

Community Health Needs Assessment

2016

Prepared for

Cooley Dickinson Health Care

Adopted by: Cooley Dickinson Healthy Communities Committee September, 2016

By

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



**Partners for a Healthier
Community, Inc.**



Collaborative for Educational Services
Everyone is a learner



Consultant Team

Lead Consultant

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

Consultants

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

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

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Executive Summary

Introduction and Methods

Cooley Dickinson Health Care (CDHC), a Massachusetts General Hospital Affiliate, includes an acute care community hospital that offers medical/surgical, orthopedic, obstetric/gynecologic, psychiatric, geriatric, palliative, emergency, ambulatory, diagnostic, and rehabilitation services; Cooley Dickinson VNA & Hospice, which provides home health and hospice nursing and rehabilitation visits; and Cooley Dickinson Medical Group, comprised of primary and specialty care physicians, nurse practitioners, nurse-midwives, and other providers. CDHC serves Hampshire and Southern Franklin County residents in the Five College region of the Pioneer Valley.

CDHC is a member of the Coalition of Western MA Hospitals (“the Coalition”) a partnership between ten non-profit hospitals and insurers in the region. The Coalition formed in 2012 to bring hospitals in Western Massachusetts together to share resources and work in partnership to conduct their community health needs assessments (CHNA) and address regional needs. In 2013, CDHC conducted three focus groups and 13 key informant interviews in order to update their 2011 CHNA. For the 2016 CHNA, CDHC worked in collaboration with the Coalition to conduct the assessment. The assessment was conducted to update the findings of CDHC’s CHNA so that CDHC can better understand the health needs of the communities it serves and to meet its fiduciary requirement as a tax-exempt hospital.

The assessment focuses on communities in Hampshire and Franklin Counties, the primary service area of CDHC. When identifying the health needs that can be addressed to improve the health of the population, the assessment used the social and economic determinants of health framework since it is recognized that these factors contribute substantially to population health. The prioritized health needs identified in the CHNA include community level social and economic determinants that impact health, barriers to accessing quality health care, and specific health conditions and behaviors within the population. The assessment included analysis and synthesis of 1) a variety of social, economic and health data; 2) findings from recent community assessment reports; and 3) information from nine focus groups and 17 key informant interviews some of which were conducted specifically for CDHC, and others which were conducted by other Coalition members and were relevant to this CHNA. Vulnerable populations were identified using a health equity framework with available data. Information from this CHNA will be used to inform the updating of CDHC’s community health improvement strategies and to inform the Coalition’s regional efforts to improve health.

Findings

Below is a summary of the prioritized community health needs identified in the 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 CDHC's 2011 CHNA and continue to impact the health of the population in the CDHC service area. Social, economic, and community level needs identified in this CHNA include:

- **Lack of resources to meet basic needs** – The CDHC service area has higher rates of *poverty* than the state, with the highest rates found in Amherst and Northampton. Twenty-six percent of children living in the CDHC service area qualify for free or reduced lunch. Although the median family *income* in Hampshire County is comparable to the state, a number of communities fall below this amount. The lowest median family incomes were found in parts of Northampton and Easthampton. In the communities of Easthampton and Northampton, 8% of eligible individuals do not have a high school diploma which contributes to unemployment and the ability to earn a livable wage.
- **Housing needs** – A lack of *affordable housing* is a need that impacts CDHC service area residents. Over a third of the population in CDH's service area is housing cost burdened. *Homelessness* also impacts the health of residents in Western Massachusetts, and some individuals in the CDHC service area. Increased services for homeless individuals were identified as a need. *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.
- **Transportation** - Regional and local public health officials interviewed for the 2016 CHNA identified an overall need for increased transportation options for the region. Individuals who do not own a vehicle face difficulties accessing educational and employment options or participating in community-based programs that promote health, such as exercise and nutrition programs, or other activities that promote social connection. Among households with vehicles, those with limited resources struggle to maintain and utilize their vehicles.
- **Food insecurity and food deserts** – *Food insecurity* impacts the ability of many CDHC service area residents to access food overall, including food to promotes good health. Portions of Amherst, Northampton, Easthampton, and South Hadley have rates of food insecurity greater than 15%. In addition, parts of Northampton and Amherst are also considered *food deserts*, which are areas where low-income people have limited access to grocery stores.

Barriers to Accessing Quality Health Care

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

- **Limited availability of providers** – Select locations and populations within the CDHC service area were identified as health care professional shortage areas. Key informant interviewees identified the need for increased mental health and substance use providers and treatment programs, increased health services for the homeless population, and increased dental

services for low-income individuals as needs for the service area. For low-income individuals living in the service area, availability of primary care providers is more limited.

- **Insurance related challenges** - Focus group participants identified the cost of co-pays, services that are not covered by insurance and the limited number of providers that accept MassHealth as barriers to accessing the care and services needed to maintain their health. Key informant interviewees also identified state MassHealth insurance policies that negatively impact access to providers and services, and contribute to siloed care delivery as barriers, particularly those that impact patients with both mental health and substance use conditions.
- **Lack of transportation** – Transportation was one of the most frequently cited barriers to accessing health care and health-related services. A lack of transportation has a large impact on the elderly, low-income individuals, and those living in rural areas. Key informant interviewees identified the need for public transportation for low-income patients after discharge, as well as a need for translation of transportation routes and information for non-native English speakers.
- **Lack of care coordination** – Increased care coordination is a need for individuals in the CDHC service area. Topics identified in focus group and interviews include the need for coordinated care between providers in general; a need for increased coordination to manage co-morbid substance use and mental health disorders; and the need for increased connections between hospitals, community organizations, and schools.
- **Health literacy, language barriers, and cultural humility**– The need for health information to be understandable and accessible was identified in this assessment. Data from focus groups indicate the need for increased *health literacy*, which includes the need to understand health information, types of services and how to access them, and how to advocate for oneself in the healthcare system. In addition to patient education, the need for provider education about how to communicate with patients about medical information in a way that is accessible to patients was also cited. The need for training in *cultural humility* as a means to deliver *culturally sensitive care* was identified as a prioritized health need in this assessment. Regional public health leaders interviewed for this CHNA called for increased training in this area for health care providers to serve the needs of increasingly diverse community residents.

Health Conditions and Behaviors

- **Chronic health conditions** – High rates of **obesity, cardiovascular disease, diabetes, pediatric asthma, and asthma disparities**, many of which were identified as prioritized health needs in the 2013 CHNA continue to impact CDHC service area residents. Over 50% of adults in Hampshire and Franklin County are overweight or obese. Though national and regional childhood obesity rates have been falling, many children continue to struggle with overweight and obesity with high rates observed among children in Easthampton. Between 17-21% of older adults in Hampshire and Franklin County have heart disease and 23–30% of all adults have hypertension, with rates of over 50% observed among older adults. Many adults are impacted by or at risk for diabetes with 13-19% of adults in Hampshire and Franklin County estimated to have pre-diabetes or diabetes. In Hampshire and Franklin Counties, over 10% of school children have asthma with rates as high as 17% observed in some communities.

Racial and ethnic asthma disparities were found with Blacks and Latinos experiencing disproportionately high asthma ER visit rates compared to Whites in Hampshire County.

- **Need for physical activity and healthy diet** - Increased *physical activity* and consumption of fresh fruits and vegetables was identified as a need for CDHC service area residents. In their key informant interviews for this CHNA, Hampshire County public health personnel identified the increase in sedentary lifestyles in recent years as a concern. Low rates of physical activity and healthy eating contribute to high rates of chronic disease. Low rates of physical activity can also negatively impact mental health.
- **Mental health and substance use disorders** - Substance use (including tobacco, alcohol, and other drugs) and mental health were noted to be two of the most urgent health needs impacting the area in interviews with local and regional public health officials and in key informant interviews and focus groups conducted for CDHC and the Coalition. *Substance use disorders* overall and specifically opioid use were of particular concern. *Opioid use disorder* has been declared a public health emergency in Massachusetts. There was overwhelming consensus from focus group and key informant interviews conducted for this CHNA about the need for increased education across all sectors to reduce the stigma associated with mental health and substance use as well as the need for more treatment options. *Tobacco* use remains high with approximately 16-20% of adults in Hampshire and Franklin Counties who smoke. Though community efforts have successfully reduced youth substance use in some communities, it continues to remain high. LGBTQ youth are particularly impacted by high rates of depression and elevated substance use rates.
- **Infant and perinatal health risk factors** - Infant and perinatal health factors were identified as health needs in the 2016 CHNA. The need to reduce rates of smoking during pregnancy was identified in this CHNA, as well as the need to increase *prenatal care* utilization.
- **Sexual Health** - *Teen pregnancy* was identified as a concern in Franklin County and Easthampton, where rates were more than double the statewide rate.

Vulnerable Populations

Available data indicate that **children and youth, older adults**, people with **mental health** conditions, some communities of color, particularly **Latinos and Blacks, LGBTQ individuals**, and **veterans** experience disproportionately high rates of some health conditions or associated morbidities when compared to that of the general population in the CDHC service area.

Individuals with **low income** levels, those living in **poverty**, and those who are **homeless** are also disproportionately impacted by poor health. Overall, more data is needed to understand the unique factors that impact the health of each of these vulnerable populations.

Summary

The CDHC service area, which consists of communities in Hampshire and Franklin Counties, continues to experience many of the same health needs identified in CDHC's 2011 CHNA. Social and economic challenges experienced by some members of the population in the service area contribute to the high rates of chronic conditions and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health disparities observed among vulnerable populations, which include children, older adults, Latinos, Blacks, LGBTQ adults

and youth, veterans, low-income individuals, homeless persons and those living in poverty. Additional data is needed to better understand the needs of these populations in order to reduce inequities. Some members of the CDHC service area population, particularly vulnerable populations, continue to experience barriers that make it difficult to access affordable, quality care. Some barriers, such as transportation, are related to the social and economic conditions in the community, and others relate to the healthcare system itself. Mental health conditions and substance use disorders were consistently identified as top health concerns impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. The opioid crisis has emerged as a top issue impacting the health of the community. Progress has been made to address some of the prioritized health needs previously identified, such as childhood obesity; however, rates remain high and work to address health conditions and the underlying social determinants of health must continue.

Introduction

About Cooley Dickinson Health Care

Cooley Dickinson Health Care (CDHC), a Massachusetts General Hospital Affiliate, includes Cooley Dickinson Hospital, an acute care community hospital that offers medical/surgical, orthopedic, obstetric/gynecologic, psychiatric, geriatric, palliative, emergency, ambulatory, diagnostic, and rehabilitation services; Cooley Dickinson VNA & Hospice, which provides home health and hospice nursing and rehabilitation visits; and Cooley Dickinson Medical Group, comprised of primary and specialty care physicians, nurse practitioners, nurse-midwives, and other providers. Cooley Dickinson Health Care serves Hampshire and Southern Franklin County residents in the Five College region of the Pioneer Valley.

Mission: To provide CDHC patients and communities with the best health care in the most appropriate setting.

Community Benefits Mission: Cooley Dickinson Health Care Corporation will work in partnership with community leaders in business, government, education, religion, public health, healthcare and other areas to develop and enact a common vision of improving the health status of the communities and people we serve.

The community health improvement mission will be accomplished by providing accessible, quality health care services at a reasonable price, by taking an active role in assessing community needs, by developing a plan and allocating resources to said needs, and by serving as a role model for other institutions.

The above mission was affirmed by the Cooley Dickinson Health Care Corporation Board of Trustees, February 1995; revised, August 1996 and October 2009.

The Coalition of Western Massachusetts Hospitals

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

Coalition has since expanded to ten members and is currently conducting collaborative work to address mental health needs in the region. CDHC has been part of the Coalition since 2012 and worked collaboratively with the Coalition on select aspects of the 2013 CHNA process.

Community Health Needs Assessment (CHNA)

This 2016 CHNA was conducted to update the findings from CDHC's 2011 CHNA and findings from the 2013 CHNA, which included focus groups, interviews, and a community survey. The 2016 CHNA was conducted so that CDHC can better understand the health needs of the community it serves and to meet CDHC's fiduciary requirement as a tax-exempt hospital. The 2010 Patient Protection and Affordable Care Act (PPACA) requires tax-exempt hospitals and insurers to "conduct a Community Health Needs Assessment [CHNA] every three years and adopt an implementation strategy to meet the community health needs identified through such assessment." Information from this CHNA will be used to update and revise the community health improvement strategies developed by CDHC in 2013 and to identify regional needs and areas of action to address needs.

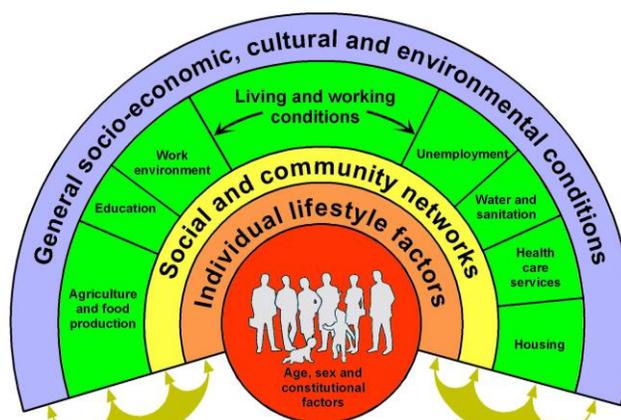
This CHNA was conducted in collaboration with the other Coalition hospitals/insurers. Integral to this needs assessment was the participation and support of community leaders and representatives who provided input through steering committee participation, stakeholder interviews and focus groups, a preliminary findings review meeting, and a community listening session.

Methodology for 2016 CHNA

Social and Economic Determinant of Health Framework

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

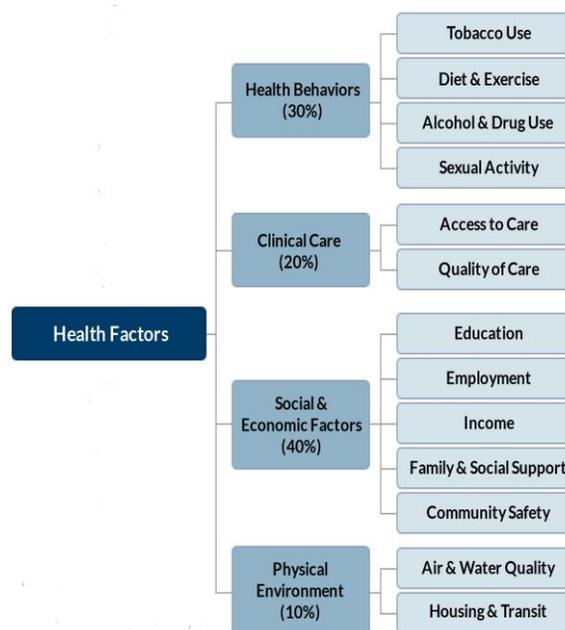
Figure 1. Determinants of Health



Source: Dahlgren & Whitehead, 1993

Among these “modifiable” factors that impact health, social and economic factors are estimated to have the greatest impact. The County Health Rankings model (Figure 2), developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, estimates how much these modifiable factors contribute to health, based on reviews of the scientific literature and a synthesis of data from a number of national sources. It is estimated that social and economic factors account for 40% of our health, followed by health behaviors (30%), clinical care (20%), and the physical environment (10%). Many health disparities occur as a result of inequities in these **determinants of health**.

Figure 2. County Health Rankings Model - Health Factors



Source: County Health Rankings

Among Massachusetts counties, County Health Rankings ranked Hampshire County fifth in the state for health outcomes and third for health factors. Franklin County ranked eighth in health outcomes and seventh in health factors.²

Assessment Methods

The primary goals of the 2016 CHNA were to update the previous CHNAs and identify potential areas of action. The prioritized health needs identified in this CHNA include **community level social and economic determinants that impact health, barriers to accessing quality health care**, and specific **health conditions and behaviors** within the population. Assessment methods included:

- analysis of social, economic and health **quantitative data** from MA Department of Public Health, the U.S Census Bureau, the Centers for Disease Control and Prevention [CDC] Behavioral Risk Factor Surveillance System [BRFSS], the County Health Ranking Reports, Community Commons, and a variety of other data sources;
- analysis of findings from four **focus groups** and four **key informant interviews conducted** specifically for CDHC (Appendix II);
- analysis of findings from an additional five **focus groups** and **13 key informant interviews** that were conducted for other Coalition members and considered relevant for this CHNA (Appendix II);
- review of **12 existing assessment reports** published since 2013 that were completed by community and regional agencies serving Hampshire and Franklin 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: Amherst, Easthampton, and Northampton. Other communities were included as data was available and analysis indicated an identified health need for that community.

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

Prioritization Process

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

Community and Stakeholder Engagement

The input of the community and other important regional stakeholders was prioritized by the Coalition as an important part of the 2016 CHNA process. Below are the primary mechanisms for

community and stakeholder engagement (see Appendix I for list of community representatives and other stakeholders included in process):

- A **CHNA Steering Committee** was formed that included representatives from each hospital/insurer Coalition member as well as public health and community stakeholders from each hospital service area. Stakeholders on the Steering Committee included local and regional public health and health department representatives; representatives from local and regional organizations serving or representing medically underserved, low-income or minority populations; and individuals from organizations that represented the broad interests of the community. When identifying community and public health representatives to participate, a stakeholder analysis was conducted by the Coalition and Consultants to ensure geographic, sector (e.g. schools, community service organizations, healthcare providers, public health, and housing) and racial/ethnic diversity of community representatives. By including these stakeholders on the Steering Committee, the community and public health representatives had input on the CHNA process used to identify and prioritize community health needs, CHNA findings, and dissemination of information. Assessment methods and findings were modified based on Steering Committee feedback. The Steering Committee met monthly from October 2015 – July 2016.
- **Key informant interviews** and **focus groups** were conducted to both gather information that was utilized to identify priority health needs and engage the community. Key informant interviews were conducted with health care providers, health care administrators, local and regional public health officials, and local organizational leaders that represent the broad interests of the community or that serve medically underserved, low-income or communities of color populations in the service area. Interviews with the local and regional public health officials were used to identify current and emerging high priority health areas and healthcare and community factors that contribute to health needs. Focus group participants included individuals representing the broad interests of the community, including community organizational representatives, vulnerable population community members (e.g. low-income, people of color), and other community stakeholders. Topics included health needs for: transgender and lesbian populations, veterans and military families, maternal and infant/child health, and for individuals with mental health and substance use conditions. Key informant interviews and focus groups were conducted from February 2016 – April 2016.
- A **preliminary CHNA findings review meeting** was held with hospital and community representatives to vet findings and obtain input on whether findings resonated with their understanding of the community and whether any important areas were missing. Prioritized health needs and presentation of data were revised based on feedback from this meeting.
- A **community listening session** was held to vet the revised list of prioritized health needs with community members and modifications were made based on findings from this session. At this session, attendees also provided information on existing resources in the community to address prioritized health needs.

Limitations and Information Gaps

The assessment focused on community determinant areas for which data was available. Given time, resource and data availability limitations, our analysis was not able to examine every health and community issue. Much of the quantitative data gathered for this report was provided by the Massachusetts Department of Public Health (MDPH) as part of a pilot effort to provide data for community health needs assessments. Challenges were experienced as this was their first effort to pull this data across multiple divisions in the short timeframe needed for this assessment. MDPH was very supportive in pulling together supplemental data, and this experience will inform the continued development of data for future CHNAs. The assessment is based on the best available data given these time and resource constraints.

This assessment utilized both 2012 and 2013 age-adjusted hospitalization and emergency room (ER) data from MDPH. This data was available at the community level if counts were 11 or higher. MDPH suppresses data for counts less than 11 because of data instability and confidentiality concerns. The 2012 data included information on select communities (Amherst, Easthampton, and Northampton), counties, and the state. The 2013 dataset included data for counties and communities within CDHC's service area, unless it was suppressed. 2013 data was used to identify communities with high rates within the service area. Rates presented for small communities should be interpreted with the understanding that estimates for these communities have wide confidence intervals and the potential to vary widely. Hospitalization and ER rates are based on the number of hospitalizations and ER visits reported to the state. They may include an individual utilizing these healthcare services on multiple instances within the timeframe examined.

Much of the social and economic data was obtained through Community Commons (CC), which is an online needs assessment tool that provides up-to-date data from a number of federal and non-profit data sources. The tool allows for customized data for a hospital service area based on county or zip code. As CDHC's service area was defined by zip code, and zip codes do not always align with community borders (e.g. some zip codes cross town/city borders), the aggregate data from the hospital service area may differ slightly from the service area defined by community borders.

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

Hospital Service Area

The service area for Cooley Dickinson Health Care includes 20 communities located in Franklin and Hampshire counties (Table 1). The total population of this area exceeds 130,000 residents, and over 60% live in Amherst, Easthampton and Northampton - all located in Hampshire County. Other towns in the service area range in size from approximately 900 to over 5,000 residents. There is a mix of rural and urban populations as defined by the U.S. Census Bureau (Figure 3). The population is densest surrounding Northampton, Easthampton, and Amherst (CC, US Census Bureau, Decennial Census 2010). Urban areas consist of census tracts and/or blocks which meet the minimum population density requirement (2,500-49,999 for urban clusters and over 50,000 for urbanized areas) or are adjacent and meet additional criteria.

This service area is home to several colleges and one large university, resulting in widely varying ages and population compositions. Amherst, which is the home of the University of Massachusetts-Amherst, has a student population of almost 30,000, and a median age of 21 years. Northampton, on the other hand, with a student population of about 2,500, has a median age of 39 years. The median age across Hampshire County is 36 and Franklin County, to the north, has a median age over 44 years.

Racial and ethnic diversity varies widely as well. In Amherst over 20% of the population identifies as Black or African American, Asian, or two or more races. Those who identify as Hispanic and Latino comprise 7% of the total population (Table 2). In Northampton, over 12% of the population identifies as Black or African-American, Asian or two of more races, and 8% of the population identifies as Hispanic or Latino. County-wide, 5% of the population in Hampshire County and 4% of the population in Franklin County identify as Hispanic or Latino (ACS, 2010-2014).

Per capita income in the CDHC service area exceeds that of both Hampshire and Franklin Counties as a whole. The poverty rate in the service area is 15%, slightly higher than the statewide rate of 12%. This higher rate may be partially due to the large student population since students living off-campus are included in the census. Even though the child poverty rate is below the state rate, 11% of children are estimated to live in poverty. Given the abundant academic resources in the region, education rates are high. Over 94% of service area residents have a high school diploma, and over 40% have a bachelor's degree or higher. The unemployment rate for this area is below the state average at 4%. The unemployment rate is based on the number of people who are either working or actively seeking work. Many residents are employed in the service industry. A robust arts and entertainment industry and health care-social service industry also provide many jobs. Public transportation is available to nine towns and cities via two bus systems: the Franklin Regional Transit Authority, which serves the northern portion of the service area, and the Pioneer Valley Transit Authority, which serves the southern portion. Both systems also offer paratransit services for people with disabilities within $\frac{3}{4}$ mile of a fixed route in order to facilitate access to medical care.

Table 1. Communities in CDHC Service Area

	2014 Population Estimate
Franklin County	
Ashfield	1,731
Deerfield*	5,054
Leverett	1,856
Shutesbury	1,770
Sunderland	3,679
Whately	1,515
Hampshire County	
Amherst	39,774
Belchertown	14,846
Chesterfield	1,248
Cummington	872
Easthampton	16,036
Goshen	1,069
Hadley	5,301
Hatfield	3,290
Huntington	2,179
Northampton	28,554
Plainfield	650
Southampton	6,078
Westhampton	1,634
Williamsburg	2,472
Worthington	1,179
Total Service Area	140,787

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

Note: The following villages are a part of service area and are listed based on the towns in the above list: Florence, Haydenville, Leeds, West Chesterfield, West Hatfield, North Hatfield, and North Amherst.

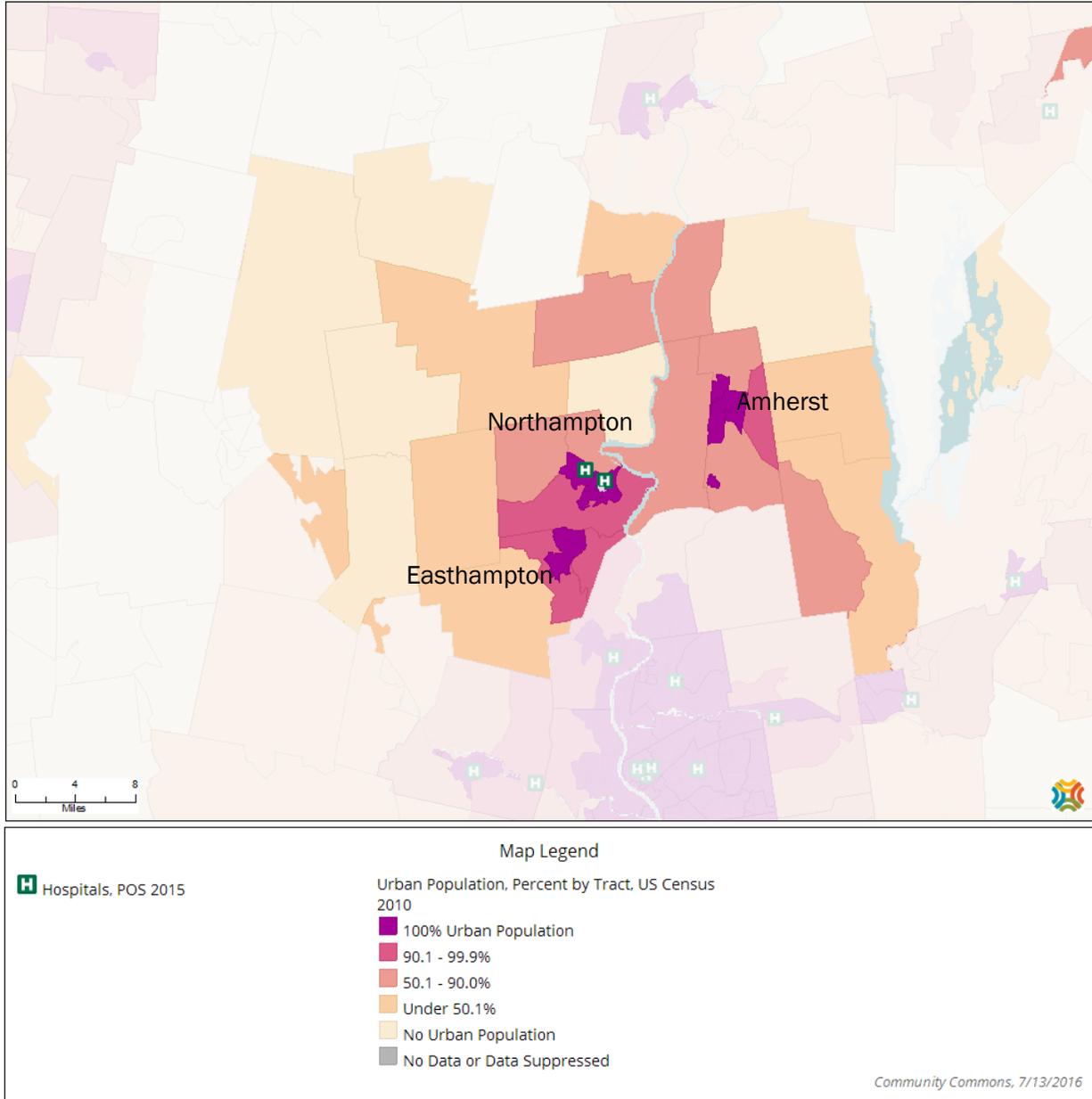
*Only the South Deerfield portion of Deerfield is part of the service area

Table 2. Sociodemographic Characteristics of the CDHC Service Area

Sociodemographic Characteristic	CDHC Service Area*	Franklin County	Hampshire County
Total population	140,787	71,300	160,328
Age			
Median age (years)	NA	44.9	35.8
Under 5 years	3.6%	4.6%	3.7%
5 to 17 years	12.3%	14.3%	12.4%
18 to 44 years	44.2%	64.4%	70.2%
64 and over	13.1%	16.7%	13.7%
Race and Ethnicity			
One race	97.9%	97.8%	97.9%
White	88.3%	94.1%	89.1%
Black or African American	2.7%	1.1%	2.7%
American Indian and Alaska Native	0.2%	0.3%	0.1%
Asian	5.8%	1.7%	5.1%
Native Hawaiian and Other Pacific Islander	0.1%	0.0%	0.1%
Some other race	0.9%	0.7%	0.8%
Two or more races	2.1%	2.2%	2.1%
Hispanic or Latino origin (of any race)	5.1%	3.5%	5.0%
White, not Hispanic or Latino	NA	91.8%	85.3%
Language Spoken at Home (population over 5)			
Speak language other than English at home	NA	6.2%	9.5%
Educational Attainment			
Population 25 years and over			
Less than high school graduate	14.1%	8.1%	6.4%
High school graduate (includes equivalency)	NA	27.6%	24.9%
Some college or associate's degree	NA	29.9%	25.5%
Bachelor's degree or Higher	NA	34.3%	43.2%
Income			
Median Income - Individual	NA	\$27,360	\$24,131

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

Figure 3. Urban Populations in the CDHC Service Area



Source: CC, U.S. Census Bureau, Decennial Census 2010

Prioritized Health Needs of the Community

The following are the prioritized health needs identified for CDHC's service area, which consist of communities in Hampshire and Franklin Counties. The prioritized health needs of the community served by CDHC are grouped into three categories: (I) community level social and economic determinants that impact health, (II) barriers to accessing quality health care, and (III) health conditions and behaviors. Many of the prioritized health needs identified in the previous CHNA continue to impact the community. Though the hospital and community partners have taken many actions to address these needs, it can take many years of sustained efforts to improve the community level social and economic factors that impact health or health conditions impacting the community. See the "Impact of Actions Taken by Hospital Since Last Community Health Needs Assessment," page 42, for a list of actions taken by the hospital to address the previously identified prioritized health needs.

I. Community Level Social and Economic Determinants that Impact Health

Below are the community level social and economic determinants of health that impact CDHC's service area.

Lack of Resources to Meet Basic Needs

In CDHC's service area, which includes parts of Hampshire and Franklin Counties, some residents struggle with **poverty** and **low levels of income**. The connections between poor health and poverty, low levels of income, and access to fewer resources are well established. This can also be pronounced for low-income individuals living in **rural** communities. Low-income individuals are more likely to be negatively impacted by the chronic stress associated with challenges in securing basic necessities that impact health, such as housing, food, and transportation.

In the CDHC service area 15% of the population lives in poverty (Table 3), which surpasses the statewide rate. The highest poverty rates are found in Amherst and Northampton (Figure 4). One-third of the population in Amherst lives below the federal poverty level.³ Because university/college students living off-campus are included in the census, it is likely that this high rate is partially driven by students. The federal poverty level is extremely low and omits a sizeable portion of the population that is struggling economically. The percent of the population living below 200% of the federal poverty level better captures the extent of poverty. Approximately 27% of Hampshire County and 30% of Franklin County residents live in households with incomes at or below 200% the federal poverty level. The highest levels are concentrated in parts of Northampton, Amherst, Whately, Sunderland, Belchertown, and Easthampton (CC, U.S. Census Bureau, ACS 2010-2014). The median family income in Hampshire County is comparable to the state; however, a number of communities fall below this amount. The lowest median family incomes are found in parts of Northampton and Easthampton. Additionally, Franklin County's median family income is lower than the state (CC, U.S. Census Bureau, ACS 2010-2014). In the service area, 4% of the population is unemployed (5 statewide) (CC, US Dept. of Labor, February 2016). In key informant interviews with regional public health officials, poverty was identified as a factor that impacts overall health, access to health care, and access to programs and services that promote health.

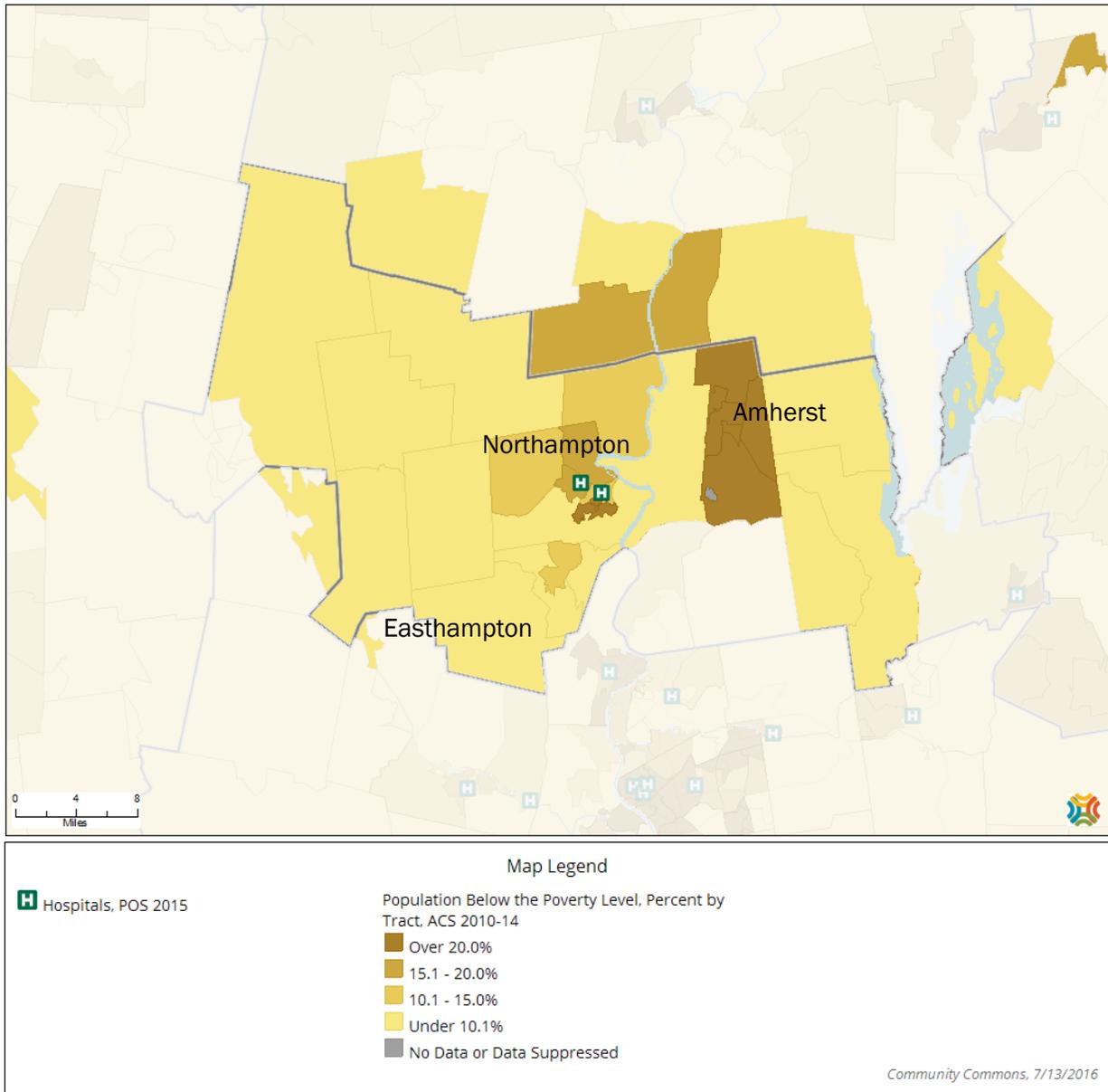
Table 3. Socioeconomic Factors

	CDHC Service Area	Massachusetts
Median Family Income*	n/a	\$86,132
Unemployment**	4.1%	4.7%
Poverty*		
Population living below federal poverty level	14.5%	11.6%
Population living below 200% of federal poverty level	28.7%	25.0%
Children living below federal poverty level	11.2%	15.1%
Children eligible for free or reduced lunch*	25.7%	38.3%
No high school diploma*	5.8%	10.5%

Sources: *CC 2016, U.S. Census Bureau, 2010-2014; no high school diploma among adults age 25 and older

**CC 2016, US Department of Labor, Bureau of Labor Statistics. February 2016

Figure 4. CDHC Service Area Poverty Rates



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

Low levels of educational attainment also contribute to availability of resources to meet basic needs. Levels of education are strongly correlated with both employment status and the ability to earn a livable wage. Approximately 6% of CDHC service area residents age 25 and older do not have a high school diploma (CC, U.S. Census Bureau, ACS 2010-2014), and in the communities of Easthampton and Northampton, rates are higher at 8%.^{4,5}

Vulnerable Populations

Children and people of color are disproportionately impacted by poor socioeconomic status in the CDHC service area.

- Twenty-six percent of **children** living in the CDHC service area qualify for free or reduced lunch, and 11% live below the federal poverty level. In parts of Northampton and Amherst, child poverty rates exceed 25% (CC, U.S. Census Bureau, ACS 2010-2014).
- Poverty rates are higher among **Latinos, Blacks, and Asians** (CC, U.S. Census Bureau, ACS 2010-2014).

Housing Needs

Regional public health officials interviewed for this CHNA identified a need for more affordable housing. Additionally, homelessness and a need for increased services to support the health and wellness of homeless individuals and families were identified in this CHNA.

Lack of affordable housing is an issue that impacts some CDHC service area residents. Housing cost burden is defined as more than 30% of income going towards housing. Over a third of the population in CDHC's service area is housing cost burdened, with rates greater than 50% in part of Amherst. These high rates are likely due in part to the inclusion of college students living off-campus in the census data. Among renters in Hampshire County, half are housing cost burdened (Community Commons, U.S. Census Bureau, ACS 2010-14). 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.

Homelessness was identified as a health concern for CDHC service area residents in 2013, and continues to be an issue. Findings from a focus group conducted by CDHC in 2013 identified a need for year-round homeless shelters, and Hampshire County public health personnel interviewed for the 2016 CHNA identified a need for increased services to support the needs of the homeless population. Despite a decrease in overall homelessness in the region in recent years, rates of homeless families have increased with higher rates of *homeless* families in Western MA as compared to state and national rates.⁶ From 2013 to 2015, the number of homeless families in Western Massachusetts increased from 631 to 909 families. In 2015, there were 339 homeless youth (age 24 and under), and 280 of these youth identified as parents.⁷ The number of homeless youth is likely an underestimate since homeless youth without children tend to avoid traditional shelters and services.⁸

Poor housing conditions also impact the health of residents. Older housing combined with limited resources for maintenance can lead to problems (e.g. mold, pest/rodent exposure) that contribute to asthma and other respiratory illnesses; exposure to environmental contaminants such as lead paint, asbestos, and lead pipes; and safety and accessibility issues for children, elderly or disabled populations. In Hampshire County, 27% of occupied housing structures were built in 1939 or earlier, with rates even higher among the rental housing stock (37%) (U.S. Census Bureau, ACS 2010-14). Franklin County has an even larger proportion of older housing, with 36% of all occupied housing units built before 1940. Easthampton and Northampton have a large number of older homes with 31% and 47% of homes built before 1940, respectively (U.S. Census Bureau, ACS 2010-14).

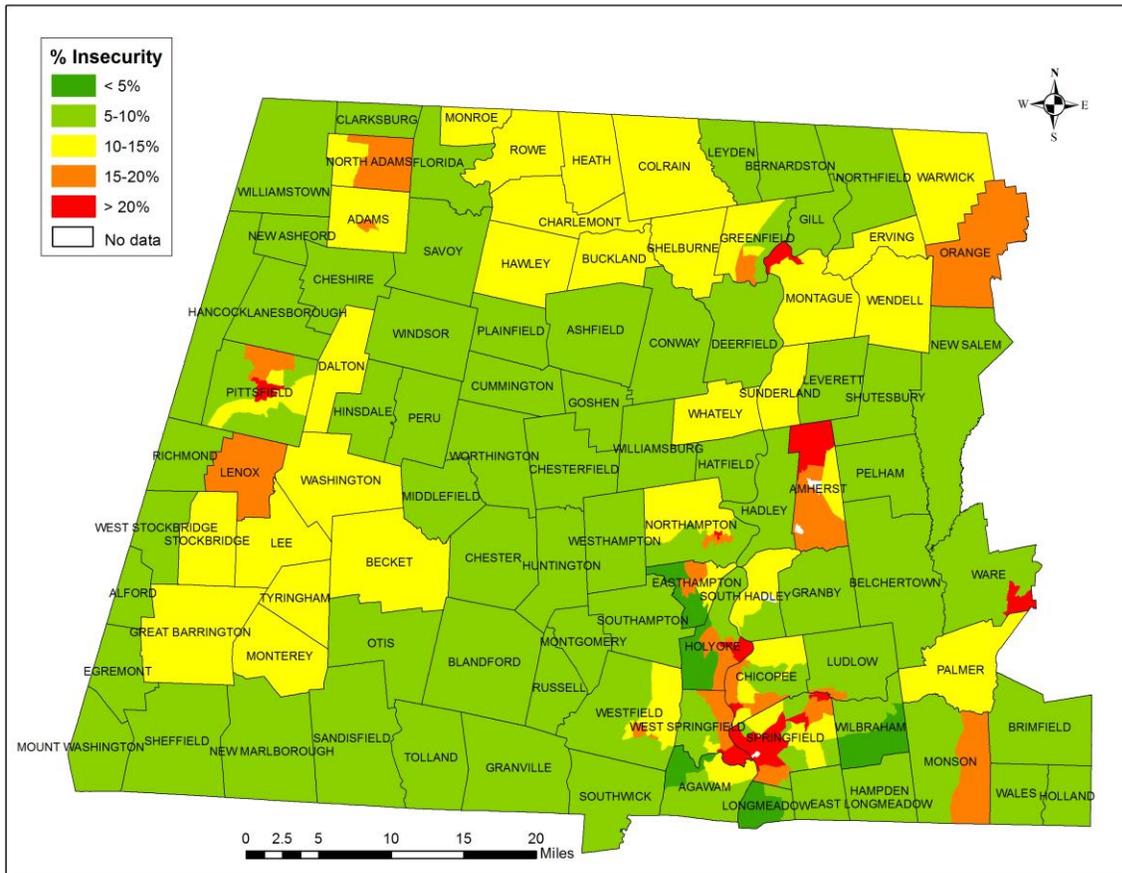
Transportation

Regional public health officials interviewed for the 2016 CHNA identified increased transportation options as an overall community need for the region. Individuals who do not own a vehicle face difficulties accessing educational and employment options; community-based programs that promote health, such as exercise and nutrition programs; and other activities that promote social connection. Lack of accessible transportation has a great impact on the health of low-income or elderly populations living in rural areas, where public transportation may have limited routes and frequency of service. An estimated 8% of households in Hampshire County and 7% in Franklin County do not have vehicles, and in Amherst and Northampton, rates are higher at 11% and 10%, respectively (U.S. Census Bureau 2010-2014). Among those with vehicles, those with limited resources struggle to maintain and utilize their vehicles. The Community Action 2015 needs assessment found that the top transportation barrier was that limited resources resulted in the use of uninsured or unsafe vehicles.⁹

Food Insecurity and Food Deserts

Food insecurity impacts the ability of many CDHC service area residents to access healthy food. Hampshire County public health personnel interviewed for this CHNA noted the importance of good nutrition. Eating nutritious food is good for promoting overall health and is important for managing many chronic health conditions. However, not all individuals and communities have equal access to healthy food. Food insecurity is a measure of inadequate or uncertain access to food, including healthy food, and is estimated based on social and economic characteristics such as income. The food insecurity rate is 11% in Hampshire County and 10% in Franklin County. The rates among children are even higher at 15% in Hampshire County and 17% in Franklin County.¹⁰ As can be seen in a map of food insecure census tracts in Western MA (Figure 5), portions of Amherst, Northampton, and Easthampton have rates of food insecurity greater than 15%.

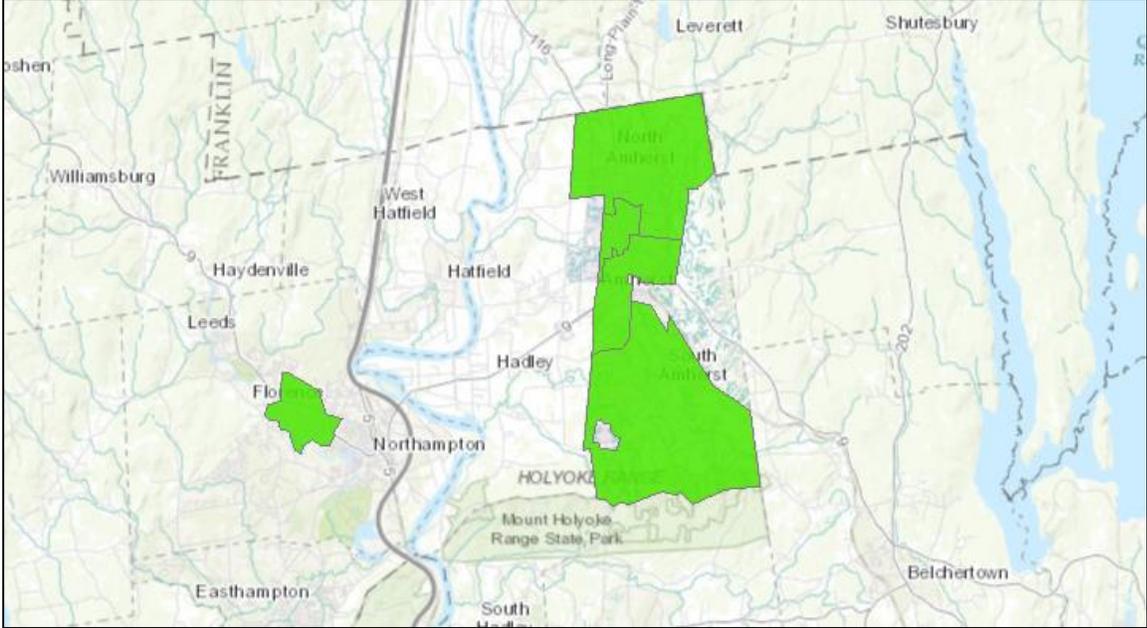
Figure 5. Food Insecurity Rates in Western MA



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

The CDHC service area also has several **food deserts**. Low-income individuals are more likely to live in food deserts, which are areas where grocery stores and other options to purchase healthy foods are far away and difficult to access for people that either do not own a vehicle or where public transportation is limited. Figure 6 highlights in green the parts of Northampton and Amherst that have areas that the USDA has identified as food deserts.

Figure 6. USDA Food Atlas Food Desert Areas in the CDHC Service Area



Source: USDA Food Access Research Atlas; accessed 5/31/16

USDA Food desert: at least 500 low-income people in a census tract live more than one mile away from a grocery store in urban areas and more than 10 miles from a grocery store in rural areas

II. Barriers to Accessing Quality Health Care

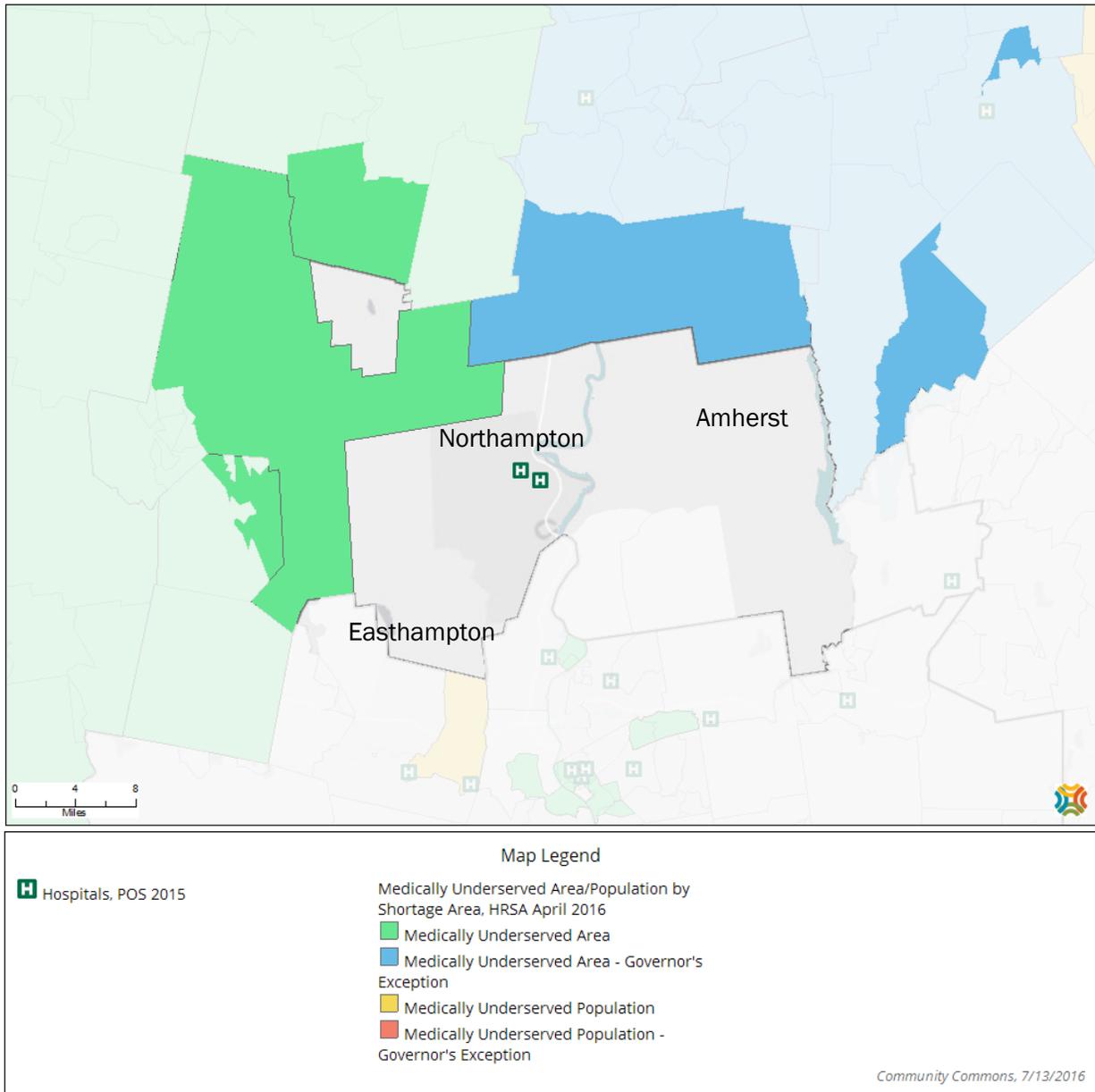
Various barriers to accessing quality health care were identified as a need in the 2016 CHNA and are detailed in the sections below.

Limited Availability of Providers

In 2013 key informant interviews and focus groups, respondents indicated that access to health services and availability of primary care providers was low for individuals with low-income, low educational levels, language barriers, or that were living in very rural areas. In addition, interviewees and focus groups conducted in 2013 for CDHC identified long wait times for urgent, specialty, and routine wellness care and a limited number of primary care providers that accept new patients as barriers.

The U.S. Health Resources and Services Administration designated medically underserved areas and populations in Hampden and Franklin Counties (Figure 7). Medically underserved status is based on availability of primary care providers, infant mortality rate, poverty rate and proportion of older adults. Medically underserved areas are based on the overall population, whereas medically underserved populations refer to a specific group based on economic, cultural, or linguistic barriers. A Governor's exception refers to a medically underserved area or population designated at the request of a Governor based on documented unusual local conditions and barriers to accessing personal health services.

Figure 7. Medically Underserved Areas/Populations in CDHC Service Area



Source: Community Commons, HRSA 2015

Hampshire County public health personnel interviewed for this CHNA, as well as findings from focus groups and key informant interviews conducted for other Coalition members overwhelmingly reported a need for increased access for both mental health and substance use services for acute, maintenance, and long-term care. They also cited the need for increased dental services for low-income individuals and innovative health care options for homeless individuals, such as health care offered directly at homeless shelters.

According to a member of the Massachusetts Oral Health Advocacy Taskforce, adults on MassHealth experience challenges accessing dental services because of the shortage of dental providers

accepting MassHealth and insufficient coverage of services. Although access to pediatric dentists has improved over the years, access to dental services remains a challenge for adults. This need was echoed in results from a 2014 community partner survey conducted by Community Action of the Franklin, Hampshire, and the North Quabbin Regions, where most respondents reported gaps in low-cost dental care and/or providers who accept MassHealth. Nearly half of respondents felt that low-cost dental care did not exist or that dental care was inaccessible and unaffordable.¹¹ Population to dental provider ratios in Hampshire County are lower than that of the state (1550:1 vs 1070:1 in MA) (County Health Rankings, 2016).

Insurance Related Challenges

Findings from focus groups and key informant interviews conducted with health care providers and administrators for hospitals/insurer for the Coalition identified multiple barriers imposed by the health insurance system. These obstacles directly impact adequate treatment of multiple health concerns, most notably mental health and substance use conditions. Issues related to insurance coverage present barriers to affordability and accessibility of care. Issues identified include:

- gaps in service coverage for mental health and substance use treatment between public and private insurance;
- reimbursement policies and guidelines that silo care;
- limited number of providers that accept patients with public insurance due to bureaucratic requirements (i.e. paperwork to become an approved provider in addition to low reimbursement rates). This lack of Medicaid providers was most significant in rural communities across Western Massachusetts.

“Substance abuse and mental health are definitely connected, but based on how they are funded and regulated, they are completely separate... We can’t treat substance abuse and mental health together even though it is the most effective way. ”

- Focus Group Participant,
Mental Health and Substance
Use Focus Group

Findings from focus groups conducted with residents noted the high cost of deductibles and co-pays for medication and services as barriers to accessing the care and services they need, as well as general frustrations with navigating the health insurance system.

Additionally, both health care administrators and community residents interviewed for this CHNA identified the “three strikes and you’re out” guidelines for Medicaid patients as an obstacle. Behavioral health patients who miss three consecutive appointments have their cases closed. Similarly, MassHealth patients reported that if they miss three consecutive appointments with a primary care provider, they are required to find a new provider. It is not clear if this is due to MassHealth policy or primary care provider policy. This is an additional challenge in areas where providers that accept MassHealth are limited. Key informant interviewees identified multiple barriers that can contribute to missing three consecutive appointments:

- lack of transportation;
- financial concerns;

- the impacts of a health condition, such as a physical disability or mental health disorder, that may make it difficult for a person to leave their home.

Lack of Transportation

Transportation arose as a barrier to care in previous CDHC assessments and among interviewees in the 2016 CHNA. Nonetheless, key informant interviews with regional public health officials for the 2016 CHNA cited transportation as one of the top barriers to accessing health care and services. Hampshire County public health personnel interviewed for this CHNA noted a need for expanded public transportation for low-income populations, translated schedule information for non-English speakers, and better connections between the bus system and CDHC for hospital discharges.

Local assessments also support this need. A 2015 transportation gap analysis conducted for CDHC found that 57% of survey respondents had missed healthcare appointments as a result of transportation challenges, and 81% reported that transportation difficulties and/or a lack of transportation make it harder to buy fresh groceries or exercise.¹²

In addition, in the 2015 Community Action Needs Assessment for Franklin, Hampshire, and North Quabbin regions, lack of transportation was cited as a significant barrier to accessing healthcare services.¹³ In a survey conducted for the needs assessment, 56% of the respondents reported that transportation services to community health centers, hospitals, and medical providers were non-existent, inaccessible, and/or unaffordable.¹⁴ In the assessment, Community Action proposes a few potential solutions to ease transportation barriers, including ride share programs; Good News Garage Model of fixing donated cars and selling them for the cost of repairs; asset development programs to help people save money for vehicles and other financial education; and exploring other ways to make services more accessible to people who do not have transportation.¹⁵

Lack of Care Coordination

Regional public health officials interviewed for the 2016 CHNA identified lack of care coordination as a prioritized community health need and a key to addressing health inequities in the region. Care coordination refers to the coordination of patient care and information among all healthcare and other service providers to promote health.

Findings from focus groups and key informant interviews conducted for Coalition members for this CHNA identified important areas where care provided by multiple providers continues to be uncoordinated and results in challenges. Examples include:

- lack of coordination in managing the overlap between mental health and substance use;
- a need for more linkages between hospitals, school, community organizations, and emergency responders to better manage the opioid crisis;

“We need comprehensive prevention work in the schools. It has been embraced in a patchwork fashion.

*- Key Informant Interviewee,
Regional Public Health Official*

- the barriers that occur as a result of decentralized health care services (i.e. having to travel to multiple locations for care, testing, and medications), which can impact patient ability to follow the treatment plan;
- the need for community health workers (CHWs) to increase access and care coordination and to address issues related to transportation, health literacy, care coordination, and navigating the health care system.

Health Literacy, Language Barriers, and Cultural Humility

The need for health information to be understandable, accessible, and provided with cultural humility was identified as a regional need in this assessment.

My experience in the community shows me that providers need to understand why people don't participate. Provider systems are not structured to give explanations - the providers need to make sure that families understand."

- Key Informant Interviewee
Regional Public Health Official

Health literacy is defined by the CDC as the capacity for an individual to find, “communicate, process, and understand basic health information and services to make appropriate health decisions.”¹⁶ Findings from focus groups conducted for Coalition members for this CHNA identified the need for increased health literacy, including:

- the need for patient education about health information, types of services and how to access them;
- support for patients to better advocate for themselves to ensure they are getting the information and services they need;
- provider education to ensure that patients understand what they are being told during a clinical encounter, including giving them time to process information, asking if they understand what they are being told, and using less medical jargon.

Language barriers can create multiple challenges for both patients and health care providers. Increasing availability of interpreters as well as translation of health material into a wide range of languages are specific actions that health care institutions can take to help address this barrier. Findings from 2013 focus groups and key informant interviews conducted to update the CDHC CHNA identified language barriers as a challenge to accessing healthcare. Similarly, the 2015-2017 Community Action needs assessment that focused on Franklin, Hampshire and the North Quabbin area identified immigrants and individuals speaking English as a second language as the population group that was the most underserved in the community. In a survey conducted for that needs assessment, 44% of community service providers who responded to the survey indicated that in Hampshire County, translation services at hospitals and healthcare facilities did not exist or were “... inaccessible, or unaffordable” and 48% felt services existed but were strained to capacity. In addition to improving access to interpreters and translated materials, respondents suggested more free instruction in English. Also, respondents noted that although the Hampshire, Franklin and North Quabbin Region is predominately White, the number of immigrants and people for whom English is a second language is increasing.¹⁷

In Hampshire County, 9% of the population speaks a language other than English at home (U.S. Census Bureau, ACS 2010-14), and 1% of the CDHC service area population lives in linguistically isolated households (CC, U.S. Census, ACS 2010-2014). Linguistic isolation is defined by the U.S. Census Bureau as a household in which all members older than age 14 speak a non-English language and have difficulty with English. The largest concentrations of linguistically isolated households living in CDHC service area are in Sunderland, Whately, and Amherst (CC, US Census 2010-2014).

Cultural Humility

The need for culturally sensitive care was identified as a prioritized health need in the 2013 CHNA and continues to remain so. Increased training in cultural humility as a means to deliver more culturally sensitive care was identified in the 2016 CHNA. Cultural humility refers to a commitment among health care providers to self-reflection and evaluation in order to reduce the power imbalance between patients and providers, and to the development of health care partnerships that are based on mutual respect and equality.¹⁸

Regional public health officials interviewed for the 2016 CHNA called for increased training for health care providers to deliver culturally sensitive care. In their focus group, faith-based community leaders noted that cultural sensitivity is not limited to a racial or ethnic culture, but also includes care for often-stigmatized groups such as people with mental health problems and/or substance use disorders, veterans, LGBTQ individuals, ex-offenders, homeless individuals, and youth. Focus group participants also noted that in some cultures, asking providers a question is seen as disrespectful.

III. Health Conditions and Behaviors

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

In this section we examine 2013 hospitalization and ER visit data by communities within the service area. State level data for 2013 was unavailable. Additionally, 2012 data was available for select communities (Amherst, Easthampton, and Northampton) and is presented in figures below. As discussed in limitations, hospitalization and ER data for small communities should be interpreted with the understanding that they have wide confidence intervals and estimates can vary widely.

Chronic Health Conditions

Chronic health conditions remain an area of prioritized health need for CDHC service area residents.

Data from the current CHNA shows that residents experience high rates of chronic health conditions and associated morbidity, particularly for obesity, **diabetes**, **cardiovascular disease** and pediatric **asthma**. A chronic health condition is one that persists for a long period of time, and typically can be controlled but not cured. According to the CDC, chronic disease is the leading cause of death and disability in the U.S. By 2020 it is estimated that 81 million Americans will have multiple chronic conditions.¹⁹ A **healthy diet** and **physical activity** play an important role in preventing and managing chronic diseases.

Obesity

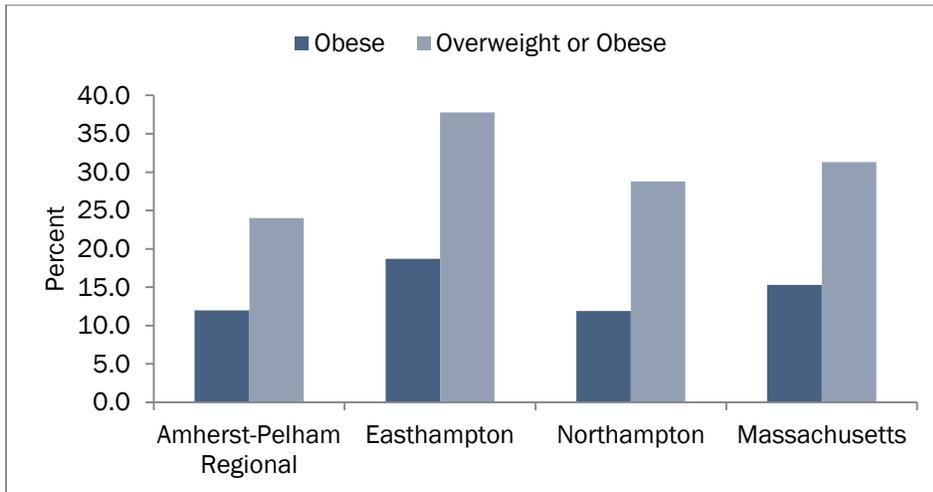
In their key informant interviews for the 2016 CHNA, Hampshire County public health personnel identified obesity as one of the most urgent health needs in the CDHC service area. In Hampshire County an estimated 20% of adults struggle with obesity and 56% are overweight or obese. Similarly, in Franklin County 22% of adults are obese and 54% are overweight or obese (MA: obese - 24%; overweight/obese - 59% (BRFSS 2012-2014). While rates in Franklin and Hampshire are lower than the state rate, obesity is a national epidemic and contributes to chronic illnesses such as cancer, heart disease, and diabetes. Obesity can impact overall feelings of wellness and mental health status. A healthy diet and physical activity play an important role in achieving and maintaining a healthy weight.

Though childhood obesity rates have been falling nationally and within some communities in the region over the last few years, rates among children remain high. Among select communities examined, rates range from 19% in Easthampton to 12% among students in Northampton and the Amherst-Pelham Regional School District (Figure 8). Nearly one in four children in the Amherst-Pelham Regional School District are overweight or obese, and in Easthampton more than one in three students are overweight or obese (Figure 8). Childhood obesity was only examined in select communities, and county-level childhood obesity data is not available.

Vulnerable Populations

- **Children** experience high rates of overweight and obesity which increases their risk for adult onset chronic diseases such as diabetes, and it also increases their risk for being obese and experiencing chronic disease as an adult.

Figure 8. Childhood Obesity Rates for Select School Districts in the CDHC Service Area



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

Cardiovascular Disease (CVD)

Cardiovascular disease (CVD) includes diseases that affect the heart and blood vessels, including coronary heart disease (CHD), angina (chest pain), heart attack (myocardial infarction), and stroke. CVD is a priority health need because of the high prevalence of CHD among older adults, the high prevalence of CVD risk factors such as hypertension among older adults and the general population, and the high rates of CVD hospitalizations in some CDHC service area communities.

Older adults experience high rates of heart disease in the CDHC service area. Approximately 21% of Medicare enrollees 65 years and older in Hampshire County and 17% in Franklin County have heart disease (24% for Massachusetts) (Medicare 2014, one-year estimate).

There is a high prevalence of conditions that increase the risk of CVD, including hypertension (high blood pressure) and high cholesterol, observed in the CDHC service area. Among adults living in Hampshire County, 23% have high blood pressure (CC, BRFSS 2006-2012) and 30% have high cholesterol (CC, BRFSS, 2011-2012). Similarly, among adults in Franklin County 24% have hypertension (CC, BRFSS 2006-2012) and 31% have high cholesterol (CC, BRFSS 2011-12). The prevalence of hypertension is even greater among older adults. Over half of older adults in Hampshire and Franklin County (58% and 54%, respectively) have hypertension (MA: 55%) (Medicare 2014, one-year estimate).

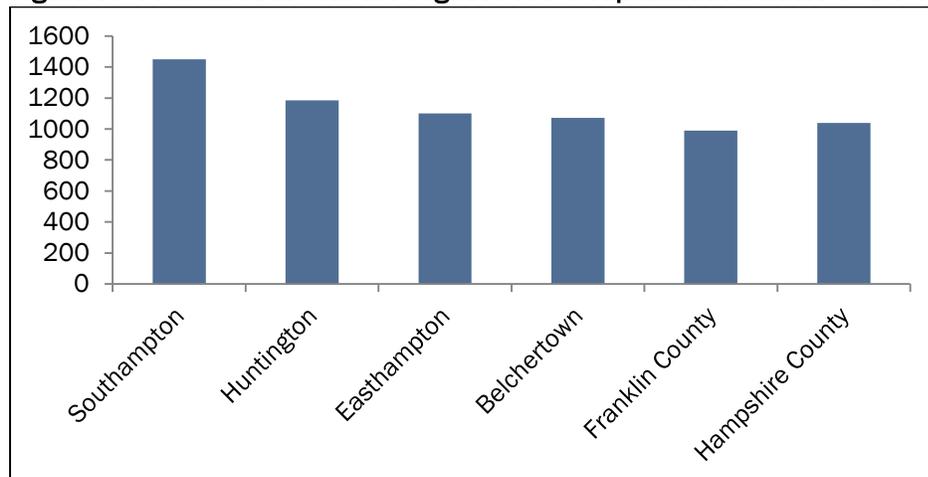
High rates of CVD hospitalizations were observed in some CDHC service area communities. Figure 9 illustrates the communities with the highest CVD hospitalization rates in 2013, with the highest rate

observed in Southampton (Figure 9). Southampton and Easthampton were also among the top four communities with the highest stroke hospitalization rates (MDPH, 2013).

Vulnerable Populations

- **Older adults** experience high rates of CHD and hypertension as described above.

Figure 9. Communities with the Highest CVD Hospitalization Rates in the CDHC Service Area, 2013



Source: MDPH, age-adjusted per 100,000

Diabetes

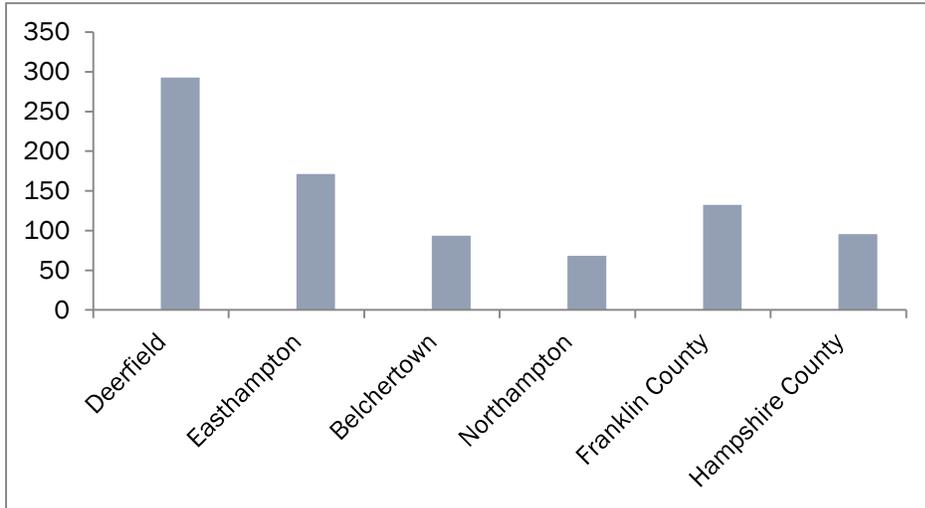
Findings from key informant interviews with regional public health leaders and Hampshire County public health personnel for this CHNA identified diabetes as one of the most pressing health needs for the area. An estimated 5% of Hampshire County residents and 9% of Franklin County residents have **diabetes** (MA- 9%). Approximately 13% of Hampshire County residents and 19% of Franklin County residents have either **pre-diabetes or diabetes** (statewide 16%) (BRFSS, 2010-2012). Diabetes (the vast majority of which is Type 2 diabetes [T2D]) is one of the leading causes of death and disability in the U.S. and is a strong risk factor for cardiovascular disease. The CDC estimates that 9.3% of people in the U.S. have diabetes, of which 27.8% are undiagnosed.²⁰ Pre-diabetes is when a person has high blood sugar levels that are not high enough for a diagnosis of diabetes. An estimated 15-30% of people with pre-diabetes will develop T2D within 5 years. T2D can be prevented and managed with a combination of weight loss, exercise, medication, and maintaining a healthy diet.²¹

Diabetes hospitalization rates are a measure of severe morbidity due to diabetes. Among the CDHC service area communities, 2013 hospitalization rates for diabetes were highest in Deerfield, Easthampton, Belchertown, and Northampton (Figure 10). Figure 11 illustrates diabetes hospitalizations in 2012 and 2013 in select communities.

Vulnerable Populations

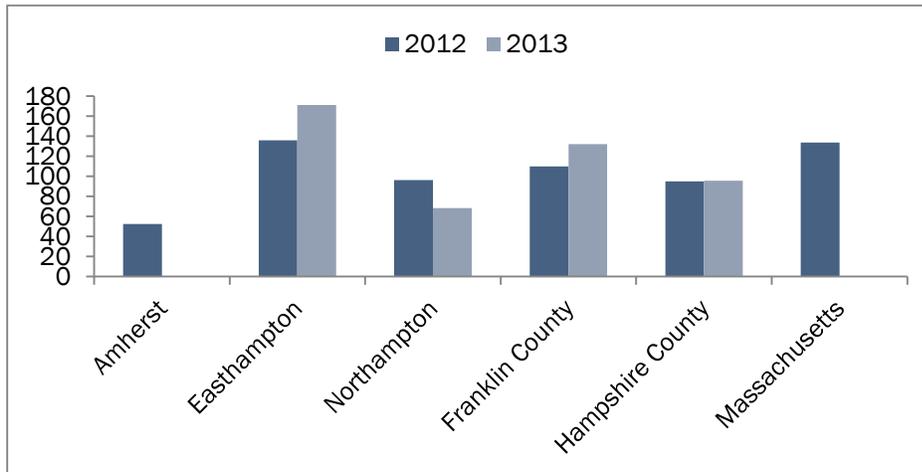
- **Older adults** experience higher rates of diabetes with Medicare data indicating that approximately 21% of Medicare enrollees age 65 and older in Hampshire and Franklin Counties had diabetes in 2014 (Medicare 2014, one-year estimate).

Figure 10. Communities with the Highest Diabetes Hospitalization Rates in the CDHC Service Area, 2013



Source: MDPH, age-adjusted per 100,000;
 *Data available for less than 10 communities

Figure 11. Diabetes Hospitalization Rates in Select CDHC Service Area Communities, 2012-2013



Source: MDPH, age-adjusted per 100,000
 *Amherst 2013 rate suppressed

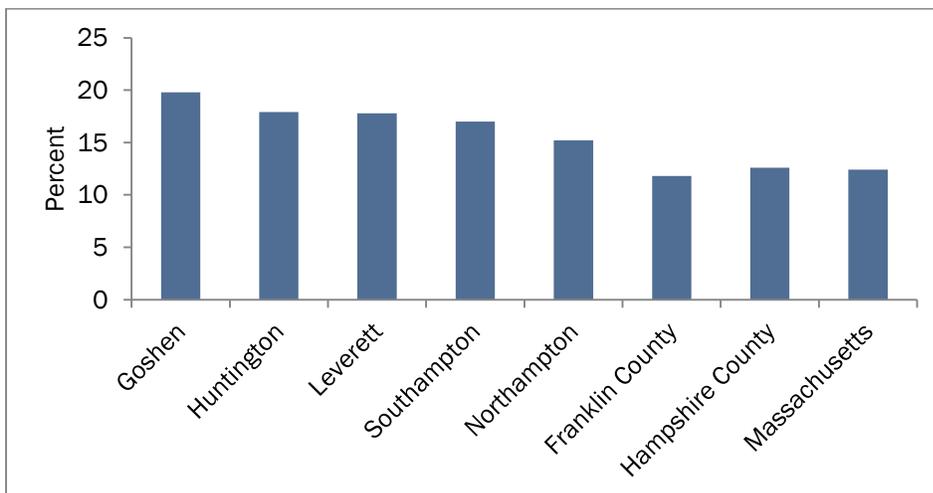
Asthma

Asthma impacts many children and disproportionately impacts some communities of color in the CDHC service area. Asthma is a common chronic respiratory disease that affects the health and quality of life of children and adults. Asthma can be impacted by different factors in the environment including cigarette smoke, second hand smoke, air pollution, pollen levels, and mold, dust, and other household contaminants or exposures. Findings from key informant interviews conducted with regional public health leaders as well Hampshire County public health personnel for this CHNA identified the need for increased partnerships to improve air quality as a means to address high rates of asthma.

Among school children in Hampshire and Franklin County, 12-13% have asthma (MA- 12%) (MDPH EPHT, 2013-2014). More than 17% of students in elementary and middle school have asthma in Goshen, Huntington, and Leverett (Figure 12).

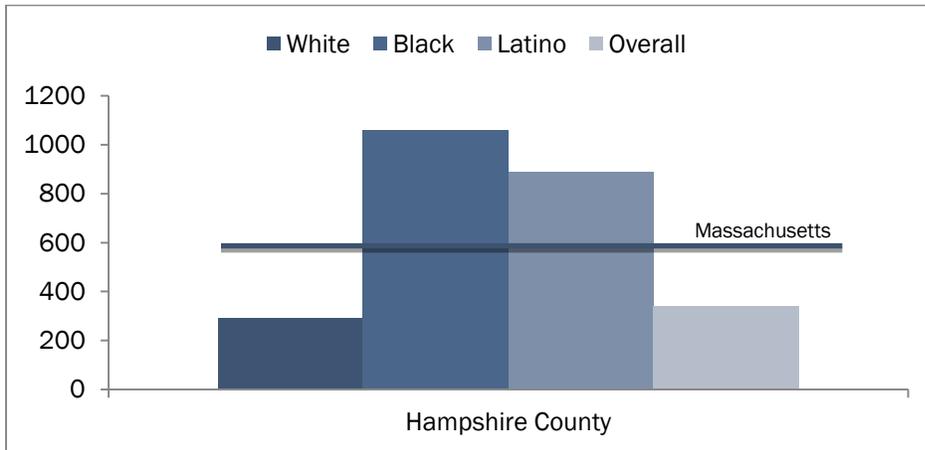
Additionally, racial and ethnic disparities were observed in ER visit rates for asthma. In Hampshire County, the 2012 ER visit rate among Blacks was over 3.5 times that of Whites and 85% greater than the overall state rate (Figure 13). The rate among Latinos was three times that of Whites and 55% more than the overall state rate (MDPH, 2012). Disparities were also observed among Franklin County ER visit rates (MDPH, 2012).

Figure 12. Communities with the Highest Pediatric Asthma Prevalence in the CDHC Service Area, 2013-2014 School Year



Source: MDPH, Environmental Public Health Tracking System, School Year 2013-2014

Figure 13. Hampshire County Asthma ER Visit Rates by Race/Ethnicity, 2012



Source: MDPH, age-adjusted per 100,000

Vulnerable Populations

- **Children** with asthma are a vulnerable population of concern. Pediatric asthma prevalence is high in some CDHC service area communities.
- **Blacks** and **Latinos** experienced disparities in asthma-related ER visits.

Need for Increased Physical Activity and Healthy Diet

Increased physical activity and consumption of fresh fruits and vegetables among CDHC service area residents continues to be a prioritized health need identified in previous assessments. In their key informant interviews for this CHNA, Hampshire County public health personnel identified the increase in sedentary lifestyles over recent years as a concern. The need for increased youth programming that encourages physical activity, among other program area needs, was cited as a need by one regional public health official in their key informant interview.

Among Massachusetts residents in the CDC's BRFSS 2013 survey, only 9% of respondents met the vegetable consumption recommendation and 14% met the fruit consumption recommendations,²² which are comparable to national rates. Only 55% of adults in the Springfield Metropolitan Statistical Area - which consists of Hampden, Hampshire, and Franklin Counties - engaged in 30 or more minutes of moderate activity on five days per week or 20 minutes of vigorous activity on three or more days per week (BRFSS 2009). These rates are affected by the availability of affordable healthy food and safe places to be active as well as individual knowledge and behaviors. In a survey conducted by Community Action in 2014, over half (54%) of respondents reported that health and wellness services, such as nutrition, weight loss services, and public recreation opportunities, were inaccessible, unaffordable, or did not exist in Hampshire County.²³

Mental Health and Substance Use

Mental health and substance use were identified as needs in the previous assessments and continue to be a prioritized health need as identified by CDHC key informant interviewees and across all focus groups and interviews conducted for Coalition hospitals/insurer to inform this CHNA.

Substance use disorders overall, and opioid use specifically, were identified as top issues. There was overwhelming consensus among focus group participants and health care providers and administrators about the need for:

- Increased education across all sectors to reduce the stigma associated with mental health and substance use;
- Increased access to treatment and the need for long term care;
- Increased integration between the treatment of mental health and substance use disorders;
- The impact of mental health conditions and substance use on families;
- Increased training for physicians to address mental health and substance use concerns in the primary care setting.

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

- Focus group participant,
Access to mental health and substance use services

Mental Health

An estimated 12% of Hampshire and Franklin County residents have poor mental health on 15 or more days in a month (11% statewide) (BRFSS 2012-2014). Though mental health is commonly thought of as the absence of mental illness, mental well-being extends beyond the presence or absence of mental disorders, and has been defined by the World Health Organization as the “state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”²⁴ Only 17% of U.S. adults are estimated to be “in a state of optimal mental health.”²⁵ Mental health is an indicator of health itself, but also contributes to physical health and inequities.

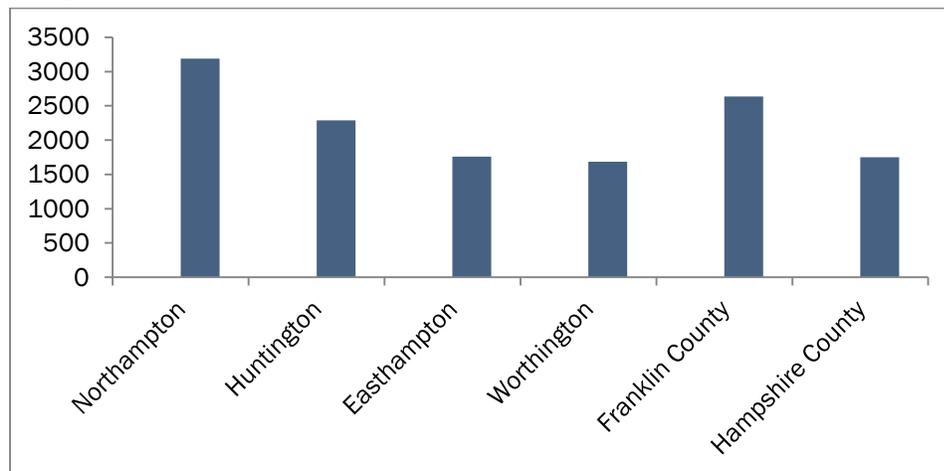
“Mental health and substance abuse are overlapping - we should not look at them as separate”

-Key Informant Interviewee,
Substance Use Treatment Specialist

Depression is the most common type of mental illness, and it affects more than 26% of U.S adults.²⁶ It is estimated that by 2020, depression will be the 2nd leading cause of disability worldwide, and children are a particularly vulnerable population.²⁷ Mental illness often co-occurs with substance use disorders and impacts physical health as well.

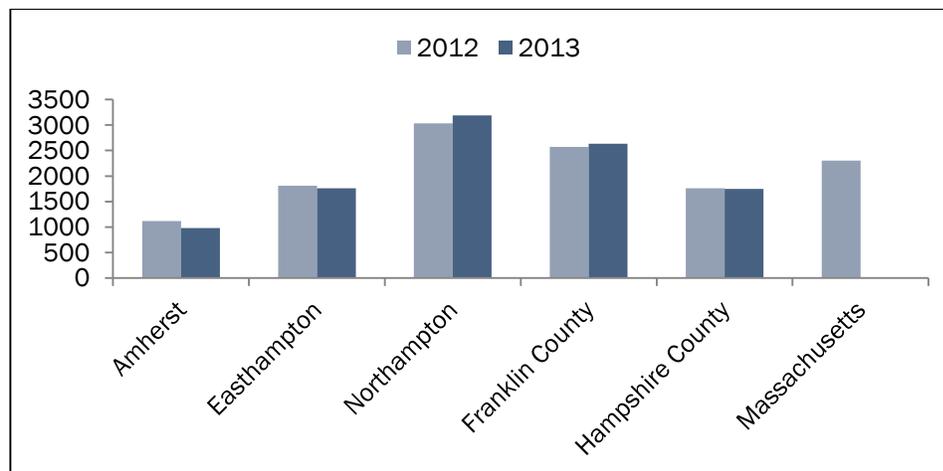
Figure 14 illustrates the communities with the highest mental health disorder ER visit rates in the CDHC service area, with high rates observed in Northampton. Figure 15 illustrates 2012 and 2013 ER visit rates among select communities.

Figure 14. Communities with the Highest Mental Health Disorder ER Visit Rates in the CDHC Service Area, 2013



Source: MDPH, age-adjusted per 100,000; *Data available for less than 10 communities
 Note: mental health disorder ER visits include those related to substance use

Figure 15. Mental Health Disorder ER Visit Rates in Select CDHC Service Area Communities, 2012-2013



Source: MDPH, age-adjusted per 100,000
 Note: mental health disorder ER visits include those related to substance use

Vulnerable Populations

- **Youth** are disproportionately impacted with mental health issues. In Hampshire County, approximately a third of 8th, 10th, and 12th graders experienced depressive symptoms.²⁸ Findings from the Franklin County/North Quabbin Youth Risk Behavior Survey (2013) indicate that 26% of youth respondents felt sad or hopeless, for two or more weeks, that they

stopped doing some usual activities, and 16% of students considered attempting suicide over the past year.²⁹

- **LGBTQ** youth are also disproportionately impacted with mental health issues. Findings from the Hampshire County 2011 PNAS found that more than half of LGBTQ youth reported feelings of depression over past year (52%). An analysis of the 2013 Franklin County/North Quabbin Youth Risk Behavior Survey echoed this disparity, with 53% of LGBTQ youth reporting depression. Additionally, 45% of LGBTQ youth considered suicide in the past year compared to 12% among their heterosexual peers.³⁰ In a focus group conducted for CDHC for this CHNA with a focus on health care needs for lesbians, participants noted a need for mental health care providers and practices that are specifically oriented to the needs of the LGBTQ population.
- **Veterans** with untreated mental health conditions, especially PTSD, were identified as a concern. Findings from focus groups conducted with veterans and military families for CDHC for this CHNA identified that it is common for active duty service members and veterans to avoid seeking treatment because they fear a lack of confidentiality with their records, which could in turn negatively impact benefits, service, and opportunities for employment.
- **Blacks** experience mental health related disparities. In Hampshire County, the ER visit rate among Blacks is more than double that of Whites and 76% higher than the overall statewide rate. In Franklin County, the rate among Blacks is 41% greater than that of Whites and 56% higher than the overall statewide rate. Disparities are also present in Amherst and Northampton where the rates are as much as three times the rate of Whites in each community, respectively (MDPH, 2012).
- **Latinos** experienced high ER visit rates for mental disorders with rates in Franklin County 32% higher than that of Whites and 46% greater than the overall statewide rate. In Easthampton, the rate among Latinos was just over 50% more than that of whites and 16% greater than the overall statewide rate (MDPH, 2012).
- **Older Adults** experience a high prevalence of depression. Approximately 17% of Medicare enrollees 65 years and older in Hampshire and Franklin Counties had depression in 2014 (MA: 16%) (Medicare 2014, one-year estimate).

What is really scary is when veterans with untreated PTSD get Alzheimer's."

- Focus Group Participant,
Health Care Needs of Military
Families

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

- Focus group participant, Mental
Health and Substance Use Focus
Group

Substance Use

High rates of *substance use* continue to be a prioritized health need for the community. An estimated 16% of Hampshire County and 20% of Franklin County residents smoke **tobacco** as compared to 16% statewide (BRFSS 2012-2014).

Though community efforts have successfully reduced substance use in some communities, youth alcohol and substance use continues to be high in Hampshire and Franklin County.

- In Hampshire County, half of 12th graders reported drinking alcohol and one third reported using marijuana within the past 30 days, which was higher than national rates.³¹
- In Franklin County/North Quabbin Region, 54% of 12th graders reported drinking alcohol and 42% reported using marijuana within the past thirty days.³²
- Findings from the 2013 Youth Risk Behavior Survey indicate that LGBTQ youth from Franklin County/North Quabbin are more likely to have used alcohol (34% vs. 29% of heterosexual youth), marijuana (38% vs. 20% of heterosexual youth), prescription narcotics (14% vs. 6% of heterosexual youth), and other drugs in the past 30 days.³³
- Results from the 2011 Prevention Needs Assessment Survey (PNAS) also identified higher rates of drug and alcohol use among LGBTQ youth compared to their heterosexual peers.³⁴

In a survey conducted by Community Action in 2014, nearly 30% of respondents felt that substance use treatment services, including those for tobacco, alcohol, and other drugs, were inaccessible, unaffordable, or did not exist in Hampshire County. Gaps in substance use prevention strategies were also reported by respondents.³⁵

Substance use disorders (SUD) refer to the recurrent use of drugs or alcohol that result in health and social problems, disability, and inability to meet responsibilities at work, home, or school. Risk factors for SUD include genetics, age at first exposure, and a history of trauma. Substance use related ER visit and hospitalization rates were among the highest ER visit and hospitalization rates of those examined for the CHNA. Figure 16 illustrates the communities in the CDHC service area with the highest ER visit rates that occurred due to substance use in 2013. As can be seen in Figure 17, Northampton ER visit rates were higher than both counties and the state. Hospital providers who participated in feedback sessions for the 2016 CHNAs noted that substance use ER and hospitalization visit rates are likely an underestimate as people with substance use disorder are sometimes given a primary mental health diagnosis instead to satisfy criteria for admission.

Opioid use disorder has rapidly emerged as a public health crisis in Massachusetts and across the country. Between 2002 and 2013 in the U.S. there has been an almost three-fold increase in opioid-related deaths.³⁶ In Massachusetts alone, the number of opioid-related deaths in 2014 represents a 65% increase from 2012.³⁷

“Substance abuse programs as a rule don't want to admit someone from a psychiatric hospital. It's very siloed on both sides.”

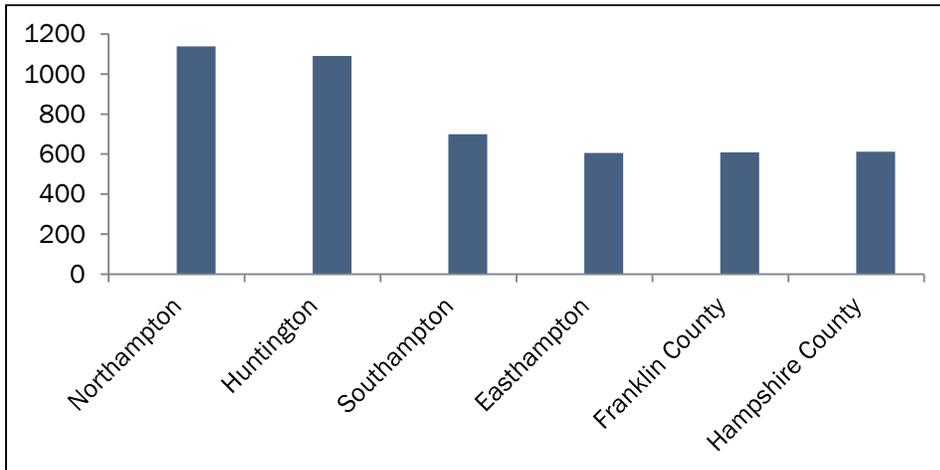
– Key Informant Interviewee,
Mental Health/Substance Abuse
Professional

Opioid overdose fatalities in Franklin County are higher than that of the state with 13 fatalities per 100,000 as compared to 11 statewide. This is despite lower opioid overdose hospitalization rates in Franklin County (49 vs. 104 per 100,000 in MA).³⁸ Data from Massachusetts state police indicate that approximately 40% of opioid overdose related fatalities in the first six months of 2014 were attributed to heroin, pharmaceutical opioids, and fentanyl. Additionally, many of the opioid overdose fatalities in the first six months of 2014 were the result of using a combination of drugs including heroin, pharmaceutical opioids, fentanyl, cocaine, methadone, antidepressants, antipsychotics, benzodiazepines, stimulants, and muscle relaxants.³⁹

In key informant interviews and mental health/substance use focus groups conducted for other Coalition members for this CHNA, health care providers and administrators identified the need for:

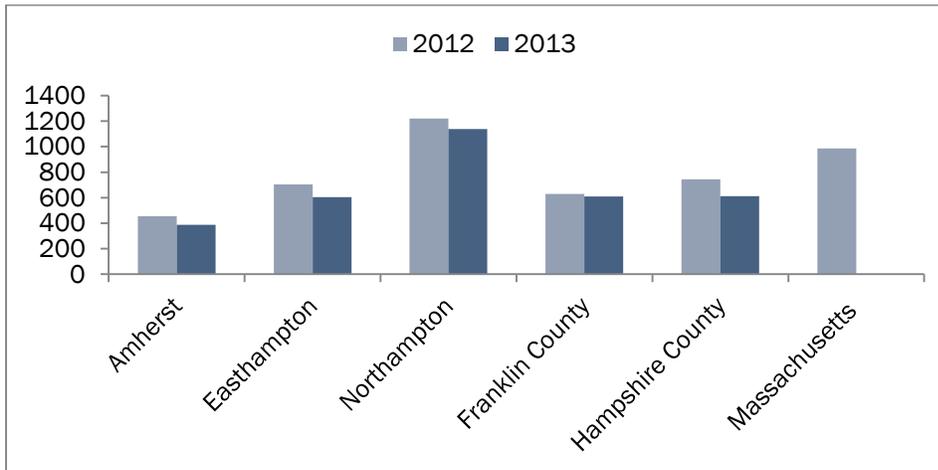
- increased institutional support to promote harm reduction approaches, such as Narcan, to reduce morbidity and mortality that occur as a result of opioid overdose;
- more access to long-term medication assisted treatment (MAT) programming;
- continued focus on therapeutic, not just pharmaceutical, treatment of substance use disorders;
- more support and prevention education for youth, particularly those with histories of trauma.

Figure 16. Communities with the Highest Substance Use Disorder ER Visit Rates in the CDHC Service Area, 2013



Source: MDPH, age-adjusted per 100,000; state data only available for 2012; *Data available for less than 10 communities

Figure 17. Substance Use Disorder ER Visit Rates in Select CDHC Service Area Communities, 2012-2013



Source: MDPH, age-adjusted per 100,000

Vulnerable Populations

- As with mental health concerns, **veterans** with substance use concerns are more likely to be undertreated, due to concerns over lack of confidentiality and potential loss of benefits, active duty status, and employment opportunities.
- **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, substance use among Hampshire and Franklin County youth exceeds national levels, and rates are particularly high among **LGBTQ youth**.
- **Blacks** in Hampshire County had a substance use ER visit rate more than double that of Whites in the same county and 91% greater than the overall statewide rate. In Northampton the rate among Blacks is over 5 times that of whites and 6 times the overall statewide rate (MDPH, 2012).
- **Latinos** experienced opioid-related hospitalizations double the rate of Whites in Franklin County and the overall statewide rate. Latinos also had higher substance use hospitalizations in Hampshire County and Northampton compared to that of Whites in the same geography. In Northampton, the substance use hospitalization rate among Latinos was over twice that of Whites and over three times the overall statewide rate (MDPH, 2012).

Infant and Perinatal Health Risk Factors

Infant and perinatal health risk factors were identified as health needs in the 2013 CHNA and continue to impact CDHC service area residents. **Preterm** birth (<37 weeks gestation) and **low birth weight** (<2,500 grams) are among the leading causes of infant mortality and morbidity in the U.S., and can lead to health complications throughout the life span. Early entry to **prenatal care**, as well as adequate prenatal care, are crucial components of health care for pregnant women that directly impact birth outcomes, including preterm birth, low birth weight, and infant mortality (infant death before age 1). **Smoking during pregnancy** is a risk factor that increases the risk for pregnancy complications and affects fetal development.⁴⁰

In Hampshire and Franklin Counties, an estimated 13-16% of women did not receive adequate **prenatal care**, and 18-19% started prenatal care after their first trimester (Figure 18). Adequacy of prenatal care is based on whether a woman entered prenatal care early in pregnancy (within the first trimester) and number and timing of prenatal visits. Although these rates are lower or comparable to the state, they represent a sizeable proportion of women who did not receive adequate prenatal care and/or entered prenatal care after the first trimester.

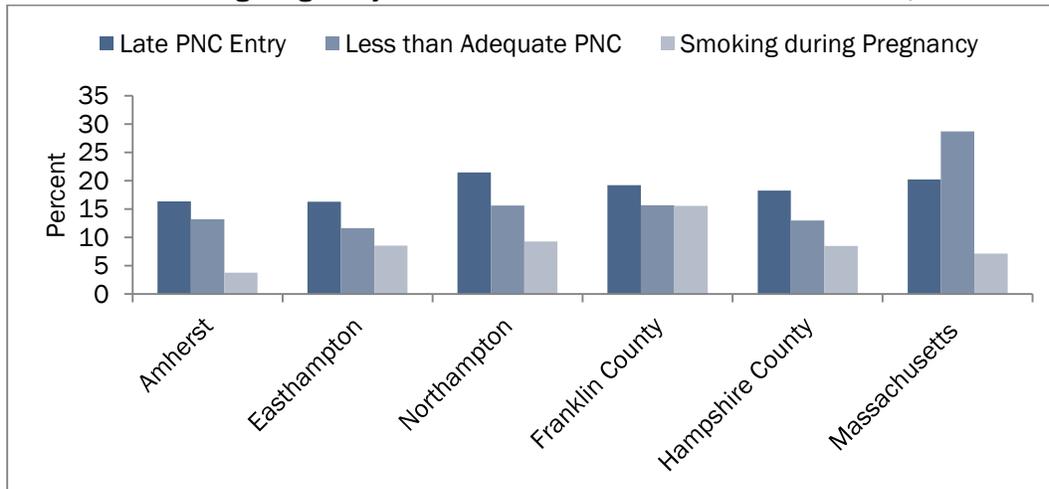
“Don’t forget the fathers.”
- Focus Group Participant,
Maternal and Child Health Focus
Group

Another area of need is **smoking during pregnancy**. Nearly 9% of Hampshire County women and 16% of Franklin County women reporting smoking during pregnancy among births to residents of those Counties (MDPH, 2012). In Easthampton and Northampton approximately 9% of women smoked during pregnancy in 2012, which was slightly higher than the state (7%) (MDPH, 2012).

“It shouldn’t be so hard when you’re trying to get pregnant, especially in this area.”
- Focus Group Participant,
Access to Health Care for
Lesbians

Participants in a focus group on maternal and child health needs conducted for another Coalition hospital for this CHNA expressed a need for the health care system to be more understanding about the challenges women experience managing their own care as well as the care of their families. Additionally, participants agreed on the need for support around stress, anxiety, and social isolation, particularly in the postpartum period. Findings from a CDHC focus group focused on lesbian access to health care, specifically noted the need for more supportive policies for non-heterosexual couples seeking assisted reproductive services.

Figure 18. Percent of Women with Late Entry to Prenatal Care, Less Than Adequate Prenatal Care, or that Smoked During Pregnancy in Select CDHC Service Area Communities, 2012



Source: MDPH, adequate prenatal care includes women that received adequate or adequate plus care
 *Late PNC entry is entry to prenatal care after the 1st trimester

Vulnerable Populations

- **Black women** experienced disparities relative to prenatal care adequacy. In Hampshire County, a third of Black women obtained less than adequate prenatal care, which was more than double rate among Whites and 16% greater than the overall statewide rate. In Amherst, the rate among Black women, though comparable to the overall statewide rate, was 82% higher than that of Whites.
- **Latinas** experienced disparities related to prenatal care. Though lower than the overall statewide rate, in Hampshire County one in five Latinas did not receive adequate prenatal care, which was 54% greater than the rate among Whites in the same County. In Northampton, a quarter of Latinas did not receive adequate prenatal care compared to 14% among Whites. Rates of late entry to prenatal care were higher among Hampshire County Latinas than Whites, and in Amherst, the percentage of Latinas who entered prenatal care after the first trimester was 60% higher than Whites and slightly higher than the overall statewide rate.

Sexual Health

Teen Pregnancy

Teen birth rate in Franklin County is three times the statewide rate (15 vs. 5 per 1,000). The rate in Easthampton was also high and more than twice that of the state (MDPH 2014).

Vulnerable Populations

- Teen pregnancy rates are particularly high among **Latinas** in Hampshire County compared to the rate among Whites.

IV. Vulnerable Populations of Concern

CDHC requested focus groups for the 2016 CHNA to assess the health needs of lesbians, transgender individuals, veterans and military families.

Lesbian and Transgender Health

Findings from focus groups with lesbians and transgender persons identified the need for increased training for providers and staff to provide culturally sensitive and appropriate care. Participants from the lesbian focus group noted an overall need for a reproductive health care clinic focused specifically on LGBTQ health. Specific needs identified included sexual health education for LGBTQ individuals that are sexually active and more supportive services for LGBTQ couples seeking assisted reproductive technology care.

Recommendations from participants in both focus groups identified the need for:

- Provider and staff training around LGBTQ health care needs overall and transgender in specific;
- Increased staff that identify as LGBTQ;
- Paperwork and electronic forms that can be updated to include preferred pronouns, especially for individuals whose names are not yet legally changed;
- Creating a welcoming space including gender neutral bathrooms, nametags for staff that include pronouns, and signage indicating that the clinic is a LGBTQ-safe space;
- Continued engagement with the LGBTQ community to improve services.

“There are no options in the computer to fit me.”

- Focus Group Participant,
Access to Healthcare for
Lesbians

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

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

“I am anxious about getting in a car accident. If I am not conscious, how will the EMT’s treat me? The ER staff? Who will advocate for me?”

- Focus Group Participant,
Access to Healthcare for
Transgender Persons

Health Needs of Veterans and Military Families

Veterans were identified as a vulnerable population of need. To better understand the needs of this population, CDHC conducted two focus groups for this CHNA, one with veterans, and one with military families. Needs identified through these focus groups include:

- Provider and community education to combat stigma faced by veterans, including perceptions of mood disorders, mental health, conditions, and substance use disorders;
- Increased training for civilian health care providers and staff to adequately meet and assess unique needs faced by veterans;
- High rates of untreated PTSD and substance use disorder due to the fear of disclosing either and potentially losing benefits or employment opportunities;
- Need for more peer-support groups outside of the VA system;
- Need for more services to support transition back to civilian life, both for veterans and their families;
- Need for more education for military families about signs and symptoms of mental health conditions, and what actions to take, *before* their family member is discharged and returns home.

“97% of anyone in the medical field is not adequately prepared to deal with anyone with PTSD or veterans in general”

- Focus Group Participant,
Health Care Needs Of Veterans

“Spouses are supporting the vets - who is supporting them?”

- Focus Group Participant,
Health Care Needs Of Veterans

Other Vulnerable Populations Identified

Available data presented throughout this report indicate that **children and youth, older adults**, and some communities of color, particularly **Latinos** and **Blacks**, experience disproportionately high rates of some health conditions or associated morbidities when compared to that of the general population in the CDHC service area.

- Children and youth experienced high rates of asthma and are impacted by obesity. They are also vulnerable with regard to mental health and substance use.
- Older adults had higher rates of chronic disease, hypertension and depression.
- Latinos and Blacks experienced higher rates of hospitalizations due to some chronic illnesses, mental health conditions, and substance use disorder. Latinas experienced higher rates of teen pregnancy and disparities in prenatal care. Numerous factors contribute to these racial and ethnic inequities. A key informant interview with a Hampshire County public health personnel identified institutional racism stating that it is “... a silent killer.” Institutional racism has been defined as racial inequities in access to goods, services, and opportunities such as quality education, housing, employment opportunities, medical care and facilities, and a healthy physical environment.⁴¹ Dr. Camara Jones, the President of the American Public Health Association, describes institutional racism as “normative, sometimes legalized, and often manifests as inherited disadvantage.” It does not necessarily transpire

at the individual level, but is structurally embedded in our systems, regulations, and laws. Institutional racism is perpetuated by structural barriers and inaction in the face of need.⁴²

Individuals with **low income** levels, those living in poverty, especially children and people of color, and those who are **homeless** are also disproportionately impacted by poor health. Though data was not available for health conditions by income/poverty level, these health determinants have been consistently documented with poor health outcomes. In addition, individuals with **disabilities** are a potential vulnerable population because of challenges accessing services, though data was not available to assess needs.

Overall, more data is needed to understand the unique factors that impact the health of each of these vulnerable populations.

Community & Hospital Resources to Address Identified Needs

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

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

Access to care

Program: Hampshire County Health Access Task Force

CDHC joined with the Hilltown Community Health Centers and other agencies, Town of Amherst, and residents to plan and create the John P. Musante Community Health Center. The Center will open in 2017. CDHC assisted with feasibility studies on cash flow and fund raising; architectural fees; program design and community engagement/outreach.

Project: Improved access to care by improving access to transportation

CDHC worked with the United Way of Hampshire County and the Pioneer Valley Planning Commission to research, write, and release the report “Getting to Healthy.” The report studied transportation barriers to health care and provided recommendations to improve access. CDHC also provided pilot project funding to the Amherst Survival Center to send clients to medical appointments and the City of Northampton Office of Planning and Sustainability to develop a template to map a Complete Streets initiative. The template, once developed, can be used by other municipalities. CDHC participates in the Hilltown Regional Coordinating Council, hosted by the Hilltown CDC and provided funding, data, and support to study access to medical care and transportation barriers for rural, isolated seniors and people with disabilities. The Hilltown Community Health Centers, Councils on Aging, Stavros, and others are partners in this project.

Supporting Health Equity

Project: Latino Access to Health Care

CDHC provided an annual grant to Casa Latina to provide patient navigation, information and referral, and case management services.

Chronic disease rates and preventive practices

Program: A Positive Place

CDHC provides confidential, equitable and integrated medical and social case management and health related support services, emergency assistance, risk assessments/reduction, and housing assistance to increase engagement/retention in care, reduce the rate of transmission, and improve

quality of life. Services are provided at A Positive Place, off-site at infectious disease specialist, and in people's homes, jail, hospital, treatment program, nursing home, or other location as needed.

Behavioral Health

Program: Reducing teen substance abuse

CDHC provided financial support to the SPIFFY Coalition to implement the Prevention Needs Assessment (PNAS) survey. The PNAS assists local substance abuse prevention coalitions to plan programs based on local data on youth behaviors and associated risk and protective factors at the individual, family, school, and community levels. CDHC also participates regularly in SPIFFY meetings, Northampton Prevention Coalition, and the Easthampton Healthy Youth Coalition.

Project: Improve coordination of community system of care

CDHC worked with non-profit mental health agencies, the Mass. Dept. of Mental Health, the Mass. Dept. of Public Health, and the National Alliance on Mental Illness – Western Massachusetts chapter to map our current “system” of behavioral health care. CDHC identified opportunities to improve the system with a goal of improving the functioning of the continuum of care including promoting available services; increasing awareness of services that are available; coordinating with other hospitals in the region; and educating the community about stigma. CDHC worked with other health care systems in the region to implement Mental Health First Aid training. Our President and Chief Executive Officer signed NAMI's CEO pledge to reduce stigma. Nearly 100 people attended a lecture on stigma as part of our Massachusetts General Hospital lecture series. And CDHC hosted two events during Mental Health Awareness Month to bring awareness of local resources to people who experience mental health problems and their families.

Project: Reduce impact of opioid abuse

CDHC joined the Hampshire Heroin Opiate Prevention and Education (HOPE) Coalition and helped to establish a Health Care Solutions committee. CDHC printed and helped distribute educational materials for people seeking help. CDHC created Narcan prescription cards for the emergency department. CDHC created an internal task force to address opioids as a health care system.

Healthy Eating/Active Living and Tobacco Control – Easthampton Projects

Project: Healthy eating/active living

Project: Tobacco control

CDHC provided funding and support for a variety of projects including multi-generational cooking and gardening; school gardens; healthy food demonstrations to elderly men; healthy food demonstrations to municipal employees; and healthy food demonstrations to the general public. CDHC also supported tobacco treatment initiatives by expanding the number of health care staff trained in tobacco treatment. CDHC supported training for landlords to create smoke-free housing.

Summary

The CDHC service area, which consists of communities in Hampshire and Franklin Counties, continues to experience many of the same health needs identified in CDHC's 2011 CHNA. Social and economic challenges experienced by some members of the population in the service area contribute to the high rates of chronic conditions and other health conditions identified in this needs assessment. These social and economic factors also contribute to the health disparities observed among vulnerable populations, which include children, older adults, Latinos, Blacks, LGBTQ adults and youth, veterans, low-income individuals, homeless persons and those living in poverty. Additional data is needed to better understand the needs of these populations in order to reduce inequities. Some members of the CDHC service area population, particularly vulnerable populations, continue to experience barriers that make it difficult to access affordable, quality care. Some barriers, such as transportation, are related to the social and economic conditions in the community, and others relate to the healthcare system itself. Mental health conditions and substance use disorders were consistently identified as top health concerns impacting the community, and the inadequacy of the current systems of care to meet the needs of individuals impacted by these disorders arose as an important issue that needs to be addressed. The opioid crisis has emerged as a top issue impacting the health of the community. Progress has been made to address some of the prioritized health needs previously identified, such as childhood obesity; however, rates remain high and work to address health conditions and the underlying social determinants of health must continue.

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Appendix I: Stakeholders Involved in CHNA Process

Steering Committee Members

Focus Group Participants

Key Informant Interviewees

Steering Committee Members

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

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

Focus Group Participants

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

Cooley Dickinson Health Care: Health Care Needs of Veterans

- 10 participants
- All post 9-11 veterans

Cooley Dickinson Health Care: Health Care Needs of Military Families

- 7 participants
- All female
- Mostly spouses, also one parent, one daughter

Cooley Dickinson Health Care: Access to Health Care for Lesbians

- 4 participants
- All female, between the ages of 31-60 years old
- All identified as White and Non-Hispanic
- Half identified as lesbian, and half as queer.

Cooley Dickinson Health Care: Access to Health Care for Transgender Persons

- 10 participants
- Primarily 20's and early 30's
- Nine identified as White

Health New England: Access to Health Care for Low-Income Individuals

- 6 participants
- All participants were females: all identified as straight
- Most over 51 years old
- All identified as White, and Non-Hispanic

Baystate Noble Hospital: Mental Health and Substance Use

- 8 participants
- 3 women and 5 men; aged 31-60 years old
- All identified as White, Non-Hispanic
- Most identified as straight

Mercy Medical Center: Mental Health and Substance Use

- 13 family member participants (mostly parents)
- Most identified as White, Non-Hispanic
- Majority aged 51-60 years old

Holyoke Medical Center: Mental Health and Substance Use

- 9 participants

- Primarily male, aged 51-60
- Identified as white, Hispanic, and African-American

Baystate Medical Center: Maternal and Child Health

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

Key Informant Interviewees

Name (Last, First)	Title	Organization	Organization Serving Broad Interests of Community	Organization Serving Low-Income, Minority, And Other Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Depart- ment Staff
<i>Hampshire County Public Health Officials and Community</i>					
Jackie Duda	Health Agent	Easthampton Health Department			
Julie Federman	Health Director	Town of Amherst			
Merridith O'Leary	Director	Northampton Health Department			
Natalia Munoz	Journalist and Resident				
<i>Health New England</i>					
Robert Azeez	Medicaid Behavioral Health Manager	Health New England			
Kerry LaBounty	Medicaid Program Manager	Health New England			
David Silva	Medicaid Community Leader	Health New England			
Jacking Spain, MD	Medicaid Program Medical Director	Health New England			
<i>Public Health Personnel</i>					
Caulton-Harris, Helen	Commissioner of Public Health	City of Springfield	X		X
Dennis, Soloe	Western Region Director	Massachusetts Department of Public Health (MDPH)			X
Garcia, Luz Eneida	Care Coordinator	MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit			X
Hyry-Dermith, Dalila	Supervisor	MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit			X
Metcalf, Judy	Director	Quabbin Health District	X		X

Name (Last, First)	Title	Organization	Organization Serving Broad Interests of Community	Organization Serving Low-Income, Minority, And Other Medically Underserved Populations	State, Local, Tribal, Regional, or Other Health Depart- ment Staff
O'Leary, Meredith	Director	Northampton Health Department	X		X
Steinbock, Lisa	Public Health Nurse	City of Chicopee	X	X	X
Walker, Phoebe	Director of Community Services	Franklin Regional Council of Governments (FRCOG)	X		X
White, Lisa	Public Health Nurse	Franklin Regional Council of Governments (FRCOG)	X		X

Appendix II: Focus Group and Key Informant Interview Summaries

Focus Group Reports

- Cooley Dickinson Health Care: Health Care Needs of Veterans
- Cooley Dickinson Health Care: Health Care Needs of Military Families
- Cooley Dickinson Health Care: Access to Health Care for Lesbians
- Cooley Dickinson Health Care: Access to Health Care for Transgender Persons
- Health New England: Access to Health Care for Low-Income Individuals
- Baystate Noble Hospital: Mental Health and Substance Use
- Mercy Medical Center: Mental Health and Substance Use
- Holyoke Medical Center: Mental Health and Substance Use
- Baystate Medical Center: Maternal and Child Health

Key Informant Interviews

- Hampshire County Public Health Officials and Community
- Health New England
- Public Health Personnel

Focus Group Report: Health Care Needs of Veterans

Participants: Veterans

Primary Hospital/Insurer: Cooley Dickinson Health Care

Date: February 16, 2016

Executive Summary

Participant Demographics

The focus group had 10 participants, all post 9-11 veterans.

Areas of Consensus

Participants were in agreement about several major areas:

- Access to health care, both inside and outside of the VA system, can be very challenging. VA is an antiquated system with long waits, but it's familiar to and with veterans. Outside of the VA system, care is better, but costly, and veterans' issues are not as well understood.
- Stereotypes about veterans, in health care and among the population in general, hinder veterans' access to health care and support networks
- Active duty service members, including those in the national guard, fear seeking help for behavioral health issues because of a lack of confidentiality and the possibility of a bad conduct discharge, which would cost them their benefits.

Recommendations

- Provide professional development to health care providers, particularly to first responders and intake personnel at civilian hospitals and medical centers, concerning issues and needs specific to veterans.
- Facilitate connections between the VA and civilian hospitals, so that records can be transferred across systems (at veterans' request) and billing is streamlined.
- Keep records of treatment for mental health and substance abuse completely confidential, so that seeking help for these issues does not negatively impact a soldier's current position or a veteran's eligibility for federal jobs.
- Veterans need more help accessing medical services and receiving emotional support when they transition to civilian life.

Quotes

- "We lose thousands of veterans every day just because something wasn't done quickly enough"
- "I tell people I'm a veteran and they assume I'm going to have an episode and go off"
- "97% of anyone in the medical field is not adequately prepared to deal with anyone with PTSD or veterans in general"
- "Many veterans are getting hit financially as a result of the VA not paying bills or taking a long time to pay bills"
- "I've fallen behind in life as a result of being a vet"

Focus Group Report: Health Care Needs of Military Families

Participants: Families of veterans

Primary Hospital/Insurer: Cooley Dickinson Health Care

Date: February 22, 2016

Executive Summary

Participant Demographics

The focus group had six participants - all women. Five have spouses who had served in the past 15 years (post 9/11). One has a son who is active military. One additional woman (female, adult daughter of a Veteran) was interviewed by phone afterwards and her input is included in this report.

Areas of Consensus

Participants were in agreement about several major areas:

- Access to health care, both inside and outside of the VA system, is difficult. Long wait time for services at VA, lack of mental health services at VA. Outside of the VA system veterans' issues are not as well understood, insurance becomes a barrier.
- Lack of support for transition from military/reserves to civilian life, both for veteran and family members. Need access to support groups, resources, assistance accessing resources (including appropriate health care, insurance.)
- Active duty service members, including those in the national guard, fear seeking help for behavioral health issues because of a lack of confidentiality and the possibility of a bad conduct discharge, which would cost them their benefits. They also fear they will be demoted, or lose out on promotions. This carries into civilian life. There is a strong stigma against mental health issues - sign of weakness.

Recommendations

- Educate Primary Care Providers about veteran's needs and issues so they can make appropriate referrals, especially around mental health issues.
- Veteran's want more "say" over their health care, including the ability to choose their own health care providers, insurance. Especially outside of the VA.
- Keep records of treatment for mental health and substance abuse completely confidential, so that seeking help for these issues does not negatively impact a soldier's current position or a veteran's eligibility for federal jobs.
- Families of Veterans, especially spouses, need support with the transition to civilian life. What to expect, where to find support groups, how to support their spouse and children, what to watch for in terms of mental health issues, how to navigate insurance and health care providers. They need this information and support *before* their family member is discharged.

Quotes

- "Spouses are supporting the vets - who is supporting them?"
- "The transition (from military to civilian life) is always hard on everyone."
- "Most of our friends and even his family don't get it" (referring to PTSD)
- "What is really scary is when veterans with untreated PTSD get alzheimer's..."
- "I wish there were more people to oversee their care at the VA and to make sure they are getting appropriate treatment."

Focus Group Report: Access to Health Care for Lesbians

Participants: Lesbians

Primary Hospital/Insurer: Cooley Dickinson Health Care

Date: March 1, 2016

Executive Summary

Participant Demographics

Four women participated in the focus group, and an additional three participated in follow-up telephone interviews (two of the three women were a married couple who participated simultaneously). Of the four women in the focus group, all identified as non-Hispanic whites. Three were age 31-40, and one was age 51-60. Two identified as lesbian, and two as queer.

Areas of Consensus:

- Three of the four women in the focus group have sought or are seeking assisted reproduction care, and they agreed that this process has been made needlessly challenging by the attitudes and policies they have encountered from health care providers.
- Mental health care is challenging to access, because many practices are not taking new patients, and the need to find someone who is LGBTQ-friendly and covered by insurance limits choices even more.

Recommendations:

- Establish a reproductive clinic oriented toward the LGBTQ population. This is a growing need that is not being met by traditional health care practices. It would not only be used by many people in the area, but could draw in people from other parts of New England and New York as well.
- Establish a behavioral health clinic oriented toward the LGBTQ population.
- Let people know that CDH is exploring these issues and trying to improve its connections with the LGBTQ community

Quotes:

- “It shouldn’t be so hard when you’re trying to get pregnant, especially in this area.”
- “Providers ask me about sexual activity, and when I say yes, they assume I need contraception. I have been marked down as abstinent. I still have sexual health needs, even if I don’t need contraception.”
- “There are no options in the computer to fit me.”

Focus Group Report: Access to Health Care for Transgender Persons

Participants: Transgender persons

Primary Hospital/Insurer: Cooley Dickinson Health Care

Date: March 8, 2016

Executive Summary

Participant Demographics

Ten people participated with a range of ages, primarily 20's and early 30's. Nine identified as white, one person of color.

Areas of Consensus

- There is a lack of information on how to transition, both from mental health providers and primary care providers. There are few resources, few specialists - PHP's don't know where to refer people who want to get more information about how to transition.
- There is a lack of trans-competency among health care providers, including front desk staff, aides, social workers, and other health care providers. This includes making assumptions about pronoun preferences, personal anatomy, and routine tests needed (or not needed.)
- Electronic forms/history needs to be updated to include correct pronouns. Even if insurance requires provider to use person's birth name/pronoun, staff should still make an effort to use person's chosen name/pronoun. Add this to the electronic history so person does not have to continually correct staff/providers.

Recommendations

- Establish a clinic oriented toward the transgender population. This is a growing need that is not being met by traditional health care practices.
- CDH needs to make serving the transgender population an ongoing dialogue. One focus group is not enough. Continue to engage the transgender population in identifying solutions.
- Hire more transgender and gender nonconforming people.
- Put pronouns on staff name tags/badges. Put up signs in waiting rooms with a rainbow saying "This is a safe place." Be sure staff have training in trans-competency.
- Provide gender neutral bathrooms.
- Cultural competency training for medical, social service, and mental health staff, including clerical and front desk staff/volunteers.

Quotes

- At an annual physical, PCP says to person getting ready to transition "Let's check out those testicles while you still have them!"
- When seeing a provider for the first time, and revealing that they are transgender, provider says "This will be fun - you are like a guinea pig for us."
- "My doctor brought other doctors in to look at me because I was Transgender. Like I was a novelty. It makes me not want to see doctors anymore."
- Referring to an experience in the ER "It is horrible to be lying on a gurney in the hallway while the staff try to figure out where to put you. Why don't they just ask me?"

- “I am anxious about getting in a car accident. If I am not conscious, how will the EMT’s treat me? The ER staff? Who will advocate for me?”
- “The doctors talk about transgender issues during Grand Rounds, but they don’t do anything about it. They just pay lip service to our issues.”
- “Don’t make assumptions about where Trans people want to go for inpatient treatment. Just because Brattleboro has a GLBTQ unit does not mean that is where I want to be. I might rather stay at CDH or Baystate where I am closer to friends and family.”
- When going to pharmacy to pick up prescription for hormones, pharmacist says “You are too young to be on hormones, why are you using these?”
- “The physicians expect us to educate them about trans issues. We should not have to be the experts. We want doctors who are informed about trans issues.”
- A female presenting transgender person who identifies as male says: “When I see my PCP I check the female box (instead of the male or transgender box) because I don’t want to have to go through the [expletive] of explaining who I am to people who don’t get it. It feels horrible. Every time. I hate it.”

Focus Group Report: Access to Health Care for Low-Income Individuals

Participants: Mothers

Primary Hospital/Insurer: Health New England

Date: April 5, 2016

Executive Summary

The focus group consisted of six female residents of a low-income housing development in Greenfield, MA. Discussions revolved around access to healthcare, including gaps and barriers to obtaining needed services.

Poverty was an underlying theme of this focus group. Poverty is a significant barrier to health. Respondents spoke about their inability to afford medications, transportation to appointments, childcare, and gym memberships.

Participant Demographics

6 participants, recruited through the housing coordinator at a low-income housing complex located in Greenfield

- All participants were females: all identified as straight
- Age distribution:
 - 1: 21-30 years old
 - 1: 41-50 years old
 - 2: 51-60 years old
 - 2: >60 years old
- All identified as White, and not Hispanic/Latino

Areas of Consensus

- Participants generally agreed that lack of transportation is a significant barrier to accessing needed care. Most participants rely on others for rides or use public transportation.
- Public transportation was reported to run infrequently, and/or have limited drop off locations that require a secondary form of transport (or walking in areas that are not pedestrian friendly.)
- “TP1’s” (insurance funded transportation system) have to be scheduled in advance, and do not make accommodations for accompanying a dependent.
- Participants agreed that waiting for appointments is a barrier. They reported that it can take a few days to see a doctor when sick, a few weeks to see a specialist, and up to a year to schedule a routine physical. Limited access to transportation compounds this issue.
- Participants agreed that they have limited input in setting the goals and priorities for their health.
- Most participants reported feeling rushed during appointments; not having enough time for questions; and having a limited understanding of medical jargon when discussing medical conditions.
- Half of the participants reported limited dental coverage.
- Changes in prescription coverage as a result of recent insurance changes were a frustration for most participants.

Recommendations

- Increased availability of transportation options for those that don't own cars.
- More free venues for exercise and more nutrition/diet support services.
- More comprehensive dental and vision coverage.
- Better training for customer service representatives at insurance companies and doctor's office.
- More social workers/patient navigators to assist with paperwork, scheduling appointments, transportation, and support during (and to prepare for) doctor's appointments.

Quotes

- "My son has been on his medication for 13 years, and now they are saying that they cannot cover it. They offer an alternative, but we have already done all of the alternatives- Why step backwards?"
- "Everyone in my house was sick last month. I had already taken too much time from work. I couldn't get appointment with primary care doctor that worked with my schedule, so I went to the clinic. Then the clinic made me wait for authorizations."
- "TP1s only apply to that one person. It is difficult for single parent- you can't bring your kids with you."
- "You have to wait 45 minutes for a 5-minute appointment. I think of things afterwards because they rush you and you don't have time to think about it sometimes."

Key Issues

Question	Synthesis of Responses
1. What has you/your family member's experience with the health care system been like	Participants primarily focused on barriers to obtaining prescription medication, including: <ul style="list-style-type: none">• The cumbersome and timely preauthorization process• Insurance company stopping coverage of certain prescription drug benefits• Co-pays for prescription medications• Waiting for prescriptions to be filled In response to this question, participants primarily focused on service coverage as opposed to interpersonal interactions when seeking care

Question	Synthesis of Responses
<p>2. Please tell me about barriers you've experienced when trying to get care</p>	<ul style="list-style-type: none"> • Most participants agreed that transportation was a significant barrier to getting care • Although transportation vouchers (“TP1’s”) are available, they are limited to doctor’s appointments (i.e. not pharmacy visits) and are only valid for the patient receiving services (and therefore do not cover the cost of bringing or accompanying a child/dependent to an appointment) • TP1 vouchers must be scheduled nearly a week in advance, so are not helpful in emergency situations • Specialty services (i.e. optician) that accept their insurance are not located on a bus line- this requires paying for taxi fare, or walking on the shoulder of the road • Services that are not housed in one location are more difficult to access; this means more time away from work to access all services • A few participants noted barriers surrounding vision care, specifically limited optician services within a reasonable distance • Insurance only covers one pair of glasses/year, which can be challenging for children who are prone to damage them; when broken, it can take up to 6 months to repair • Other barriers mentioned included difficulty getting appointments to see Primary Care Provider (PCP) with short notice, long office waits, and cumbersome authorizations required to visit urgent care clinics. • Although some providers have e-portals for communication, participants reported the cost of Internet service and availability of computers as a barrier to accessing this service • Most reported missing appointments that have to be booked far in advance • If three consecutive appointments are missed, the patient it required to find a new PCP • Most reported long wait times for appointments (2 days for urgent care, a few weeks for specialty care, 1 year for primary care)
<p>3. When you have gotten medical care (PCP, ER, specialty), what has your experience been like?</p>	<ul style="list-style-type: none"> • The majority of participants reported long wait times in doctor’s offices, and short appointment times • One participant expressed feelings of not being listened to • Participants report feeling rushed during appointments, and forgetting to ask questions • The use of medical jargon is frustrating

Question	Synthesis of Responses
<p>4. Who do you call if you or a family member has a health crisis? (i.e. family member, clergy, doctor, mental health professional, friends, police, emergency room, hotline?) Who do you contact if you have a concern about your treatment or recovery?</p>	<ul style="list-style-type: none"> • Answers varied: some participants call 911, others call a family member to avoid the high cost of taking an ambulance • Some participants reported calling their doctor's office if they have concern about their treatment or recovery • One participant noted that you sometimes get a faster response if you call to speak to a nurse • Most participants referred to seeking professional input (call lines at doctor's office) versus seeking input from family or other social support connections
<p>5. How much input do you have in setting the goals and priorities in taking care of your health?</p>	<ul style="list-style-type: none"> • Most participants reported having limited input or choices in the services and care they receive. • This is linked to limited appointment time and use of medical jargon that confuses patients
<p>6. What health services are valuable/not valuable, what services do you need to meet your health goals, where do you get services?</p>	<ul style="list-style-type: none"> • Participants generally agreed that follow-up appointments seemed like they were for no reason, and were a waste of time • It appears that individuals could benefit from increased education about what conditions need immediate care and/or prescription medication • Two participants shared stories about their doctors making recommendations that they could not afford, including attending a specific seminar and buying PediaSure • Half of the participants spoke about needing to have medications and conditions explained in plain language, and requested less medical jargon overall • Two participants reported their doctors told them to go home and Google their questions

Question	Synthesis of Responses
<p>7. What other services would help you achieve your health needs/recovery goals?</p>	<p>Participants mentioned the following services:</p> <ul style="list-style-type: none"> • Services for diet and exercise, including diet educators, nutritionists, and no-cost exercise facilities • Participants were either unaware of gym membership reimbursements, or were unable to pay out of pocket at the time • The length of time to get reimbursed was noted to be a barrier to using this service • More dental services • Childcare for appointments and in general • Patient navigators/social workers to help with insurance sign-ups, paperwork, transportation, coordinating appointments, etc. • Patient advocates/navigators to help prepare questions while waiting for appointments, elucidate medical jargon and navigate appointments • Increased transportation services • Job training
<p>8. If you could change any aspect of the health care system that you have experienced, what one or two things would you change that would have the most positive impact?</p>	<ul style="list-style-type: none"> • The majority of participants focused on training customer service professionals at insurance companies and doctors' offices to ease a patient's ability to navigate the system and get prompt responses. • Need for expanded dental coverage (more than just "pulling and cleaning") • For doctor appointments: more time, be listened to more, have more input and choices, simplify language
<p>9. Are there some health or other services available now but you cannot access them because of when or where they are offered? What are they and what are the barriers?</p>	<ul style="list-style-type: none"> • Participants mentioned limited accessibility to women's health services • When asked, all 6 participants reported not receiving routing OB GYN care • Other services mentioned throughout the focus group include: <ul style="list-style-type: none"> ○ Glasses- better replacement options for young children ○ Dental Care- increased services, such as dentures

Focus Group Report: Mental Health and Substance Use

Participants: Professionals working in the area of mental health and/or substance abuse services.

Primary Hospital/Insurer: Baystate Noble Hospital

Date: February 26, 2016

Executive Summary

This focus group explored mental health and substance abuse services and access to care for pediatric and adult populations. Participants had backgrounds working and/or engaging with populations with mental health and/or substance abuse issues, ranging from direct services, to educational contexts, to public service.

Participants concurred that the severe need for mental health and substance abuse care and services for both adults and youth far exceeds what is available. The most significant issue for participants was the shortage of inpatient and outpatient mental health and substance abuse treatment providers and facilities. Many individuals seek care in the emergency room, and the lack of discharge options contributes to long waiting periods in the ER. Additionally, individuals are subjected to long gaps for follow-up care, which is a serious barrier to recovery and a hazard. An overall system of training and treatment that separates mental and substance use care was also discussed as a significant issue given frequency of dual diagnoses in these areas.

The other major issue for participants related to the insurance system dictating care through coverage, limiting access with high deductibles, and discouraging practitioners from serving low-income populations with non-commercial insurance due to bureaucracy and low reimbursement rates. Participants repeatedly noted that the time spent obtaining approval for care or submitting claims detracted from time spent with patients. This, along with the powerful role of the pharmaceutical industry in shaping care systems, was the dominant theme among participants.

Participant Demographics

Eight individuals participated in the focus group. Three participants were women and five were men. All eight participants identified as White and Non-Hispanic. Participants ranged in age between 31-over 60. Most participants identified as straight, while two identified as gay or lesbian.

Areas of Consensus

Shortage of providers and facilities for emergency and long-term inpatient and outpatient care for adult and pediatric mental health and substance abuse

- Community lacks information about available services
- Difficulty recruiting and retaining sufficient number of qualified clinicians, especially psychiatrists, especially in practices that take Mass Health and treat youth
- Limited access and availability of services forces patients needing intensive and long-term treatment to seek care in the emergency department
- Limited or no follow-up options after leaving emergency department, or placement on long waitlists that put patients at serious risk and more likely to return to ED
- Culture that emphasizes quick fixes in the training and treatment of mental and substance use issues
- Mental health and substance use treatment are siloed, despite frequent comorbidity. Both require long term, multifaceted, responsive, high touch treatment.
- The insurance system and pharmaceutical industry present some of the most significant barriers to care

- Dictates patient options for treatment
- High deductibles deter people from accessing care
- Extensive paperwork and low reimbursement rates reduce a practitioner's time with patients and deter practitioners from serving low-income populations
- Pharmaceutical industry has a significant role in catalyzing the current opioid crisis through proliferating read access to opiate drugs
- Paradigm shift needed in which mental health and substance abuse are treated with the same urgency and system of substantive long-term support as other chronic diseases

Recommendations

- More mental health and substance abuse providers, services, and facilities
- More information for patients about how to access mental health and substance abuse services and resources
- Support for patients and families to deal with severe stigma attached to mental and substance abuse issues
- Expanded proactive early education on substance use
- Systems change how mental health and substance abuse services are insured so patients can access the care they need and so providers can focus on patients rather than negotiating coverage and treatment options with insurers
- Paradigm shift so mental health and substance abuse are treated as medical conditions, comparable to chronic diseases, with implications for training treatment, insurance coverage, available services
- Integrated treatment of mental and substance use issues

Key Issues

Question	Synthesis of Responses
<p>1. What are the 3 most urgent health needs/problems in your service area?</p>	<ul style="list-style-type: none"> • Access issues: <ul style="list-style-type: none"> ○ Financial burden of care ○ Lack of sufficient outpatient and inpatient services for youth and adults with behavioral health issues ○ Lack of awareness within the community about services and resources for mental health and substance abuse ○ Difficulty navigating the system relative to getting treatment and insurance coverage • Systemic problems with the insurance system and government regulations- wasted time getting authorization for care, paperwork, coding systems, insurance dictates care • Mental/Behavioral health services, outpatient and inpatient services • Other urgent needs/problems: <ul style="list-style-type: none"> ○ Stress, Depression, Anxiety ○ Dental Care ○ Homelessness ○ A culture which prioritizes quick fixes at a low cost. This is reinforced by mental health and substance abuse training
<p>2. What specific vulnerable populations are you most concerned about and why?</p>	<ul style="list-style-type: none"> • Youth • Prevention and early interventions for substance abuse and mental health issues • Medicating and overmedicating youth can have long-term negative consequences • Elderly • Other vulnerable populations: <ul style="list-style-type: none"> ○ People with substance abuse issues and their families ○ People with chronic conditions ○ People with comorbid mental health and substance abuse disorders. ○ Low-Income people, who are at the mercy of insurance companies and struggle with other issues like transportation ○ People who don't earn enough to afford care but earn too much to qualify for subsidized care ○ Pregnant teens and overwhelmed parents ○ Veterans, who may have PTSD or other mental illnesses and are using substances as a coping strategy

Question	Synthesis of Responses
<p>3. What are the most serious barriers or service gaps that adult consumers face in accessing mental health and substance use care?</p>	<ul style="list-style-type: none"> • Severe shortage of providers and services offering inpatient and outpatient treatment for mental health and substance use • Insurance system and the pharmaceutical industry: <ul style="list-style-type: none"> ○ Even with insurance, the cost of care (high deductibles) may deter people from getting services ○ Control insurance companies exert over care and access to treatment ○ Insurance industry has influenced the availability of services and created service gaps, most particularly the shortage of outpatient and inpatient services for mental health and substance abuse ○ Low reimbursement rates and excessive paperwork are barriers to providers, many of whom opt to only accept private insurance, further limiting services for low-income consumers ○ Many practitioners would rather spend time with patients than on the phone with insurance companies determining and negotiating coverage for treatment ○ Low insurance reimbursement rates are also barriers for hiring practitioners; practices have difficulty recruiting qualified practitioners in all areas, and acutely in both adult and pediatric psychiatry • Severe shortage of detox facilities • The industry is slanted toward pharmaceutical solutions and away from longer-term relationship-based therapeutic treatment • Financial barriers and the prohibitive cost of care for many and especially for low-income adults and families. <ul style="list-style-type: none"> ○ People in the middle who don't qualify for health subsidies but are also not earning enough to comfortably pay for care ○ Disparities in coverage between public and commercial insurance • Burden of accessing care falls on the patient. The system is already incredibly difficult to navigate, but when you are struggling with a mental health or substance abuse issue, you may not be able to manage appointments and medication

Question	Synthesis of Responses
<p>4. What are the most serious barriers or service gaps that children, adolescents, and young adults face in accessing mental health and substance use care?</p>	<ul style="list-style-type: none"> • HIPAA-- barrier to continuity of care, particularly when providers are prohibited from obtaining information about previous or on-going patient treatment or student • Insurance system, both commercial and governmental-- limits access to care, in an arena where options for youth are already limited. Government regulations and paperwork have sacrificed a provider's time with patients. Some practices actually avoid Medicaid patients because of the bureaucratic burden. • Lack of mental health services for youth, including limited options and long waitlists. It is more difficult to find mental health outpatient care for youth than adults. The shortage of mental health outpatient care options impacts continuity of care, leaving inappropriate and even dangerous gaps between inpatient and outpatient care.
<p>5. In light of the opioid use epidemic, what are the most pressing issues and needs around access to care for detox, long-term treatment, criminalization, and stigma? What are other needs or trends in opioid addiction in your service area and what impact does that have on providers and services?</p>	<ul style="list-style-type: none"> • More treatment and detox beds in the area. In addition to a shortage in detox beds, there is a shortage of post-detox treatment and follow-up care. • Need to treat substance abuse and mental health together, or to at least remove the barriers of addressing these co-morbid conditions. Funding and regulations perpetuate this separation even though treating these conditions together is more effective. • Liability issues influencing access to care. Risk aversion deters providers from using harm reduction models even though they more effective in the long run. Higher liability working with certain populations (i.e. youth). • Need more proactive treatment, including resources to catch substance abuse early before it escalates to full blown addiction. Narcan and detox beds are considered reactive responses. • The pharmaceutical industry has perpetuated the opioid crisis by pushing pain medication, and now drugs like Narcan. • The opioid crisis has made it difficult for terminally ill cancer patients to access pain medication.
<p>6. What are the major needs, service gaps or barriers for accessing mental health and substance use care in a crisis situation, such as urgent/emergency care in the emergency department? What is working well and what can be improved?</p>	<ul style="list-style-type: none"> • Shortages in inpatient and outpatient beds. When there no discharge options, patients end up waiting in the hospital. • Model of aftercare used by Westfield State brings together the individual, their family, their providers, and the school has been effective to ensure the individual doesn't fall through the cracks. • Having a community of support is needed for recovery

Question	Synthesis of Responses
<p>7. What about long-term mental health and substance use care needs for adults and youth? What are the needs for such services and who is most vulnerable when those services are not available?</p>	<ul style="list-style-type: none"> • Education for youth about substance abuse both in the school and outside. • Other needs: Peer group based support for youth, more resources, and improvement in the insurance realm
<p>8. What do you think community leaders think about the philosophy of harm reduction for addiction including the use of Narcan and needle exchange?</p>	<ul style="list-style-type: none"> • Narcan is necessary but does not treat the problem or root cause of why people are using opioids in the first place <ul style="list-style-type: none"> ○ People are not mandated to go into treatment after receiving Narcan • Shift in the use of Methadone and Suboxone from temporary treatment to long-term maintenance
<p>9. If you could change any aspect of the mental health and substance abuse care system, what one or two things would you change that would have the most profound positive impact on access and care for the populations we've been discussing?</p>	<ul style="list-style-type: none"> • Changes in the insurance system. Treatment/care and profit are opposing forces and insurance should be nonprofit. • Institute mental health screenings for youth, comparable to annual physicals and vaccinations
<p>10. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</p>	<ul style="list-style-type: none"> • Improve the insurance system
<p>11. How would you recommend that your local hospitals/insurers and the Western Massachusetts Hospital Coalition work in closer partnership with local and regional municipal public health entities and other community partners after the CHNA is completed? What specific ways can such partnerships be supported and sustained?</p>	<p>Recommendations included:</p> <ul style="list-style-type: none"> • Create more opportunity for providers to be heard. A practitioner will have a better sense of what treatments are successful, and these recommendations should be brought up the ladder and to government. • Involve and inform policy makers. • Create a complaint/feedback process. • The Hospital should take the lead role in bringing together care providers and groups that are already working towards common goals but are disconnected. • Accountability and action.

Quotes

- “Substance abuse and mental health are definitely connected, but based on how they are funded and regulated, they are completely separate. In the mental health hospital, we can’t treat someone for substance abuse, we have to treat them for mental health. At an outpatient mental health clinic, if someone has a problem with heroin, we have to make sure

to find a mental health condition too otherwise we can't bring him in. We can't treat substance abuse and mental health together even though it is the most effective way. With the way it is funded, it has to be separate."

- "It's about continuity of care...We know from 24-hour care a day into 1-hour of care bi-weekly in two months from now is a really long inappropriate gap. It makes it really hard, and it makes it really dangerous. We've seen these people come back to the ED again and again and again."
- "You can't treat an opioid addiction in the Emergency Room and that's what we're doing."
- "'You really need to be in detox, but there are no detox beds so go home and call detoxes tomorrow. If that doesn't work, call them the next day.' If there aren't, call another hospital, and then the next day do the same. Maybe in a few weeks some hospital will say we have a bed, come in.' That's the reality of what is going on."
- "Lots of the stuff we do is reactive. For a child who is starting to have problems with Percocet, you call a program and they say to call back in 2 months. By then, it evolves into a full addiction. The system doesn't allow us to address substance abuse issues early on before they evolve into more serious issues."

Focus Group Report: Mental Health and Substance Use

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

Primary Hospital/Insurer: Mercy Medical Center

Date: February 11, 2016

Executive Summary

Participant Demographics

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

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

Areas of Consensus

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

Recommendations

- More staff training around the disease of addiction and mental illnesses and how behavior is affected by the disease process
- Treatment services need to be better matched to disease progression and take into account the chronic, progressive and relapsing characteristics of mental illness and substance use disorders

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

Quotes

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

Key Issues

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

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

Focus Group Report: Mental Health and Substance Use

Participants: Service Providers and Public School Leaders

Primary Hospital/Insurer: Holyoke Medical Center (HMC)

Date: February 18, 2016

Executive Summary

Participant Demographics

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

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

Areas of Consensus

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

Recommendations

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

Quotes

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

Key Issues

Question	Synthesis of Responses
<p>1. What are the 3 most urgent health needs/problems in your service area?</p>	<ul style="list-style-type: none"> • opioid abuse; (opiates are a problem, but also substance abuse in general; with marijuana seen as legalized, there has been an increase in marijuana smoking and use in youth) • obesity • asthma • mental health issues, especially among children
<p>2. What specific vulnerable populations are you most concerned about? And why?</p>	<ul style="list-style-type: none"> • Youth ages 15-25 , because of the availability of drugs; • alcohol use starting with younger kids; age 10+ as shown by alcohol drinking on the school bus, coming to school drunk and what incarcerated persons tell us about their use of drugs at very young ages

Question	Synthesis of Responses
<p>3. What are the most serious barriers or service gaps that consumers face in accessing mental health and substance use care?</p>	<ul style="list-style-type: none"> • Lack of transportation. • Language; there is need for more bilingual capacity in services and educational materials • Kids who are inappropriately medicated is a big issue; too many kids are suffering from trauma and not being treated. • Lack of insurance; people think everyone has insurance, but if you live under a bridge, you do not have insurance.
<p>4. What are the major needs, service gaps or barriers accessing mental health and substance use care in a crisis situation, such as urgent/emergency care in the emergency department? What is working well and what can be improved?</p>	<ul style="list-style-type: none"> • Need to allocate funds to organizations working with schools and the hospital around improving crisis and emergency care • Kids don't get the follow-up care they need once they're in the system. For example, a child whose mom or dad is in the criminal justice system, or kids go into foster care, they go off the radar completely and are disconnected from care. • There are no placement options for children after crisis care; lack of emergency youth shelters, even temporary ones. • If a student is homeless, there is no place to take them after the crisis; they can easily get disconnected from school, and other services.
<p>5. What about long-term mental health and substance use care needs? What are the needs for such services? Who is most vulnerable when those services are not available?</p>	<ul style="list-style-type: none"> • Geriatric patients are lacking placement options. Nursing homes don't take behavioral patients outside of small dementia units. With Medicaid/ Mass Health, some nursing homes don't accept these because of payment issues. • LGBTQ - this population needs the most and gets the least. • At Holyoke Community College, there is a growing population of students facing issues of homelessness, bullying and behavioral health needs. In the LGBTQ student group, there is concern about bullying, discrimination; levels of stress are very high.

Question	Synthesis of Responses
<p>6. What are other needs or trends in opioid addiction in this area and what impact does that have on providers and services?</p>	<ul style="list-style-type: none"> • Holyoke Health Center has been proactive in educating staff about opioid overdose prevention. Staff members are trained in the use of Narcan; they have Narcan kits and information in English and Spanish. What is not working as well is that people are still afraid to talk about it. • There is a lot of education going on right now to train providers in safer prescribing. • MDPH working with medical schools in MA on teaching doctors about opioid overuse. • Overdose deaths have been significant in past year and this is waking up people. All of a sudden, wealthy children are dying and this is opening up minds and resulting in more media attention • There's also a problem with social acceptability of drug use. People have in their minds that marijuana use is OK.
<p>7. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</p>	<ul style="list-style-type: none"> • We need more sports, things to do, to keep youth involved, have conversations. Get to know kids, families. Not just sports, also arts, music, crafts, computers. • We have the Youth Task Force and it got money from SAMHSA, but not in that kind of coordinated, big-picture way. We need more capacity than any small organization can manage. Coalitions are doing a great job, but coalitions come, make an impact, move on; we need more permanence. • Universal Pre-K is a huge need in a community like Holyoke; the sooner kids are in the system, the better they will be. Starting earlier, we can identify issues before they become big problems. By the time they start school, it's harder to address them.

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

Focus Group Report: Maternal and Child Health

Participants: Mothers

Primary Hospital/Insurer: Baystate Medical Center

Date: March 7, 2016

Executive Summary

Participant Demographics

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

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

Areas of Consensus

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

Recommendations

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

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

Quotes

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

Key Issues

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

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

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

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

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

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

Key Informant Interview Report: Hampshire County Public Health Personnel and Community

Dates:

February 3rd - February 15th, 2016

Interview Format:

Phone interviews, approximately 45 minutes in length.

Participants:

- Jackie Duda, Health Agent, Easthampton Health Department
- Julie Federman, Health Director, Town of Amherst
- Merridith O’Leary, Director, Northampton Health Department
- Natalie Munoz, Journalist and Resident

Question	Synthesis of Responses
<p>1. What local policies and social conditions predispose people in your community/service area to good health and mental wellness? Are there groups of people who benefit from these policies/social conditions more than others?</p>	<p>All four respondents mentioned local policies and social conditions. They included:</p> <ul style="list-style-type: none"> • Access to healthy food • Alcohol and tobacco enforcement/compliance checks • Walkable environment • Public transportation • Young, health-oriented population • Active Northampton Healthy Youth Coalition and SADD chapter • Municipal wellness programs • Local agencies providing support to the needy • Community is accepting and welcoming of people with mental health issues • Focus on public health within capital projects • “Institutional racism is a silent killer” <p>Each respondent also noted that many of these benefits accrue to those who need them the least (although one noted that lower-income people are more likely to benefit from tobacco-free workplace policies). Lower-income people lack access or opportunity to engage with these policies. Resources are not accessible if you do not speak English. One respondent noted that her community does not have supports for homeless people.</p>

<p>2. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</p>	<p>Respondents noted the need for:</p> <ul style="list-style-type: none"> • Healthy markets in low-income areas • Workplace wellness initiatives • Efforts around perception of harm for marijuana • A larger health department • Better public transportation, and easy to access information about schedules (non-English speakers) • Improved walkability • A stronger connection with CDH, especially around transportation and discharges • Intentional connections between providers and patients - including non-English speakers. Ads in bilingual news outlets.
<p>3. What are the 3 most urgent health needs/problems in your service area?</p>	<p>Two of the four respondents mentioned drug abuse and mental health (with one specifying hoarding being a particular problem). Other issues, each of which was named by one person, were:</p> <ul style="list-style-type: none"> • Unvaccinated/under-vaccinated children • Low levels of youth engagement • Perception of city as drug-friendly • Heart disease • Obesity
<p>4. What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area? What evidence/data do you have to illustrate this increase?</p>	<p>All four respondents mentioned opioid abuse. Other issues mentioned as increasing included:</p> <ul style="list-style-type: none"> • The under- and unvaccinated rate (data from public schools; may not reflect true rate) • Hoarding, particularly in the elderly population • Sale of flavored nicotine products and accessories • Sedentary lifestyles
<p>5. What gaps in services exist in addressing these needs? What are barriers to filling these gaps?</p>	<p>Gaps in services included a lack of Narcan training, a need for greater awareness of substance abuse issues overall, and silos in treatment for substance abuse and mental health issues. The major barrier cited was the lack of recognition of the magnitude of the problem. One respondent also mentioned that there is a lack of connection among agencies working on the same issues, and another mentioned that hospital reimbursement rates do not support looking at outcomes.</p>
<p>6. In addition to more funding, what resources do you need to better address these emerging or increasing health concerns?</p>	<p>Resources that respondents mentioned included:</p> <ul style="list-style-type: none"> • Assistance in implementing programs and policies • Access to subject experts, particularly around hoarding issues • A whole-city vision for health, including the top levels of government • Support groups around mental health and substance abuse
<p>7. What specific vulnerable populations are you most concerned about? And why?</p>	<p>Respondents mentioned the mentally ill (hoarding was noted by two respondents), the homeless, addicts and their families, unconnected youth (not in school or working), and very low income people who cannot pay co-pays or get transportation for health care. These are the people who have difficulty advocating for themselves, getting support for what they need. Also elderly.</p>

<p>8. Externally, what resources or services do you wish people in your area had access to?</p>	<p>Respondents mentioned:</p> <ul style="list-style-type: none"> • A partnership to work on air quality, to address a high rate of asthma • More money for community outreach and education • Suboxone induction and treatment • Health care in the town center • Transportation to health providers • A homeless shelter that provides health care • Smoking cessation programs for post-partum mothers • Dental care for low-income people • Culturally relevant resources targeted to non-English speakers
<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>Respondents suggested the following:</p> <ul style="list-style-type: none"> • Having an open forum to discuss problems and share ideas about what resources are available • Forming political associations with town and city government leaders • Including public health personnel in hospital meetings <p>Two respondents suggested that a regular structure for meetings, rather than meeting on an ad-hoc basis, would help sustain the partnership.</p>
<p>10. Is there anything else you would like to share?</p>	<p>One respondent noted that food-borne illnesses are also becoming a particular concern, because this could become a big issue at any time. Another expressed appreciation that HNE is involved with this process, and reported she would like to see them expand their panel of mental health providers. One respondent noted that CDH should partner with culturally competent/bilingual community partners to inform policies/practices.</p>

Key Informant Interview Report: Health New England

Dates:

February 3rd - February 15th, 2016

Interview Format:

Phone interviews, approximately 1 hour in length.

Participants:

- David Silva, Medicaid Community Leader
- Robert Azeez, Medicaid Behavioral Health Manager
- Kerry LaBounty, Medicaid Program Manager
- Jackie Spain, MD, Medicaid Program Medical Director

Summary:

Interviewees range in their professional roles within Health New England, yet there were multiple areas of consensus, including:

- Increased capacity to treat substance use disorder and mental health needs within primary care
- More care coordination, including increased access to transportation and multiple services offered in one location/in closer proximity to each other
- Need for more patient education about what constitutes “good care” (for example, more intervention is not always appropriate, but is often expected/defined as receiving good care)
- Rural areas face multiple barriers to health, including limited programming, transportation barriers, low access to healthy foods
- A need to collect more data
- Insurance policies (lose coverage or provider after missing 3 consecutive appointments) significantly impact patients with behavioral health needs (mental health and addiction) who often miss appointments as a result of their health condition
- Need for patient education to improve overall health literacy
- Need for provider training to improve cultural sensitivity/competency

Quotes:

- “Heart of improving health care, giving people that ability to lead a healthy lifestyle”
- “Need to get beyond ‘we deliver care, they pay for care’ to ‘where can we bring common resources to bear?’
- “Do not make assumptions about what we think that problems are- get a better sense of community needs, and act based on data and not what you think.”
- “Use community agencies, churches, etc. to reach people to make differences.”
- “How we get care and who we trust may depend on who we are.”
- “If we are truly patient centered, then we really need to be patient center.”

Question	Synthesis of Responses
1. What are the 3 most urgent health needs/problems impacting your members?	<ul style="list-style-type: none"> • Poverty • Lack of access to nutritional foods (food deserts) • Lack of transportation • Homelessness- difficult for member engagement and follow up • Untreated Behavioral Health (BH) conditions • Unmet maternal, Child, Health (MCH) needs (i.e.-access to contraception, late entry to prenatal care, poor birth outcomes) • Diabetes, hypertension, CVD, diabetes block
2. What health issues have emerged and/or dramatically increased in prevalence in the last 1-2 years in your area?	<ul style="list-style-type: none"> • Opioid use disorder • Hepatitis C from chronic alcohol use and opioid use (current treatment carries an extremely high internal cost) • Unmet behavioral health needs • Obesity, cardiovascular disease, Type 2 Diabetes block • Asthma
3. What specific vulnerable populations are you most concerned about? And why?	<ul style="list-style-type: none"> • Minority populations, specifically African American and Latino/a • Disparities in cancer screening rates by race/ethnicity • Homeless individuals/families • Rural poor (who have the highest ER and ambulance utilization rates) • Those with Substance use (SA) issues • Youth not engaging in routine PC- lack of immunizations • Socially isolated individuals • Obese and underactive children and the earlier onset of adult diseases • Children in foster care system (fragmented care, hard to follow) • Incarcerated adults/adolescents (fragmented care, hard to follow)

<p>4. Please discuss the barriers to accessing care such as (1) logistical, family, psychosocial, financial, geographical; (2) health insurance (coverage of benefits, cost sharing, etc.); (3) type of care people are seeking (primary, dental, behavioral, specialty); (4) lack of providers (if so, what kind); and (5) other.</p>	<p><u>Structural/logistical:</u></p> <ul style="list-style-type: none"> • Access to and affordability of transportation (MassHealth transportation system is not accessible for unplanned medical needs) • Distance to providers (rural areas) • Distance between services required to be compliant (ex. if x-ray, lab, and pharmacy are all in different places, people may be more likely to end up seeking all of those services in the ER) • State regulations- can change plan daily, this impacts continuity of care • Rules for BH care for Medicaid population: cases are closed after 3 no-shows, but various barriers can contribute • BH issues themselves pose barrier to care (ex. depression) <p><u>Providers:</u></p> <ul style="list-style-type: none"> • Lack of providers in rural areas that accept Medicaid • Lack of specialty providers that accept (ex. dental and dermatology) • Lack of BH providers, overall • Long wait times for specialty and primary care (leads to high emergency room (ER) utilization) <p><u>Housing instability:</u></p> <ul style="list-style-type: none"> • Housing instability makes tracking members challenging, changing contact info means some might lose insurance because they don't see notices • Notices sent re: maintaining insurance are not always at the appropriate literacy level/translated <p><u>Cultural:</u></p> <ul style="list-style-type: none"> • Latino population, less importance placed on timeliness in terms of making appointments (mentioned by ¾ interviewees) • White populations have less family support systems as compared to AA and Latino populations • Fear of losing benefits if health improves • Cultural ideas of what good care is (for some, lots of med and interventions are seen as good quality care, if not received from PCP, go to ER to get- this relates more to overuse)
<p>5. Please discuss quality of care as reported by members and/or clinicians (perceptions of quality of care members are receiving- i.e. do people believe that the care they are getting has value?)</p>	<ul style="list-style-type: none"> • Members are frustrated by access to and time to get appointments • Providers are frustrated by lack of compliance and rates of no shows • Need for more integration of BH care into routine PC (primary care) • Need for more culturally sensitive care (more training for specialty populations- transgender individuals, adolescents, varying ethnic groups)

<p>6. Please discuss the access to and availability of community resources needed to be healthy (built or community environment (e.g.- food, safety); fitness/gym facilities; benefits covered by health insurance; community organizations).</p>	<ul style="list-style-type: none"> • Rural areas- programming is limited, or spread out/located in pockets that can be difficult to get to • Urban areas- programs exist, but often people are unaware of what is available • Need for lower cost gyms, afterschool programs not just focused on homework • Lack of culturally tailored programming, especially in rural areas • Lack of access to healthy, culturally relevant foods • Lack of safe areas for recreation
<p>7. Please discuss health behaviors of concern (ex. tobacco use, alcohol & drug use, lack of physical activity, etc.) and the barriers to engaging in healthy behaviors among members.</p>	<p><u>Exercise and nutrition:</u></p> <ul style="list-style-type: none"> • Lack of exercise options for children: team sports are cost-prohibitive, and transpiration is an issue (4/4 mentioned) • HNE offers reimbursement for gym memberships, vastly underutilized in Medicaid pop- not exactly certain why • Food deserts • Lack of education about portion size • Come cultural practices/beliefs: a “fat baby is a healthy baby” • Lack of cultural support for breastfeeding • SNAP benefits for farmers market underutilized in urban area due to lack of culturally relevant foods; more utilized in rural areas, <i>if</i> members can get transport to farmers market <p><u>Non-compliance with medication/treatment protocols</u></p> <ul style="list-style-type: none"> • Lack of comprehension about chronic health conditions- (i.e. feel better, stop meds) • Lack of understanding about preventative health, importance of continuous care to manage chronic conditions • Cultural beliefs and attitudes and expectations of western medications • Lack of understanding about medications (e.g. antibiotics, stimulant meds) • Education for Latino population about new diagnoses is not given enough time; often need 1-1 and more time to understand diagnosis and importance of adherence to meds and lifestyle recommendations <p><u>Multigenerational health patterns:</u></p> <ul style="list-style-type: none"> • Parental lack of education and modeling (3/4 interviewees) • Multigenerational patterns of SA and MH • Need more opportunities for fun, physical activity (ex. adult sports leagues/softball to get entire families active)

<p>8. 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? Specifically, what can Health New England do to help impact the health of its most vulnerable members?</p>	<p><u>Overall:</u></p> <ul style="list-style-type: none"> • More support for peer education model (2/4 mentioned) • More collaboration across multiple sectors- business community, faith-based, hospitals, etc.) • More grassroots education in rural areas about substance use • More accessible resources • Shift perception of hospital as a stand-alone entity, increase its role in screening people for unmet health needs, link people to resources to address social determinants of health • Bundled rates that support education and visit, support/fund peer educators, support providers <p><u>For HNE specifically:</u></p> <ul style="list-style-type: none"> • Explore alternative reimbursement models • Community perception that HNE is not involved in the community- perhaps sponsor a sports team, or support transportation efforts for rural sports programs • Partner more with providers to explore alternative models of health care delivery by using shared resources
<p>9. If time: Is there anything else you would like to share?</p>	<ul style="list-style-type: none"> • Need to collect better data on who is being seen and what their needs are • Need to improve cultural competence/sensitivity

Key Informant Interview Report: Public Health Personnel

Dates:

January 2nd - February 1st, 2016

Interview Format:

Phone interviews, approximately 45 minutes in length.

Participants:

- Helen Caulton Harris, Commissioner of Public Health, City of Springfield
- Soloe Dennis, Western Region Director, Massachusetts Department of Public Health (MDPH)
- Dalila Hyry-Dermith, Supervisor, MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit
- Luz Eneida Garcia, Care Coordinator, MDPH Division for Perinatal, Early Childhood and Special Needs, Care Coordination Unit
- Judy Metcalf, Director, Quabbin Health District
- Merridith O'Leary, Director, Northampton Health Department
- Lisa Steinbock, Public Health Nurse, City of Chicopee
- Phoebe Walker, Director of Community Services
- Lisa White, Public Health Nurse, Franklin Regional Council of Governments

Question	Synthesis of Responses
<p>1. What local policies and social conditions predispose people in your community/service area to good health and mental wellness? Are there groups of people who benefit from these policies/social conditions more than others?</p>	<p>All respondents agreed that the region provides excellent health services, but many talked about the difficulty some populations have in accessing them. Lack of transportation is a major issue for some groups of people throughout the service area.</p> <p>Respondents from Hampden county had difficulty naming local policies and service conditions other than health care institutions that promote health and wellness. One mentioned Mass Health as expanding access to most people. In Franklin and Hampshire counties, respondents named access to fresh local food, compliance policies around tobacco and alcohol, town-based programs such as senior centers, Mass in Motion, public transportation, and access to mental health providers as predisposing people toward good health.</p>
<p>2. What kind of structural and social changes are needed to tackle health inequities in your community/service area?</p>	<p>Again, the most frequently mentioned issue is lack of transportation. Other changes that would help improve inequities included:</p> <ul style="list-style-type: none"> • Help families understand what resources are available to them • Follow through beyond initial outreach • Workforce development • Affordable/improved housing • Continuity of care around addiction treatment • Healthy markets • Workplace wellness programs • Education around harm associated with marijuana • Coordination of care/avoiding readmission

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

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

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

Appendix III: Data Tables

Hospitalization Rates among Select Communities in Franklin and Hampshire Counties, 2012 and 2013

Hospitalization and Emergency Room Visit Rates for Select Franklin and Hampshire County Communities by Race/Ethnicity, 2012

Behavioral Risk Factor Surveillance System (BRFSS) Prevalence Estimates for Health Behaviors and Conditions by County

Hospitalizations and Emergency Room Visits for Conditions by Top Communities with Confidence Intervals, 2013

Hospitalizations among Select Communities in Franklin and Hampshire Counties, 2012 and 2013

*MDPH, 2012; rates are per 100,000 and are age-adjusted

Geography	Hospitalizations								ER Visits					
	Stroke		Heart Disease/ Cardiovascular Disease		Diabetes		Respiratory COPD		Asthma		Mental Disorders		Substance Use	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Amherst	149.7	NA	177.4	737.9	52.5	NA	121.5	NA	130.1	215.3	1115.2	981.5	453.2	386.0
Deerfield	NA	277.5	NA	816.0	NA	292.9	NA	NA	NA	619.3	NA	1290.2	NA	311.0
East Hampden	183.8	219.6	269.4	1101.1	136.0	171.3	524.9	NA	331.8	339.8	1808.7	1760.5	704.4	604.7
Montague	286.2	NA	381.8	1200.3	196.8	NA	459.7	NA	839.0	589.7	3409.2	2640.3	842.9	896.6
Northampton	175.2	NA	205.9	1009.8	96.4	68.2	346.1	NA	339.1	307.2	3033.4	3188.0	1221.9	1138.3
Orange	244.2	NA	381.8	1102.6	198.4	NA	NA	NA	897.6	675.2	3217.6	2983.5	779.2	709.0
Ware	185.8	NA	200.2	1392.9	124.0	NA	260.7	NA	1293.3	1216.9	4516.3	3651.1	2297.1	1113.0
Franklin County	199.2	203.5	242.8	989.3	110.1	132.3	290.9	NA	570.6	538.7	2570.0	2634.7	629.4	608.8
Hampshire County	182.1	200.2	207.5	1038.1	95.1	95.5	247.7	NA	337.7	326.3	1759.9	1750.4	743.7	612.2
MA	219.5	NA	264.5	NA	198.4	NA	325.5	NA	571.9	NA	2304.4	NA	986.5	NA

Hospitalization and Emergency Room Visit Rates for Select Franklin and Hampshire County Communities by Race/Ethnicity, 2012

Geography	Race / Latino Ethnicity	Hospitalizations					ER Visits		
		Diabetes	Stroke	CHD	Substance use	Opioid-Related	Asthma	Mental Disorders	Substance Use
Amherst	White	NA	148.3	137.0	219.3	218.3	92.9	1336.2	594.1
Amherst	Black	NA	NA	NA	NA	NA	NA	2238.2	NA
Amherst	Latino	NA	NA	0	NA	NA	NA	461.9	NA
Amherst	Asian/ Pacific Islander	NA	NA	NA	NA	NA	NA	NA	NA
Easthampton	White	122.8	171.7	250.4	569.2	581.7	306.8	1772.9	681.4
Easthampton	Black	NA	NA	NA	NA	NA	NA	NA	0
Easthampton	Latino	NA	NA	0	NA	NA	NA	2677.5	NA
Easthampton	Asian/ Pacific Islander	NA	NA	NA	NA	NA	0	NA	NA
Northampton	White	90.5	180.4	187.3	459.6	565.1	267.8	2920.5	1143.6
Northampton	Black	0	0	NA	NA	NA	NA	8612.3	6303.9
Northampton	Latino	NA	NA	NA	1274.8	1512.5	939.8	3386.2	1002.1
Northampton	Asian/ Pacific Islander	NA	NA	NA	NA	NA	NA	577.2	NA
Franklin County	White	108.1	194.2	243.7	386.4	398.2	527.3	2554.2	642.5
Franklin County	Black	NA	NA	0	NA	NA	2729.6	3604.8	NA
Franklin County	Latino	0	NA	NA	NA	806.1	1024.4	3375.1	656.1
Franklin County	Asian/ Pacific Islander	NA	NA	NA	NA	NA	NA	NA	0
Hampshire County	White	91.2	181.5	192.5	377.5	434.8	292.1	1755.1	743.4
Hampshire	Black	NA	NA	NA	NA	404.3	1057.9	4054.0	1887.1

County									
Hampshire County	Latino	NA	NA	NA	711.9	781.1	888.4	1935.6	585.7
Hampshire County	Asian/ Pacific Islander	NA	NA	NA	NA	NA	NA	355.5	182.6
Massachusetts Total	White	115.9	208.2	257.9	392.6	412.3	417.0	2315.4	1019.5
Massachusetts Total	Black	320.2	309.5	244.4	260.2	292.4	1279.1	3101.9	1301.8
Massachusetts Total	Latino	222.8	246.7	290.5	317.8	398.7	1162.1	2610.7	1107.6
Massachusetts Total	Asian/ Pacific Islander	43.1	149.7	137.0	39.8	12.7	147.8	423.8	126.1

Behavioral Risk Factor Surveillance System (BRFSS) Prevalence Estimates for Health Behaviors and Conditions By County

Geography	Obese*	Over-weight or Obese*	Heart Disease**	Stroke*	Heart Attack or MI*	Diabetes*	Pre-diabetes*	Poor Mental Health (15+ days)*	Current Smoker*	Binge Drinker*
Berkshire County	22.0	56.3	6.7	3.1	5.30	9.4	6.8	10.8	20.6	18.4
Hampden County	28.8	64.7	7.9	3.4	5.06	13.2	7.6	15.9	21.5	16.1
Hampshire County	20.0	55.9	5.5	2.6	3.74	4.7	8.6	12.1	15.5	23.0
Franklin County	22.4	54.4	4.4	NA	3.63	8.7	10.3	12.4	19.7	17.8
Worcester County	27.3	62.9	5.8	2.4	3.75	10	8.0	11.2	19.0	19.1
Massachusetts	23.6	59.0	6.1	2.4	4.0	9.0	7.3	11.1	16.1	18.7

*Direct estimates 2012-2014

**Direct estimates 2011, 2012, 2014

NA - estimate unavailable

Hospitalizations and Emergency Room Visits for Conditions by Top Communities with Confidence Intervals, 2013

Rank	Hospitalizations				ER Visits		
	Diabetes	Stroke	CVD	Substance Use	Asthma	Mental Disorders	Substance Use
1	Deerfield 292.9 (153.7-432.1)	Southampton 308.2 (165.8-450.6)	Southampton 1450.0 (1141.7-1758.3)	Huntington 1293.6 (786.5-1800.7)	Deerfield 619.3 (381.3-857.4)	Northampton 3187.9 (2986.2-3389.7)	Northampton 1138.3 (1023.7-1252.9)
2	Easthampton 171.3 (111.0-231.6)	Deerfield 277.5 (145.6-409.4)	Huntington 1184.1 (737.5-1630.8)	Belchertown 501.4 (379.5-623.3)	Granby 372.7 (200.5-544.8)	Huntington 2287.2 (1618.9-2955.4)	Huntington 1091.0 (600.4-1581.5)
3	Belchertown 93.6 (40.6-146.5)	Hadley 232.6 (122.0-343.2)	Easthampton 1101.1 (956.3-1245.0)	Easthampton 491.3 (382.3-600.3)	Hadley 354.3 (168.7-539.9)	Easthampton 1760.5 (1553.2-1967.8)	Southampton 699.4 (474.1-924.8)
4	Northampton 68.2 (38.3-98.1)	Easthampton 219.6 (155.5-283.8)	Belchertown 1071.4 (896.4-1246.4)	Northampton 462.5 (386.5-538.6)	Easthampton 339.8 (245.6-433.9)	Worthington 1685.8 (731.0-2639.6)	Easthampton 604.7 (487.9-721.4)

Appendix IV: Community and Hospital Resources to Address Identified Needs

Priority Health Need	Resource Organization Name	Description of Services Provided	Website Address
Income and Employment	Community Action! of Hampshire and Franklin Counties	Federally designated Community Action Agency serving low-income individuals and families	http://www.communityaction.us/index.html
Education	The Literacy Project; sites in Northampton and Amherst	Provides free adult education classes at 3 levels: basic literacy, pre GED, through GED. provides access to post-secondary education and job training skills	http://www.literacyproject.org/
Housing	HAP Housing	Housing assistance to tenants, homebuyers homeowners and rental property owners; largest nonprofit developer of affordable housing in Western Massachusetts' serves Hampden and Hampshire Counties	http://www.haphousing.org/default
	Center for Human Development (CHD)	Homelessness Services; shelters and information and referral	http://chd.org/adult-services/homelessness-services/
	ServiceNet	Shelters and homelessness services for adults and families; homelessness prevention and support	http://www.servicenet.org/content/shelter-and-housing-services
Transportation	Franklin Regional Transit Authority (FRTA)		http://frta.org/
	Pioneer Valley Transit Authority (PVTA)		http://www.pvta.com/
Food Insecurity,	Brown Bag-Food for Elders Program	Food Bank of Western Massachusetts provides a free bag of healthy groceries	https://www.foodbankwma.org/get-help/brown-bag-food-for-elders/

Priority Health Need	Resource Organization Name	Description of Services Provided	Website Address
Food Deserts		to eligible seniors once a month at local senior centers and community organizations.	
	Food Assistance online list from Forbes Library	Information on free meals and food pantries in greater Northampton and Amherst areas	http://forbeslibrary.org/community/resources/northampton-area-food-assistance/
	Center for Self Reliance at Community Action!	Offers food to families, information and referrals to other services and programs; hosts fresh food and cooking demonstrations and nutrition workshops	http://www.communityaction.us/center-for-self-reliance-food-pantry.html
Obesity	Support Groups	Support groups, exercise, and education workshops that cover topics related to weight loss, nutrition and exercise	http://www.gazettenet.com/Updated-Support-Groups-3174602
	Healthy Hampshire/Mass In Motion	Community-based coalition to improve health equity through improved access to healthy eating and active living	http://www.northamptonma.gov/1482/Healthy-Hampshire
Cardiovascular Disease	Heart & Vascular Care Services	Comprehensive diagnostics, and treatment options for coronary artery disease (CAD), heart rhythm disorders (arrhythmias) heart failure; cardiac surgeries for adults and children; cardiology clinical trials	http://www.cooley-dickinson.org/main/cardiovascular-services.aspx
Diabetes	Diabetes Education Center	Services for the evaluation, treatment, and management of diabetes and other endocrine disorders; education, information, classes and support groups	http://www.cooley-dickinson.org/main/diabeteseducation.aspx
	Diabetes Education and Self-Management Program	Help adult patients and their families learn to manage their diabetes and live full and productive lives.	http://www.cooley-dickinson.org/main/programs-at-cede.aspx
Nutrition	Women, Infants and Children	Services for pregnant, breastfeeding, and post-partum women and children	http://www.communityaction.us/wic-women-infants-and-

Priority Health Need	Resource Organization Name	Description of Services Provided	Website Address
	(WIC)	up to age 5, provides checks to buy nutritious foods	children.html
	Mass In Motion	Community-based coalition to improve health equity through improved access to healthy eating and active living	http://www.northamptonma.gov/1482/Healthy-Hampshire
Physical Activity	Cooley Dickinson Health Care Physical Therapy Services	Information, resources, coaching and education, stretching, core strengthening, walking and strength training to improve or restore physical function and fitness levels	http://www.cooley-dickinson.org/main/physical-therapy-programs.aspx
	Hampshire Regional YMCA	Fitness sessions, swimming, dance classes, after-school care, summer camps, senior health initiatives, yoga, Live Strong, weight loss programs	http://www.hrymca.org/
Asthma	Pioneer Valley Asthma Coalition	Community partnership that works to improve the quality of life for individuals, families and communities affected by asthma	www.pvasthmacoalition.org
Mental Health	Cooley Dickinson Behavioral Health Care	Provides Hospital, Substance Use Disorder treatment and support, Mental Health services	http://www.cooley-dickinson.org/main/home.aspx

Priority Health Need	Resource Organization Name	Description of Services Provided	Website Address
	Clinical & Support Options	Comprehensive behavioral health corporation; provides Emergency & Acute Services, Community Based Family Support Services, Outpatient Mental Health and Substance Abuse Services, and Clubhouses	http://www.csoinc.org/
	Hilltown Community Health Center	Therapy and substance abuse services for children, adolescents, adults, and elders through individual, group, and family therapy sessions	https://www.hchcweb.org/connect-to-services/service-we-offer/behavioral-health/
Substance Use Disorder: Tobacco	Massachusetts Department of Public Health	Quit smoking resources and information; toll-free support line: 1-800-QUITNOW	http://makesmokinghistory.org/quit-now/health-insurance-benefits/
Substance Use Disorder: Opioids and Other Substances	CleanSlate Addiction Treatment Center (Suboxone Treatment)	Patient-focused treatment for opioid, alcohol and other drug addictions; appointment-based outpatient treatment	http://cleanslatecenters.com/
	Behavioral Health Network (BHN) Addiction Services	Comprehensive addiction services including detox, post-detox residential series, long-term residential, day treatment programs, and outpatient services.	http://bhninc.org/content/addiction-services
	Needle Exchange Program	Needle exchange programs in Holyoke and Northampton, provides sterile needles to injection drug users, trainings on Naloxone, education and counseling, health education and screening on infectious disease	http://www.tapestryhealth.org/index.php/services/prevention/needle-exchange

Priority Health Need	Resource Organization Name	Description of Services Provided	Website Address
	Hampshire HOPE	Regional coalition that works to prevent and reduce opioid abuse and substance use; supports and advocates for expanded support and recovery services; trains, educates, advocates, and provides resources on opiate abuse and overdoses	http://www.hampshirehope.org/
	SPIFFY Coalition	Promotes teen health in Hampshire County; works with schools and community partners to establish and support effective youth development and health-promotion programs, provides training and technical assistance on evidence-based practices, involves and empowers youth	http://www.collaborative.org/programs/community-health/spiffy-coalition
Prenatal and Perinatal Care	Cooley Dickinson Women's Health Services	Midwife services; Childbirth Center; Menopause treatment; Maternity services; Birth control; Pregnancy services; Nursing and midwifery services; labor and delivery services	http://www.cooley-dickinson.org/cdmg/womens-health1.aspx http://www.cooley-dickinson.org/cdmg/womens-health-midwifery.aspx

Priority Health Need	Resource Organization Name	Description of Services Provided	Website Address
	MotherWoman	Developed the Western Massachusetts Perinatal Support Coalition Network; provides support groups and training	http://www.motherwoman.org/
Teen Pregnancy	Community Action!	Healthy Families: free home visiting support program for first time parents, age 20 and under, living in the Franklin, Hampshire, and North Quabbin regions	http://www.communityaction.us/healthy-families-support-for-parents-under-21.html
	Massachusetts Department of Public Health Teen Pregnancy Prevention Program	Promotes healthy behavior, responsible decision making and increased opportunities for at-risk youth using evidence-based programs in targeted communities	http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/primarycare-healthaccess/adolescent-health/overview.html

Appendix V: County Health Rankings, 2016

County Health Rankings, 2016

Shaded columns are rankings based on the 14 counties in Massachusetts. Lower numbers indicate better status. A rank of 14 indicates a county is ranked last in the state.

The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.

The County Health Rankings measure the health of nearly all counties in the nation and rank them within states. The Rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights.

For more information, visit: <http://www.countyhealthrankings.org/>

	Massachusetts	Hampshire County	Hampden County	Franklin County	Berkshire County	Worcester County
Health Outcomes		5	14	8	11	7
Length of Life		5	14	7	12	8
Premature deaths	5,100	4,700	6,600	5,500	6,200	5,500
Quality of Life		5	14	8	10	7
Poor or fair health	14%	12%	19%	12%	13%	12%
Poor physical health days	3.5	3.3	4.4	3.5	3.4	3.1
Poor mental health days	3.9	3.9	4.5	4.0	4.1	3.6
Low birthweight	8%	6%	8%	7%	8%	7%
Health Factors		3	14	7	9	11
Health Behaviors		6	14	8	7	11
Adult smoking	15%	15%	18%	15%	15%	16%
Adult obesity**	24%	21%	29%	22%	23%	26%
Food environment index**	8.3	8.1	7.9	8.1	7.9	8.2
Physical inactivity**	22%	16%	26%	18%	20%	23%
Access to exercise opportunities	94%	86%	94%	72%	79%	91%
Excessive drinking	20%	24%	18%	20%	18%	19%

	Massachusetts	Hampshire County	Hampden County	Franklin County	Berkshire County	Worcester County
Alcohol-impaired driving deaths	29%	28%	32%	27%	21%	31%
Sexually transmitted infections**	349.2	222.2	576.5	257.2	320.0	278.0
Teen births	17	4	37	20	21	19
Clinical Care		2	12	7	3	9
Uninsured	4%	4%	5%	4%	4%	4%
Primary care physicians	940:1	690:1	1,410:1	1,420:1	910:1	960:1
Dentists	1,070:1	1,550:1	1,300:1	1,540:1	1,310:1	1,500:1
Mental health providers	200:1	140:1	160:1	160:1	150:1	250:1
Preventable hospital stays	56	47	63	49	44	55
Diabetic monitoring	90%	89%	89%	90%	91%	89%
Mammography screening	74%	77%	71%	72%	73%	70%
Social & Economic Factors		3	14	7	11	9
High school graduation**	85%	90%	73%	84%	84%	86%
Some college	71%	78%	59%	67%	63%	67%
Unemployment	5.8%	5.0%	7.8%	5.3%	6.5%	6.2%
Children in poverty	15%	13%	26%	17%	20%	15%
Income inequality	5.4	4.9	5.7	4.5	4.9	5.0
Children in single-parent households	31%	31%	47%	33%	36%	29%

	Massachusetts	Hampshire County	Hampden County	Franklin County	Berkshire County	Worcester County
Social associations	9.5	9.6	8.7	12.4	11.8	8.8
Violent crime**	434	245	641	379	403	447
Injury deaths	46	42	53	49	58	48
Physical Environment		10	13	11	14	12
Air pollution - particulate matter	10.5	10.7	10.7	10.6	10.8	10.5
Drinking water violations		Yes	Yes	Yes	Yes	Yes
Severe housing problems	19%	17%	19%	16%	18%	16%
Driving alone to work	72%	71%	83%	78%	79%	82%
Long commute - driving alone	41%	35%	27%	35%	23%	41%