Community Needs Assessment–FY 2016
# Table of Contents

- Introduction ........................................................................................................... 3
- Methodology ........................................................................................................... 3
- Data Analysis .......................................................................................................... 4
- Key Findings ............................................................................................................ 5
- Overview 2014 Health Status .................................................................................. 6
- Results and Discussion ............................................................................................ 11
- Behavioral Health ..................................................................................................... 12
- Obesity .................................................................................................................... 17
- Chronic Disease ....................................................................................................... 21
- Access to Health Care ............................................................................................. 28
- Recommendations .................................................................................................. 30
- Appendices .............................................................................................................. 31
  - Appendix A ............................................................................................................ 31
  - Appendix B ............................................................................................................ 32
  - Appendix C ............................................................................................................ 35
INTRODUCTION

Saint Anne’s Hospital is a member of Steward Health Care System, the largest fully integrated community care organization in New England. It is a general medical-surgical hospital, including inpatient and outpatient geriatric behavioral health treatment in Fall River, MA, with an additional 15 geriatric behavioral health beds at our satellite unit at New England Sinai Hospital (NESH) in Stoughton. In addition, Saint Anne’s Hospital provides specialized care for oncology, orthopedics, pain management and pediatrics.

Saint Anne’s maintains a Community Health Benefits Department that focuses on integrating care across the spectrum of hospital, primary and community-based care. A Community Health Benefits Advisory Committee comprising hospital leadership, representatives of local health and human service organizations, faith-based coalitions, law enforcement, and community health centers guides the planning and implementation of the hospital’s community health initiatives. Per the Massachusetts community health benefits mandate established by the Attorney General to assess community health needs every three years, Saint Anne’s Hospital conducted a 2015 Community Needs Assessment (CNA). Recommendations put forth by the prior 2012 Community Needs Assessment were considered and implemented in the 2015 assessment design.

Methodology

The decision was made to utilize for this assessment the key findings and health indicators as published in the 2014 (report) Health Status of Community Health Network Area 25 (CHNA25), which includes the communities of Fall River, Somerset, Swansea, and Westport, MA. Prepared by Partners for a Healthier Community, Inc., this public report is comprehensive in scope and provides current data that aligns with Saint Anne’s Hospital primary service area (PSA). Through the Determination of Need (DoN) process set by the MA Department of Public Health for the approval and licensure to construct (designated) new hospital services, Saint Anne’s Hospital provided the source funding for the 2014 Health Status of CHNA25 report. It’s use in this 2015 community health needs assessment supports a non-duplication of services. Our (SAH) 2015 assessment also included community focus groups and a key informant survey which served to identify the areas of greatest concern and need whose make-up was as follows:

1. Community Focus Groups (three separate sessions) included Hispanic and Brazilian women and men of all ages, U.S. veterans, persons in recovery, individuals without permanent housing, religious leaders, community health workers, and health care providers.

2. Key Informant Survey of Community Leaders included individuals who work with constituent groups to provide an overview of the needs and concerns for those groups; 87 total respondents, of whom 76% work in human services or health care and 53% of whom live in the PSA.
It was recommended in the prior 2012 SAH community health needs assessment to gather information on the health care concerns of the area Brazilian Portuguese- and Spanish-speaking populations, specifically related to access to health care. Trained bi-lingual, bi-cultural medical interpreters facilitated the non-English-speaking focus groups. Focus group questions were translated into and asked in the native languages, respectively. The Spanish-speaking community focus group was held at the Templo Misionero on Quarry Street, Fall River, on Sunday, September 20, 2015, with 20 participants. The Brazilian Portuguese-speaking community focus group was held at the Christian Church, on Plymouth Avenue, Fall River, on Sunday, September 28, 2015, with 30 participants. The third focus group, conducted in English by members of the Community Health Benefits Department at SAH, was held at the First Baptist Church on North Main Street, Fall River, on Wednesday, September 9, 2015, with 12 participants. Demographics, health insurance status and other personal information were not collected from the focus group participants to ensure anonymity and to encourage honest responses. Refer to Appendix A for Community Focus Group Questions and Appendix B for Key Informant Survey.

Data Analysis

Results in this report are based on both qualitative and quantitative data.

Focus group responses from community members as well as open-ended questions on the key informant survey provide the qualitative data. These primary qualitative data were compared across all sources for summarizing into trends and significant health concerns.

The close-ended questions on the key informant survey and the health statistics as summarized in the 2014 Health Status of CHNA 25 Report provided the quantitative data, reported in percentages and frequencies.

The priority concerns were selected based on the following criteria:
- Identification as concerns by both focus group participants and key informant respondents
- Disease/condition rates higher than the state average
- Disease/condition rates increasing over time
Key Findings

This report provides the results of an examination of the health status and social factors affecting vulnerable populations within the primary service area for Saint Anne’s Hospital and identifies the health priorities for targeted interventions and services.

Analysis of the primary and secondary data sources revealed the following as the most imminent community health concerns:

• Behavioral Health
  – Mental health, including suicide
  – Substance use disorder/drug addiction, including alcoholism
• Obesity
• Chronic disease management, specifically type 2 diabetes
• Access to health care
  – Lack of health insurance or other financial related barriers
  – Transportation
  – Language barriers, including the availability of bi-cultural/bi-lingual providers

Per the 2015 America’s Health Rankings® Annual Report, these major challenges align closely with those identified at the national level. There are alarming increases in rates of U.S. drug deaths, diabetes, obesity, and children in poverty.²

Source: http://www.americashealthrankings.org/MA/Overall

• Drug Deaths:
  From 2014 to 2015, drug deaths in MA increased 13% from 12.1 to 13.7 per 100,000 population
  In Fall River, drug deaths are currently tracking to continue with double digit increases (2015).

• Obesity:
  – Nationally in the past 2 years, obesity increased 7.2% from 27.6% to 29.6% of adults.
  In 1999, obesity was less than 12% of adults. In Fall River, 32.2% of adults are obese (2013).

• Type 2 Diabetes:
  – Self-reported diabetes continues to increase—now at 10.0% of the adult population.
  – Twenty years ago (1995), it was 4.4% of the adult population.
  In Fall River, 13.8% of the adult population has diabetes (2013).

• Children in Poverty:
  In the last year, the percent of U. S. children under the age of 18 living in poverty increased by 6 % from 19.9 % to 21.1 %. In Fall River 36% of children under age 18 live in poverty (2013).
These findings equip Saint Anne’s Hospital with an updated blueprint to develop a responsive and targeted three-year community health action plan. In addition to community input in identifying key health concerns, an overarching finding of the Needs Assessment was the gap in connecting available resources to the under-served/under-represented populations. Key informants identified those who are under-served/under-represented in the community as:

- people at or below the poverty line
- people who lack knowledge about preventive health measures and chronic disease
- people for whom English is a second language
- the elderly

As one community leader who works with at-risk veterans suggested, “Throw out the fliers, brochures and tri-folds, and meet them on the street with peer-to-peer assistance by community health workers.”

Overview –

**2014 Health Status of CHNA 25 Report**

“The Massachusetts Department of Public Health established the Community Health Network Area (CHNA) effort in 1992. Today this initiative involves all 351 towns and cities through 27 Community Health Networks. Each of the 27 Community Health Networks collaboratively identifies local and regional health priorities, designs community-based prevention plans, and tracks success in achieving healthier communities. CHNAs develop new health improvement projects as initial projects are completed”.


The Community Health Network Area 25 (CHNA25) is a coalition of local public, non-profit, and private sector groups that work together to build healthier communities through community-based prevention planning and health promotion. The 2014 **Health Status of CHNA 25 Report** summarizes the health status of its service network - the communities of Fall River, Somerset, Swansea and Westport, collectively referred to as Greater Fall River. The report was created to provide a single data source for the development of the 2014-2019 Community Health Action Plan for Partners for a Healthier Community (CHNA25). Saint Anne’s Hospital plays an active role in implementing the CHNA 25 community-wide health action plan.
Regional Health Disparities

As reported in the 2014 Health Status of CHNA 25 Report, the association between health status and socioeconomic background is well documented. Race, income level, educational attainment, and other social determinants are among the best predictors of health outcomes. The Centers for Disease Control and Prevention defines social determinants as the “complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities.” These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. The Robert Wood Johnson Foundation Commission to Build a Healthier America notes that health status improves as income rises (see Graph 1), and this pattern holds true for African Americans, Hispanics, and Whites (see Graph 2). While adults who are living at or below the federal poverty level are more likely to report being in poor or fair health, the report notes that, “even adults with middle class incomes are less healthy than those with higher incomes.” This pattern is referred to by many as the “socioeconomic gradient in health.”
% Adults Age 25+ With Poor/Fair Health

Note: FPL=Federal Poverty Level
Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, National Health Interview Survey data, 2001-2005 (see www.commissionhealth.org)
Graph 2 Income Race & Health Status

On average, persons who are economically disadvantaged, less educated, and of a racial or ethnic minority have poorer levels of health in comparison to their counterparts with higher incomes, higher levels of education, and who are white. Massachusetts ranks 49th in the nation for disparity in health status based upon education attainment level. Per the 2015 America’s Health Rankings® Annual Report, there is a 36.5% difference between adults aged 25 and older who have a high school education versus than those without who report their health is very good or excellent, the number one ranked state has a percentage difference of 14.9.7

Disparity in health status is significant in Greater Fall River residents. As stated in the CHNA25 Report, “almost one-fifth of South Coast residents report having fair or poor health: with the highest rates in Fall River at 27.5% in Fall River and 18.4% in Greater Fall River, compared to just 14 % statewide”. (Source: BRFSS 2011, via MassCHIP)

It is also well documented that individuals with higher education attainment, higher household incomes who are non-Hispanic white have higher rates of health insurance coverage as compared to less educated, poor and minority populations (i.e., Blacks, Asians and Hispanics). Per the U.S. Census Bureau, stratified by race, in 2014, Hispanics had the lowest rate of health insurance coverage nationally.8

The National Healthcare Disparities Report from the Agency for Healthcare Research and Methodology (mandated annually by Congress) concludes that while quality of care is improving, disparities regarding access to care are actually increasing.

The report points out that, “These disparities may be due to differences in access to care, provider biases, poor provider-patient communication, or poor health literacy”.9 In addition, a growing body of research indicates that living and working conditions, including housing quality, exposure to pollution, work site safety, access to healthy and affordable foods, and proximity to safe places to exercise have a significantly greater effect on health than risky behaviors.10

Regional Backdrop

The 2014 Health Status of CHNA 25 Report identified vulnerable populations as those living in census tracts with 30% or more residents below the poverty level and with 25% or more residents with less than a high school diploma or equivalency. In the map below prepared by the Center for Policy Analysis, University of Massachusetts-Dartmouth, 2013, in the Greater Fall River region, the PSA for Saint Anne’s Hospital has significant vulnerable populations as defined above.
Fall River, with a population of 88,712, is a low-income city with a per capita income of $21,257 that is well below the state average of $35,763. Comparatively, Fall River has a higher rate of poverty than the state. In 2013, the U.S. Census Bureau reported the poverty threshold for an individual at $11,888. In comparison to the statewide average of 11.4%, 23.3% of Fall River residents and 36% of children under the age of 18 lived below the poverty line. While Latinos/Hispanics (of any race) account for only 7% of the demographic composition of Fall River, 57% live below the poverty level.\textsuperscript{11}

Since income levels are correlated with education levels, it follows that Fall River has a lower level of educational attainment compared to the state as a whole. Statewide, the 2014 high school graduation rate was 86.1%, while the rate for Fall River was 60.8%.\textsuperscript{12}

\textbf{Figure 2. Vulnerable Populations Footprint – Fall River}
Effective September 2015, Fall River reported an unemployment rate of 7.4%. While that is much improved from the reported rate in January 2015, of 10.7%, it is nearly double the state average of 4.5%. Fall River has the 9th highest rate of unemployment in the Commonwealth. And probably of more impact, Fall River wages as a percentage of the state wages have been falling year after year and continue to do so (i.e., state wages are rising at a faster rate than Fall River; see Graph 3). The unemployment rate is falling more in line with the state but wages are not keeping pace, indicating that most of the jobs being created are lower-paying, part-time and without health insurance benefits.

RESULTS AND DISCUSSION

This report provides the results of an examination of the health status and social factors affecting the vulnerable populations within the primary service area (PSA) of Saint Anne’s Hospital and identifies the health priorities for targeted interventions and services. This pro-active evaluation of the health needs of its most vulnerable residents better positions both the hospital and its community partners to provide the comprehensive and integrated care required to manage and maintain a healthy community.

Analysis of the primary and secondary data sources revealed behavioral health (mental health and addiction/substance use disorder/s), obesity, chronic disease management (specifically of type 2 diabetes), and access to health care as the areas of greatest concern.
Behavioral Health

Mental Health

Per the 2014 Health Status of CHNA 25 Report, behavioral health hospitalization discharge rates for the PSA are significantly higher than state average. Fall River has the highest rates for both addiction/substance abuse and mental health, and they are trending upward. The above-average rates indicate a need to improve behavioral health outcomes in the service area. Addiction and mental health issues were reported as two of the top five community health concerns by 93% and 84% of the respondents to the key informant survey, respectively. Additionally, the focus groups articulated that behavioral health was a major health issue in the community. There was a belief that there were not enough behavioral health resources available, especially bi-lingual/bi-cultural providers.

Community leaders also cited a need for building behavioral health service capacity and increasing training for and diversity among clinicians. The need for increased collaboration and communication between behavioral health and primary care providers was also recommended to improve care coordination and patient compliance. Possible strategies include embedding primary care services within outpatient behavioral health settings or vice versa.

Behavioral health patients face great obstacles in receiving needed services. Behavioral health stigma is a main barrier preventing patients who might otherwise seek health resources from doing so from fear of social ostracism or discrimination. Additionally, behavioral health patients face difficulty in accessing social services, including adequate housing, proper health insurance, and employment support, which are known social determinants of health.

Behavioral health issues have a serious impact on overall health. People with behavioral health conditions are at higher risk than others for physical illness and disability associated with the prevalence, progression, and outcome of some of today’s most pressing chronic diseases, including diabetes, heart disease, and cancer. Behavioral health disorders can have harmful and long-lasting effects — including high psychosocial and economic costs — not only for people living with the disorder, but also for their families, schools, workplaces, and communities.

Behavioral health issues drive indirect costs that accumulate through reduced labor supply, public income support payments, reduced educational attainment, and costs associated with other consequences such as incarceration or homelessness. The cost of medical care for this population is, on average, much higher than the cost of medical care for people without behavioral health conditions. Better behavioral health services for this population would likely reduce the costs of their physical health care and produce significant overall savings in health spending.
Depression is one of the most common complications of chronic disease. It is estimated that as many as one-third of individuals with a serious medical condition experience symptoms of depression. In some cases, the occurrence, management, and progression of a chronic disease can trigger clinically significant depression. As stated in the 2014 Health Status of CHNA 25 Report, the 2009 Behavioral Risk Factor Surveillance System (BRFSS) found a high percentage of Fall River residents reporting experiencing poor mental health and depression compared as to the remainder of the residents in Bristol County, the state and the nation. The suicide rate for the area is slightly higher than the state, but less than the other two comparable geographic areas. MDPH data found that 55 % of suicide victims in Fall River had a mental health problem, 29% had a history of substance or alcohol abuse, and 22% had a job loss or financial problems (CHNA25 Report)

<table>
<thead>
<tr>
<th>Table 24</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>15+ days of poor mental health in past 30 days</td>
</tr>
<tr>
<td>15+ days experiencing sad, blue or depressed feelings in past 30 days</td>
</tr>
<tr>
<td>Suicide rate (per 100,000)</td>
</tr>
</tbody>
</table>

Source: Massachusetts Department of Public Health 2009

“Suicide is a preventable mental health condition,” stated Annemarie Matulis, director, Bristol County Regional Coalition for Suicide Prevention, during her October 28, 2015, on-site SAH provider training, “Suicide is Everyone’s Business: The Current State of Suicide & Suicide Prevention in Fall River.” Yet, Bristol County, per Matulis, is currently a suicide hot spot in the Commonwealth, experiencing an upward trend. Of great concern to the findings of this Community Health Needs Assessment, year to date, through mid-November 2015, 28% of the confirmed suicides in Bristol County were from Saint Anne’s PSA, and all but one from Fall River. The profile is consistent statewide – middle-aged men (in Fall River – average age was 44 years old) with a clinical history of depression. Most were also addicted to alcohol and/or drugs, including prescription medication.
Matulis went on to state that more than 6,000 people in Bristol County have been traumatized by and are suffering from suicide loss without any support services in place for them. Per the Centers for Disease Control (CDC) and the National Institute for Health (NIH) guidelines, it is estimated that for every suicide, 115 people minimally are traumatized by the loss.14

As a start to addressing this community health problem, Matulis recommends developing an easy-to-use comprehensive resource guide as well as developing peer-to-peer support networks for both attempt survivors and loss survivors. While far from complete, this work has been started. On Monday, October 19, 2015, under the direction of Matulis, Fall River convened the first meeting of an ad hoc task force to address suicide as a community health issue. Staff from Saint Anne's Hospital are and will be active participants.

The statistics at the national level are equally alarming. According to Mental Health America, “nearly 5,000 young people, ages 15 to 24, kill themselves every year in the United States, and that rate has tripled since 1960.”

Source: http://www.mentalhealthamerica.net/

Addiction/Substance Use Disorder

“The United States is experiencing an epidemic of drug overdose (poisoning) deaths. Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). These findings indicate that the opioid overdose epidemic is worsening. There is a need for continued action to prevent opioid abuse, dependence and death, improve treatment capacity for opioid use disorders, and reduce the supply of illicit opioids, particularly heroin and illicit fentanyl.”


On October 21, 2015, the Massachusetts Department of Public Health confirmed that 1,089 people in the commonwealth died of an opioid overdose in 2014 – a 20% increase over numbers in 2013 and a 63% increase over 2012.

“As these nightmarish numbers climb higher, we must be even more vigilant of what we can do for treatment and prevention”.

- Carole Fiola, State Representative, D-Fall River

Addiction/substance use disorder may directly involve the misuse of drugs and alcohol, but it is also associated with a range of destructive social conditions. Such conditions include family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. Moreover, both social attitudes and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues.
Per the 2014 Health Status of CHNA25 Report, Massachusetts ranks among the top five states in the country for the highest reported rates of drug and alcohol use among adults and youth. Fall River has the highest reported use of heroin in the state. In 2008, there were 1,190/100,000 admissions for injection drug use in Fall River, as compared to 424/100,000 admissions for the state. Reported use rates of all listed substances, including cocaine, crack and heroin, are twice the state rate, and relapse for those using needles one year after treatment is almost three times the state rate. According to the Massachusetts Department of Public Health, the age-adjusted annual death rate from alcohol and other drug use in Fall River is more than double the state average (31.6/100,000 vs. 14.8/100,000). White non-Hispanic residents are more likely to have an opioid-related ER visit. The area’s hospitalization rate resulting from heroin or prescription opioids far exceeds that of the state. Age-adjusted opioid mortality rates in Fall River have also been more than twice as high as the state rate since 2007 (CHNA25, Report).

Table 25

<table>
<thead>
<tr>
<th>Substance Use Indicators</th>
<th>Fall River</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions rate for injection drug use (per 100,000)</td>
<td>1,190</td>
<td>858.3</td>
<td>424</td>
</tr>
<tr>
<td>Binge Drinking among adults</td>
<td>16%</td>
<td>16.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Mortality from alcohol and other drug use (per 100,000)</td>
<td>31.6</td>
<td>17.5</td>
<td>14.8</td>
</tr>
</tbody>
</table>

(Source: MASSCHIP)

As reported in the Herald News, “72% of Fall River residents have a prescription for highly addictive opiates such as oxycodone and methadone, which places the Spindle City well above the state average of 40%”.

“We have an epidemic in Fall River like no other city or community,” State Representative Alan Silvia, Democrat-Fall River, said, adding that he has filed legislation that would seek to limit physicians to writing no more than three days’ worth of opiate prescriptions at any given time.

Silvia listed high unemployment, poverty, more public housing than most communities and low educational attainment as likely factors”.

Source: http://www.heraldnews.com/article/20140311/NEWS/140319276
Fall River has an acute opioid addiction problem that has grown increasingly worse since 2012. Opioid dependence abuse is at times related to an increased tolerance to prescription medication for managing chronic pain, and frequently is the reported pathway to abusing heroin. Per MDPH statistics and as reported in the Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) Regional Strategic Plan, the city had 149 deaths and acute care hospitalizations due to opioid use between 2010 and 2012, whereas in 2014 alone, Fall River had 656 acute care encounters; 612 non-fatal overdoses and 44 deaths. From January through November 2015, Saint Anne’s Hospital Emergency Department reported 2,621 patient visits for a diagnosis of behavioral health, substance abuse and/or overdose.

“The prescription drug and heroin crisis is wearing families down to the bone. We need to give them hope.”

-U.S. Senator Edward Markey, D-Massachusetts

Focus group input highlighted substance abuse as a major community health issue. Participants voiced a need for more substance abuse prevention in the form of education and outreach. Additionally, some participants mentioned that developing more capacity in detoxification and inpatient treatment centers and outreach to reduce mental health stigma were needed. Overwhelmingly, research indicates that addiction is a chronic medical condition requiring long-term treatment. Massachusetts recently launched a public awareness campaign to overcome the societal stigma that addiction is a moral failing and instead is a medical illness. In 2014, SAH took its first step in addressing the culture of care for persons with addiction by creating the role of an Addictions Nurse Specialist filled by a Certified Addictions Registered Nurse (CARN).

Community leaders surveyed identified prescription drug/opioid abuse as a public health crisis. Interventions that were suggested included establishing comprehensive substance abuse education and providing cessation resources such as support groups and coping resources such peer support groups to community members. Throughout 2015, Saint Anne’s Hospital actively advocated for a Fall River chapter of Learn to Cope (LTC), a peer-led support group for families who are struggling with loved ones addicted to prescription opioids or heroin. Advocacy efforts to provide a Fall River-based LTC will continue in 2016 and will not ease until the goal is met. Saint Anne’s Hospital has offered to be the host site. Per the MDPH Substance Abuse Trust Fund – FY2015 Quarterly Report published in June 2015, expansion of LTC Chapters across the Commonwealth is a recommended initiative and is being implemented through the fund (page 3 of the report).


As reported in The Herald News (http://www.heraldnews.com/2015), the City of Fall River (MOAPC) was awarded a $500,000 cluster grant from the Massachusetts Department of Public Health, Bureau of Substance Abuse (MDPH-BSAS), to benefit the citizens of Fall River, and also those of Taunton and Dighton, by addressing opioid misuse and abuse and overdose prevention. Saint Anne’s Hospital clinical staff serve on the two community-based task forces that are actively planning and implementing evidence-based prevention programs to reduce and prevent overdoses and opioid drug abuse.
Examples of targeted community interventions include:

- Education on the safe storage and disposal of opioids
- Training for parents and educators/athletic coaches on the risk factors of student athletes who are prescribed opioid medications. Student athletes are at increased risk for opioid addiction.
- Provider trainings in safe prescribing practices
- Training in the dispensing of Narcan, medication to reverse fatal overdose, to increase access and decrease preventable deaths due to overdose

The grant period began on January 1, 2015, and ends on June 30, 2020. Saint Anne’s Hospital Community Health Benefits plan will remain committed to addressing this public health crisis long-term through innovative programming and support of new legislation.

“I understand that some of our proposals disrupt the status quo. They’re supposed to. The status quo is unacceptable.”

-Charlie Baker, Governor of Massachusetts

**Obesity**

Obesity ranked among the five top community health issues cited by 60% of key survey respondents and was identified as a major health concern in all of the constituent focus groups. Obesity is one of several risk factors also associated with chronic disease, especially Type 2 diabetes.

The ability to maintain a healthy weight is both a health behavior and a health outcome associated with nutrition and physical activity. Per the 2014 *Health Status of CHNA 25 Report*, since 2000, the population of adults in our PSA who are overweight or obese has increased dramatically. As of 2011, 65.7% of Greater Fall River adults were overweight (defined as having a Body Mass Index [BMI] of more than 25). Approximately half of this group (32.2%) in Greater Fall River weighed enough to qualify as obese (BMI>30). Comparatively, 59.3% of Massachusetts adults were overweight in 2010, and 22.7% were obese.
Community input cited the lack of access to healthy foods and nutrition education as contributing factors to the rise in obesity rates. The U.S. Department of Agriculture (USDA) defines food security as “access at all times to nutritionally adequate and safe foods for an active, healthy life”.  

In 2013, 10.6% of the population in Massachusetts experienced food insecurity. And although Massachusetts has a lower food insecurity rate than the national rate of 14.3%, food insecurity in the Commonwealth is now almost 40% higher than it was before the 2008 recession, and the rates are highest in Suffolk, Hampden and Bristol counties.  

Poverty is the number one contributing factor of food insecurity, which is correlated with low academic achievement, higher rates of absenteeism in the workplace, and increased risk for chronic disease, including mental health. Food insecurity is also correlated with higher rates of obesity in adults. The consequences of food insecurity are especially impactful for children and can cause lifelong health consequences. In addition to increased risk for chronic health conditions and poor health in general, food insecurity in children is associated with a greater risk of being overweight or obese due to lower diet quality.
Access to healthy food is related to the ability of residents to practice healthy eating behaviors, and thus reduce the risk of adverse diet-related health outcomes such as obesity, type 2 diabetes and heart disease. Statistically, residents of Bristol County have access to fewer grocery stores and supermarkets per capita as compared to Massachusetts (a combined rate of 17.5 per 100,000 residents, versus 19.8 statewide). Bristol County’s rate is 16.4, and this lower density results in a number of so-called food deserts. 19

The U. S. Department of Agriculture (USDA) describes a neighborhood as a “food desert” if at least a fifth of its residents live in poverty and a third live half a mile or more from a supermarket in urban communities, or more than 10 miles in rural areas.20 Per the 2014 Health Status of CHNA25 Report, significant portions of Fall River are technically classified as food deserts where many low-income residents live more than a half mile away from a major grocery store or supermarket. As noted in the CHNA25 Report, this disparity has been reduced by the construction of the Wal-Mart Supermarket and Sam’s Club in the South End of Fall River (see Figure 9). As part of the ongoing community action plan to address disparities in access to healthy, fresh food, CHNA25 is developing maps of walkable neighborhood markets.
Additionally, lack of access to healthy foods and nutrition education, particularly for children, was expressed in all of the focus groups. The lack of affordable foods at farmers markets in the community was also articulated by many. Implementing strategies to increase affordability at our on-site farmers market (held weekly June-October) has been earmarked as a community health priority for 2016 and will be discussed as priority at the CHNA25 Food Summit planned for January 21, 2016.

Community leader input expressed needs for increased education and interventions to address the behavioral patterns that lead to obesity. Interventions suggested by providers included physical education programs for elementary and middle schools, community fitness challenges, and education on nutrition and healthy life style choices. Input from the Hispanic and Brazilian community focus groups echoed provider input. While Fall River has one of the longest consecutively running community fitness challenges, feedback from diverse primary data sources indicates the need to better engage the Limited English Proficient (LEP) communities.

Source: USDA Food Environment Atlas. Orange denotes low-income census tracts where most residents have no access to a grocery store or supermarket within 0.5 miles; green denotes no access within one mile.
Chronic Disease
Specifically Type 2 Diabetes

Primary source data, focus group participants and key informants all recognized chronic disease, specifically type 2 diabetes, as a major community health issue in the Saint Anne’s Hospital service area. There are three major types of diabetes: Type 1, Type 2 and gestational. Type 2 diabetes is the most common, accounting for 90-95% of all cases. It begins when the body cannot produce enough insulin to remove sugar from the blood stream. An elevated blood sugar level harms blood vessels and affects circulation, increasing the risk of heart disease, stroke, kidney disease, non-traumatic lower-limb amputation, blindness, and premature death.

Obesity is a major risk factor contributing to the development of Type 2 diabetes. Smoking, poor nutrition, lack of physical activity and low socioeconomic factors are also associated with increased risk for Type 2 diabetes. The co-morbidity of Type 2 diabetes and obesity tends to be associated with poorly controlled blood sugar, blood pressure, and cholesterol levels – making the complications of type 2 diabetes more severe, including increasing the risk for cardiovascular disease and stroke.21 Because Type 2 diabetes is associated with numerous modifiable behaviors such as smoking, obesity, physical inactivity, and poor diet, it is an ideal target for prevention.

Published in 2015 by the Centers for Disease Control and Prevention (CDC), the Diabetes 2014 Report Card reports 29.1 million people or 9.3% of the U.S. population are estimated to have diabetes in 2013.22 Comparative numbers are even higher for Fall River; of the 10.3% of Fall River residents diagnosed with diabetes, 54% are obese. Per the 2014 Health Status of CHNA 25 Report, diabetes has grown in prevalence in Greater Fall River and in Massachusetts since 2000. In 2010, 13.8% of Fall River’s adults had diabetes compared to 7.4% of residents statewide, an 86% higher rate (see Table 52).

Table 52

<table>
<thead>
<tr>
<th>Diagnosed With Diabetes in Lifetime</th>
<th>2000</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall River</td>
<td>8.4%</td>
<td>13.8%</td>
</tr>
<tr>
<td>New Bedford</td>
<td>8.2%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Greater Fall River</td>
<td>6.1%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Greater New Bedford</td>
<td>7.6%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>5.8%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

Source: BRFSS, via MassCHIP
“The diabetes and obesity epidemics, combined with longer life spans, have increased the lifetime risk of developing diabetes to about 40% for U.S. adults. The risk is the same for both men and women.”


Of great concern also are the individuals who have pre-diabetes. Individuals with pre-diabetes have blood sugar levels that are higher than normal but not high enough to be diagnosed. The CDC reports an estimated 86 million U.S. adults – more than 1 out of 3 – had pre-diabetes in 2012. In Massachusetts, 35% of adults have pre-diabetes but only 7% are aware of this and know that they are at increased risk for developing Type 2 diabetes, heart disease, stroke, and the other complications associated with diabetes.23

Pre-diabetes is a serious health condition. With increased awareness of the risk factors for diabetes and increased access to health screenings and other health care interventions, it is an ideal target for prevention.

“Without making any sustainable lifestyle changes, 15-30% of individuals with pre-diabetes will go on to develop diabetes within the next 5 years.”

Source: MA Behavioral Risk Factor Surveillance System BRFSS, 2013

Studies show that onset of Type 2 diabetes is largely preventable through lifestyle modifications like losing weight, increasing physical activity, and improving dietary choices. Participants who completed the National Diabetes Prevention Program (DPP), an evidence-based lifestyle change program for preventing Type 2 diabetes, lost an average of 12 pounds and lowered their risk 58% over 3 years.24 Saint Anne’s Hospital Diabetes Education Department alone or in collaboration with a community partner offers the DPP to the community 2-3 times per year.

Race and ethnicity are also risk factors for developing diabetes.25 Per the 2014 Health Status of CHNA 25 Report, health data show that many Fall River residents from minority racial/ethnic groups have health behaviors and indicators that place them at increased risk for increased disease morbidity and mortality. Data for the reporting period of 2009-2011 from the Massachusetts Department of Public Health (MDPH) indicate increased risk for blacks and Hispanics for diabetes, smoking, obesity, and hypertension.

- Black non-Hispanic and Hispanic residents have a higher diabetes mortality rate than white non-Hispanic residents in the region (38.7% and 21.4% respectively, vs.17.6 per 100,000 population).
- Obesity in adults was highest among Hispanics at 32.3%, followed by black-non Hispanic at 30.9%
The increased risk for diabetes and obesity disproportionately experienced by members of racial and ethnic minority groups has emerged an identifiable community need. Targeting evidence-based, culturally competent interventions to prevent Type 2 diabetes and obesity will be goals in the 2016 community health plan.

In addition to contributing to adverse health outcomes, diabetes accounts for increased direct and indirect health care expenditures. In 2012, it is estimated that diabetes cost the United States $245 billion; $176 billion in direct medical costs (i.e., medical goods and services, including costly hospitalizations) and $69 billion in indirect costs (i.e., absenteeism, lost productivity, disability, and premature death).26

As indicated in the 2014 Health Status of CHNA25 Report, rates of hospitalization for diabetes were 41% higher in Fall River than the state but almost equivalent to national rates. Diabetes mortality was 19% higher for Fall River than state figures but 23% lower than national rates.

<table>
<thead>
<tr>
<th>Diabetes Hospitalization and Mortality Rates</th>
<th>Fall River</th>
<th>Bristol County</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Hospitalization rate (per 100,000)</td>
<td>687.3</td>
<td>504</td>
<td>487.6</td>
<td>688</td>
</tr>
<tr>
<td>Diabetes Mortality rate (per 100,000)</td>
<td>17.3</td>
<td>16.4</td>
<td>14.5</td>
<td>22.4</td>
</tr>
</tbody>
</table>

MDPH: Centers for Disease Control & Prevention 2010

Diabetes is the seventh leading cause of death in the United States and is a major risk factor for cardiovascular disease (CVD) and stroke, the leading and fifth leading causes of death, respectively.27

Health statistics support the strong correlation between diabetes and cardiovascular disease (CVD):

- Adults with diabetes are two to four times more likely to have heart disease or a stroke than adults without diabetes.
- At least 68% of people age 65 or older with diabetes die from some form of heart disease; and 16% die of stroke.
- The American Heart Association considers diabetes to be one of the seven major controllable risk factors for cardiovascular disease.

See: http://www.heart.org/HEARTORG/Conditions/Diabetes/DiseaseDiabetes_UCM_313865_Article.jsp#
Health outcomes as analyzed in the Health Status of CHNA25 report the following:

Heart disease:

The prevalence of heart disease in Greater Fall River is higher than it is statewide. Heart disease is a broad term used to describe a range of diseases that affect one’s heart. Indicators of cardiovascular health in the region include incidence of:

- **High blood cholesterol** – 43% of residents in Fall River and 40.5% of residents in Greater Fall River have been diagnosed with high blood cholesterol in their lifetime vs 34% of all MA residents.
- **Hypertension or high blood pressure** – is also more prevalent in this region than statewide and has increased across the region since 2001 (see Table 50).

### Table 50

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fall River</strong></td>
<td>30.1%</td>
<td>33.1%</td>
</tr>
<tr>
<td><strong>New Bedford</strong></td>
<td>31.6%</td>
<td>37.3%</td>
</tr>
<tr>
<td><strong>Greater Fall River</strong></td>
<td>31.4%</td>
<td>33.2%</td>
</tr>
<tr>
<td><strong>Greater New Bedford</strong></td>
<td>26.3%</td>
<td>34.9%</td>
</tr>
<tr>
<td><strong>Massachusetts</strong></td>
<td>23.6%</td>
<td>29.2%</td>
</tr>
</tbody>
</table>

*Source: BRFSS, via MassCHIP*

- **Strokes** are more prevalent than statewide. In 2010, 4.9% of adults in Fall River and 4.1% in Greater Fall River report having had a stroke in their lifetimes. This compares to 2.5% of residents statewide. The percentage of adults who report they have had a stroke increased in each study area from 2006 to 2010, while the percentage declined slightly at the statewide level (see Graph 21).

**Graph 21: Had a Stroke, 2006-2010**
Respiratory health

Respiratory health is reflected by incidence of asthma (CHNA25 Report). The lifetime prevalence of asthma in the South Coast is higher than the statewide percentage of 15.3%: 23.7% in Fall River and 20.6% in Greater Fall River (see Tables 54 and 55). Emergency Room visits and hospitalizations rates for asthma are also much higher in the region and have increased since 2000 (see Graph 25).

Table 54

<table>
<thead>
<tr>
<th>Asthma</th>
<th>Fall River</th>
<th>Bristol County</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of Asthma among adults</td>
<td>16.7%</td>
<td>14.5%</td>
<td>14.7%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Pediatric Emergency Room visit rates for children 0-14 (per 100,000)</td>
<td>2,595.9</td>
<td>1,458.5</td>
<td>2,137.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Asthma Hospitalization rate (per 100,000)</td>
<td>324.2</td>
<td>189.9</td>
<td>151</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Centers for Disease Control & Prevention Surveillance 2011*

Table 55

<table>
<thead>
<tr>
<th>Diagnosed With Asthma in Lifetime</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall River</td>
<td>23.7%</td>
</tr>
<tr>
<td>New Bedford</td>
<td>22.4%</td>
</tr>
<tr>
<td>Greater Fall River</td>
<td>20.6%</td>
</tr>
<tr>
<td>Greater New Bedford</td>
<td>17.5%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

*Source: BRFSS, via MassCHIP (2011)*

Smoking is the U.S.’s leading cause of preventable death, contributing to 480,000 deaths annually. Secondhand smoke causes 41,000 deaths yearly, and 10.9 million suffer from a smoking-related illness. Approximately 14 million major medical conditions are attributed to smoking, which damages nearly every body organ and causes respiratory disease, heart disease, stroke, cancer, preterm birth, low birth weight, and premature death. Smoking shortens lifespan an average of 10 years. The U.S. annual smoking cost: $170 billion in direct medical expenses and $156 billion in lost productivity. When smokers quit, heart attack risk drops sharply after just 1 year.

*Source: www.americashealthrankings.org*
Smoking has decreased since 1990 from 29.5% to 18.1% of the U.S. adult population (2015), 3.4% higher than the State rate of 14.7% and 6.1% higher than the Healthy People 2020 Goal of 12%. Still, 1 in 6 adults smoke and that number is disproportionately higher among the less educated and economically disadvantaged (CDC Report, November 13, 2015).

**Cancer**

As reported in the CHNA25 Health Status Report, the overall cancer incidence rates have been growing since 1990 both locally and statewide.

**Graph 26. Invasive Cancer Incidental Rate (All Types) 1990 to 2008**

![Graph showing cancer incidence rates from 1990 to 2008 for Fall River, New Bedford, Greater Fall River, Greater New Bedford, and Massachusetts.](image)

Source: Massachusetts Department of Public Health, MassCHIP (age adjusted rates)
Given the high smoking rate, it is not surprising that the rate for lung and bronchus cancers for males are 47.8% higher than statewide rates. Female lung and bronchus cancer rates were, on the other hand, 5.2% lower. Lung cancer deaths for the area were 56.8 per 100,000 compared to the state’s 50.9 per 100,000.

Table 56

<table>
<thead>
<tr>
<th>Cancer Incidence</th>
<th>Fall River</th>
<th>Bristol County</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Incidence (per 100,000)</td>
<td>107.8</td>
<td>124.8</td>
<td>132.3</td>
<td>124.3</td>
</tr>
<tr>
<td>Prostate Cancer Incidence (per 100,000)</td>
<td>125.8</td>
<td>162.2</td>
<td>165.1</td>
<td>154.8</td>
</tr>
<tr>
<td>Male Lung and Bronchus (per 100,000)</td>
<td>122.7</td>
<td>99.5</td>
<td>83</td>
<td>86.4</td>
</tr>
<tr>
<td>Female Lung and Bronchus (per 100,000)</td>
<td>61.7</td>
<td>64.0</td>
<td>65.1</td>
<td>55.5</td>
</tr>
</tbody>
</table>


This data on the health status of our PSA give us an updated snapshot on which to develop strategies and innovative programs to make the community healthier. Improvement in health status can be mitigated by health behaviors that include healthy eating, active living, weight control, participation in health screenings, and other preventive measures.

As an example of how population health can be moved in a positive direction, in December 2015:

The Centers for Disease Control and Prevention reports rate of new diabetes cases in United States fell by about one fifth from 2008 to 2014; decline follows decades of nonstop increase; cases fell to 1.4 million in 2014 from 1.7 million in 2008; evidence points to better eating habits.

Data Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Health Interview Statistics, data from the National Health Interview Survey. Data computed by personnel in the Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.
Access to Health Care

When asked on the Key Informant Survey, “What do you believe are the biggest obstacles that people face in accessing health care?”, responses clustered around three main issues:

**Cost/Financial Reasons:**
- Financial difficulties: 78.16%
- Unable to pay for medical care: 56.32%
- Higher co-pays and deductibles: 55.17%
- No insurance: 42.53%

**Transportation:** 68.97%

**Language Barriers:** 49.43%

Access to health care is used as an overarching term for identifying disparities in obtaining health care due to health care costs/lack of health insurance, transportation and language barriers, including the availability of bi-cultural/bi-lingual providers.

**Barrier 1 - Cost/Financial Reasons:**

In 2014, less than 5% of Massachusetts residents were without health insurance coverage. However, in all three focus groups, community members cited a number of issues related to health insurance coverage and cost, from understanding coverage requirements to high co-pays, deductibles and other out-of-pocket expenses. Plans with higher deductibles, coinsurance requirements and co-pays are a growing trend. Shifting more of the health-care cost to consumers creates unintended adverse effects on health status. As example, consumers trying to control rising costs shop for the cheapest, no-frills plans, while meeting mandatory coverage laws. As a result, they avoid preventive care office visits and health screenings; and what could be minor health problems treated in primary care offices become critical health conditions presenting in hospital emergency rooms, requiring costly medical services/tests, medications, and, in many cases, hospitalization. Per the 2014 Health Status of CHNA 25 Report, data from the Behavioral Risk Factor Statewide Survey (BFRSS 2013) indicate that a high percentage of Fall River residents report they could not see a physician due to cost (10.9% vs. a state average of 7%). High unemployment and lack of health insurance due to job loss or other factors affect residents’ ability to access health care.

The U.S. health care system is complex and difficult to navigate. Community members described problems understanding insurance policies, eligibility requirements, and difficulty with complex enrollment applications. Barriers to health insurance enrollment and navigation were particularly salient for the Spanish-speaking and Brazilian/Portuguese-speaking communities. While SAH has bilingual Portuguese- and Spanish-speaking financial counselors who provide education on health insurance and enrollment assistance within the hospital and at limited off-site events, the need for more community-based assistance is noted and planned for 2016.
Access to health care 2016 intervention strategy:

- Provide community-based, bilingual assistance in understanding health insurance plans and enrollment to community members through partnerships with community service organizations, faith-based groups and other community partners.

**Barrier 2 - Transportation:**

Transportation was cited in all of the community focus groups as a major barrier to accessing care, especially preventive care, including screenings and primary care appointments. Findings indicate that the current public transit system in the city of Fall River is inadequate in both geographic reach and in service hours and frequency. Barriers to public transportation have adverse effects on the health outcomes among the population for whom it is intended to serve. The lack of adequate transportation to health resources is noted as a serious community issue and will be addressed in the 2016 community health benefits plan.

Access to health care 2016 intervention strategies:

- Continued use of hospital vehicles for transporting at-risk, vulnerable patients to medical care, including cancer treatments and outpatient geriatric behavioral health.
- Support of Bus Riders United, a community-based advocacy group working to extend and expand the public transit system for Fall River and surrounding communities, including greater access to New Bedford.

**Barrier 3 - Language Barriers:**

In 32.4% of Fall River households, English is not the primary language spoken versus the state average of 16.5%.

A significant number of community members reported language barriers as a major issue in accessing health care. The lack of bi-lingual/bi-cultural providers, especially for behavioral health services, was cited repeatedly in the Spanish and Brazilian focus groups. The Fall River area lost its designation as a Health Professional Shortage Area (HPSA). An HPSA designation allowed medical providers to participate in incentivized loan repayment plans and scholarship programs which aided in attracting a more diverse provider corps.

It is well documented in the research literature that language barriers negatively impact access to health care and health status/health outcomes. Language barriers adversely affect “the degree to which individuals have the capacity to obtain, process, and understand basic health information and then use that information to make appropriate decisions to prevent or treat illness”. This is referred to as functional health literacy. Cultural competency training for providers, including medical interpreters, assist in mitigating the language barriers as expressed by community members – for it is not just about the ability to translate language, but it is also about understanding the beliefs and traditions of different cultures and ethnicities. Additionally, the availability of health information and health screening materials (i.e., colon cancer screening kits) in native/first languages can contribute to functional health literacy and increase health screening compliance rates and other positive population health
behavior change. Saint Anne’s Hospital declared 2015 as the Year of Cultural Inclusion and Diversity and through its “Stop. Think. Care.” initiative sponsored monthly cultural competency trainings across the spectrum of care. Culturally competent care and diversity inclusion remain actionable objectives for the 2016 community health benefits plan.

Access to health care 2016 intervention strategy:
- Provide community-based, bilingual assistance in understanding health insurance plans and enrollment to community members through partnerships with community service organizations, faith-based groups and other community partners.
- Continue to provide trainings in cultural competency to promote culture of inclusion.

Recommendations

The previous section identified the major public health issues within our PSA. The following section outlines the recommendations made at both the community level and at the health care system level to address these pressing issues. Saint Anne’s Hospital, in collaboration with community partners, is well positioned to positively impact population health while improving access to and the experience of health care within the community hospital setting.

Community-wide:
- Use community health workers (CHWs) and/or peer-specialists who are trusted members of the constituent groups and are trained in health prevention behaviors and chronic disease management to connect the at-risk, underserved population to available resources.
- Create collaborations to decrease stigma attached to addiction and to mental health.
- Implement/increase health education and outreach for all problem areas (i.e., substance abuse disorder, mental health, health literacy, chronic disease self-management, nutrition education, and healthy lifestyles); include within school curricula.
- Create community-based suicide prevention program and support services for suicide attempt survivors and loss survivors.
- Increase access to affordable healthy foods, nutrition education and address behavioral patterns that lead to obesity.

Health Care System:
- Increase behavioral health service capacity across the spectrum of care.
- Increase diversity among providers.
- Increase collaboration and communication between behavioral health and primary care providers to improve care coordination and patient compliance. Possible strategies include embedding primary care services within outpatient behavioral health settings or vice versa.
- Provide education to front-line caregivers and school/community leaders on the signs of substance abuse and mental illness, including suicide risk, and how to access available resources.
- Survey hospital capabilities to increase transportation resources to facilitate access to care; support community-based advocacy to enhance public transit system.
Appendices

• Appendix A: Focus Group Questions
• Appendix B: Key Informant Survey
• Appendix C: References

Appendix A

FOCUS GROUP QUESTIONS

1. What concerns you the most about living here? (Why?)
2. What is healthy about your community?
3. What do you or other people you know do to stay healthy?
4. What do you believe are the top three areas of health concerns within the community?
5. What suggestions do you have to address these concerns?
6. What populations would you identify as underserved or underrepresented within the community?
7. What do you feel are the biggest obstacles to health access for your community? Such as transportation, language barrier, someone to watch children or disabled love one at home, unable to take time off from job?
8. What do you like the most about living in your community? (Why?)
9. *Is mental health a major issue within your community? Are you aware of a lot of people with mental health issues?
   *Is substance abuse a major health issue within your community? Are you aware of a lot of people with substance abuse problems?
   * Is there a major issue with any of the following problems? Domestic violence, gang/youth violence, elderly abuse/neglect, child abuse/neglect/suicide?
   * Anything else that should be mentioned that is a major problem?
10. Do you or someone you know have issues with any chronic disease? (Chronic diseases are health issues like diabetes, hypertension, obesity, asthma). How do these issues affect the way you or they live work play? (to the moderator, look for possible issues that chronic disease causes – asthma preventing school attendance, diabetes hindering job prospects)
11. Do you know anybody with issues of dementia or Alzheimer’s disease? Do you see this issue as increasing, decreasing, or staying the same?
12. Do you think most people have a primary care physician or see a physician regularly? How easy or hard is it to access primary care services? Why?

13. Do you think most people have a yearly dental check-up/cleanings or regular dental work? How easy or hard is it to access dental health resources/services? Why?

14. What health services do you think people need that are not being offered?

15. In what ways can Saint Anne’s Hospital serve the community better?

Appendix B

Saint Anne’s Hospital

Community Health Needs Assessment

Key Informant Survey

1. Choose the type of organization for which you work?
   - Business
   - Health care provider (i.e., hospital, clinic, physician, or dental practice, pharmacy)
   - Municipal department (i.e., schools, police/fire, Council on Aging)
   - Non-profit organization/social service agency
   - Other ________________________________
   - Religious organization

2. Choose the type of organization for which you work?
   - Business
   - Health care provider (i.e., hospital, clinic, physician, or dental practice, pharmacy)
   - Municipal department (i.e., schools, police/fire, Council on Aging)
   - Non-profit organization/social service agency
   - Other ________________________________
   - Religious organization

3. Choose the type of organization for which you work?
   - Business
   - Health care provider (i.e., hospital, clinic, physician, or dental practice, pharmacy)
   - Municipal department (i.e., schools, police/fire, Council on Aging)
   - Non-profit organization/social service agency
   - Other ________________________________
   - Religious organization

4. Do you live in the Greater Fall River Area? (Defined as: Fall River, Somerset, Swansea, Westport)
   - No  □ Yes
5. What do you think are the best features about this community?

6. How would you identify the community that you work with? (i.e. youth, elderly population, specific minority population, etc.)

7. What are the top three areas of general concern within the community that you work with?

8. What services do you perceive as being most needed within the community?

9. What do you think are the top five health issues in the community?
   - Alcoholism
   - Asthma
   - Cancer
   - Diabetes
   - Domestic violence
   - Drug abuse/addiction
   - Heart disease
   - High blood pressure/stroke
   - Lung disease
   - Mental health issues
   - Oral/dental hygiene
   - Overweight/obesity
   - Smoking
   - Suicide
   - Other (please specify)

10. What do you believe are the biggest obstacles that people face in accessing health care? (Check all that apply)
    - Cannot get an appointment
    - Cultural beliefs
    - Don't have a doctor
    - Don't see a need for a doctor
    - Fear
    - Financial difficulties
11. What are the top five populations that you identify as underserved or underrepresented within the community?
☐ Elderly
☐ People at or below the poverty line
☐ People who lack knowledge about chronic disease
☐ People who lack knowledge about oral hygiene
☐ People who lack knowledge about preventative health measures
☐ People, families without access to healthcare
☐ Those for whom English is a second language
☐ United States Veterans
☐ Other (please specify)

12. What three improvements/services should be made for a healthier community?
☐ Access to healthier food
☐ Mental health services
☐ Safe places to walk and play
☐ Substance abuse rehabilitation services
☐ Transportation
☐ Wellness programs
☐ Other (please specify)

13. In what ways is Saint Anne’s Hospital serving the community well? (please specify)

14. In what ways can Saint Anne’s Hospital improve the health and well-being of the community?
Appendix C- References


2 See http://www.americashealthrankings.org/MA/Overall


4 See http://www.cdc.gov/socialdeterminants/Definitions.html


6 See http://www.americashealthrankings.org/MA/Overall

7 See http://www.americashealthrankings.org/MA/Overall


13 See http://www.homefacts.com/unemployment/Massachusetts.html

14 See: http://www.suicidology.org/about-aas/board


19 See: U S Census Bureau, County Business Patterns: 2011 (via Community Commons)


28 See: www.americashealthrankings.org


30 See: http://www.hrsa.gov/publichealth/healthliteracy/healthlit about.html