

Hilltown Community Health Center

Community Health Needs Assessment (CHNA) – 2025
“Communities Engaged in Health”



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Executive Summary

Hilltown Community Health Center (HCHC) conducted the 2025 Community Health Needs Assessment (CHNA) to understand the current health status, social conditions, and emerging needs across the Hilltowns and Pioneer Valley of Western Massachusetts. As the primary safety-net provider for much of this region, HCHC delivers integrated medical, dental, behavioral health, optometry, nutrition, weight management, and community programs, many of which are located in communities facing geographic isolation, rural poverty, provider shortages, and limited access to both transportation and broadband. This assessment ensures that HCHC remains aligned with the priorities of HRSA, HHS, and the Massachusetts Department of Public Health, while responding directly to the voices and lived experiences of the communities we serve.

The CHNA incorporates quantitative and qualitative data from patient surveys, focus groups, partner agencies, regional hospital CHNAs, and state and national datasets. Despite differences between the Pioneer Valley and Hilltown delivery areas, clear themes emerged across all sources. Community members consistently identified mental health concerns, chronic disease, and access barriers, including provider availability, transportation limitations, and difficulty securing affordable, healthy food, as major challenges affecting everyday health and well-being. The region also experiences greater burdens of chronic illness, higher rates of hypertension and diabetes, and more social and economic challenges than statewide averages.

Based on this comprehensive analysis, HCHC identified three priority areas for the 2025–2028 CHNA cycle for the Board to consider:

1. Mental Health Needs, with a Focus on Aging Seniors and Rural Communities

Mental health concerns, including depression, anxiety, stress, and social isolation, continue to rise. Older adults in rural areas face disproportionate barriers, including transportation challenges, reduced social support, limited behavioral health workforce availability, and difficulties accessing telehealth. Priorities for this cycle should include expanding integrated behavioral health care, strengthening partnerships with senior centers and councils on aging, and developing rural mental health outreach models that meet older adults where they are.

2. Chronic Disease Prevention and Management, with Emphasis on Food Insecurity, Diabetes, and Hypertension

Chronic conditions remain prevalent and are worsened by food insecurity, transportation challenges, and limited access to nutrition-related support. HCHC should continue to strengthen its integrated care model through Food as Medicine programming, enhanced A1c and blood pressure monitoring, culturally and linguistically appropriate diabetes education, and inter-departmental approaches that include medical, dental, optometry, behavioral health, weight management, nutrition, and community programs.

3. Increasing Access to Healthcare through Workforce Stability, Transportation Support, and Broadband Access

Provider shortages, long wait times to get appointments, and inconsistent broadband connectivity limit access to timely, high-quality care. For rural residents, transportation remains a defining barrier. HCHC should continue its efforts to expand the workforce through academic affiliations, recruitment and retention strategies, and training pathways; advocate for improved transportation options; and support regional initiatives to expand broadband so residents can successfully use telehealth and patient portals.

These priorities reflect both the strengths and ongoing challenges of the region, while aligning with HCHC's commitment to access and whole-person care. The 2025 CHNA should guide organizational strategy, quality improvement, resource allocation, and partnerships over the next three years, ensuring that HCHC continues to meet the evolving needs of the Hilltowns and Pioneer Valley with compassion, fairness, and integrity.

1. Introduction

Purpose

Hilltown Community Health Center (HCHC) is conducting this Community Health Needs Assessment (CHNA) to better understand the current health status, social conditions, and service needs of the rural Hilltowns, the Pioneer Valley, and the surrounding service areas of Western Massachusetts. This assessment guides the organization's strategic priorities, quality improvement efforts, and community partnerships, ensuring that care remains accessible, fair, and responsive to emerging needs.

Rooted in HCHC's mission to provide high-quality, compassionate, and accessible healthcare to all people, regardless of ability to pay, this CHNA helps identify barriers to care and opportunities for collaboration that strengthen the health and resilience of the people in our service area. The findings inform HCHC's service delivery, program development, and long-term strategic planning across medical, dental, behavioral health, optometry, weight management, nutrition, and community outreach programs.

By conducting the CHNA every three years, HCHC demonstrates compliance with HRSA's expectations for community-based governance, responsiveness to local needs, and ongoing assessment of social drivers of health (SDOH). The process also supports coordination with local hospital systems and aligns with DPH's emphasis on cross-sector collaboration and community engagement in public health planning. This CHNA is guided by and strives to be aligned with the current priorities of the U.S. Department of Health and Human Services (HHS), the Health Resources and Services Administration (HRSA), the Massachusetts Department of Public Health, and those of Baystate Noble Hospital and Cooley Dickinson Hospital.

Methodology

This CHNA was developed through a collaborative, multi-method approach that incorporated both quantitative and qualitative data. Key sources of information include:

1. Community Surveys: Distributed through HCHC and partner agencies such as the Chesterfield Council on Aging, the Hilltown CDC, Hampshire Public Schools, and the Gateway Regional School District.
2. Regional Hospital CHNAs: Findings from the Community Health Needs Assessments conducted by Baystate Noble Hospital and Cooley Dickinson Hospital (Mass General Brigham).
3. Public Health and Clinical Data: Reports from agencies that analyze community health and social conditions, including Uniform Data Systems (UDS), the Massachusetts Department of Public Health (MDPH), the CDC, Blue Cross Blue Shield of Massachusetts, and the Public Health Institute of Western Massachusetts.

4. Focus Groups: Sessions held across the service area with stakeholders such as the Hilltown Community Development Corporation, the Food Policy Council, and Amherst Town Council Wards.

Limitations

HCHC used a comprehensive strategy to understand the health needs, strengths, and challenges of the service area. As a smaller FQHC with limited staffing, HCHC relies on a blended approach, participating in the CHNA processes of two regional hospitals while also conducting its own surveys and focus groups to obtain direct community insights. Because the hospital service areas overlap with, but do not fully mirror, HCHC's service area, this CHNA represents a synthesized interpretation of multiple data sources. The findings reflect a merged analysis of hospital CHNAs, public health datasets, and HCHC's own locally collected information to create a cohesive picture of community needs.

2. Community Description /Service Area

HCHC Service Area

The service area for HCHC includes 25 communities located in Hampshire, Hampden, and Berkshire counties of Western Massachusetts. The 25 communities from 37 ZIP codes include: 1) Amherst, 2) Belchertown, 3) Blandford, 4) Chester, 5) Chesterfield (including the village of W. Chesterfield), 6) Cummington, 7) Easthampton (including a portion of Westhampton), 8) Goshen, 9) Granby, 10) Granville, 11) Hadley, 12) Hatfield, 13) Hinsdale 14) Huntington, 15) Middlefield, 16) Northampton, 17) Pelham, 18) Plainfield, 19) Russell, 20) South Hadley 21) Southampton, 22) Southwick, 23) Westfield (including a portion of Montgomery), 24) Williamsburg, and 25) Worthington. Patients from the towns identified in *Service Area Map and Table* comprise 75% of HCHC's patient population.



While the populations in HCHC’s service area share many characteristics, due to very different geographic features, HCHC’s service area can be broken down into two unique service “delivery areas”: the Hilltown delivery area and the Pioneer Valley delivery area.

Hilltown Delivery Area: The Hilltown delivery area is characterized by low population density, geographic isolation, pockets of rural poverty, and few opportunities for local employment. The Hilltown communities, apart from the City of Westfield, are designated as 100% rural by the state of Massachusetts and the USDA. They have an average municipal population, excluding the City of Westfield, of less than 2000 residents. Westfield is included in this delivery area because its proximity to the Huntington Health Center has resulted in almost 1000 patients from Westfield utilizing the health center in 2025.

Many patients also come from other Hilltowns and other communities that are technically not part of the service area, but who seek HCHC’s services. Numerous residents from the towns of Ashfield, Westhampton, Hawley, Savoy, Windsor, Peru, Washington, Otis, Sandisfield, Tolland, Granville, and Southwick utilize HCHC services.

Pioneer Valley Delivery Area: The Pioneer Valley delivery area, served primarily by HCHC’s Amherst site, reaches the more populous areas of Hampshire County. The area is characterized by a greater racial, linguistic, and cultural makeup than the Hilltown delivery area. The Pioneer Valley is in Western Massachusetts, straddling the Connecticut River. There is one bridge across the Connecticut River in the county, between Hadley and Northampton. The only major highway, Interstate 91, is on the west side, so residents of the eastern half of the county, which includes Amherst, do not have easy access to either the north or south. Located in a largely agricultural area, the larger towns contain many educational institutions, including the Five Colleges (Amherst, Mt. Holyoke, Smith, Hampshire, and the University of Massachusetts).

a. Health System Landscape

HCHC is the primary safety net provider for much of the region. The nearest hospitals, Baystate Noble (Westfield) and Cooley Dickinson (Northampton), are 30–45 minutes from many communities, underscoring the need for local, integrated care. HCHC’s Primary Care Medical Home model integrates medical, dental, behavioral health, optometry, weight management, and nutrition, and collaborates with many regional and state partners to close health quality gaps.

Service Area Socioeconomic Profile (2025)¹

Town	Population	Median Household Income	% Below Poverty	Educational Attainment ² (%)	Top Occupations	Transportation	Unemployment (%)
Chesterfield	704	73906	9.3	42.0	Education, Healthcare	Car commute avg 28 min	3.8
Cummington	1011	83875	6.8	38.5	Manufacturing, Services	Car commute avg 30 min	4.1
Goshen	483	88077	9.9	40.2	Construction, Education	Car commute avg 27 min	3.9
Huntington	857	58646	24.6	32.0	Retail, Services	Car commute avg 29 min	5.2
Middlefield	175	79167	5.2	36.8	Agriculture, Services	Car commute avg 32 min	4.0
Plainfield	577	60313	15.3	34.5	Construction, Education	Car commute avg 31 min	4.3
Worthington	1147	91181	2.9	44.0	Education, Healthcare	Car commute avg 30 min	3.7
Williamsburg	4020	107708	3.9	46.5	Education, Retail	Car commute avg 26 min	3.6
Blandford	363	90865	0.6	41.2	Manufacturing, Services	Car commute avg 33 min	3.5
Chester	552	79167	8.6	35.0	Construction, Retail	Car commute avg 32 min	4.2
Granville	1977	104583	6.3	43.8	Education, Healthcare	Car commute avg 28 min	3.8
Russell	690	103906	6.1	42.5	Retail, Services	Car commute avg 29 min	3.9
Southwick	9237	106779	4.2	45.0	Education, Healthcare	Car commute avg 27 min	3.6

¹ American Community Survey (ACS) 2023–2025 5-Year Estimates. U.S. Census Bureau. Available at:

<https://www.census.gov/programs-surveys/acs/data.html>

Esri Updated Demographics 2025 Projections. Available at: <https://www.esri.com/data>

County Health Rankings 2024. Available at: <https://www.countyhealthrankings.org>

CDC PLACES 2024. Available at: <https://www.cdc.gov/places>

U.S. Bureau of Labor Statistics (BLS). Employment and unemployment data. Available at:

<https://www.bls.gov>

This data was pulled by Co-pilot on 11/25/2025 and was audited for accuracy. Different resources list different data sets. For example, Statistical Atlas lists lower median household incomes.

² Refers to adults over age 25 who received a bachelor’s degree or higher.

Westfield	40834	78307	8.9	39.0	Manufacturing, Retail	Car commute avg 25 min	4.4
Becket	2430	79226	8.4	37.5	Construction, Services	Car commute avg 34 min	4.1
Amherst	40834	78307	8.9	72.0	Education, Services	Transit + car commute avg 20 min	3.2
Belchertown	3129	75284	10.0	45.9	Healthcare, Education	Car commute avg 29 min	3.9
Easthampton	17896	69337	8.7	44.0	Retail, Education	Car commute avg 24 min	4.0
Granby	1306	94663	6.8	43.0	Education, Healthcare	Car commute avg 28 min	3.7
Hadley	5325	112450	4.5	50.0	Education, Retail	Car commute avg 22 min	3.5
Hatfield	2051	97235	9.0	48.0	Education, Manufacturing	Car commute avg 23 min	3.8
Northampton	29571	80981	11.3	55.0	Education, Healthcare	Transit + car commute avg 18 min	3.6
Southampton	6224	114531	1.8	49.0	Education, Retail	Car commute avg 21 min	3.4
South Hadley	18168	92740	8.2	47.0	Education, Healthcare	Car commute avg 23 min	3.7

The socioeconomic landscape of the Hilltowns and Pioneer Valley reveals significant variation across the 25 communities served by HCHC, illustrating both the strengths and challenges that influence health outcomes, access to care, and daily living conditions. While the region includes pockets of relative economic stability, many towns face barriers associated with rural isolation, lower income levels, transportation limitations, and disparities in educational attainment.

b. Population Distribution and Rurality

Many Hilltown communities, such as Middlefield (population 175), Goshen (483), and Plainfield (577), have extremely small populations and are geographically dispersed. This isolation impacts access to healthcare, employment, grocery stores, and social support. Larger communities such as Amherst, Northampton, Westfield, Easthampton, and South Hadley serve as population anchors but still experience gaps in transportation, housing affordability, and access to primary care. The stark contrast between micro-communities and larger towns underscores the need for tailored approaches to service delivery.

c. Income, Poverty, and Economic Stability

Median household income varies widely across the service area, ranging from \$58,646 in Huntington to more than \$114,000 in Southampton. Several Hilltown communities, including Plainfield (15.3% below poverty), Huntington (24.6%), and Northampton (11.3%), experience substantially higher poverty rates than the state average. These economic disparities influence food security, chronic disease management, housing stability, and the ability to access transportation or broadband.

Communities with higher poverty rates often correspond to lower educational attainment and employment in lower-wage sectors, further intensifying economic barriers. By contrast, more affluent towns such as Hadley, Granville, and Williamsburg demonstrate higher incomes, lower poverty, with more residents employed in education and healthcare.

d. Educational Attainment and Workforce Composition

Educational attainment ranges from 32% in Huntington to 72% in Amherst, where the presence of numerous colleges significantly skews the data. Many Hilltowns have educational attainment rates between 35% and 45%, often reflecting fewer local educational or employment opportunities. Occupations across the region reflect the local economy:

- Hilltown communities rely heavily on construction, agriculture, manufacturing, and retail.
- Pioneer Valley towns more commonly report education and healthcare as dominant sectors.

These patterns influence income, insurance stability, and health literacy, factors that directly shape patient engagement and health outcomes.

d. Transportation as a Persistent Barrier

Transportation access is a defining challenge across the service area. Nearly every Hilltown community relies on car travel with average commutes of 27–34 minutes, underscoring the lack of public transit, long travel distances, and limited access to specialty care. Amherst and Northampton are the only communities with notable transit access, yet even these towns experience congested corridors and limited cross-county routes.

For many patients, especially older adults, individuals with mobility limitations, and those living in poverty, the reliance on private vehicles creates barriers to attending medical, dental, optometry, behavioral health, and specialty care appointments.

f. Employment and Economic Vulnerability

Unemployment rates across the service area remain relatively low (generally between 3.4% and 5.2%), but this does not capture underemployment, seasonal employment, or the nature of low wage work common in rural communities. Towns with higher unemployment, such as

Huntington (5.2%) and Westfield (4.4%), also experience higher poverty and lower educational attainment, contributing to greater unmet health and social needs.

Key Themes Emerging from the Socioeconomic Profile

- **Rural isolation** remains a central driver of limited access to healthcare, transportation, healthy food, and broadband services.
- **Income and poverty disparities** indicate concentrated pockets of economic barriers, particularly in the Hilltowns, that correlate with increased health risks.
- **Educational attainment levels** vary widely, impacting health literacy and the ability to navigate increasingly complex healthcare systems.
- **Occupational patterns** reflect local economic structures, with many residents working in physically demanding, lower-wage jobs that may increase chronic disease risk.
- **Transportation barriers** continue to be one of the most significant obstacles to timely and consistent care.

Overall Implications

The socioeconomic diversity of the service area requires flexible, community-specific strategies rather than one-size-fits-all solutions. The Hilltowns region may benefit from intensified outreach, expanded community health worker support, mobile services, and food security programs. Meanwhile, more urbanized communities in the Pioneer Valley may require enhancements to behavioral health integration, chronic disease management, and navigation support for increasingly diverse populations.

3. Community Health Needs/Priorities

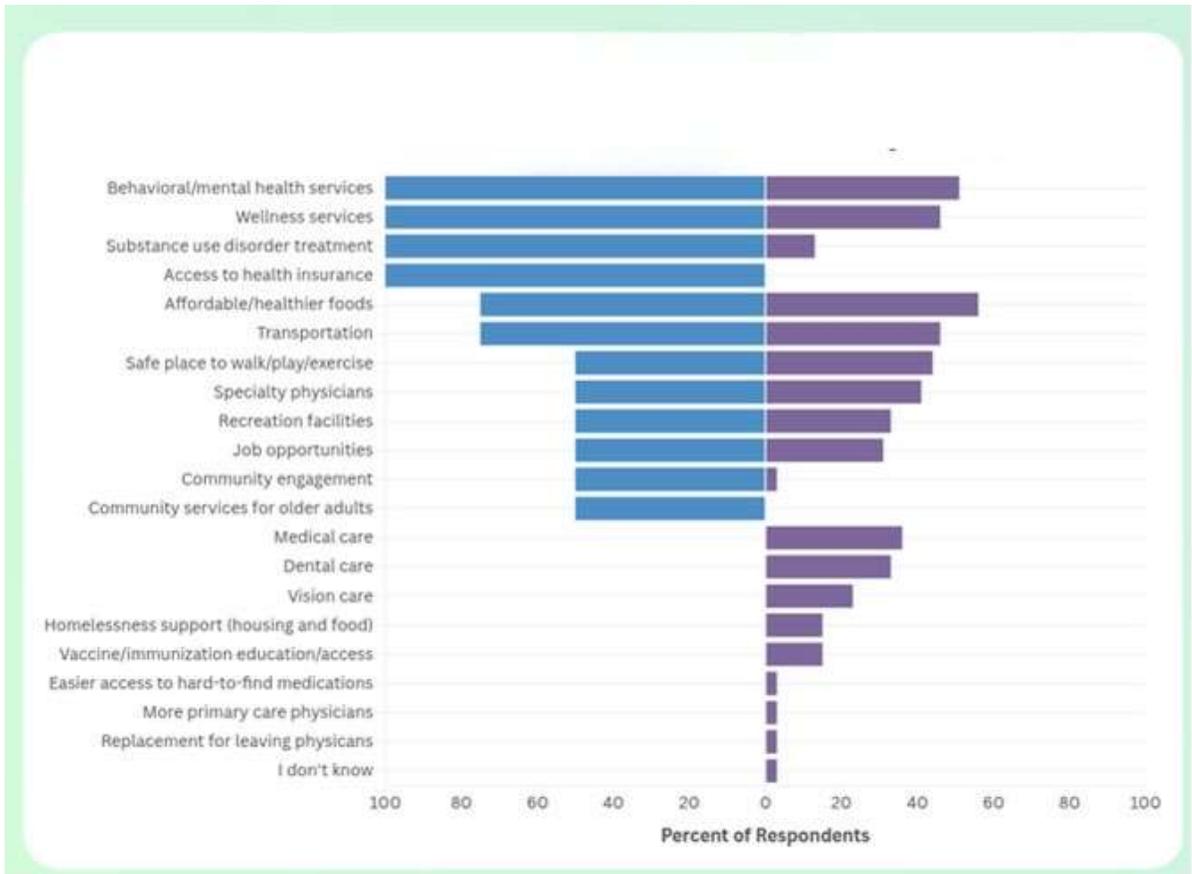
This section will break down the community needs data into three segments, followed by a summary of overall needs. These segments are: locally sourced survey and focus group respondents, priorities from the CHNAs for Baystate Noble Hospital and Cooley Dickinson Hospital, and national and state-level data regarding the strengths and needs of the HCHC service area.

1. Survey and focus group respondents

Survey

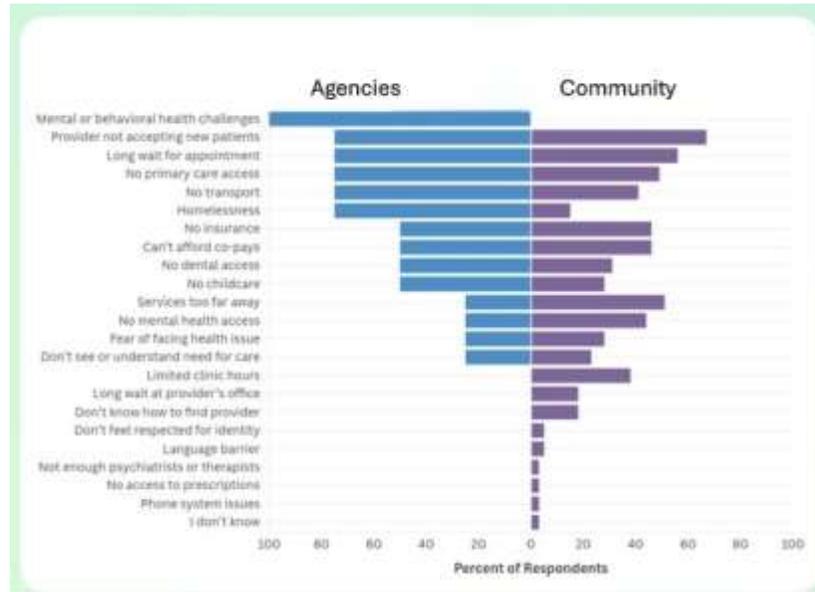
HCHC created a survey that provided space for patients and agency partners to answer questions about what they view as community priorities. While the data from this survey is not as robust as the other data sets that will be presented, this data directly represents the voices of folks whom we care for and with whom we partner. While many questions were included in the survey, this narrative will focus on three survey questions of comparison across patient and partner groups

Q1: What are the biggest health issues or concerns in your community?



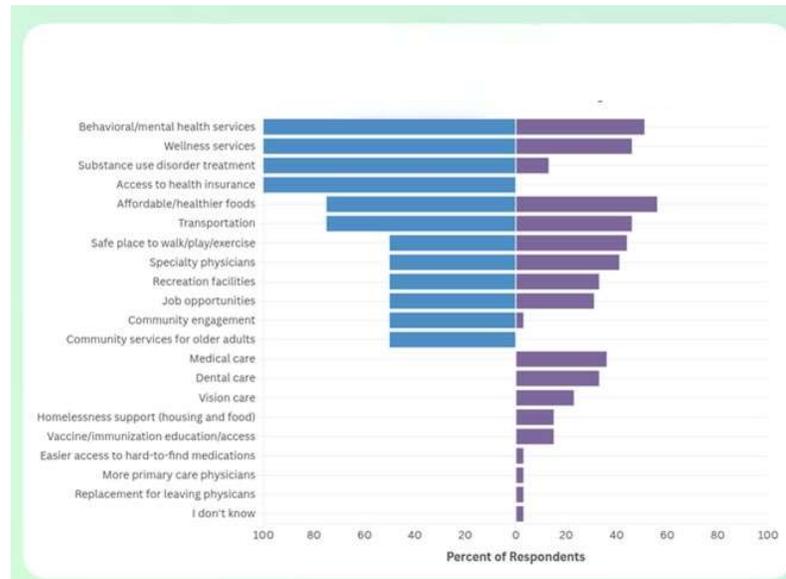
The respondents from the two groups had presented different priorities, but in general, both pointed to mental health and access to healthy food as health concerns, with the community also prioritizing oral health. When combined with feedback from the focus groups, we can ascertain that mental health for all ages, access to healthy food, and oral health/dental care are the three most pressing health concerns.

Q2: What keeps people in your community from seeking treatment for health care needs?



Except the importance of behavioral or mental health challenges, the respondents from both groups were in alignment on the question of access to healthcare. The themes of lack of access due to scheduling availability and wait times were prevalent. The Community group also pointed to distance being a barrier.

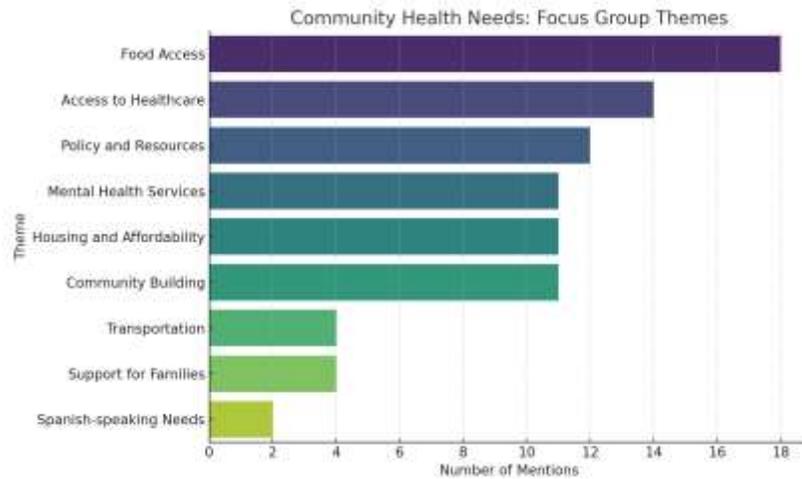
Q3: Which of the following are needed to improve the health of your family and neighbors?



The respondents were again aligned regarding resources needed to improve their health and their family’s health, although the community prioritized access to affordable, healthy food as a primary need. Both groups included behavioral health services, wellness services, and transportation as top priorities.

Focus Groups

The following aggregate data from the focus groups demonstrates that they, too, share similar priorities regarding the needs of the communities.



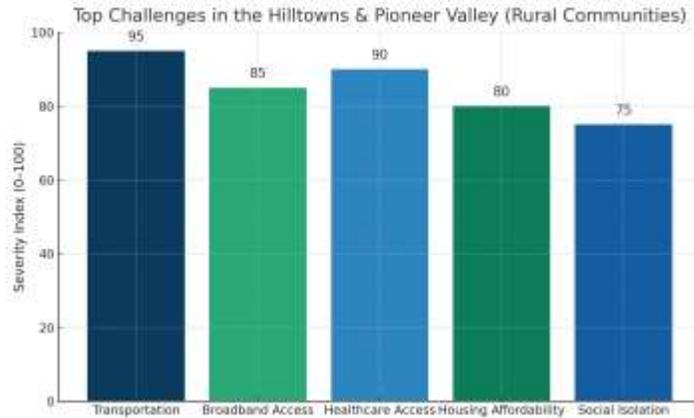
Access is a recurring theme, including access to food, healthcare, and mental health services. Interestingly, transportation was very low on the focus group priorities. It is also interesting that housing and community building, or a feeling of belonging, were as important as mental health services.

2. Priorities from the CHNAs for Baystate Noble Hospital and Cooley Dickinson Hospital

HCHC has traditionally pulled many of its data points and themes for its own CHNA from those published by Baystate Noble Hospital and Cooley Dickinson Hospital. The HCHC service area is split equally between the service areas of these hospitals. HCHC staff typically participate either as consultants or participants in the data collection and CHNA creation of each hospital. Therefore, it is not surprising to see similar themes emerge.

Community Challenges

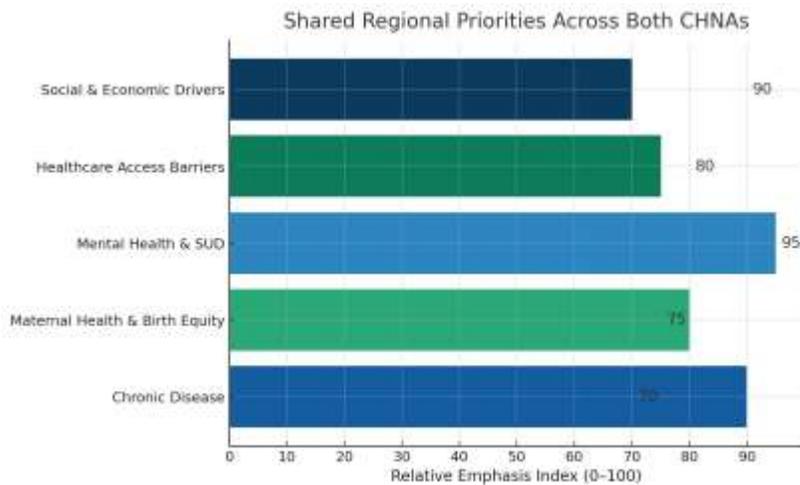
The many communities in the HCHC service area face many challenges. These challenges can differ across communities and hospital systems. The infographic is an analysis of the challenges that each CHNA shared, providing a glimpse of what the HCHC service area experiences:



This analysis suggests that transportation and access to healthcare are the most prevalent challenges that the people who reside in the Hilltowns and Pioneer Valley experience.

Priorities

Based on data from the CHNAs, a synthesis of the prioritized needs of Baystate Noble and Cooley Dickinson has revealed suggestions for HCHC to consider as service-wide needs.

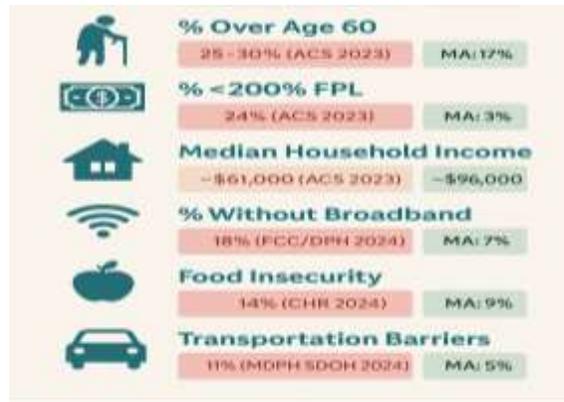


The final priorities of each CHNA both reflect and differ from the priorities that HCHC data suggest are important. However, mental health and substance use disorders, chronic disease, healthcare access, and social and economic drivers of health, which include the concern of food security and transportation, are high priorities for both hospital systems.

3. State and national data regarding the strengths and needs of the HCHC service area.

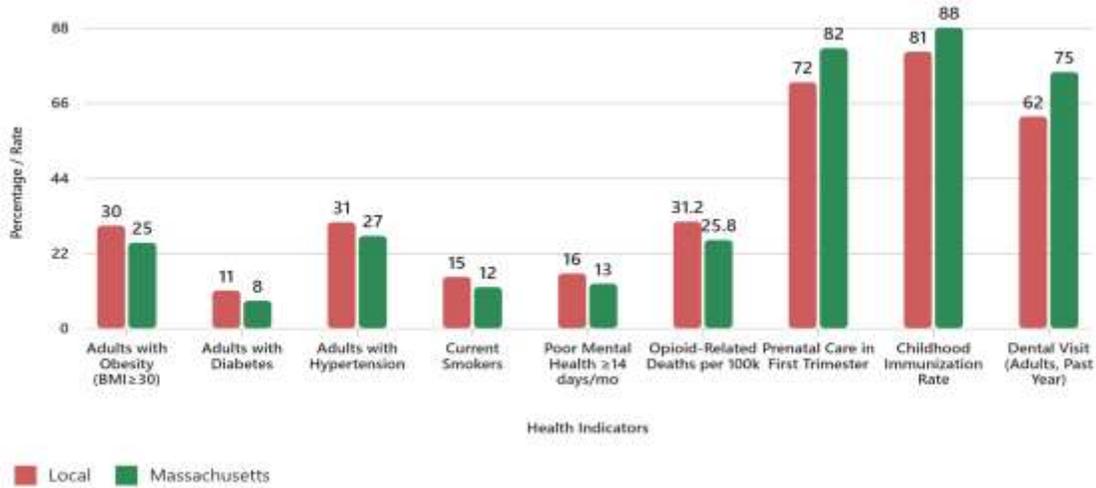
Numerous agencies report on data regarding the experiences of people who live in the HCHC service area, with a primary focus on Hampshire County. Quantitative data sources include

HRSA UDS (2022–2024), MDPH, ACS (2018–2023), County Health Rankings (2024), CDC PLACES/BRFSS Demographics and Social Conditions (selected indicators)³:



From this brief snapshot, it is evident that the service area experiences greater social needs than the state of Massachusetts as a whole. Each of these points aligns with the regional data that point to issues of access to food, transportation, income, and information.

When health status indicators are examined, it is clear that chronic disease is experienced more deeply in the HCHC service area⁴ than in the state of Massachusetts as a whole.



³ ACS (American Community Survey)2023, UDS (Uniform Data System)2023, FCC / DPH (Federal Communications Commission / MA Dept. of Public Health)2024, CHR (County Health Rankings)2024, and MDPH SDOH (MA Dept. of Public Health Social Determinants of Health)2024.

⁴ Sources: Data on adults with obesity and poor mental health is from CDC PLACES 2024. Current smoker rates are from BRFSS 2023. Opioid-related deaths and prenatal care data are from the Massachusetts Department of Public Health (MDPH) 2023. Childhood immunization rates are from Massachusetts Department of Public Health (DPH) 2024. Dental visit data is from the Uniform Data System (UDS) 2023. Adults with diabetes and hypertension percentages align with CDC PLACES 2024 estimates.

The table suggests that chronic disease, specifically obesity, hypertension, and diabetes, continues to be a high priority for HCHC. Moreover, mental health needs are greater in the service area. People in the services area also experience higher rates of opioid related deaths than does Massachusetts as a whole..

b. Summary of Priority Areas for the 2025–2028 CHNA Cycle

Based on a comprehensive analysis of quantitative data, stakeholder interviews, community surveys, workforce trends, and input from patients and partners across the Hilltowns and Pioneer Valley, several key issues emerged as the most pressing needs for the region. These priorities reflect both persistent challenges identified in the 2023 CHNA and new concerns emerging from demographic shifts, economic pressures, and changes in healthcare access. For the 2025–2028 CHNA cycle, Hilltown Community Health Center (HCHC) should focus on three overarching priority areas: mental health needs, chronic disease prevention and management, and increasing access to healthcare.

Priority 1: Mental Health Needs: Aging Seniors and Rural Communities

Mental health concerns continue to rise across the service area, with needs emerging among older adults living in rural communities. Survey participants, community partners, and clinical data all highlighted increasing levels of depression, anxiety, social isolation, and caregiver strain. Rural seniors face unique challenges, including limited access to specialized behavioral health services, fewer social supports, transportation barriers, and difficulties navigating technology needed for telehealth.

This priority includes developing age-friendly behavioral health supports, expanding integrated care models, strengthening partnerships, and tailoring outreach strategies for rural residents who may experience isolation, housing instability, or chronic health conditions that exacerbate mental health needs.

Priority 2: Chronic Disease Prevention and Management: Food Insecurity, Diabetes, and Hypertension

Chronic disease remains a significant concern across the Hilltowns and Pioneer Valley, particularly in the context of increasing rates of diabetes, pre-diabetes, hypertension, and obesity. Food insecurity, reported at high levels across the region, directly impacts disease progression and the ability of patients to manage complex conditions. Many households reported difficulty accessing affordable, nutritious foods due to transportation limitations, lack of nearby markets, or limited income.

For the 2025–2028 cycle, HCHC should continue strengthening prevention and management efforts by integrating medical, nutritional, dental, optometric, and behavioral health strategies. Priorities include expanding Food as Medicine initiatives, enhancing A1C and blood pressure

monitoring, improving culturally and linguistically appropriate diabetes education, increasing screening for social drivers of health, and deepening partnerships with mobile markets, food pantries, and community organizations. By addressing these issues in tandem, HCHC aims to reduce complications, prevent hospitalizations, and support long-term wellness.

Priority 3: Increasing Access to Healthcare: Workforce Stability, Transportation, and Broadband Access

Access to healthcare remains a central challenge for rural communities, shaped by provider shortages, travel distance, and limited digital infrastructure. Workforce stability and development continue to be among the most significant barriers to care, both locally and nationally, with ongoing shortages in primary care, dental, behavioral health, and nursing. HCHC's ability to recruit and retain qualified staff directly impacts appointment availability, continuity of care, and access to essential services.

Transportation barriers remain a major access issue for patients across the Hilltowns, where geographic distance and limited public transit options make it difficult to attend appointments. At the same time, gaps in broadband connectivity affect patients' ability to use telehealth, patient portals, remote monitoring tools, and online health resources.

Addressing this priority should involve continued investment in workforce recruitment and retention strategies, strengthening partnerships with academic institutions, advocating for expanded rural transportation solutions, and supporting community efforts to improve broadband infrastructure. Together, these strategies are essential to ensuring that residents can access high-quality, timely healthcare regardless of location or income.

4. Actions Taken on Priorities from the 2023 CHNA

Following the 2023 Community Health Needs Assessment, Hilltown Community Health Center (HCHC) identified three primary areas of focus: limited provider availability, food insecurity, and youth and family mental health, including the broader impacts of chronic illness. Over the past cycle, HCHC has taken coordinated, strategic action, often in partnership with regional stakeholders, to address these needs. The work described below reflects progress made, lessons learned, and areas that continue to require long-term investment as we move into the 2025 CHNA.

1. Limited Provider Availability

Provider availability remained one of the most urgent challenges identified in 2023, reflecting both local workforce shortages and nationwide gaps in primary care, dental, and behavioral health staffing. To strengthen access and stabilize the provider pipeline, HCHC implemented multiple recruitment and retention strategies, including:

- Securing a grant from the Massachusetts Executive Office of Health and Human Services to enhance primary care recruitment through paid internships, sign-on bonuses, and tuition reimbursement.
- Assisting newly hired providers with access to state and federal Loan Repayment programs.
- Establishing new affiliations with academic institutions offering degree or certification pathways related to primary care.
- Deepening collaborative relationships with colleges and universities, including participating in joint research, presentations, and training initiatives.

While these steps improved capacity in several areas, provider availability remains a major priority entering the 2025 CHNA cycle, particularly as workforce shortages continue across the country.

2. Addressing Food Insecurity

Food insecurity continued to be a significant concern across the Hilltowns and Pioneer Valley, particularly for patients managing chronic diseases. In response, HCHC expanded and strengthened initiatives designed to improve access to nutritious food and reduce barriers for families:

- Secured a grant in partnership with the UMass School of Nursing to launch a Food as Medicine program, connecting patients with fresh produce to support food security and improve health outcomes, such lowering as A1C levels and hypertension.
- Partnered with the Food Bank of Western Massachusetts and the United Way of Franklin and Hampshire County to support food distribution, linking community health workers with patients who screened positive for food insecurity on the SDOH assessment.
- Collaborated with local and regional mobile markets to increase access to healthy foods and better connect patients with available community resources.

These efforts not only supported immediate needs but also enhanced long-term nutritional stability for high-risk patients and families.

3. Health Disparities and Chronic Illness

The 2023 CHNA highlighted significant health disparities within the service area related to chronic illness. In response, HCHC implemented a comprehensive strategy to improve health outcomes using a whole-person care approach:

- Launched a Weight Management Program offering integrated medical care, behavioral health support, and nutrition counseling. The program emphasizes health literacy, understanding key numbers, and building sustainable habits.
- Developed inter-departmental charters to coordinate chronic disease management. Optometry prioritized outreach and screening for diabetic retinopathy and glaucoma; Dental implemented blood-pressure screenings for all patients to monitor hypertension; Behavioral Health brought on a provider specializing in the behavioral dimensions of eating and wellness.
- Secured a grant to expand diabetes education specifically for patients who use Spanish during health encounters.
- Piloted a practice transformation model that created team-based care structures to address each patient’s whole-health needs.
- Partnered with Baystate Health and the PURCH Program (Population-based Urban and Rural Community Health) to conduct a medical-student-led project addressing the needs of growing Russian and Ukrainian-speaking populations. As a result of this work, Russian is now the second most interpreted language at HCHC.
- Established a hybrid Navigator/CHW position to provide more efficient and coordinated support for patients requiring assistance with both insurance navigation and social-determinant-of-health resources.

5. Conclusion

The 2025 Community Health Needs Assessment underscores the resilience of the communities HCHC serves and the continued need for coordinated solutions to address persistent gaps in mental health access, chronic disease management, and healthcare availability. Across all data sources, community members expressed concerns that reflect both local challenges and broader rural health trends: high rates of chronic illness, limited provider availability, barriers to transportation and broadband, rising mental health needs, and significant economic and social pressures that impact health outcomes.

At the same time, the CHNA highlights meaningful progress since the 2023 assessment. HCHC strengthened recruitment efforts, expanded nutrition and chronic disease programs, piloted innovative practice transformations, deepened cross-sector partnerships, and broadened access to culturally and linguistically appropriate care. These accomplishments demonstrate HCHC’s commitment to responding to community needs with creativity, collaboration, and compassion.

Looking ahead to 2025–2028, HCHC remains dedicated to advancing the three priority areas identified in this assessment. Addressing mental health needs, especially among aging adults, will require ongoing investment in integrated behavioral health models and community-based

supports. Combating chronic disease and food insecurity will demand sustained attention to preventative care, nutritional access, and culturally responsive education. Strengthening healthcare access will rely on continued workforce development, stronger digital infrastructure, and solutions that reduce transportation barriers for rural residents.

HCHC will continue to listen to community voices, engage local partners, monitor emerging trends, and evaluate progress to ensure that programs and interventions remain responsive and effective. This CHNA reaffirms HCHC's mission to provide access to high-quality integrated healthcare and promote well-being to all and serves as a foundation for strategic planning and resource allocation over the next three years. Through shared commitment and continued collaboration, HCHC aims to build a healthier, more connected future for every person in the Hilltowns and Pioneer Valley.