

ATTACHMENT 5B

SOUTH SHORE HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT



Community Health Needs Assessment 2019-2021



EXECUTIVE SUMMARY

BACKGROUND AND PURPOSE

Since 1994, the Massachusetts Attorney General's Office has published Community Benefit Guidelines that encourage nonprofit hospitals and health maintenance organizations (HMOs) to address community health issues. In 2012, the federal Affordable Care Act (ACA) further reinforced these expectations by mandating that these entities engage in similar assessment, planning and community health improvement activities. To identify leading social determinants, major health issues and vulnerable populations, the Community Benefit Guidelines encourage institutions to conduct comprehensive community health needs assessments (CHNAs) and to develop strategic implementation plans to address the issues that arise. In developing these materials, institutions are expected to fully engage the community-at-large and to collaborate with other community health stakeholders, including health departments, service providers, and community-based health and social service organizations.

The primary goals for the CHNA and this report are to:

- Assess community health need, defined broadly to include health status, social determinants and service system strengths and weaknesses
- Engage the community, including local health departments, service providers across sectors and community residents
- Identify the leading health issues and the population segments most at-risk based on a review of the quantitative and qualitative information gathered by the assessment

This CHNA should be used as a source of information and guidance to:

- Clarify issues related to community characteristics, barriers to care, existing service gaps, community need and other health-related factors
- Prioritize and promote community health investment
- Inform and guide a comprehensive, collaborative community health improvement planning process

APPROACH

The CHNA was conducted in three phases, which allowed for compilation of an extensive amount of quantitative data (Phase 1), engagement of key public health stakeholders, community residents and service providers (Phase 2), and analysis and prioritization of findings for use in a strategic Implementation Strategy (Phase 3). Individuals from across the region were engaged in the assessment and planning process.

Stakeholders and community residents were invited to share their thoughts through interviews, focus groups, community forums, a community survey, and a final Community Health Strategic

Retreat. While it was not possible for this assessment to involve all community stakeholders, the Steering Committee tried to be as inclusive as possible and provided a broad range of opportunities over many months. Those involved, particularly those who participated in interviews, focus groups and community forums, showed a deep commitment to strengthening the region's health system, particularly for people most at-risk.

CHNA SERVICE AREA

South Shore Health's Community Benefits Service area included the 33 towns that make up the South Shore region of Massachusetts. The CHNA is a population-based assessment, meaning it considers the needs of the entire population regardless of demographics, socioeconomics, or other characteristics. As per the Community Benefit Guidelines that govern the CHNA, special attention was given to understand the needs of populations that are disadvantaged, face disparities in health-related outcomes, and are deemed most at-risk or vulnerable.

COMMUNITY HEALTH PRIORITIES

The CHNA was designed as a population-based assessment and the goal was to identify the full range of community health issues affecting the region. The issues identified are framed in a broad context to ensure that the breadth of unmet needs and community health issues are recognized.

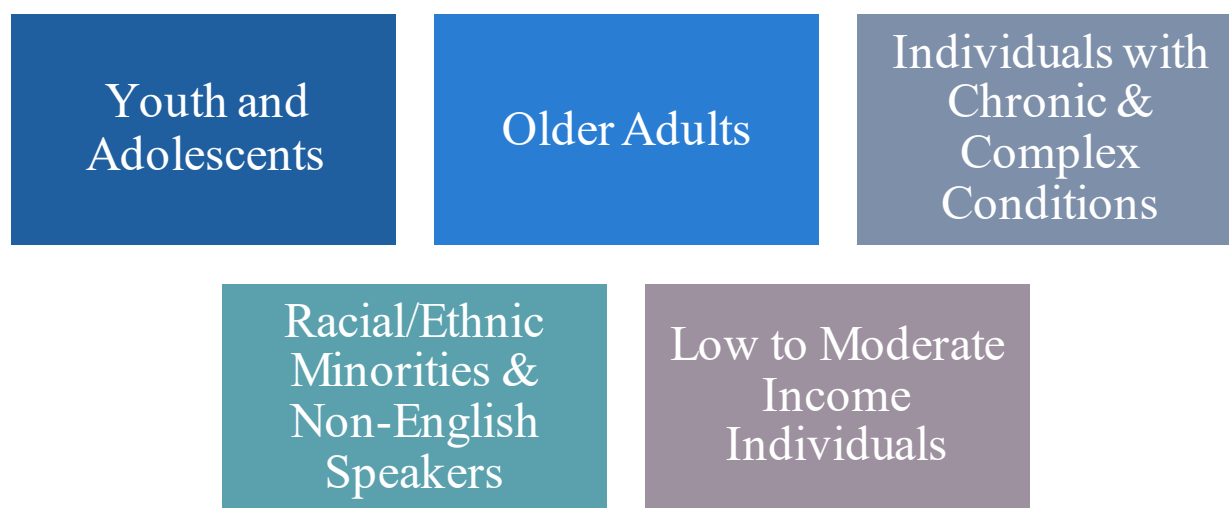
With this in mind, the Steering Committee framed the leading community health issues into four priority areas:



Please see Page 39 of this report for a detailed description of health priorities.

PRIORITY POPULATIONS

All segments of the population face challenges that may limit their ability to access health services, regardless of age, race/ethnicity, income, family history, or health status. In the body of this report, there is a comprehensive review of the full breadth of quantitative and qualitative data that was compiled for this project. This review includes findings that touch on challenges common among residents throughout the region, across all demographic and socioeconomic segments. However, in order to target the region's limited resources and comply with state and federal guidelines, the CHNA prioritizes segments of the population with complex health needs or who face significant barriers to care. With this in mind, the Steering Committee and Advisory Committee identified five population segments that organizations should prioritize as they invest their resources and develop their strategic implementation plans. These segments include:



For a detailed description of priority populations, please see Page 36 of this report.

ACKNOWLEDGEMENTS

South Shore Health's 2019 Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) were overseen and managed by the Hospital's Office of Home and Community Care. The CHNA and IS were developed through a collaborative process involving both administrative and clinical staff at SSH, and Steering and Advisory Committees made up of health and social service providers, community health advocates, and other community leaders. The Steering and Advisory Committees met periodically throughout the assessment and planning process in order to inform the assessment and planning approach, oversee progress, and provide critical feedback on preliminary and final results.

Since the beginning of the assessment in July of 2018, more than 100 individuals participated in interviews, focus groups, and community forums. In addition, 80 community members from SSH's primary service area completed a Community Health Surveys. The information gathered as part of these efforts allowed SSH to engage the community and gain a better understanding of community capacity, strengths, and challenges as well as community health status, barriers to care, service gaps, and underlying determinants of health.

SSH would like to thank everyone who was involved in this effort who invested their time, effort, and expertise through interviews, surveys, community forums, and listening sessions to ensure the development of a comprehensive, thoughtful, and quality CHNA and IS. While it was not possible for this assessment to involve all of the community's stakeholders, care was taken to ensure that a representative sample was engaged. Those involved showed commitment to strengthening the regions health system, particularly for those segments of the population who are most at-risk.

SSH was supported in this work by John Snow, Inc. (JSI), a public health consulting and research organization dedicated to improving the health of individuals and communities in the United States and around the world. SSH appreciates the contributions that JSI has made in analyzing data, engaging the community, and conducting research throughout CHNA and IS development process.

South Shore Health Community Health Needs Assessment 2019

Steering Committee

Jann Ahern, Vice President of Home & Community Health, South Shore Health
Tina Dwyer, Director of Care Coordination/Community Benefits Officer, South Shore Health
Julie Kembel, Board Member, Friends of South Shore Health
Chris O'Connor, Senior Vice President of External Affairs and Marketing & Chief Development Officer,
South Shore Health
Karen Peterson, Senior Director of Health & Well-being, South Shore YMCA
Lisa Rabideau, Director of Patient Relations and Service Excellence, South Shore Health

South Shore Health Community Health Needs Assessment 2019

Advisory Committee

Dr. Gene Green, President & Chief Executive Officer, South Shore Health
Pam Whelton, Executive Vice President of South Shore Health System; President of South Shore
Hospital
Jann Ahern, Vice President of Home & Community Health, South Shore Health
Ben Asfaw, Vice President of Quality Management, South Shore Health
Cara Babachicos, Senior Vice President & Chief Information Officer, South Shore Health
Stephen Coco, Senior Vice President & Chief Financial Officer, South Shore Health
Dr. Kimberly Dever, Vice President of Medical Affairs, South Shore Health
Edward Liao, Vice President of Clinical & Ancillary Services, South Shore Health
Mark Mahnfeldt, Vice President of Operations, South Shore Health
Dr. Nareesa Mahammed-Rajput, Chief Medical Information Officer, South Shore Health
Chris O'Connor, Senior Vice President of External Affairs and Marketing & Chief Development Officer,
South Shore Health
Timothy Quigley, Senior Vice President & Chief Nursing Officer, South Shore Health
Wayne Stockbridge, Chief Human Resource Officer, Chief Administration Officer, Senior VP of Human
Resources and Administration, South Shore Health
Susan Wood, Vice President of Ambulatory Operations, South Shore Health
Lisa Braude, Executive Director Strategy & Planning, Aspire
Phillip Chong, CEO, Quincy Asian Resources, Inc.
Allison Conlon, Manager of Care Progression, South Shore Health
Jennifer Croes, Executive Director/Cancer Center Administration, South Shore Health
Roxanne Desmarais, Director of Administrative Operations (Home & Community Care), South Shore
Health
Emily Dionne, Manager of Nutrition, South Shore Medical Center
Eugene Duffy, Director of Emergency Services, South Shore Health
Tina Dwyer, Director of Care Coordination/Community Benefits Officer, South Shore Health
Adrienne Gerlach, Executive Director of Value Based Operations, South Shore Health
James Green, Executive Director Orthopedics, South Shore Health
Dr. David Halle, Regional Medical Director, South Shore Health
Katie Howard, Outreach Coordinator/Community Benefits, South Shore Health
Julie Kembel, Board Member, Friends of South Shore Health
Dr. Edward Nalband, Internal Medicine, South Shore Medical

**South Shore Health Community Health Needs Assessment 2019
Advisory Committee (continued)**

Kim Noble, School Health Partnership
Karen Peterson, Associate Director, South Shore YMCA
Lisa Rabideau, Director of Patient Relations and Service Excellence, South Shore Health
Lisa Royer, Director of Home and Health Resources, South Shore Health
Tammie Ryan, Director, South Shore Visiting Nurses
Antony Sheehan, President, Aspire
Nadiene Shweiri, Fairing Way
Valerie Sullivan, Mass in Motion Health Coordinator, Weymouth
Dr. Jason Tracy, Chairman of Emergency Medicine, South Shore Health
Dr. William Tollesfen, EMS Medical Director, South Shore Health
Lola Tom, Consultant

TABLE OF CONTENTS

Executive Summary	1
Acknowledgements	5
I. Background, Purpose and Approach	9
Background.....	9
Purpose.....	9
Service Area.....	11
Assessment and Planning Approach	12
Data Limitations.....	15
II. Regional and Community Characteristics	16
Age and Gender	16
Race and Ethnicity.....	17
Foreign Born	18
Language	19
Disability Status.....	20
Socioeconomic Characteristics	21
III. Key Findings: Social Determinants of Health and Barriers to Care	23
Housing	23
Transportation.....	24
Food Access.....	24
Health Literacy	25
IV. Key Findings: Behavioral Risk Factors and Health Status	26
Behavioral Risk Factors.....	26
Health Status Issues	28
V. Key Findings: Population and Community Health Priorities	36
Priority Populations	36
Community Health Priorities	39
Appendices	
Appendix A: Community Engagement Approach	43
Appendix B: South Shore CHNA Databook.....	47
Appendix C: Resource Inventory	51
Appendix D: Implementation Strategy.....	58

I. BACKGROUND, PURPOSE AND APPROACH

BACKGROUND

This Community Health Needs Assessment (CHNA) is the culmination of eight-months of work that began in July 2018 and ended in March 2019. The report is a comprehensive assessment of community needs for the South Shore region, including regional assets, strengths, and weaknesses. The assessment includes quantitative data from federal, state and local sources, and qualitative information captured through community interviews, focus groups, community forums and a strategic retreat. The process engaged community residents as well as community health service providers and other stakeholders across all sectors. This report summarizes key findings and identifies, based on quantitative data and input from all those involved, the leading community health issues in South Shore Health's service area. It also identifies the populations most at-risk for health-related challenges and disparities that should be prioritized in SSH's and the community health improvement efforts.

The CHNA findings will serve as the foundation for the creation of an Implementation Strategy (IS), which will outline how South Shore Health plans to address the unmet needs identified in the assessment. This assessment may serve as a resource for community health improvement efforts throughout the region.

PURPOSE

Not-for-profits such as hospitals and health maintenance organizations (HMOs) play essential roles Massachusetts' health care system by helping to ensure that residents have access to the health-related services they need to live healthy and productive lives.

In its voluntary Community Benefits Guidelines for hospital and HMOs, the Massachusetts Attorney General's Office encourages these not-for-profits to conduct a comprehensive community health needs assessment. In conducting the CHNA, and developing and implementing subsequent Implementation Strategies, these institutions are expected to engage community residents and to work in close cooperation with community health stakeholders, including health departments, community coalitions, service providers, and other community-based health and social service organizations. The Attorney General's Community Benefits Guidelines have been in place since 1994. In 2010, the Federal Affordable Care Act (ACA) further reinforced these expectations for not-for-profit hospitals by mandating that they engage in similar assessment, planning and community health improvement activities as required by the state.

The primary goals for the CHNA and this report are to:

- Assess community health need, defined broadly to include health status, social determinants, environmental factors, and service system strengths and weaknesses
- Engage the community, including local health departments, service providers across sectors and community residents, as well as SSH hospital leadership and staff
- Identify the leading health issues and the population segments most at-risk based on a review of the quantitative and qualitative information gathered by the assessment

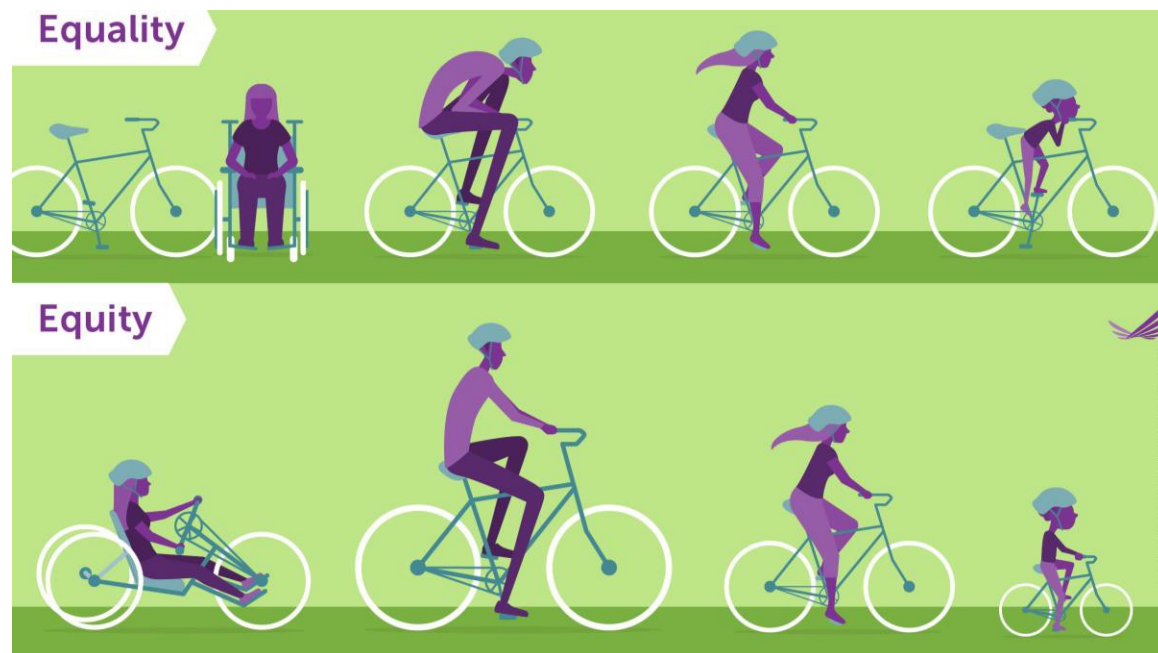
This CHNA may be used as a source of information and guidance to:

- Clarify issues related to community characteristics, barriers to care, existing service gaps, unmet community need and other health-related factors
- Prioritize and promote community health investment
- Inform and guide a comprehensive, collaborative community health improvement planning process, and
- Facilitate discussion within and across sectors regarding community need, community health improvement, and health equity.

This CHNA was conducted with the support and involvement of senior leadership at South Shore Health. Representatives from senior leadership served on the Advisory and Steering Committees, participated in key informant interviews, and were involved in the development of the Implementation Strategy.

The Steering and Advisory Committees understood the need for the CHNA to be aligned with the state's broader agenda of promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity, the attainment of the highest level of health for all people, requires focused, ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices.

Figure 1: Equality vs. Equity



SERVICE AREA

South Shore Health's Community Benefits Service area included the 33 towns that make up the South Shore region of Massachusetts:

Figure 2: South Shore Hospital Service Area



The CHNA is a population-based assessment, meaning it considers the needs of the entire population regardless of demographics, socioeconomics, or other characteristics. As per the Community Benefit Guidelines that govern the CHNA, special attention must be given to address the needs of populations that are disadvantaged, face disparities in health-related outcomes, and are deemed most at-risk or vulnerable. As a result, the Implementation Strategy that will be developed based on the CHNA will focus on the geographic, demographic, socio-economic segments most at-risk as well as those identified with physical, behavioral, and emotional challenges.

ASSESSMENT AND PLANNING APPROACH

The assessment process began with the creation of a Steering Committee made up of representatives from South Shore Health, along with a representative group of key community partners with extensive knowledge of the community and its service system. The Steering Committee provided vital input and oversaw the day-to-day assessment and planning efforts of the CHNA. The Steering Committee met approximately every two weeks (in-person and via conference call) to review project activities and ensure that the assessment met Attorney General and federal Internal Revenue Service (IRS) Guidelines. The Steering Committee also assisted in the formation of the Advisory Committee.

The Advisory Committee included senior leadership and representatives from community health partners throughout the region. This group met three times over the course of the assessment; they provided input on the assessment approach, vetted preliminary findings, and helped to prioritize community health issues and target populations. The Steering and Advisory Committees also reviewed and approved this CHNA report and the subsequent Implementation Strategy and CHIP.

With respect to the assessment, the CHA used a three-phased process:

Phase One involved a rigorous and comprehensive review of existing quantitative data, along with 30 interviews with community stakeholders.

Phase Two involved a more targeted assessment of need and broader community engagement activities, including five focus groups with health, social service and public health service providers. In Phase Two, the CHNA also conducted five community forums that were marketed to the public at-large. Finally, 80 residents completed a web-based Community Health Survey to provide input on leading social determinants of health, clinical health issues, and vulnerable populations. A detailed description of the Community Engagement approach is included in Appendix A.

Phase III involved a series of strategic planning activities. In addition to developing the CHNA report, the primary activities in Phase III were meetings with the Steering and Advisory Committees to discuss integrated findings, prioritize community health issues, identify vulnerable populations, and discuss potential responses.

Quantitative Data Analysis

JSI collected quantitative data from a broad range of sources to characterize the community, measure health status, and inform a comprehensive understanding of the health-related issues. Whenever possible, data was captured at the municipal level. The primary sources of data were the Massachusetts Department of Public Health and the U.S. Census Bureau. The primary data sources and data sets are listed below. Data analysis was performed to test for statistically significant differences between data at the municipal level and the Commonwealth overall.

- U.S. Census Bureau, American Community Survey 5-Year Estimates (2012–2016)
- Massachusetts Vital Records, Mortality (2015)
- Massachusetts Hospital Inpatient Discharges (2008–2012)
- Massachusetts Hospital Emergency Department Discharges (2008–2012)
- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2016)

Community Interviews

JSI conducted interviews with 30 community leaders, service providers, public officials, community residents and other stakeholders. A list of the people interviewed for the CHNA is included in Appendix A. Phone interviews were conducted using a standard interview guide. The purpose was to identify the leading social determinants of health, the major health issues facing the region, and the populations most at-risk or vulnerable.

Focus Groups

JSI conducted five focus groups:

- South Shore Health Patient Family Advisory Council
- Behavioral health providers
- Youth and adolescent providers
- Law enforcement/Public safety
- Community Health Network Area 23

These sessions provided an opportunity to gather input from service providers, community leaders, and community residents with an emphasis on engaging those who serve or represent populations that experience health disparities. Focus groups were organized in collaboration with the Steering Committee.

Community Forums

JSI conducted five community forums—open and marketed to the public by South Shore Health, host locations, and the Steering Committee. Forums were held in Abington, Hingham, Marshfield, Quincy, and Weymouth. In total, the forums were attended by approximately 30 community residents. During these forums, JSI presented preliminary findings from the quantitative and qualitative data compiled for the assessment and facilitated discussions with community residents to gather feedback and opinions on community health.

Community Health Survey

JSI and the Steering Committee created a short web-based survey for community residents. The web-based survey was created using SurveyMonkey and was marketed via South Shore, Steering Committee members, and Advisory Committee members. The survey was open for one month and received 80 responses.

A full listing of the community engagement activities and approaches, including a description, count and method of activities conducted, is included in Appendix A.

Prioritization

After all data-gathering activities, the Advisory Committee came together for a strategic retreat. The primary goals of this session were to:

1. Summarize and discuss the leading issues from the CHNA in a full group session
2. Discuss the findings of the CHNA through a series of small-group breakout sessions
3. Prioritize leading health issues, social determinants of health and vulnerable/at-risk populations

These plenary and breakout group sessions allowed participants to review and discuss the full breadth of quantitative and qualitative findings from Phases One and Two, as well as consider the segments of the population that were thought to be most affected by these issues. Retreat participants then participated in a polling process to identify the populations most at risk and the health-related issues that participants believed should be prioritized to best address the findings from the assessment.

Draft and Final Community Health Assessment Report

Once the CHA Strategic Retreat was completed, JSI collaborated with the Steering Committee to finalize community health priorities and priority populations. JSI then developed draft and final versions of this CHNA report, with feedback provided through an iterative process.

As required by Federal and Commonwealth Guidelines, this CHNA is posted on South Shore Health's website and is available in hardcopy by request. There was no written feedback on the

previous CHNA or Implementation Strategy (formerly known as the Community Health Implementation Plan, or “CHIP”) since its posting in 2015. There was also no feedback on the Massachusetts Attorney General’s website, which publishes the hospital’s community benefits reports and provides an opportunity for public comment. The Steering Committees encourage feedback and comments on this report; any feedback is taken into account when updates and changes are made to the Implementation Strategy or to inform future CHNA processes.

DATA LIMITATIONS

Assessment activities of this nature typically face limitations in quantitative and qualitative data collection. With respect to the project’s quantitative data, the most significant limitation was the availability of timely data. Relative to most of the rest of the U.S., Massachusetts does an exemplary job at making comprehensive data available at the state, county and municipal levels through the Massachusetts Department of Public Health. The breadth of demographic, socioeconomic and epidemiologic data available was enough to facilitate an assessment of community health needs and support the implementation plan development process.

A major limitation was that much of the epidemiologic data available, particularly at the municipal level, was at least three to five years old. The list of data sources included in this report provides the dates for each of the major data sets provided by the Commonwealth. Great effort was made to ensure that the data reported was the most current. The data was still valuable and enabled the identification of health needs relative to the Commonwealth and specific communities. However, older datasets may not reflect recent trends in health statistics. Additionally, the quantitative data was not stratified by age, race/ethnicity, or income, which severely limited the ability to identify the most at-risk segments of the population in an objective way. Qualitative activities allowed for exploration of these issues, but the lack of objective quantitative data constrained this effort.

With respect to qualitative data collection, every effort was made to promote focus groups, community forums, and the community health survey and to engage a representative sample of community members.

II. REGIONAL AND COMMUNITY CHARACTERISTICS

To understand community needs and health status for the service area, we must begin with a description of the population's geographic and demographic characteristics, as well as the underlying social, economic, and environmental factors that affect health status and equity. This information is critical to:

- Recognizing disease burden, health disparities and health inequities
- Identifying target populations and health-related priorities
- Targeting strategic responses

The CHNA captured a range of quantitative and qualitative data related to age, gender, race/ethnicity, income, poverty, education, employment, and other determinants of health. These data provided valuable information that characterized the population and provided insights into the leading inequities.

The following is a summary of key findings related to community characteristics. Conclusions were drawn from quantitative data and qualitative information collected through interviews, focus groups and community forums. Summary data is included below. More expansive data tables are included in the South Shore Health Data Book (Appendix B).

The South Shore region sits on the Eastern edge of Massachusetts between Boston and Cape Cod. It includes cities and towns in both Norfolk and Plymouth Counties. The region's climate is typical of New England, where summers are warm and humid, and winters are cold and snowy. Brockton and Quincy are the two most populous cities in the region.

AGE AND GENDER

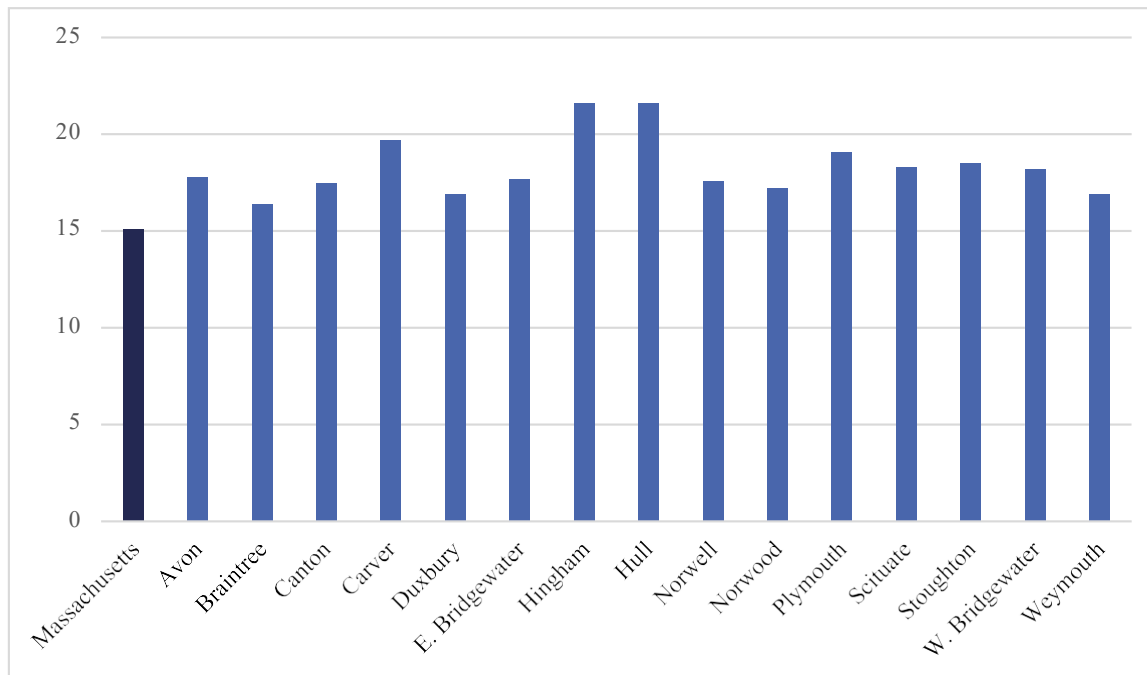
Age and gender are fundamental factors to consider when assessing individual and community health status. Men tend to have shorter life expectancies and more chronic illnesses than women. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.^{1,2}

Figure 3 includes those towns in the service area with a significantly higher percentage of residents over 65 compared to the Commonwealth overall.

¹ Linda Lyons, "Age, Religiosity, and Rural America," Gallup Web Site, <http://www.gallup.com/poll/7960/age-religiosity-rural-america.aspx>, (March 11, 2013)

² Harvard Men's Health Watch, "Mars vs. Venus: The Gender Gap in Health," Harvard Health Publications Web Site, http://www.health.harvard.edu/newsletter_article/mars-vs-venus-the-gender-gap-in-health, (January 2010)

Figure 3: Percentage of Residents Over 65



Source: U.S. Census Bureau 5-Year Estimates, 2012-2016

RACE AND ETHNICITY

An extensive body of research illustrates the health disparities that exist for racial/ethnic minorities and foreign-born populations. According to the CDC, non-Hispanic Blacks have higher rates of premature death, infant mortality and preventable hospitalization than non-Hispanic Whites.³ Individuals with limited English proficiency (LEP), defined as the ability to read, speak, write or understand English “less than very well,” have lower levels of medical comprehension. This leads to higher rates of medical issues and complications, such as adverse reactions to medication.^{4,5} These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. Interviewees and community forum participants alluded to issues of overt and discreet prejudice in the region, especially for non-English speakers.

³ Centers for Disease Control and Prevention, “CDC Health Disparities and Inequalities Report (CHDIR),” Centers for Disease Control and Prevention Web Site, <https://www.cdc.gov/minorityhealth/chdireport.html>, September 10, 2015

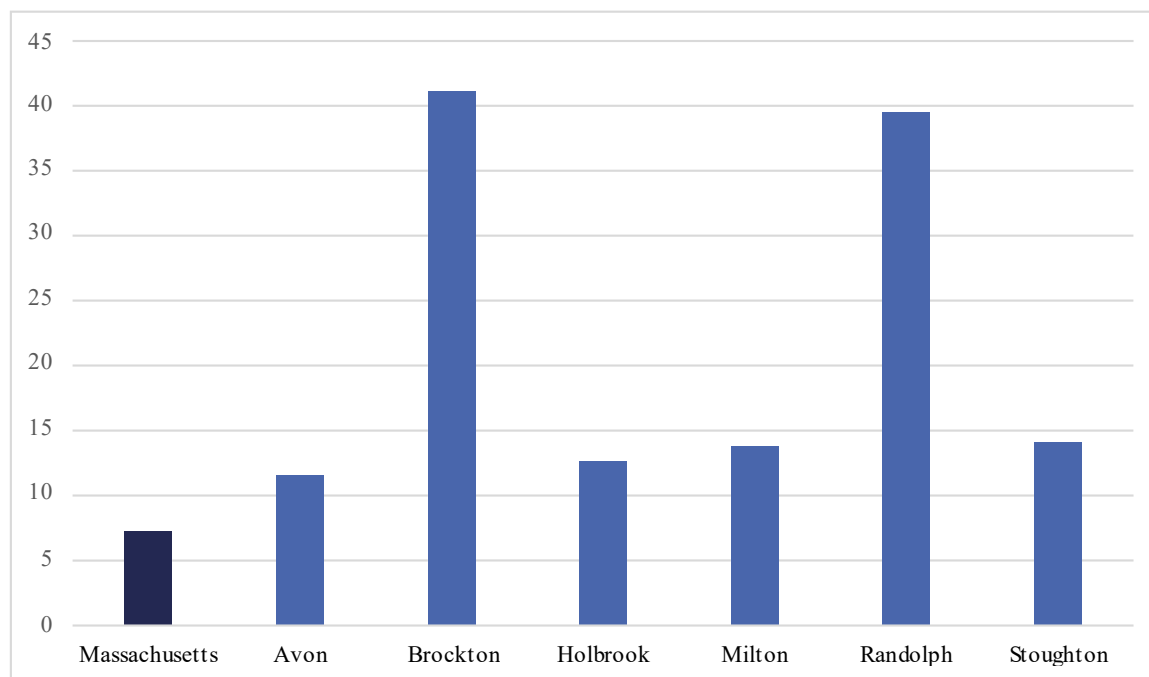
⁴ E Wilson, AH Chen, K Grumbach, F Wang, and A Fernandez, “Effects of Limited English Proficiency and Physician Language on Health Care Comprehension,” *Journal of General Internal Medicine* 20, no. 9 (Sep 2005): 800-806.

⁵ Joshua S. Coren, Frank A. Filipetto, and Lucia Beck Weiss, “Eliminating Barriers for Patients With Limited English Proficiency,” *Journal of the American Osteopathic Association* 109, no. 12 (December 2009): 634-640.

The service area is predominantly White, though there were a handful of cities and towns that were more diverse:

- In Abington (12%), Brockton (41%), Holbrook (13%), Milton (14%), and Randolph (40%), and Stoughton (14%), the percentage of the population that was Black/African American was significantly higher than the Commonwealth overall (7%). (*Figure 4*)
- In Braintree (9%), Quincy (28%), Randolph (12%), and Sharon (16%), the percentage of the population that was Asian was significantly higher than the Commonwealth overall (8%).

Figure 4: Percentage of Black/African American Residents



Source: U.S. Census Bureau 5-Year Estimates, 2012-2016

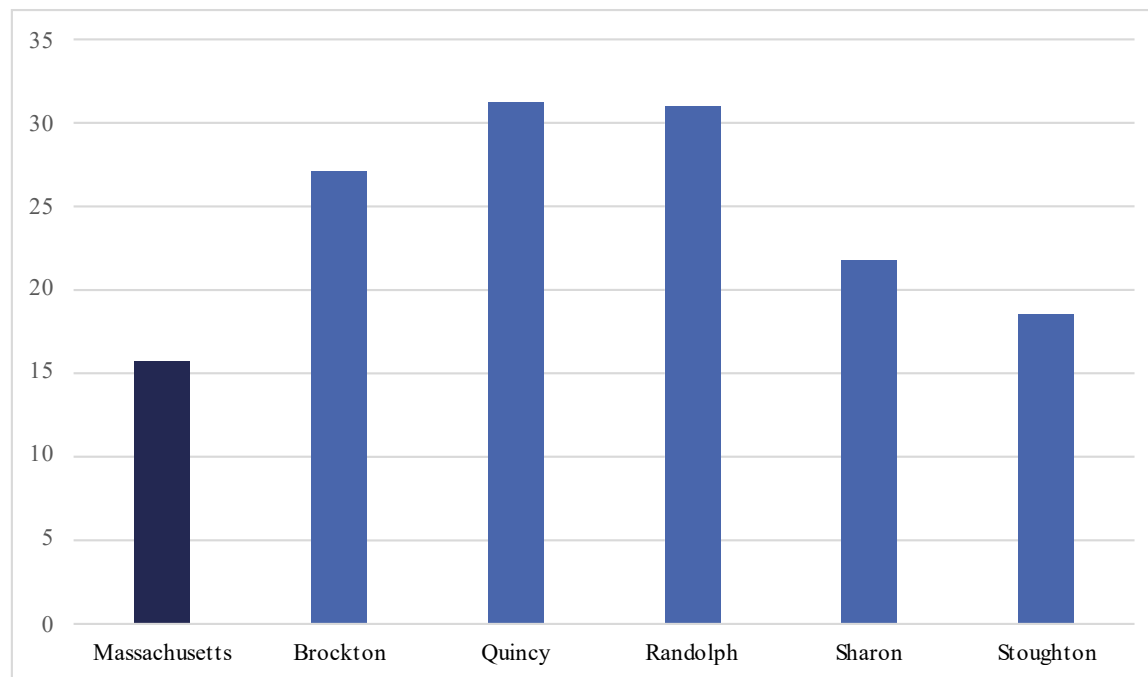
FOREIGN BORN

Many key informants and focus group/forum participants reported that foreign-born residents experience extreme stress and anxiety related to immigration status, especially in the context of current political debate. Fear of detainment and deportation prevents individuals from seeking vital community services and health care—and from engaging in their communities. These barriers allow health inequities to persist, creating undue burden on health care institutions and impeding prevention efforts.

Figure 5 includes those towns in the service area who have a foreign-born population

significantly higher than the Commonwealth overall.

Figure 5: Percentage of Foreign-Born Residents



Source: U.S. Census Bureau 5-Year Estimates, 2012-2016

LANGUAGE

Language barriers pose significant challenges to providing effective and high-quality community services and health care. While many larger health care institutions, including South Shore Hospital, have medical interpreter services available at their facilities, research has found that the health care providers' cultural competency is key to reducing racial and ethnic health disparities. Community focus group and forum participants supported these ideas, specifically noting a need for more providers that speak Chinese, Portuguese, and Spanish. Beyond the need for diverse providers, participants also referred to the importance of hiring diverse support staff (medical assistants, certified nursing assistants, phlebotomists, etc.) and administrative staff to mediate other issues such as medication management, scheduling, and arrangement of follow-up services.

While the majority of those in the service area speak English, there were several towns with a significantly high percentage of individuals who spoke a language other than English in the home and individuals with limited English proficiency (speaking English "less than very well") compared to the Commonwealth overall (23% and 9%), respectively:

- In Brockton, 40% of the population speaks a language other than English at home; 20% of that population speaks English less than very well. The most common foreign languages spoken are Indo-European languages (e.g., French, Spanish).
- In Quincy, 37% of the population speaks a language other than English at home; 21% of

that population speaks English less than very well. The most common foreign languages spoken are Asian and Pacific Islander languages (e.g. Chinese, Vietnamese).

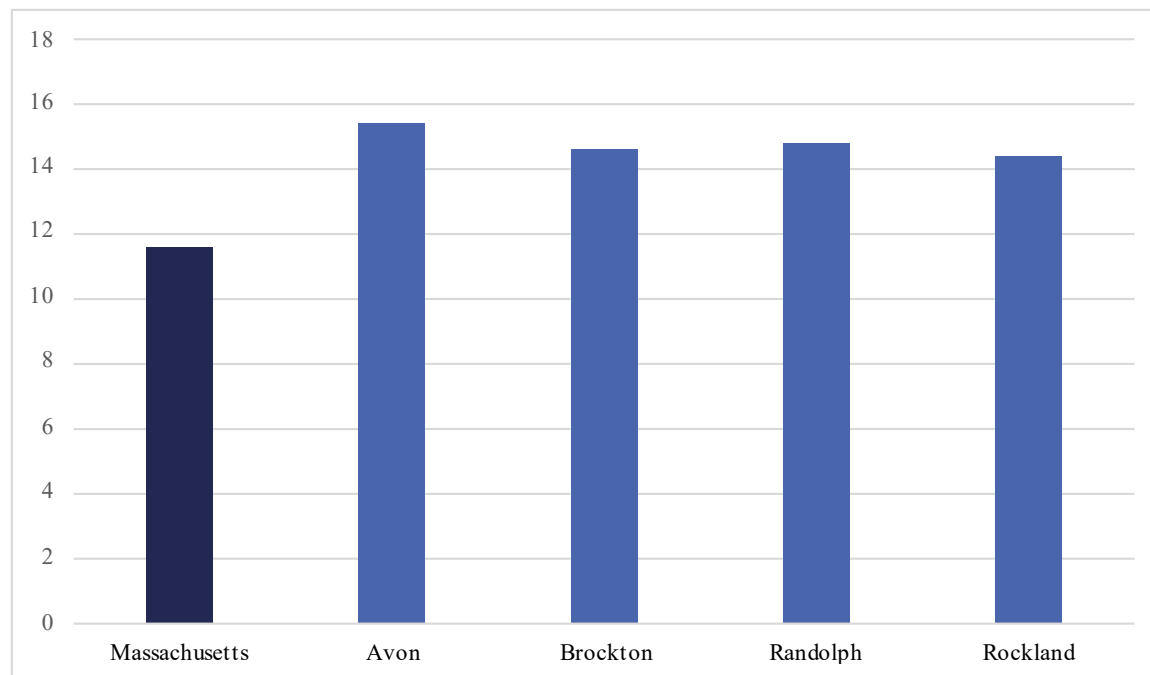
- In Randolph, 38% of the population speaks a language other than English at home; 16% of the population speaks English less than very well. The most common foreign languages spoken are Indo-European languages and Asian and Pacific Islander languages.
- In Sharon, 28% of the population speaks a language other than English at home. The most common languages spoken are Indo-European languages and Asian and Pacific Islander languages.

DISABILITY STATUS

Across the service area, the percentage of the civilian noninstitutionalized population who identify as disabled was lower or significantly lower in many municipalities compared to the Commonwealth, though there were some exceptions.

Figure 6 includes those towns in the service area that had significantly higher percentages of disabled residents compared to the Commonwealth overall.

Figure 6: Percentage of Disabled Residents



Source: U.S. Census Bureau 5-Year Estimates, 2012-2016

SOCIOECONOMIC CHARACTERISTICS

Socioeconomic status (SES), as measured by income, employment status, occupation, education and the extent to which one lives in areas of economic disadvantage. It closely linked to

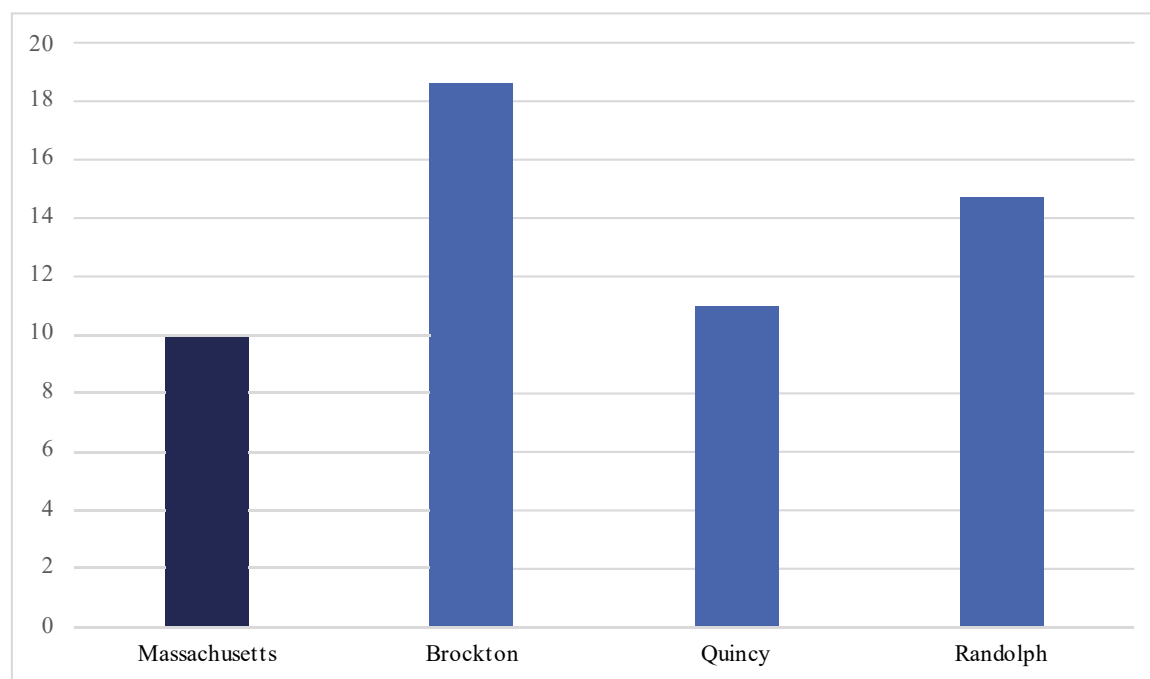
morbidity, mortality and overall well-being. Lower than average life expectancy is highly correlated with low-income status.⁶

Education

Higher education is associated with improved health outcomes and social development at the individual and community levels.⁷ People with less education are more likely to experience health issues, such as obesity, substance use and injury.⁸ The health benefits of higher education include better access to resources, safer and more stable housing, and better engagement with providers. Proximate factors associated with low education that affect health outcomes include the inability to navigate the health care system, educational disparities in personal health behaviors, and exposure to chronic stress.⁹

Figure 7 shows the towns in the service area where the percentage of the population with less than a high school diploma was significantly high compared to the Commonwealth overall.

Figure 7: Percent of Residents with Less Than a High School Diploma



Source: U.S. Census Bureau 5-Year Estimates, 2012-2016

⁶ Raj Chetty, Michael Stepner, Sarah Abraham, Shelby Lin, Benjamin Scuderi, Nicholas Turner, Augustin Bergeron, and David Cutler, "The Association Between Income and Life Expectancy in the United States, 2001-2014," *Journal of the American Medical Association* 315, no. 16 (April 26, 2016): 1750-1766.

⁷ Emily B. Zimmerman, Steven H. Woolf, and Amber Haley, "Population Health: Behavioral and Social Science Insights – Understanding the Relationship Between Education and Health," Agency for Healthcare Research and Quality Web Site, <https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html>, September 2015

⁸ Centers for Disease Control and Prevention, "Adolescent and School Health: Health Disparities," Centers for Disease Control and Prevention Web Site, <https://www.cdc.gov/healthyyouth/disparities/index.htm>, August 17, 2018

⁹ Zimmerman, *Population Health*

Employment, Income, and Poverty

Lack of gainful and reliable employment is linked to several barriers to care, such as lack of health insurance, inability to pay for health care services and copays, and inability to pay for transportation that would enable them to receive services. In many key informant interviews, stakeholders stressed that certain populations struggle to find and retain employment for a variety of reasons—ranging from mental and physical health issues, to lack of childcare, to transportation issues and other factors. In Brockton (7%) and Rockland (8%), the unemployment rate among civilian labor force was significantly higher than the Commonwealth overall (5%).

Like education, income impacts all aspects of an individual's life, including the ability to secure housing, needed goods (e.g. food, clothing), and services (e.g. transportation, healthcare, childcare). It also affects one's ability to maintain good health. While many of the municipalities had median household incomes that were significantly higher than the Commonwealth overall, key informant interviewees and focus group/forum participants reported that there were pockets of poverty throughout the service area, even in towns that were considered to be affluent.

- In Brockton, Quincy, and Randolph, the median household income was significantly lower than the Commonwealth overall.
- In Brockton, the percentage of all residents, families, those under 18, those over 65, and female headed households living below the federal poverty line (18%), was significantly higher than the Commonwealth overall.

III. KEY FINDINGS: SOCIAL DETERMINANTS OF HEALTH AND BARRIERS TO CARE

The social determinants of health are the conditions in which people live, work, learn and play.¹⁰ These conditions influence and define quality of life for many segments of the population in the CHNA service area. A dominant theme from key informant interviews and community forums was the tremendous impact that the underlying social determinants, particularly housing and transportation, have on residents in the service area.

HOUSING

Lack of affordable housing and poor housing conditions contributes to a wide range of health issues, including respiratory diseases, lead poisoning, infectious disease and poor mental health.¹¹ At the extreme are those without housing, including those who are homeless or living in unstable or transient housing situations. They are more likely to delay medical care and have mortality rates four times higher than those who have secure housing.¹²

According to a 2013 study of America's 25 largest cities, lack of affordable housing was the leading cause of homelessness. Adults who are homeless or living in unstable situations are more likely to experience mental health issues, substance use, intimate partner violence and trauma; children in similar situations have difficulty in school and are more likely to exhibit antisocial behavior.¹³ Many key informants and participants in forums and focus groups expressed concern over the limited options for affordable housing and how this affects all individuals, including families with children, young professionals, and older adults with fixed incomes. Most homes in the service area were owner-occupied. Figure 7 shows towns in the service area that had a significantly high percentage of renter-occupied units compared to the Commonwealth overall.

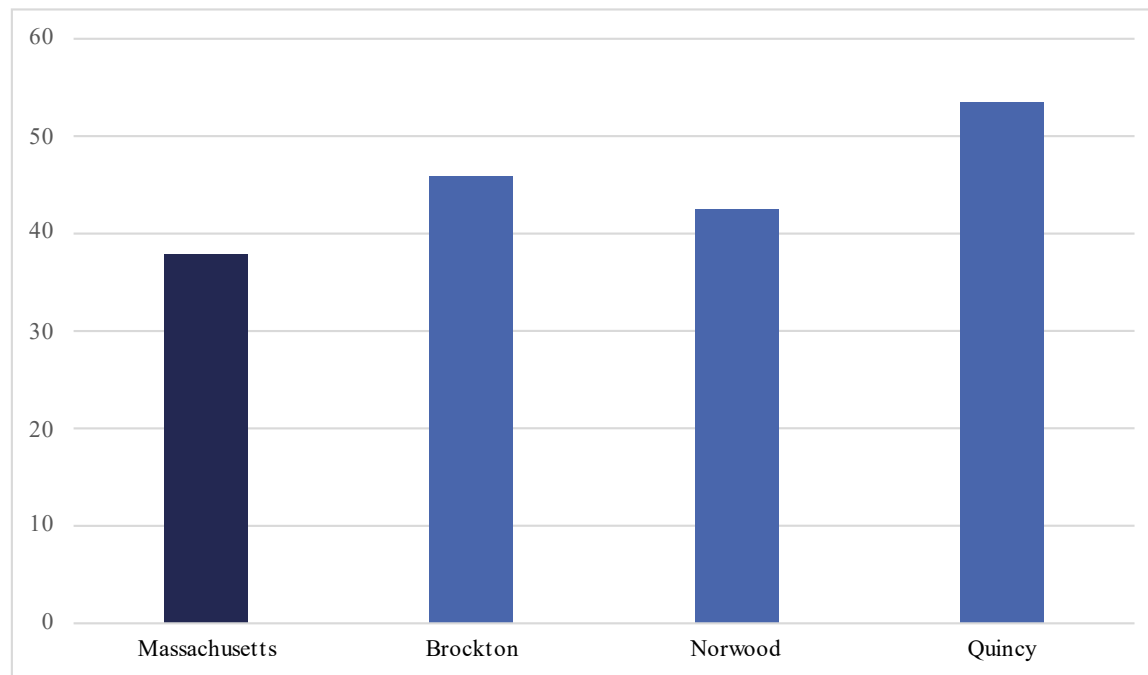
¹⁰ Centers for Disease Control and Prevention, "Social Determinants of Health: Know What Affects Health," Centers for Disease Control and Prevention Web Site, <https://www.cdc.gov/socialdeterminants/>, January 29, 2018.

¹¹ James Krieger and Donna L. Higgins, "Housing and Health: Time Again for Public Health Action," *American Journal of Public Health* 92, no. 5 (2002): 758-768.

¹² Thomas Kottke, Andriana Abariotes, and Joel B. Spoonheim, "Access to Affordable Housing Promotes Health and Well-Being and Reduces Hospital Visits," *The Permanente Journal* 22, (2018): 17-079.

¹³ Kottke, *Access to Affordable*

Figure 8: Percent of Renter-Occupied Units



Source: U.S. Census Bureau 5-Year Estimates, 2012-2016

TRANSPORTATION

Lack of transportation has a significant impact on access to health care services and is a determinant of whether an individual or family has the ability to access the basic resources that allow them to live productive and fulfilling lives. Access to affordable and reliable transportation widens opportunity and is essential to addressing poverty, unemployment and goals such as access to work, school, healthy foods, recreational facilities and a myriad of other community resources.

There is very limited data to characterize issues related to transportation. However, interviewees, focus group/forum participants, and survey respondents felt that transportation was a critical barrier to health and access to care. Many reported that it was easier to get in and out of Boston than it was to get around the South Shore. For those living outside the limits of Massachusetts Bay Transit Authority (MBTA) service area, options were particularly limited.

FOOD ACCESS

Issues related to food insecurity, food scarcity and hunger are often discussed as risk factors to poor physical and mental health for both children and adults. There is an overwhelming body of evidence to show that many families, particularly low-income families of color, struggle to access food that is affordable, high-quality and healthy. While it is important to have grocery stores placed throughout a community to promote access, research shows that

there are a number of factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food and cultural appropriateness of food offerings.¹⁴ Increasingly, food pantries are used as long-term strategies to supplement monthly shortfalls in food. Pantries and community meal programs have evolved from providing temporary or emergency food assistance to providing ongoing support for individuals, families, seniors living on fixed income, people with disabilities and adults working multiple low-wage jobs to make ends meet.

Many interviewees and community forum participants mentioned local efforts to combat food insecurity and provide education on healthy choices. Although many are working towards total food security in the region, some felt there was still work to be done.

- In Brockton (29%) and Randolph (19%), a significantly greater percentage of the population received Food Stamp/SNAP benefits in the past 12 months compared to the Commonwealth overall (13%).

HEALTH LITERACY

Health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions. Low health literacy can have a major impact on health, as patients can have difficulty locating providers, following doctors' instructions, understanding medication directions and managing chronic conditions, among other issues.

Populations most likely to experience low health literacy are older adults, racial/ethnic minorities, people with low levels of education, low-income individuals, non-native speakers of English, and people with compromised health status.¹⁵ During community forums and interviews, the need for improved health literacy arose as a key priority, especially for new immigrants and refugees. Immigrants experience higher rates of morbidity and mortality than other segments of the population, and disproportionately suffer from a number of serious diseases. It is important for health providers and support staff to adopt culturally sensitive communication practices to improve the health literacy of immigrant populations.¹⁶

¹⁴ The Food Trust, "Access to Healthy Food and Why It Matters: A Review of the Research,"

http://thefoodtrust.org/uploads/media_items/executive-summary-access-to-healthy-food-and-why-it-matters.original.pdf

¹⁵ Office of Disease Prevention and Health Promotion, "Quick Guide to Health Literacy Fact Sheet: Health Literacy Basics,"

<https://health.gov/communication/literacy/quickguide/factsbasic.htm>

¹⁶ GL Kreps and L Sparks, "Meeting the Health Literacy Needs of Immigrant Populations," *Patient Education and Counseling* 71, no. 3 (2008): 328-332.

IV. KEY FINDINGS: BEHAVIORAL RISK FACTORS AND HEALTH STATUS

At the core of the CHNA process is understanding access-to-care issues, leading causes of morbidity and mortality, and of the extent to which populations and communities participate in certain risky behaviors. This information is critical to assessing health status, clarifying health-related disparities and identifying health priorities. This assessment captures a wide range of quantitative data from federal and municipal data sources. Qualitative information gathered from key informant interviews, focus groups, forums, and the community health survey informed this section of the report by providing perspective on the confounding and contributing factors of illness, health priorities, barriers to care, service gaps and possible strategic responses to the issues identified. This data augmented the quantitative data and allowed for the identification of the demographic and socioeconomic populations most at risk of experiencing barriers to care that have historically affected minority groups disproportionately.

BEHAVIORAL RISK FACTORS

There is a clear connection between certain health risk factors—such as obesity, lack of physical exercise, poor nutrition, tobacco use and alcohol abuse—and health status, the burden of physical chronic and complex conditions, and issues related to mental health and substance use. Among interviewees, there was a strong feeling certain populations, like racial/ethnic minorities and low-income individuals, were more likely to experience poor outcomes related to health risk factors.

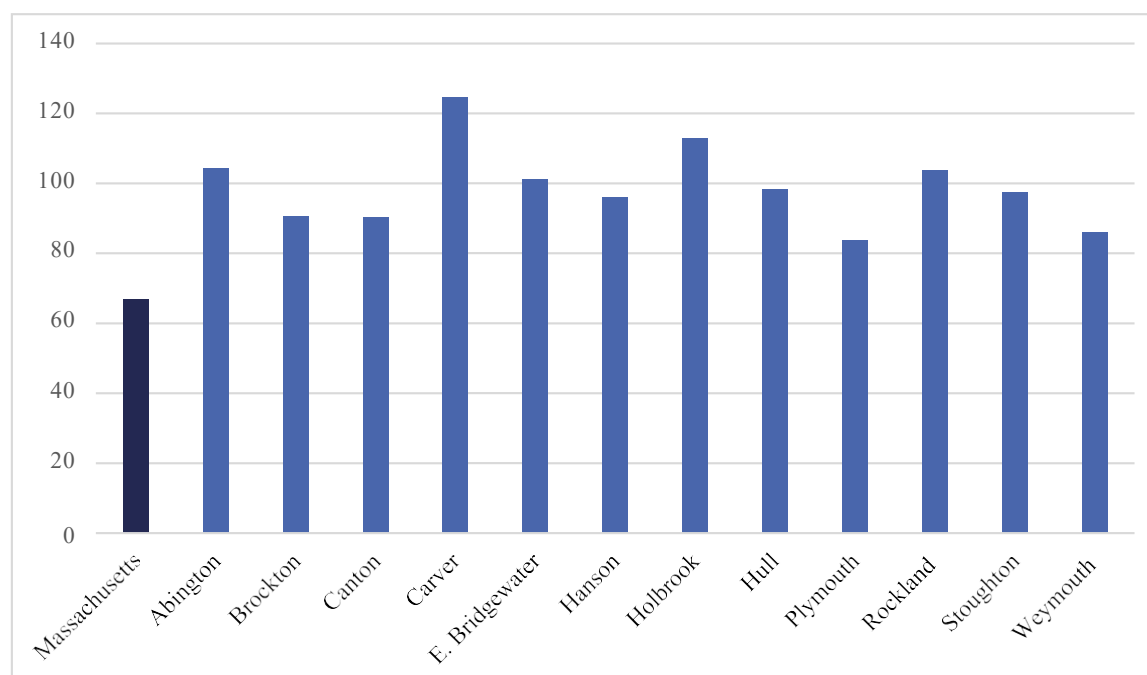
Nutrition, Fitness, and Obesity

Lack of physical fitness and poor nutrition are among the leading risk factors associated with obesity and chronic health issues. Adequate nutrition helps prevent disease and is essential for the healthy growth and development of children and adolescents, while overall fitness and the extent to which people are physically active reduce the risk for many chronic conditions and are linked to good emotional health. Over the past two decades, obesity rates in the United States have doubled for adults and tripled for children. Overall, these trends have spanned all segments of the population, regardless of age, sex, race, ethnicity, education, income or geographic region.

Figure 9 includes those towns in the service area where the rate of obesity hospitalizations

was significantly high compared to the Commonwealth overall.

Figure 9: Obesity Hospitalizations (Age-Adjusted Rates Per 100,000)



Source: Massachusetts Inpatient Discharges, 2008-2012 (from Massachusetts Department of Public Health)

Tobacco and E-Cigarettes

Reducing tobacco use is the single most effective way to prevent death and disease in the U.S. Each year, more than 480,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 30 more people suffer with at least one serious tobacco-related illness, such as chronic airway obstruction, heart disease, stroke or cancer.

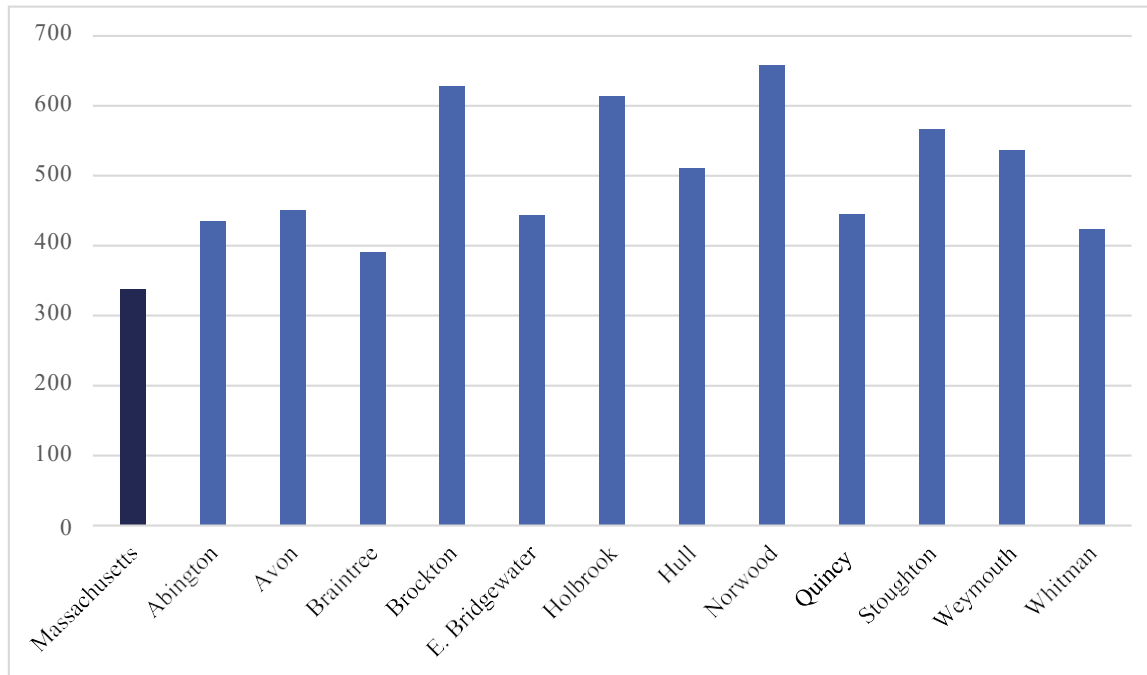
Interviewees and participants in focus groups and forums identified e-cigarette/vaping use as an emerging area of concern for young people. While originally thought of as a safer alternative to cigarettes, the effects of using electronic cigarettes remain to be seen. What is known, however, is that these products, depending on the device used, may be used discreetly in schools, restaurants and other public places. Furthermore, these products are available in a variety of flavors, making them more attractive to children and teens.

Alcohol Use

Risky behaviors related to alcohol are strongly correlated with chronic medical and mental health issues. Alcohol abuse raises the risk of developing chronic illnesses and increases the severity of illnesses once they emerge. Although much recent national and regional dialogue centers on the opioid epidemic, alcohol was also mentioned as an issue in the realm of substance misuse.

Figure 10 shows those towns in which alcohol/substance use-related hospitalizations were significantly high compared to the Commonwealth overall.

Figure 10: Alcohol/Substance Use-Related Hospitalizations (Age-Adjusted Rates Per 100,000)



Source: Massachusetts Inpatient Discharges, 2008-2012 (from Massachusetts Department of Public Health)

HEALTH STATUS ISSUES

Health Insurance and Access to Care

Whether an individual has health insurance—and the extent to which it helps to pay for needed acute services and access to a full continuum of high-quality, timely and accessible preventive and disease management or follow-up services—has been shown to be critical to overall health and well-being. Access to a usual source of primary care is particularly important, since it greatly affects the individual's ability to receive regular preventive, routine and urgent care—and to manage chronic diseases.

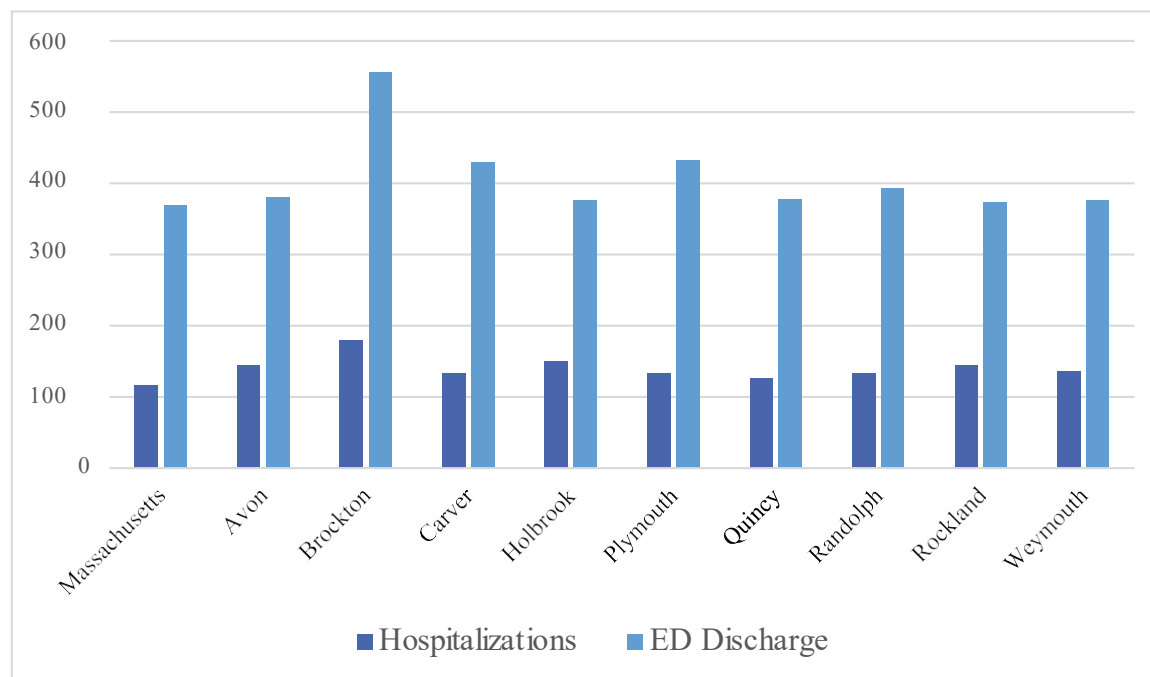
While Massachusetts has one of the highest health insurance coverage rates in the U.S., there are still pockets of individuals without coverage, including young people, immigrants and refugees, as well as those with low incomes. In Avon (6.0) and Brockton (4.2), the percentage of the population without health insurance was significantly higher than the Commonwealth overall (3.2).

All-Cause Hospitalization, Emergency Discharge, and Mortality

It is important to understand that certain populations face barriers to care that drive inappropriate hospital utilization and high rates of chronic disease. For example, individuals awaiting citizenship may delay seeking routine and preventative care out of fear of deportation, and utilize the emergency department more often than those with access to primary care. All-cause hospitalization, emergency discharge, and mortality rates do not indicate that all residents of a municipality have equal or similar access to care simply based on proximity to services. For example, not all residents in Weymouth have better access to health services than those in other municipalities, simply because they live closer to the hospital.

Figure 11 shows those towns in the service area in which hospitalization and emergency discharge rates were significantly high compared to the Commonwealth overall.

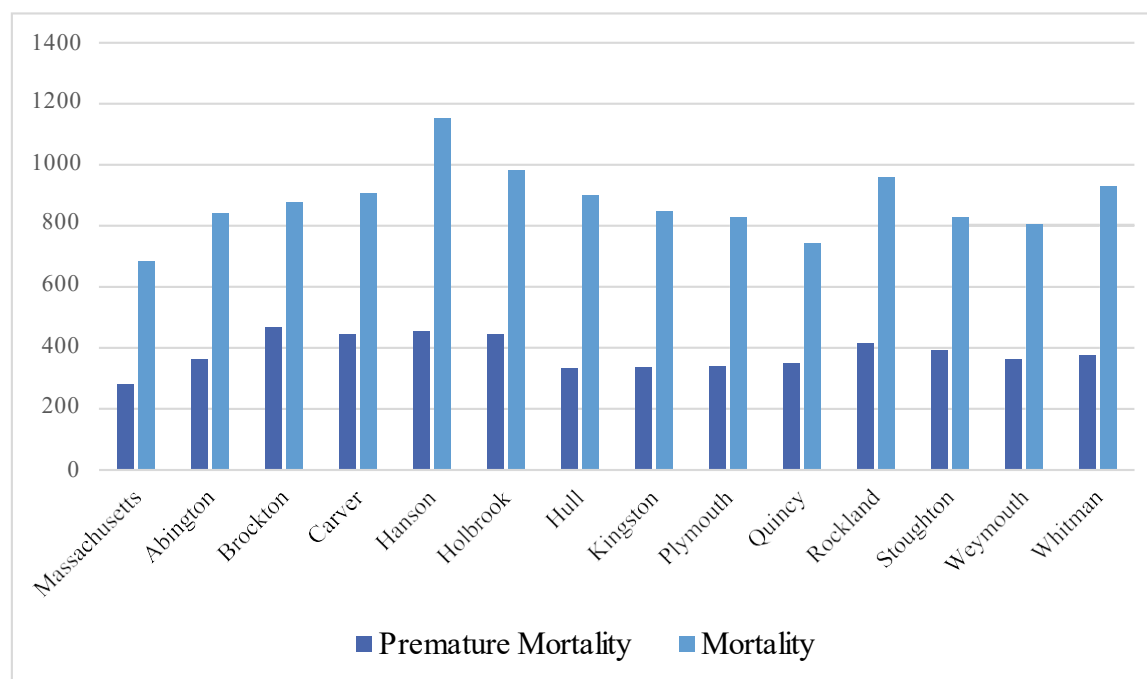
Figure 11: All-Cause Hospitalizations and ED Discharges (Age-Adjusted Rates per 100,000)



Source: Massachusetts Inpatient and Emergency Department Discharges, 2008-2012 (from Massachusetts Department of Public Health)

Figure 12 shows those towns in the service area in which premature mortality and all-cause mortality rates were significantly high compared to the Commonwealth overall.

Figure 12: Premature Mortality and All-Cause Mortality (Age-Adjusted Rates per 100,000)



Source: Massachusetts Department of Public Health, Vital Statistics (2015)

Chronic and Complex Conditions

Chronic and complex diseases such as heart disease, stroke, cancer and diabetes are responsible for approximately 7 in 10 deaths each year. Treating people with chronic conditions accounts for 86% of our nation's health care costs. Half of all American adults (ages 18 and over) have at least one chronic condition. Nearly 1 in 3 have multiple chronic conditions. Perhaps most significantly, chronic diseases are largely preventable, despite their high prevalence and dramatic impact. This underscores the need to focus on health risk factors, primary care engagement and evidence-based chronic disease management. There was broad, if not universal, acknowledgement and awareness of these pervasive health issues among interviewees and most forum participants.

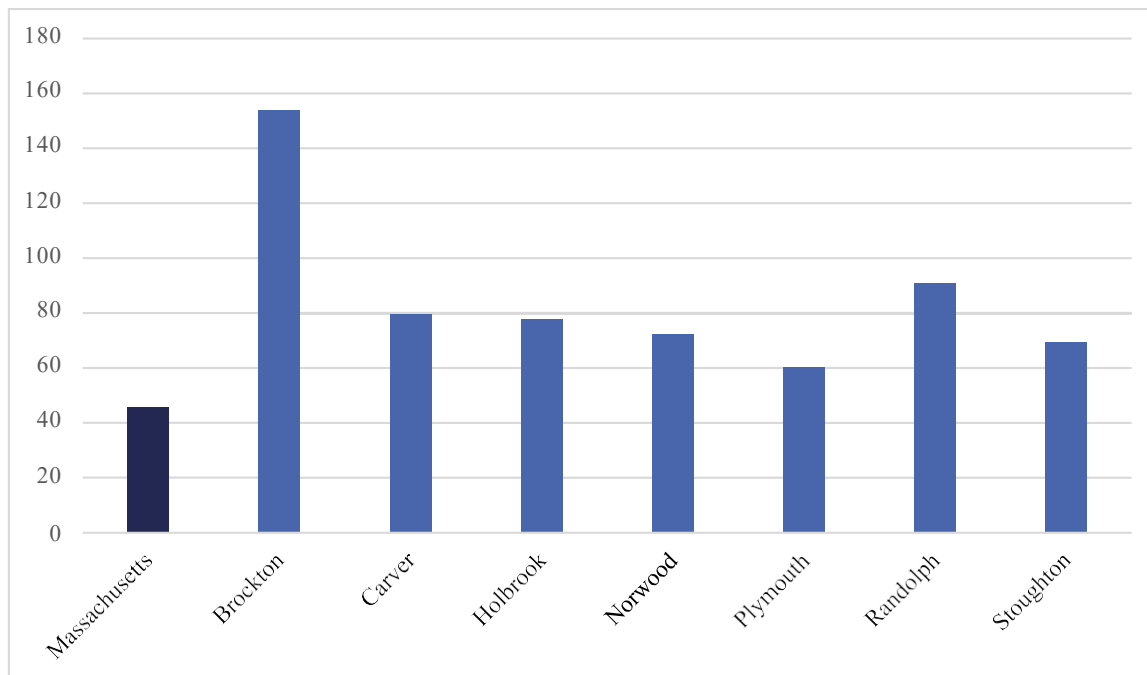
Cardiovascular and Cerebrovascular Disease

Cardiovascular and cerebrovascular diseases are affected by a number of health and behavioral risk factors, including obesity and physical inactivity, as well as the use of and environmental exposure to tobacco and alcohol use. Hypertension, or high blood pressure, increases the risk of more serious health issues, including heart failure, stroke and other forms of major cardiovascular disease. Racial disparities in hypertension and related disease outcomes are well documented. African-American men and women are at an increased risk for hypertension compared to their White counterparts, which has dramatic effects on life expectancy. The age of onset for stroke is earlier for African Americans, and the stroke

mortality rate is double compared to White individuals.¹⁷

- In Brockton (154.0), Carver (79.7), Holbrook (77.7), Norwood (72.1), Plympton (60.4), Randolph (90.7), and Stoughton (69.4), hypertension hospitalization rates were significantly higher than the Commonwealth overall (45.5) (*Figure 13*)
- In Bridgewater (208.2), Brockton (192.5), West Bridgewater (247.7), the heart disease mortality rate was significantly higher than the Commonwealth overall (138.7).

Figure 13: Hypertension Hospitalizations (Age-Adjusted Rates per 100,000)



Source: Massachusetts Inpatient Discharges, 2008-2012 (from Massachusetts Department of Public Health)

Cancer

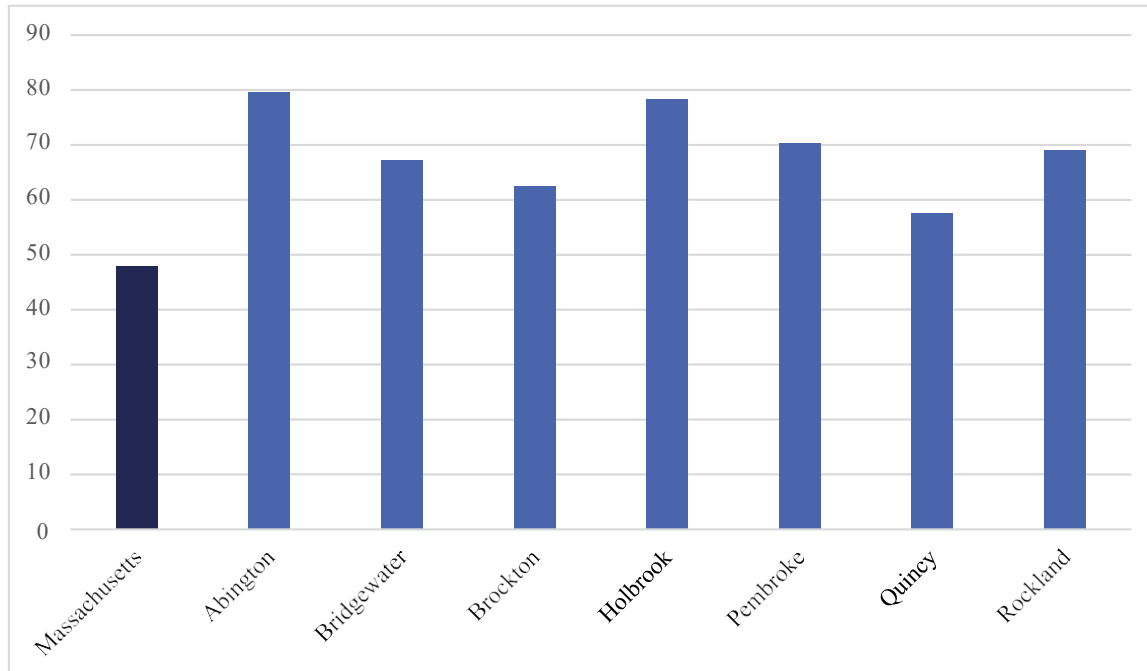
Experts have identified risk and causal factors associated with cancer, but more research is needed to understand many unknowns. The majority of cancers occur in people who have no known risk factors, though the most common risk factors are well known: age, family history of cancer, smoking, overweight/obesity, excessive alcohol consumption, unprotected exposure to the sun, unsafe sex and exposure to airborne environmental and occupational pollutants. Outcomes and death rates resulting from all forms of cancer show major disparities, which are directly associated with race, ethnicity, income and comprehensive medical health insurance coverage, or lack thereof.

- In Brockton (184.4) and Marshfield (220.7), the all-cause cancer mortality rate was significantly higher than the Commonwealth overall (152.8).

¹⁷ Daniel T. Lackland, "Racial Differences in Hypertension: Implications for High Blood Pressure Management," *American Journal of Medical Sciences* 348, no. 2 (2014): 135-138.

- In Braintree (58.0), Easton (60.8), Pembroke (2.4), Plymouth (77.7), and Stoughton (66.9), the rate of breast cancer hospitalizations was significantly higher than the Commonwealth overall (39.08).
- In Abington (79.6), Bridgewater (67.3), Brockton (62.), Holbrook (78.3), Pembroke (70.4), Quincy (57.6), and Rockland (69.1), the rate of lung cancer hospitalizations was significantly higher than the Commonwealth overall (47.9). (*Figure 14*)

Figure 14: Lung Cancer Hospitalizations (Age-Adjusted Rate per 100,000)



Source: Massachusetts Inpatient Discharges, 2008-2012 (from Massachusetts Department of Public Health)

Respiratory Diseases

Respiratory diseases, such as asthma and chronic obstructive pulmonary disorder (COPD), are exacerbated by behavioral, environmental and location-based risk factors, including smoking, diet and nutrition, substandard housing and environmental exposures (e.g., air pollution, secondhand smoke).

- In Avon (231.0), Norwood (198.6), Randolph (252.1), Rockland (238.9), Weymouth (184.2), and Whitman (170.0), asthma hospitalization rates were significantly higher than the Commonwealth overall (151.9).
- In Quincy (46.6), the chronic lower respiratory disease mortality rate was significantly higher than the Commonwealth overall (33.0).

Mental Health

Mental health—including depression, anxiety, stress, serious mental illness and other conditions—was overwhelmingly identified as the leading health issue for residents of the South

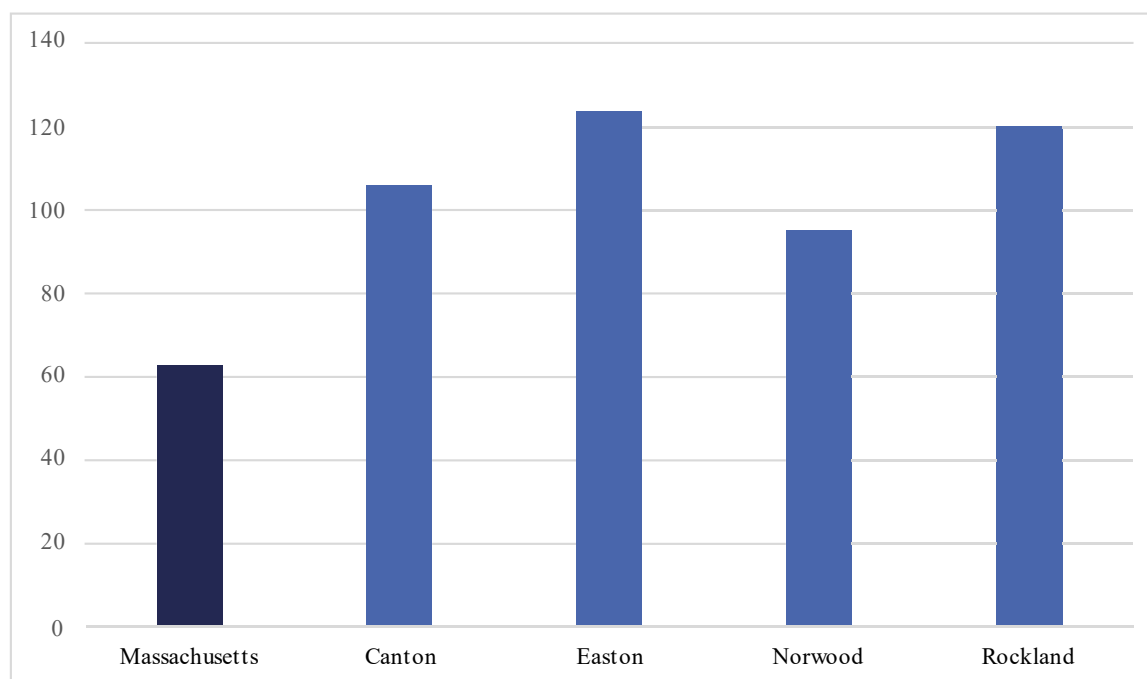
Shore Region. Individuals from across the health service spectrum discussed:

- The burden of mental health related to the level of generalized stress and anxiety felt by the general public
- Co-morbidity among those with substance use issues
- The prevalence of mild to moderate depression across all segments of the population
- The prevalence of anxiety and stress among youth and adolescents, attributed to pressure to succeed at school, social media/bullying, etc.
- Social isolation amongst older adults

There was consensus that there was a strong network of service providers, advocates, and coalitions/task forces working to address these issues in the region.

- In Brockton (1,290.1), Holbrook (949.4), Norwood (1,460.2), and Stoughton (894.8), the mental disorder hospitalization rate was significantly higher than the Commonwealth overall (837.9).
- In Canton (105.9), Easton (123.6), Norwood (95.2), and Rockland (121.8), the mental disorder mortality rate was significantly higher than the Commonwealth overall (62.9).
(Figure 15)

Figure 15: Mental Disorder Mortality (Age-Adjusted Rate per 100,000)



Source: Massachusetts Department of Public Health, Vital Statistics (2015)

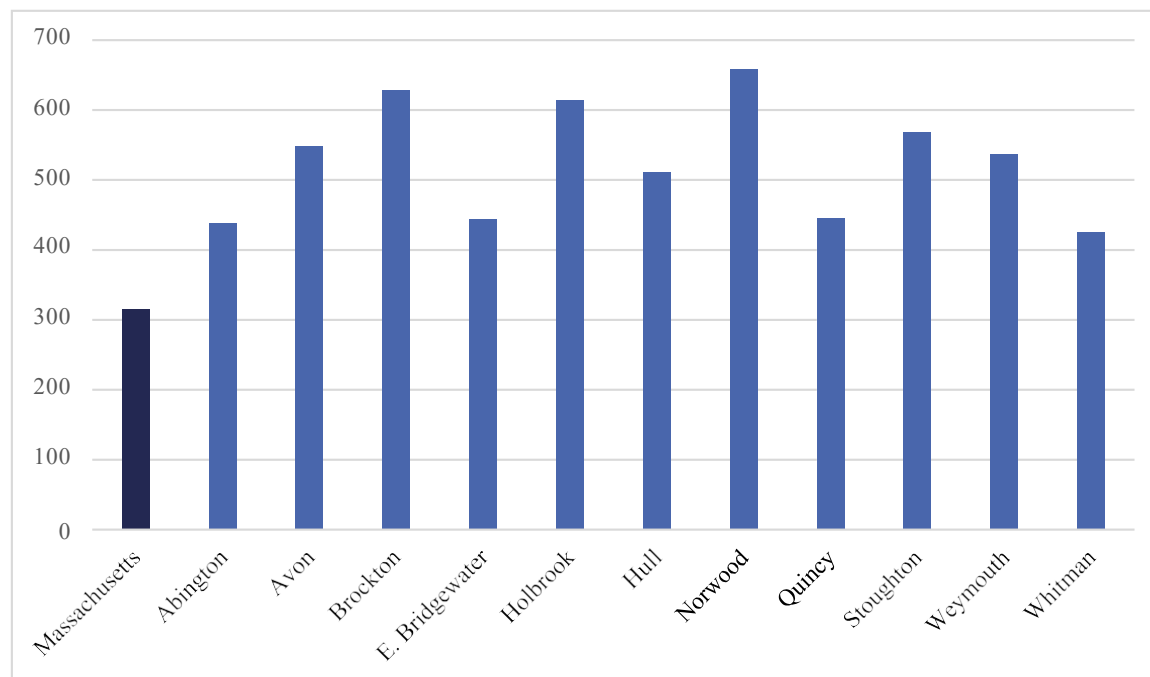
Substance Use (Opioids, Alcohol, and Other Drugs)

Second to mental health, substance use was named as a leading health issue among key informants and focus group/forum/survey participants. Behavioral health providers reported that

individuals continue to struggle to access care services, including rehabilitation and detox, outpatient treatment and medication-assisted treatment. As with mental health services, there are a number of community partners working to fill service gaps and address the needs of both individuals and the at-large community, although some individuals may face delays or barriers to care due to limited providers and specialists, limited treatment beds and social determinants that impede access (e.g., housing, employment, transportation, etc.). Participants were particularly concerned about the effects of the opioid epidemic on the individuals using drugs, and their children and families.

- In Abington (437.7), Avon (548.2), Brockton (578.9), East Bridgewater (443.8), Holbrook (603.6), Hull (478.2), Norwood (698.4), Quincy (381.1), Rockland 9531.8), Stoughton (541.4), Weymouth (517.4), and Whitman (427.8), the opioid hospitalization rate was significantly higher than the Commonwealth overall (315.6). (*Figure 16*)
- In Brockton (51.6), Hanson (96.1), Quincy (43.6), and Weymouth (47.1), the rate of opioid-related fatal overdoses were significantly higher than the Commonwealth overall (24.6).

Figure 16: Opioid Hospitalizations (Age-Adjusted Rates per 100,000)



Source: Massachusetts Inpatient Discharges, 2008-2012 (from Massachusetts Department of Public Health)

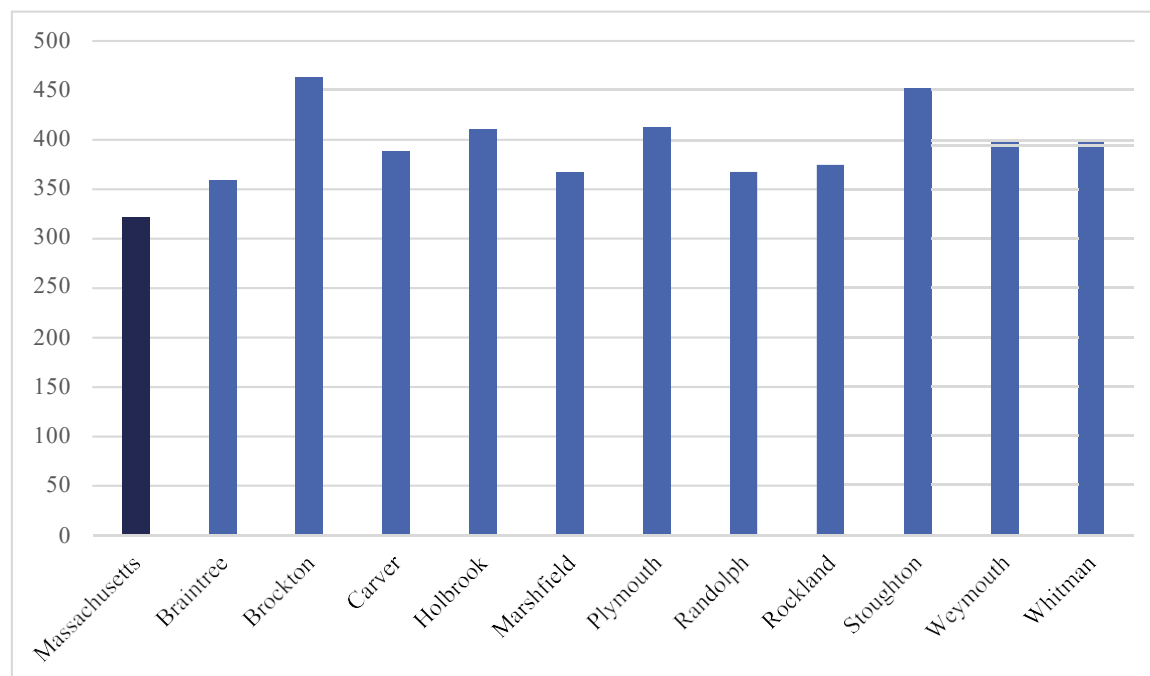
Infectious Disease

Though great strides have been made to control the spread of infectious diseases in the U.S., they remain a major cause of illness, disability and even death. STIs, diseases transmitted through drug use, vector-borne illnesses, tuberculosis, pneumonia and influenza are among the infectious diseases that have the greatest impact on modern American populations.

Though not named as a major health concern by interviewees or participants of forums and focus groups, disease burden must be tracked to prevent outbreaks and identify patterns in morbidity and mortality. Young children, older adults, individuals with compromised immune systems, injection drug users and those having unprotected sex are most at risk for contracting infectious diseases.

- In Bridgewater (358.7), Brockton (463.4), Cohasset (388.9), Holbrook (411.0), Marshfield (367.7), Plymouth (412.8), Randolph (367.6), Rockland (374.8), Stoughton (453.3), Weymouth (395.2), and Whitman (399), the influenza hospitalization rate was significantly higher than the Commonwealth overall (322.2). (*Figure 17*)
- In Brockton (26.6), the HIV/AIDS hospitalization rate was significantly higher than the Commonwealth overall (12.4).
- In Brockton (37.3) and Hanover (63.0), the infectious and parasitic disease mortality rate was significantly higher than the Commonwealth overall (18.9).

Figure 17: Influenza Hospitalizations (Age-Adjusted Rates per 100,000)



Source: Massachusetts Inpatient Discharges, 2008-2012 (from Massachusetts Department of Public Health)

V. POPULATION AND COMMUNITY HEALTH PRIORITIES

Once the assessment's findings were compiled, the Advisory Committee together to participate in a strategic planning prioritization retreat on December 4, 2018. This meeting involved a diverse, representative group of 20 participants, including representatives from SSH's leadership and staff, local health departments, health and social service providers, and other community-based groups. The retreat allowed participants to:

- 1) Review and discuss the full breadth of quantitative and qualitative findings from Phases One and Two of the assessment process, and
- 2) Discuss and agree on SSH's community benefits community health priorities and priority populations.

A presentation was made at the outset of the meeting summarizing key findings related to community characteristics, social determinants of health, substance use, mental health, chronic/complex conditions and health system challenges. After the presentation, participants were given the opportunity to ask questions and provide their input, which helped to augment and clarify the findings collected to-date. After this initial full group session, the retreat participants split up into four breakout groups of 4-5 people each to deliberate on the full breadth of information compiled by the assessment, including all of the quantitative data and the qualitative information provided through the project's interviews, focus groups, community forums, and community survey. The breakout groups were provided all of the quantitative data compiled by the assessment (See Appendix B) as well as a document summarizing all of the qualitative information compiled through the assessments engagement activities. During these small breakout groups, participants were asked to review the data provided and to try to come to agreement on what they thought were the three most significant unmet community health issues (e.g., social determinants, barriers to care, health risk factors, and health issues) and the three population segments most at-risk. After the small breakout groups, participants came back together to share the results of the breakout discussions and ultimately to agree on a set of ranked community health priorities and priority populations.

PRIORITY POPULATIONS

Based on the deliberations at the retreat, the following populations within SSH's service area were identified as most vulnerable and likely to face the greatest disparities in access and health outcomes.

- Youth and Adolescents
- Older Adults

- Low to Moderate Income Individuals and Families
- Racial/Ethnic Minorities and Non-English Speakers
- Individuals with Chronic & Complex Conditions

The following is a brief discussion of the rationale for selecting these segments and the challenges they face.

Youth and Adolescents

Youth and adolescents were identified as among the most vulnerable and at-risk populations in the region. Participants' reasons for believing this group should be prioritized varied but included the impacts of substance use, depression, stress, and anxiety as well as poor nutrition, inactive lifestyles, and the impacts of family trauma and instability at home.

Adolescence is a critical transitional period that includes biological and developmental milestones that are important to establishing long-term identity and independence, but can lead to conflict, isolation and tension between adolescents and parents or caregivers. During this time, young people may struggle to access health education and information, social services, or may be seen by providers that misunderstand the needs of those in this age group. Although adolescents are generally healthy, they do struggle with health and social issues, such as obesity (e.g., poor nutrition and lack of physical activity), mental health (e.g., depression, anxiety, suicide), substance use (e.g., cigarettes/vaping, marijuana, alcohol, opiates), sexually transmitted infectious, and injuries due to accidents.¹⁸

Older Adults

According to quantitative data and qualitative information gathered through interviews, focus groups, and community forums, the health of older adults is considered one of the highest priorities in the South Shore region. This is true throughout the service area, but is particularly true in the suburban areas. Besides chronic disease, the impacts of poverty, affordable housing, transportation, and lack of family support/isolation were identified as the leading health issues. As some of the highest utilizers of health services and specialty care, older adults are more at risk of experiencing poor care coordination and gaps in health care, such as specialty care, behavioral health and case management services. While clinical integration and care coordination efforts have been improved, fragmentation of care persists. Many cite the need for geriatric services, specialty providers, and long-term care resources to support older adults in maintaining their independence.

The challenges faced by older adults came up in nearly every interview, focus group, and community forum. Older adults (65+) are among the fastest growing age groups in the United States and the Commonwealth. The first “baby boomers,” adults born between 1946 and 1964,

¹⁸ HealthyPeople, “Adolescent Health,” <https://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health>

turned 65 in 2011. Over the next 20 years, these baby boomers will continue to enter the older adult cohort. By 2030, the CDC and the Healthy People 2020 Initiative estimate that 37 million people nationwide (60% of the older adult population ages 65 and over) will need to manage more than one chronic medical condition. The ability to live independently and to “age in-place”—or to find the least restrictive housing option—is a major issue among older adults and their caregivers.

Low to Moderate Income Individuals and Families

There was a great deal of agreement from participants at the prioritization retreat as well as those who participated in interviews, focus groups, and community forums that those in low and moderate-income groups should be prioritized. Participants discussed the challenges that individuals and families face with respect to their health and overall well-being when they are forced to decide between housing, food, heat, health care services, childcare, transportation or other essentials. These choices often lead to missed care or delays in care, either due to the direct costs of care (co-pays and deductibles) or the indirect costs of transportation, childcare, or missed wages. Since housing and food are typically the most expensive of life’s essentials, these are seen as the most problematic issues. The choices that many are forced to make limit their ability to maintain a healthy, productive lifestyle or to live near their family or social support networks. There was nearly a consensus that lack of affordable low- and middle-income housing was a leading problem for the region. When asked about housing safety, several interviewees and participants of focus groups and forums noted that many residents are concerned about maintaining housing quality, particularly the mitigation of conditions that exacerbate asthma in children (e.g., mold, pests, insufficient heating and cooling systems, poor ventilation).

Participants also spoke of the intense challenges that many moderate income individuals and families face due to the high cost of living in the region combined with the fact that most of those in the middle-income group are not eligible for public programs like Medicaid, food stamps, Healthy Start, and other subsidized services. Many participants also commented on the increasing issues of homelessness and/or housing instability. Many commented that these burdens were increasing due to the opioid crisis and the lack of job opportunities and affordable housing, particularly for those between the ages of 45 and 64, who are not eligible for Medicare or social security.

Racial/Ethnic Minorities and Non-English Speakers

One of the most common comments and reflections about the health of the South Shore Region was the challenges that many racial/ethnic minorities and non-English face with respect to the social determinants, health care access, and overall health status. Information gathered from the assessment as well as information from the academic literature, highlight the disparities in health insurance status, access to care, and health outcomes that these segments face. These segments

also struggle with the tremendous impact of discrimination and racism. Many of those who were interviewed or participated in the needs assessment's interviews, focus groups, or community forums spoke of the inherent social injustices and inequities that remain in our society today.

As discussed above, racial/ethnic minorities and non-English speakers are more likely to be affected by language access, limited acculturation, limited health literacy and other social determinants of health like poverty, food access and transportation. They are also often affected by trauma, stress and uncertainty, due to their legal status. As a result, either directly or indirectly, these factors can often lead to disparities with respect to access to care and other health-related outcomes.

Individuals with Chronic & Complex Conditions

Though substance use and mental health were the focus for many key informants, providers, and residents, one cannot ignore that heart disease, stroke and cancer are the leading causes of death in the nation and the Commonwealth. Along with other conditions, including asthma and diabetes, these conditions are considered to be chronic and complex and can strike early in one's life, possibly ending in premature death. It is also important to note that the risk and protective factors for many chronic/complex conditions are the same, including tobacco use, lack of physical activity, poor nutrition, obesity, and alcohol use.

Individuals with chronic/complex conditions often face significant barriers to care (e.g., transportation, lack of health literacy, fragmented care). These issues are exacerbated for older adults and those that are disabled. Many key informants cited a need for care management, navigation, and care coordination for these populations. Several residents also suggested needs for caregiver support and resource programs.

COMMUNITY HEALTH PRIORITIES

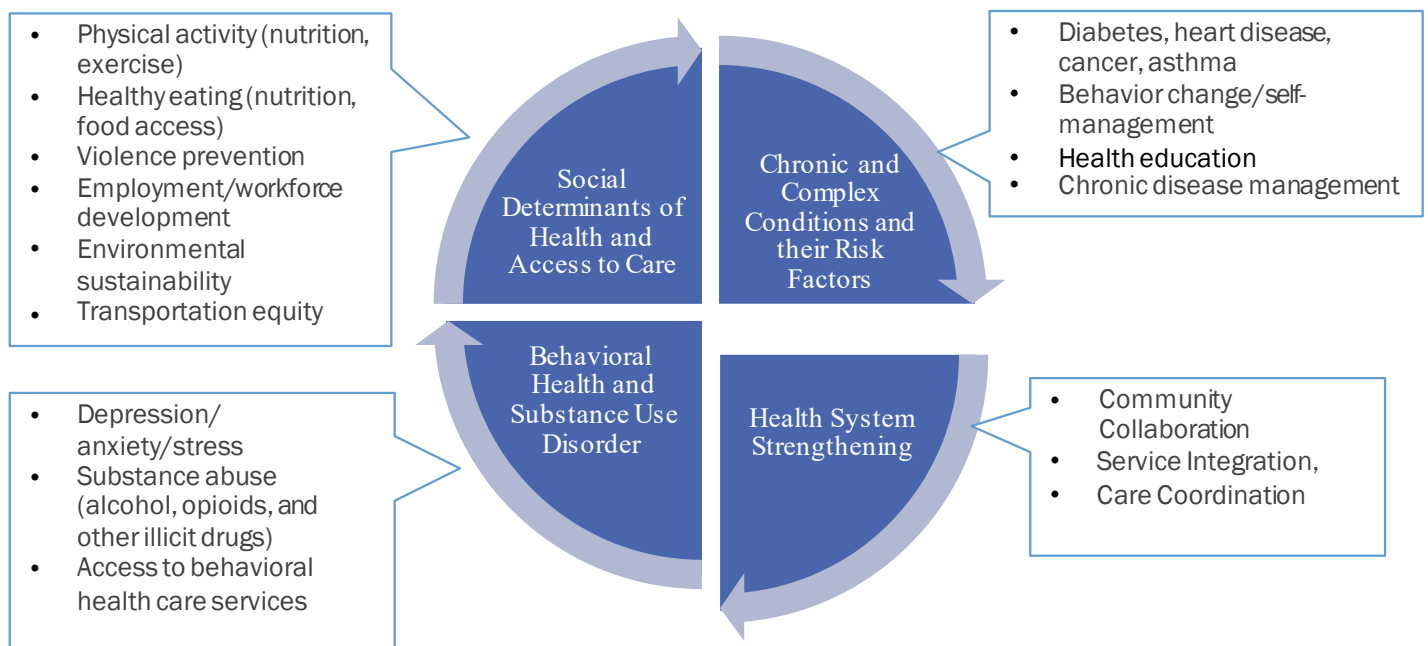
Behavioral Health and Substance Use Disorder

As it is throughout the Commonwealth and the nation, the burden of behavioral health and substance use/misuse on individuals, families, communities and service providers in the South Shore Region is overwhelming. Nearly every key informant interview, focus group and community forum included discussions on this topic. From a review of the quantitative and qualitative information, depression, anxiety, stress, alcohol, opioids and marijuana use are the leading issues in this domain. There was particular concern and discussion regarding the impact of depression and the opioid epidemic on the region.

When it comes to behavioral health and substance use, no segment of the population is left untouched, although different behavioral health issues or substances are of lesser or greater concern among some segments. Prevalence, incidence and service utilization rates (i.e., inpatient

hospitalization, emergency department visits and public program utilization) are higher in a number of cities/towns in the service area when compared to the Commonwealth. Community health interventions vary greatly depending on whether they target those with mild to moderate issues or severe issues. Those who participated in the retreat and the other qualitative components of the assessment thought both segments needed to be addressed.

Despite increased community awareness and sensitivity about the underlying issues and origins of behavioral health, substance use, and addiction, there is still a great deal of stigma related to these conditions. There is a general lack of appreciation for the fact that these issues are often rooted in genetics, physiology and environment, rather than an inherent, controllable character flaw. There is, however, a deep appreciation and a growing understanding for the role that trauma plays for many of those with behavioral health and/or substance use issues, with many people using illicit or controlled substances to self-medicate and cope with loss, violence, abuse, discrimination and other unresolved traumatic events. There are also major gaps in capacity when it comes to behavioral health and substance use services (i.e., screening, assessment and treatment), particularly for low-income, MassHealth-insured, uninsured or underinsured individuals.



Social Determinants of Health and Access to Care

A dominant theme from the strategic retreat as well as from the community interviews, focus groups and forums was the tremendous impact that underlying social determinants of health, particularly the impact that poverty/income, housing, transportation and access to healthy foods have on the entire population. These issues have an especially intense impact on low-income,

immigrants, non-English speakers and other vulnerable segments of the population. The single most common comment that we heard from participants when asked what the leading health-related issue were for residents of the region was affordable housing, poverty, transportation, and food access.

Improvements in health status begin with knowledge of the population's characteristics as well as the underlying social, economic, and environmental factors that affect health and health equity. More specifically, determinants such as poverty, employment opportunities, domestic and community violence, transportation, racial segregation, literacy, provider linguistic/cultural competency, social support, and community integration limit many people's ability to care for their own and/or their families' health. Lack of physical activity, poor nutrition, alcohol abuse, and tobacco are the leading risk factors for chronic disease and poor emotional health. Addressing these issues and developing healthy habits in these areas are among the most important things people of all ages can do to improve their health. Physical activity helps prevent many diseases (e.g. heart disease, diabetes and some cancers), strengthens bones and muscles, reduces stress and depression, and makes it easier for people to maintain a healthy body weight. Eating a healthy diet can help lower people's risk for heart disease, high blood pressure, diabetes, osteoporosis and certain cancers. Alcohol consumption and not using tobacco can dramatically reduce one chances of contracting heart disease, diabetes, or respiratory disease.

Chronic and Complex Conditions and their Risk Factors

Among those who participated in the assessment, mental health and substance use issues were widely perceived to be the leading health issues in the service area. Nonetheless, one cannot ignore the fact that heart disease, stroke and cancer are the leading causes of death in the nation, the Commonwealth and the South Shore Region. Roughly, 6 in 10 deaths may be attributed to these three conditions combined. If you include respiratory disease (e.g., asthma, COPD) and diabetes, which are in the top 10 leading causes across all geographies, then one can account for the vast majority of causes of death.

All of these conditions are typically considered to be chronic and complex and can often strike early in one's life, quite often ending in premature death. In this category, according to those who participated in the strategic retreat, interviews, focus groups and forums, heart disease, diabetes and hypertension were thought to be of the highest priority, although cancer was also discussed frequently. There are a number of cities and towns in the service area who have higher rates of certain types of cancer than in the Commonwealth overall. It is also important to note that the risk and protective factors for nearly all chronic/complex conditions are much the same, including tobacco use, lack of physical activity, poor nutrition, obesity and alcohol use.

Health System Strengthening

The South Shore region has a strong and comprehensive health care system that spans the full

health care, social service, community health, and public health continuum. There is also a strong and committed network of safety net institutions that help to ensure that residents get the services they need regardless of their ability to pay and the barriers they face. However, this does not mean that everyone in the SSH's service area receives the highest quality services when they want it and where they want it. In fact, as discussed above, despite the overall success of the Commonwealth's health reform efforts, data captured for this assessment shows that substantial segments of the population face significant barriers to care and struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers and shortages of providers willing to serve MassHealth-insured, low income, uninsured patients, or underinsured patients across the socio-economic spectrum.

Those who do not speak English or who are from cultures outside of the American mainstream face ongoing challenges. Health care and social service providers across the region strive to ensure appropriate linguistic access and to provide services that are culturally sensitive, yet many of those who were involved in the CHNA process expressed concerns that many non-English speakers face extreme challenges that hinder their ability to get the care they need for themselves and their families.

Many of those who participated in the assessment also reflected on how fragmented the system can be for those with complex needs who need to be seen by multiple providers. Referrals between providers and information sharing after a visit with a provider can be very challenging to manage and contributes to the difficulty many people have in navigating the system. This is true for all population segments but is particularly true for older adults, non-English speakers and immigrants.

Health service providers, including SSH, social service providers, community coalitions, local health departments, and the full range of other community-based organizations have made great strides in recent years to integrate services and coordinate care for the region across the continuum of care. However, as stated above care for many is still fragmented and poorly coordinated. It can also be challenging for service providers to share information and make referrals in ways that reduce stigma, facilitate patient engagement, improve care coordination, and promote improved health status. SSH and its partners need to continue to invest in efforts that build community capacity, encourage the free flow of information between patients and providers, and promote collaboration and partnership across the continuum.

Appendix A:

Community

Engagement Summary

South Shore Health

Summary of Community Engagement Activities

Community Interviews (26) Purpose: Community interviews were done to collect qualitative information from key health and social service providers, city/town officials, representatives from community organizations or advocacy groups, and other community leaders to: • Confirm and refine findings from secondary data • Provide community context • Clarify needs and priorities of the community. Methods: JSI worked with South Shore Health to identify a representative group of interviewees. Interviews were approximately 30-60 minutes long and were conducted by-phone using a structured interview guide created by the JSI Project Team. Detailed notes were taken for each interview.	See list of interviewees attached
Focus Groups (5) Purpose: Focus groups were conducted with key segments of the population, and/or key types of service providers or community stakeholders. This activity allows for the collection of targeted and nuanced information than what is gathered in a community forum or community health survey. Focus groups: • Augment findings from secondary data and key informant interviews • Allow for exploration of strategic and programmatic options to address identified health issues, service gaps, and/or barriers to care. Methods: Focus groups were conducted using a structured guide developed by the JSI Project Team. Each group lasted approximately 60 minutes depending on the size of the group. Participants were recruited by South Shore Health and community partners. Detailed notes were taken at each session and will be compiled and analyzed to identify key themes.	1. South Shore Health Patient Family Advisory Council (PFAC) 2. Behavioral Health Providers 3. Youth & Adolescent Services Providers 4. Public Safety 5. Community Health Network Area 23

Community Forums (5) Purpose: Community forums allow for the capture of information directly from community residents and, to some extent, representatives from local service providers or community organizations. Input is captured from residents on: • Community health needs and priorities • Service system gaps • Barriers to care across a wide array of health-related service and community resource domains (e.g., health, housing, transportation, safety, food access) Forums support the development of a sound and objective health needs assessment. Method: South Shore Health determined an appropriate host for the Community Forum to ensure that residents had an accessible and safe space to gather and share their thoughts. Forums will take place over a 60-90 minute period and will involve a structured and/or interactive set of plenary and group activities depending on the size of the group.	1. Weymouth Elder Services 2. Quincy YMCA 3. Hingham Elder Services 4. Marshfield Council on Aging 5. Abington Council on Aging
Community Health Survey Purpose: The Community Health Survey allowed for the capture of information directly from community residents. Input was captured from residents on: • Leading social determinants of health, clinical health issues, and vulnerable populations • Utilization and familiarity with hospital Community Benefit programming • Health services that are difficult to access Method: JSI worked with South Shore Health to develop a 10-minute Community Health Survey. Surveys were available online and in hard copy. Survey was open for approximately 1 month. Findings from online and hard copy surveys were integrated for final analysis.	80 Responses

South Shore Health Key Informant Interviewees

Dr. Gene Green, President & CEO, South Shore Health

Pam Whelton, Executive Vice President of South Shore Health System; President of South Shore Hospital

Jann Ahern, Vice President of Home & Community Health, South Shore Health

Tim Quigley, Senior Vice President & CNO, South Shore Health

Robert McCrystal, Blue Hills Community Health Network Area

Kym Williams, Program Director, Blue Hills Community Health Network Area

Cynthia Sierra, CEO, Manet Community Health Center

Eugene Welch, President & CEO, South Cove Community Health Center

Dr. Daurice Cox, President & CEO, Bay State Community Services

Antony Sheehan, President, Aspire

Christine Murphy, Founder, Cohasset Social Service League

Sandra Lindsey, CEO, South Shore Elder Services

Karen Peterson, Associate Executive Director, South Shore YMCA

Dr. Barbara Green, Youth Health Connection

Walter Sweeney, Chief of Police, Hanover

Eugene Duffy, Director of EMS/Paramedics, South Shore Health

Philip Chong, CEO, Quincy Asian Resources, Inc.

Lola Tom, Consultant and Community Activist

Heloisa Araujo, Family United Methodist Church

Beth Ann Strollo, CEO, Quincy Community Action Program

Jack Cocio, CEO, South Shore Community Action Council

Rick Doane, Executive Director, Interfaith Social Services

Melissa Pond, Principal Planner, City of Quincy

John Yazwinski, President/CEO, Father Bill's & MainSpring

Karen Vinciguerra, Human Resources, South Shore Health

Katelyn Szafir, Director of Health and Well-Being, South Shore YMCA

Appendix B:

South Shore Health

Data Book

South Shore Hospital Service Area Demographics & Social Determinants

Data Source: US Census Bureau, American Community Survey 2012-2016 5-Year Estimates

Data shaded in orange is statistically higher compared to the Commonwealth overall.
Data shaded in blue is statistically lower compared to the Commonwealth overall.

	Massachusetts	Plymouth County	Abington	Avon	Braintree	Bridgewater	Brockton	Canton	Caver	Cohasset	Duxbury	E. Bridgewater	Easton	Halifax	Hanover	Hanson	Hingham	Holbrook	Hull	Kingston	Marshfield	Milton	Norwell	Norwood	Pembroke	Plymouth	Plympton	Quincy	Randolph	Rockland	Scituate	Sharon	Stoughton	W. Bridgewater	Weymouth	Whitman		
Population																																						
Male (%)	48.3	48.7	43.8	50.7	47.1	53.3	48.0	46.4	49.0	49.0	47.3	45.6	48.4	48.0	48.3	51.3	47.0	49.0	48.0	45.0	46.0	46.0	49.3	48.0	49.0	48.0	52.0	48.0	46.0	51.0	48.0	48.0	47.0	51.0	47.0	48.0		
Female (%)	51.3	51.3	56.2	49.3	52.9	46.7	5.0	53.6	50.0	50.0	52.7	54.4	51.6	5.0	51.7	48.3	52.0	50.0	51.0	54.0	53.0	53.0	50.7	51.0	50.0	51.0	47.0	51.0	53.0	48.0	51.0	51.0	52.0	48.0	5.0	51.0		
Under 5 years (%)	5.4	5.3	5.3	4.0	5.3	4.3	7.0	5.0	2.0	0.0	4.8	4.4	4.0	3.0	6.3	4.4	0.0	0.0	3.0	4.0	5.0	6.0	6.0	5.0	4.0	4.0	6.0	5.4	5.0	6.0	4.0	0.0	5.0	4.0	6.0			
Under 18 years (%)	20.6	22.5	19.6	16.5	22.0	18.3	25.0	22.0	19.0	26.0	26.5	21.0	22.0	21.8	27.3	21.3	25.0	16.0	13.0	22.0	22.0	24.0	27.0	19.0	23.0	19.0	18.0	16.0	19.0	20.0	24.0	29.3	19.0	21.0	19.0	2.0		
25 to 54 years (%)	40.2	38.5	39.4	42.5	39.0	36.3	39.0	41.0	3.0	36.0	34.3	40.0	37.0	42.0	36.3	39.4	34.3	4.0	35.0	38.0	37.0	35.0	3.0	44.0	39.0	39.0	42.0	47.0	40.2	42.0	34.0	37.3	38.0	36.0	41.0	42.0		
Over 65 years (%)	15.3	16.2	14.5	17.8	16.4	12.8	1.0	17.0	19.0	15.4	16.9	17.0	13.0	14.5	1.0	1.0	21.0	15.0	21.0	16.0	15.0	15.0	17.0	17.0	13.0	19.0	15.0	15.0	15.0	16.0	18.0	14.0	18.0	18.0	16.0	12.0		
Civilian Veterans	6.4	8.3	8.9	7.6	7.4	7.7	5.0	6.0	10.0	7.0	6.5	6.0	9.3	5.5	7.4	6.0	8.0	9.0	8.0	8.0	8.0	5.0	8.0	6.0	8.0	9.0	9.0	5.0	5.0	7.0	7.0	5.0	6.0	9.0	7.0	8.0		
Disabled (Civilian noninstitutionalized population)	11.6	11.3	12.4	15.4	11.7	8.2	14.6	10.0	12.0	0.0	7.0	12.0	0.0	7.5	8.5	10.0	8.0	15.0	13.0	10.0	10.0	8.0	8.0	11.0	10.0	10.0	11.0	11.0	14.8	14.0	7.0	7.8	12.0	9.0	1.0	10.0		
Race, Ethnicity, Origin																																						
White alone (%)	79.3	84.6	92.6	76.0	82.4	86.0	44.0	83.0	94.0	98.0	97.3	95.0	91.0	97.0	95.7	94.0	96.0	82.0	95.0	96.0	95.0	75.0	97.0	84.0	94.0	93 (1.2)	97.0	63.0	41.0	93.0	96.0	79.0	76.0	91.0	86.0	95.0		
Black or African American alone (%)	7.3	9.3	2.5	11.6	4.3	7.4	41.0	5.0	1.0	0.0	0.5	0.0	4.0	1.0	0.6	2.0	0.0	12.0	0.0	0.0	0.0	13.0	0.0	4.0	0.0	1.0	0.0	5.0	39.3	3.0	0.0	2.0	14.0	4.0	4.0	0.0		
Asian alone (%)	6.0	1.3	2.7	7.0	9.0	1.3	1.0	6.0	1.0	0.0	1.0	1.0	1.0	0.0	1.6	1.0	1.0	3.0	0.0	0.0	0.0	7.0	0.0	7.0	1.0	1.0	0.0	28.0	11.0	0.0	0.0	16.3	3.0	0.0	5.0	0.0		
Native Hawaiian and Other Pacific Islander (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
American Indian and Alaska Native (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Some Other Race (%)	4.0	2.5	0.5	2.4	0.7	1.4	8.4	1.0	0.0	0.0	0.2	0.0	1.0	0.0	0.8	0.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	2.0	0.0	1.0	0.0	1.0	4.2	0.0	0.0	0.4	2.4	1.0	0.0	1.0		
Two or More Races (%)	3.0	2.3	1.1	2.5	2.3	2.7	3.0	2.5	2.0	0.0	0.6	1.0	1.0	0.5	1.0	2.0	1.0	0.0	1.0	1.0	1.0	2.0	1.0	1.0	3.0	2.0	1.0	2.0	3.0	2.0	1.0	1.5	2.0	2.0	2.0	2.0		
Hispanic or Latino of Any Race (%)	10.5	3.6	2.5	4.4	2.3	4.0	10.0	4.0	1.0	0.0	0.7	1.0	2.0	3.0	0.8	1.0	1.0	8.0	2.0	2.0	1.0	4.0	1.0	5.0	2.0	2.0	2.0	3.0	7.8	1.0	1.0	3.0	4.0	6.0	3.0	1.0		
Foreign Born (%)	15.3	8.6	6.9	16.0	14.9	6.3	27.0	14.0	2.0	3.0	2.0	2.0	6.0	5.0	4.3	2.0	5.0	13.0	5.0	3.0	4.0	13.0	3.0	17.0	3.0	6.0	2.0	31.0	31.0	4.0	3.0	21.0	18.0	3.0	10.0	2.0		
Naturalized U.S. Citizen (%)	52.0	60.0	68.4	68.0	65.3	56.5	57.0	70.4	74.0	78.0	74.3	66.0	72.0	61.0	86.3	72.0	71.0	75.0	61.0	61.0	56.0	69.4	81.0	47.0	68.0	46.0	76.0	55.0	70.0	65.0	69.0	69.4	73.4	76.0	57.0	60.0		
Not a U.S. Citizen (%)	47.4	39.5	31.6	32.0	34.3	43.5	42.0	30.0	25.0	21.0	25.0	33.0	27.0	38.0	13.5	27.0	28.0	25.0	38.0	38.0	43.0	30.4	18.4	52.0	31.0	53.0	23.0	44.0	29.3	34.0	30.0	30.4	26.0	23.0	42.0	39.0		
Language Spoken at Home (Population >5 Years)																																						
Language other than English (%)	22.7	12.0	8.1	24.7	17.9	10.0	40.0	15.0	2.0	6.0	2.6	3.0	9.0	3.8	4.5	3.0	5.0	17.0	7.0	5.0	7.0	18.0	3.0	21.0	2.0	7.0	5.0	37.0	38.0	6.0	3.0	28.0	23.0	7.0	13.0	4.0		
Speak English less than very well (%)	8.3	4.8	3.2	6.0	6.7	3.0	19.0	5.0	0.0	1.0	0.0	1.0	1.0	0.8	2.5	0.0	1.0	5.0	2.0	1.0	2.0	3.0	0.0	6.0	0.0	2.0	0.0	20.3	16.3	1.0	0.0	7.4	9.4	0.0	4.0	1.0		
Spanish (%)	8.4	2.4	0.6	3.0	1.8	3.3	7.5	3.0	0.0	0.0	0.8	1.0	1.0	1.0	0.6	0.5	0.0	6.0	1.0	1.0	1.0	3.0	1.0	4.0	0.0	1.0	1.0	2.0	5.6	0.0	1.0	1.0	3.0	4.0	2.0	1.0		
Speak English less than very well (%)	3.3	0.8	0.2	0.3	0.6	0.5	3.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Other Indo-European languages (%)	8.0	8.4	4.6	15.0	6.8	5.0	30.0	6.0	1.0	4.0	1.0	1.0	5.0	1.0	3.0	1.0	3.0	7.0	4.0	2.0	5.0	8.0	2.0	11.0	1.0	4.0	3.0	8.0	18.4	4.0	1.0	14.0	16.4	2.0	6.0	2.0		
Speak English less than very well (%)	3.3	3.3	2.0	3.5	1.6	1.3	15.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	1.4	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0	3.0	0.0	1.0	0.0	3.0	7.5	1.0	0.0	3.0	7.0	0.0	1.0	0.0		
Asian and Pacific Islander languages (%)	4.0	0.7	1.0	6.0	7.0	1.0	1.0	3.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	1.0	2.0	0.0	0.0	0.0	5.0	0.0	3.0	0.0	0.0	0.0	24.0	10.0	0.0	0.0	10.4	2.0	0.0	3.0	0.0		
Speak English less than very well (%)	1.3	0.3	0.4	2.0	3.6	0.7	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.4	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	16.0	6.0	0.0	0.0	3.0	1.0	0.0	1.0	0.0		
Other Languages (%)	1.4	0.6	1.9	0.0	2.2	0.6	1.0	2.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.5	0.4	2.0	0.0	0.0	1.0	3.0	0.0	0.0	2.0	1.0	0.0	1.0	0.0			
Speak English less than very well (%)	0.3	0.1	0.7	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Housing																																						
Vacant housing units (%)	9.8	10.0	4.7	5.0	3.9	6.4	0.0	4.0	6.0	12.0	9.8	0.0	3.0	3.9	0.8	0.0	4.4	2.0	16.0	5.0	12.0	3.0	4.3	4.0	5.0	15.0	4.0	6.0	5.0	6.0	11.0	5.4	7.0	9.0	3.0	0.0		
Owner-occupied (%)	62.1	75.5	67.6	74.5	70.5	75.4	54.0	78.0	92.0	80.0	89.3	83.0	81.0	90.0	85.5	90.0	82.0	80.0	6.0	79.0	7.0	82.0	92.0	57.0	87.0	7.0	8.0	46.0	68.0	72.0	85.0	88.0	71.0	86.0	64.0	72.0		
Monthly owner costs exceed 30% of household income (%)	32.7	34																																				

South Shore Hospital Service Area Clinical Indicators

All data received from the Massachusetts Department of Public Health

Data shaded in orange is statistically higher compared to the Commonwealth overall.

Data shaded in blue is statistically lower compared to the Commonwealth overall.

*Data suppressed due to small numbers.

		Massachusetts	Plymouth County	Abington	Avon	Braint	Bridgewater	Brockton	Canton	Carver	Cohasset	Duxbury	E. Bridgewater	Easton	Halifax	Hanover	Hanson	Hingham	Holbrook	Hull	Kingston	Marshfield	Milton	Norwell	Norwood	Pembroke	Plymouth	Plympton	Quincy	Randolph	Rockland	Sctuate	Sharon	Stoughton	W. Bridgewater	Weymouth	Whitman	
Overall Morbidity and Mortality (age-adjusted rates per 100,000)																																						
All cause	Hospitalizations (2008-2012)	11569.7	13396.4	13805.5	14484.7	12846.3	11571.7	17907.4	12195.5	13355.4	10135.4	9796.1	13673.7	11976.5	12493.9	10432.3	12860.2	10228.6	15031.4	12589.2	11914.3	11822.0	11328.5	10606.5	14280.3	12369.5	13340.9	13020.4	12557.2	13333.3	14368.7	11056.6	9880.5	14904.4	14382.8	13528.4	13851.0	
	ED discharges (2008-2012)	36897.6	37707.1	32195.8	37995.5	31181.1	22695.0	55596.8	29599.3	42966.0	19615.1	23578.5	27243.4	23178.4	30379.1	22263.4	27024.8	20260.3	37639.6	32377.8	34463.8	26585.7	29129.4	20997.4	36985.6	29102.5	43226.1	36438.0	37678.9	39265.6	37369.0	20981.0	22148.3	37021.0	28011.9	37531.5	32421.7	
	Mortality (2015)	684.5	722.3	840.2	876.2	714.8	771.4	877.9	748.2	906.1	650.4	552.4	813.3	814.3	761.9	812	1152.1	603.0	979.9	899.1	847.8	88	524.8	610.4	771.3	812.2	828.7	854.3	743.2	769.1	958.0	759.6	629.0	827.5	610.9	803.3	928.5	
	Premature mortality for <75 yr population (2015)	279.6	294.1	361.2	415	259.1	388.5	465.6	275.8	445	257	153.3	341.3	279.1	255.7	240.3	452.9	152.2	442.7	332	334.7	258	164.2	214.7	342.7	255.2	339.95	355.2	349.6	391.1	416	241.4	229.1	392.3	204	361.1	373.7	
Injuries and Poisonings	Hospitalizations (2008-2012)	852.1	974.0	924.1	1042.6	978.1	810.8	1289.2	928.8	920.5	907.1	770.4	1050.0	828.3	842.0	793.4	940.8	775.6	1035.3	979.8	876.4	891.3	843.3	807.2	1062.9	970.9	938.0	1052.0	907.5	931.8	1071.1	873.8	778.6	1117.6	1031.1	985.9	981.5	
	Mortality - Accidents (2015)	58	71.3	78.6	135.3	60.2	76.7	107.5	76.6	93.5	*	40.2	71.3	59.3	*	62.3	112.7	13.9	96.4	53.8	*	33.8	21.5	*	80.4	45.2	77.4	*	80.7	80.3	122.5	60.8	*	90.8	*	82.4	99.5	
	Mortality - Self Inflicted (2015)	9.0	9.6	*	*	*	*	12.4	*	0.0	0.0	0.0	0.0	*	*	0.0	0.0	0.0	0.0	*	0.0	*	0.0	*	0.0	*	0.0	15.4	*	11.5	*	*	*	18.2	0.0	*	*	
Motor Vehicle Related	Hospitalizations, 2008-2012	59.3	90.5	112.0	87.9	68.1	68.1	118.4	70.7	100.2	68.6	56.3	96.5	61.0	109.4	74.5	110.2	48.3	114.0	95.2	92.3	83.2	59.0	62.9	63.1	105.3	74.9	215.9	67.5	90.1	90.5	67.3	45.8	89.3	86.0	84.8	105.6	
	Mortality (2015)	5.4	6.8	*	0.0	*	*	8.7	*	*	0.0	*	*	*	*	0.0	0.0	0.0	0.0	*	0.0	*	0.0	0.0	*	0.0	*	0.0	6.1	20.0	*	*	0.0	*	0.0	8.5	0.0	
Assault	Hospitalizations (2008-2012)																																					
	Mortality (2015)	2.0	2.2	0.0	*	0.0	0.0	7.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	*	0.0	0.0	0.0	0.0	0.0	*	0.0	*	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Behavioral Health																																						
Alcohol/substance use (age adjusted per 100,000)																																						
Hospitalizations, 2008-2012		337.6	383.6	434.9	450.9	391.6	272.4	628.6	365.8	312.6	270.4	194.2	443.3	343.1	339.1	266.1	297.1	207.8	614.2	511.6	210.6	310.1	250.1	298.6	658.6	328.5	318.8	300.8	445.7	289.8	517.3	307.5	267.3	567.6	415.8	537.1	424.6	
	Related ED discharges, 2008-2012	858.8	862.9	750.7	1044.9	740.0	541.6	1636.2	491.2	638.3	588.1	567.3	763.3	436.1	698.2	611.0	629.9	545.7	953.3	1193.1	539.4	628.8	413.5	635.6	911.0	649.9	739.6	624.9	1468.4	542.1	1041.0	694.0	409.5	755.0	673.1	1112.3	832.4	
Opioids (age-adjusted per 100,000)																																						
Hospitalizations (2008-2012)		315.6	350.7	437.7	548.2	331.8	211.7	578.9	351.0	289.1	152.0	160.4	443.8	271.0	256.1	245.5	306.1	177.5	603.6	478.2	170.6	254.3	196.3	256.6	698.4	355.0	237.7	248.6	381.1	249.3	531.8	264.5	257.7	541.4	388.2	517.4	427.8	
Related ED discharges (2008-2012)		259.6	327.4	415.4	357.5	324.5	188.7	429.7	197.5	320.3	138.1	141.5	474.6	203.9	270.1	270.3	353.4	465.0	532.4	548.3	207.0	249.5	130.4	340.8	465.8	378.4	263.2	226.0	385.4	186.5	540.4	266.3	165.3	371.8	299.1	566.1	408.3	
Opioid-related fatal overdose (2015)		24.6	36.0	38.4	*	26.7	41.7	51.6	30.7	66.6	0.0	*	*	31.1	*	96.1	0.0	*	*	*	*	*	18.5	*	38.6	*	43.6	37.3	57.5	*	*	42.5	0.0	47.1	38.3			
Mental Disorders (age adjusted per 100,000)																																						
Hospitalizations (2008-2012)		837.5	679.5	675.0	721.2	659.3	515.7	1290.1	715.6	434.0	406.7	372.8	743.0	581.8	461.4	393.8	560.6	376.5	949.4	767.5	365.5	426.4	516.6	535.9	1460.2	466.3	476.1	352.5	790.6	615.1	840.8	483.0	621.2	894.8	670.2	802.4	761.9	
Related Hospitalizations (2008-2012)		3839.5	4309.5	4273.5	4888.5	3938.5	3428.3	6533.0	3621.1	3928.0	3083.1	2568.7	4728.7	3710.7	3591.8	2686.3	3754.9	2546.1	4957.4	4342.6	3787.0	3353.1	2725.6	2981.7	5013.8	5 - 3852.13	4134.8	4070.5	3919.4	3676.4	5171.1	3121.8	2745.5	5018.6	4528.3	4488.8	4457.6	
ED discharges (2008-2012)		2091.9	2199.8	1907.2	1952.7	1924.3	1259.5	3496.8	1352.9	2267.7	1278.1	1533.6	1666.4	1159.7	1885.1	1526.1	1834.1	1309.7	2351.5	2646.2	1882.9	1790.5	1154.4	1537.1	2174.9	1720.3	2351.6	1918.7	3077.2	1721.7	2359.8	1596.0	1205.6	1836.8	1563.2	2614.7	2033.5	
Related ED discharges (2008-2012)		4990.4	4848.9	4619.6	4475.4	3758.3	2686.6	7759.1	2982.9	4514.5	2550.1	2347.5	3938.7	2458.3	3705.1	3002.1	3851.5	2411.6	5416.8	5032.6	2953.3	3231.2	2380.5	2867.2	4187.5	3644.4	3753.7	3380.4	4779.3	3693.1	5892.1	3100.8	2433.0	3888.5	3727.9	5366.4	4792.7	
Mortality (2015)		62.9	61.2	96.4	*	76.1	30.4	79.6	105.9	42.7	*	42.8	98	123.6	*	91.6	93.1	64.1	69.1	79.5	88.7	81.0	43.0	92.6	95.2	47.4	51											

	Massachusetts	Plymouth County	Abington	Avon	Braintree	Bridgewater	Brockton	Canton	Carver	Cohasset	Duxbury	E. Bridgewater	Easton	Halifax	Hanover	Hanson	Hingham	Holbrook	Hull	Kingston	Marshfield	Milton	Norwell	Norwood	Pembroke	Plymouth	Plympton	Quincy	Randolph	Rockland	Scituate	Sharon	Stoughton	W. Bridgewater	Weymouth	Whitman
Mortality (2015)	18.9	21.9	*	*	25.2	*	37.3	*	*	*	0.0	34.4	*	0.0	63.0	*	20.5	39.7	*	*	*	*	36.9	20.1	37.6	19.4	0.0	18.2	18.1	*	23.5	28.8	20.7	*	20.2	61.3
Elder Health (Age-adjusted rates per 100,000)																																				
Falls																																				
Hospitalizations (2008-2012)	366.9	419.3	379.2	421.3	465.1	364.2	462.6	427.7	366.1	477.5	442.9	451.6	405.3	348.8	382.5	393.7	426.7	406.8	429.7	410.5	454.8	435.0	388.3	489.9	439.7	452.5	410.5	424.0	406.3	454.0	428.7	384.6	482.1	419.5	456.0	435.2
ED discharges (2008-2012)	2763.9	2826.1	2391.7	2734.0	2839.3	2063.2	3093.4	2605.7	3215.9	2185.8	2541.5	2157.1	2164.4	2505.4	2033.1	2235.0	2135.7	2477.6	2887.7	3151.5	2481.4	2509.5	2050.5	3050.3	2605.3	3657.9	3530.4	3158.7	2228.1	2985.8	2056.8	2065.9	2840.2	2240.2	3068.2	2398.7
Hip fracture hospitalizations (2008-2012)	83.8	93.7	83.9	79.4	113.0	93.7	101.3	95.9	72.3	113.8	87.4	97.0	87.2	58.3	71.6	119.2	99.8	82.4	95.6	95.8	93.9	83.9	98.3	99.6	95.2	99.9	80.1	91.5	80.0	94.7	81.5	72.9	98.9	132.1	101.0	92.5
Alzheimers deaths	20.2	22.5	*	*	24.9	*	15.1	15.9	37.2	*	62.0	0.0	*	0.0	*	*	25.3	*	*	*	27.5	18.9	*	10.7	*	50.5	0.0	19.1	14.1	26.7	19.3	33.9	27.0	0.0	24.7	*
Parkinson's deaths	7.7	8.4	*	0.0	*	*	*	*	*	*	0.0	0.0	*	0.0	*	*	*	*	*	*	*	*	11.2	*	12.1	0.0	8.6	*	*	*	*	*	*	*	7.4	*

Appendix C:

Resource Inventory

MULTI-SECTOR COLLABORATIVES AND COMMUNITY HEALTH PARTNERSHIPS	
ORGANIZATION	CITY
Blue Hills Community Health Alliance (CHNA 20)	Regional
Milton Substance Abuse Prevention Coalition	Milton
South Shore Community Partnership	Regional
Greater Brockton Health Alliance	Regional
Organizing Against Substances in Stoughton (OASIS)	Stoughton
LOCAL PUBLIC DEPARTMENTS AND OFFICES	
ORGANIZATION	CITY
Health Departments and Boards of Health	All
Fire Departments	All
Police Departments	All
School Districts, Departments, and School Boards	All
Recreation Departments	All
Department of Youth and Family Services	All
Elder Services/Councils on Aging	All
Transportation Departments	All
Housing Authorities	All
Public Libraries	All
BUSINESS AND COMMUNITY DEVELOPMENT	
ORGANIZATION	CITY
Local Chambers of Commerce	All
ADULT EDUCATION	
ORGANIZATION	CITY
Milton Adult Education	Milton
Literacy Program of Greater Plymouth	Plymouth
Plymouth Career Center	Plymouth
Quincy Career Center	Quincy

EARLY CHILDHOOD, YOUTH, AND ADOLESCENT SERVICES

Organizations	City
Milton Early Childhood Alliance	Milton
Quincy Community Action Programs	Quincy
Step Ahead Early Education	Randolph
Head Start	Marshfield and Plymouth
Community Action Committee of Cape Cod and the Islands	Regional
PACE Child Care Works	Regional
The Conway Children's Advocacy Center of Plymouth County	Brockton
South Shore Stars	Randolph and Weymouth

LEGAL AID

Organizations	City
New Center for Legal Advocacy	Plymouth
South Coastal Counties Legal Services	Brockton/Hyannis
District Attorney's Office	Regional

FOOD SECURITY AND HEALTHY EATING

Organizations	City
Interfaith Social Services	Quincy
Friendly Food Pantry	Randolph
Milton Community Food Pantry	Milton
Concord Baptist Church	Milton
Quincy Crisis Center Food Delivery Program	Quincy
South Shore Elder Services Meals on Wheels	Braintree
SNAP	Quincy
Community Lunch Program	Quincy
Salvation Army	Quincy
Faith Covenant	Quincy
Quincy WIC Program	Quincy
Randolph Food Pantry	Randolph
Southwest Community Food Center (QCAP)	Quincy
Weymouth Food Pantry	Weymouth
Carver Food Pantry	Carver
Our Lady of Lourdes	Carver
Cohasset Food Pantry at St. Anthony Parish Rectory	Cohasset
Duxbury Interfaith Council	Duxbury
Duxbury Lion's Club Pantry	Duxbury
Saint Paul's Church of the Nazarene	Duxbury
Halifax Congregational Church	Halifax
Our Lady of the Lake	Halifax
First Baptist Church	Hanover

CHARITABLE ORGANIZATIONS	
Organizations	City
United Way of Greater Plymouth County	Brockton and Plymouth
HOUSING PROGRAMS AND SHELTER/EMERGENCY HOUSING	
Organizations	City
Milton Senior Housing/Unquity House	Milton
Winter Valley	Milton
Father Bill's & Mainspring	Quincy & Brockton
Carolina Hill Shelter	Marshfield
David Jon Louison Child Center	Brockton
Housing Solutions for Southeastern Massachusetts	Kingston
Pilgrim's Hope Family Shelter	Kingston
Rehoboth Shelter	Norwell
South Shore Habitat for Humanity	Weymouth
DOMESTIC AND INTERPERSONAL VIOLENCE	
Organizations	City
DOVE, Inc.	Quincy
South Shore Women's Resource Center	Plymouth
Health Imperatives	Regional
MULTI SERVICE AGENCIES	
Organizations	City
Milton Residents Fund	Milton
Quincy Community Action	Quincy
Bay State Community Services	Quincy
Boston Chinatown Neighborhood Center	Quincy
Quincy Family Resource Center	Quincy
South Shore Community Action Council	Regional
Brockton Area Multi Services (BAMSI)	Brockton
CULTURAL ORGANIZATIONS	
Organizations	City
Asian American Service Association	Quincy
Enhance Asian Community Health	Quincy
Quincy Asian Resources, Inc.	Quincy

DISABILITY AND SPECIAL NEEDS EDUCATION AND SERVICES

Organizations	City
The Arc of South Shore	Weymouth
Kennedy-Donovan Early Intervention	Kingston
Disabled Person's Protection Commission	Braintree
South Shore Autism Center	Norwell
Community Connections Day Centers	Plymouth
North River Collaborative	Rockland
South Shore Education Collaborative	Hingham
South Shore Therapies	Weymouth, Pembroke, Cohasset

SERVICES FOR OLDER ADULTS

Organizations	City
Senior Centers	All
Hancock Park Adult Day Health	Quincy
Senior Resource Center, Inc.	Quincy
South Shore Elder Services Meals on Wheels	Braintree
Old Colony Elder Services	Brockton

EMPLOYMENT AND CAREER SERVICES

Organizations	City
Quincy Career Center	Quincy

FAITH-BASED PARTNERS AND ORGANIZATIONS

Organizations	City
Interfaith Social Services	Quincy
First Methodist Church	Weymouth
My Brother's Keeper	Easton

HIGHER EDUCATION

Organizations	City
Curry College	Milton
Laboure College	Milton
Quincy College	Quincy
Eastern Nazarene College	Quincy
University of Massachusetts Boston	Boston

HEALTH CARE SERVICES		
Organizations	City	Service Type
South Shore Hospital	Weymouth	Emergency and Acute-Care Hospital
Beth Israel Deaconess Milton	Milton	Emergency and Acute-Care Hospital
Beth Israel Deaconess Plymouth	Plymouth	Emergency and Acute-Care Hospital
South Cove Community Health Center	Quincy	Community Health Center
Manet Community Health Center	Quincy	Community Health Center
A New Way Recovery	Quincy	Behavioral Health
Bay State Community Services	Quincy & Plymouth	Behavioral Health
Good Shepherd's Maria Droste Counseling	Quincy	Behavioral Health
Aspire Health Alliance (formerly South Shore Mental Health)	Quincy	Behavioral Health
Adcare	Quincy	Behavioral Health
Gavin Foundation	Quincy	Behavioral Health
Lamour Counseling	Randolph	Behavioral Health
Mass Bay Counseling	Quincy & Marshfield	Behavioral Health
New Life Counseling & Wellness Center	Randolph	Behavioral Health
Cape Behavioral Health Center	Hyannis	Behavioral Health
Bayview Associations Evaluation and Counseling	Hyannis, Plymouth, Q	Behavioral Health
High Point Treatment Center	Plymouth	Behavioral Health
Pembroke Hospital	Pembroke	Behavioral Health
Plymouth Center for Behavioral Health	Plymouth	Behavioral Health
Skills for Living	Norwell	Behavioral Health
Vinfin	Plymouth	Behavioral Health
Seasons Hospice	Milton	Long-term care and chronic illness
Visiting Nurses Association	Norwell	Long-term care and chronic illness
ACCESS Program	Plymouth	Long-term care and chronic illness
American Cancer Society	Hyannis	Long-term care and chronic illness
Bay Path Rehabilitation and Nursing Center	Duxbury	Long-term care and chronic illness
Beacon Hospice	Plymouth	Long-term care and chronic illness
Old Colony Hospice	West Bridgewater	Long-term care and chronic illness
Hospice of the South Shore	Regional	Long-term care and chronic illness
South Shore Visiting Nurses Association	Regional	Long-term care and chronic illness
RECREATION AND ENRICHMENT		
Organizations	City	
Germantown Neighborhood Center	Quincy	
Houghs Neck Community Center	Quincy	
South Shore YMCA	Regional	
Randolph Intergenerational Center	Randolph	
Old Colony YMCA	Regional	
Boys and Girls Club	Plymouth and Marshfield	

VETERANS SERVICES**ORGANIZATION****CITY**

Operation Homefront

Quincy

James Hurley Senior and Veterans Center

Randolph

TRANSPORTATION**ORGANIZATION****CITY**

GATRA

Plymouth region

Plymouth and Brockton Street Railway

Plymouth

Appendix D:

Implementation Strategy

SOUTH SHORE HEALTH
COMMUNITY HEALTH NEEDS ASSESSMENT AND PLANNING
Implementation Strategy

Once South Shore Health's Community Health Needs Assessment (CHNA) was complete, the Steering Committee and the Advisory Committee participated in a strategic retreat that allowed them to review the full-breadth of quantitative and qualitative findings from the assessment, as well as to begin the CHIP development process. The Steering and Advisory Committees discussed the full range of findings by community health domain (i.e., social determinants, chronic/complex conditions, mental health, substance use, elder health) and then participated in a process that identified the population segments and health-related issues that they believed should be prioritized for South Shore Health's Implementation Strategy. Once the priorities were identified, the Steering Committee discussed the range of community health/community benefit activities that were currently being implemented, as well as emerging strategic ideas that they believed should be included in SSH's Implementation Strategy to respond to the prioritized community health issues.

The following is a summary discussion of the priority populations and community health issues that were prioritized by the Steering Committee with input from the Advisory Committee and other stakeholders at SSH and in the community-at-large. The hospital and its leadership are committed to Community Benefit budget planning, which will ensure the funds and resources available to carry out its community benefit mission and to implement activities to address the needs identified by their Community Health Needs Assessment. Recognizing that community benefit planning is ongoing and will change with continued community input, the SSH community benefit plan will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues may arise, which may require a change in the Implementation Strategy or the strategies documented within it. Senior management and the Board of Trustees are committed to assessing information and updating the plan as needed.

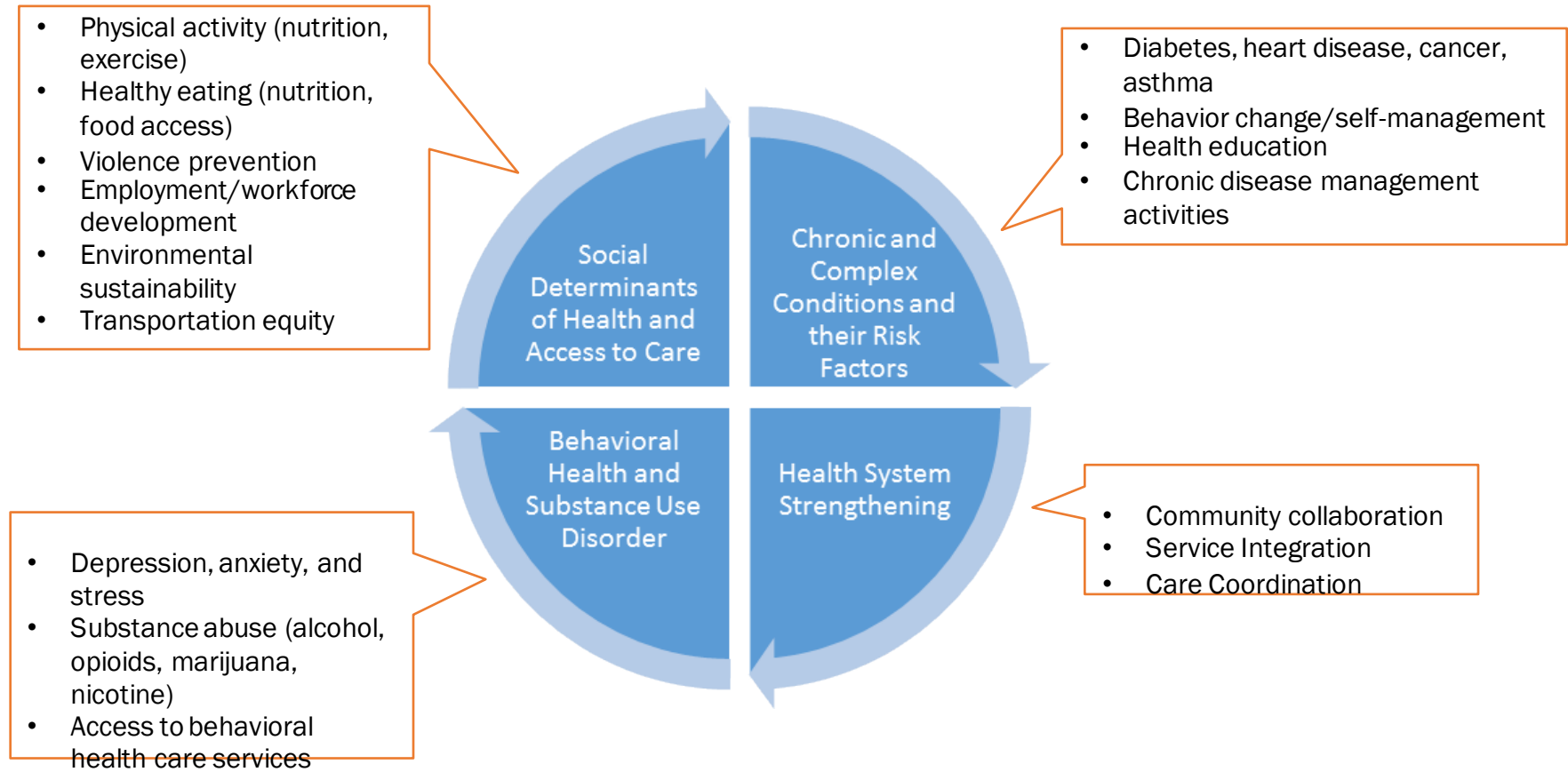
PRIORITY POPULATIONS

South Shore Health is committed to improving the health status and well-being of all residents living throughout its service area. Based on the assessment's quantitative and qualitative findings, including discussions with residents and community stakeholders, there was broad agreement that the Implementation Strategy should prioritize specific segments of the population that have complex needs or face significant barriers to care. The assessment identified youth and adolescents, older adults, individuals with chronic and complex conditions (e.g., cancer, diabetes, COPD), racial/ethnic minorities and non-English speakers, and low-to-moderate income individuals as key priority populations.



COMMUNITY HEALTH PRIORITIES

SSH's CHNA approach and process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the Steering Committee, with the support of hospital leadership and the CHNA Advisory Committee, framed the community health needs into four priority strategic domains, which together encompass the broad range of health issues facing residents living in SSH's service area. Based on assessment findings, the Steering Committee identified sub-priorities within each strategic domain, which further guided the development of the Implementation Strategy.



IMPLEMENTATION STRATEGY

Priority Area 1: BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER			
Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Develop outreach, education, and support programs for those with or at-risk of behavioral health and substance use issues	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase number of people who are outreached to and are educated about the risks, protective factors, and impacts of behavioral health and substance use in clinical, school-based, home-based, and other community-based settings • Reduce the stigma that those with behavioral health and substance use issues face in clinical, school-based, home-based, and other community-based settings • Increase the number of people who are engaged in appropriate primary care and specialty care services, including behavioral health and substance use services • Increase the number of people who are engaged in peer-to-peer programs geared to those with behavioral health and substance use issues targeting youth/adolescents, older adults, homeless, formerly incarcerated adults, and other high risk population segments	• Conduct behavioral health awareness, education and stigma reduction activities at health fairs, community events (e.g., councils on aging, YMCAs), and school-based settings, as well as in clinical settings (e.g., hospital outpatient and ED settings, outpatient primary care and specialty care settings, home-health, other post-acute settings) • Support the use of recovery coaches or peer counselors in community-based settings targeting those at high-risk including homeless, recently incarcerated, and those in recovery. Continue to support collaborative community based groups such as the South Shore Community Health Initiative. • Implement or promote support groups for caregivers, family members and those with behavioral health and substance use issues in clinical, school-based, home-based, other community-based settings • Promote initiatives to address hoarding in the community, continue to support South Shore Community Partnership (CHNA 23) which support local efforts to educate the community and combat hoarding.

Priority Area 1: BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Increase Access to Behavioral Health and Substance Use (BH/SU) Services	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase BH/SU screening and referral activities in clinical, school-based, home-based, other community-based settings • Increase the number of primary care and specialty care providers who regularly screen for BH/SU issues • Increase the number of primary care and specialty care practices that have integrated BH/SU services or enhanced referral relationships with community-based BH/SU providers • Enhance BH/SU integration activities in hospital inpatient and emergency department settings with respect to screening, assessment, and referral. • Enhance partnerships with law enforcement and other first responders with respect to identifying, screening, assessing, and referring those in need to treatment. • Develop behavioral health and substance use telehealth programs for patient care and provider consults in primary medical care and medical specialty care settings • Increase the number of people at community organizations where those at high-risk of overdose spend time who are trained on the use of narcan • Increase the availability of narcan in key community settings	• Conduct BH/SU screening and referral activities in targeted community settings (e.g., councils on aging, school-based health centers, home health visits, etc.) • Work with SSH's owned and affiliated primary care practice sites to develop and expand integrated BH/SU programs • Implement screening, assessment, treatment and/or referral activities in hospital inpatient and emergency department settings • Continue to support or enhance activities conducted through Plymouth County Outreach to follow-up with substance users after an overdose episode and provide counseling at Drop-in locations • Supply and train use of Narcan in community-based settings (e.g., libraries, churches, shelters, etc.)

Priority Area 1: BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Decrease Depression and Social Isolation	• Older Adults • Low-to-moderate income	• Increase the number of residents who have access to affordable transportation • Increase the number of older adults who are screened for BH/SU issues • Increase the number of adults and older adults who are isolated who are outreached to and are encouraged or actively involved in positive social activities • Increase the number of people outreached to and educated about domestic violence. Develop a culture of awareness and action related to domestic violence, including elder abuse	• Support organizational and/or regional transportation resources that improve access to timely transportation services • Develop or support elder health screening initiatives that include depression screening with internal and external partners • Support Councils on Aging programs that support social interaction • Conduct staff training on identifying domestic violence/elder abuse situations • Advocate for policy changes that facilitate functional assessments in cases of self-neglect
Enhance Caregiver Support and Reduce Family/Caregiver Stress	• Older Adults • Individuals with chronic and complex conditions	• Increase the availability of evidence-based family/caregiver support • Increase the number of people participating in family and caregiver support programs aimed at those who are caring for individuals with complex or chronic medical, behavioral, or substance use issues • Improve care coordination and care management	• Implement “Powerful Tools for Caregivers” Program (or some similar caregiver support program) with internal clinical and community-based partner to support patients, community residents, and caregivers who are dealing with a chronic illness or disability to reduce personal stress; improve patient/caregiver/family communication, better deal with difficult feelings; and make tough caregiving decisions. • Continue support of South Shore Health’s Aphasia group for patients/family members struggling with Aphasia often following a stroke. • Continue support of caregiver groups held for family members/caregivers struggling with stress of caregiving or grief following the loss of a loved one. Goals are to provide support and education to the community.

Priority Area 2: SOCIAL DETERMINANTS OF HEALTH (SDOH) AND ACCESS TO CARE

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Link those who face barriers to health care access or disparities in health outcomes due to social determinants of health to appropriate community-based services	- Youth and Adolescents - Older Adults - Low-to-Moderate Income - Racial/ ethnic minorities and Non-English speakers	- Increase the number of individuals in at-risk groups who are screened for social determinants in clinical, school-based, home-based, and other community-based settings - Increase the number of people who are screened positive for SDOH issues who are linked to community-based services that will address their social issues - Develop a social determinants of health resource inventory - Develop systems that actively link those who screen positive to services that are part of the regional service inventory	Implement a SDOH screening and referral program similar to CMS' Accountable Health Communities (AHC) model (Aunt Bertha) (https://innovation.cms.gov/initiatives/ahcm/)
Enhance Access to timely transportation services for those in need who do not have access to a personal car	- Older Adults - Low-to-Moderate Income - Individuals with chronic/complex conditions	- Decrease the number of elders and low income individuals who face transportation barriers when trying to access health care services or other essential services or supports - Decrease no-show rates in clinical settings - Increase percentage of elders and low income individuals who have a primary care follow-up appointment after hospital discharge	- Continue to implement Help to Home Van Program providing transportation home to patients discharged from the hospital - Work with Councils on Aging (COA) and other community partners to explore how to best leverage and coordinate transportation resources

Priority Area 2: SOCIAL DETERMINANTS OF HEALTH (SDOH) AND ACCESS TO CARE

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Address Food Insecurity for low- to moderate income individuals and families	• Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers	• Increase access to healthy foods	• Support local food banks, meals on wheels, and farmers market programs • Support the use of “pop up” food pantries and other similar evidence-based food security programs • Support school-based and elder services organizations-based programs addressing food insecurity, such as the Pilot program at Weymouth High School, Boston Food Pantry provides healthy food choices at no cost to the community. • Support local farmer’s markets to combat food insecurities in the community.
Enhance Access to Health Care Services for Low Income Individuals / Families	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase access to insurance coverage • Increase access to appropriate primary care and specialty care services • Reduce reliance on hospital emergency department for primary care and other non-urgent conditions	• Support SHINE Program that provides counseling on insurance information to ensure that seniors receive their maximum coverage available • Implement Emergency Department Triage Program for low- to moderate-income segments of the population, supporting programs through patient navigation with federally funded community health centers such as Manet and South Cove in Quincy.

Priority Area 2: SOCIAL DETERMINANTS OF HEALTH (SDOH) AND ACCESS TO CARE

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Support Workforce Development and Creation of Employment Opportunities	- Youth and adolescents - Older Adults - Low-to-Moderate Income - Racial/ ethnic minorities and Non-English speakers)	Increase mentorship, training, and employment opportunities for youth, young adults, and adults	- Organize and support Pipeline Programs to enhance skills and career advancement - Provide opportunities through career initiatives or college-level courses for employees - Offer ESOL classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class. Work with the vulnerable population providing opportunities to develop skills allowing for professional growth. - Provide job and career introductory opportunities for community residents, supporting programs that will provide a skill base and improve opportunities for growth. - Provide job and career introductory opportunities for middle and high school students
Increase Availability of Transitional Housing and Housing Supports for those Most At-risk	- Low-to-Moderate Income - Racial/ ethnic minorities and Non-English speakers	- Increase the availability of transitional housing for those in need with complex behavioral, cognitive, or developmental problems - Increase the number of people in low-to moderate- income brackets who receive housing supports and/or counseling	- Partner with community organizations to implement and outreach and referral program to help ensure that those in need of housing supports or counseling have access to the services they need - Expand availability of transitional housing - Support organizations who provide transition housing or housing supports

Priority Area 3: CHRONIC AND COMPLEX CONDITIONS AND THEIR RISK FACTORS

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Promote Wellness, Behavior Change, and Engagement In Appropriate Care	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase the number of people who are educated about the risks and protective factors of chronic health conditions as well as basic wellness with special emphasis on hypertension, diabetes, depression/anxiety, respiratory illness) • Increase the number of people screened for the leading health issues and link those who screen positive to the services and supports they need • Increase the number of people engaged in appropriate primary care and specialty care services • Increase the number of people who are trained in CPR and other life saving activities	• Participate in health fairs for enhanced screening, health literacy, and community education • Promote and organize community workshops and educational sessions on key health issues in community venues via Speakers Bureau with the goal of educating the public and engaging participants in appropriate primary care and specialty care services • Link patients to and provide free sessions of the American Lung Association's Freedom From Smoking program • Provide education and behavior change counseling as well as other treatments in school-based settings with respect to smoking and vaping • Conduct screening and referral activities with respect to targeted health-related issues and social determinant of health issues in hospital, outpatient, and other community settings. • Promote chronic disease education regarding risk and protective factors, and behavior change as well as promote access to appropriate care at health fairs and community events (school-based, community-based, and worksite settings) • Promote cancer screening, education, counseling, peer support and survivorship programs. • Reach out to the Brazilian community and provide primary care through the Brazilian Community Health Project with health screenings and other primary care services

Priority Area 3: CHRONIC AND COMPLEX CONDITIONS AND THEIR RISK FACTORS

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Increase Physical Activity and Healthy Eating	- Youth & Adolescents - Older Adults - Low-to-Moderate Income - Racial/ ethnic minorities and Non-English speakers - Individuals with chronic/complex conditions	- Increase access to healthy diverse foods - Increase the number of youths, adults, families and elderly who are provided counseling & coaching on physical exercise, nutrition, and obesity - Increase access to services for individuals and families who suffer from food insecurity	- Partner with the YMCA to implement nutrition and weight loss classes facilitated by a registered dietitian - Support programs to increase access to healthy foods and support nutritional education such as farmers markets, cooking classes etc. - Support and implement programs that increase opportunities for physical activity for those most at-risk
Reduce Falls in Elders	Older Adults	- Increase balance training and physical activity; management of existing illness; and home modifications - Increase the number of individuals and families who receive home visits to assess safety	- Participate in MA Department of Public Health Matter of Balance Program with community-based partners (e.g., COAs, South Shore Elder Services, other elder services organizations, primary care providers) - Participate in evidence based Fall Reduction programs such as “Matter of Balance” to provide education to patients who have had a fragility fracture to prevent further falls

Priority Area 3: CHRONIC AND COMPLEX CONDITIONS AND THEIR RISK FACTORS

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Improve Chronic Care Management	• Older Adults • Individuals with chronic/complex conditions	• Increase the number of primary care and specialty care practice sites who are engaged in evidence-based, chronic disease management services • Increase the number of people with chronic conditions who are referred from primary care and linked to needed, non-clinical community services • Increase access to chronic care case management services • Increase the number of adults with diabetes, hypertension, and other chronic diseases who receive evidence-based counseling/coaching and treatment	• Implement evidence-based protocols in primary care and specialty care settings (e.g., Million Hearts Campaign) • Explore geriatric care management programs with internal and external partners • Facilitate support groups for those with chronic conditions • Participate and support MA Department of Public Health Stanford Self-Management Support Program workshops in community-based settings, including Councils on Aging, YMCAs, and South Shore Elder Services.

Priority Area 4: HEALTH SYSTEM STRENGTHENING

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Promote Collaboration with Community Health Partners (External Focus)	- State/Local Health Departments - Health, social service, and other health-related Community partners - Community Coalitions - SSH Patients - Community- At-large	- Increase or enhance information sharing with local health departments and other community health partners - Align SSH's CB/CH strategy with SSH's DoN Community Health Initiatives and SSH's broader hospital vision/ business plan - Build workforce and organizational capacity with respect to information sharing, service integration, care coordination, and the quality of services provided - Increase the number of partnerships in the community within and across sectors to address priority health issues and improve overall community health	- Share needs assessment findings with local health departments and other community partners across sectors (e.g., clinical providers, social service providers, community-based organizations through tailored reports, data dashboards, and meeting presentations) - Meet periodically with local health departments and other key community partners to share SSH vision and CB plans/accomplishments as well as discuss potential collaborations - Participate in community health task forces, community coalitions, and CHNA meetings - Distribute mini grant funds (\$5-10K grants) to community health partners to support ad hoc activities that are aligned with SSH's CB priorities, through distribution of the Critical Care Expansion project-DoN. - Continue formal, substantive partnerships with at least 4 key, external community partners on activities tied to SSH's CB priorities and SSH's overall population health management strategy - Continue formal substantive, partnerships with the Community Health Network Areas (CHNAs) that operate in SSH service area
Promote Collaboration with Community Health Partners (Internal Focus)	SSH Clinical and Administrative Staff	- Increase awareness of SSH's CB/CH plans and accomplishments - Increase the number of clinical and other hospital staff who participate in SSH's Speaker's Bureau - Align SSH's PHM/business strategy with CB strategy	- Report Community Benefit (CB) plans and accomplishments (orally and in writing) to SSH staff/clinicians - Present community health awards to staff and clinicians who have made exemplary contributions to CB and community health activities - Continue to support the development of the SSH "Speakers Bureau" as a resource for the community

Priority Area 4: HEALTH SYSTEM STRENGTHENING

Goal	Target Population	Programmatic Objectives	Core Elements of CHIP / Implementation Strategy
Enhance Care Coordination, Counseling, and Referral Services During/After Hospital Discharge	• Older Adults • Individuals with chronic/complex conditions	• Reduce inappropriate hospital readmissions • Reduce fragmentation of services in the community • Improve discharge planning protocols, counseling, and care transition plans • Increase referral rates to primary care setting after discharge • Improve medication management	• Strengthen existing hospital care transition programs related to reducing inappropriate hospital readmissions, improving discharge planning/counseling, and improving care transitions • Build collaboration between primary care providers, elder services agencies, home health providers, and other community-based partners • Implement “Honoring Choices” Program (or some similar options planning counseling initiative) with internal and external clinical and community-based partners to help adults make a health care plan that honors their choices all through their lives (e.g., COAs and other elder services organizations, primary care providers) • Strengthen Caregiver support Program (or some similar caregiver support program) with internal clinical and community-based partner to support patients, community residents, and caregivers who are dealing with a chronic illness or disability to reduce personal stress