



Holyoke Medical Center

2026 - 2028

STRATEGIC IMPLEMENTATION PLAN





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The complete CHNA findings are available at [HolyokeHealth.com/chna](https://www.holyokehealth.com/chna). For questions or comments, please contact HMC Community Benefits Director, Lisa Schechterle, at: Schechterle_Wray_Lisa@holyokehealth.com.





INTRODUCTION

2026 - 2028 Strategic Implementation Plan

Holyoke Medical Center's (HMC) Community Health Needs Assessment (CHNA) was completed in 2025. The results were reviewed and approved by Holyoke Medical Center's Board of Directors. The results were also reviewed by HMC's Community Benefits Advisory Committee, Health Equity Committee, and Patient & Family Advisory Committee. These groups also helped to guide Holyoke Medical Center's 2023 Community Benefits Strategic Implementation Plan (SIP).

The SIP is the organization's multi-year guide of goals and strategies to address significant health needs identified in the CHNA, while also aligning with the health priorities of the Department of Public Health and Executive Office of Health & Human Services. The goal is to improve the health status of our community, particularly of those most at risk. HMC also looks to continue partnerships with a broad range of community non-profit organizations to support their efforts that align with the CHNA needs identified, and unite us in achieving a common goal. This implementation plan will be reviewed and updated as needed annually, taking the changing needs identified by the community into consideration.

In addition, HMC reports all pertinent community benefit activities annually as required by the Massachusetts Office of the Attorney General.

Holyoke Medical Center Mission Statement: Our Mission at Holyoke Medical Center is to improve the health of all people in our community. We do that with honesty, respect and dignity for our patients, visitors and staff. We do that through expert and compassionate care, education and knowledge sharing, community partnerships, fostering innovation and growth and by inspiring hope in all we touch. We do that by being good stewards of our resources and providing efficient and cost effective care to all.

Holyoke Medical Center Community Benefits Mission Statement: Holyoke Medical Center will collaborate with community partners to assess and improve the health needs of our residents. We will do this by providing resources, education, and services to address the needs of our community members who are most vulnerable.



Introduction

2026-2028 Strategic Implementation Plan Summary

HMC's Strategic Implementation Plan (SIP) was developed in response to the 2025 Community Health Needs Assessment (CHNA). The SIP outlines strategies to address the health needs that were identified. This plan shares HMC's services and community benefits activities the hospital will address, how the needs were determined, and what HMC will not address and why. Each health need was reviewed to see which were most significant to the community and if they were already being addressed; which best aligned with the hospital's strengths; which would have the most impact; and which had the resources available to support the need.

About Holyoke Medical Center

HMC is a 219-bed independent community hospital with over 1,800 employees serving individuals and families throughout the cities and towns of the Pioneer Valley. The medical staff includes more than 350 physicians and consulting staff. HMC is a nationally accredited hospital and is the first and only hospital in Western Massachusetts to obtain the prestigious accomplishment of becoming certified in the ISO 9001:2015 Quality Management System. This full-service hospital provides a complete line of inpatient and outpatient medical and surgical services. Holyoke Medical Center is a member of Valley Health Systems in Holyoke, which also includes the affiliates Holyoke Medical Group and Holyoke Visiting Nurse Association & Hospice Life Care. To learn more, visit [HolyokeHealth.com](https://www.holyokehealth.com).



PROCESS

Holyoke Medical Center Community Health Needs Assessment Process

Community interviews and data gathering started in late 2024 and continued into 2025. Stakeholder and community meetings were set up throughout HMC's service area. People were asked questions regarding what they thought were the most pressing health concerns in our community, barriers to being healthy, inequities in our region, root causes of inequities, assets in our region, and what gaps or challenges service providers and health providers face trying to address these issues. They were also shown the key findings from the 2022 CHNA and asked if those needs were still relevant, and what they would add or delete from the list. The questions were formulated in partnership with the Western Mass Hospitals Coalition, which consists of Baystate Health, Mercy Medical Center, Berkshire Health Systems, and Cooley Dickinson Hospital. Survey data was obtained through Massachusetts Department of Public Health (MDPH) [Community Health Equity Survey \(CHES\)](#)¹, the [2024 Chicopee Youth Health Survey](#)² of 10th/12th grade students conducted by the Public Health Institute of Western Massachusetts, The Greater Boston Food Bank [Food Access Report](#)³, as well as through HMC's Health Related Social Needs (HRSN)

screenings. MDPH intentionally sought to reach key populations such as people of color, LGBTQIA+ individuals, people with disabilities, older adults, rural residents, and more. Additional data was accessed from America's Health Rankings, U.S. Census Bureau, Bureau of Labor Statistics, National Plan and Provider Enumeration System, Centers for Medicare & Medicaid Services, Federal Bureau of Investigation's Uniform Crime Reporting Program, MDPH Bureau of Substance Addiction Services, MA Registry of Vital Records and Statistics, MDPH and MA Office of the Chief Medical Examiner, U.S. Department of Agriculture, MA Department of Transitional Assistance Office of Bureau Policy Analytics, U.S. Department of Housing and Urban Development (HUD) Annual Homeless Assessment Report (AHAR), Robert Wood Johnson Foundation, Substance Abuse and Mental Health Services Administration (SAMSHA), Way Finders, and Center for Disease Control. The results of the assessment informed the hospital's 2026-2028 Strategic Implementation Plan. The complete CHNA findings are available at HolyokeHealth.com/chna.



KEY FINDINGS SUMMARY

Most Pressing Health Concerns:

- ✓ Mental health
- ✓ Substance use and addiction
- ✓ Chronic diseases (diabetes, hypertension, asthma, dementia, obesity)
- ✓ Food insecurity and nutritional deficits
- ✓ Housing instability and homelessness
- ✓ Limited support for children and adolescents
- ✓ Economic instability and lack of opportunity
- ✓ Healthcare access challenges
- ✓ Aging population needs
- ✓ Educational support



Key Findings

Barriers to Health and Well-being:

Housing & Environment

- Unsafe housing, evictions, aging infrastructure
- Landlord neglect, building code violations
- High rents, long waitlists, complex housing processes
- Out-of-state property ownership
- Neighborhood violence, drug paraphernalia

Healthcare Access

- Emergency department overuse, long wait times
- Burnout among professionals
- Lack of dental coverage for Medicare
- High cost of care and medications
- Insurance gaps, low-income ineligibility

Social & Cultural Barriers

- Mistrust of healthcare systems (especially among immigrants)
- Health illiteracy, language barriers (Haitian, Latino)
- Cultural stigma around mental health
- Limited access to healthy food and green space
- Digital divide (internet, devices, tech literacy)
- Transportation and time constraints

Communication & Support Needs

- Clear, culturally appropriate instructions
- Native language support
- Medication management, health portal navigation
- Social connection for seniors
- Access to technology and digital tools

Populations Most Affected

- Children, youth, teens, young adults
- Seniors
- Families facing poverty, housing instability, language barriers
- Immigrant and refugee groups
- Grandparent caregivers, non-traditional guardians
- LGBTQIA+ individuals
- Unhoused individuals
- Individuals with disabilities

Root Causes of Health Inequities

- Structural poverty, rising cost of living
- Economic instability and lack of opportunity
- Disparities in access and outcomes
- Misinformation online
- Shortage of providers
- Avoidance of preventative care
- Fragmented systems, poor discharge follow-up
- Over-reliance on emergency services
- Food deserts

Service Gaps & Unmet Needs

- Poor care coordination
- Lack of awareness or navigation of services
- No unified system for root causes
- Underused preventative services
- Non-profits working in silos
- Misuse of entitlements
- Need for financial and insurance assistance

Key Findings

Prioritized Needs to Address in the 2026 SIP:

Priority 1: Access to Basic Needs/Economic Opportunity

Priority 2: Mental Health

Priority 3: Substance Use Disorder

Priority 4: Access to Healthcare

Priority 5: Chronic Disease

Vulnerable populations to concentrate on in the next 3 years

- Children, youth (especially teens, young adults)
- Seniors
- Families facing poverty, housing instability, or limited English proficiency
- Immigrant groups
- Grandparent caregivers or non-traditional guardians
- LGBTQIA+ individuals
- Unhoused individuals
- People who struggle with substance use
- Individuals with disabilities

Four Focus Issues

In addition to needs identified by the Community Health Needs Assessment, the following were identified by the Executive Office of Health and Human Services and the Department of Public Health as significant statewide issues. The Attorney General Guidelines encourage hospitals to consider these four issues, along with local needs identified, when creating their Strategic Implementation Plan:

1. Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes
2. Housing Stability / Homelessness
3. Mental Illness and Mental Health
4. Substance Use Disorders

The Department of Public Health has also adopted six health priorities, and the Attorney General's Office also encourages hospitals to consider these six priorities when planning community benefits initiatives:

1. Built Environment
2. Social Environment
3. Housing
4. Violence
5. Education
6. Employment

1. Access to Basic Needs / Economic Opportunity

Similar to the 2022 CHNA, the [2025 Robert Wood Johnson County Health Rankings report](#)⁴ ranked Hampden County last out of the 14 counties as the least healthy county in Massachusetts. The report emphasized that Hampden County's health challenges are not just medical but are influenced by factors such as poverty, education, food insecurity, and other social determinants of health. The 2025 HMC CHNA identified:

- 15% of HMC's service area and 24% of Holyoke residents live in poverty.
- 47% of residents in rented homes in Holyoke have housing costs that exceed 30% of their income. Similarly, 46% of renters in HMC's service area have excessive housing costs of over 30% of income.
- In a survey of 3,000 people conducted by [The Greater Boston Food Bank](#)³ for their fifth annual food access report, Hampden County was among the counties with the highest food insecurity in MA, with 54% of households surveyed reporting food insecurity in 2024, a 6% increase from the 2023 report. Many of those households often skip meals or go entire days without eating due to a lack of resources. In addition, 40% of those adult respondents in food-insecure households skipped needed medical, dental or prescription care in the past year compared to 8% in food-secure households.
- In HMC's service area, 11% of homes are without a vehicle. In the city of Holyoke, about 17% of residents live without a vehicle. In some Holyoke neighborhoods, however, the percentage is significantly higher: 25% in Springdale and The Flats, 31% in South Holyoke, 32% in the downtown area, and 41% of households in the Churchill section of Holyoke lack a vehicle.
- 5,945 people in HMC's service area do not have health insurance coverage.
- The 2024 Point-in-Time (PIT) Count identified 2,901 homeless individuals in Hampden County, marking an 8% increase from 2023.
- 24% of total households in HMC's service area receive SNAP (Supplemental Nutrition Assistance Program) benefits. According to an [interactive Department of Transitional Assistance map](#)⁵ made public by MassLive in 2025, 43% of Holyoke residents rely on SNAP benefits.
- In Health Related Social Needs Assessments conducted in HMC's Pediatric Care offices, more than 17% of respondents said they were food insecure in 2024.

1. Access to Basic Needs / Economic Opportunity

- Among underrepresented individuals surveyed in the [2023 MDPH CHES¹](#) in HMC's service area:
 - 10.6% of survey respondents did not have a steady place to live
 - 11.5% were worried about losing their housing
 - 21.5% had internet connectivity issues
 - 37.3% applied for/received economic assistance
 - 33% did not have enough money at the end of the month, and another 31.8% had just enough
 - 51.7% had trouble paying for any basic needs in the past year



1. Access to Basic Needs / Economic Opportunity

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to all basic needs	Addition of social worker in the ED	Number of patients assisted	HMC staff time	HMC Security, ED social workers, HMC Community Navigation, Providence Ministries for the Needy, Springfield Rescue Mission, Safe Passage, Alianza, 413cares.org, Friends of the Homeless, Western MA Network to End Homelessness, CHD, Way Finders, The Samaritan Inn, Valley Opportunity Council, OneHolyoke CDC, Holyoke Housing Authority, The Salvation Army, Lorraine's Soup Kitchen, Enlace de Familias, Holyoke Police Department's Opioid Outreach Team	All patients with a focus on those that are economically disadvantaged, in need of insurance, shelter, food or connection to social services	Y1, Y2, Y3
	Screen patients for Health Related Social Needs (HRSN) in practices, inpatient and Emergency Department (ED) and refer to services as appropriate	Number of screenings	HMC and HMG staff time	Mass Health Community Partners Program, Innovative Care Partners (through CHD) and Clinical & Support Options, HMC Community Navigation, Project Bread, Eat Well, Community Servings, Just Roots, area food pantries, HMC Case Management, HMC Financial Counseling and other HMC staff; 413CARES.org	All patients with a focus on those that are economically disadvantaged, in need of insurance, shelter, food or connection to social services	Y1, Y2, Y3
	Provide victims of domestic assault with connections to needed services		HMC and HMG staff time	Community Legal Aid, Safe Passage, Christina's House	Victims of domestic assault	Y1, Y2, Y3
	Outreach card that promotes calendar of meal distributions, transportation schedule, financial counseling and language assistance	Number of cards distributed	HMC staff time and print shop costs	The Salvation Army, Lorraine's Soup Kitchen, Enlace de Familias, Hope for Holyoke, Holyoke Public Library, OneHolyoke CDC, area senior centers, Holyoke Housing Authority and other housing developments	Economically disadvantaged individuals, individuals whose primary language is not English, individuals without health insurance or are food insecure	Y1, Y2, Y3
	Backpacks with essentials for unhoused	Number of backpacks distributed	Financial contribution and HMC staff time	HMC Patient Family Advisory Committee, HMC Case Management	Unhoused patients	Y1, Y2, Y3

1. Access to Basic Needs / Economic Opportunity

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to food	Provide free meals through local non-profit organizations	Number of meals served	Financial contribution and HMC staff time	HMC kitchen staff, Providence Ministries for the Needy / Kate's Kitchen, The Salvation Army, Lorraine's Soup Kitchen, Greater Holyoke YMCA, Holyoke Boys & Girls Club, Holyoke Community College Culinary Arts Institute, Community Roots/ Holyoke Veterans Lunch Group, Hope for Holyoke	Economically disadvantaged individuals	Y1, Y2, Y3
	Adopt-a-Family Holiday Program	Number of people served and grocery store gift cards provided to families	HMC staff time	HMC staff and Holyoke Boys & Girls Club	Economically disadvantaged families	Y1, Y2, Y3
	HMC Farmers' Market	Number of people served; Number of SNAP/ HIP cardholders served	Financial contribution and HMC staff time	HMC staff, Greater Holyoke Chamber of Commerce, Holyoke Farmers' Market, Let's Move Hampden County 5-2-1-0, Holyoke Health Center, Nuestras Raices, Hampden County Community Health Improvement Plan, local farms and food trucks	All HMC patients, staff, and community members with a focus on those that are economically disadvantaged	Y1, Y2, Y3
	Provide SNAP and HIP education to patients and in the community	Number of engagements	HMC staff time	HMC practices; Holyoke Farmers' Market, Providence Ministries for the Needy / Kate's Kitchen, The Salvation Army, Lorraine's Soup Kitchen, Greater Holyoke YMCA, Holyoke Boys & Girls Club, Nuestras Raices, Communities Involved in Sustaining Agriculture	Economically disadvantaged individuals	Y1, Y2, Y3
	Assist elders and those with disabilities with applications for Meals on Wheels, SNAP/HIP and referrals to food pantries		HMC staff time	HMC Community Navigation, Access Care Partners, Department of Transitional Assistance, Margaret's Pantry, Lorraine's Soup Kitchen, Westfield Food Pantry, Neighbors Helping Neighbors, The Salvation Army, United Way Pioneer Valley, mobile food banks	Economically disadvantaged seniors	Y1, Y2, Y3

1. Access to Basic Needs / Economic Opportunity

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to food	Educational outreach regarding healthy food, use of farmers' markets, education of SNAP/ HIP benefits, cooking demonstrations, connect to food pantries, promote a diet with more fruits and vegetables, and use of community gardens	Number of engagements at farmers' markets, senior centers and other community based organizations	HMC staff time, HMC print shop costs	HMC Community Navigation, Holyoke Food Policy Council, Mass in Motion, Communities Involved in Sustaining Agriculture, Access Care Partners, Department of Transitional Assistance, Margaret's Pantry, Communities Involved in Sustaining Agriculture, Lorraine's Soup Kitchen, Westfield Food Pantry, Neighbors Helping Neighbors, United Way of Pioneer Valley, mobile food banks, Holyoke Public Library, area senior centers, The Salvation Army and other community based organizations	All community members with a focus on those that are economically disadvantaged	Y1, Y2, Y3
Expand knowledge and awareness/education of healthcare career pathways	Providing youth with opportunities for career exploration and encourage future in healthcare as appropriate	Number of educational engagements provided by HMC staff to area students	HMC staff time	Holyoke Safe Neighborhood Initiative, HMC employees, US Department of Justice, area high schools	All youth with a focus on at-risk youth or from economically disadvantaged families	Y1, Y2, Y3
Increase access to education	Support safe walking routes to school for children; Reduce absenteeism	Number of items donated	Financial contribution and HMC staff time	Safe Routes to School / Walking School Bus	Children in economically disadvantaged families	Y1, Y2, Y3
	Provide children with support and the necessary tools to succeed in school	Number of items donated	Financial contribution and HMC staff time	Holyoke Safe Neighborhood Initiative; Holyoke, Chicopee and West Springfield McKinney-Vento programs	Children in economically disadvantaged families	Y1, Y2, Y3
	Assist families through the process of registering for preschool or kindergarten; Assist families with access to Individualized Education Plans (IEP) or support services for education advocates		HMC staff time	HMC Community Navigation, Holyoke, Westfield, Chicopee, South Hadley, West Springfield Public Schools	Families of pediatric patients or young adults in transitional care in need of a bridge from healthcare to education due to chronic disease, disability, low income, immigrant/refugee status or various other reasons	Y1, Y2, Y3

1. Access to Basic Needs / Economic Opportunity

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to employment	Assist individuals seeking employment with connections to employment agencies		HMC staff time	HMC Community Navigation, MassHire, MassAbility	Individuals in need of assistance connecting to employment due to chronic disease, disability, low income, immigrant/refugee status or various other reasons	Y1, Y2, Y3
	Help youth earn money, gain experience and prepare youth for future of meaningful, unsubsidized employment	Number of hours spent in co-ops and internships	HMC staff time	HMC Center for Learning, Human Resources and participating host departments; MassHire YouthWorks, and area high schools	Youth in need of work experience	Y1, Y2, Y3
Support for local non-profit organizations in their efforts to care for individuals at risk of, or experiencing homelessness	Provide necessities for pop up warming shelter in Holyoke and other organizations as needed	Donations and referrals	Financial contribution and HMC staff time	Providence Ministries for the Needy, Community Roots / Holyoke Veterans Lunch Group, Western Massachusetts Network to End Homelessness	Individuals experiencing homelessness	Y1, Y2, Y3
Connect patients and community members to housing resources, emergency shelters and social services	Provide resources to individuals in need of shelter whether determined through HRSN screening or arriving in the ED. Also assist patients with Way Finders applications	Number of referrals	HMC staff time	HMC Security, ED social workers, HMC Community Navigation, Providence Ministries for the Needy, Springfield Rescue Mission, Safe Passage, Alianza, 413cares.org, Friends of the Homeless, Western MA Network to End Homelessness, Center for Human Development, Way Finders, The Samaritan Inn, Valley Opportunity Council, OneHolyoke CDC, Holyoke Housing Authority	Individuals experiencing homelessness or housing instability; victims of domestic violence	Y1, Y2, Y3
Connect patients to utility assistance	Assist patients with fuel assistance applications		HMC staff time	HMC Community Navigation, Valley Opportunity Council	Economically disadvantaged patients	Y1, Y2, Y3

1. Access to Basic Needs / Economic Opportunity

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Reduce transportation barriers to care	Provide two free shuttles to the hospital for Holyoke residents	Ridership	Financial contribution and HMC staff time	Valet Park of America	Patients in Holyoke without transportation	Y1, Y2, Y3
	Provide door-to-door van service to the hospital for Holyoke residents that are not on shuttle route	Ridership	Financial contribution and HMC staff time	Valet Park of America	Patients without transportation	Y1, Y2, Y3
	Provide Pioneer Valley Transit Authority (PVTA) bus pass or Lyft service home for those outside of hospital transportation routes without vehicle as needed	Number of patients transported	Financial contribution and HMC staff time	Lyft, PVTA	Patients without transportation	Y1, Y2, Y3
Improve access to quality and equity of care with a focus on initiatives addressing health-related social needs and specific improvement areas relating to health quality and equity	Health Related Social Needs screening in ED, inpatient, outpatient care	Number of patients screened	HMC staff time	HMC internal and external health equity committees, 413cares.org , MA Coalition for the Homeless, Project Bread, Community Servings, EatWell, Boston Accountable Care Organization, Inc. (BACO) and local community based organizations	All patients	Y1, Y2, Y3
	Continue the collection and use of race, ethnicity, and language (REaL) data as well as Sexual Origin Gender Identity (SOGI) data	Data compiled	HMC staff time	HMC Center for Learning and Development, Quality, and Community Navigation departments	All patients	Y1, Y2, Y3



2. Mental Health

Mental health issues remain a concern for both adults and youth in Hampden County. Since the 2022 CHNA, the average number of mentally unhealthy days reported by adults has risen from 5.2 to 6 days per month, indicating a modest but meaningful increase in emotional distress. The HMC CHNA identified the following risk factors that could impact mental health:

- 35.2% of seniors live alone.
- 18.3% of adults live alone.
- 6.7% of youth aged 16-19 are disconnected, meaning they are no longer enrolled in school or employed.
- 8.1% of households are language isolated, meaning no one over the age of 14 speaks English “very well.”

Results of the [2023 MDPH CHES](#)¹ of underrepresented individuals showed that:

- 36.1% of respondents reported a mental health condition
- 32.9% experienced psychological distress in the past month.
- 27.6% have diagnosed depression.
- 24.6% usually or always feel isolated from others.
- 7.4% have had suicidal ideation in the past year.

Among youth, findings from the [2024 Chicopee Youth Health Survey](#)² reveal that 32% of 10th and 12th grade students experienced persistent feelings of sadness or hopelessness—lasting nearly every day for two consecutive weeks—severe enough to interfere with their daily activities. In HMC’s service area:

- 21.5% of youth respondents said they felt anxious, nervous, or on edge nearly every day over the last 12 months.
- 58.4% of youth in that same survey said they needed to talk to someone in the past 12 months.
- Nearly 20% of respondents said they had tried a nicotine vapor product, and 18% said they’ve used vape products daily.

2. Mental Health

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to care	Support for patients seen through ED by crisis and inpatient psychiatry team		HMC staff time	HMC Center for Behavioral Health, HMC Community Navigation, The Care Team	HMC service area	Y1, Y2, Y3
	Outreach through area non-profit organizations regarding services offered	Number of health education outreach events in the community and number of individuals in attendance	HMC staff time	HMC Center for Behavioral Health, HMC Community Navigation, Hope for Holyoke, Kate's Kitchen, The Salvation Army, Lorraine's Soup Kitchen	Underserved and economically disadvantaged populations	Y1, Y2, Y3
	Collaborate with outside agencies to ensure patient needs are being met for mental health, SUD and chronic disease appointments	Number of patient referrals	HMC staff time	HMC Community Navigation, Mass Health Community Partners Program, Innovative Care Partners (through Center for Human Development), Clinical & Support Options	Patients with mental health, substance use disorder and chronic disease	Y1, Y2, Y3
	Provide care and response to serve individuals, students, and families identified in the community as having an acute and elevated risk, and connect them to services	Number of at-risk individuals connected to necessary services	HMC staff time	Holyoke Hub Community Mobilization Initiative including Holyoke Police Dept.'s Outreach Program, Holyoke Public Schools, Hampden County Sheriff's Dept., HMC Community Navigation, and over 40 other local agencies; Community health workers	Community members with unaddressed mental health and substance use disorder	Y1, Y2, Y3
	Provide care and response to serve area college students, and families identified as having an acute and elevated risk, and connect them to services		HMC staff time	Area colleges and universities including Amherst College, Westfield State University, Mt. Holyoke College	Community members with unaddressed mental health and substance use disorder	Y1, Y2, Y3

2. Mental Health

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to care	Partner with area facilities for extended care		HMC staff time	Mountain View, The Odyssey House, Center for Human Development, BHN, West Central Mental Health; Children - Lorenzi Health, Criterion Child Enrichment, Gandara (CBHI - child behavioral health therapy in home) Baystate Family Advocacy Center, YMCA after school programs	Individuals with an unmet need for extended mental health care	Y1, Y2, Y3
	HMC's Outpatient Psychiatric Consultation Service (OPCS) which provides timely support to patients in the community who suffer from psychiatric illness that can be treated in a primary care outpatient setting - OPCS creates a bridge for patients between primary care and psychiatric specialist	Number of patients referred to psychiatric nurse practitioner or LICSW	HMC staff time	HMC Center for Behavioral Health staff, HMC Community Navigation, HMC Primary Care practices	Individuals with an unmet mental health need seen through convenience of primary care provider	Y1, Y2, Y3

2. Mental Health

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to care	Reduce transportation barriers to care	Ridership	HMC financial commitment to support two shuttles in the community, valet parking, and door-to-door van service through Valet Park of America as well as funding of Lyft. Bus passes for patients if not on HMC transportation route	HMC Center for Behavioral Health, Peter Pan Bus Lines, Pioneer Valley Transit Authority, Lyft	Individuals in need of care that do not have a vehicle	Y1, Y2, Y3
	For Medicaid patients discharged from the ED with a principle diagnosis of mental illness or intentional self-harm: provide ED discharge instructions to encourage 7-day follow up appointments as well as provide post ED discharge phone calls to encourage 7-day follow up appointments	Number of discharged patients that receive follow up call	HMC staff time: behavioral health, primary care, ED, Community Navigation	ED providers and primary care providers	MassHealth patients ages 6-64	Y1 and then reassess
	Connect patients with an urgent need for services to appropriate care		HMC staff time	413cares.org , MA Roadmap to Behavioral Health Reform - 988 hotline number, MA network of community health centers including the Center for Human Development office, Gateway in Chicopee, Behavioral Health Network's BHN WellBeing clinics in Springfield and Westfield Gateway and BHN WellBeing clinics all have the same 24-hour phone number, 413-301-9355	Individuals with an urgent need for mental health services	Y1, Y2, Y3

2. Mental Health

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to care	Financial counseling services for those in need of insurance	Number of patients assisted with insurance application process	Financial contribution and HMC staff time	HMC financial counseling department	Patients without insurance coverage and in need of financial assistance	Y1, Y2, Y3
	Partner with Central Pioneer Valley Public Health District to promote CredibleMind, mental health and wellness app	Number of cards printed	HMC staff time	Central Pioneer Valley Public Health District, The Salvation Army, Kate's Kitchen, Lorraine's Soup Kitchen, health fairs, Greater Holyoke YMCA	Individuals looking to learn more about mental health and resources available	Y1, Y2, Y3
Increase access to care for youth	Partner with River Valley Counseling Center by ServiceNet to provide school based teen clinics	Number of students served	HMC staff time	River Valley Counseling Center by ServiceNet, Holyoke High School North Campus, Holyoke High School Dean Campus, William R. Peck Middle School	Youth at Holyoke middle and high schools	Y1, Y2, Y3
	Support for children needing enhanced mental health services (pediatric practices)	Number of children served	HMC staff time	Department of Mental Health, Department of Developmental Services	Youth in need of mental health support	Y1, Y2, Y3
	Crisis assessment on kids in ED		HMC staff time	Behavioral Health Network, Center for Human Development, Baystate Child Partial Hospitalization Program	Youth in need of mental health support	Y1, Y2, Y3
Provide support for gambling and gaming addiction	Provide space at no charge on campus for support groups	Number of meetings	HMC space and staff time	Gamblers Anonymous	Individuals and their family members in need of gambling addiction support	Y1, Y2, Y3
Increase social connections for seniors	Support of educational presentations such as fall prevention workshops and activities such as knitting and fitness classes at senior centers	Participation in programs, sponsorship	Financial contribution and HMC staff time	Holyoke, Chicopee, South Hadley, Westfield, and West Springfield Senior Centers	Seniors	Y1, Y2, Y3

3. Substance Use Disorder

The [Substance Abuse and Mental Health Services Administration or SAMSHA](#)⁶, defines drug addiction as a chronic disease where people compulsively seek and use drugs despite harmful consequences. In 2022, in Hampden County, there were 230 opioid-related overdose deaths according to the [Massachusetts Department of Public Health](#)⁷, representing nearly 10% of the state total. The number of deaths for 2023 is estimated to be about the same. Additionally, recent data from the [Massachusetts Department of Public Health's Bureau of Substance Addiction Services \(BSAS\) dashboard](#)⁸ in 2024, shows that alcohol is the leading cause of substance-related Emergency Room visits in Hampden and Hampshire counties as well as the state, making up nearly 75% of all substance-related ER visits. Similar to previous CHNAs over the years, alcohol and drug misuse were a primary concern among key informant interviews and community meetings. In addition to providing treatment and recovery, reducing stigma, increasing access to care, and providing education to prevent overdoses in the community were all top concerns.

HMC currently operates a Comprehensive Care Center for addiction treatment, provides emergency-department interventions with medication for opioid or alcohol use disorder (MOUD/MAUD), and coordinated follow-up care.

In December of 2025, the City of Holyoke completed an [Opioid Community Needs Assessment](#)⁹. Based on this needs assessment, the city is currently working on an opioid response program on how to best use Holyoke's

opioid settlement funds. With over a million dollars received so far, the City of Holyoke will be awarded approximately \$3.6 million through 2039. As part of this, the city will conduct a needs assessment every three years.

A survey of 62 people was included as part of Holyoke's needs assessment and the following key data points were shared as a result of the responses:

- 56.5% were Holyoke residents and identify as concerned community members
- 9.7% were active users or persons in recovery
- 80.6% of survey respondents reported discarded needles as experienced opioid issue
- Basic life needs (46.8%) and mental health services (41.9%) were found to be the most needed services
- 25.8% found information about opioid use disorder "somewhat easy" to access
- 37.1% "don't know" how easy it is to access treatment services
- Demographics of respondents: 27.4% aged 35-44; 72.6% White/Caucasian; 22.6% Hispanic/Latino; 69.4% female; 22.6% LGBTQ+

HMC will continue to partner with the Holyoke Health Department and support the [City of Holyoke's Opioid Response](#)¹⁰.

3. Substance Use Disorder

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Strengthen overdose prevention strategies within HMC	Distribution of Take Home Naloxone in ED, Addiction Consult Services and Comprehensive Care Center	Number of Take Home Naloxone distributed	HMC staff time from Addiction Consult Services, Pharmacy, Comprehensive Care Center; Applying for grant funding	HMC Addiction Consult Services, Comprehensive Care Center, Pharmacy, recovery coaches, Tapestry Health, Holyoke Health Department	Individuals with substance use disorder	Y1, Y2, Y3
Strengthen overdose prevention and recovery initiatives within the community	Partner with Holyoke's Opioid Response Task Force	Number of activities	HMC staff time	Holyoke Health Department, Holyoke Office of Community Development, Tapestry Health	Individuals with substance use disorder	Y1, Y2, Y3
Prevent substance related deaths	Overdose prevention training	Number trained	HMC recovery nurses to provide training	YMCA and other outside organizations interested in having community members or staff trained	General population and individuals with substance use disorder	Y1, Y2, Y3
	Preventative education in the community	Number of engagements	HMC recovery nurses to provide education	Area colleges, high schools, youth organizations, and community based organizations	General population and individuals with substance use disorder	Y1, Y2, Y3
Provide support for any associated negative consequences to use	Harm reduction kits distributed to patients and through community organizations	Number distributed	Comprehensive Care Center cost to purchase fentanyl test strips, etc.	Hope for Holyoke, Providence Ministries for the Needy/Kate's Kitchen, Tapestry Health	Individuals with substance use disorder	Y1, Y2, Y3
Reduce stigma	Educational video at HMC nursing orientation to reduce stigma	Number trained	HMC Marketing, Addiction Consult Services, Center for Learning and Development, nursing staff	HMC staff; Tapestry Health	Individuals with substance use disorder	Y1, Y2, Y3
	General education for all staff through employee newsletter and annual competency training - all staff trained in words not to use	Number of employee trainings	HMC Marketing, Center for Learning, Addiction Consult Services	HMC staff	Individuals with substance use disorder	Y1, Y2, Y3
	SUD Care Committee	Number of activities	HMC Addiction Consult Services, HMC staff	HMC Addiction Consult Services	Individuals with substance use disorder	Y1, Y2, Y3

3. Substance Use Disorder

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Reduce stigma	Stigma flyers / posters for each department in hospital and mental health units	Number of HMC department partners	HMC staff time, print shop, and financial contribution	HMC Addiction Consult Services, HMC staff, HMC practices, HMC Partial Hospitalization Program	Individuals with substance use disorder and their families	Y1, Y2, Y3
	Partner with Central Pioneer Valley Public Health District to promote CredibleMind, mental health and wellness app	Number of cards distributed	HMC staff time	Central Pioneer Valley Public Health District, The Salvation Army, Kate's Kitchen, Lorraine's Soup Kitchen, health fairs, Greater Holyoke YMCA	Individuals looking to learn more about mental health and resources available	Y1, Y2, Y3
Support for patients struggling with recovery	Recovery coaches in ED		HMC Behavioral Health, HMC Addiction Consult Services; Applying for grant funding	City of Holyoke Opioid Fund, City of Holyoke Community Police, Hope for Holyoke, Tapestry Health	Individuals with substance use disorder	Y2, Y3
Support for individuals struggling with substance use disorder	Community outreach on substance use awareness, education and resources	Number of outreach engagements	HMC Behavioral Health, HMC Addiction Consult Services	Holyoke Police Department's Opioid Outreach Team, Hope for Holyoke, Hampden County Sheriff's Dept.	Individuals with substance use disorder	Y1, Y2, Y3
	Alcoholics Anonymous (AA) meetings on HMC behavioral health units	Number of meetings	HMC staff time	HMC Addiction Consult Services, Alcoholics Anonymous	Patients with substance use disorder	Y1, Y2, Y3
	Provide free space on campus for AA and Al-Anon support group meetings	Number of meetings	HMC meeting room space and staff time	HMC security staff, AA and Al-Anon	Individuals with substance use disorder and their families	Y1, Y2, Y3
Increase access to care	Provide care and response to serve individuals identified as having an acute and elevated risk, and connect them to services	Number of at-risk individuals connected to necessary services	HMC staff time	Holyoke Hub Community Mobilization Initiative including Holyoke Police Dept.'s Outreach Program, Holyoke Public Schools, Hampden County Sheriff's Dept., HMC Community Navigation, and over 40 other local agencies, community health workers	Community members with unaddressed mental health and substance use disorder	Y1, Y2, Y3

3. Substance Use Disorder

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to care	Provide free transportation	Ridership	HMC financial commitment to support two free shuttles in the community, valet parking, and door-to-door van service through Valet Park of America as well as funding of Lyft; Bus passes for patients not on the HMC transportation route	HMC Comprehensive Care Center, Valet Park of America, PVTA, Peter Pan bus lines, Lyft	Individuals in need of care that do not have a vehicle	Y1, Y2, Y3



4. Access to Healthcare

Access to healthcare is a foundational element in achieving positive health outcomes. By removing barriers such as transportation, language, and health insurance, patients are more likely to seek the care they need. Regarding healthcare, the [2023 MDPH CHES](#)¹ of underrepresented individuals within HMC's service area showed:

- 20% of survey respondents in HMC's service area had an unmet healthcare need in the past year.
- 17.3% had an unmet need for mental health care in the past year.
- 16.4% had an unmet need for an ongoing health condition in the past year.
- 12.1% had an unmet need for short-term illness care in the past year.



4. Access to Healthcare

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Increase access to care	Home visits	Number of patient visits	HMC staff time and financial contribution for mileage reimbursement	HMC Community Navigation Department	Patients without transportation, single parent households with children or elderly	Y1, Y2, Y3
	HMC Family Nurse Practitioner staffed at The Care Center	Number of The Care Center students receiving care and referrals through Family Nurse Practitioner	HMC Family Nurse Practitioner	The Care Center, area primary care providers	Young mothers under the age of 25 who are also economically disadvantaged and had their education interrupted by parenting	Y1, Y2, Y3
	Create outreach card that promotes transportation, financial counseling, language interpreters, community meal distributions in English, Spanish, and Haitian Creole	Number of cards distributed	Financial contribution and HMC staff time	Providence Ministries for the Needy / Kate's Kitchen, The Salvation Army, Lorraine's Soup Kitchen, Holyoke Public Library, Greater Holyoke YMCA, Holyoke Boys & Girls Club, Community Roots/Holyoke Veterans Lunch Group, area housing development offices	Low income, underserved members of the community	Y1, Y2, Y3
	Addition of primary care providers	Increase in number of appointments	HMC staff time	Holyoke Medical Group, HMC Community Navigation Department	Community members in need of a primary care provider	Y1
Provide care in patient's preferred language	Provide interpretive services 24/7 either in person or through telephone/video	Number of encounters provided	Financial contribution and HMC staff time	HMC Interpreter Services department: on site, in-person interpreters, language mediators - staff members with interpretive capabilities, local language service companies	Patients whose primary language is not English	Y1, Y2, Y3
	Provide translation for printed materials in Spanish as requested and meet additional language needs as patient is assessed	Number of requests for translated materials	Financial contribution and HMC staff time	HMC Interpreter Services department: on site, in-person interpreters, language mediators - staff members with interpretive capabilities, local language service companies; HMC print shop	Patients whose primary language is not English	Y1, Y2, Y3

4. Access to Healthcare

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Reduce transportation barriers to care	Provide two free shuttles in the city of Holyoke	Ridership	Financial contribution and HMC staff time	Valet Park of America	Patients without transportation	Y1, Y2, Y3
	Provide door-to-door van service in Holyoke for those that aren't on shuttle route	Ridership	Financial contribution and HMC staff time	Valet Park of America	Patients without transportation	Y1, Y2, Y3
	Provide PVTa or Lyft service home for those outside of hospital transportation routes without vehicle as needed	Number of patients transported	Financial contribution and HMC staff time	Lyft, PVTa	Patients without transportation	Y1, Y2, Y3
Increase access to testing and maintenance plan for good health	In-home blood draws and telehealth follow up	Number of patients receiving anticoagulation telehealth and in-home blood draws at no additional cost	HMC staff time and financial contribution for mileage reimbursement	HMC Anticoagulation department, HMC Lab, Loomis Communities, Massachusetts Veterans' Home at Holyoke	Patients with transportation and mobility challenges	Y1, Y2, Y3
Reduce financial barriers to care	Financial counseling and assistance applying for health insurance	Number of individuals assisted with financial counseling/applications	Financial contribution and HMC staff time	HMC financial counselors, HMC community navigation and other HMC staff	Low income patients and those without medical insurance coverage	Y1, Y2, Y3
Increase access to care for youth	Partner with River Valley Counseling Center by ServiceNet to provide school based teen clinics	Number of students served	HMC staff time	River Valley Counseling Center by ServiceNet, Holyoke High School North Campus, Holyoke High School Dean Campus, William R. Peck Middle School	Youth at Holyoke public middle and high schools	Y1, Y2, Y3

4. Access to Healthcare

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Improve access to quality and equity of care with a focus on initiatives addressing health-related social needs and specific improvement areas relating to health quality and equity	Health Related Social Needs screening in ED, inpatient, outpatient care	Number of patients screened	HMC staff time	HMC internal and external health equity committees, 413CARES.org, MA Coalition for the Homeless, Project Bread, Community Servings, EatWell, Boston Accountable Care Organization, Inc. (BACO), Wellsense, and local community based organizations	All patients	Y1, Y2, Y3
	Increase the collection and use of race, ethnicity, and language (REaL) data as well as Sexual Origin Gender Identity (SOGI) data	Data compiled	HMC staff time	HMC Center for Learning and Development	All patients	Y1, Y2, Y3
Increase access to preventative care and education	Provide educational workshops on site and in the community such as fall prevention, pulmonary conditions, pain management, stroke awareness, etc.	Number of community members reached	HMC staff time	Senior centers, skilled nursing facilities, high schools, Holyoke YMCA	Seniors, adults, teens	Y1, Y2, Y3



5. Chronic Disease

Chronic diseases such as heart disease, diabetes, cancer, and respiratory illnesses represent the leading causes of death and disability in the United States and were a concern mentioned often during CHNA community interviews. They also account for the majority of healthcare costs. In addition, the Executive Office of Health and Human Services and the Department of Public Health have identified chronic disease as a significant statewide issue and encourage hospitals to incorporate chronic disease into their SIP. The CHNA highlighted that within HMC's primary service area, [CDC BRFSS PLACES 2023](#)¹¹ data estimates:

- More than 11% have diabetes. In certain lower-income census tracts within Holyoke, that number increases to 22%.
- More than 7% have cancer. In some areas of Holyoke, Chicopee, and Westfield, that number increases to 11%.
- More than 30% have obesity. In certain lower-income census tracts within Holyoke, that number increases to 43% of the Flats section, 44% of downtown Holyoke, 45.2% of Churchill, and 51.4% of south Holyoke having obesity.
- More than 25% have a disability. In certain lower-income census tracts within Holyoke, that number increases to 45.5% of the Flats section, 50% of downtown Holyoke, 49.7% of Churchill, and 57.7% of residents in the south Holyoke section having a disability.



5. Chronic Disease

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Reduce 2.3% disparity in Hispanic/Latino patients with diabetes poor control rate (HbA1c >9.0%) as compared to non-Hispanic patients in HMC Primary Care practices regardless of insurance	Provide additional culturally sensitive diabetes education and importance of A1c screening	Reduction in HbA1c among Hispanic/Latino group to close current gap of 2.3% higher than the non-Hispanic group - Eliminate the performance gap amongst two groups; Perform at least one annual A1c screening to the target population	HMC staff time	HMC Endocrinology, HMC Primary Care, HMC Community Navigation, HMC Interpretive Services	The program will serve 18-75 year old Hispanic Latino population with HbA1c > 9%.	Y1
	Diabetes support group in English and Spanish	Number of support group attendees (open to both patients and community members)	HMC staff time	HMC Endocrinology, HMC Primary Care, HMC Community Navigation, HMC Interpretive Services	The program will serve 18-75 year old Hispanic Latino population with HbA1c > 9%.	Y1 and will reassess
	Training medical team on diabetic treatment protocols to guide patient care	Reduction in HbA1c among Hispanic/Latino group to close current gap of 2.3% higher than the non-Hispanic group - Eliminate the performance gap amongst two groups; Perform at least one annual A1c screening to the target population	HMC staff time	HMC Endocrinology, HMC Primary Care, HMC Community Navigation, HMC Interpretive Services	The program will serve 18-75 year old Hispanic Latino population with HbA1c > 9%.	Y1 and will reassess

5. Chronic Disease

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Reduce 2.3% disparity in Hispanic/Latino patients with diabetes poor control rate (HbA1c >9.0%) as compared to non-Hispanic patients in HMC Primary Care practices regardless of insurance	Provide culturally tailored educational sessions in various settings (i.e., community events, telephonic outreach, virtual sessions, home visits, community, etc.) to address HRSN barriers and increase awareness of community resources to help offer better control/management of diabetes	Reduction in HbA1c among Hispanic/Latino group to close current gap of 2.3% higher than the non-Hispanic group - Eliminate the performance gap amongst two groups; Perform at least one annual A1c screening to the target population	HMC staff time	HMC Endocrinology, HMC Primary Care, HMC Community Navigation, HMC Interpretive Services, Nuestras Raices	The program will serve 18-75 year old Hispanic Latino population with HbA1c > 9%.	Y1 and will reassess
Provide nutrition and diabetes education in the community	Community outreach including culturally relevant food preparation and sampling, and diabetes education	Number of engagements within the community	HMC staff time and educational give-a-way items	Holyoke Farmers' Market, Greater Holyoke YMCA, OneHolyoke CDC, HMC Community Navigation, HMC Endocrinology, Lorraine's Soup Kitchen, Kate's Kitchen, The Salvation Army, Let's Move Hampden County 5210, Holyoke Public Library, and area senior centers	All community members with a focus on economically disadvantaged individuals; individuals diagnosed with diabetes or obesity	Y1, Y2, Y3
Increase access to healthy food and exercise, use of farmers' market, and educate the importance of a diet with more fruits and vegetables	Host farmers' market on campus at HMC	Number of consults with farmers' market coach, and visits to market	HMC staff time and educational give-a-way items	Let's Move Hampden County 5210, Holyoke Health Center, Holyoke Farmers' Market through the Greater Holyoke Chamber, Greater Holyoke YMCA, area senior centers, and other community based organizations	All community members with a focus on economically disadvantaged individuals; individuals diagnosed with diabetes or obesity	Y1, Y2, Y3

5. Chronic Disease

Goal / Impact	Strategies / Initiatives	Measure	Hospital Resources	Internal / External Partnerships	Target Population	Timeline
Provide preventative education and screening for heart disease	Incorporate blood pressure screenings and educational materials to community meal distributions that HMC provides at senior centers, HMC farmers' market and at health fairs	Number of engagements within the community	HMC staff time and educational give-a-way items	Let's Move Hampden County 5210, Holyoke Farmers' Market through the Greater Holyoke Chamber, Greater Holyoke YMCA, area senior centers, and other community based organizations	All community members with a focus on economically disadvantaged individuals	Y1, Y2, Y3
Provide preventative education in community and encourage early screening for cancer	Community outreach	Number of engagements within the community	HMC staff time	Holyoke Farmers' Market, Greater Holyoke YMCA, OneHolyoke CDC, HMC Community Navigation, HMC Endocrinology, Lorraine's Soup Kitchen, Kate's Kitchen, The Salvation Army, Let's Move Hampden County 5210	All community members with a focus on economically disadvantaged individuals	Y1, Y2, Y3
Provide support for those diagnosed with cancer	Monthly support group in English and Spanish	Number of attendees	HMC staff time and financial contribution	HMC Oncology department patients, staff and volunteer HMC employee committee members	Patients with a cancer diagnosis	Y1, Y2, Y3

HEALTH NEEDS NOT BEING ADDRESSED (DIRECTLY)

HMC is dedicated to supporting the community it serves by staying true to its mission, leveraging its expertise and capabilities, and maintaining a strong organizational foundation to deliver a wide range of services and community benefits.

The IRS has identified the following reasons for not addressing a health need identified in a CHNA:

- Resource constraints,
- Other facilities or organizations in the community are addressing the need,
- Relative lack of expertise or competencies to effectively address the need,
- A relatively low priority assigned to the need, and/or
- A lack of identified effective interventions to address the need.

Based on these criteria, HMC will continue to collaborate with existing community partners to support the following needs that were not specifically addressed with direct interventions in the SIP:

- Limited Access to Technology
- Housing and Homelessness

Category	Reason Not Being Addressed	Needs	Explanation
Limited Access to Technology	Other specialized organizations are addressing the need	Expanded access to reliable internet for basic needs, digital skills and literacy training	This need is being addressed by community organizations such as the Alliance for Digital Equity, Massachusetts Broadband Institute, Pioneer Valley Planning Commission, Tech Foundry and area senior centers. HMC will continue to assist patients as needed, collaborate with community organizations to support digital-health literacy efforts when appropriate and ensure hospital technology (such as patient portals) remains accessible and user-friendly.
Housing and Homelessness	Other specialized organizations are addressing the need	Additional safe, code compliant, accessible and/or affordable housing	This need is being addressed by area agencies such as Way Finders, Valley Opportunity Council and the Center for Human Development. HMC will continue to collaborate with housing and homelessness-response organizations, provide referrals, and participate in initiatives that address the health needs of individuals experiencing housing instability.

References

- 1 Massachusetts Department of Public Health (MDPH) Community Health Equity Survey (CHES): <https://www.mass.gov/info-details/about-the-community-health-equity-survey-ches>
- 2 2024 Chicopee Youth Health Survey of 10th/12th Grade Students conducted by the Public Health Institute of Western Massachusetts: https://irp.cdn-website.com/8a359c3c/files/uploaded/CYRBS_2024_FrequencyReport_District_Suppressed_040825.pdf
- 3 The Greater Boston Food Bank Food Access Report: https://www.gbfb.org/wp-content/uploads/2025/06/GBFB_Food-Access-Report_2025_final.pdf
- 4 2025 Robert Wood Johnson County Health Rankings Report: <https://www.countyhealthrankings.org/health-data/massachusetts/hampden?year=2025>
- 5 Interactive Department of Transitional Assistance Map: <https://www.masslive.com/news/2025/10/town-by-town-mass-map-shows-where-snap-cuts-will-hit-hardest-find-your-city.html>
- 6 Substance Abuse and Mental Health Services Administration or SAMSHA: <https://www.samhsa.gov/substance-use/what-is-sud>
- 7 Massachusetts Department of Public Health Opioid-Related Overdose Deaths: <https://www.mass.gov/doc/opioid-related-overdose-deaths-by-county-june-2024-0/download>
- 8 Massachusetts Department of Public Health's Bureau of Substance Addiction Services (BSAS) Dashboard: <https://www.mass.gov/info-details/bureau-of-substance-addiction-services-bsas-dashboard>
- 9 City of Holyoke 2025 Opioid Community Needs Assessment: https://drive.google.com/file/d/1i-JqfPYjUC1mlp_R3Dv_HI_RPO9vYPTp/view
- 10 City of Holyoke's Opioid Response: <https://www.holyoke.org/opioid-response/#:~:text=For%20more%20information%2C%20please%20visit,forward%20to%20seeing%20you%20there!>
- 11 CDC BRFSS PLACES 2023 Data: <https://www.cdc.gov/places/index.html>