Cooley Dickinson Hospital Community Benefits Plan 2016

The Cooley Dickinson Hospital mission:
Cooley Dickinson Hospital's vision is to make the mid-Pioneer Valley the nation's model healthy community. One of the components of that vision is to improve access to programs to meet the community's medical needs and partner with the community to develop practices that encourage health and a high quality of life.

Through its healthy communities committee Cooley Dickinson monitors local health status and works collaboratively to improve health. In this community benefits plan, Cooley Dickinson will describe its mission, structure, and processes for community health engagement. We will then describe our approach to community health assessment and we will provide our community benefits plan for fiscal year 2016.

To provide our patients and communities with the best health care in the most appropriate setting.

The Cooley Dickinson Hospital community benefits mission:
Cooley Dickinson Health Care Corporation (Cooley Dickinson) 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.

Healthy Communities Structure:
The Cooley Dickinson Hospital healthy communities committee was established in 1995 to carry out the community health mission of the hospital. The committee membership includes a mix of community members and hospital representatives, including a physician, senior staff and board members.

The healthy communities committee guides community health assessment and planning, including approving the community benefits plan and budget. The committee reviews program goals and makes recommendations for interventions to improve community health.

Community Health Assessment
Cooley Dickinson Hospital conducted a formal community health assessment and published the results in 2014. The health assessment built on an earlier assessment, published in 2011.

The initial health assessment included a comprehensive review of secondary data sources, categorized by community and/or county, within the hospital's service area. Where possible, data is further analyzed by gender, age, and race. Data sources include MassCHIP, Behavioral Risk Factor Surveillance Survey, Hospital Discharge data from the Massachusetts Department of Public Health, Hampshire County and Franklin County Prevention Needs Assessment Survey,

United States Census Bureau, Food Environment Atlas, MDPH Birth Reports, Massachusetts Cancer Registry, MDPH Pediatric Asthma Surveillance, and local school health data.

Each section includes charts, graphs, and a narrative analysis of the information. The report has been widely disseminated in the Pioneer Valley. The report is available at www.cooley-dickinson.org.

In 2013 we supplemented the health assessment by participating in the Pioneer Valley Planning Commission led report: State of the Pioneer Valley. This report summarizes key indicator data including health, education, and quality of life. The report can be viewed at: http://www.pvpc.org/activities/data-state-people-feb-2013.shtml

We also supported the implementation of the Prevention Needs Assessment Survey in area middle and high schools. The survey was conducted by the Strategic Planning Initiative for Families and Youth (SPIFFY), in partnership with school districts. Survey data includes youth risk and protective factors and risky behaviors, http://www.collaborative.org/programs/families-and-youth/data

We built on these data reports by engaging residents in qualitative data collection and discussions about priorities.

We consider the health assessment role to be an ongoing process of monitoring community health trends, engaging the community in identifying needs and solutions, and building local capacity to understand and improve community health. We published our 2014 health assessment emphasizing the following qualitative data.

- A regional survey of health needs was conducted, in collaboration with other Pioneer Valley hospitals.
- Key informant interviews were conducted with 13 health and human service providers and agency directors.
- Three focus groups were conducted. Areas of focus were: Easthampton, health access, and mental health.
- Three community forums were conducted. Areas of focus were: Easthampton, health access, and mental health.

Forum participants were given an overview of the health assessment and a summary of the qualitative data. Through group discussion and activities we received input into priorities for action. This input informed the development of our community benefits plan.

In FY 2015, Cooley Dickinson provided grant support to several projects based on findings from the needs assessment.

In FY 2015 Cooley Dickinson, in partnership with the Pioneer Valley Planning Commission and Hampshire County United Way, released Getty to Healthy – a report about transportation barriers and possible solutions.

Also, in FY 2015, Cooley Dickinson, in partnership with area behavioral health programs and state agencies, mapped the current and preferred behavioral health “systems.” A companion report provides recommendations.

Our plan is consistent with the Healthy People 2020 (Centers for Disease Control and Prevention) focus on the social determinants of health. Our plan and budget are organized according to these categories:

- Access to care
- Health reform
- Supporting health equity
- Chronic disease rates and preventive practices
- Behavioral health
- Healthy eating and active living

Our plan is based on health assessment data and community feedback. The plan will be revised based on our evolving understanding of needs through health assessment data collection and community engagement.

Access to care

Program: Hampshire County Health Access Task Force

Target population: Local residents who are uninsured or underinsured including those with mental illness, immigrants, homeless, and veterans.

Need: Massachusetts leads the nation in residents with insurance coverage with nearly 100% coverage, according to data released by the Center for Health Information and Analysis in June, 2014.

Even with coverage, access to primary and specialized care is challenging for some people. An earlier report by the Hampshire County Health Access Task Force the board of Hampshire HealthConnect and the hospital's healthy communities committee recommended solutions. The task force identified six potential solutions:

- Using community health workers
- Increasing use of case management
- Increasing cultural competence
- Improving coordination and communication across silos
- Creating a health center in Amherst
- Creating primary care walk-in service in the hospital emergency department

The committee evaluated the possible solutions against the following criteria: practical, affordable, availability of a lead entity, and acceptability by the population being served. The committee assigned workgroups to further study the feasibility of these solutions. Preliminary studies have been or are being conducted to determine feasibility. The process to design and develop the proposed health center satellite continues and has solid community support. A space downtown has been identified and the Town of Amherst has voted to approve funds to relocate a program from that space to make it available. The Hilltown Community Health Center leads this project, with support from the hospital and other community partners. The project has received a major grant from the federal government to prepare the site.

Goal: Continue supporting the planning efforts to establish a satellite health center in Amherst.

Outcome: Patients, especially vulnerable populations, in the Cooley Dickinson Hospital service area will have increased access to medical and dental care.

Short term goals: Assist with feasibility studies on cash flow and fund raising; assist with architectural fees; assist with program design and community engagement/outreach

Access to care
Project: Improved access to care by improving access to transportation

Target Population:
Residents in the CDHCC service area

Need: The regional survey referenced earlier asked about barriers to receiving needed care. 2.6% of responses cited lack of transportation. Although other barriers such as lack of insurance, inability to afford care, and problems with hours/scheduling an appointment were bigger barriers, transportation emerged as a key theme in the focus groups and community forums. Key informant interviewees also identified insufficient public transportation as a significant barrier to accessing community assets and services. People who attended the community forum on transportation identified some specific transportation barriers as they seek health care or health supporting services.

- PVTA van service availability/accessibility is limited; one can be denied use of the van; times for van service do not fit needs; as a result, people use an ambulance for transportation
- Need to take 3 buses to get from Amherst to Northampton; can take hours
- No rides home after discharge from hospital; patients may not be able to afford a cab ride and often don't feel well enough to take the bus home

Cooley Dickinson worked with the Pioneer Valley Planning Commission and the United Way of Hampshire County to collect and study data to better understand qualitative information learned during community forums. Data includes distance, time, and cost from community to hospital by various means of transportation. The project also is exploring alternatives to providing services that don't rely on transportation – such as telemedicine.

Cooley Dickinson participates in the Hilltown Regional Coordinating Council to study transportation needs (including medical) of seniors.

Goal: Increase access to transportation to medical appointments and other places/activities that support health

Outcome: Residents are able to get where they need to go for health care and activities that support health

Short term goals: Implement small projects to improve transportation to health care and related services:

- Provide pilot project funding to the Amherst Survival Center to send clients to medical appointments
- Provide funding and support to the City of Northampton Office of Planning and Sustainability to develop a template to map a Complete Streets initiatives. The template, once developed, can be used by other municipalities.
- Participate in the Hilltown Regional Coordinating Council, hosted by the Hilltown CDC and provide funding, data, and support to study elders access to medical care and transportation barriers. Councils on Aging are partners in this project.

This project addresses the Massachusetts health priorities of access to health, and health equity,

Supporting Health Equity
In addition to the community benefit programs described below, Cooley Dickinson Health Care has begun a Health Equity Task Force. Initially, the Task Force will focus internally as it

identifies polices, practices, and staff educational opportunities to increase health equity. Later, the Task Force will expand by adding community members and broadening its scope to include the wider community.

Supporting Health Equity
Project: Latino Access to Health Care

Target population: Hampshire County Latino residents

Need:
Previous Community Health Assessments and Casa Latina's needs assessment showed that the Latino population of Hampshire County has grown by 34% in the past 20 years and Latinos comprise 4.7% of the population of Hampshire County (2010 U.S Census). They are uninsured at higher rates than other ethnic groups; they often face challenges such as financial hardship, immigration status (undocumented), language barriers, racial discrimination, and lack of information about the health care system. Overall, they are more likely than other racial or ethnic groups to report their health as fair or poor (37%) and suffer higher rates of disability, diabetes, and being overweight or obese than White non-Hispanics. Unfortunately, Hampshire County lacks sufficient bi-lingual primary care doctors, specialists, and mental health practitioners.

Casa Latina is a unique organization in Hampshire County that acts a stepping stone for Latino residents to navigate the social and health systems in the Pioneer Valley. Casa Latina's 40 year history has allowed its staff to support generations of Latino families meet economic challenges and establish themselves in our community. Their services support the Latino resident at all points in the human life cycle. They assist Spanish-speaking Latino parents to make and attend pre-natal visits, apply for health insurance, obtain WIC services, find child care. They support families to establishing economic security, through assistance with finding and maintaining housing and employment. Casa Latina's work does not stop when they give residents a resource and phone number; instead they walk with residents through the process of filling out applications, understanding and collecting information, and assisting with calls where language is a barrier. Casa Latina's culturally competent staff empowers Latino residents to learn how to navigate systems and become more self-sufficient and advocate for other residents in the community. Casa Latina also reaches this mission through popular education programs, the content of which is driven by the needs expressed by the Latino community in Hampshire County. The educational programming they provide has resulted in development of Latino residents engaging in greater leadership roles within other community organizations; improved health habits and reduction in isolation of Latino elderly residents.

In 2014 and 2015, Cooley Dickinson provided a grant to establish a health navigator project. One of the areas of focus was Easthampton, MA. The grant was also designed to support operations and development of a strategic plan and a plan to become more financially viable.

Goal: Provide patient navigation, information and referral, and case management services to Latino residents of Hampshire County.

Outcome: Latino residents will be able to navigate the local health care system resulting in greater patient satisfaction with it.

Short-term goal: Provide a grant opportunity for a local Latino serving program to provide patient navigation, information and referral, and case management services.

This project addresses the Massachusetts health priority of supporting health disparities.

Chronic disease rates and preventive practices
Program: A Positive Place

Target population: People living with HIV/AIDS in Hampshire and surrounding counties. Although the overall rate of new infections has decreased over the years in the Commonwealth due to innovative and successful prevention work, A Positive Place continues to see an increased number of clients using our services. In FY 2014 APP served 186 PLWH. Our target population includes: 76% male, 23% female, and 1% transgender; 64% are between the ages of 40-59, and more than 10% over 60. In our area, as in the state and the nation, we see health disparities among certain populations, with dramatically high rates of infection among men who have sex with men (55%), and in communities of color (25% Latinos, and 15% African American). 20% of APP clients are people who are either currently using intravenous drugs or who have in the past. The Infectious Disease Specialists report a much higher rate among their patients among those patients 80-92% is co-infected with Hep C. We see a small increase in consumers whose mode of transmission was through heterosexual contact. Most APP consumers are on public insurance. Over half of all APP clients live at or below 100% of poverty, and another 45% live at or below 200% of the federal poverty level for income. 12% are homeless/chronically homeless and 20% are at risk of homelessness. 38% of our clients reside in Hampshire County, 48% in Hampden, and 10% in Franklin. We serve veterans—a relatively transient group who often present with multiple social case management and medical needs for a brief period of time, and then return to their local community or another VA facility. We serve a large rural clientele, as well as growing urban and transient populations. Upward of 90% of clients have experienced violence and deal with its impacts (e.g., substance use, mental health challenges, sex offenses).

Need:
In our largely rural area isolation, lack of transportation, stigma, fear, and depression inhibit many PLWH from accessing care; even the less rural areas have limited and scattered medical and social services. Many clients are experiencing the natural effects of aging combined with co-morbid conditions, which is taking its toll and increasing challenges to navigating systems. A dearth of trauma-specific care for survivors and wait lists for mental health services exacerbates adherence challenges, and a lack of psychiatrists and access to psych medications continues to be a problem, especially for those suffering cognitive impairments from the virus. Many of our clients experience higher rates of chronic disease. Other barriers to access include poverty, drug addiction, and cultural distrust of our health care system and providers. The lack of culturally competent services/ providers is a significant barrier for our Latino, Black, and MSM clients. Homelessness and/or the risk thereof in a county with a historically high FMR, combine with poverty, court involvement, and addiction, making transiency a way of life and access to services irregular. 18-20% of people living with the virus are unaware of their status, thus increasing the risk of transmission

Goals:
Based on our stigmatized and marginalized target population and the needs outlined above, critical components of APP treatment and prevention include equal access to and coordination of quality medical care and medication, community-based services and government benefits; trauma-informed/culturally competent services; home-health services; peer support, navigation & advocacy; education around medication adherence and risk/transmission reduction; mental health/substance use support; medical transportation, emergency food assistance, and stable housing. Accessing these basic needs can be difficult, and is often exacerbated for many of our clients due to substance abuse and histories of trauma, loss of income due to inability to work, histories of incarceration, and other challenges linked to poverty, racism, language, etc.

Our three goals, aligned with those of the National HIV Strategy, are:
1. Increasing access to and retention in care and health outcomes for PLWHA
2. Reducing health disparities based on race, ethnicity, gender, sexual orientation and eliminating health inequities
3. Reducing number of new HIV infections

Short term goals: Provide confidential, equitable and integrated medical and social case management and health related support services, emergency assistance, risk assessments/reduction, housing assistance, to increase engagement/retention in care, reduce

the rate of transmission, and improve quality of life. Services are provided in ACHC office, off-site at infectious disease specialist, and in people's homes, jail, hospital, treatment program, nursing home, or other location as needed.

This project addresses the Massachusetts health priorities of access to health, and health equity, health reform, chronic disease management.

Behavioral Health
Program: Reducing teen substance abuse

Target Population:
Middle and High School students in the CDHCC service area

Need:
According to the 2013 Hampshire County Prevention Needs Assessment Survey results, alcohol use has been decreasing the past few years among 8th, 10th and 12th graders; cigarette use has declined among 10th and 12th graders while use rates have not changed much for 8th graders. Marijuana use has decreased among 10th and 12th graders, but increased among 8th graders.

There are four substance abuse prevention coalitions in Hampshire County, including three with federal Drug Free Communities grant funding – Easthampton Healthy Youth Coalition, the Northampton Prevention Coalition, and the South Hadley Prevention Coalition. SPIFFY (Hampshire County) completed its Drug Free Communities grant funding. Prevention is effective when it is based on local data, applies evidence based strategies based on that data, and engages a range of partners to enact programs and environmental changes. Local coalitions and school districts need support to implement the Prevention Needs Assessment Survey.

Goal: Reduction in teen substance use.

Outcome: Schools will analyze their Prevention Needs Assessment Survey data and identify priority interventions.

Short term goal: Program planning based on local data on youth behaviors and associated risk and protective factors at the individual, family, school, and community levels.

Behavioral Health
Project: Improve coordination of community system of care

Target Population:
CDHCC area residents with mental health needs and/or substance use disorders

Need: In the late winter of 2013, Cooley Dickinson and other Pioneer Valley hospitals commissioned a survey of health issues. In the CDHCC area 926 people completed the survey. When asked to state the top health issues that need to be addressed, mental health was the second highest concern, with 8.9% of respondents choosing it. When Cooley Dickinson conducted key informant interviews in the summer of 2013, access to mental health care was suggested as a measure for community health. Cooley Dickinson conducted a focus group about mental health in the summer of 2013 and held a community forum in later summer 2013. Both groups included patients, family members, advocates, and providers. Several needs were identified including access to psychiatrists, early screening, day treatment, and transitional care. The group also identified access to housing, shelters, family resources, long wait times and

access to primary care to address medication/prescription renewal. Another theme was the need for more education about mental illness among first responders and emergency staff. CDHCC convened a local group of providers and representation from patient and family interests to map the current system of care and develop a vision where people can get their needs for behavioral health services met anywhere they are.

Cooley Dickinson joined the other hospitals in the Pioneer Valley, large non-profit behavioral health providers, the Mass. Department of Mental Health, the Mass. Department of Public Health, and the National Alliance on Mental Illness (NAMI)– Western Mass. to select one specific project. The group chose to implement Mental Health First Aid and will develop and implement a training plan in the coming year.

Goal 1: Create a better coordinated and communicated system of mental health care.

Outcome: Residents needing behavioral health services will be able to obtain it.

Short term goals: Patients, families, and providers will develop a plan to improve 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.

- Implement Mental Health First Aid training
- Sign NAMI's CEO pledge to reduce stigma
- Provide a Mass. General Hospital lecture on stigma
- Host a panel presentation and discussion with providers and people who experience mental health problems

This project addresses the Massachusetts health priorities of access to health, and health equity, health reform, chronic disease management.

Behavioral Health
Project: Reduce impact of opiate abuse

Target Population:
CDHCC area residents with substance use disorders and those at risk

Need: Hampshire County is made up of 20 small towns and two small cities with a total population of 159,795. The population of Hampshire County is predominantly white (85.9%), with small, roughly equal percentages of Hispanics, African-Americans, and persons reporting 2 or more races. 15.7% are under the age of 18 and the median age is 34 years. The 2014 County Health Rankings ranked Hampshire County 1st among the 14 Massachusetts counties for quality and access to clinical care and rated it 3rd for socio-economic factors, 9th for physical environment and 6th for overall quality of life. According to this report, 20% of Hampshire County residents report excessive drinking. The Pioneer Valley Planning Commission's "State of the Pioneer Valley" report of January 2013 gave the Pioneer Valley as a whole a rating of "C+" in regards to substance abuse, and Northampton was found to have substance abuse treatment admissions higher than the Valley's average of 17.9 per 100 people.
Cooley Dickinson Hospital data shows that opioid poisoning is increasing in magnitude and severity. Based on ICD-9 and E code data, the emergency department averaged 89 cases of opioid overdose per year from 2009-2011 and 124 per year from 2012-2013, a 72% increase. Current opioid overdose death rates in the Northwestern District Attorney's area (encompassing both Hampshire and Franklin counties) are 18.9 deaths per 100,000 while the state rate in 2013 was 10.1 per 100,000. Although deaths and non-fatal hospital encounters for opioid poisoning from 2010-2012 (per MA DPH) were less than 11 in Amherst, Easthampton, South Hadley, Belchertown and Pelham, Northampton had 22 during that time period and Ware had 11. Additionally, more recent data provided by the District Attorney's office shows a 175% increase in opioid fatalities in all of Hampshire County from 2011-2013 and in 2013 the death rate in Hampshire County was 42% higher than that of the state. A Massachusetts Department of Public Health data set compiling a comparison between two time periods for cities/towns with 10 or more unintentional opioid overdose deaths between 2008 and 2012, shows Northampton with a 50% increase in deaths from 2008-2012 as compared to 2003-2007.

Goal: Participate in a community collaborative effort to reduce overdose and death from opiate use

Outcome: Opiate-related overdose incidence will decrease

Short term goals: Assist the coalition to establish a Health Care Solutions committee.
Print and distribute educational materials for people seeking help.
Review and revise, if needed, opioid prescribing policy
Participate in community prevention and education initiatives
Provide NARCAN prescription cards in the emergency department
Assess the feasibility of expanding treatment options
Develop and implement internal plans to increase provider education

Healthy Eating/Active Living, Tobacco Control – Easthampton Projects
Project: Healthy eating/active living
Project: Tobacco control

Target Population: Easthampton residents

Need: Heart disease (approximately 270 per 100,000) and cancer (approximately 180 per 100,000) are the leading causes of death in Easthampton and rates of each are higher in Easthampton than in surrounding communities. Poor dietary behavior and inadequate physical activity also contribute to heart disease and cancer deaths. Ninety-six Easthampton residents participated in a regional health survey conducted in the winter of 2013. Three of the top five concerns expressed by CDHCC area residents were: not enough exercise (7.4%), obesity (7.1%), and poor dietary choices (5.9%).

Smoking is a leading contributor to these deaths and Easthampton smoking rates (20%) are higher than the Massachusetts rate (16%) as well as other local communities. Additionally, the percentage of women who smoke during pregnancy is higher in Easthampton (12%) than the Massachusetts rate (7%) and other local communities.

Based on health assessment results including feedback from the community, CDHCC provided grants for several projects in Easthampton. Project accomplishments in 2014 include training a local medical provider to become a tobacco treatment specialists; eliminating the "smokers corner" near the high school; and providing training to landlords for their rentals to become smoke free.

There were also several projects that focused on healthy eating and/or physical activity. For example, one project conducted an assessment of the condition of sidewalks in the community to assist the City to prioritize which sidewalks for repair so that walkers will be safer and more confident that their local environment supports them to be physically active. Another project created a community garden at the school and provided education and support to teachers to be leaders in the project. A project at the community center provided healthy food for youth during the summer and also offered a community education series on healthy eating.

Goal 1: Establish or enhance projects to improve healthy eating and engagement in physical activity.

Outcome: Increased readiness by Easthampton to improve sidewalks; increased participation in school gardening; increase physical activity by City employees.

Short term goals: Providing funding and support for a variety of projects.

Goal 2: Establish or enhance projects or programs to prevent or reduce tobacco use.

Outcome: Decrease incidence of smoking adjacent to high school.