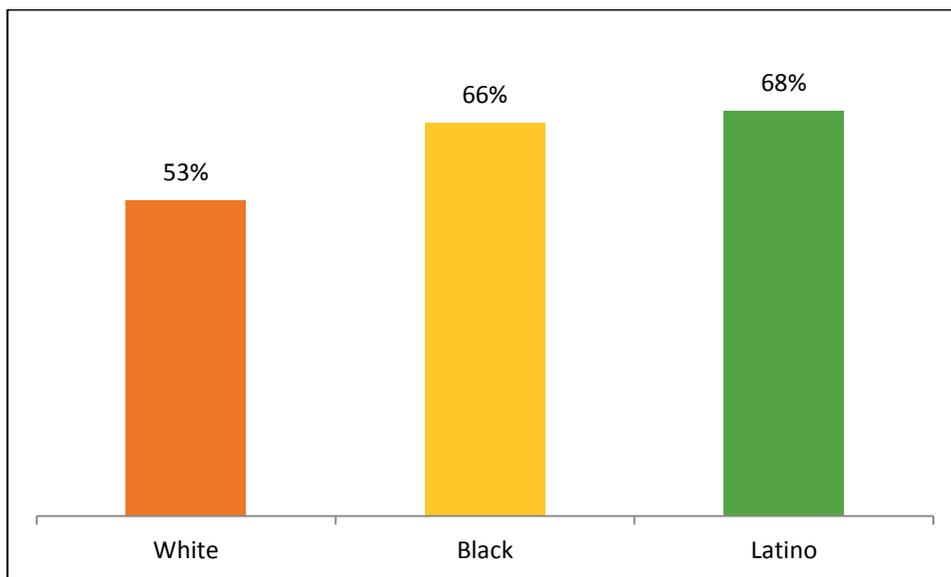
Statewide, the most prevalent forms of cancer for men are prostate (23%), bronchus/lung (14%), colon/rectum (8%), and urinary/bladder (8%). For women, the most prevalent forms are breast (30%), bronchus/lung (14%), colon/rectum (8%), and uterine (7%). Cancer of the bronchus/lung accounted for approximately 27% of all cancer deaths from 2011 – 2015 statewide.¹²¹

Need for Increased Physical Activity and Healthy Diet

Increased physical activity and consumption of fresh fruits and vegetables was identified as a community need in the last CHNA. Among Massachusetts residents in the CDC’s Behavioral Risk Factor Surveillance System 2013 survey, only 11% of respondents met the vegetable consumption recommendation and 14% met the fruit consumption recommendations. In general, women, Latinos, and people with higher income are those who are more likely to meet recommended intake levels.¹²² Students in Springfield report low levels of vegetable consumption, with about two-thirds of black and Latino students and more than half of white students responding that they had eaten either one or no vegetables in the day prior to the survey (Figure 27). Rates of eating fruit or drinking fruit juice were higher, with a majority of black (59%) and Latino (64%) students having two or more servings of fruit juice or eating fruit in the prior day.¹²³

Increasing physical activity and consuming more fresh fruits and vegetables is another identified need in Hampden County. Healthy eating and physical exercise are important habits to create and keep to prevent poor health outcomes such as cardiovascular disease, diabetes, dementia, and depression.¹²⁴ 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.

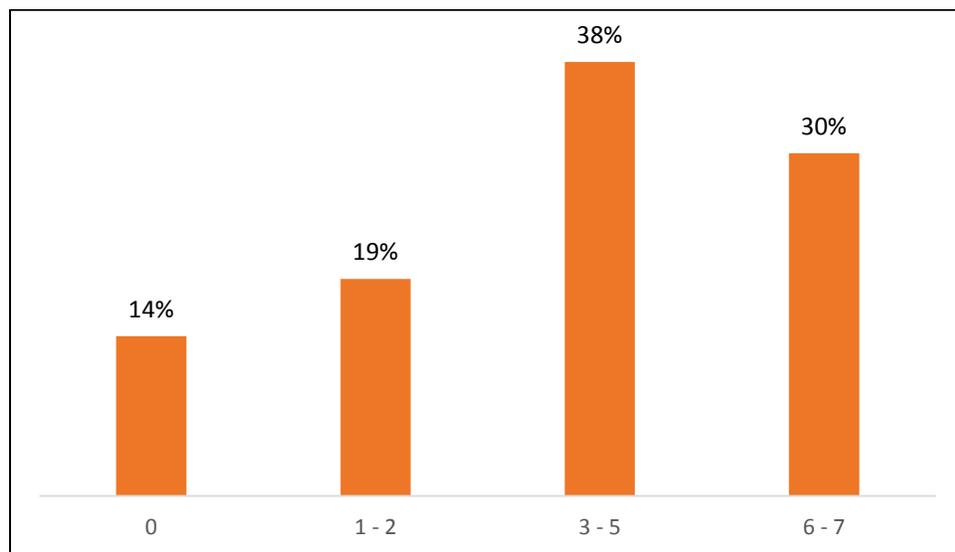
Figure 27. Percent of 8th Graders Who Ate Vegetables One Time or Less in the Prior Day, Springfield



Source: Public Health Institute of Western MA, 2017 Springfield Youth Health Survey

In Hampden County, 1 of 4 residents over the age of 20 report getting no leisure-time physical activity in the past month, slightly higher than the state rate of 22%.¹²⁵ In Springfield, 35% of adults aged 18 and over report no physical activity.¹²⁶ Most Springfield teens reported that they are active for 60 minutes with 38% reporting physical activity 3, 4, or 5 days a week (38%) or 30% reporting 6 or 7 days a week. Still, one-third report little activity with 14% reporting no physical activity (Figure 28).

Figure 28. Number of Days Physically Active for 60 Minutes or More Among 8th Graders, Springfield



Source: Public Health Institute of Western MA, 2017 Springfield Youth Health Survey

The need for increased youth programming and access to places that encourage physical activity was cited by individuals across several focus groups and interviews conducted for this CHNA, and particularly sports and after school programming that are affordable to those with low-incomes. With regard to preventing or reducing gun violence, young people, parents, staff from community organizations, and law enforcement all discussed the importance of sports as one form of activity that is attractive to youth and helps keep them from violence. Parents of children with disabilities spoke about the importance of being able to access places where their children can exercise, such as the pool and the Be Fit program at Shriners Hospital for Children - Springfield.

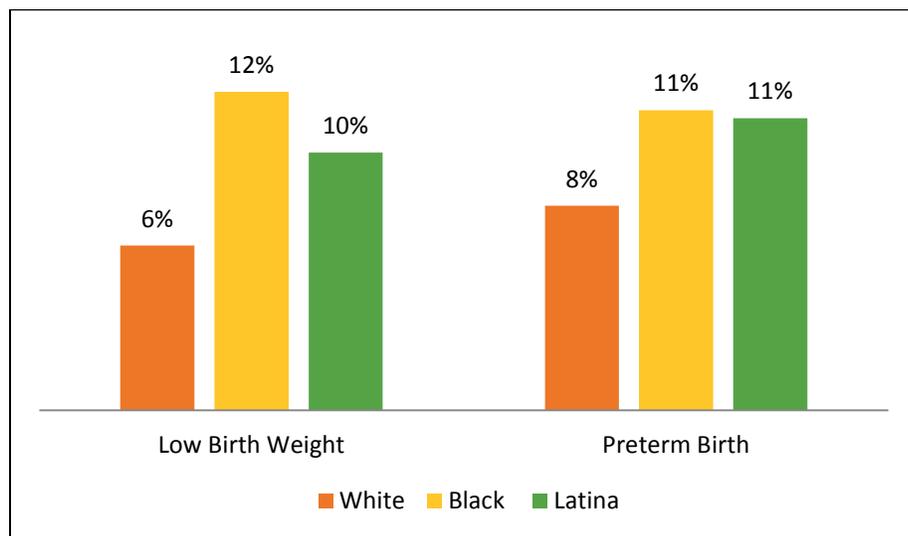
C. INFANT AND PERINATAL HEALTH

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

pregnancy is a risk factor that increases the risk for pregnancy complications and affects fetal development.¹²⁷

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

Figure 29. Birth Outcomes by Race/Ethnicity, Hampden County



Source: MDPH, 2016

An estimated 19% of women did not receive adequate prenatal care in Hampden County. National guidelines suggest that women receive routine checkups once a month for weeks 4 through 28 of pregnancy, twice a month during weeks 28 through 36, and weekly from weeks 36 to birth. The Adequacy of Prenatal Care Utilization Index (APNCU) measures utilization of prenatal care based on the time when care is initiated and frequency of care received. While adequacy of prenatal care rates are comparable to the state in general, prenatal care varies by race/ethnicity. Black women in Hampden County experience higher rates of inadequate prenatal care compared to white women (27% vs. 16%)(Figure 30). Studies suggest that racial and ethnic disparities in receiving adequate prenatal care are linked to systemic injustices facing many individuals of color, including practitioners stereotyping women of color when providing care, and unequal education opportunities.¹²⁸ Teens also had high rates of less than adequate prenatal care (27%) (MDPH, 2016).

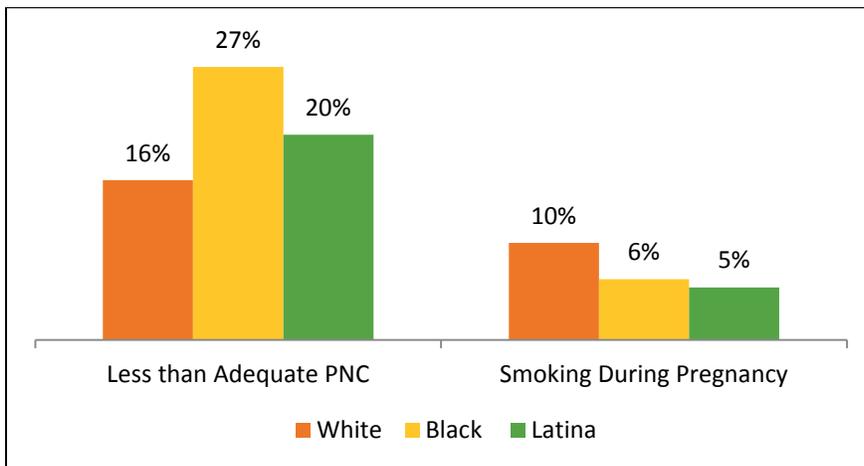
While lower than the 2016 CHNA, currently 7% of women report smoking during pregnancy in Hampden County (Table 6). When examining by race/ethnicity, rates were highest among white women (10%), as compared to black women or Latinas (Figure 30).

Table 6. Less than Adequate Prenatal Care and Smoking During Pregnancy, Hampden County and Select Communities

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

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

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



Source: MDPH, 2016

Priority populations

Outcomes by race/ethnicity illustrate inequities in Hampden County; black rates of LBW are double that of whites (12% compared to 6.2%) and Latina rates are more than 50% higher (9.7%). Black and Latina PTBs are almost 50% higher than that of whites (MDPH, 2016).

Blacks and Latinas in Hampden County have lower rates of smoking during pregnancy than whites, but higher rates of receiving less than adequate prenatal care (MDPH, 2016).

Being a pregnant teenager impacts birth outcomes, with teen moms having much lower rates of adequate prenatal care (MDPH, 2016).

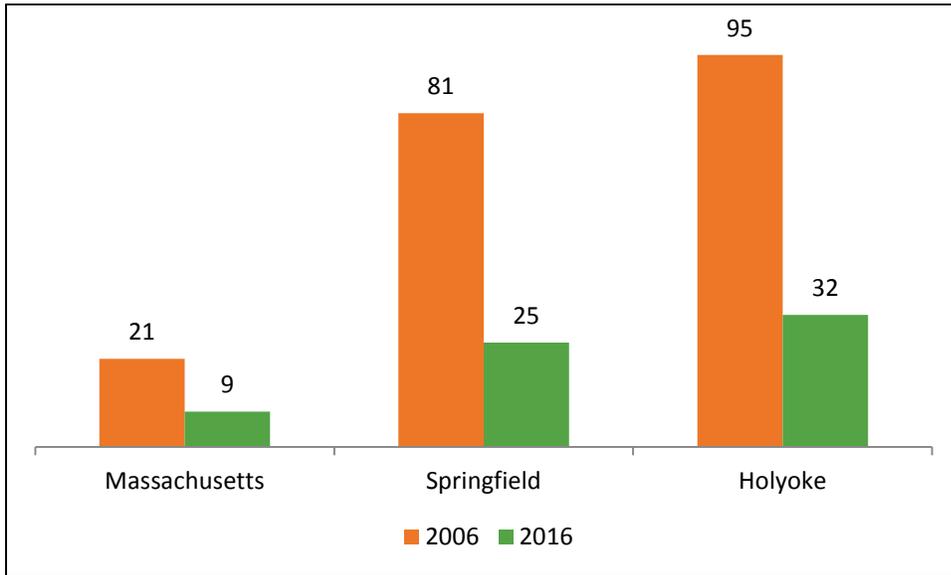
Income also makes a difference. With the proxy being type of insurance, across the state only 11% of those with private insurance were without adequate prenatal care, compared to 25% of those with public insurance (MDPH, 2016).

D. SEXUAL HEALTH

Teen Pregnancy

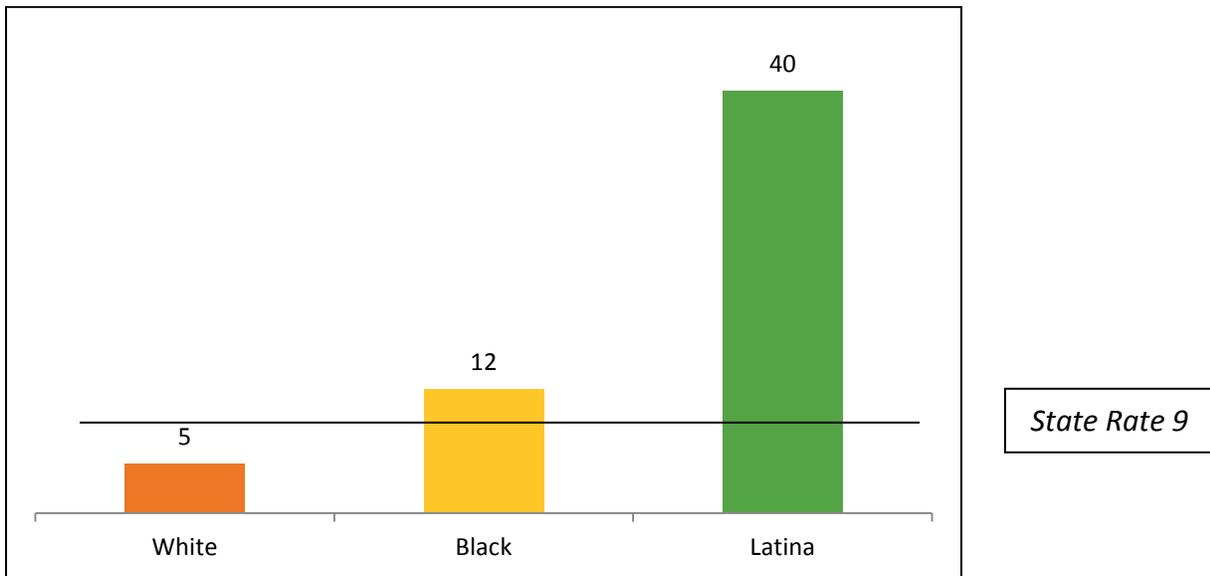
Though collaborative community efforts have made great strides in lowering the teen pregnancy rates in Hampden County, the rates remain almost double that of the state (17 vs. 9 per 1,000) with the highest rates in Springfield (25 per 1,000) and Holyoke (32 per 1,000) (MDPH, 2016).¹²⁹ From 2006, teen birth rates in Springfield and Holyoke dropped considerably. Rates in the state of the whole also decreased during this time period (Figure 31).

Figure 31. Teen Birth Rates in Massachusetts, Springfield, and Holyoke



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

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



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

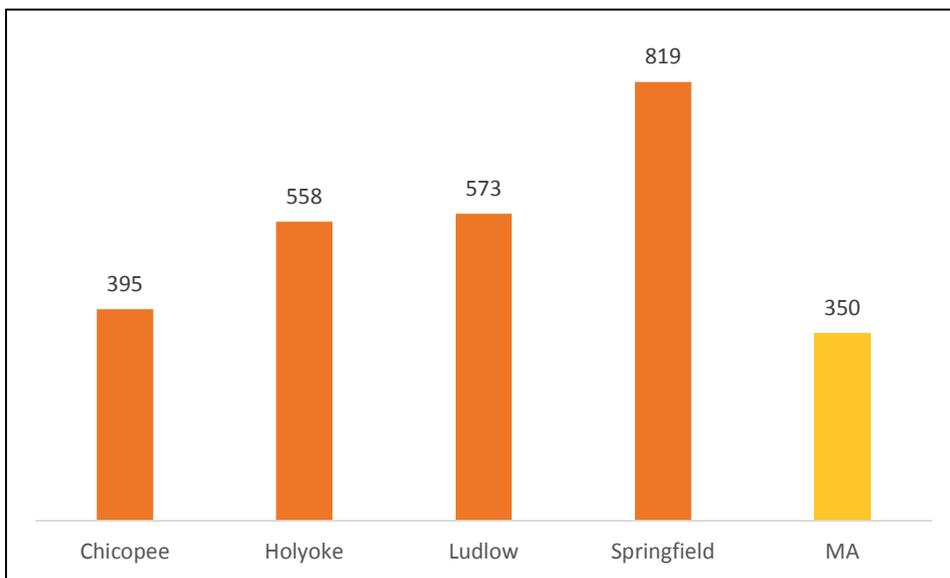
Sexually Transmitted Infections

High rates of STIs and teen pregnancy were identified as prioritized needs in the 2013 and 2016 CHNAs of hospitals serving Hampden County and these rates continue to be elevated. Unsafe sexual behavior contributes to these high rates.

Chlamydia rates are elevated in Hampden County with rates of newly diagnosed chlamydia cases 22% higher than the state (481 in Hampden County compared to 395 per 100,000 in the state).¹³⁰ Springfield has the fifth highest chlamydia incidence rate in Massachusetts (827 per 100,000 compared to statewide rate of 388) and the fourth highest gonorrhea incidence rate in Massachusetts (174 per 100,000 compared to statewide rate of 69).¹³¹

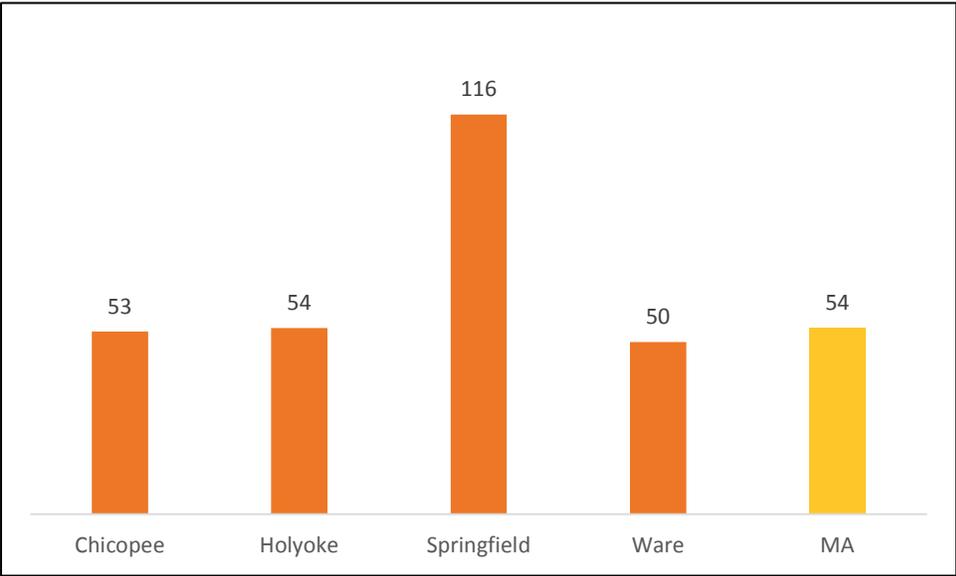
The MDPH Infectious Disease Surveillance Unit collects data on sexually transmitted infections by community. For the select communities identified for the Baystate Medical service area, Figures 33, 34, and 35 identify those with rates of chlamydia, gonorrhea, and syphilis that are higher than that of the state.

Figure 33. Chlamydia Rates in Select Communities, Hampden County



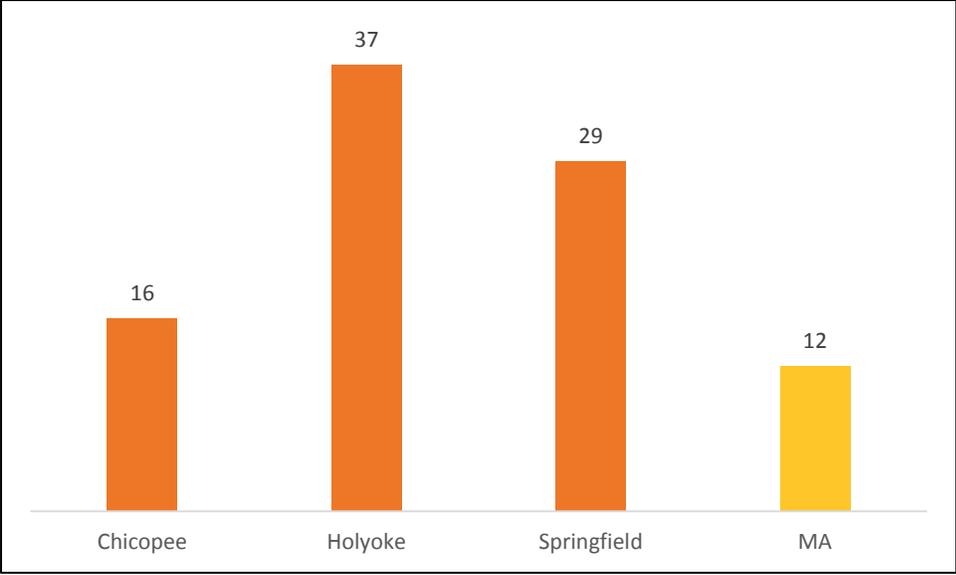
Source: MDPH, 2015. Rates per 100,000

Figure 34. Gonorrhea Rates in Select Communities, Hampden County



Source: MDPH, 2015. Rates per 100,000

Figure 35. Syphilis Rates in Select Communities, Hampden County



Source: MDPH, 2015. Rates per 100,000

Priority Populations

Young adults are at higher risk for STIs. Statewide, young adults aged 15 – 29 have the highest rates of chlamydia, syphilis, and gonorrhea compared to other ages.¹³²

Men and women have higher rates of different STIs. Statewide, gonorrhea rates among men have doubled in the last decade and men experience higher rates of gonorrhea than women. Men also experience higher rates of syphilis, reflecting an ongoing epidemic among men who have sex with men. Women, however, have nearly double the rate of chlamydia as men.¹³³

Blacks and Latinos have higher rates of HIV infection statewide.

Teen pregnancy rates are particularly high among Latinas with a rate of 40 per 1,000 young Latina women aged 15-19 in Hampden County compared to a rate of five per 1,000 in white women (Figure 32). In Springfield and Holyoke the Latina teen birth rate is even higher (43 in Springfield, 39 in Holyoke)(MDPH, 2012-2016).

E. ALZHEIMER'S DISEASE AND DEMENTIA

Approximately 1 in every 10 people over the age of 65 has some form of dementia, as do over one-third of those over the age of 85.¹³⁴ The proportion of those living with Alzheimer's disease in almost all of the larger cities of Hampden County is larger than that of Massachusetts. Springfield (17%), Holyoke (19%), West Springfield (16%), and Palmer (15%) all are above the Massachusetts rate of 14%.¹³⁵ Between 2010 and 2035, the proportion of people over the age of 60 is projected to grow from 20% of the population to 28% in Hampden County, with the number of older adults increasing from approximately 92,000 in 2010 to an estimated 140,000 in 2035.¹³⁶

The Alzheimer's Association notes that between 2000 and 2017, the number of deaths from Alzheimer's disease has increased 145%.¹³⁷ 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.¹³⁸

4. Priority Populations of Concern

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

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

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

5. Geographic Areas of Concern

Springfield, Holyoke, and occasionally Chicopee had consistently higher rates for the majority of health conditions identified as prioritized health needs. These communities also disproportionately experience numerous social and economic challenges which contribute to the health inequities. These communities include the largest proportions of residents of color, so health inequities experienced by these communities contribute to the many racial and ethnic disparities observed in Hampden County.

V. Community and Hospital Resources to Address Needs

Hospital Resources		
Organization Name	Description of Services Provided	Contact
BeHealthy Partnership Accountable Care Organization – Patient Family Advisory Council (PFAC)	A diverse group of patients, family members, and community members who represent the collective voice of patients and families and aim to ensure the delivery of high-quality, safe, and positive memorable health care experiences for patients and their families at Baystate Health hospitals.	https://www.baystatehealth.org/about-us/community-programs/health-initiatives/patient-family-advisory-council
Acute Care for Elders (ACE) Unit	A nationally recognized geriatric care model that has significantly improved clinical outcomes – while preserving the well-being and strength of patients so that they can more easily return to their homes, their independent lives.	https://www.baystatehealth.org/giving/our-priorities/acute-care-for-elders-unit
Baystate Adult Partial Hospitalization Baystate Child Partial Hospitalization	Provides short-term intensive psychiatric services for patients ages 18 and older in need of crisis intervention and stabilization. Program participation may function in lieu of inpatient psychiatric treatment or as a necessary transition after a brief inpatient hospitalization. Children ages 5 to 18 who have emotional, behavioral, or psychiatric difficulties may receive compassionate, intensive crisis intervention and stabilization through talk therapy and activities aimed at improving emotional well-being.	https://www.baystatehealth.org/services/behavioral-health/adult-partial-hospitalization-service https://www.baystatehealth.org/services/behavioral-health/child-partial-hospitalization-program
Baystate Behavioral Health Care	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 Centers (Brightwood, Mason Square, High Street)	Located in Springfield’s low-income neighborhoods that have both HPSA and MUA/MUP designation, Baystate Medical health centers are primary care first-contact sites for thousands of underserved, low-income people.	https://www.baystatehealth.org/locations/mason-square-neighborhood-health-center https://www.baystatehealth.org/locations/high-street-health-center https://www.baystatehealth.org/locations/brightwood-health-center-centro-de-salud

Hospital Resources

Organization Name	Description of Services Provided	Contact
Baystate Family Advocacy Center	The Baystate Family Advocacy Center provides assessment, treatment, and crisis support to child abuse victims and their non-offending caretakers affected by child abuse, domestic violence, and homicide in western Massachusetts.	https://www.baystatehealth.org/services/pediatrics/family-support-services/family-advocacy-center
Baystate Financial Assistance and Counseling	Baystate Health provides financial counseling services to inpatient and outpatient individuals. This assistance includes linking patients to available funding sources such as Medicaid and Medicare and determining whether they are eligible for Health Safety Net or Baystate's Financial Assistance Program.	https://www.baystatehealth.org
Baystate Health Support Groups	Support groups that cover topics related to weight loss and stroke.	https://www.baystatehealth.org/patients/support
Baystate Home Health	Provides high-quality care, expressly tailored to meet each patient's needs. Our home health team works together to ensure a safe and swift recovery from illness, accident, or surgery in the comfort of home.	https://www.baystatehealth.org/services/home-health
Baystate Interpretive Services	Provides free language services to patients whose primary language is not English.	https://www.baystatehealth.org/patients/support/interpreter-services
Baystate Neighbors Program	Baystate Health provides qualifying employees with financial assistance to purchase homes in Springfield.	http://springfieldnhs.org/employer-assisted-program
Baystate Obstetrics and Gynecology (OB/GYN)	Offers comprehensive obstetrics and gynecology care to women of all ages in western Massachusetts.	https://www.baystatehealth.org/services/ob-gyn
Baystate Springfield Educational Partnership	Provides career pathway programming to Springfield students with an expressed interest in the health care professions.	https://www.baystatehealth.org/about-us/community-programs/education-training/bsep
Baystate Summer Scholars Program	Provides opportunity for those entering their junior or senior year at a four-year university to participate in a mentored research project, project-based research methodology instruction, clinical and non-clinical observations.	https://www.baystatehealth.org/education-research/education/baystate-undergraduate-programs/summer-scholars
Business Resource Groups (BRGs)	<p>The Business Resource Group Mission is: "To be a respected voice that moves and creates positive, measurable impact on BH goals. We do this by building an inclusive, collaborative workplace that leverages the intersection of our diverse employees and communities. We strive to create meaningful connections that inspire and cultivate a culture where we all belong."</p> <p>LGBTQ+ Pride & Allies Black Employees Connecting Military, Veterans and Honor Guard BH Women Empowered</p>	<p>Kara Wolf Diversity & Inclusion Consultant kara.wolf@baystatehealth.org</p>

Hospital Resources

Organization Name	Description of Services Provided	Contact
	Different Abilities Young Professionals BH Cultural Responsive Care Baystate Women in Medicine & Science	
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
Consumer Health Library	The Consumer Health Library was established by Baystate Health to offer free library resources and services to patients and their families.	https://www.baystatehealth.org/patients/support/consumer-health-library
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
Dispatch Health	Brings comfortable healthcare directly to a patient's home. Skilled providers arrive with the tools necessary to provide advanced medical care and are supported by our technological infrastructure that ensures quality and improves outcomes.	https://www.dispatchhealth.com/about-us/
Heart & Vascular Care Services	Comprehensive diagnostics, and treatment options for coronary artery disease, heart rhythm disorders, heart failure; cardiac surgeries for adults and children; cardiology clinical trials.	https://www.baystatehealth.org/services/heart-vascular
MIGHTY (Moving, Improving and Gaining Health Together at the Y)	MIGHTY is a pediatric obesity treatment program for ages 5-21 years old held at the Springfield YMCA and includes 14 – two-hour sessions which include physical activity, nutrition, and behavior modification.	https://www.baystatehealth.org/services/pediatrics/specialties/weight-management-program
Parent Education Classes	Provide education and support for expectant parents and families including breastfeeding resources, childbirth and breastfeeding classes, infant care, and keeping baby safe classes, babysitter academy, and grandparent's class, as well as yoga classes for before and after you give birth.	https://www.baystatehealth.org/services/ob-gyn/support-services/childbirth-parent-education-classes/baystate-medical-center
Patient Family Advisory Councils	The Baystate Health Patient & Family Advisory Council (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'.	https://www.baystatehealth.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
Poverty Simulation	The Baystate Poverty Simulation is an educational activity that aims to provide health care professionals and students essential insight into the lives of vulnerable populations while more largely focusing on providing culturally humble, empathetic, and patient-centered care.	https://education.baystatehealth.org/povsim

Community Organizations

Organization Name	Description of Services Provided	Contact
African Diaspora Mental Health Association	Minority-owned outpatient mental health clinic providing culturally-specific behavioral health and educational services in Massachusetts.	https://admha.org/
After Incarceration Support Services	The AISS assists formerly incarcerated people in all aspects of their lives as they transition from incarceration into the community. Many of them face a range of issues, such as addiction, mental health problems, lack of identifying documents, employment obstacles, financial concerns, limited education, poor housing situations (or lack of housing), etc. They also cope with a lack of familial support, poor self-esteem, fear of failure, and a constant temptation to return to the criminal lifestyle.	http://hcsdma.org/aiss-3/
Alzheimer's Association (Massachusetts and New Hampshire)	The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.	https://www.alz.org/manh
Arise for Social Justice	A member-led community organization dedicated to defending and advancing the rights of poor people. Whose mission is to educate, organize, and unite low-income people to know what their rights are, stand up for those rights, and achieve those rights.	https://www.arisespringfield.org/
Behavioral Health Network Addiction Services Outpatient Services Carlson Recovery Center	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. The center treats dually-diagnosed clients with both mental health and substance use disorders through the Enhanced Acute Treatment Program. Services are available 24 hours per day.	http://bhninc.org/
Big Brothers Big Sisters of Hampden County	Provide children facing adversity with strong and enduring, professionally supported one-to-one relationships that change their lives for the better, forever.	http://www.bigbrothers-sisters.org/
Black Men of Greater Springfield	Providing positive experiences and activities for black youth. Dedicated to exposing students to highly successful African-American role models that emphasize their ability to achieve and become contributing members of our community, society, and the world.	http://www.bmogspringfield.org/index.html
Springfield Boys and Girls Club	Provides, in a safe environment, programs that inspire, educate, guide, enable, and support all young people to realize their full potential as productive, responsible, respectful citizens and leaders.	http://www.sbgc.org/

Community Organizations

Organization Name	Description of Services Provided	Contact
Brianna Fund for Children with Physical Disabilities	Founded to assist children with physical disabilities by eliminating barriers of access to community resources. With the goal that children with physical disabilities will enhance their capacity for living a full and productive life, the Brianna Fund has to date provided grants to over 46 families in the Greater Springfield community.	https://www.briannafund.org/
Caring Health Center	CHC's team of community health workers, health navigators, and interpreters ensures that patients receive comprehensive care that addresses their cultural, economic, and language needs, while its behavioral health specialists deliver services to address a wide range of emotional and other issues.	http://caringhealth.org/index.html
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
CleanSlate Addiction Treatment Center (Suboxone Treatment)	Patient-focused treatment for opioid, alcohol, and other drug addictions; appointment-based outpatient treatment.	http://cleanslatecenters.com
Clinical and Support Options (CSO)	A "one-stop" model of comprehensive, holistic services to individuals and families with multiple and complex issues.	https://www.csoinc.org/
Springfield Community-Based Doula	Dedicated to improving birth outcomes in vulnerable populations of Springfield by reducing racial inequities in infant and maternal health. Train community-based labor companions, or doulas, to empower women and families before, during, and after birth.	https://www.springfieldcommunitybaseddoulas.org/
Community Legal Aid	Provides free civil legal services to low-income and elderly residents. Regardless of how much money you have, we assure fairness for all in the justice system, protecting homes, livelihoods, health, and families.	https://communitylegal.org/
Community Services Institute	A family-owned clinic focused exclusively on outpatient, trauma-informed psychotherapy, psychiatry, and psychological assessment.	http://communityserv.com/
Community Survival Center	A non-profit agency that helps families struggling to provide the basics: food, clothing, and household items.	http://communitysurvivalcenter.org/
Compañeras	Dedicated to assisting, supporting, and empowering those whose lives are affected by battering and abuse.	https://www.womanshelter.org/
Council on Aging	Focused on improving and enhancing quality of life for elder residents by striving to ensure that all elder residents are afforded the opportunity to live a lifestyle based on independence, and to mature with dignity and security.	https://www.springfield-ma.gov/hhs/index.php?id=council_on_aging
Counter Criminal Continuum Policing (C3)	The Springfield Police Department and Massachusetts State Police C3 teams facilitate unity of effort and criminal intelligence gathering by, with, and through interagency, community, and private enterprise cooperation in order to detect, disrupt, degrade and dismantle criminal activity.	https://www.springfield-ma.gov/police/

Community Organizations

Organization Name	Description of Services Provided	Contact
Dress for Success	Provide each client with professional attire to secure employment and furnish her with a confidence that she carries forever and the knowledge that she can actively define her life, the direction she takes and what success means to her.	https://westernmass.dressforsuccess.org/
Dunbar Community Center	Provides martial arts, fitness sessions, dance classes, after-school care, summer camp, senior health initiatives, and mentoring opportunities.	http://www.springfieldy.org/family-centers/dunbar-y-family-community-center/
First Pioneer Valley Dream Center Isaiah's Closet	A multicultural, bilingual (English-Spanish), faith-based, and volunteer driven non-profit organization that loves and serves others; the homeless, disenfranchised, the struggling families, and individuals from all walks of life.	http://firstpvdreamcenter.org/our-story
Food Bank of Western Massachusetts Brown Bag Food for Elders Program	Distributes food to member agencies in Berkshire, Franklin, Hampden, and Hampshire counties. These independent pantries, meal sites, and shelters are on the front lines of emergency food assistance in the region, playing a crucial role helping individuals, 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/
The Gándara Center Addiction Services Outpatient Mental Health Services Youth Outreach Programs	The Gándara Center promotes the well-being of Hispanics, African-Americans, and other culturally diverse populations through innovative, culturally competent behavioral health, prevention, and educational services.	https://gandaracenter.org
Gardening the Community	A food justice organization engaged in youth development, urban agriculture, and sustainable living to build healthy and equitable communities.	http://www.gardeningthecommunity.org/
Girls Inc. of the Valley	Inspires all girls to be strong, smart, and bold by providing them the opportunity to develop and achieve their full potential.	https://www.girlsincvalley.org/
Girls on the Run	A nonprofit organization dedicated to creating a world where every girl knows and activates her limitless potential and is free to boldly pursue her dreams.	https://www.girlsontherunwesternma.org/
Greater Springfield Senior Services Inc. Aging Services Access Point	A private nonprofit organization dedicated to maintaining a quality of life for older adults, caregivers, and persons with disabilities. This mission is achieved through the provision of programs and services which foster independence, dignity, safety, and peace of mind.	https://www.gsssi.org/index.html
Habitat for Humanity	Seeking to put God's love into action, Habitat for Humanity brings people together to build homes, communities, and hope.	https://www.habitatspringfield.org/

Community Organizations

Organization Name	Description of Services Provided	Contact
Hampden County Addiction Task Force	A collaboration of community resources, law enforcement (local and state), health care institutions, service providers, schools and community coalitions, individuals, and families whose goal is to focus on a county-wide approach to address drug addiction, overdose, and prevention.	https://hampdenda.com/community-safety-and-outreach-unit/hampden-county-addiction-taskforce/
Head Start	Committed to providing low-income children and their families with a Beacon of Hope and source of support for a brighter future. Head Start strives to do so by providing high-quality comprehensive child development services to enrolled children and empowering families to achieve stability in their home environment.	http://hcsheadstart.org/index.htm
Home Grown Springfield	The culinary and nutrition program of Springfield Public Schools that aims to eliminate student hunger by increasing the quality, sustainability, and efficiency of the child nutritional programs in our schools and community.	https://www.homegrownspringfield.org/
Hope for Holyoke Recovery Support Center	Free peer-to-peer support groups, relapse preventions and tobacco cessation support groups, social events, job readiness activities, advocacy, and recovery coaching.	https://gandaracenter.org/hope-for-holyoke/#HFH
International Language Institute	Promotes intercultural understanding by providing high-quality language instruction and teacher training.	https://ili.edu/
Jewish Family Services Refugee Resettlement	Provides behavioral health programs and new American programs, as well as supports for older adults. Multi-cultural, multi-lingual staff provides comprehensive services which includes case management, family reunification, employment, English as a Second Language, school and health support, and counseling.	www.jfswm.org http://www.jfswm.org/healing-world/refugee-services
Link to Libraries	Link to Libraries collects and distributes new books to elementary school libraries and nonprofit organizations and to enhance the language and literacy skills of children of all cultural backgrounds.	https://www.readby4thgrade.com/programs/link-libraries/
Live Well Springfield	A coalition that brings together over 30 organizations working together to build and sustain a culture of health in Springfield that includes the broadest definition of health, including healthy eating, active living, the built environment, economic opportunity, housing, and education.	http://www.livewellspringfield.org
Massachusetts Trans Political Coalition (MTPC)	Dedicated to ending oppression and discrimination on the basis of gender identity and gender expression. Rooted in social justice, MTPC educates the public, advocates with state, local, and federal government, engages in activism, and encourages empowerment of community members through collective action.	https://www.masstpc.org/
Martin Luther King Jr. Family Services	A multi-cultural and multi-service agency dedicated to being "Keepers of the Dream", we nurture and empower the aspirations of individuals, families, and youth to achieve new realities of peace, social and economic justice, self-determination, self-actualization, and self-sufficiency.	https://www.mlkjrfamilyservices.org/

Community Organizations

Organization Name	Description of Services Provided	Contact
Mass 211	An easy to remember telephone number that connects callers to information about critical health and human services available in their community. It serves as a resource for finding government benefits and services, nonprofit organizations, support groups, volunteer opportunities, donation programs, and other local resources.	https://mass211.org/
MassHire	Local people interacting with local job seekers and businesses to assist people in building their skill sets to meet the needs of businesses.	https://masshirespringfield.org/about/
Maternal Child Health Commission	The Maternal Child Health Commission (MCHC) promotes a community that nurtures all families to have healthy pregnancies and healthy children.	https://www3.springfield-ma.gov/hhs/index.php?id=nursing-programs
Men of Color Health Awareness (MOCHA)	A program aimed to address the poorer health and higher levels of stress that men of color in Springfield experience compared to other groups. Our goals are to empower men of color to play an active role in health care through health education and wellness classes.	http://mochaspringfield.org/
Mental Health Association	Offers programs such as mental health services, developmental disabilities services, homeless services, internship programs, recovery from addiction services, and an emotional health and wellness center.	https://www.mhainc.org/
Mental Health First Aid	An 8-hour course that teaches you how to identify, understand, and respond to signs of mental illnesses and substance use disorders.	https://www.mentalhealthfirstaid.org/
MetroCare of Springfield	An organization founded on the principle of providing residents of western Massachusetts with reliable and accessible caregiving. The goal is to provide culturally aware services to a diverse community of individuals with the objective to keep individuals happy and healthy in their homes.	http://metrocareofspringfield.com/en_US/
MotherWoman	Promotes the resilience and empowerment of mothers and their communities by building community-capacity and advocating for just policies through evidence based research and grassroots organizing.	https://motherwoman.org/
National Association of Mental Illness (NAMI) Western Massachusetts	The nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.	https://www.nami.org/Local-NAMI/Details?state=MA&local=0011Q000022GArKQAW
Neighborhood Councils	City-certified local groups made up of people who live, work, own property, or have some other connection to a neighborhood. Neighborhood Council Board Members are elected or selected to their positions by the neighborhoods themselves.	https://www.springfield-ma.gov/planning/index.php?id=neighborhoodcouncils
New England Farm Workers' Council	A multi-faceted human services agency dedicated to improving the quality of life for low-income people throughout the northeast. In addition to migrant and seasonal farm workers and their families, the agency serves inner-city and low-income groups.	http://www.partnersforcommunity.org/default/index.cfm/about-pfc/affiliates-programs/nefwc/

Community Organizations

Organization Name	Description of Services Provided	Contact
New England Justice for Our Neighbors: Trinity United Methodist Church	As a neighborhood church, Trinity is committed to helping all people who want to become active, vital members of the community. Trinity Church works toward justice for all and offers services such as free legal advice.	http://www.newenglandjfon.org/
New North Citizens' Council (NNCC)	Serves at risk- youth through services including: groups, workshops, structured recreation projects, video development, and outreach efforts. NNCC addresses two of the needs of the client population: Afterschool leadership/Education program and Outreach/Mentoring Street Worker.	https://www.springfield-ma.gov/police/index.php?id=155
Open Doors Social Services	A program that provides case management, housing search assistance, medical, mental health, and substance abuse referrals for homeless people living in area shelters, on the streets, or temporarily doubled up with friends or relatives.	http://www.openpantry.org/open-door-social-services.php
OutNow	A support group for LGBTQ+ youth from the greater Springfield Area.	http://outnowyouth.org/
Parent Villages	Parent Villages builds bridges between parents, youth, advocates, community leaders, and educators to close the opportunity gap and improve education for students.	https://www.facebook.com/parentvillages/
Pioneer Valley Asthma Coalition	A coalition of health professionals and institutions, community groups and residents, public health organizations, municipal and state agencies, academic institutions, schools, day care, housing and environmental groups committed to improving asthma and environmental conditions that affect health in western Massachusetts.	www.pvasthmacoalition.org
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/
Planned Parenthood	Provides sexual health and reproductive services including: abortion services, birth control, emergency contraception, general healthcare, HIV/STI testing, pregnancy testing, LGBT services, and more.	https://www.plannedparenthood.org/health-center/massachusetts/springfield/01107/western-massachusetts-health-center-2662-90610
Project Baby	A community organization addressing disparities in infant mortality rates in the city of Springfield, Massachusetts and in Hampden County.	http://projectbabyspringfield.org/
Project Coach	Works to bridge the economic, educational, and social divisions facing Springfield youth by empowering and training inner-city teens to coach, teach, and mentor elementary school students in their neighborhoods.	https://www.projectcoach.smith.edu/

Community Organizations

Organization Name	Description of Services Provided	Contact
Rebekah's Closet	Outreaches to young families in the area seeking support providing for their infants and toddlers. Families can receive diapers, wipes, clothing, toys, books, and furniture as they become available.	https://www.uccholyoke.org/programs-events/rebekahs-closet/
Revitalize Community Development Corporation (CDC)	The mission is to revitalize homes, neighborhoods, and lives through preservation, education, and community involvement.	https://www.revitalizecdc.com/
ROCA	The mission is to disrupt the cycle of incarceration and poverty by helping young people transform their lives.	https://rocainc.org/
Ronald McDonald House	When children are sick and being treated at Springfield area medical facilities, the Ronald McDonald House of Springfield, Massachusetts is a welcome "home away from home" for children and their families. A dedicated group of volunteers assist a full time house manager to sustain the House. Families have the privacy of their own bedroom and bath and communal support of dining and recreation facilities.	https://rmhc-ctma.org/what-we-do/rmh-springfield/
Salvation Army	Offers a range of programs and services encompassing everything from after-school programs, social clubs, and parenting classes through drug and alcohol rehabilitation and disaster response. We regularly partner with churches, charities, and other organizations to reach and assist as many people as possible.	https://springfield.salvationarmy.org/
Scan 360	The Scan 360 Family Center assists families who have a family member with a developmental disability to navigate the service system.	https://disabilityinfo.org/records/springfield-community-access-network-family-center-scan360/
Springfield 311	Gives the public responsive and easy access to all of Springfield's government services. Allows departments to focus and improve their process and provide the residents of Springfield with a well-managed and proficient government.	http://faq.springfieldma.intel.ligovsoftware.com/1home.aspx
Springfield Adult Basic Education Directory	Educational resources for adults and out-of-school youth, for Basic Literacy, English as a Second Language, HiSET preparation and testing, Transition to College, Workplace Education, and Family Literacy.	https://www.springfieldlibrary.org/library/springfield-adult-basic-education-directory/
Springfield Coalition for Opioid Overdose Prevention (SCOOP)	Trains, educates, advocates, and provides support and resources to all who are affected by opiate abuse and overdoses.	http://www.springfield-ma.gov/hhs/index.php?id=scoop-about
Springfield Department of Health and Human Services	Protects the public health and environment of the City of Springfield through education, inspections, sampling and monitoring, and enforcing federal, state, and local codes as they pertain to public health issues.	https://www.springfield-ma.gov/hhs/

Community Organizations

Organization Name	Description of Services Provided	Contact
Springfield Food Policy Council	Serves as a diverse group of stakeholders that provides a comprehensive examination and ongoing assessment of Springfield's food system as well as ongoing recommendations for policy and built-environment solutions to improve access to fresh, affordable, and culturally appropriate food for those who live and work in the City of Springfield.	https://www.springfieldfoodpolicycouncil.org/
Springfield Healthy Home Collaborative	City-wide collaboration to address health issues faced by residents due to poor housing conditions, including asthma.	http://springfieldhealthyhomes.org/asthma-triggers/
Springfield Partners for Community Action	Federally designated Community Action Agency for the greater Springfield area, serving low-income individuals and families.	http://www.springfieldpartnersinc.com
Springfield Rescue Mission	Meets the physical and spiritual needs of the hungry, homeless, addicted, and poor by introducing them to Christ and helping them apply the Word of God to every area of their lives.	https://springfieldrescuemission.org/
Square One	The vision of Square One is to affect meaningful change that results in better lives and more promising futures for children, families, and our communities. It achieves this vision by raising funds, advocating on behalf of children and families, delivering research-based solutions, and developing needed services that promote education, health, safety, holistic development, and self-reliance.	https://www.startatsquareone.org/
Stavros	Helps people with disabilities and deafness to develop the tools and skills they need to take charge of their own lives.	https://www.stavros.org/
Stonewall Center	Provides support, resources, programming, and advocacy for lesbian, gay, bisexual, trans, queer, intersex, asexual (LGBTQIA) and allied students, staff, and faculty at UMass Amherst and for the larger Pioneer Valley.	https://www.umass.edu/stonewall/
Stop Access Drug-Free Communities Springfield	City-wide coalition, coordinated by the Gandara Center, works to prevent and reduce underage drinking and marijuana use in the Mason Square, South End, and Forest Park neighborhoods of Springfield.	https://gandaracenter.org/cchild-adolescent-family-services/#stop-access
Suit-Up Springfield	Guides the young men of Springfield on professional attire and becoming professionally minded.	http://suitupspringfield.com/
Sunshine Village	Built on the belief that adults with disabilities can lead rich, meaningful lives, Sunshine Village is a thriving, vibrant community where adults and their families come to connect, learn, contribute—and shine.	https://www.sunshine.us/
Tapestry Health Needle Exchange Program	Provides sexual and reproductive health services, LGBT health services, HIV health and prevention, family nutrition services, syringe access and disposal, overdose prevention,	https://www.tapestryhealth.org http://www.tapestryhealth.o

Community Organizations

Organization Name	Description of Services Provided	Contact
	and community trainings. Needle exchange programs in Holyoke and Northampton, sterile needles to injection drug users, trainings on Naloxone, education, and counseling.	rg/index.php/services/prevention/needle-exchange
The Children's Study Home	Serves children, adolescents, and families with special needs throughout the Pioneer Valley and Cape Cod areas. Children served are often struggling to cope with behavioral, psychiatric, and cognitive issues related to the experiences they have survived.	https://studyhome.org/
The Gray House	Helps its neighbors facing hardships to meet their immediate and transitional needs by providing food, clothing, and educational services in a safe, positive environment in the North End of Springfield.	http://grayhouse.org/
The Parent and Community Engagement Center (PACE)	The "go to place" for Springfield families. The PACE Center recognizes the important role parents and community partners have in the education of our children and the Center offers a centralized place for services for parents and other caring adults.	http://sps.ss18.sharpschool.com/departments/pace
United Way of Pioneer Valley	For almost 100 years United Way of Pioneer Valley has served as our community's fundraiser. But UWPV doesn't just raise money; today's United Way is a focused, results-driven system that works year-round to change community conditions and create lasting solutions. Through strong partnerships with volunteers, local businesses, government, and nonprofit organizations, United Way accomplishes what no one can do alone.	https://www.uwpv.org/
UniTy of Pioneer Valley	A peer led psychosocial support group for transgender individuals, their allies and all GLBTs.	https://groups.yahoo.com/neo/groups/unity-of-the-pioneer-valley/info
Urban League of Springfield	Serves the African American Community in Greater Springfield by advocating for and providing model services that enhance the academic and social development of young people and families, promoting economic self-sufficiency, and fostering racial inclusion and social justice.	http://ulspringfield.org/
Valley Bike	A collaboration and partnership with Bewegen Technologies and Corps Logistics to bring bike share to the region in the communities of Amherst, Holyoke, Northampton, South Hadley, and Springfield.	https://www.valleybike.org/system/
Valley Eye Radio	Broadcasts local news and information to reading impaired listeners throughout the Pioneer Valley.	http://valleyeyeradio.org/
Veteran Services	The City of Springfield Department of Veterans' Services' primary duty is to provide information, counsel, and assistance to veterans and their dependents as may be necessary to enable them to procure the benefits to which they are or may be entitled relative to employment,	https://www.springfield-ma.gov/hhs/index.php?id=veterans

Community Organizations

Organization Name	Description of Services Provided	Contact
	vocational, or other educational opportunities, hospitalization, medical care, pensions, and other veteran benefits.	
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
Western Mass Elder Care	A private, non-profit agency that aims “to preserve the dignity, independence, and quality of life of elders and persons with disabilities desiring to remain within their own community.” We offer a variety of services for elders, their families and caregivers, and persons with disabilities.	https://www.wmeldercare.org/employment-and-volunteering/
YMCA of Greater Springfield	Recreation and physical health classes for youth through adults, including nutrition and diet. Includes the MIGHTY pediatric obesity prevention program.	www.springfieldy.org

VI. Input and Actions Taken Since Previous CHNA

1. Community Input on Previous CHNA and Implementation Strategy

To solicit written input on Baystate Medical'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 Medical 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 Medical Center CBAC.

COMMUNITY LEVEL SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

Adopt a Classroom is an annual initiative to donate school supplies to local Springfield public schools. It is a response to the continued call from the community to increase resources to meet basic needs. Over 175 plastic storage bins are placed through the Springfield-based campuses to collect a range of supplies for each school year. For the 2019 school year, donations will benefit six schools: Brightwood Elementary School, German Gerena Community School, Lincoln Elementary School, Margaret C. Ells School, Milton Bradley Elementary School, and William N. Deberry Elementary School.

Baystate Springfield Educational Partnership (BSEP) builds relationships with interested and committed students from the City of Springfield and guides these students' experiences towards careers in health care. The BSEP program offers a variety of hospital-based learning experiences that provide opportunities to explore different careers, engage in more comprehensive observation experiences, and prepare for potential internship or employment opportunities. This is not an employment program and internship and employment opportunities are not a guaranteed program activity. In FY18, the BSEP program engaged 307 (unique number of participants is smaller) high school students from all Springfield High Schools and several charter and private schools. The program coordinated four pathology based summer workshops for 66 students, summer internships at Baystate Medical for 13 graduating seniors from Springfield, and placed 14 students in work experience throughout the year as part of the Workforce Innovation and Opportunity Act (WIOA) program. In addition, BSEP has always

been intentional in investing into the education of their previous students. In FY18, they awarded 18 former BSEP participants \$25,000 in scholarships to support their pursuit of undergraduate and graduate education. Total Baystate scholarships awarded to date now exceeds \$670,000.

Holiday Drive – “In the Spirit” Holiday Toy Drive is an annual initiative conducted where all donations benefit local children served by our three community-based health centers, Baystate Mason Square Neighborhood Health Center, Baystate General Pediatrics at High Street, Baystate Brightwood Health Center, and Martin Luther King Jr. Family Services in Mason Square, and New North Citizens’ Council in the North End. In 2018, Baystate Medical delivered over 1,500 toys and other greatly needed items for infants, and winter outerwear that were collected through the drive. In addition to the toys, over \$1,500 in gift cards were donated. Members of the Baystate Medical CBAC, our neighbors from Atwater Park Civic Association, and friends at AMR Ambulance also made generous donations to the toy drive.

Baystate Medical has continued to partner with Square One and Springfield Department of Health and Human Services to build a nationally certified **Springfield Diaper Bank**. The mission of Baystate Health is to improve the health of the people in our communities every day, with quality and compassion. 1 in 3 American families struggle to provide diapers for their babies. Diaper Bank initiatives thrive to improve the health of the underserved populations and the vulnerable babies and the infants. Baystate Medical has donated over 12,000 diapers to be distributed through the city, free of cost. The Springfield “Baby Bottoms” Diaper Bank committee consists of the following partners: Springfield Department of Health and Human Services, Square One, WIC, Springfield Housing Authority, Springfield City Libraries, The Gray House, and The Family Resource Center. All agencies received parts of the donation to distribute at their respective locations.

Baystate Health is an active member of the **Western Massachusetts Health Equity Network (WMHEN)**. The WMHEN formed in October 2014 to continue to find ways to advance health equity in western Massachusetts. The Network concentrates on four areas, one of which is racial justice. The other three include finding ways to make community health data available, developing a cross sector collaboration to address health inequities, and identifying important new policies to support that will create more health equity in western Massachusetts. The WMHEN is coordinated out of the School of Public Health and Health Sciences at UMass Amherst. The central mission of WMHEN is to bring together those interested in health equity in western Massachusetts and determine what steps we can take as a region to advance health equity in our over 100 cities and towns in four counties. Recently, Baystate Medical funded WMHEN with a 3 year, \$30,000 community benefits grant. A portion of the money was used to host a 2018 Western Massachusetts Health Equity Summit that brought in over 300 people last October. A third summit will be planned for 2020.

BARRIERS TO ACCESSING QUALITY HEALTH CARE

The BeHealthy Partnership Accountable Care Organization - a MassHealth accountable care partnership plan option. The BeHealthy Partnership is made up of the Baystate Health Care Alliance, which is an accountable care organization (ACO), and Health New England, which is the managed care organization (MCO) for the plan. Through the BeHealthy Partnership plan, patients get the support of caring health care providers who live and work in the community. Coordinated care helps ensure that patients – especially the chronically ill – get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. The BeHealthy Partnership includes primary care providers (PCPs) who are based at five nearby health centers in Springfield, Massachusetts:

- Baystate General Pediatrics at High Street
- Baystate High Street Health Center Adult Medicine
- Baystate Mason Square Neighborhood Health Center
- Baystate Brightwood Health Center
- Caring Health Center

Baystate is committed to reducing health disparities in Springfield and has invested significant resources in three **community-based health centers** and pediatric clinic located in Springfield’s low-income neighborhoods that have both HPSA and medically underserved areas/medically underserved populations (MUA/MUP) designation. Baystate health centers are primary care first-contact sites for thousands of underserved, low-income people. In FY18, these community training sites for our Medical Residency Program provide continuity of care for 25,705 unduplicated patients and over 98,574 patient encounters/visits annually, most of whom reside in an MUA/MUP. Through the various sponsored programs (grants), Baystate Medical is able to provide enhanced services such as HIV/STI/Hep C screening and treatment to high risk, vulnerable populations, who share a disproportionate burden of certain diseases. Our health centers are Patient-Centered Medical Homes, which means our patients have a direct relationship with their doctor who coordinates a team of health care professionals who all work together to manage their care.

Dispatch Health - a mobile urgent care service designed to reduce emergency room 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 in western Massachusetts. Seven days a week from 8am to 10pm 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.

Baystate 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 offer 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.

Population-based Urban and Rural Community Health (PURCH) – a track of University of Massachusetts Medical School based at Baystate is an innovative, four-year track where students can focus on health care issues common to urban and rural under-served populations—and come to understand the complex interwoven social and environmental factors that affect them. 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. The educational experiences are built upon year to year so students are able to progressively develop knowledge and skills while building important community relationships to improve health outcomes in under resourced communities. The population and community education experiences are designed based on the health priorities of the communities served by Baystate Health. The health priorities are identified from the CHNA, the CHIP, and the population health priorities of the Accountable Care Organization, BeHealthy Partnership.

Poverty Simulation - poverty is a reality for many individuals and families and is often portrayed as a stand-alone issue. But unless you've experienced poverty, it's difficult to truly understand how complex and interconnected issues of poverty really are. Baystate’s Academic Affairs Department is tasked with onboarding and training incoming medical residents. To help these medical residents and other clinical team members be better prepared to care for our patients with cultural humility, especially our more vulnerable patients, they participate in a poverty simulation. A Poverty Simulation is an interactive immersion experience that bridges the gap from misconceptions of living in poverty to ones of understanding and awareness by breaking down stereotypes and sensitizing participants to the realities and stresses of poverty. The Poverty Simulation is not a game; but rather is based on real individuals and families and their lives. The goals of a Poverty Simulation are to promote poverty awareness, increase understanding, and inspire local change. The hope is that by participating in the Simulation, Baystate’s medical residents will deliver patient-centered care with cultural humility and be inspired to make

change in our local community. Poverty Simulation will be included as learning module for cultural competency at Baystate Health.

Trauma and Injury Prevention (TIP) - educates the community members on Stop the Bleed. The members are given information so they can confidently perform life-saving hemorrhage control until pre-hospital personnel can arrive and assume the care of the injured. Providing these basic life-saving techniques that anyone can perform at the scene will save lives. Training kits have been purchased so Baystate Health can continue to build and grow its training capacity in the region.

HEALTH CONDITIONS AND BEHAVIORS

Baystate Family Advocacy Center (BFAC) provides help to over 300 children and families in crisis. Children and families that have been traumatized by child abuse, sexual assault or exploitation, or exposure to violence or homicide can find help at the BFAC, a nationally accredited Child Advocacy Center (CAC) serving children and families in Hampden county and surrounding areas. The BFAC's multi-disciplinary team provides culturally sensitive, comprehensive assessment of treatment needs, advocacy, and coordination of services for children and families after a forensic interview, a child abuse medical assessment, or a call on the intake hotline. In addition, staff members provide evidence-based, trauma-focused individual and family therapy as well as group therapy for children and non-offending caregivers. The Mental Health Team continued to experience a very busy year and saw a total of 5,137 visits in 2018 compared to 4,745 in 2017, an 8% increase. The volume for the forensic interviews remains steady at around 400 per year.

The BFAC continues to strengthen its presence in the community as a dynamic, trauma-focused Children's Advocacy Center. The Victims of Crime Act (VOCA) grants, Trauma Focused Assessment and Treatment Program, and the Homicide Bereavement Program, provided over \$775,000 in FY18 in funding towards services provided at the BFAC to children and families impacted by sexual abuse, physical abuse, and commercial sexual exploitation, child witness to violence, community violence, and homicide. In FY19 the BFAC's VOCA funding was increased to over \$1,100,000. These programs continue to provide best practice evidenced-based psychotherapies and case management services to children and their families in western Massachusetts. From January of 2019 until June of 2019 the BFAC has trained approximately 250 individuals in order to increase the awareness and response to human trafficking. The BFAC has also expanded their traumatic grief services this past year.

Using a 2018 NY Life Foundation the BFAC developed the Suicide Bereavement Program which service children 3-17 years old and their families after the loss of someone to death by suicide. Individual, group, and family therapy as well as meaning making activities and response to schools are included in this programming. Services are available for children and adolescents in English or Spanish.

The BFAC was awarded a third SAMHSA/NCTSN grant in October 2016, allowing BFAC to expand its training throughout the state of Massachusetts and into Puerto Rico. It is a five-year, \$2 million grant

which funds Partners in Care: Community-Based Implementation of Evidence-Based Treatment for Childhood Trauma's (Partners in Care). The project's overarching goal is to improve access to and quality of evidence-based trauma-informed care for children and families who experience trauma and loss by addressing health disparities and reducing barriers to treatment throughout Massachusetts. In 2018 the BFAC was awarded an additional million dollar supplement to expand its services in Puerto Rico.

Baystate Transgender Support Group, a partnership with UNITY of Pioneer Valley, continues to be a primary and critical link for transgender individuals in western Massachusetts. As the only transgender support group in the region, UNITY has been active for over 10 years. It provided participants access to information on services such as mental health services, social and spiritual support networks as well as links to primary health care within Baystate Health. Support group participants and UNITY of Pioneer Valley increase public awareness of transgender needs by participating in educational community events, health fairs, and open forums that promote education of transgender care and services.

MIGHTY (Moving, Improving and Gaining Health Together at the Y) is a community-based multi-disciplinary pediatric obesity treatment program. It is held at the Springfield YMCA, Greater Westfield YMCA and Greenfield YMCA and includes 14 – two-hour sessions which include physical activity, nutrition, and behavior modification. It targets children and adolescents age 5-21 and lasts for 1 year. Sessions are augmented by individual exercise training, weekly phone calls, monthly group activities, cooking classes, free swimming lessons with the YMCA, behavioral health consults, and gardening experience. In addition participants and their families are given a free six-month long membership to their local YMCA. Ongoing monthly maintenance groups are available to all previous program participants. In FY18 the MIGHTY program had a very successful and busy year, enrolling and serving over 200 obese children and their families, and continues to expand with several new programmatic options and increased staff for both exercise and nutrition. Almost 50% of our participants decreased their body mass index during the program this year.

COMMUNITY BENEFITS ADVISORY COUNCIL INVESTMENTS

Baystate Medical's **CBAC** continues to meet regularly the second Thursday of each month and is inclusive of employees, representatives of the community, and target populations that the hospital serves. The CBAC's core roles include advocacy for community benefits within Baystate and in the community, reviewing the hospitals annual community benefits reports, providing input into the hospitals community health needs assessment and strategic implementation plan, formerly referred to as implementation strategy, and helping the hospital link its community benefit strategy to an overall vision of reducing health disparities, promoting community wellness, and improving access to care for vulnerable populations.

Baystate Medical and its CBAC continued to foster community partnerships and awarded grant funding to select partners through a request for proposal process to further address health needs identified in the 2016 community health needs assessment. The funded community partners and initiatives include:

- **Men of Color Health Awareness (MOCHA) Ludlow Jail Project** Ludlow County was awarded a mini-grant to deliver the MOCHA program of education, skills building, and support to men of color to improve their physical, mental, emotional, and spiritual health upon their release from jail. Funding ended in 2018.
- **Project Coach** is an outcome-based initiative that works to bridge the economic, educational, and social divisions facing Springfield youth by empowering and employing inner-city teens to coach, teach, and mentor elementary school students in their neighborhoods. Funding ends in 2019.
- **Revitalize CDC's Healthy Homes Initiative** is an outcome-based initiative that provides home repair and health self-management education that improves the health and quality of life for low-to-moderate families living in substandard housing in Springfield. Funding ends in 2019.
- **Way Finders Healthy Hill Initiative** is an outcome-based, multi-year initiative to improve the health and wellbeing of residents in the Old Hill neighborhood in Springfield through youth engagement, walking clubs, and resident empowerment. Funding ends in 2019.

Other one-time community benefits discretionary grants have also been awarded to meet the health needs, priorities, and social determinants of health highlighted in the 2016 CHNA. For FY19, organizations funded through grant making include:

- Arise for Social Justice
- Dress for Success of Western Massachusetts, Inc.
- EmbraceRace
- Empty Arms Bereavement Support Group
- Gandara Center
- Girls Inc. of Holyoke
- International Language Institute of Western Massachusetts
- Martin Luther King Jr. Family Services
- Massachusetts Association of Community Health Workers (MACHW)
- Parent Villages
- Pioneer Valley Planning Commission (PVPC)
- Public Health Institute of Western Massachusetts (PHIWM)
- Ronald McDonald House of Springfield
- Springfield Department of Health and Human Services (SDHHS)
- Way Finders
- Western Massachusetts Health Equity Network

In addition, Baystate Health has a long standing partnership with **Public Health Institute of Western Massachusetts (PHIWM)**, contracting with them to provide content knowledge and expertise in the areas of chronic disease, mental health, health promotion, health education, behavior change, and systems and policy change to assist grantees in the development and implementation of evaluation plans to foster capacity-building. PHIWM provides evaluation support and technical assistance for grantees awarded funding through the request for proposal process.

Another project Baystate Health has taken on in partnership with PHIWM is the creation of a **community resource database (CRD)** named **413Cares**. The project's goal is to create a regional network of CRD users, where community and healthcare provider networks work together to build and maintain a system for producing a shared comprehensive and dynamic community resource inventory. Baystate Health approached PHIWM to lead this regional effort using DON funding that was earmarked for supporting a Community Health Worker Initiative. This project will create a stated desired opportunity for ready access to community resources. Although members/consumers are screened for social needs, providers are too often screening in isolation without the capacity to ensure referral and linkage to an appropriate community resource. This is a three year project that will service all of Hampden County.

VII. Summary

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

VIII. References

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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

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

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

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

Mercy Medical Center: Cancer Support Group Participants

- 10 participants
- 5 women and 5 men
- 6 people were between the ages of 51 to 70; 1 person was under 50, 1 person was between 71 – 80, and two people were over 80
- All 10 people identified as white

Baystate Medical Center: Men Exposed to Gun Violence in Springfield

- 10 participants; all male
- All between the ages of 18 - 25
- 3 identified as black, 5 as Latino

Baystate Medical Center: Women Exposed to Gun Violence in Springfield

- 8 participants; all female
- All between the ages of 18 - 25
- Half identified as black, half as Latino

Hampshire County

Cooley Dickinson Hospital: Community forum with Older Adults - Northampton

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

Cooley Dickinson Hospital: Community Forum with Older Adults - Amherst

- 40 participants

- Mostly women
- All participants were older adults, mostly age 60+
- Roughly 90% white, 10% People of Color

Franklin County

Baystate Franklin Medical Center: People Experiencing Homelessness

- 9 participants
- 4 women and 5 men
- 3 age 31 – 40; 4 age 41 – 50; 1 age 51 - 60
- 7 white, 1 black Latina, 1 American Indian

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

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

Baystate Franklin Medical Center: Youth of Color

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

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

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

Hampden, Hampshire, Franklin, Berkshire, and Worcester Counties

Health New England: Adults Living with Disabilities

- 7 participants who were patients or clients of Caring Health Center
- 4 women, 3 men
- All People of Color
- All spoke English

Key Informant Interviewees

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

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

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
Berkowitz-Gosselin, Leah	LICSW, Clinical Social Worker	Family Advocacy Center's Homicide Bereavement Program		X	
Caisse, Edward III	High Risk Reentry Program Coordinator	Hampden County Sheriff's Department		X	
Gonzalez, Joesiah	Director of Youth Services	New North Citizen's Council		X	
Judd, Christine	Director	Roca Springfield and Holyoke		X	
Wheeler, Felicia	Mother and advocate				
Baystate Franklin Medical Center					
1. Calabrese, Jessica 2. Carey, Cameron 3. Ewart, Jared 4. Hamilton, Wes 5. Heidenreich, Maria 6. Hoynnoski, Arley 7. Jacobson, Allie 8. Luippold, Susan 9. Petrie, Maegan 10. Sayer, Ed 11. Van der Velden, Allison 12. Welenc, Susan	1. Chief Operating Officer 2. Development Director 3. Accountant 4. Chief Information Officer 5. Medical Director 6. Chief Financial Officer 7. Information Officer 8. Human Resources 9. Accountant 10. Chief	Community Health Center of Franklin County	X	X	

Name (Last, First)	Title	Organization	Organization Serves Broad Interests of Community	Organization Serves Low-Income, Minority, & Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Department Staff
	Executive Officer 11. Dental Director 12. Population Health				
1. Avery, Jennifer 2. Brzezinski, Jen 3. Chartrand, Ken 4. Laurel, Charles 5. Margosian, Alex 6. Mercado, Reuben 7. Neubauer, Deb 8. Pliskin, Ariel 9. Schwartz, Levin	1. Reentry Caseworker 2. Reentry Caseworker 3. Reentry Coordinator 4. Clinician 5. LICSW Clinician 6. Reentry Caseworker 7. Clinician 8. Clinical Intern 9. Director, Clinical and Reentry Services	Franklin County Sheriff's Department		X	
Public Health Personnel					
Caulton-Harris, Helen	Commissioner of Public Health	City of Springfield, Public Health Department			X
Cluff, Ben	Veterans' Services Coordinator	Massachusetts Department of Public Health, Bureau of Substance Use Services			X

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
Federman, Julie	Health Director	Town of Amherst			X
Hry-Dermith, Dalila	Supervisor	Massachusetts Department of Public Health, Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit			X
Walker, Phoebe	Director of Community Services	Franklin Regional Council of Governments			X

Community Chats

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

Organization (46)	Population	Location	# of Participants (total: 759)
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
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

Organization (46)	Population	Location	# of Participants (total: 759)
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 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 Council	Community Members-Parents	Springfield	7
The Carson Center	Non-Profit Staff	Westfield	18
UMMS-Baystate Community Faculty	Health Care Professionals	Springfield	11
UniTy of Pioneer Valley	Transgender Adults	Springfield	9
Westfield Residents with Mild Cognitive Impairment	Community Members with Mild Cognitive Impairment	Westfield	10

Organization (46)	Population	Location	# of Participants (total: 759)
Westfield Senior Center	Older Adults	Westfield	13

Community Conversations

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

Baystate Medical Center: At Martin Luther King Jr. Family and Community Services in Mason Square in Springfield

- 45 participants
- Wide range of ages
- Women and men participated
- Primarily African-American

Baystate Medical Center: Spanish-speaking Conversation, at Riverview Senior Center in Springfield

- 40 participants
- Majority older adults
- Men and women participated
- Primarily Latino/Hispanic

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: Gun Violence and Youth: Young Men

Primary Hospital/Insurer: Baystate Medical Center

Topic of Focus Group: Gun violence and youth: Young men

Date of Focus Group: 2/19/2019

Facilitator: Kim Gilhuly

Note Taker: Tenzin Tsepal

Executive Summary

- A. Participant Demographics:
 - Ten men participated.
 - All participants were between the ages of 18 and 30. Three were aged 18 to 21, and five were aged 22 to 30.
 - Five men were African American/black, and five were Hispanic/Latino.
- B. Areas of Consensus:
 - See below table: Question 2 - Causes of gun violence in Springfield.
- C. Areas of Disagreement:
 - Some believe cops are corrupt and don't respond; others believe cops are there and running into the bullets.
 - Some believe the media truthfully covers shootings in Springfield; others do not believe this.
- D. Recommendations:
 - Provide more mentoring and job programs.
 - Make sure youth have something to do other than getting involved in a life of guns.
 - Gun control actions, like increasing sentencing and making it harder to get guns can help.
 - Improving school systems, so that students who are failing are supported more.
 - Encouraging youth to create their own positive rap music that doesn't focus on gangs and guns and violence may also help.
- E. Quotes:
 - "It affects you badly. You just spoke to that person and then an hour or a day later you find out your friend was shot. Most of the time, we are going to keep living, and that's the hard part."
 - "It is very scary and not funny. It is heartbreaking to realize people you know are not alive. "

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

Key Issues

Question	Synthesis of Responses
1. What is gun violence?	Gun violence includes shooting, gun powder, shells, bullet holes, loss of friends and family, suicide, gangs.
2. Causes of gun violence in Springfield?	<ul style="list-style-type: none"> ● Guns are omnipresent and really easy to get. People are exposed to them at an early age. They are just part of life in Springfield. ● Rap music is a bad influence on the uptake of gangs, guns, and violence. ● Gun violence causes many types of serious mental health issues. ● There are a lot of reasons why people resort to shooting (e.g., territories, gangs, fights over women, domestic violence, suicide), but the fact that everyone has a gun means that they resort to gun violence as the response. ● There has been an uptick in gun violence since 2014, when someone named Caleb was killed, resulting in a lot of retribution shootings and killings.
3. How does gun violence affect you and people in general?	<p>The effects mentioned by participants included:</p> <ul style="list-style-type: none"> ● Mental health effects (e.g., grief, sadness, insomnia, stress, heartbreak from others' deaths) ● Hypervigilance, paranoia, panic, fear ● Anger ● Trying to be more peaceful
4. How old were you when you first saw guns?	Most participants said they didn't remember a time when they weren't exposed to guns in the neighborhood. Some said they were exposed to guns as early as age 3 or 5. One participant said “I picked up a gun off the ground at age 5.” People also talked about knowing how to recognize when someone has a gun – in the way they walk, their demeanor of

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

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

Focus Group Report: Gun Violence and Youth: Young Women

Primary Hospital/Insurer: Baystate Medical Center

Topic of Focus Group: Gun violence and youth: Young women

Date of Focus Group: 2/28/2019

Facilitator: Kim Gilhuly

Note Taker: Nikki Burnett

Executive Summary

A. Participant Demographics:

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

B. Areas of Consensus:

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

C. Areas of Disagreement:

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

D. Key Recommendations:

Young people at risk for gun violence would benefit from:

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

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

E. Quotes:

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

Key Issues

Question	Synthesis of Responses
1. What is gun violence?	Participants defined gun violence as a situation with a gun or a hammer.
2. Causes of gun violence in Springfield?	<p>Participants said the main cause of gun violence was gangs. People use guns when fighting with each other, for retaliation, and when a fight escalates - from a fist fight to using guns. Other causes include:</p> <ul style="list-style-type: none"> ● Drama caused by jealousy, drama around baby mamas ● Thinking gun use is "normal" because they grow up around guns ● Feeling scared and feeling like they need a gun for protection. Scared people are more likely to shoot and not think about the consequences. ● Peer pressure and thinking gun use is cool. ● Having a gun even though they don't know how to shoot ● Young guys in gangs showing off guns to kids they want to recruit ● People on the sidelines of a fight pushing the fighters to shoot each other ● Not feeling loved at home by parents and finding their family on the street
3. How does gun violence affect you and people in	<p>Effects include:</p> <ul style="list-style-type: none"> ● PTSD, anxiety, hypervigilance, other mental health effects

Question	Synthesis of Responses
<p>general?</p>	<ul style="list-style-type: none"> ● Fear - some participants said they weren't scared and that you just react in the moment, but many said they were scared for their children and their children's fathers ● Knowing that gun violence is real. One participant said her cousin died, and that she saw the bullets on the street. It all happened and she just reacted however she did, but later thought "I could have died".
<p>4. How old were you when you first saw guns?</p>	<p>Some participants said that guns have been around all of their lives. Some said guns were around when they were eight years old or when they were sixth graders. The participants generally agreed that guns are usually introduced to kids by middle school, when they are recruited into gangs. They felt that middle school is the time to intervene, or even before.</p>
<p>5. How does the community respond to gun violence (neighborhood, law enforcement, media)?</p>	<ul style="list-style-type: none"> ● Neighborhoods: People don't "band together". Mostly they keep to themselves so they don't have someone going after them. "Snitches get stitches. We learned this in elementary school." ● Law Enforcement: Usually law enforcement is not helpful. They "start shooting first", and they shoot either because they see a gun and are scared or because they can. Sometimes cops are helpful, but they aren't doing enough - they don't respond fast enough, or they help only when they want to. There have been several incidents when cops let people fight for a while and <i>then</i> break it up. ● Media: Lots of people get their news on social media. Some of this news is true, and some is not. Social media often reports news about gun violence quicker than the news media. "Facebook lets us know what's really happening." ● Hospitals: EMTs take too long to get to the scene when there are fights or gunshots.
<p>6. Your ideas for how to reduce gun violence in Springfield</p>	<p>Ideas for reducing gun violence included:</p> <ul style="list-style-type: none"> ● Programs (like Roca), sports, activities, and afterschool programs, which can keep people off the streets. But these activities have to be affordable in order to be helpful. ● Jobs and opportunities ● Cops being more involved in the community. Cops in Holyoke are a good example because they go to neighborhoods where there are guns and gangs and hand out flyers, sign people up for programs, and talk with people and get to know them. <p>Many participants mentioned barriers to reducing gun violence. When asked this focus group question, participants' first response was that nothing can be done. But when the focus group facilitator said "You said kids are exposed in middle school – should something be done then?"</p>

Question	Synthesis of Responses
	<p>participants had ideas (listed above). Some participants felt that mediation is not helpful. Some were concerned about vetting staff for activities. One person pointed out a boxing coach who was later found to be molesting boys.</p>
<p>7. How can “systems” prevent gun violence?</p>	<p>Participants named some issues with school prevention efforts.</p> <ul style="list-style-type: none"> ● Metal detectors at schools reduce some risk of gun violence, but they are inadequate, people can get around them, and they are not enforced enough. ● Teachers don’t pay attention to their students. ● Teachers have not had the experiences that the students are having in their neighborhoods, so how can they understand? Teachers judge their students and don’t know how to handle them or react. <p>Suggestions for prevention at schools included:</p> <ul style="list-style-type: none"> ● Training teachers and program staff in how to deal with trauma and people who have been through trauma ● Having gun violence be part of the curriculum <p>Recommendations for prevention in community based programs included:</p> <ul style="list-style-type: none"> ● Hiring staff who have had experience in the neighborhood (like Roca), so that they know what people are going through and can relate to them. ● Funding more programs, sports opportunities, and jobs <p>A recommendation for prevention in hospitals was that hospitals could have a program like Scared Straight, where they hand out flyers or show young kids the reality of gun violence, with pictures of gun trauma.</p> <p>A recommendation for prevention through law enforcement in Springfield was to use the model in Holyoke, where the cops are really involved. They are out on the worst streets, talking with people at a table, handing out flyers for programs kids can go to.</p>
<p>8. How easy is it to get guns in Springfield?</p>	<p>Very easy. “I can call up somebody right now and get one.”</p>

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

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

Primary Hospital/Insurer: Baystate Franklin Medical Center

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

Date of Focus Group: 2/19/2019

Facilitator: Kat Allen

Note Taker: Jeanette Voas

Executive Summary

A. Participant Demographics:

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

B. Areas of Consensus:

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

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

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

Key Issues

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

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

Question	Synthesis of Responses
	<ul style="list-style-type: none"> ○ Another said: providers need to be able to educate patients about things like that ● At times, there have been shortages of HRT meds and I have been unable to get them at the pharmacy. It's awful.
<p>3. Where do you get medical care & do you get the care you need?</p>	<ul style="list-style-type: none"> ● CHC, Baystate, VMG, CSO, alternative providers ● Mix of satisfaction with providers: I'm comfortable, I'm ready to move, I don't talk with my doc about anything ● Dental is awesome at CHC! ● Bad experiences: <ul style="list-style-type: none"> ○ Hole in the system: I hit my head at work, I have symptoms that prevent me from working, but I don't have a diagnosis and without a diagnosis, I can't get disability or any kind of assistance. ○ In CT, when I was suicidal I was admitted to hospital into awful conditions, with people freaking out all around and guards. There was no trans support, no recognition. You've got to make accommodations and be trans knowledgeable. I was ready for help and that's how I got treated. ○ I've been in Baystate psych ward. They're not trans knowledgeable. And the reason why is that they send trans people up to Brattleboro Retreat, but that unit is poorly resourced, as compared to other units.
<p>4. Local resources that have helped you be healthier</p>	<ul style="list-style-type: none"> ● (Long silence before anyone answered) ● Recovery Learning Center, for community and mental health support
<p>5. What else/what other services would be helpful?</p>	<ul style="list-style-type: none"> ● A central go-to place for trans people to find out where to get trans-friendly services. An GLBQ+ and transgender resource center. A hub that people know about, one entry point. <ul style="list-style-type: none"> ○ There's word of mouth, and everyone says to go to the same provider and that provider is booked solid ○ For someone new in town, it's hard to navigate ● When people go into crisis here, they often get sent to respite. But respite sucks for trans people. Their policies make no sense, so they usually don't accept trans people. Trans people who could be in a less locked-down situation end up getting pushed into the hospital. ● Opportunities for improving health & talks about health resources that don't all go back to exercise and eating well. Some of us can't exercise, and the healthy food is the most expensive food.
<p>6. What do you do to stay healthy?</p>	<ul style="list-style-type: none"> ● Exercise, take care of yourself be fit & active, mentally healthy and happy ● Dance, as often as possible ● I need Baystate to understand that people are falling through the

Question	Synthesis of Responses
	<p>cracks.</p> <ul style="list-style-type: none"> • Marijuana has been helpful. Looking for increased accessibility and lower price.
<p>7. Recommendations from one participant who wrote up her thoughts for us</p>	<ul style="list-style-type: none"> • Remove gender-specific signage • Stockpile and make available HRT meds when supplies become low • Set a gift fund for transgender surgical procedures for those who cannot afford them. • Hire health care providers—especially mental health providers—who are themselves trans or GNC • Recruit medical professionals with specific training with trans people. • Conduct mandatory training of all health care employees for trans-friendly environment • Involve trans people in provider hiring & interviewing process • Get involved in retraining influential people and the community at large to create a more inclusive environment

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

Focus Group Report: Youth of Color

Primary Hospital/Insurer: Baystate Franklin Medical Center

Topic of Focus Group: Youth of Color

Date of Focus Group: 2/19/2019

Facilitator: Kat Allen

Note Taker: Jeanette Voas

Executive Summary

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

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

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

D. Quotes:

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

Key Issues

Question	Synthesis of Responses
<p>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.

Question	Synthesis of Responses
	<ul style="list-style-type: none"> ○ We see lots of anxiety, panic attacks, depression ● JUULing, including in school ● Some parents are against vaccination; kids can't decide on their own to get vaccinated
2. Health issues unique to young people of color?	<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.
3. How well are those challenges addressed	<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.
4. Discrimination that impacts health	<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.
5. Local resources that contribute to health	<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
6. What else is needed	<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

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

Focus Group Report: People Living Unsheltered in Greenfield, Massachusetts

Primary Hospital/Insurer: Baystate Franklin Medical Center

Topic of Focus Group: People living unsheltered in Greenfield, Massachusetts

Date of Focus Group: 1/23/2019

Facilitator: Kat Allen

Note Taker: Jeanette Voas

Executive Summary

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

Key Issues

Question	Synthesis of Responses
<p>1. biggest things that make it hard for you to be as healthy as you would like to be</p>	<ul style="list-style-type: none"> • Inadequate mental health care, especially for those with dual diagnoses. <ul style="list-style-type: none"> ○ Not enough beds ○ Not enough capacity at Greenfield methadone clinic ○ Nursing homes don't take people on methadone ○ Not enough follow up, continuity of care when you leave a program ○ It's taken a long time to get an accurate diagnosis ○ DMH beds for respite are taken up by people who don't want to be there and aren't taking advantage of services; and there are others who need higher level of care • People with substance use disorders and mental health diagnoses are not listened to and face discrimination in medical system. <ul style="list-style-type: none"> ○ Long waits for appointments, can't get in to see my own doctor, communication problems with provider organizations
<p>2. services currently available to people experiencing homelessness in Franklin County</p>	<ul style="list-style-type: none"> • In Greenfield, excellent resources for a small town. • We need more shelters. • Here it's a transportation issue. <ul style="list-style-type: none"> ○ Sometimes you have to travel a ways for care (e.g. to methadone clinic in Springfield) ○ If you're in any kind of treatment you can get a free bus pass. ○ Greenfield needs weekend and evening bus service. • We have to leave the shelter at 8:00am and there's nowhere to go. • Breakfast and lunch at Salvation Army & you can shower there. • Plenty of meals offered – if you can get there
<p>3. Barriers for people experiencing homelessness to accessing these services</p>	<ul style="list-style-type: none"> • Transportation <ul style="list-style-type: none"> ○ No weekend service ○ If you don't have a stable address, you don't get PT1 (transportation voucher) • Have to be sober to access many services • Long waits to get into shelters
<p>4. What else is needed to help people experiencing homelessness be healthier</p>	<ul style="list-style-type: none"> • Warm places to be during the day • Productive things to do during the day <ul style="list-style-type: none"> ○ We could volunteer to help out, to make things • Keep old buildings and let the homeless people who want to better themselves get to work on them
<p>5. Source/availability of</p>	<ul style="list-style-type: none"> • Have used many medical resources in town – Baystate, Valley

Question	Synthesis of Responses
medical care	<p>Medical, CHCFC, Health Care for the Homeless (Springfield) – and have moved among them</p> <ul style="list-style-type: none"> • Have had both positive and negative experiences with medical system • Are able to get preventive care if they choose to • Limited availability of dental care – only a certain number of patients on certain days
6. Measures to stay as healthy as you can while experiencing homelessness	<ul style="list-style-type: none"> • Eat healthy food <ul style="list-style-type: none"> ○ Ready availability of food ○ Plenty of fruits and vegetables ○ A lot of options at shelter; can cook own food ○ Shout out to Stone Soup! • Rest • Walk • Garlic/herbs/other personal remedies and habits

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

Focus Group Report: Users of a Rural Food Pantry

Primary Hospital/Insurer: Baystate Franklin Medical Center

Topic of Focus Group: Users of a Rural Food Pantry

Date of Focus Group: 1/31/2019

Facilitator: Kat Allen

Note Taker: Jeanette Voas

Executive Summary

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

- “Because our population is small, our priorities get kicked down the road.”

Key Issues

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

Question	Synthesis of Responses
	<p>do lab draws, prescriptions.</p> <ul style="list-style-type: none"> • Pharmacies that deliver up here. • Ambulance could take people to appointments when it's not on call. • Telehealth • Group exercise classes • Clothing closet (there's one in Colrain at First Baptist)
<p>7. What you do to stay healthy, despite the challenges</p>	<ul style="list-style-type: none"> • I don't smoke or drink • I go to bed at a reasonable hour • I walk my dog • I garden • We have a strong social network

**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</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

Question	Synthesis of Responses
<p>there gaps in services, and how do these gaps impact older adults? Think about older adults with limited English, or who are people of color, or live in a rural area, identify as GLBQ+, transgender, or from other underrepresented groups.</p>	<ul style="list-style-type: none"> ● Day programs for frail elders ● Care coordination services to integrate care more seamlessly
<p>3. Most older adults in our community have at least 1 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
2019 Community Health Needs Assessment**

Focus Group Report: Experience with Healthcare and Basic Needs for Disabled Adults

Primary Hospital/Insurer: Health New England

Topic of Focus Group: Experience with healthcare and basic needs for disabled adults

Date of Focus Group: 3/5/2019

Facilitator: Gail Gramarossa

Note Taker: Caitlin Marquis

Executive Summary

A. Participant Demographics:

- Seven participants who were patients or clients of Caring Health Center
- Four women, three men
- All People of Color
- All spoke English

B. Areas of Consensus:

- Caring Health Center provides several services to help patients understand and carry out the roles they play in maintaining their own health, such as cooking classes, exercise classes, crocheting circles, etc.
- MassHealth-provided transportation is unreliable and drivers tend to be disrespectful or apathetic toward patients. A great deal of the conversation was dedicated to this topic.
- Supplemental and emergency food resources are inadequate and difficult to access. SNAP benefits awarded sometimes do not feel worth the invasive application process, and food pantries in Springfield can be chaotic and difficult to make use of without transportation home from the pantries. The latter problem is exacerbated by poorly maintained housing with elevators in disrepair.
- Participants had experienced instances of both targeted and structural racism that discouraged them from using emergency and support services.
- For a variety of reasons, accessing services to address basic needs can be a highly stressful experience that causes participants to question whether accessing those services is worth the stress.
- The healthcare system comes across to many of the participants as hasty, uncoordinated, and emotionally apathetic. There were accounts of pharmacists, doctors, and homecare providers all lacking the time and information required to help patients understand and receive the care they need.

C. Recommendations:

- Doctors, nurses, or staff in the doctor's office should do the work of arranging transportation and billing MassHealth
- Eliminate Yellow Cab as a Provider Requested Transportation (PT-1) provider

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

D. Quotes:

- Transportation:
 - “She waited for an hour and it was like 0 degrees outside and she was waiting and we wasn’t gonna leave her so we ended up waiting with her, but God forbid if she was by herself. You’re relying on someone to give you a ride and then you call but nobody answers so what do you do? Do you wait around or do you leave?”
 - “I’ve watched [name redacted] stand out there four two hours waiting for a driver, and then the driver comes up with only attitude. My brother, that woman lives all the way out in Timbuktu. She travels out here on a bus sometimes, and then to leave her here to have her family come all the way out here to drive her home--ridiculous. Nevermind she has emotional issues. We all have emotional issues.”
 - “In 2015, I got sick and went to Baystate. 9:30 at night, no bus to come back from Baystate to King Street, snow to my knee. I walked from Baystate to King Street [about 3 miles], snow to my knee. Nobody at the hospital asked ‘how are you getting home?’”
- Food
 - “I did the groceries but the elevator wasn’t working and I live on the fourth floor. I went in one trip with all my groceries and when I got to the last floor, I had a heart attack. I stood there; nobody was around. So, I said, ‘I have to bring this home,’ so I crawled over, and brought my groceries to the house... The elevator was out for like two weeks.”
 - “If you’re going in to apply [for SNAP], it’s because you need it. So, if I’m telling you I’m coming here and I’m degrading myself, giving you all my business, and then you want to tell me ‘okay, we can only give you \$15,’ I’m like ‘uh, what is

\$15 gonna do?’ You’d be lucky if you can get some eggs, some milk, some bread and that’s it.”

- Health care
 - “I watched a video on Facebook... saying that there is a separation of how black people are treated in emergency rooms versus other nationalities of people... I have noticed myself, whether it’s Baystate, Mercy, Noble, or any other hospital, when I [a black man] have an issue, I have to wait an hour or two just to get a doctor to come see me, and then for somebody to tell me, ‘Oh, we don’t have enough doctors,’ that makes no sense to me. You’re a hospital. Baystate is one of the top five hospitals in America. You have a helipad, and you’re telling me there’s not enough doctors in here?”
 - “My biggest issue is respect. I feel like a paycheck; I don’t feel like a person. I feel like a docket number; I don’t feel like a person. You don’t even know my name.”

Key Issues

Question	Synthesis of Responses
<p>1. How do you see your own role in taking care of your health? What do you see as your responsibilities to help yourself stay healthy?</p>	<ul style="list-style-type: none"> ● Eating healthy ● Exercising ● Getting out and socializing with others ● Taking advantage of the cooking, exercise, crocheting, etc. classes offered by Caring Health Center ● Being an advocate for myself--actively participating in activities and my primary care ● Understanding the choices I have, speaking up when I don’t want something, and getting help somewhere else when I need it ● Working with an advocate provided by the healthcare system ● Calling my care coordinator when I need something
<p>2. Let’s talk about some day-to-day issues that can affect health. Are there services to meet basic needs such as food, housing, and transportation that you have had trouble accessing or getting enrolled into? What has been your experience trying to use such services? Do you feel that you are aware of the wide range of such services that you could</p>	<ul style="list-style-type: none"> ● Having to make repeated calls to schedule transportation for regularly scheduled appointments ● Elderly people and people with limited mental capacity have to call back to arrange transportation over and over again, and this can create serious consequences for someone who needs urgent or steady care ● Transportation works well less than half the time ● Worrying about transportation being reliable for family members or loved ones ● Sometimes rides don’t show up for people who scheduled them and those people don’t have anyone else to call for rides, and there is no number to call if the ride doesn’t show up ● The people who come to pick up patients are rude, disrespectful,

Question	Synthesis of Responses
<p>use and be eligible for? What services would you like to know more about?</p>	<p>and treat people very poorly. They don't talk to or treat the people they are picking up as if they know they are physically and/or mentally disabled.</p> <ul style="list-style-type: none"> ● There is a lack of empathy and understanding among drivers of all types of transportation. ● When Yellow Cab is called for transportation, they don't call the riders and sometimes they leave if the rider is not looking in the right place for them and doesn't come out in time. Yellow Cab gets paid regardless of whether they actually pick up a patient or not.
<p>3. Which of the basic needs we talked about - food, housing, and transportation, for example - pose the greatest problem for you? What happens when you can't get access to food, housing or transportation? What are some of the social, emotional, mental, physical or financial impacts?</p>	<ul style="list-style-type: none"> ● Transportation is among the top five hardest basic needs to access ● If walking or taking the bus is an option, that is preferable to the provider-scheduled transportation ● When scheduling transportation, providers ask if people have mobility impairments, but then drivers say that it is not their job to accommodate those mobility impairments. ● The transportation providers don't answer the phone at busy times ● Even if it is not a problem to walk to pantries, it is a challenge to walk home with all the groceries. There used to be workers who would help with this at Caring Health Center, but they shut that program down. ● SNAP benefits are not enough to sustain someone with all the nutrients they need for a whole month ● Some buildings don't have elevators and people have to carry loads of groceries from the food pantries up the stairs ● The DTA requires a ton of information in order to just get someone \$15 a month in SNAP benefits, causing clients to wonder if it's worth it ● The SNAP benefits the DTA gives out have gone down, but the cost of food has gone up ● The lines at food pantries are aggressive and cause participants to question whether it is worth it to go to food pantries ● The wait at a pantry can be as long as two hours and some pantries have let certain people jump the line ● One participant experienced another pantry-goer making degrading comments about Puerto Ricans
<p>4. What has been your experience when you try get health care? What has worked well? What has not worked well or has been a real problem in getting the health care you need?</p>	<ul style="list-style-type: none"> ● Hospitals engage in practices that appear racist to one of the participants ● Emergency rooms say that they don't have enough doctors to treat all the patients in the emergency room ● Emergency rooms don't have the specialists or equipment needed to test people for all the issues they come in with ● It is very expensive to have even a short visit with an emergency room doctor

Question	Synthesis of Responses
	<ul style="list-style-type: none"> • Doctors in emergency rooms and specialists aren't getting records from primary care providers with enough timeliness to have a complete understanding of a patient's health issues within a visit • Doctors prescribe medications that have side effects that force patients to choose between the lesser of two evils, and patients may not have the capacity or resources to treat the side effects as a separate issue. Doctors don't take the time to determine if patients might be susceptible to the side effects.
<p>5. What happens when you are not able to get the health care that you need? What are some of the social, emotional, mental, physical or financial impacts?</p>	<p>This question was not explicitly asked or answered.</p>
<p>6. How does managing your disability fit into the overall picture of trying to get health care services when you need them? What would help your living with a disability?</p>	<p>This question was not explicitly asked or answered.</p>
<p>7. When you get health care services, how much do you think the doctors, nurse, therapists or other healthcare providers really understand what you experience from your disability? How would you rate them in terms of that understanding?</p>	<ul style="list-style-type: none"> • Caring Health Center understands mental disabilities but only provides limited care on the physical disability side • Doctors only treat patients for one issue at a time and don't take a holistic view of dealing with physical disabilities • Doctors don't always treat patients with respect and empathy, and don't take the time required to get to know patients' names or really understand their issues • Caring Health Center has too many clients and makes patients feel like they are just getting dealt with as quickly as possible • There is too much of a separation in treatment between physical and mental health • The pharmacy isn't giving out enough doses of insulin to get one participant through more than two or three days
<p>8. Let's talk about home care services. What has worked well in any home care services you have had? What has not worked well? What do you see as lacking in home care services? What would make home care services better?</p>	<ul style="list-style-type: none"> • The doctor asks at every visit if patients need care at home • Help with eating and cooking more nutritiously • Providing an in-home nutritionist • Better background checks and oversight for home care providers • Home care providers aren't necessarily always doing the work they are getting paid to do • Aligning diagnoses for home care because the doctors and the home care providers don't always agree that home care is required • Home care available around the clock for surgery recovery

Question	Synthesis of Responses
<p>9. Is there anything else you think we need to know about what it is like living with a disability? What would help? Everyone go around and say one thing that we maybe haven't said yet.</p>	<ul style="list-style-type: none"> ● Better housing ● Getting a call from my doctor to check-in every six months or so ● Nothing, everything is good ● More accessible housing for a wheelchair or for other disabilities ● Assisted living for people with disabilities ● Empathy, less focus on statistics and working "by-the-book" ● Individualized care ● For doctors to make sure that patients are okay when they are leaving, and then conduct a follow-up call to make sure patients have what they need ● Doctors being on time and taking more time with patients ● Doctors getting to know patients on a personal level ● More coordination between emergency care and primary care ● Reducing the wait time between emergency room visits and follow-up treatment ● Getting enough doses of insulin from the pharmacy to get through more than a few days before coming back

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

Focus Group Report: Cancer

Primary Hospital/Insurer: Mercy Medical Center

Topic of Focus Group: Cancer

Date of Focus Group: 3/4/2019

Facilitator: Kim Gilhuly

Note Taker: Eve Sullivan

Executive Summary

A. Participant Demographics:

- Ten participants - five women and five men.
- One person was aged 41 – 50, three people were aged 51 – 60, three people were aged 61-70, one person was aged 71 – 80, and two people were over age 80.
- All participants were white

B. Areas of Consensus:

- Mercy's Cancer Support Group has been an incredible and vital source of assistance, advocacy, support and love for people in treatment, their caregivers, and after cancer. People were effusive about the Support Group and most were long-time participants.
- The position of Nurse Navigator or Social Worker to help people and families navigate the cancer care, medical, support services, and insurance systems is incredibly important.
- People appreciated doctors and other staff who are dedicated, seem to go the extra mile, and are truly caring. The cancer care at Mercy was very appreciated.
- Impacts of cancer are grief, the difficulty of dealing with uncertainty, whole-family impacts (ranging from family members not wanting to talk about it to divorce), and the ongoing nature of cancer – "it never ends".

C. Key Recommendations:

- Need a Children/Youth Cancer Support group for children or grandchildren of people who have cancer.
- Make sure other hospitals (such as Baystate) have Cancer Support Groups that meet every week and are for all cancer types.
- Make sure other hospitals (such as Baystate) have a nurse or social worker navigator to help patients and their families navigate the medical, support services, and insurance systems.
- Assistance and guidance and support is especially needed in times when a patient is near death but it's not entirely clear. If some kind of person or program could be created for those patients and those times, it would be helpful.

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

D. Quotes:

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

Key Issues

Question	Synthesis of Responses
<p>1. Strengths of Mercy's cancer treatment and support</p>	<ul style="list-style-type: none"> ● Every single person mentioned the cancer support group, and couldn't say enough about it. They liked that it was a single group for people with any kind of cancer, rather than type-specific support groups. They also liked that the group meets once a week (instead of once a month or less frequently). ● Having all services and treatment in one place. "I had to leapfrog from one place to another before but now it is much nicer to have all care together." ● Devotion, kindness, and commitment from all staff (doctors, nurses, navigators, etc.). There were several stories of incredible devotion and follow up by doctors and other staff. ● Having a nurse navigator or social worker to help coordinate care, navigate insurance, and advocate for you and your family. ● One person called out the importance of the spiritual aspect of Mercy as a Catholic hospital.
<p>2. Suggestions/recommendations</p>	<ul style="list-style-type: none"> ● Doctors and staff on the care team need to educate all cancer patients that the support group exists. ● Other hospitals should have Cancer Support Groups modeled after

Question	Synthesis of Responses
	<p>Mercy's.</p> <ul style="list-style-type: none"> ● The nurse navigator position is key to being able to navigate your services and get the services and treatment you need. One person mentioned that Baystate doesn't have this position. ● Wish there was a Cancer Support group for children and youth. ● Help and guidance in those times when it's not clear what to do because it seems like the end (see Question 4).
<p>3. Impacts of going through cancer</p>	<ul style="list-style-type: none"> ● Not knowing how much to tell children, and seeing the impact on children and younger family members. ● Cancer affects everyone in the family. ● Sometimes cancer tears families apart due to grief and reactions to grief. Some never get through their grief. ● Some family members just will not talk about the cancer. ● There is survivor's guilt. ● Cancer is frightening. ● The ongoing nature of cancer, which it often returns, and the uncertainty can wear on people. "Cancer never ends". ● One couple didn't have kids because of the cancer. ● One person mentioned losing their job because of the cancer, and ending up divorced.
<p>4. Barriers to treatment or support services</p>	<ul style="list-style-type: none"> ● Navigating the medical and insurance system can be a challenge ● High deductibles and copays, but there are individuals (social workers, pharmacists) that can help get these costs down ● One heartfelt barrier people mentioned is that it's difficult to know what to do when the outcome is unclear – mentioned by a couple of people about when is best to end treatment, start hospice, give up hope for healing. A guide around that uncertainty would be helpful.
<p>5. Have you seen inequities in treatment by race, sex, income, sexual preference, or other?</p>	<ul style="list-style-type: none"> ● Participants had not experienced inequity. They hypothesized that people might experience "barriers" (not inequities) due to financial issues, bad insurance mostly. But several with public insurance felt that they were treated well at Mercy.
<p>6. Policy or practice suggestions that Mercy could support to decrease risk of cancer</p>	<ul style="list-style-type: none"> ● Laws, regulations, and more education about e-cigarettes and the risks of smoking in general ● One person was against regulation and in favor of education ● Practice suggestion: Hospital should make sure every patient has a survivor care plan when they are through with their treatment. Now when people are done they are just sent out on their own to "deal." Everyone should have something written down about what to do after they are no longer receiving treatment, whether it's a pamphlet, a business card with a phone number, or something else. This plan would be something that patients could also take to any future doctor they need to see as part of their history.

**Coalition of Western Massachusetts Hospitals/Insurer
2019 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:
 - i. Swift and satisfactory response to bullying incidents where children with disabilities are the targets.
 - ii. Providing therapies and supports that were perceived by parents to be necessary to their children's success, but that insurance companies will not cover because they expect schools to provide them.
 - iii. Creating accurate assessments that would qualify students for services that the parents perceived to be necessary for their children's success.
 - iv. Advocating for students with disabilities.
- Expand the umbrella of children who qualify for the BFit program: Many parents noted how essential the BFit program was to their children's physical and social success, but some parents noted that they had to fight or have advocates fight to get their kids into the program because their children did not technically qualify.
- Streamline diagnoses: Create broader categories of diagnoses to increase access to services without having to have kids misdiagnosed. Provide consistency in support for the same diagnosis across healthcare and school environments.
- Consolidate information about support for children with disabilities: Make information about specialists more readily available and easy to access, particularly by empowering specialists and healthcare providers with knowledge about other specialists in the area. Make information about physical activity opportunities available at Shriners and other healthcare providers' offices.
- Employ adult and therapeutic mentors, psychologists, therapists, etc. to help kids cope with bullying.
- Use advocacy groups, such as the Special Education Parent Advisory Council (SEPAC or SpedPAC), as a vehicle to identify issues that many students with disabilities are facing and elevate them to the attention of higher authorities in the school department.
- Make exercise and durable equipment more available and affordable for increasing physical activity opportunities and capacity in the home.

D. Quotes:

- Bullying:
 - *[Translating for Spanish speaker] "When [some kids at school] poured juice on her daughter she went to the school department and put in a complaint. They*

told her that they cannot move her from that school because it has to be three incidents back-to back... When she brought it to the attention of the principal in [the middle school], they just moved her into another school in the same building as where the bullying was occurring.”

- *“My son...told me... he was being assaulted... in every class and every day.... They started a bullying investigation and they asked me for his statement and we wrote out the statement, but before I could drop off his statement they closed the investigation and they told me that they didn’t find that any bullying had happened. When I asked them how they could conclude the investigation without my son’s statement, they said they just used some information that I mentioned in an email. They said that none of the students witnessed it.”*
- *“Living in Holyoke or Springfield, you cannot ignore the racial difference... If you are a Hispanic parent, particularly if your English isn’t what they think it should be, there is a huge gap and a much different response. There is also a large group of kids who are labeled special ed who are really just English Language Learners”*
- Access to specialty medical services:
 - *“My daughter was seeing a physiatrist in West Springfield who was great... but then she left the practice and was no help in terms of telling us where to go next. She suggested that we try Boston... I did try Boston, but it was a 3-month process to even get her in there. We finally got her in there and I like it, but four or five times a year, we’re driving to Boston, and she’s four, so it’s not fun.”*
 - *“Some of the specialists that we do see... they’re not helpful in expediting the process or making referrals, or sending her where she needs to go.... That information is not out there.”*
 - *“My daughter’s doctor in Boston told me she needed therapies for two years... I have so much difficulty, struggle, and pressure on me, on my husband, on my family.... Every night I have to cry. I went to Baystate [for my daughter’s recommended treatment] and after a while they said that the insurance wouldn’t cover it, and I had to call many people and after a gap [in her treatment] they sent me to [another hospital], and then after a while, they told me the insurance wouldn’t pay again. Then, finally, they sent me here to Shriners and the same thing happened. I said ‘no! I am done with this. My daughter needs these therapies. When she is making gains and progress, why do you want to stop it?’... This is the end of her therapies now, and again, I’m scared they are going to put gaps in between. This is my nightmare I have every day.”*
- Physical Activity Opportunities:
 - *“BFit has helped my daughter from being the most uncoordinated kid to being able to ride a bike last year.”*
 - *“[My son’s high school] just started Special Olympics two years ago and [my son] was afraid to do it, but we have a competition in two weeks and [my son] is doing real good... he was literally afraid to walk off the bus [before] because he was afraid people were going to make fun of him.”*

- *“I asked one of the physical therapists for swimming opportunities for my daughter because swimming is very good for relieving neuromuscular pain and she said we used to have [a pool] at Shriners but they closed it for financial reasons, and I would like them to open it again because a pool is actually a treatment for our children.”*

Key Issues

Question	Synthesis of Responses
<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
<p>Is their response effective?</p>	<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

Question	Synthesis of Responses
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
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
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
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
What services do you access in the community?	<ul style="list-style-type: none"> ● This question was only answered with regards to services that support physical activity. See question 8.
6. What specialty care services does your child need, that you lack access to (at Shriners or in the area)?	<ul style="list-style-type: none"> ● Psychiatrists ● Child psychiatrists ● Neuropsychologists
What is not offered here in western Massachusetts?	<ul style="list-style-type: none"> ● Psychiatrists
7. What are some of the	<ul style="list-style-type: none"> ● Lack or dearth of certain specialists in western Massachusetts

Question	Synthesis of Responses
<p>barriers you face in obtaining access to the types of specialty medical services that your child needs? (awareness, availability/waitlists, insurance/cost, travel, etc.)</p>	<ul style="list-style-type: none"> ● 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
<p>8. Where do you receive help with your child's access to physical activity opportunities (Shriners, other organizations, other hospitals)?</p>	<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
<p>Which organizations do you access for services?</p>	<ul style="list-style-type: none"> ● Shriners ● Springfield Jewish Community Center ● Whole Children ● Ultimate Sports Program ● Children's Miracle Network ● Baystate Hospital ● Mount Holyoke College ● Miracle League ● Special Olympics

Question	Synthesis of Responses
	<ul style="list-style-type: none"> ● 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>What is not offered here in western Massachusetts?</p>	<ul style="list-style-type: none"> ● This question was not specifically answered
<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>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 getting it into the marketplace (insurance sometimes won't cover this equipment and it can be expensive) ● 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

Question	Synthesis of Responses
	<ul style="list-style-type: none"> ● 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>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

Appendix IV. Key Informant Interview Summaries

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

Key Informant Interview Report

Hospital/Insurer: Baystate Medical Center

Interviewer: Kim Gilhuly

Interview Format: Phone and in-person interviews, about 1 hour in length.

Participants:

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

Question	Synthesis of Responses
<p>1. What are the causes of gun violence in Springfield for young men?</p>	<p>Poverty creates toxic and chronic stress, the need to fulfill basic needs, and lack of opportunity in these neighborhoods for jobs and positive activities. Trauma that young men have witnessed their whole lives in the home or on the streets can lead to grief from losing people and anger, bitterness, aggression, and impulsivity. Another cause is not having positive caring adults in their lives that young men can connect to and feel safe with. Examples include the lack of two parent homes, missing fathers and male role models, and mothers who are not great parents or are severely impacted by poverty, drugs, and/or incarceration, which can make raising children challenging. In addition, in many cases everyone in the neighborhood is involved in gangs or other lifestyles that include guns. In such neighborhoods, having to pull the trigger to save face is the norm.</p> <p>Other causes include:</p> <ul style="list-style-type: none"> ● Feeling like life has no value or hope, which makes it easy to pull the trigger ● Incredibly easy access to guns ● Schools that are underperforming and contribute to the devaluing of people in the neighborhood ● The lack of trauma-informed practices by institutional actors like police and schools
<p>2. What could have been put in place to divert them from</p>	<p>All interviewees mentioned identifying the young people who are highly at risk and impacted by gun violence early to prevent them from using</p>

Question	Synthesis of Responses
<p>pulling the trigger?</p>	<p>guns. They also said mentioned:</p> <ul style="list-style-type: none"> ● Mentors in combination with mental health providers and other wraparound services ● Getting youth connected to activities that line up with their interests, which will connect them to positive, caring adults ● Psychoeducation about brain science and trauma ● A public health campaign to the general public and community about the impacts of trauma ● Treatment of students with gun trauma and grief with lenience in school rather than suspensions ● Support for young people who are trying to make a fresh start instead of putting more barriers in their way ● More preventive programs for fourth and fifth graders, rather than reactive programs for older kids who are involved in gun violence
<p>3. What are the impacts of gun violence in a person’s life?</p>	<p>Interviewees mentioned the following possible impacts:</p> <ul style="list-style-type: none"> ● A young person's mindset could be locked into a certain way of viewing the world (e.g., as a place where gun violence is normal) ● Trauma, toxic stress, fear, anxiety, hypervigilance, being stuck in a fight/flight/freeze mode ● Impulsivity, being overly reactive, and not knowing how to deal with your emotions ● Poor physical health (e.g., heart disease, diabetes) as a result of ongoing cortisol release due to stress and fear ● The need to dominate, be powerful, and influence others ● Low levels of successful at school, work, in their daily routines ● Death ● Traumatic grief that impacts the whole family, community, and a person's ability to parent ● Risk to other family members
<p>4. Programs in Springfield that have done a good job at preventing or reducing gun violence</p>	<p>Interviewees mentioned the following programs:</p> <ul style="list-style-type: none"> ● Roca, which works with the highest risk youth, offers psychoeducation on the effect of trauma and on brain science, and uses cognitive behavioral therapy to help young men and women pause, not be impulsive, and deal with their emotions ● The Shannon Community Safety Initiative, which funds programs such as the YMCA, the Dunbar Community Center, the Boys and Girls Club, and Acorn, which create safe spaces for youth ● After Incarceration Support Services runs a mentorship program for young adults aged 17 to 24. ● The High Risk Reentry Program at Hampden County Sheriff’s Department ● The Safe and Successful Youth Initiative ● Winter and summer basketball leagues that are part of Holyoke Safe Neighborhoods Initiative

Question	Synthesis of Responses
	<ul style="list-style-type: none"> ● The New North Citizens' Council ● The Youth Advisory Council at the Department for Youth Services (DYS), which offers youth a stipend for sitting on the council and completing a community service activity once a month ● Restorative Justice Circles, which are used at Roca and Holyoke High School ● The Western Massachusetts Violence Prevention Coalition ● The Homicide Bereavement Program's "Standing Together" event, which honors the lives of people who have died from gun violence ● The Mass Mentoring Partnership, which trains basketball coaches and volunteers to identify youth who have experienced trauma and to work with them
<p>5. How could these good programs that currently exist be improved?</p>	<p>Programs funded by the Shannon Community Safety Initiative provide safe havens for youth, but they should focus more on the root issues of gun violence, connecting people to benefits, and helping young people get jobs. These programs should also have a therapist on staff to help students dealing with issues related to gun violence. After school activities like football and basketball are expensive and should be subsidized so more students can participate. Springfield programs listed above, such as Roca and the Dunbar Community Center, could serve as probation options, rather than sending youth to detention programs. Legislators and representatives from the police, schools, and community service organizations who are missing from the Western Massachusetts Violence Prevention coalition should be included.</p>
<p>6. General ideas for how to reduce/prevent gun violence</p>	<p>Interviewees gave a number of ideas, including:</p> <ul style="list-style-type: none"> ● Identifying youth early who need prevention or intervention ● Mentoring, which can help support and encourage youth to make different choices ● The creation of more programs for 13 to 16 year olds, who are the most vulnerable to gangs and drugs ● Keeping youth in programs even if they age out ● Funding at community centers for activities that are not sports, like dance, singing, and art ● Teaching social-emotional skills in the course of all activities ● Dealing with the underground market where guns are sold because it is more problematic than the legal market ● Making sure all agencies and nonprofits that work with young people are linking them up to basic needs, like clothing, housing, and employment. ● Job training ● Creating a bridge organization around gun violence that would link judges in juvenile courts to youth mental health counseling and the provision of basic needs ● Having more mental health counselors who are from similar racial

Question	Synthesis of Responses
	<p>and ethnic backgrounds as the youth they help</p> <ul style="list-style-type: none"> ● Having ex-gang members and others who have left a life of gun violence serve as support, role models, and consultants to youth ● Building support systems for youth and their families that include case managers, mentors, and other support professionals and services ● A pilot program with 10 to 20 youth aged 17 to 24 who have been involved in gangs and gun violence. Youth would go to Baystate Medical Center (BMC) three days a week for 12 months for job readiness training and mentorship. They get a certificate, help with getting their driver's license and registering a car, help with getting a job, and \$1,000 once they complete the program.
<p>7. Resources and ideas from other places</p>	<p>Interviewees mentioned the following three resources:</p> <ul style="list-style-type: none"> ● Prevention Institute: UNITY Roadmap, Imperative Side of Safety, THRIVE tool for health and resilience in vulnerable communities ● The book <i>Murder is No Accident – Understanding and Preventing Youth Violence in America</i> by Deborah Prothrow-Stith ● Child College Savings Accounts, which are used in Oklahoma, Cleveland, San Francisco and possibly all over California. The city or state or county opens an account with seed money for each kindergartener. Evidence shows this gives kids hope and they have better educational attainment and social emotional learning.
<p>8. What can systems do?</p>	<p>Regarding legislation or practice/policy change, interviewees offered the following ideas:</p> <ul style="list-style-type: none"> ● The crime bill of 2018 raised the age of juvenile jurisdiction and reduced the amount of time before you can seal your juvenile record. This is good because if you seal your record you can move forward, get your driver's license. Young people should know about this law and seek to seal their records. ● Legislators could come to Roca and speak to youth ● Gun control legislation could create red flags for people with mental illnesses so they can't purchase a gun, impose stricter penalties for people who do not lock up their gun, and impose longer jail sentences if people are caught with a stolen gun. ● Appoint officials who are thinking about reducing gun violence from a public health lens to relevant positions of power. ● Create more funding for surveillance, like cameras where ShotSpotter goes off that can take pictures of guns being fired. <p>Ideas for schools included:</p> <ul style="list-style-type: none"> ● Do more restorative justice circles at high schools beyond Holyoke High School. Roca trains people to lead restorative justice circles. ● Train teachers about warning signs. If a kid is acting out, something

Question	Synthesis of Responses
	<p>might be going on for them at home. Teachers need to have relationships with kids so they know what’s going on.</p> <ul style="list-style-type: none"> ● Have counselors at schools to help kids grieve. ● Don’t suspend kids if they are having a bad day. <p>Ideas for what the police and the courts can do included:</p> <ul style="list-style-type: none"> ● Community Care Cooperative (C3) is great, and helps the community know the police and feel comfortable calling them. Get the word out so more people participate in C3. ● Hub & COR are system-wide approaches to deal with violence, substance use disorders, and other issues. All providers (such as the school, BMC, the Behavioral Health Network, Roca) come together and conference with each youth. If any of them have noticed something going on with that person, they all respond immediately with extra support. ● Deal with racist practices at the police department ● Promote and support the new Young Adult Court that Roca is planning, which includes pretrial and post-conviction, where the sentence would be to go to Roca. <p>Suggestions for community centers included:</p> <ul style="list-style-type: none"> ● Create more community centers and fund the ones that already exist to do more, make accessibility easier for kids and parents, and decrease the barriers to using these programs like fees. ● Externally evaluate these programs so that western Massachusetts knows what works best out of everything they are doing and what is not useful. <p>Suggestions for what hospitals and EMTs can do included:</p> <ul style="list-style-type: none"> ● Figure out how to work in collaboration with Roca staff so they can visit and get in touch with people who are in the hospital due to gun violence and stop retaliation. HIPAA is an obstacle. ● Ambulances take a long time to respond to incidents of gun violence, so help them to respond more quickly. ● Treat victims of gun violence and their families the same way you would treat anyone suffering from trauma or heart disease – with respect and support, privacy in a consultation room instead of the public area, and encourage the support of a large family or neighborhood rather than punishing them.
<p>9. Role of families in preventing gun violence</p>	<p>Parents need to get involved in their children's lives and act like parents rather than friends. They should not be too scared to confront their children if they find drugs or a gun in their room, but rather should have</p>

Question	Synthesis of Responses
	<p>information about how to handle such a situation. Families also need to support youth who are trying to embrace non-violence. In addition, programs must develop relationships with parents and families, like inviting them to sports activities, family nights, and back to school events.</p>
<p>10. Who needs to be at the table advocating for changes in our systems in order to reduce gun violence?</p>	<p>Community members who have been impacted by gun violence should help advocate for system change. They can share their experiences to make gun violence real for those who haven't experienced it. Others who should be more involved in advocacy for system change include:</p> <ul style="list-style-type: none"> ● Criminal justice systems, such as the District Attorney, police commissioner, police chief of Holyoke, chief of probation, public defenders, DYS, juvenile court system, and Hampden County Corrections ● Schools, social service agencies, youth organizations, and the faith community ● Baystate Health ● Legislators and people with power who come to the funerals
<p>11. What are barriers to making these changes?</p>	<p>The barriers described by interviewees included:</p> <ul style="list-style-type: none"> ● Politics ● Limited resources ● Lack of trust within agencies ● Lack of trust by the community ● Racism – even though talking about racism can be a barrier, there is a lot of inherent racism ● Not enough mental health counselors who look like the youth they assist ● The lack of an umbrella organization that brings all agencies and support professionals and the community together to address and help those at risk ● Support professionals who are jaded by their jobs, such as an older police officer who doesn't want to change their methods

Quotes:

- “To ask them to do anything but survive would be ludicrous.”
- “It’s all trauma.”
- “Many youth, in these environments feel as though ... life has no value, not theirs or the lives of others. Those types of feelings make it easy for someone to pull a trigger or become addicted to alcohol or drugs.”
- “Some impulsive decisions have come from immediate high stress situations or anger that they have not learned to control or deal with.”

- “It’s great to take a youth that was on the wrong road and get him on the right road, but we should be equally excited about preventing the next generation of youth from going down the wrong roads to begin with.”
- “A lot of people fail to realize that the lifestyle they live is for so many different reasons - but it’s grievance, anger, bitterness, for losing people they love.”
- “Impulsivity – people don’t take time to problem-solve, and when they have a gun they use it.”
- “[The youth involved in gun violence] don’t trust systems because systems haven’t helped them.”
- “People grow up on a certain street, with a certain clique, and it’s just their neighborhood, not a ‘gang’. When someone gets shot, they say it’s ‘gang related’ and that out the sympathy the kid. It’s racist because when a white person gets stabbed or shot, that’s not what they say.
- “When my son was murdered, they showed his juvie picture. They never came to my house and asked for a picture where he played sports. Every season he played basketball and football. But they just used the juvie picture.”
- They have a grant to help pay for funeral if a person is shot. “They have a whole fund for death. But not for living.”
- “It’s time to move beyond focus groups and study sessions.”
- “The biggest impact [of gun violence to an individual and a community] is a mindset impact, locking someone into a way to view the world at a young age.”

**Coalition of Western Massachusetts Hospitals/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 Hoynnoski (CFO), Maria Heidenreich (Med Dir), Cameron Carey (Dev Dir), Maegan Petrie (Accountant), Allison van der Velden (Dental Dir), Allie Jacobson (Info), Jessica Calabrese (COO), Susan Welenc (pop health), Susan Luippold (Human Res.), Wes Hamilton (CIO)

Question	Synthesis of Responses
<p>1. 3 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 • 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.
<p>3. Specific vulnerable populations of concern</p>	<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

Question	Synthesis of Responses
	<p>regimes & take a toll on families</p> <ul style="list-style-type: none"> • 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
<p>4. Gaps to health care of most concern</p>	<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)
<p>5. Barriers</p>	<ul style="list-style-type: none"> • Transportation • Language • Psychiatric services • Housing • Food insecurity – has gotten worse • Poverty • Illiteracy
<p>6. What’s missing that we’re not seeing in the data</p>	<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.
<p>7. Opportunities for prevention to keep people out of hospital</p>	<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 \$\$.
<p>8. What’s needed apart from more funding</p>	<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

Question	Synthesis of Responses
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 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 Franklin Medical Center

Interviewer: Kat Allen, with Jeanette Voas taking notes

Interview Format: In person interview, 1.25 hours

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

Question	Synthesis of Responses
1. 3 most urgent health needs	<ul style="list-style-type: none"> • Livable wages/Housing <ul style="list-style-type: none"> ○ Housing with support for mental health challenges ○ Housing for people with mental health issues <i>and</i> sex offense charges or arson in their histories. ○ Greenfield has about 200 homeless people; many are formerly incarcerated ○ Many leave here and end up couch surfing in environments that aren't safe • Residential treatment, particularly for dual diagnosis (which is true of most of our clients here). <ul style="list-style-type: none"> ○ To get into a dual diagnosis program you have to be suicidal. People may have to lie to get in. ○ And there are guys in East Spoke who have a plan to kill themselves, but when their insurance hits a limit, they're out of the program. ○ Or any violent behavior can get them dismissed from East Spoke. • Case workers and coordination of services in the community <ul style="list-style-type: none"> ○ We have 3 reentry caseworkers here and hundreds of clients who have left the jail ○ Many services do not communicate with one another ○ Points of transition are when things fall apart the most. There are disconnects between services and levels of care. ○ Barriers to successful reentry are huge for clients with mental health, substance issues and trauma history. <ul style="list-style-type: none"> ▪ It's hard for them to engage in any community apart from the one that landed them in jail in the first place ▪ Or some have no family, no friends ▪ It's hard when they have to go to new providers to

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

Question	Synthesis of Responses
	<p>cannot bill for treating people in jail. Inreach could help.</p> <ul style="list-style-type: none"> • People are free to NOT show up for services. <ul style="list-style-type: none"> ○ How many follow through with reentry plans and resources, and for those who don't, why not? ○ Because our clients suffer from chronic anxiety, depression and trauma, it's hard for them to follow up, and we should start from the assumption that they're not going to go. ○ Agencies should share data so clients don't have to retell their stories multiple times. We don't need to ask so many questions at intake. ○ Gaps in insurance – restrictions on what's available to whom, for how long • Effective contingency programs for MAT. • Lack of options for people who have mental health needs and CORIs. <ul style="list-style-type: none"> ○ They're high-need, not best served in jail, but there's no place for them to go. So they come here. • Clinicians to do ride-alongs with police to use discretion to help keep people out of the criminal justice system • Community case workers who are not tied to a particular agency, so clients aren't cut off when they're no longer connected to the agency
<p>5. What's missing, what important things are not showing up in the data</p>	<ul style="list-style-type: none"> • Generational legacies <ul style="list-style-type: none"> ○ Children are removed from parents who can't take care of them, but what's the long-term success of foster care? • What happens to clients who haven't been able to complete treatment because of insurance? <ul style="list-style-type: none"> ○ For example, they go into intensive treatment to normalize the situation, but may have to leave when they don't feel they're ready.
<p>6. What else is needed to better address health issues</p>	<ul style="list-style-type: none"> • We're pruning the tree, not going for the cause in the roots. • The skewed distribution of wealth has put us in this position. • Our system of judgment and punishment is proven not to work. We need to unravel this narrative and orient ourselves towards a more scientifically valid perspective. • We have a DBT program here, and it applies to teaching skills to clients and to staff, to structuring the environment to make it conducive to this work, and to generalizing skills to clients' natural environments. It's a strategy for applying what you learn in different environments.
<p>7. What do you wish you could refer people to outside the jail?</p>	<ul style="list-style-type: none"> • Housing, housing, housing. • There's hardly any sober housing in the western region. • The GAAMHA House in Greenfield, with 6 beds for women (no children) is a model. It's where I would want to refer my clients who don't need constant supervision. For those without supports, it's like

Question	Synthesis of Responses
	<p>a family. But it can accommodate only six!</p> <ul style="list-style-type: none"> • More community reentry caseworkers. • Adult leisure services <ul style="list-style-type: none"> ○ Provide outdoor experiences, music, theater, something to engage in creatively ○ No-cost/inexpensive outlets for leisure ○ Community center with safe environment ○ Being bored is a trigger ○ DMH invested in a Club House model in Boston. It's a turned-up community center, with prosocial stuff, voc rehab, meals. You go and you're participating in community.
<p>8. Partnerships between hospital and public health organizations?</p>	<ul style="list-style-type: none"> • Let's sit down and talk about how we can work together, including Mayor's office, DA, probation. We need to talk the same language and share the same vision. • Baystate plans to relocate behavioral health to one place. How will the hospital help people to relocate back to their own communities? • With hospitalization, the emphasis is on stabilization (with drugs so patients don't kill themselves) and release. How can we make subsequent services more available?
<p>9. What else?</p>	<ul style="list-style-type: none"> • We need collaboration across agencies not just at administrative level but among people on the ground working with clients. • Instead of implementing a program and thinking it's done, we need long-term planning and ongoing implementation. • Here at the jail, we have latitude to experiment, to see what works and what doesn't. We've focused on transitions, specific needs, and reinforcement throughout the system. • When we look at vulnerable groups, we mustn't get sucked into silos – physical health, mental health, co-occurring, homeless, etc.)

Quotes:

- “There are guys at East Spoke who have a plan to kill themselves, but when their insurance hits a limit, they're out of the program.”
- “We work with clients on the outside no matter what. They will tell us, “I can use all the drugs I want and still get Suboxone.” They can sell it.”
- On Suboxone: “The thing I'm in jail for is like a door prize they give me as I leave. Do I really need to go to meeting?”
- “It would be great if we had naturally flowing levels of care. Step downs, with direct partnerships instead of hoping, hoping. Now it's all reliant on an incredible amount of effort and resourcefulness.”
- “We see trauma and retraumatization. When you can't get housing, that's traumatizing. When kids are taken away, that's traumatizing. It's a generational problem for most of our clients.”
- “One client said the jail was the only home he had ever experienced. When he had a baby, he brought the baby back as if to meet his family.”

- “We need warm handoffs. Our clients have chronic anxiety, depression and have experienced trauma. We say to them, “When you get out of here, you’re going to talk to some new people and they’re going to help you.” Of course they’re not going to go! The way we’ve created transitions is not suited to the clients. We should start from the assumption that they’re not going to go.”
- “We have family-focused programming here, but we don’t have another half to this. We don’t know who’s working with the family. We’re kind of hoping. What’s the context people are returning to?”
- “There are problems with how people get sorted out – who goes to jail, who goes to mental health treatment. I have people here who don’t belong in jail. They won’t come out of here any better. ”
- “Even the way we think about collaboration needs to be rethought. We tend to connect administrators together. I talk to clients every day and I have no idea what’s going on out there. We need collaboration among people who are actually doing the work. ”

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

Key Informant Interview Report

Hospital/Insurer: Mercy Hospital

Interviewer: Kim Gilhuly

Interview Format: Phone interviews, from 30 – 45 minutes in length.

Participants:

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

Question	Synthesis of Responses
<p>1. Strengths of Mercy’s Cancer care and support services.</p>	<ul style="list-style-type: none"> • Get patients in very quickly – important for the stage of cancer and getting treatment. Much quicker in comparison to other places. • Very committed, responsive, and talented doctors and staff • Treat all kinds of cancer – breast, colorectal, prostate, other – but specialty is lung cancer – have specialized surgeons and services. • Have a robust support team – two nurse navigators, two social workers and one patient advocate dedicated to the Cancer Center. Have amazing spiritual counseling. • Also have lung cancer screening program – the earlier you detect the better the outcomes are. • Have an amazing Cancer Support group. • We have a Patient Fund here that people contribute to.
<p>2. Services and supports that you wish Mercy had.</p>	<ul style="list-style-type: none"> • Better programs to treat the psychological side of things. “The C word is a really scary thing.” • Services to help people feel emotionally well, such as massage, reiki, pet therapy, acupuncture, meditation, hypnosis. Classes in how to do make-up, moisturizer to use for your skin, sleeping changes. “Things that help people feel their best when they are feeling their worst.” Almost impossible to get reimbursed for these things. • Clinical trials – have to send to Boston or Hartford. • Cancer survivorship support – more people are surviving (great!) but need guidance, support, mental health services during survivorship • Education for patients – what is cancer, how do you access care, etc. • Smoking cessation for oncology patients (not just lung cancer)
<p>3. Barriers people face that it would be helpful to address (or address more)</p>	<ul style="list-style-type: none"> • Transportation – shuttle, better taxi service, make sure taxi voucher program through the Patient Fund is still running, that cancer patients are accessing Mercy Hospital Uber services, even some sort of valet parking services and help getting exhausted and nauseous

Question	Synthesis of Responses
	<p>patients through the parking lot and the hospital.</p> <ul style="list-style-type: none"> • Co-pay assistance – can be very large and we don’t have assistance • Financial counseling – have support from social workers if people need help w/ their insurance companies, but having someone in the Cancer Center to think through the cost of their treatment (which can be huge) would be helpful. Can access financial counseling for all of Mercy, but would be good to have in Cancer Center. • Bilingual assistance • Mental health needs • More community outreach so people know about the Cancer Center. We have amazing services here and many people don’t even know we’re here.
<p>4. Models for care in other places that would be good at Mercy</p>	<ul style="list-style-type: none"> • Genetic counseling and genetic lab services to enable targeted therapies (if a tumor has a specific genetic makeup there may be specific drugs). Must have ability to identify the problem, counsel, provide therapy for that problem, and then counsel families as to what it might mean for them. • Breast cancer screening that is more immediately responsive. Would mean having a standby radiologist do a “wet read”, if something is suspicious get immediate same-day appointment for ultrasound or biopsy. Now Mercy has a primary care model, PCP order mammogram, it’s read in a day or so, results back to PCP. It’s just slower. Our breast cancer screening to treatment should mirror how fast and responsive our lung cancer screening to treatment is. • Palliative care team inside the Cancer Center. Mercy has a palliative care service just for inpatient, we would like to have an outpatient service. We have a pharmacist pain specialist we can access, but would be good to have palliative care at the Cancer Center.
<p>5. Impacts of cancer diagnosis</p>	<ul style="list-style-type: none"> • Devastating. • Scary, anxiety-provoking, general emotional distress. • Impacts not just the person with cancer but caregivers • People need to know – I have cancer, what does it mean for me, my family, will I work again. It would be great if we could explain to every cancer patient their prognosis, therapy, how to survive cancer. Just not sure if any of our first line clinicians, primary care docs, have the time.
<p>6. Cancer prevention efforts that Mercy is doing</p>	<ul style="list-style-type: none"> • Lung cancer screening at the hospital. If you can identify lung cancer early on, you can treat it early and prognosis is much better. • We did one free lung cancer screening day last year and will do one this year. • Did some work through Transforming Communities Initiative educating adolescents about the harms of smoking. • Helped pass Tobacco 21 in Springfield and the state. Some of those same youth in the education sessions were able to talk to legislators. • Work with Tobacco Free Springfield – meet to see who is selling

Question	Synthesis of Responses
	<p>tobacco to whom.</p> <ul style="list-style-type: none"> • Education about cervical cancer screening for Healthcare for the Homeless.
<p>7. Cancer prevention efforts that would be good to do</p>	<ul style="list-style-type: none"> • Continue lung cancer screening • Mobile CT scan so lung cancer screening didn't NEED to be done at the hospital. • HPV vaccination outreach and education – the Cancer Committee is planning on doing some of this in the coming year. • Do HPV screening event and a prevention/education program.
<p>8. Policy or practice change that Mercy could support that would decrease risk of or reduce cancer (like Mercy supported Tobacco 21 law last year)</p>	<ul style="list-style-type: none"> • Lung cancer is the deadliest cancer (only about 17% of people are alive 5 years after diagnosis). Outcomes are much better if caught earlier. • Push the U.S. Preventative Services Task Force to incorporate lung cancer screening into doctors' computer programs so they are prompted to ask patients if they fit the criteria. • Insurance companies should expand the criteria for lung cancer screening – it is very narrow now (age 55 – 77, former smokers within 15 years, family history) and many more people would benefit. • Expand awareness in 1) health care community and 2) general public of importance of lung cancer screening. • Address the barrier that regulatory and compliance puts on hospitals setting up ancillary services (massage, meditation, acupuncture, etc.). Now it's very hard to bring in outside services because of laws and rules that implicate that hospitals are trying to coerce patients to come. • Resources for HPV education and screening.
<p>9. Have you witnessed any inequities in cancer treatment or services by race, income, gender, sexual preference, or in any other way?</p>	<ul style="list-style-type: none"> • No.
<p>10. Anything else?</p>	<ul style="list-style-type: none"> • Would like to see cancer rates for different types of cancer in the hospital service area incorporated into the CHNA. • Mercy does some amazing stuff, would be great if the larger community knew about it. Healthcare for the Homeless, community work through Transforming Communities Initiative, other. This all should be publicized! • Heresy, but would be great if we could have ONE cancer center in the Springfield area and everyone get treated there rather than duplicating services. Not sure everyone would agree.

Quotes:

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

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

Key Informant Interview Report

Hospital/Insurer: Shriners Hospital

Interviewer: Catherine Brooks

Interview Format: Phone interviews, approximately 30 minutes - 1 hour in length.

Participants:

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

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

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

Question	Synthesis of Responses
<p>7. What do you know about the frequency or type of bullying that occurs towards youth with disabilities in the local schools?</p>	<p>It's definitely a big issue. There are estimates that 70% of children with disabilities are bullied at school. It's usually verbal abuse, taunting, and staring. Schools can combat this with integrating children, lunch groups, model play.</p>
<p>8. How does bullying affect the physical and mental health of youth with disabilities? In what ways does bullying impact them differently than youth without disabilities?</p>	<p>Bullying diminishes self-confidence, which is already low for these children - they cower down, withdraw. They sometimes exhibit selective mutism. It can lead to physical issues - for example, a child who won't use a walker for fear of being singled out could fall more often and get hurt. The impact varies - some students aren't aware of it, because their disability impedes their perception, but others range the gamut from being bothered by it to being acutely aware. It makes their disability even more traumatic for them. It can be hard to know what is bothering them and how to address it.</p>
<p>9. What types of bullying prevention education would be helpful for children with disabilities and their families? Who do you think should do it?</p>	<p>Kids get a lot of general, schoolwide messages, but they don't internalize them. There needs to be more of a connection. Kids need to express how the bullying makes them feel, in encounter groups mediated by adults, or the parents of bullied children could do this. Maybe bring bullies and victims together to work on projects, again with adult supervision.</p> <p>Difference of opinion over doing it in school vs. in outside groups. One respondent thinks that kids are more receptive to messages that they get in fun, social settings. Another talked about the need to do it in school so that they don't have to transfer skills learned in an outside setting to the school setting.</p>
<p>10. If resources were available to spend on initiatives that might address the problem of bullying and children with disabilities, what types of things do you think should be done? What should we consider... educational programs, public campaigns to promote inclusion/integration and acceptance? Who should we target for these initiatives... the individuals with disabilities themselves, families, caregivers, schools...</p>	<p>Exercise programs that are adapted for people with disabilities - builds self-confidence, self-worth, makes them less vulnerable to bullying. Currently there is a lack of quality fitness programs for people with disabilities - a lot of the organized activities for them are around food.</p> <p>It's best to start with young children, and use school settings to build awareness, provide information. You can use spaces and events where parents and families gather. It's important to start in elementary school - begin the work of building decent people who appreciate each other.</p>

Question	Synthesis of Responses
etc.?	
11. Is there anything we haven't discussed that you'd like to mention before we finish the interview?	<p>There should be an educational health collaborative, modeled after the program in Connecticut, established here - it brings people together, and provides momentum and continuity for goals.</p> <p>Professionals need to underscore the importance of using schools as a conduit for providing information to families.</p>

Quotes:

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

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

**Coalition of Western Massachusetts Hospitals/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 service area?	The issues most frequently named were mental health, substance use, obesity, chronic diseases.
4. In the last 1-2 years what	Public health officials in Hampshire and Franklin counties mentioned

Question	Synthesis of Responses
<p>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>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 • 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</p>	<p>Resources and services mentioned included:</p> <ul style="list-style-type: none"> • Transportation • Better pain management services (Stanford has a course about

Question	Synthesis of Responses
<p>access to?</p>	<p>creative, non-medical approaches to pain management)</p> <ul style="list-style-type: none"> • 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 emerging in the next 5 years?</p>	<p>Issues mentioned included:</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

Question	Synthesis of Responses
	insurance and health services <ul style="list-style-type: none"> 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 Medical Center

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

Date of Focus Group: 2/08/2019

Facilitator: Melissa Pluguez-Moldavskiy NAHN-Western Massachusetts

Note Taker: Brittney Gonzalez

Location: Riverview Senior Center, Springfield, Massachusetts

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 Responses
<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, Massachusetts

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 Responses
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.

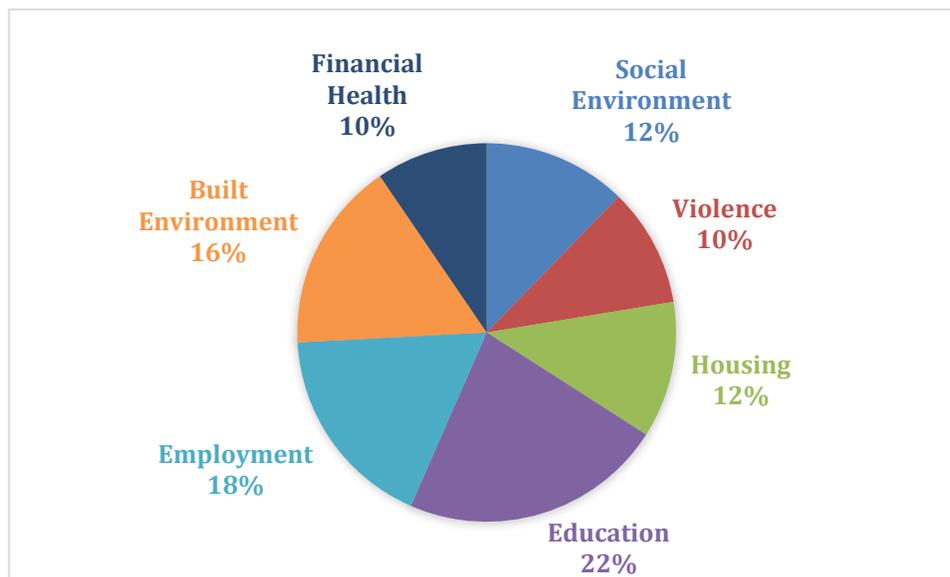
Figure 1: Chat Participants

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.