Community Health Needs Assessment Implementation Plan

FY 2023 - FY 2025

STURDY MEMORIAL HOSPITAL

May 2022

With a mission of providing high quality care in both the inpatient and outpatient settings, Sturdy Memorial Hospital and Medical Associates undertook a comprehensive Community Health Needs Assessment (CHNA) in February 2022. The purpose of the CHNA is to evaluate the health needs of individuals living in the hospital service area within Bristol and Norfolk counties in Massachusetts. The assessment examined a variety of health indicators, including chronic health conditions, access to health care, and social determinants of health. Sturdy Memorial Hospital and Medical Associates contracted with Holleran Consulting, a research firm based in Wrightsville, Pennsylvania, to execute this project.

The completion of the 2022 CHNA enables Sturdy Memorial Hospital and Medical Associates to take an in-depth look at its community. Healthy communities lead to lower health care costs, improved health outcomes, robust community partnerships, and an overall enhanced quality of life. Sturdy Memorial Hospital and Medical Associates is committed to the people it serves and the communities where they reside.

The prioritized health needs, as discussed during the May 2, 2022 prioritization meeting, are listed below:

- Access to Healthcare and Prevention Services
- Behavioral Health and Substance Abuse
- Chronic Disease Management and Prevention
- Cancer Prevention Education and Screening

Sturdy Memorial Hospital's Board of Managers approved the 2022 Community Health Needs Assessment and Implementation Plan for FY2023-FY2025 on October 24, 2022.

Priority: Access to Care and Prevention Services

Rationale: Access to providers is critical to healthy outcomes in a population. Provider density, or the provider to population ratio measures the opportunity for community members to be seen by a physician. According to County Health Rankings, Bristol County is ranked 13th of 14 counties in Clinical Care Rank where a ranking of "1" is considered the best. The Clinical Care Rank evaluates provider density as well as a community's access to health prevention programs such as vaccinations and cancer screenings. Norfolk County ranked much higher and is 2nd among Massachusetts counties. While a majority of survey respondents perceive there to be a sufficient number of primary care providers and medical specialists in the community, accessing them seems to be the issue. This is confirmed by a large majority of survey respondents who selected transportation and the availability of providers/appointments as key health barriers. Importantly, only 4.2% "agree" or "strongly agree" that there are enough bilingual providers to meet demand.

Specific provider to population ratios vary by county. The ratio of individuals to one primary care physician in Bristol County is alarmingly high (1,893:1) when compared to Massachusetts and the National Benchmark (968:1 and 1,050:1 respectively). The National Benchmark represents the 90th percentile and only 10% of counties are better. The same is true for the dentist ratio in Bristol County which is 1,457:1 while the National Benchmark is 1,260:1. Poor provider densities in Bristol County may translate into longer wait times to get a doctor's appointment and primary care doctors and dentists who do not accept new patients. It is worth noting that free or low-cost dental care was identified by key informants as "Missing." "Dental health seems to be the often-hidden source of inflammation and other problems that invite disease." By contrast, provider densities in Norfolk County for primary care physicians and dentists are an area of strength. Fortunately, mental health provider density in both counties is favorable.

The data demonstrate that residents of the primary and secondary service areas are almost entirely covered by health insurance. This is advantageous in terms of being able to afford doctor's visits and to seek preventative treatment rather than waiting for a medical crisis to occur. However, insurance coverage is not the only variable impacting health outcomes. The inability to navigate the health care system was selected by key informants as the most significant barrier to accessing the health care system.

For key informants, access to care issues and uninsured individuals seems to have become much more important of an issue; now selected by over half in 2022 as compared to one-third in 2019. Factors mentioned as impacting access include the limited availability of preventative care such as immunizations and screenings and outreach services, affordability and the inability to pay out of pocket expenses, lack of transportation and a heightened lack of trust in the health care system. Access to education about the need for routine medical care and prevention as well as the ability to attend medical appointments by having time off from work and a means of transportation also impact access and health status. Overall, key informants called for better care coordination that looks at the needs of the whole person and improved collaboration among community organizations

The availability of preventive healthcare and educating the community around preventative health behaviors can positively impact health outcomes. Cancer screenings and vaccinations can lower the rate of chronic and infectious diseases. The percent of Bristol County residents receiving a flu vaccination is 45%, somewhat higher than the state (41%), but lower than the National Benchmark of 52%. However, only 36% of residents in Norfolk County receive an annual flu vaccination. On a positive note, in both counties over half of woman receive mammograms each year and this is higher than the National Benchmark of 49%. Also, several infectious and sexually transmitted diseases are less prevalent in Bristol and Norfolk counties than in Massachusetts and the U.S. including HIV/AIDS, infectious syphilis, chlamydia and gonorrhea. However, the case rate of tuberculosis (per 100,000) in Norfolk County (3.8) is high when compared to Massachusetts (2.6) and the U.S. (2.7). The rate in Bristol County is much lower at 0.9.

Objective: Address barriers and challenges that residents face in Sturdy Memorial's service area in accessing and navigating health care needs and services

ACCESS TO HEALTHCARE AND PREVENTION SERVICES Strategies	Metrics and Progress
Sturdy will Increase access to SMH and SMA providers through recruitment and retention of providers, both primary and specialty care providers	•
Sturdy Memorial Hospital will research and identify possible telemedicine opportunities.	•
Sturdy Memorial Hospital will explore opportunities to reduce transportation barriers for patients.	•
Sturdy Memorial will explore "off-hour" clinic opportunities for patients with little daytime flexibility	•
Sturdy Memorial will continue to explore opportunities to support our aging population including supportive care.	•
Sturdy Memorial will explore ways to improve the process of connecting ED patients to a PCP as appropriate	•
Sturdy Memorial will continue to connect uninsured or underinsured patients to financial counselors	
Sturdy Memorial will explore the opportunity to partner with local dentist offices for screening services	•

Priority: Affordable Housing and Income

Rationale: Important secondary data for the primary and secondary service areas such as cost of living, poverty level and average rent and home values are key in identifying the impact that income and affordable housing have on health. For those living at or below the poverty level, finding affordable housing is difficult and when found, may be less than optimal. Poor housing conditions are associated with a wide range of health conditions including respiratory illness, asthma, lead poisoning, injuries and mental health. It is well documented that when housing is affordable, financial burdens are alleviated and more household resources are available for health care and healthy food, which lead to better health outcomes. Of the key informants, 66.7% chose low-income/poor populations as the most underserved. The median income for households and families is highest in the secondary service area and higher in the primary service area ($133,129 and $120,549 respectively) than both the state and the nation. While high median incomes may seem ideal, the data show that home values and median rents are also high. In both the primary and secondary service areas, far more households own their own homes than rent as compared to the state and nation. Median home values, particularly in the secondary service area are much higher than in Massachusetts or the
U.S. The median home value in the secondary service area is $517,828. The median monthly rent is highest in the secondary service area as well ($1,426).

Thirty percent of a household's total income is considered the cut off for housing-cost burden and avoiding financial hardship. In the secondary service area, the percent of households in which 30% or more of income is spent on rent represents nearly half (47.6%) of all renters. When spending more than 30% on rent or mortgage, tradeoffs must be made which include buying healthy food and paying for health care. This suggests that living in these services areas (particularly the secondary service area) can be costly for residents of limited means. Homeownership and even renting an adequate home may be out of reach for some. One key informant stated, "The number of homeless individuals in the area has increased over the past two years, in particular related to the pandemic. Though resources were made available, increased mental health and substance misuse contributed to the inability to maintain housing and basic needs."

On a positive note, the percent of all families below poverty level in both the primary and secondary service area is much lower when compared to the state and the nation. (Households that are below 100% of the federal poverty level have an income less than the amount deemed necessary to sustain basic needs.) Fewer households in the service areas receive food stamp/SNAP (supplemental nutrition assistance program) benefits when compared to the state and nation. However, in the secondary service area, there is a notably higher proportion of households with one or more people 60 years and over receiving food stamps (87.1%) than the primary service area (44.9%), the state (41.7%), and the nation (38.8%). Additionally, almost one- third (30.8%) of households in the secondary service area are responsible for grandchildren which may create an added financial burden for these older residents. These findings demonstrate that older adults in the secondary service area may experience financial hardship which is disproportionately greater than younger adults.

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, Sturdy Memorial Hospital and Medical Associates planned to focus community health improvement efforts on the four (4) health and wellness focused priorities while supporting community partners in addressing Affordable Housing and Income over the next three-year cycle.

Objective: Support Sturdy Memorial's community partners in addressing Affordable Housing and Income over the next three-year cycle.

AFFORDABLE HOUSING AND INCOME Strategies	Metrics and Progress
Sturdy will support the ongoing expansion of affordable housing within the communities it serves.	• Support the construction of affordable housing through Habitat for Humanity, both financially and through volunteer service.
Sturdy will actively support mentorship and internship programs locally to develop employment opportunities	• Internship opportunities offered • Volunteer opportunities offered • Recruitment fairs

Priority: Behavioral Health and Substance Abuse

Rationale: Increasingly, mental health disorders and substance abuse have been linked to a higher risk of developing and dying from chronic diseases, such as diabetes, cardiovascular disease and infectious diseases. When not addressed, mental health issues including suicide can be a burden on population health as well as on individuals. Behavioral health encompasses traditional mental health and substance use disorders, as well as overall psychological well-being. Addressing mental/behavioral health issues involves focusing on social determinants of health through an array of social and community avenues. Consistently, the secondary data find Bristol County to have greater mental health and

behavioral health needs than Norfolk County. Despite the fact that mental health provider density is reported to be adequate, mental health services were identified by 75% as the top "Missing" community resource. This issue seems to have intensified since 2019, with fewer informants perceiving there to be sufficient mental health providers now. Self-assessed health status is a measure of how an individual perceives his or her health and can be a predictive measure for overall health outcomes in a population. County Health Rankings measures length of life and perceived physical and mental health. Norfolk County received a ranking 3 of 14 counties for Health Outcomes (with 1 being the healthiest). Bristol County is ranked much lower at 12. In Bristol County, residents experience 4.9 poor mental health days on average per month and 16% are in poor or fair health. In Norfolk County people fair somewhat better and experience 4.1 poor mental health every 30 days. Eleven percent are in poor or fair health. Both counties have a higher average number of poor mental and physical health days than the National Benchmark. Intentional self-harm (suicide) is often the result of an untreated mental health condition. The crude death rate per 100,000 for suicide is higher in Bristol County (9.4) than in Norfolk County (7.5) or Massachusetts, but lower than the U.S. (12.4).

The misuse of and addiction to opioids, including prescription pain relievers, heroin, and synthetic opioids such as fentanyl is a serious national crisis that affects public health on the local, state and national levels. Addiction can lead to overdose and a rise in neonatal withdrawal syndrome. Fortunately, due to increased focus on this issue, fatal opioid deaths have been declining in recent years and this is true for the primary and secondary service areas. Likewise, the opioid prescribing rate per 100 persons declined in Bristol and Norfolk counties from 2017 to 2020.

Objective: Improve access and integration/coordination of mental health and substance use disorder services in the area.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE Strategies	Metrics/What are we measuring	Potential Partnering/External Organizations
Continue to provide individual, group, medication assisted treatment and other mental health services including support through partnership with Column Health	• Number of patient referrals to program • Number of intakes per month • Number of telehealth visits	• Column Health • SMA Practices • Concert Health
Continue screening for behavioral health and substance use disorders, explore further opportunities for education and screening tools.	• All practices are utilizing the PHQ-9 screening tool	• Concert Health
Increase the number of primary care practices and specialty practices within SMA that have integrated behavioral health services available	• Leverage virtual screen/intervention tools	• Concert Health
Sturdy will explore opportunities to collaborate with local organizations to address the high percentage of youth in our service area who report thoughts of self-harm and engage in high risk behaviors such as binge drinking, and drug use.	• Support peer-to-peer counseling for teen program, including screening and intervention tools	• Attleboro Norton YMCA
Sturdy will work with community organizations to identify a comprehensive list of current mental health providers within the service area	• Rapid triage network to get patients to right location of service at	• City of Attleboro • Manet Health • Fuller Hospital

	the right time	
Explore telemedicine opportunities for behavioral health patients.	• Explore virtual assessment and management tools	• Concert Health

Priority: Mortality and Chronic Disease Management

Rationale: Many chronic diseases such as diabetes, heart disease, respiratory disease, and stroke are caused by key risk behaviors and are among the most common causes of death and disability in the United States. These behaviors have significant health and economic costs to the community and its members.

In general, the primary service area has higher crude death rates per 100,000 than the secondary service area, with the exception of diabetes and stroke. The top 2 leading causes of death in 2020 for both service areas are heart disease and all cancers, with rates higher than the state and nation for cancer. The third leading cause of death in the primary service area is chronic lower respiratory disease but is stroke in the secondary service area. Although data about smoking are not available for the services areas, a larger proportion of adults in Bristol County are smokers (19%) than in Norfolk County, the state and compared to the National Benchmark. Smoking is a common cause of chronic obstructive pulmonary disease, a type of respiratory disease and is also correlated with chronic health conditions such as lung cancer, stroke, and heart disease.

The crude death rate from diseases of the kidney (nephritis, nephrotic syndrome and nephritis) as well as from septicemia and pneumonitis (due to solids and liquids) are higher in both counties than the state and the nation. Chronic liver disease and cirrhosis is higher in Bristol County than Norfolk County, the state or nation. The hepatitis virus as well as alcohol abuse are often associated with liver disease and unhealthy lifestyle choices.

Key informants selected some chronic and comorbid conditions as key health issues. These include overweight/obesity, diabetes, cancer, and heart disease. Significant barriers such as the inability to obtain doctor's appointments, a lack of bilingual providers, a lack of providers who accept Medicaid/Medical Assistance and limited knowledge of good health practices in the community were chosen. These issues reduce the likelihood that individuals are routinely treated for chronic and comorbid conditions. This in turn, can lead to poor health outcomes. Yet many chronic diseases are largely preventable. Making healthy lifestyle choices may reduce mortality, lower the risk of developing chronic diseases and improve health status overall. Addressing these barriers and improving health literacy through outreach can directly impact underserved communities.

Objective: Prevent, detect, and manage chronic illnesses prevalent in Sturdy Memorial's service area

MORTALITY AND CHRONIC DISEASE MANAGEMENT Strategies	Metrics/What are we measuring	Potential Partnering/External Organizations

Sturdy will continue to participate/host health fairs for screening, health literacy, and community education.	• Women's Wellness Fair • Connecting Our Communities: Just for the HEALTH of It • Healthy Living Events – food preparation and lifestyle choices • In person and virtual events – how to live with diabetes (and prevention), etc.	• American Heart Association • American Diabetes Association • YMCAs • Manet Health • Health Departments • Councils on Aging • City of Attleboro
Sturdy will continue to support current programs that increase opportunities for physical activity for those most at risk.	• The number of referrals to each program • The number of patients enrolled • The number of provider meetings held to bring awareness to the programs	• YMCAs • City Attleboro
Sturdy will explore opportunities and programs that increase access to health foods and support nutritional education	• Cooking demonstrations – virtual and in person • Discussions with the YMCA about potential support for food scarcity programs is underway and ongoing.	• YMCAs • City Attleboro • Empty Bowls
Sturdy will continue to improve care coordination for diabetic/pre-diabetic patients	• Provider Grand Rounds on latest interventions	• SMA Practices • YMCA
Sturdy will Increase screening for pre-diabetic patients and refer to appropriate resources	• Referrals to the YMCA pre-diabetes program for those that meet program criteria. Numbers to be provided at next update.	• YMCAs
Sturdy will collaborate with community partners as part of the Healthy Living Consortium to increase education and awareness in the community.	• Act as convener and begin Consortium	• YMCA

Priority: Obesity and Weight Management

Rationale: Key informants selected overweight/obesity as being among the top 5 key health issues in the region and stressed the lack of healthy food, the knowledge of how to prepare it and the lack of time to exercise. Eating well and exercising are important in maintaining a healthy weight and reducing community obesity rates (measured by a BMI of 30 or more). Physical inactivity, poor nutrition habits, and lack of access to healthy food and exercise opportunities are known risk factors that contribute to obesity and other chronic conditions, such as diabetes, cancer, and heart disease.

The food environment index measures the proximity of one's home to a grocery store and food insecurity which is the lack of consistent access to a reliable source of nutritious food and enough food for an active, healthy life. It may reflect

a households' need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. In Bristol County, where adult obesity is 29%, the food environment index is 8.5. Norfolk County on the other hand, has a food environment index above the National Benchmark (9.3) and a lower percentage of adult obesity (25%). One key informant remarked, "One challenge is that jobs do not pay living wages, so people have to work more than one job. This leaves little time for meal planning and cooking, easier to just eat fast food. Working multiple jobs makes it more difficult to find time to exercise. More recently the cost of food is also a huge issue."

A community's health and overall quality of life is also affected by access to exercise opportunities which is measured by the proportion of residents who live reasonably close to a physical activity location. These may include parks or facilities identified by the NAICS code 713940 (gyms, community centers, YMCAs, pools, etc.). Despite having very reasonable access to exercise opportunities in both counties, 24% of adults over the age of 20 are inactive in Bristol County and 18% are inactive in Norfolk County. The National Benchmark for inactivity is 19%.
The built environment plays a part in the health of residents as well. Norfolk County is ranked 8 and Bristol County is 10 of 14 counties for Physical Environment Rank (where 1 is the best).

Objective: Provide services to improve nutritional habits and facilitate increased exercise.

OBESITY AND WEIGHT MANAGEMENT Strategies	Metrics/What are we measuring	Potential Partnering/External Organizations
Sturdy will work internally with Food Services to provide healthier meal options for inpatients and cafeteria customers		• Sturdy Memorial Food Services
Provide healthy eating educational experiences – in person and virtually	• Healthy cooking • How to shop for healthy food on a budget • Eating healthy when on the run	• Stop-n-Shop • YMCAs
Sturdy will provide exercise education	•	
Sturdy will provide supportive health education – virtually and in person	• Art as therapy • Meditation/Tae Chi	• Trust the Process • Local yoga, meditation and alternative sources
Sturdy will host community events involving exercise, healthy living and wellness	• Connecting Our Community: Just for the HEALTH of it! Wellness Fair at Capron Park • Sturdy Memorial Fun Run or Walk-A-Thon	