

JESSICA PAYNE CONSULTING

QUALITATIVE RESEARCH IN EDUCATION, HEALTHCARE AND MARKETING

37 Western Lane • Amherst, Mass 01002 • 413.824.9578 • jessicapayne@comcast.net

HEALTH AND COMMUNITY:

A HEALTHCARE NEEDS ASSESSMENT FOR WESTFIELD, MASSACHUSETTS

A REPORT COMMISSIONED BY

HOLYOKE HEALTH CENTER

JAY BREINES, EXECUTIVE DIRECTOR

HOLYOKE, MA

Submitted by

Jessica Payne, Ph.D.

Jessica Payne Consulting

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I. EXECUTIVE SUMMARY

In fall 2011, Holyoke Health Center contracted with Jessica Payne Consulting to complete a healthcare needs assessment for the city of Westfield using a qualitative research process to 1) identify significant populations, current health needs, available health services, and key providers and community resources; and 2) network, build relationships and identify key stakeholders for future planning and board development. The following findings are key outcomes of this research.

Key populations of need identified through this research include: new Nepali refugees and what are expected to be growing numbers of Iraqi, Afghani, and Burmese refugees; Latinos; Russians; Ukrainians; veterans, seniors, women and adolescent girls; the homeless, low-income, working families. To varied degrees, these populations experience on-going need for primary care and treatment of chronic disease (especially heart diseases, diabetes, respiratory illness); dental care; adult and pediatric mental and behavioral health care; and treatment for substance abuse. The most important variables conditioning Westfield's healthcare environment and its areas of greatest healthcare need are the following:

- Current healthcare resources and services are substantial but due to reductions in program capacity associated with rising program costs and tightened budgets and staffing, current services are not sufficient to meet the range and depth of need across age and cultural groups.
- Access to Westfield-based Mass Health providers for primary, dental, and mental healthcare is limited relative to levels of need. Due to the need to travel outside of Westfield for care, transportation is a key barrier to healthcare provision.
- Navigating the systems to obtain and retain adequate insurance coverage is reportedly the greatest barrier to healthcare provision for patients across age groups, despite significant assistance being provided for enrollment. Insurance enrollment and management requires constant work and maintenance for patients and providers, with negative impact on access to and utilization of services.
- For a growing sector of the population, instability in income, jobs, and family infrastructure and resources is making the process of accessing adequate health insurance more difficult and more complex, and is leading to more heightened, inter-related physical, mental, and behavioral health issues that require integrated, coordinated, care for multiple (e.g. more than dual!) diagnoses.
- Although individual agencies offer coordinated and integrated services for some populations, there is an overall lack of coordinated, wrap-around services or a 'medical home' to address multiple health issues.
- The engagement of skilled practitioners with a capacity for trust, cooperation, and collaboration is one of Westfield's greatest healthcare assets.

- Seeing the level and degree of need, individual staff get involved in case management, tracking, and accessing resources by drawing upon their relationships with providers in the region. Informal collaboration leads to shared resources, and decreases chances that patients will fall through the cracks. However, this informal, relation-based process takes time and resources that go beyond staff and program capacity and is not a sustainable means to coordinate care.
- With the exception of the school district, most agencies and practices do not have the breadth of capacity to provide the level of translation services needed to improve access, facilitate outreach, and meet the actual needs of non-English speaking residents.
- For low income populations, treatment of chronic disease, dental health, and mental health are the areas of greatest healthcare need, with treatment for addiction being a frequent additional factor.
- In the current economic environment in which the low-income and working poor confront challenges on all fronts (e.g. jobs, housing, food, health, education), young to middle aged women with children are disproportionately disadvantaged (relative to men) in accessing coverage, care, and follow up for their multiple areas of need (e.g. OB/GYN services, basic primary care, mental health, and treatment for substance abuse and domestic abuse).

Low-income residents of Westfield experience a fragmented, confusing healthcare system which meets some of their needs, but is not set up to be comprehensive, coordinated, or easily accessible with regard to insurance, location, and language access. Strong relationships between providers strengthen the healthcare environment, but there is recurring and pronounced need for a healthcare infrastructure that gives providers the capacity to address multiple health issues through coordinated wrap around services.

The complex, historically situated, and constantly shifting terrain of healthcare need and provision in Westfield makes it difficult to capture any fully accurate portrait of the healthcare environment. Time and budget constraints mean that not all potential informants were contacted and there is considerably more research and networking that could and should be done. Ideally the findings presented in the full health assessment report and the relationships with members of the community that have been cultivated thus far establish a foundation for that future work.

II. INTRODUCTION

In fall 2011, Noble Hospital and Holyoke Health Center (HHC) collaborated on a project to conduct research and do preliminary planning for the development of a community health center serving the city of Westfield, Massachusetts. As part of this research, HHC contracted with Jessica Payne Consulting to complete a healthcare needs assessment using a qualitative research process to 1) identify significant populations, current health needs, available health services, and key providers and community resources; and 2) network, build relationships and identify key stakeholders for future planning and board development. Staff from HHC collaborated closely with principal researcher Jessica Payne in the project design and implementation. This report summarizes findings from the assessment research and should be read in conjunction with demographic data collected by HHC. This is a *confidential, internal document* intended for review by staff from Noble Hospital and HHC, and not for broader circulation.¹

Research and Networking Process

The research for this report expands upon a preliminary needs assessment completed by Jessica Payne Consulting in spring 2010. Payne reconnected with many individuals contacted in the first study to obtain updated information on health status, needs, and access to and use of services. Additional contacts were made through in-person and phone meetings (See Appendix A).² Research was targeted to address specific low-income populations, providers, and health issues, including:

- **Populations:** New immigrants (Bhutanese, Burmese, Iraqi, Afghani); Latinos; Russians and Ukrainians; families with young children; adolescents; adults, seniors, veterans, homeless individuals.
- **Health issues:** Chronic disease; primary care; mental and behavioral health; women's health; insurance eligibility and enrollment.

Contact was made with providers and community members in municipal, public, and private programs and organizations, schools, resettlement programs, housing agencies, community-based social programs and services, and ethnic organizations. Informants made recommendations for other contacts, leading to a broad network of connections in various organizations throughout the city. Interviews were conducted in person or by phone using the following open-ended questions which were tailored to the expertise and experience of each informant:

- **What are the most important health issues for people in this community (families,**

¹ Thanks to the following individuals for assistance in the research process: **Ronald Bryant, Allison Gearing-Kalill, Mary O'Neil, and Stan Strzempko** from **Noble Hospital**; **Patricia Boone, Jay Breines, Nancy DiMattio, Patricia Sarvela, Suzanne Smith, and Jacqueline Spain** from **Holyoke Health Center**, and the community members and service providers whose accounts inform this report.

² This report is submitted with an annotated contact list, a contact spreadsheet with recommendations for future involvement of individual informants, and notes from all interviews. See also Jessica Payne Consulting, *Holyoke Health Center/Westfield REACH Health Needs Assessment Report*, July 2010.

children, adults, elders, other special populations)?

- **What services are available for meeting people's healthcare needs?**
- **Which health needs are being met well and how and why is that happening?**
- **What are the most significant barriers to accessing healthcare services?**
- **What changes are you seeing in population, health issues, access and use of services, improved access/care, and barriers for this community?**

These open-ended questions, combined with follow up questions to elicit further elaboration, encouraged informants to speak in unstructured ways about their perspectives regarding the structure of organizations and programs, their subjective observations of populations and healthcare needs, and their experience of collaboration and partnership within the community. The resulting data was collated for common themes and concerns, and taken as a whole, reflects an interconnected network of providers and programs and recurring patterns of need, access, and utilization.

The process of building relationships among a network of committed and engaged stakeholders is an additional outcome of this research. As a tangible result, this report is submitted with recommendations for individuals who could and should play a role as this project moves forward.³ Their involvement will be based in part upon the credibility and trust that has been established through the research process, and the capacity of the research team to be effective in follow-up communication and engagement.

The findings presented here are necessarily partial. Westfield is home to a wide array of populations, stakeholders and providers, and the complex, historically situated, and constantly shifting terrain of healthcare need and provision makes it difficult to capture any fully accurate portrait of the healthcare environment. Time and budget constraints mean that not all potential informants were contacted and there is considerably more research and networking that could and should be done. Ideally the findings presented here establish foundations for that future work (see Appendix B for recommendations for further research).

III. TARGET POPULATIONS

Research targeted low-income families, children, and several special populations. The following descriptions summarize information gathered thus far.

1. NEW AND ESTABLISHED REFUGEES AND ETHNIC COMMUNITIES

NEPALESE

Ethnic Nepalese coming from camps in Nepal are the largest refugee group being resettled in Westfield, with 32 families currently residing in the city as of March 2012.⁴

³ Recommendations are provided in a contact spreadsheet attached to this report.

⁴ Ethnic Nepalese were forced to leave their homes in Bhutan beginning in 1990/91 and a majority fled to refugee camps in Nepal. After living in the camps since that time, resettlement to the US began in small numbers in 2008. Staff in Refugee and Immigrant Health in the MA Department of Public Health indicate that 50% of the ethnic Nepalese in the refugee camps remain to be resettled in sites throughout the United

Members of this population come from an agrarian background but through forced migration have lived in refugee camps since the early 1990s. Many Nepali adults arrive in the U.S. illiterate in their own language and the majority do not speak English. With no Nepali predecessors living in the region, Nepalese began arriving without established systems of support through churches or community organizations outside of resettlement agencies. Initially, they faced a complete vacuum of cultural, linguistic, social, environmental, and infrastructural familiarity, both for themselves in resettlement and among the providers whom they encountered early on.

Health status. New arrivals require basic immunization as well as screening and treatment for infectious disease (especially TB), typically have multiple acute and chronic health problems, all compounded by a history of poor nutrition and lack of dental care. Cultural acclimation to western medical measures for preventive care, treatment practices, and management and timeliness with medical appointments require is a huge adjustment. While providers note working with only a small handful of Nepali mental and behavioral health clients, the mental health challenges facing this displaced group are likely to be significant.

Resettlement services. Provision of basic resettlement services – screening for infectious disease, housing, employment, English language acquisition, enrollment and initiation of medical care-- are currently provided through the **Westfield Board of Health (BoH)**, **Lutheran Social Services (LSS)** and to a lesser extent **Jewish Family Services (JFS)**.⁵ State and local agencies often don't know who is being resettled and when until the last minute, leaving minimal time to make preparations for housing, jobs, and medical appointments and delaying access to health records. Responsible for providing screenings for infectious diseases, the BoH often sees clients for whom they have not yet received paperwork on health issues, making it difficult to assess broader health needs as they may or may not be related to infectious disease and treatment.

Approximately 2/3 of the nursing division resources are going to follow up for [Nepalese]. It takes a long time for a group to integrate to the health system here. This requires numerous phone calls and results in missed appointments, not filling prescriptions, not understanding why you take medicine when you feel okay (which requires extra teaching). Prevention does not seem to be a familiar concept to our new arrivals. Add to this the fact that it takes a long time to understand the culture of the group, which is crucial for compliance.
--Nurse

We have whole families that can't get to appointments. They start school late. Transportation is a real issue because they miss appointments. They are living a whole new life of deadlines with kids. I've never worked so much with school nurses before because other refugee groups had...families sponsoring other families with a point of contact, instead of coming here in a large group and going right into the system. --School employee

States, such that current rates of resettlement in Western MA and in Westfield in particular are likely to continue for several more years. At this time, Nepali families resettled in Westfield include 48 school-aged children, 10 disabled adults, and 8 elders. Lutheran Social Services, the primary agency resettling in Westfield, is expecting another 20 families in coming months. For information on the history of Nepali resettlement in the US (among many sources) see: <http://www.bhutanese-refugees.com/>.

⁵ LSS is resettling Nepalese through their main West Springfield office, but has expanded into Westfield because of access to housing and preference for resettling through family connections. Nepalese currently make up 85% of the Westfield LSS caseload. JFS serves refugees arriving primarily in Springfield (currently Iraqis, Nepalese, Burmese, Somalis, Rwandans and Eritreans) and West Springfield (Nepalese, Iraqis, and some Burmese).

There is general agreement that the time limits for provision of resettlement services are unrealistic given long waitlists to see PCPs (see below) and the challenges and extreme, ongoing need for basic assistance for this group.

Primary care. Nepalese are enrolled in Mass Health as part of their initial resettlement and obtain services through **Caring Health Center (CHC)**. After first and second appointments for immunization and physicals, clients have the option to choose their own PCP, but most Nepalese stay with CHC, the closest clinic providing consistent Nepali translation services. Westfield providers indicate that there are long waitlists and follow up care and case management is a persistent issue because, as one provider said, "It is nearly impossible to get an appointment at Caring Health." In order to address the complexities of Nepali care, CHC has a new refugee health coordinator who works closely with the BoH, LSS, and JFS to facilitate access to and follow up for treatment, resulting in noted improvements in the coordination of primary care, immunization, and TB treatment. Nonetheless, providers consistently cite ongoing challenges, delays, and problems coordinating care for this population.

Barriers. Nepalese face numerous interrelated cultural, environmental, and infrastructural barriers to accessing healthcare.

- **Translation.** While the school district includes staff available for translation, none of Westfield's primary care facilities offer this service. With the exception of visits to CHC, individuals generally rely on non-medically trained family members to translate for them during medical appointments and emergencies. Lack of access to translation on an impromptu basis means that Nepalese have difficulty accessing records to manage care for themselves and members of their families. This has a particular impact on children whose providers (PCPs, BoH and school nursing staff) can't access records to track treatment without parent permission.⁶
- **Transportation.** Nepali households typically include several working adults, and those who have vehicles use them to get to and from work. Access to vehicles for medical appointments is thus very limited. Busing is available but challenging when compounded with language barriers, time management issues, need for prompt arrival at appointments, difficulty getting time off from work, and the fact that getting to Springfield or West Springfield can involve confusing bus transfers. Providers typically describe clients getting lost and being late, though some indicate that clients are increasingly getting used to using the bus system.
- **Access to primary care appointments.** As noted, Nepalese and Westfield providers consistently describe difficulty getting appointments at CHC, indicating a level of need that exceeds available services and staffing.

⁶ These issues came to a head within the last year due to the case of a child who began attending school prior to completion of immunization. Since that time, the BoH, LSS and school staff have coordinated more closely to ensure that students don't begin attending school until documentation of immunization is provided. This has led to significant delays in school attendance for Nepali children, in some cases for as long as 2-3 months.

- **Access to dental care.** Most Nepalese have had limited or no dental care prior to their arrival in the States, have lived with poor health and nutrition, and have extreme need for dental care. Children can access dental care through Mass Health, but translation and transportation are significant barriers. Adult dental care is not covered through Mass Health and most families cannot afford the out-of-pocket cost of dental care.
- **Time management.** Nepalese have had to adjust to the need for prompt arrival at appointments. When critical appointments are missed and lost due to lateness, rescheduled appointments can be delayed for weeks or months, with significant implications for acute and chronic problems.
- **Coordination and wrap around care.** Nepali health needs call for closely coordinated wrap around care to ensure timely and safe treatment and follow up for multiple diagnoses and issues. While new staffing at CHC has led to improvements, language barriers, bureaucracy, and poor communication among providers is an ongoing challenge across the board, and after LSS resettlement processes, there is no system in place to facilitate wrap around services. Follow up and case management typically goes beyond both the purview and capacity of individual agencies (e.g. BoH, LSS, schools), with the result that individual staff often take it upon themselves to go beyond their official responsibilities to assist and track individuals. Providers know this is not a reliable, efficient, or sustainable structure and Nepali patients and family members talk of confusion, set backs, delays, and ongoing struggles to secure effective care.
- **Need for preventive medicine and nutrition.** Since Western approaches to preventive care and good nutrition are new to this population, there is considerable work to be done to educate patients. Providers report that when staff are available to do coordinated educational work, the results are very positive, but that generally there is not enough funding and staffing to support this need.

Westfield will continue to be a destination for new populations. We support the establishment of a health center because the biggest problem for resettlement in Westfield is the barrier to wrap around services. It's really hard to get comprehensive services integrated with WIC, substance abuse services, mental health services. So establishment of a health center would really change the dialog around refugee and immigrant resettlement in Westfield. --Refugee and immigrant health administrator

Assets. Nepalese are motivated to receive medical and dental care, even if acclimating to the healthcare system presents myriad challenges. They are navigating the bus system to access services and though the process of coordinating and access care is not smooth, typically they are eventually receiving care. Since Nepali resettlement in Westfield is contingent upon family ties, this is a tight knit community whose members who look after one another.⁷ Family members are involved in one another's healthcare, there are a handful of young adults with English language proficiency who are taking an active role in education, translation, and transportation to help their community,⁸ and adult leaders are organizing to pool resources. Within the last

⁷ Refugee resettlement is generally oriented towards locations with close proximity to basic services, but people are also resettled based on family ties. Westfield has limited housing and medical services but because of its growing community, Nepalese are being resettled there because they have family ties.

⁸ This research relied upon contributions from several young Nepalese who are working in the school district's English Language Learner program and at LSS. These individuals have become "go-to" people

year, Nepalese established the **Bhutanese Community of Western Massachusetts** as a 501(C)(3) organization to raise funds within the community to assist with funerals and city's first Nepali family purchased a home.⁹ Likewise, providers are responding to the need to coordinate care. CHC's new refugee coordination position is a case in point, as is the formation of a group of educators, providers, and members of the clergy working together to develop new systems of support and collaboration.

BURMESE, IRAQI, AFGHANI

Burmese, Iraqi, and Afghani refugees are currently being resettled in the region and while the numbers at this time are relatively small, they are expected to grow. Afghans have not begun resettling in Westfield, but Iraqis and Burmese have. Iraqi refugees make up 10% of LLS's current caseload in Westfield, with 4 families having been resettled in the last year. Providers describe members of this population as well educated, as exemplified by a former school principal who is now a paraprofessional in the Westfield elementary school her children attend. Burmese refugees make up 5% of LSS current caseload in Westfield. Further research is needed on health status, needs, access to and use of services among these populations and individuals in these groups have yet to be contacted.

RUSSIANS AND UKRANIANS

Russian and Ukrainian populations resettled in Westfield and West Springfield are a significant minority population but aside from preliminary information gathered thus far, more research is needed on health needs and access issues and individuals in this community have yet to be contacted.

Primary care. CHC provides primary care with translation for members of these populations, who also see a Russian speaking PCP in Springfield.

Health status. Children's healthcare providers report observing major dental issues among children due to a common family practice of providing honey and milk in bottles to infants and toddlers. Heart disease and diabetes are reported as common issues among elders in this population.

Language. Russian and Ukrainian students make up the largest ELL group in Westfield's elementary schools, with a concentrated population at Paper Mill Elementary. Though one provider suggested that translation was not a major barrier for these groups, provision of translation services is important in selection of care providers.

Religious and cultural community. Local Orthodox and Pentecostal religious communities and Russians already settled in the region provided essential support networks for newly arriving Russian refugees when they began coming to the area in the late 1980s and 1990s. These networks continue to provide structures of support and assistance within the community.

Outreach. From providers' perspectives, these communities are insular and members of these populations are difficult to integrate into ongoing services. For example, the Council on Aging

for Nepalese who need help getting to appointments, accessing care, and who require translation to receive care.

⁹ Nepalese are generally living in rental housing secured through LSS.

did not begin reaching out to Russian (and Ukrainian?) elders until they collaborated with a Russian LSS employee to provide English language classes on the Council's premises. While few elders involved showed up for other programs, they at least began to be familiar with the staff and some of the available programs, though further outreach and special activities would be required for broader participation. One Westfield provider indicated that domestic abuse is an issue in this population, but that despite efforts, it is unusual for Russian women to report incidents or seek services.

LATINOS

Latinos, mostly of Puerto Rican descent, make up 5% of the Westfield population and have been a presence in the city since the 1950s when families were drawn to the area for jobs in the agricultural industry. Core individuals in the Latino community have been identified but not yet interviewed so aside from some preliminary information, primary research on this group remains to be done.

Integration. Now in their 2nd, 3rd and 4th generation in the city, members of this community have established a **Westfield Spanish American Association**, are actively involved in local Catholic and Protestant churches, and are employed in key leadership positions within public, private, and municipal organizations and offices in Westfield.

Language. Particularly for elders, language remains a barrier to accessing services and while some organizations make translation services available, many others have yet to prioritize serving this community. Staff in the Council on Aging, indicate for example that because they do not have a Spanish speaking person on staff, they have made no inroads into serving Latino elders and still know very little about what their needs are. School nursing staff view teen pregnancy and poor nutrition as recurring issues for the youth that they serve.

Mental health and substance abuse is reported as an issue within this community, with clients accessing services at the Gandara Center in Springfield.

Transportation to access services is a barrier for many low-income families in the Latino community.

2. LOW INCOME FAMILIES

Accounts from providers across organizations point to a pattern of increasing economic hardship and healthcare need among low income families and the working poor, combined with decreases in available funding, staffing, and scope of healthcare services. Providers throughout the city--such as staff in Westfield's Free Clinic, the Salvation Army's Social Service Program, school nursing programs, and the Council on Aging--describe a complex array of variables influencing access to effective healthcare for this population.

People are still coming in uninsured. Insurance, is HUGE... It's not a long-term thing once you get someone on Mass Health because other things happen. People get a job and get private insurance, or they loose their job and have to reapply to Mass Health. If you're eligible for a Cobra than you can't get Mass Health so they have no health insurance. It's a huge issue without a simple answer but it impacts the healthcare of these people. --Nurse

A lot of the unnecessary ER visits are on the weekends when doctors' offices are closed, so that's where the needs are. They go in on the weekends and evenings because they need to see someone but can't take time off from work. --Nurse

Insurance Coverage. Despite the state's expanded provision of healthcare coverage, access to adequate health insurance remains a major issue. There is widespread assistance available to adults, families, seniors, and veterans to enroll in state healthcare programs, but navigating the system remains confusing (requiring entire staff positions to assist clients with the process) and coverage does not meet all needs. Programs offer limited cushion in enrollment, such that missed payments result in loss of coverage. The economic downturn has resulted in widespread instability in jobs and family income and families experience gaps in insurance as adults and parents lose jobs, transition from one job to another, or can't make payment. During gaps in coverage or in cases of only partial coverage, adults are more likely to forego costly healthcare in order to meet basic household needs. In this climate, unaddressed health problems are more likely to escalate into acute, debilitating, issues and costly ER visits. Given this overall lack of stability, having an insurance card doesn't mean you get the services that you need or that your health is improved.

Marginal employment. Economic hardship is compounded for those with marginal employment without flexibility or benefits. Adults in single parent households who don't have personal hours or sick time or who have used it up caring for other people have limited options for making it to appointments for themselves and their children. Working mothers, particularly those who have dealt with abusive partners or spouses, are particularly disadvantaged in this regard. They may well choose to put off appointments for themselves or save what limited sick time they have for when a child is sick. These constrained options limit utilization of healthcare resources.

There's not enough outreach to work with people in their homes – you have people without transportation. My clients are not middle to high class, they're lower to middle class. If one partner doesn't have a vehicle, maybe the other does. But if you have a domestic violence case, or drug use, if they don't have access to a vehicle, there's no way they can get the counseling they need. --Domestic violence advocate

Multiple diagnoses. Informant accounts point to the predominance of multiple diagnoses among low-income families and the working poor, for whom chronic disease is frequently combined with mental health and/or substance abuse issues. With limited access to wrap around services, time to get to appointments, and financial resources for any additional costs, effective treatment and follow up is difficult to achieve.

Transportation. Along with issues of coverage and insurability, transportation is a primary barrier in accessing care for this population.

3. SENIORS

There are 8,000 seniors aged 60 and over residing in Westfield, 23.8% of whom do not have a high school diploma. Heart disease, diabetes, and dementia are the most highly reported health concerns of this population, with the need for dental care being an additional and persistent area of need. For seniors on Mass Health who don't need translation, primary care is available locally, while those who need translation have to go to community health centers in Springfield, Holyoke, or Huntington. Additionally, approximately 25% of seniors in the city make use of Council on Aging services, which include 3 meals a day, weekly and monthly visits with a nurse, social events, workshops, an annual health fair, and assistance with taxes among many

other programs.¹⁰ The Council includes a SHINE staff member who provides assistance to seniors in accessing insurance coverage. Despite these services, barriers to accessing care are consistent with those of other groups.

Insurance coverage. Despite available assistance, navigating the healthcare system is a challenge for seniors. Many live on a fixed income, and if they don't qualify for Mass Health, they have limited flexibility to pay for insurance coverage and non-covered healthcare costs. Obtaining adequate coverage for prescription drugs and dental care is an ongoing area of difficulty, as is lack of coverage of costs for hearing aids and dentures. Providers express concern that the need to cover basic costs causes elders to forego purchasing medicine or obtaining needed treatment.

Transportation. For low and middle income seniors, transportation is a significant barrier limiting access to and utilization of services.

Accompaniment. Providers report on the need among elders without local family or with family who are not available to attend appointments to have people to accompany them to medical appointments to ensure and underscore comprehension of the information and instructions provided there.

4. VETERANS

Westfield is home to the largest veteran population in the region, the majority of whom are over 60. Westfield's Veterans Service department provides help accessing varied forms of assistance for both veterans and surviving spouses,¹¹ and those over 60 work with Council on Aging staff on insurance enrollment.¹² Enrollment is a persistent issue for seniors, and whether they are applying for insurance coverage, disability, or SSD, providers say that the system is confusing and fragmented. Much of the work performed by Veterans' Service staff involves accessing financial resources to augment existing health coverage. For instance, since Mass Health does not cover costs for dental care or dentures, staff members work with veterans to get these costs covered through other sources. If those efforts are not successful, veterans and their surviving spouses are left to cover costs themselves. Reports suggest that veterans' need for dental care is pronounced despite their access to sources beyond Mass Health. By contrast, primary care services are generally available and utilized.

Disabled veterans, of which there are some but not many in Westfield, are part of the VA health system and are able to access primary and dental care services through the Soldier's Home in Holyoke. Currently, only a small number of younger veterans access municipal Veterans' Services. They tend to need help bridging gaps in insurance and employment, but once they get on their feet, the Veterans' Service department knows little about them and their needs. This group is not showing up in significant numbers to address mental health issues.

¹⁰ A significant number in this group reside close to the Council offices and/or in nearby Housing Authority residences.

¹¹ Case loads in Westfield typically include a 50/50 balance between veterans and surviving spouses.

¹² 80% of the veterans who come through the Veterans' Service department work with Council on Aging staff to access state and veteran insurance coverage and funding.

5. HOMELESS

The homeless are a significant population in Westfield with pronounced need for housing, mental health, substance abuse treatment, dental care, and overall case management and follow through. Westfield is unique in providing a range of housing options for the homeless, which typically include access to on-site counseling and healthcare provided by visiting nurses. Providers throughout the city participate in an advisory group to provide a continuum of care across homeless needs, and thus reflect on area where concerted efforts to integrate services is underway. Specialized mental health treatment is an area of ongoing concern for providers. Those facing mental and behavioral health issues experience barriers accessing psychiatric care and medical treatment. The Carson Center, which provides a full spectrum of mental and behavioral health services, has limited numbers of staff psychiatrists and requires preliminary screening to determine need for this service. Homeless providers indicate that while they can bridge gaps in access to prescriptions, their concern is that their clients need on-going care and supervision by a psychiatrist. As limited new information was gathered to augment research conducted in 2010, readers are referred to the report on the first round of this health needs assessment for information about homeless healthcare services, needs, and access to care.¹³

6. WOMEN AND ADOLESCENT GIRLS

The spectrum of needs and barriers to primary, dental and mental healthcare experienced by low-income families – access to insurance, providers, transportation, translation, integrated care – applies disproportionately to women, working mothers, and single-women who are heads of households. Additionally, Westfield does not currently have providers of OB/GYN services for women and adolescent girls. The closest clinic is in West Springfield and transportation is reported as a recurring barrier for both women and adolescents. Free Clinic staff report seeing women in need of mammograms and acknowledge that this service is not locally available for those who are not on Mass Health or who don't have insurance coverage. The demands of tending to and managing their own and their children's healthcare are pronounced, meaning that acute issues get dealt with, but chronic problems, mental health, and treatment for domestic and substance abuse may not be a priority.

I have a woman I've been working with who has issues with drinking and domestic violence. We got a restraining order against the father. She was dependent on him because she didn't work. So of course she goes back. The children are exposed to the violence until she leaves. He goes to jail for 6 months and she's left with her child with him and another child with someone who pays child support. She had a job, loses her job because she's spending too much time out since there's no one to watch the kids. For the last two years she's been bouncing in and out of jobs. She hasn't had an opportunity to even address getting strong and she's still not done because he's taking her to court for visitation. There is no community-based service for her to go to to address all of the issues she's dealing with.
--Domestic violence advocate

Domestic abuse, particularly as it is couples with substance abuse, is a recurring issue in this research. 85% of domestic abuse cases seen in Westfield involve substance abuse by abusers, victims or both. In addition to New Beginnings, a Westfield women's shelter, the city is fortunate to have a committed domestic violence specialist on its policing staff who works closely with victims to access resources, treatment, and legal recourse. This provider observes

¹³ See Jessica Payne Consulting, *Holyoke Health Center/Westfield REACH Health Needs Assessment Report*, July 2010.

troubling fragmentation and lack of sufficient services for victims of domestic abuse, especially women with children and/or women with mental and substance abuse issues. Changes in the structure and provision of services and reductions in programming and staffing mean that basic services are increasingly difficult to access. Women seeking protected housing for themselves and their children have limited options (that typically require that they leave the area and take their children out of school), and those who also seek substance abuse treatment and sober housing have even fewer options. Transportation is a major barrier for many women seeking treatment. The multiple challenges women face in obtaining care and treatment for domestic abuse, let alone getting care for dual diagnoses, leave them vulnerable to either getting frustrated and discontinuing care/ treatment, or simply returning to their abusers and to abusing substances themselves.

Significantly, as a key informant on this issue observed, Westfield has yet to establish a men's group to engage domestic abuse issues: "They have to go to Springfield or Northampton for that and most of these men have no interest in anything like that."

The problem lies with health insurance. A lot of the people I deal with are not married and collecting welfare or disability in their relationships. When they split with their partners, who might have the insurance, do they have the right insurance that they need to access mental health counseling for themselves and their children? --Domestic violence advocate

7. HOUSING

The need for subsidized housing in Westfield far exceeds available housing stock. The waitlist for those who have applied and been approved for housing typically includes 1000 individuals. Further research remains to be done on housing access, Housing Authority programs, and the health needs of those residing in subsidized housing. Overall however, information on low-income families is likely to apply to this group.

IV. HEALTHCARE NEEDS

1. PRIMARY PEDIATRIC AND ADULT CARE

Westfield providers cite heart disease, diabetes, respiratory issues, digestive issues, and hepatitis as the most frequently observed chronic health issues for adults, along with ongoing mental health and substance abuse problems (see below). Respiratory health, nutrition, and mental and behavioral and learning issues as the most frequently observed issues among children. Family-based child and adult care is available through several local clinics that take Mass Health, but access to translation and coordination of care among providers are consistent barriers.¹⁴

Despite this access, the barriers to primary treatment

We still have diabetic patients coming to the Free Clinic who haven't gotten to Noble's new diabetic education program because they don't have insurance. We've tried to refer them but we haven't gotten anyone in. It's an insurance issue and also the meeting time is in the morning and there are few low-income people who can take time off from work to go to a meeting. Diabetes treatment is not as bad as it was but it's still a big issue. --Free Clinic nurse

¹⁴ For more on this topic, see demographic data compiled by HHC.

among low income populations and the working poor are significant enough that providers see the need for improved access to insurance, treatment, and coordinated wrap around services to address residents' myriad and typically layered needs.

2. DENTAL HEALTH

The need for dental care is reported as one of the biggest health issues for people in all groups and populations in Westfield. For children, youth, adults, and seniors, this involves regular, routine cleanings and treatment, followed by varying but persistent need for root canals, dentures, and other more involved treatment.

Access and insurance. Westfield is home to several dental health providers but none of them take Mass Health, and families typically travel to West Springfield, Holyoke and Springfield for dental care.¹⁵ The Westfield School District has an on-going

contract with **Tufts' Best Oral Health** to provide mobile dental services to all children connected to Head Start (now under new management), four of its elementary schools and one of its middle schools. Through this service, children can access regular, routine oral exams and treatment. Families with private insurance with dental coverage can access any number of dental clinics in Westfield and nearby cities and towns. Providers note, however, that a majority of families with private insurance don't have dental coverage and can't afford the pay dental costs, particularly during the current economic downturn. As a result, they observe a high need for this care among children and adults. Seniors and veterans face similar challenges. Those on Mass Health can access services if they have transportation, but their coverage does not include dentures or root canals, for which they have consistent need. Those with insurance but no dental coverage are often in the position of having to choose between needs and providers indicate that dental care is often not prioritized (over food or medication, for example).

There are enough dentists for kids with Mass Health to see. It's the people with private insurance and no dental coverage and they can't afford it. That's a big issue that we see with our kids.
--School nurse

We had the mobile unit through Tufts. Dr. Susana Aguero [St. Joseph Family Dental, West Springfield] was my dental consultant. If I had a child in the mobile program and there's an emergency situation, what's that family going to do if they don't have a dental home? I had it set up so that they could go to Suzanne if there was an emergency. I used the program for the families that I thought would have a hard time getting services in the community – that they wouldn't go get the services, or had transportation or translation issues. But I thought I had the best of both worlds because my kids were getting the opportunity to have a dentist in the school to examine, treat and provide preventative services three times a year. Those kids got a great opportunity. Where another child who goes to Small Smiles will get an exam and then get treatment at another time, my kids had everything done and if they were in our program for 2 or 3 years, they saw a dentist more than another kid going to an office. And the parents didn't have to take time off from work; it was right in the school setting. This program was really great. But that's because we had the local connections and the follow through. I've had families who go to the local dentist, but the families don't necessary continue with dental treatments.
--School Nurse

¹⁵ Sources mentioned that family go to Cool Smiles and Small Smiles, both in Holyoke and Springfield. In January and February 2012 when this research was conducted, no informants were aware that Holyoke Health Center's newly established dental clinic at Western Mass. Hospital was open and offering services.

Barriers. The primary barrier to accessing dental care is access to dental insurance coverage, without which a majority of families with children and adults chose to forego dental care. Lack of transportation and available time away from work to make appointments for self and children are also significant barriers. Lack of coverage for dentures is a major barrier for elders, including veterans. As a special population of note, youth in Westfield's DYS facility have access to comprehensive inpatient medical treatment as well as routine dental care, but if they need more extensive dental care, coordinators run into barriers accessing dental providers willing to treat high security patients in handcuffs and shackles.

3. MENTAL AND BEHAVIORAL HEALTH

All accounts concur that mental and behavioral health is a huge area of need in Westfield. Mass Health clients can also access mental healthcare and treatment through Bay State, though transportation to Springfield is a persistent barrier. The Carson Center is the primary local organization serving low-income

populations through an array of inpatient, outpatient, and emergency treatment programs available to adults and children on Mass Health.¹⁶ Carson Center staff describe a variety of available services that meet community needs. By contract, providers who collaborate in ongoing ways with Carson describe effective

treatment but not enough access due to long waitlists. Regular changes in mental health provisions, coverage and staffing mean that non-mental health professionals themselves find it difficult to navigate the system, identify point people, and obtain prompt responses and appointments. Mental health needs and available care have only been partially addressed through this research, but a recurring set of themes emerge from even provisional research.

A large percentage of our patients have mental health issues. They present with one issue but underlying it is often depression or anxiety. We refer to them to the Carson Center. And that takes forever. You can wait up to 3 months to see a psychiatrist. One night I was working and a doctor was there and he said, "Wow, we actually had medical issues tonight." There are so many mental health issues that it was unusual to be treating straight medical issues. So when you hear that you know that there are a lot of mental health issues coming in. --Free Clinic nurse

We see people on psychiatric meds who have moved to the area or lost insurance, and they've run out of their meds. We can't follow them and they need someone long term. The Carson Center has a long wait list. We might provide meds once but we can't do that because they need to be under someone's care. --Nurse

We have a process that delays access to psychiatry services deliberately. Jumping into medication isn't necessary the best way to go with behavioral health interventions. We require that a person goes through a psycho-social assessment with a psychologist or counselor and make a try at therapy. It's generally preferred to get benefits from therapy rather than jumping into medication. There's lots of pressure on docs to prescribe, especially with children. We make efforts to delay that. We go through our process for people to determine whether a medical evaluation is appropriate. We see it as a good treatment planning issue rather than an access issue. --Mental health provider

¹⁶ Noble Hospital contracts with Carson for provision of emergency psychiatric treatment, and the Center works closely with staff throughout most organizations in the city.

Access. The current economic climate of cuts in mental health funding and services and reductions in family income have increased barriers to mental health treatment. The environmental factors of financial stability, job security, family infrastructure, and available supports and assistance have compounded impact on access to and use of, mental healthcare. Private counseling is available but prohibitive in cost and not generally accessed by low-income adults and families. Families experiencing lapses in insurance coverage or who don't qualify for Mass Health are challenged to find affordable mental health care. Program funding cuts and space limitations mean that those requiring inpatient care are often faced with long waits to access hospital-based and residential treatment. While mental health practices strive to adjust to changing populations in Westfield, transportation, translation, and cultural stigma remain dominant barriers for many people needing treatment. And from the perspective of mental health practitioners, available reimbursements for psychiatrists and other specialists simply don't cover basic costs.

Our biggest barrier, for mental outpatient services in particular, is that like others, we're struggling to stay alive because funding that used to come through state funding lines no longer comes to outpatient clinics. We have to make it on our own based on third party reimbursements and our clinics have been losing money for the last 2-3 years since we no longer have those other funding streams in outpatient services... Reimbursement rates for psychiatry services are completely inadequate. We have to provide that service but we are always losing money because we cannot cover basic hiring costs. Other outpatient rates are too low. We have increased productivity expectations with our staff over the years, but the rates have not kept up. There are new services being funded, but the established services are not at appropriate rates. The situation is not sustainable. --Mental health provider

*The most common reason people have a delay in getting in to see a mental health provider is that...there are not enough evening appointments for children and families. We don't turn people away and we rarely have long wait lists. But sometimes we've had periods of being down on child providers. If we could hire more people to provide children's outpatient services in the evenings, we'd be thrilled. But there is too small a pool of child-trained clinicians. This is not a confined, contained behavioral health issue because most family issues are really complex and there aren't a lot of clinicians jumping into this.
--Mental health provider*

Pediatric treatment. Pediatric mental health is available through the Carson Center. The closest inpatient pediatric residential treatment is at Baystate, where need generally exceeds available space, resulting in long waits that limit access. An observed shortage of pediatric clinicians, and especially pediatric psychiatrists exists resulting in waits for appointments and a perceived limitation in access to services. This shortage is tied to the small pool of available clinicians qualified and interested to treat the range of complex and often dual or multiple diagnoses showing up among children. For some clinicians and administrators, increased

*We're dealing with several barriers in pediatric mental health. With funding cuts there are fewer human service programs across the state at state and community organizations. There are not enough child psychiatrists to go around. We run into situations where kids need outpatient psychiatry or therapy and there are month long waitlists. And since our clients are on the low end of the economic scale, there are real financial barriers, as well as lack of services in housing and other physical necessities that impact care.
--Mental health provider*

regulations on certification, record keeping and reporting for pediatric treatment are a disincentive for treating Mass Health patients. Private practices that take Mass Health find it increasingly difficult to sustain this service from a financial and staffing perspective.

Mass Health's relatively new Child Behavioral Health Initiative (CBHI) is being implemented through the Carson Center. CBHI is a family-oriented, community and outreach-based preventive program for the treatment of children with mental and behavioral diagnoses. Mental health providers coordinate treatment with families, providers, and other support networks. Further research to track CBHI program outcomes with regard to treatment and the collaboration among families and providers would be valuable as a model for future community-based healthcare provision.

4. ADDICTION

Addiction and substance abuse, while not a topic of focus for this preliminary stage of planning and research, emerged throughout this study as providers discussed school-based healthcare, domestic abuse, mental health needs, homeless healthcare, and access issues for low-income individuals and families. Accounts indicate that addiction is a widespread primary healthcare issue, as well as an underlying variable in a multitude of health and health related problems. Treatment is available through the Carson Center and in organizations providing service to the homeless, though further research is needed to determine the type and scope of programs available within the city. Access to local and regional detox programs is reportedly limited by available space ("beds"), with particular constraints for families, especially women seeking sober houses for themselves and their children. According to providers, lack of access to these services has huge repercussions for continued addiction.

*We have a huge addiction problem in Westfield. A lot of my clients are addicted to alcohol, heroin, and prescription drugs. **And unless you're suicidal you can't get treatment.** Getting a bed for detox is really difficult. McGee in Westfield medical center used to be a top detox center, but they no longer take Hampden County residents due to funding cuts. [The site in] Worcester only takes Mass Health. If you're in a crisis situation, you go to Noble hospital and talk to crisis, but by the time they intervene you're out of the crisis and frustrated [because if you don't have Mass Health] you can't access their services.
-- Domestic violence advocate*

5. COORDINATED CARE

As noted throughout this report, coordination of care and follow up care is a persistent area of concern for providers relating to primary care as it interfaces with other forms of treatment discussed here (e.g. mental health, treatment for infectious disease, etc.). With reductions in staffing and concurrent increases in demand for services, healthcare professionals and patients navigate a fragmented system. Providers consistently describe poor communication, inefficiencies, and potentially dangerous oversights as multiple providers attempt to provide care, particularly for patients with multiple diagnoses.

*Improvement is needed in coordinating care among patients. The following have occurred in the past year at least once: 1) Repetition of service: Two providers sending a patient for the same lab work; 2) Patients not going to appropriate service location: Should see PCP vs. ED; 3) Dangerous interactions/gaps in service: Two providers ordering different medications that interact and neither is aware of the other.
--Nurse*

While formal structures for coordination and communication are often non-existent or ineffective, informal structures in these areas exist in abundance. To augment limitations in their own staffing and program capacities, providers typically draw upon their relations with other providers to coordinate care and connect patients with needed resources. These informal, impromptu collaborations occur based upon immediate need and are built upon shared knowledge and experience and reciprocal trust. A domestic violence officer will contact staff in the Salvation Army's social service division to access funds for clothing or a bus trip out of town, or a school nurse will coordinate with a nurse in the BoH to address a family crisis. Reliance on informal personal and professional networks is Westfield's version of a non-programmatic, non-institutionalized "wrap around" service, since no actual formal wrap around services exist.¹⁷

The process of drawing providers together to provide a 'continuum of care' for particular populations of need is underway in some sectors and typically involves a recurring host of professionals. The school district has created a **Coordinated Health Advisory Council (CSHAC)** to draw together professionals serving school-aged children, while the district ELL director now facilitates a group of providers and members of the clergy serving the Nepalese community. A task force of people working to provide services to the homeless has been in operation for some time and is now meeting monthly through the facilitation of staff at **Domus, Inc**, Westfield's premier agency developing homeless housing. These activities reflect a community-based, collaborative ethos among providers on the front lines. These collaborative endeavors, as well as the informal 'wrap around' networking discussed above are significant resources to draw upon for the formation of community health care services.

For over a year I've been fighting for this very thing to happen and what's scary to me is that I'm the health department and I had no idea that this [planning grant for a community health center was] happening... Communication systems and networking is not very effective. You want to have a handle on what's going on in your community but you have to take care of immediate emergency health issues of public safety. I'd like to do more collaboration and be more on top of what's happening out there. --Nurse

V. HEALTHCARE BARRIERS

While patterns vary across populations and areas of healthcare, the key barriers to healthcare for low-income families and individuals discussed thus far in this report include the following:

- Economic hardship coupled with marginal employment without flexibility or benefits
- Funding cutbacks for services coupled with increased demand
- Access and coordination of services for multiple diagnoses
- Access to and navigation of system for insurance coverage
- Insurance coverage for adult dental care

¹⁷ As one exception, see comments regarding Carson Center's CBHI program, which attempts to generate a collaborative approach to pediatric mental health.

- Transportation
- Translation
- Access to primary care, mental health, and dental providers who take Mass Health
- Communication and coordination among providers
- Follow up care and case management
- Access to care during evenings and weekends
- Lack of cultural practices and education supporting preventive health
- Poor nutrition

VI. HEALTHCARE ASSETS

While healthcare needs exceed available services in Westfield, there are essential assets of the city that will drive future development of healthcare there.

Commitment and Coordination Among Providers. Westfield's existing primary care facilities, Noble Hospital, the Westfield Free Clinic, the Carson Center, Highland Valley Services, the Council on Aging, the Salvation Army social service program, Samaritan Inn, Domus, Inc., LSS, members of the clergy, the amazing host of committed school-based health and language education practitioners, and countless other organizations and staff members are a solid bedrock for future development. Some accounts suggest that collaboration between providers can be strained (e.g. for instance between CBHI staff, doctors, and family members; or between primary care providers and mental health practitioners), but the vast majority of providers convey an ethos of mutual respect, commitment to care, and an investment in working together and sharing resources. In some pockets, particularly in care for the homeless, a continuum of care exists that is a model to be drawn upon for treatment in other areas. The relationships that drive collaboration are an immeasurable resource.

Enrollment assistance. Although navigation of Mass Health, and the healthcare system overall is difficult and confusing for the vast majority, the services Westfield organizations provide to guide patients through enrollment are numerous and impressive. The Council on Aging, Noble Hospital, the schools, the Free Clinic, LSS, the office of Veterans Services, to name a few organizations, all help their constituents to enroll in Mass Health and to access other coverage for which they may be eligible.

VII. CONCLUSIONS

The city of Westfield boasts an array of primary care practitioners, and private, municipal and state-based programs and organizations to meet the array of needs of a broad and increasingly diverse population. To varied degrees, providers across the city are aware of and seeking to adjust services to meet the needs of Latinos, Russians, Ukrainians, Nepali refugees and an emerging group of refugees from the Middle East. With the current economic downturn, the

city's largest growing 'special population' is its low-income, working poor and lower-income middle class population, for whom access to and use of services is increasingly strained.

The most important variables conditioning Westfield's healthcare environment and its areas of greatest healthcare need are the following:

- Current healthcare resources and services are substantial but due to reductions in program capacity associated with rising program costs and tightened budgets and staffing, current services are not sufficient to meet the range and depth of need across age and cultural groups.
- Access to Mass Health providers for primary, dental, and mental healthcare is limited relative to levels of need. Due to the need to travel outside of Westfield for care, transportation is a key barrier to healthcare provision.
- Navigating the systems to obtain and retain adequate insurance coverage is reportedly the greatest barrier to healthcare provision for patients across age groups, despite significant assistance being provided for enrollment. Insurance enrollment and management requires constant work and maintenance for patients and providers, with negative impact on access to and utilization of services.
- For a growing sector of the population, instability in income, jobs, and family infrastructure and resources is making the process of accessing adequate health insurance more difficult and more complex, and is leading to more heightened, inter-related physical, mental, and behavioral health issues that require integrated, coordinated, care for multiple (e.g. more than dual!) diagnoses.
- Although individual agencies offer coordinated and integrated services for some populations, there is an overall lack of coordinated, wrap-around services or a 'medical home' to address multiple health issues.
- The engagement of skilled practitioners with a capacity for trust, cooperation, and collaboration is one of Westfield's greatest healthcare assets.
- Seeing the level and degree of need, individual staff regularly draw upon their professional connections with providers in the region to connect clients to needed resources outside formal infrastructures or established pathways for care. Resulting collaborations leads to shared resources and decrease chances that patients will fall through the cracks. However, this informal, relation-based process takes time and resources that go beyond staff and program capacity and is not a sustainable means to coordinate care.
- With the exception of the school district, most agencies and practices do not have the breadth of capacity to provide the level of translation services needed to improve access, facilitate outreach, and meet the actual needs of non-English speaking residents.
- For low income populations, treatment of chronic disease, dental health, and mental health are the areas of greatest healthcare need, with treatment for addiction being a frequent additional factor.
- From the perspective of gender, male and female children, seniors, and veterans and their spouses experience similar levels of need. By contrast, in the current economic environment in which the low-income and working poor confront challenges on all fronts (e.g. jobs, housing, food, health, education), compared to men, young to middle aged women with children are disproportionately disadvantaged in accessing coverage, care, and follow up for their multiple areas of need (e.g. OB/GYN services, basic primary care, mental health, and treatment for substance abuse).

For the most part, low-income residents of Westfield experience a fragmented, confusing healthcare system which meets some of their needs, but is not set up to be comprehensive, coordinated, or easily accessible with regard to insurance, location, and language access. The strong relationships that exist between providers – including formalized contracts for services as well as informal professional connections---and that lead to collaboration and cooperative problem solving are a huge resource to be drawn upon to expand access to services. But they are not enough to meet the range and depth of need experienced by people in this community.

APPENDIX A: CONTACT LIST

PROVIDERS AND STAKEHOLDERS CONTACTED

Westfield Executive and Administrative offices

Lisa McMahon. Executive Director Westfield Business Improvement District
Hilda Colon. Personnel Department, City of Westfield
Deb Mulvenna. Supervising Public Health Nurse, Westfield Board of Health
Tina Gorman. Director, Westfield Council on Aging
Karen Noblit. SHINE, Senior Health Advisor Westfield Council on Aging
Fran Aguda. Companion Program Coordinator Westfield Council on Aging
Jennifer Pappas, nurse (also works part time at Noble)
Bob Callahan. Veteran's Agent, Westfield Veterans Service Office

Westfield Public Schools

Sally Popoli. Lead Nurse, Westfield School District
Gail Szatrowski. Unified Life Education Supervisor, Westfield School District
Barbara Lavoie. Nurse, Westfield High School
Karen Chaoush. Nurse, Westfield High School
Teresa A. Benedetti, Ph.D. District ELL Coordinator, Highland Elementary School
Maureen Vosburgh, Health and Nutrition Services

Westfield Free Clinic

Connie Kelly. Volunteer Nurse, Westfield Free Clinic

Mental Health Services

Kathy Damon. Director, Carson Center
Dennis Manley. Community Service Agency Coordinator, Carson Center

Housing and Homeless Providers

Daniel Kelly. Executive Director, Westfield Housing Authority
Karen Casey. State Program Administrator, Westfield Housing Authority
Ann Lentini. Director, Domus, Inc

Domestic Violence Services

Donna Suckow. Domestic Violence Officer, Westfield Police Dept.

Department of Youth Services

Dan Green. Nurse and Clinical Coordinator, Westfield Youth Service Center

Immigrant and Refugee Resettlement

Lily Pantus. Caseworker, Lutheran Social Services
Bandhu Adhikari. Employment Counselor, Lutheran Social Services
Mohamed Mohamed. New American Program Director, Jewish Family Services
Harith Mohammed. Refugee Medical Case Manger, Jewish Family Services
Jennifer Cochrane. Director, DPH Refugee and Immigrant Health Program
Sergut Wolde-Yohannes. Coordinator of Direct Client Services, DPH Refugee and Immigrant Health Program

Churches and religious leaders/organizations

Gail LaGasse. Director, Social Service Center, Salvation Army
Luz Rodriquez. Social Service Center, Salvation Army

PROVIDERS AND STAKEHOLDERS TO BE CONTACTED

Westfield Executive and Administrative offices

Daniel Knapik. Mayor
Jeff Daley. Chief Advancement Officer
Lisa McMahon. Executive Director, Westfield Business Improvement District
Hilda Colon. Personnel Department, City of Westfield
Lynn Boscher. Executive Director, Greater Westfield Chamber of Commerce

Noble Hospital

Stan Strzempko. MD, Medical Director, Noble Hospital
Brian Sutton. MD. Noble Hospital, Westfield Free Clinic
David Mol. Executive Director of Noble Visiting Nurse and Hospice
Sandra Picard. Director of Case Management, Noble Hospital

Westfield Public Schools

Sheila Conroy. Title I
Barbara Lavoie. Nurse, Westfield High School
Karen Chaoush. Nurse, Westfield High School
Maureen Wroblewski. Nurse, Westfield Vocational
Laura Chernosky. Nurse, Highland Elementary School
Catherine Tansey. Adjustment Counselor, Westfield Schools
Carrie Fiordalice. Adjustment counselor, Westfield High School
Dale Lapoint. Family service coordinator, Head Start
Bob Gagnon. Director of Early Intervention, Westfield Infant Toddler Program.
Joe Barako. Applied Health Teacher, Westfield Vocational
Maureen Billargeon. Applied Health Teacher, Westfield Vocational

Barbara Trant. Head of Volunteers in Public Schools (VIPS)
Colleen Bean. Family Service Worker, Head Start W. Springfield.

Mental Health Services

Susan West. Incoming CEO, Carson Center
Alison Cook. Director of adult programs, Carson Center
Linda Reis. Program Manager, Westfield children's services, Carson Center.
Robin Gottardi. CBHI Family partner, Carson Center
Mary Lou Lusa. Clinical Director, West Central Family Counseling

Housing

Daniel Kelly. Executive Director, Housing Authority

Homeless Providers

Jen Luca. Counselor, Samaritan Inn.
Judy Mealy. Healthcare for the Homeless Nurse
Westfield Food Pantry

Domestic Violence Services

Delia Liquori. Domestic Violence Specialist, New Beginnings
Brenda. Domestic Violence Specialist, New Beginnings

Elder Services

John Lutz. Director, Highland Valley Services
Nancy Maynard. Director of Home Care, Highland Valley Services
Heather Cahillane. Community Development Program Director, Highland Valley Services
Laurie Cassidy. Director, W. Springfield Council on Aging

Immigrant and Refugee Communities

Bandhu Adhikari. Employment Counselor, LSS
Olga Vashenko. Caseworker, LSS works especially with Soviet seniors.
Mohammad Najib. Case Worker Coordinator, LSS West Springfield
Hari Ghorshai. Founder, Director Bhutanese Community of Western MA
Hari Khanal. Founder, Director Bhutanese Community of Western MA
Chhatra Basnet. Nepalese translator and transition assistant, Westfield School District
Narapati Kafley. Nepalese transition assistant, Westfield School District
Sahar Achmed. Iraqi paraprofessional, Highland Elementary
Westfield Spanish American Association
Agma Sweeney. City Counselor, on John Olver's staff
Leida Sanabria. Community Action
Raymond Diaz.
Pedro Rivera. Deacon at St Mary's (only Catholic parish with Spanish mass)
Isabel Castro. Manager, MCS

Ana Nunez. RN in Noble Oncology
Captain Nunez. Police officer

Churches and religious leaders/organizations

Valarie Roberts-Toler. Reverend, First United Methodist
Pastor Wally.
Elva Merry Pawle. Reverend, First Congregational Church of Westfield
New Life Christian Center Assembly of God
Gene Pelkey. Pastor, First United Pentecostal Church
Brian McGrath. St. Mary's Parish
Gail LaGasse. Social Service Center, Salvation Army
Luz Rodriquez. Social Service Center, Salvation Army

Other Organizations

Richard A. Ochs, Jr. President, Westfield Community Development Cooperation
Kiwanis Club of Westfield
Christopher Lindquist. Director, Westfield Athenaeum
Evan Dobbelle. President, Westfield State University
Richard Rubin. Executive Director, American Red Cross of Greater Westfield
William Parks. Executive Director, Boys and Girls Club of Greater Westfield
Gregg Thompson. Executive Director, YMCA Greater Westfield
Janice Mitchell. Child and Family Services of Western Massachusetts
Dena Hall. VP Marketing & Community Relations, United Bank

APPENDIX B: RECOMMENDATIONS FOR FURTHER RESEARCH & NETWORKING

The following are recommended as areas for future research and networking based upon work completed to date and contacts and topics that have yet to be sufficiently covered.

Cultural Groups

- **Nepalese:** interview community leaders and main Nepali resource people; Bhutanese Community of Western Mass; gather information on employment and housing; more information on mental health, translation services, TB treatment, and chronic disease.
- **Iraqi, Afghani, and Burmese refugees:** comprehensive health information and contacts needed for all three groups.
- **Latinos:** comprehensive health information and contacts needed; Westfield Spanish American Association; church affiliations and activities; new populations; community leaders.
- **Russian and Ukrainian:** comprehensive health information and community contacts needed; religious affiliations and activities; insurability; cultural barriers; utilization of dental services; translation and English language acquisition.
- **Women and adolescent girls:** more information needed from women/adolescents about health issues and where they are accessing services; more information is needed on domestic abuse, women's shelters, and access to dual diagnosis treatment tied to domestic abuse and substance abuse.
- **Seniors:** more information on Highland Valley services and other resources for elders.
- **Homeless:** more information on health services, counseling, and continuum of care.

Geographic, transportation and education factors

- **Land mass:** substantiate health implications of having largest land mass for a town in the state (transportation?).
- **Transportation:** More information needed on how people are getting to West Springfield and Springfield; vehicle ownership vs. use of public transportation.
- **Poverty and education:** closer assessment of populations tied to particular schools as this relates to health issues seen by nurses; interviews with more school nurses and transition assistants/translators.

Health and Related Services

- **Translation:** where are services available.
- **Free Clinic:** obtain data on health needs and services.
- **Insurability:** more information on who is getting enrolled; circumstances in which people are de-enrolled or lose coverage; implications and measures taken with gaps in insurance; variations among cultural and economic groups. More information on who has private insurance and the type of coverage they have.
- **Acute care:** more information on emergency care programs; patterns of ER use based upon health needs, time of service, cultural and economic groups, dual diagnoses, referrals, follow up.
- **Pediatric and adult primary care:** contact local providers about who they see, and how they interface with area organizations and providers.
- **Mental health:** interview additional Carson Center staff and providers at West Central Family Counseling and Noble Hospital; more information on inpatient and outpatient services, home visits, dual diagnoses; pediatric treatment.

- **Substance abuse services:** need contacts and more information on available services.
- **Housing:** more contacts and information needed on programs, access, collaboration with other organizations (Highland Valley).