Beth Israel Lahey Health

Winchester Hospital

# 2022 Community Health Needs Assessment

# Acknowledgments

This 2022 Community Health Needs Assessment report for Winchester Hospital (WH) is the culmination of a collaborative process that began in September 2021. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key collaborators from throughout WH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

WH appreciates all who invested time, effort, and expertise to develop this report and the Implementation Strategy. This report summarizes the assessment and planning activities and presents key findings, community health priorities, and strategic initiatives that are the results of this work.

WH thanks the WH Community Benefits Advisory Committee and the residents who contributed to this process. Hundreds of residents throughout WH's Community Benefits Service Area shared their needs, experiences, and expertise through interviews, focus groups, a survey, and community listening sessions. This assessment and planning process would not have been possible or as successful had it not been for the time and effort of the residents who engaged in this work.

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**Dana Zitkovsky**, MD, Chief Medical Officer

**Karen Keaney**, Chief Nursing Officer

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**Jessie Bencosme**, Council of Social Concern

**Marie Walsh Condon**, MD, Medford Family Practice

**Angeline Brady**, Center for Healthy Living, Winchester Hospital

**Dot Butler**, Winchester SAFER Coalition

**Denise Flynn**, Vice President Philanthropy, Winchester Hospital

**Christine Healey**, Director, Community Benefits & Relations, BILH

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**Deb McDonough**, Winchester Hospital Board Member

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**Adam Rogers**, Boys & Girls Club, Stoneham/ Wakefield

**Sharon Ron**, Metropolitan Area Planning Commission

**Joseph Tarby III**, Winchester Hospital Board Vice Chair

**LeighAnne Taylor**, Regional Manager, Community Benefits & Relations, Winchester Hospital

**Jane Walsh**, Chair of the Board of Trustees, Winchester Hospital

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# Introduction

## Background

Winchester Hospital (WH), founded in 1912, is a 229-bed community hospital located in Winchester, Massachusetts, that serves nearly half a million people a year and is one of the leading providers of comprehensive health care services in the area northwest of Boston. In addition to acute care inpatient services, WH provides an extensive range of outpatient medical, surgical, and obstetrical services as well as specialized care in bariatrics, cardiology, cardiac surgery, orthopedics, neurology, vascular surgery, and oncology. WH also offers a network of satellite primary care practices in several surrounding communities. Winchester Hospital's mission is "To Care. To Heal. To Excel. In Service to Our Community."

WH is committed to being an active partner and collaborator with the communities it serves. In 2019, as part of a merger of two health systems in the greater Boston region, WH became part of Beth Israel Lahey Health (BILH) - a system of academic medical centers, teaching hospitals, community hospitals, and specialty hospitals with more than 35,000 caregivers and staff who are collaborating in new ways across professional roles, sites of care, and regions to make a difference for our patients, our communities, and

one another. WH, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA).

This 2022 Community Health Needs Assessment (CHNA) report is an integral part of WH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that WH provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This assessment, along with the associated prioritization and planning processes, also provides a critical opportunity for WH to engage the community and strengthen the community partnerships that are essential to its success now and in the future. The assessment engaged nearly 1,000 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department and ambulance officials), faith leaders, other government officials and community residents.

**ASSESS** — Community health, defined broadly to include health status, social determinants, environmental factors, and service system strengths/weaknesses.

**ENGAGE** — Members of the community including local health departments, clinical service providers, community-based organizations, community residents, and hospital leadership/staff.

**PRIORITIZE** — Leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence.

**DEVELOP** — A three-year Implementation Strategy to address community health needs in collaboration with community partners.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of WH's mission. Finally, this report allows WH to meet its federal and Commonwealth community benefits requirements per the federal Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office and the Massachusetts Department of Public Health.

## Purpose

The CHNA is at the heart of WH's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that WH serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

Prior to this current CHNA, WH completed its last assessment in the summer of 2019 and the report, along with the associated 2020-2022 IS, was approved by the WH Board of Trustees on September 5, 2019. The 2019 CHNA report was posted on WH's website before September 30, 2019 and, per federal compliance requirements, made available in paper copy, without charge, upon request.
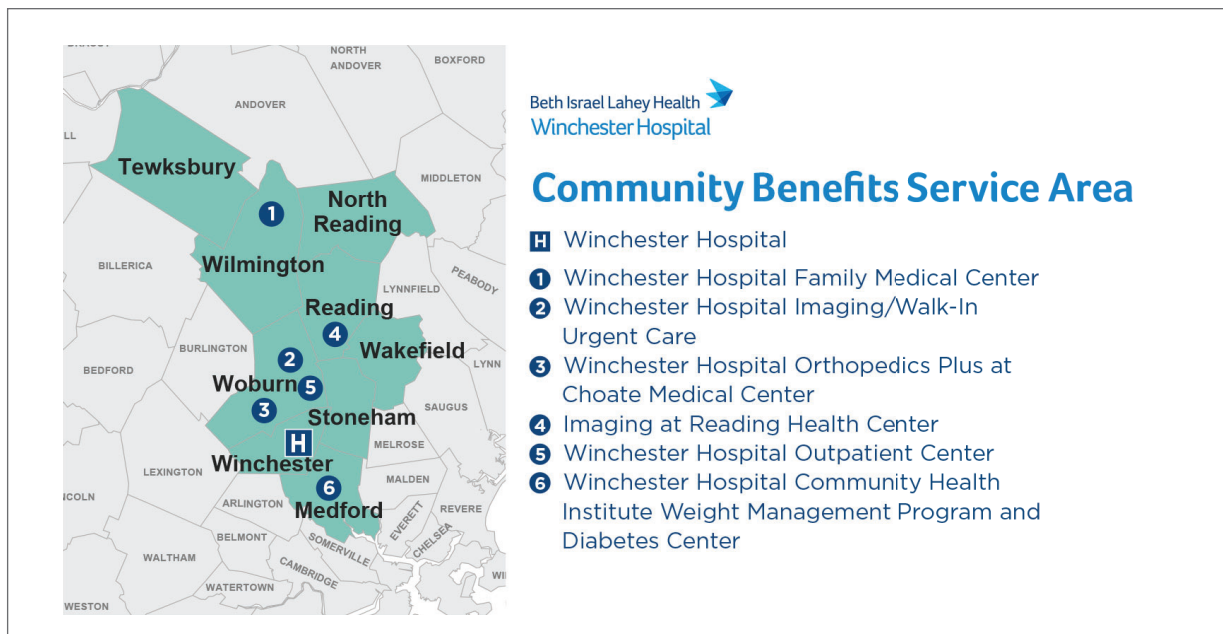
The assessment and planning work for this current report was conducted between September 2021 and September 2022 and WH's Board of Trustees approved the 2022 report and adopted the 2023-2025 IS, included as Attachment E, on September 13, 2022.

## Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within the hospital's designated CBSA. Understanding the geographic and demographic characteristics of WH's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

### Description of Community Benefits Service Area

WH's CBSA includes the nine municipalities of Medford, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn located to the northwest of Boston, Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs. There are segments of the WH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. WH is committed to promoting health, enhancing access, and



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## Community Benefits Service Area

**H** Winchester Hospital
**1** Winchester Hospital Family Medical Center
**2** Winchester Hospital Imaging/Walk-In Urgent Care
**3** Winchester Hospital Orthopedics Plus at Choate Medical Center
**4** Imaging at Reading Health Center
**5** Winchester Hospital Outpatient Center
**6** Winchester Hospital Community Health Institute Weight Management Program and Diabetes Center

delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. WH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

WH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within the CBSA. The activities that will be implemented as a result of this assessment will support all of the people who live in the CBSA. However, in recognition of the health disparities that exist for some residents, WH focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved. By prioritizing these cohorts, WH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

# Assessment Approach & Methods

## Approach

It would be difficult to overstate WH's commitment to community engagement and a comprehensive, data-driven, collaborative and transparent assessment and planning process. WH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage WH's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been hisotircally underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

The CHNA and IS development process was guided by the following principles: equity, collaboration, engagement, capacity building, and intentionality.

**Equity:**

Work toward the systemic, fair, and just treatment of all people.

**Collaboration:**

Leverage resources to achieve greater impact by working with community residents and organizations.

**Engagement:**

Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, people most impacted by inequities, and others

**Capacity Building:**

Build community cohesion and capacity by co-leading community listening sessions and training community residents on facilitation

**Intentionality:**

Be deliberate in requests for and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit

The assessment and planning process was conducted between September 2021 and September 2022 in three phases, which are detailed in the table below:

| Phase I:<br>Preliminary Assessment & Engagement | Phase II:<br>Focused Engagement | Phase III:<br>Strategic Planning & Reporting |
|---|---|---|
| Engagement of existing CBAC | Additional interviews | Presentation of findings and prioritization with CBAC and hospital leadership |
| Collection and analysis of quantitative data | Facilitation of focus groups with community residents and community-based organizations | Draft and finalize CHNA report and IS document |
| Interviews with key collaborators | Dissemination of community health survey, focusing on resident engagement | Presentation of final report to CBAC and hospital leadership |
| Evaluation of community benefits activities | Facilitation of community listening sessions to present and prioritize findings | Presentation to WH's Board of Trustees |
| Preliminary analysis of key themes | Compilation of resource inventory | Distribution of results via hospital website |

In July of 2021, BILH hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to assist WH and other BILH hospitals to conduct the CHNA. WH worked with JSI to ensure that the final WH CHNA engaged the necessary community constituents, incorporated comprehensive quantitative information for all communities in its CBSA, and fulfilled federal and Commonwealth community benefits guidelines.

## Methods

### Oversight and Advisory Structures

The CBAC greatly informs WH's assessment and planning activities. WH's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and members of the hospital's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Local public health departments/boards of health
- Additional municipal staff (such as elected officials, planning, etc.)
- Education
- Housing (such as community development corporations, local public housing authority, etc.)

- Social services
- Regional planning and transportation agencies
- Private sectors
- Community health centers
- Community-based organizations.

These institutions are committed to serving residents throughout the region and are particularly focused on addressing the needs of those who are medically underserved, those experiencing poverty, and those who face inequities due to their race, ethnicity, spoken language, national origin, religion, gender identity, sexual orientation, disability status, age, or other personal characteristics.

| Demographic, SES* & SDOH** Data | Commonwealth/National Health Status Data | Hospital Utilization Data | Municipal Data Sources |
|---|---|---|---|
| Age, SOGI***, race, ethnicity | Vital statistics | Inpatient discharges | Public school districts |
| Poverty, employment, education | Behavioral risk factors | Emergency department discharges | Local assessments and reports |
| Crime/violence | Disease registries | | |
| Food access | Substance use data | | |
| Housing/transportation | COVID-19 Community Impact Survey | | |

*Socioeconomic status      **Social determinants of health      ***Sexual orientation and gender identity

INFORM — CONSULT — INVOLVE — COLLABORATE — EMPOWER — COMMUNITY DRIVEN/LED

Low level of community engagement → Mid level of community engagement → High level of community engagement

The involvement of WH's staff in the CBAC promotes transparency and communication, andensures that there is a direct link between the hospital and many of the community's leading health and social service community-based organizations. The CBAC meets quarterly to support WH's community benefits work and met six times during the course of the assessment and planning process. During these meetings, the CBAC provided invaluable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities.

## Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, WH collected a wide range of quantitative data to characterize the communities served across the hospital's CBSA. WH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible, and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment, including results of the WH Community Health Survey, is included in Appendix B

## Community Engagement and Qualitative Data Collection

Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Accordingly, WH applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, WH employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Between October 2021 and February 2022, WH conducted 21 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 800 residents, and organized two community listening sessions. In total, the assessment process collected information from nearly 1,000 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are guides, summary findings, and other materials related to the interviews, focus groups, and community listening sessions.

**21** interviews
with community leaders

**822** survey respondents

**3** focus groups
- Boys & Girls Club
- Medford Council on Aging
- Woburn Parents.

## Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across the broad continuum of services, including:

- Domestic violence
- Food assistance
- Housing
- Mental health and substance use

- Senior services
- Transportation.

The resource inventory was compiled using information from existing resource inventories and partner lists from WH. Community Benefits staff reviewed WH's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which included a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify key partners who may or may not be already collaborating with the hospital. The resource inventory can be found in Appendix C.

## Prioritization, Planning, and Reporting

At the outset of the strategic planning and reporting phase of the project, community listening sessions were organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA. This was the first step in the prioritization process and allowed the community the opportunity to discuss the assessment's findings and for them to formally identify the issues that they believed were most important, using an interactive and anonymous polling software. These sessions also allowed participants to share their ideas on existing community assets and strengths as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the community listening sessions, the WH CBAC was engaged. The CBAC was updated on assessment progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in their own prioritization process using the same set of interactive and anonymous polls, which allowed them to identify a set of community health priorities and population cohorts that they believed should be considered for prioritization as the hospital developed its IS.

After the prioritization process, a CHNA report was developed and WH's existing IS was augmented, revised, and tailored. In developing the IS, WH's Community Benefits staff took care to retain the community health initiatives that worked well and that aligned with the identified priorities from the 2022 assessment, but also posed new strategies to address the newly identified priorities.

After drafts of the CHNA report and IS were developed, they were shared with WH's senior leadership team for input and comment. WH's Community Benefits staff then reviewed these inputs and incorporated elements, as appropriate, before the final 2022 CHNA report and 2023-2025 IS were submitted to the hospital's Board of Trustees for approval.

After the Board of Trustees formally approved the 2022 CHNA report and adopted 2023-2025 IS, these documents were posted on WH's website, alongside the 2019 CHNA report and 2020-2022 IS, for easy viewing and download. As with all WH CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that WH's Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

**Questions regarding the 2022 assessment and planning process or past assessment processes should be directed to:**

**LeighAnne Taylor**
Regional Manager, Community Benefits
and Community Relations
Winchester Hospital
41 Highland Ave.
Winchester, MA 01890
LeighAnne.Taylor@bilh.org
617-278-7028

**Christine Healey**
Director, Community Benefits and Community Relations
North Region
Beth Israel Lahey Health
25 Burlington Mall Rd.
Burlington, MA 01805
Christine.Healey@bilh.org
617-278-7026

# Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, other government officials, and community residents engaged in supporting the health and well-being of residents throughout WH's CBSA. Findings are organized into the following areas:

- **Community Characteristics**

- **Social Determinants of Health**

- **Systemic Factors**

- **Behavioral Factors**

- **Health Conditions.**

Each section begins with a highlight of key findings. This introduction is followed by graphs and other data visuals. It is important to note that these five sections do not review all of the findings collected during the assessment, rather they draw out the most significant drivers of health status and health disparities. A summary of interviews, focus groups, and community listening sessions, and a databook that includes all of the quantitative data gathered for this assessment are included in Appendices A and B.

# Community Characteristics

A description of the population's demographic characteristics and trends lays the foundation for understanding community needs and health status. This information is critical to recognizing health inequities and identifying communities and population cohorts that are disproportionately impacted by health issues and other social, economic, and systemic factors. This information is also critical to WH's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status, and other characteristics.

Based on the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the WH CBSA were issues related to age, race/ethnicity, language, disability status, and immigration status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were non-white, people of color,

immigrants, non-English speakers, and foreign-born populations in all communities.

There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers were most likely to have poor health status and face systemic challenges accessing needed services. While relatively small, these segments of the population were impacted by language, cultural barriers, and racism that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes.

One issue to be noted was the lack of data available by gender identity and sexual orientation at the municipal level. Research shows that those who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning experience health disparities and challenges accessing services.

## Population Growth

Between 2010 and 2020, the population in WH's CBSA increased by 7%, from 252,961 to 269,602 people. Wakefield saw the greatest percentage increase (9%) and Reading saw the lowest (3%).

**Population Changes by Municipality, 2010 to 2020**
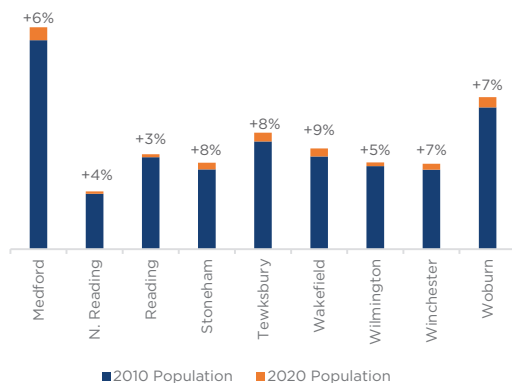


Source: US Census Bureau, 2010 and 2020 Decennial Census

## Nation of Origin

Immigration status is linked to health in many ways; individuals who are foreign-born are less likely to have access to health care and are more likely to forgo needed care due to fear of interacting with public agencies.[2]

**14%** of the WH CBSA population was foreign-born.

**Region of Origin Among Foreign-Born Residents in the CBSA, 2016-2020**



- Europe: 26%
- Asia: 39%
- Africa: 7%
- Latin America: 25%
- North America: 3%
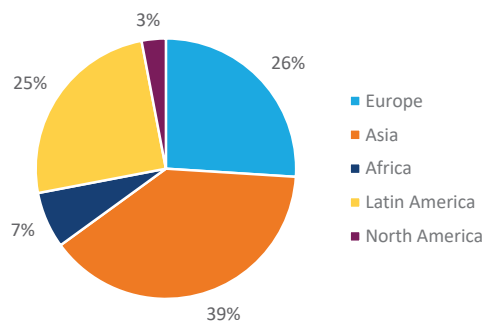
Source: US Census Bureau American Community Survey, 2016-2020

## Language

Language barriers pose significant challenges to receiving and providing effective and high-quality health and social services. Studies show that health outcomes improve when patients and providers speak the same language.[3]

**17%** of WH CBSA residents 5 years of age and older spoke a language other than English at home and of those,

**31%** spoke English less than "very well."

Source: US Census Bureau American Community Survey 2016-2020

## Age

Age is a fundamental factor to consider when assessing individual and community health status. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.

**17%** of residents in the WH CBSA were 65 years of age or older. The proportion of older adults is expected to increase by 2030, which may have implications for the provision of health and social services.

**20%** of residents in the CBSA were under 18 years of age.

Source: US Census Bureau American Community Survey, 2016-2020

## Gender Identity and Sexual Orientation

Massachusetts has the second largest lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA+) population of any state in the nation. LGBTQIA+ individuals face issues of disproportionate violence and discrimination, socioeconomic inequality and health disparities.

**5%** of adults in Massachusetts identified as LGBTQIA+. Data was unavailable at the municipal level.

**21%** of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

## Race and Ethnicity

In the WH CBSA overall, the number of residents who identified as white and American Indian/Alaska Native has decreased since 2010, while there was an increase in other census categories. Individuals who participated in the assessment reported that they felt the CBSA was increasingly diverse, though the CBSA was predominantly white.

### Race/Ethnicity by Municipality, 2016-2020
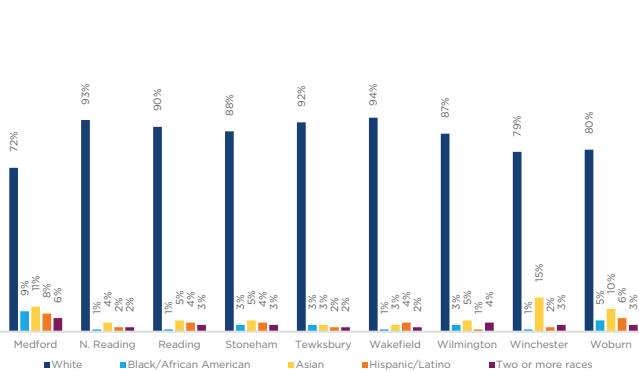


Source: US Census Bureau American Community Survey, 2016-2020

### CBSA Population Changes by Race/Ethnicity, 2010 to 2020
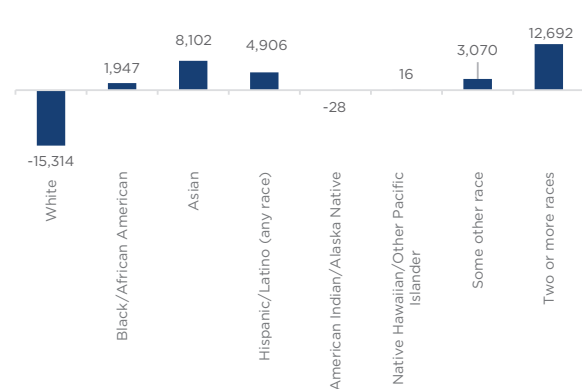


Source: US Census Bureau, 2010and 2020 Decennial Census

Note: The US Census Bureau reported that the 2020 Decennial Census significantly undercounted Black/African American, American Indian or Alaska Native, Some Other Race alone, and Hispanic or Latino populations. The Census significantly overcounted the white, non-Hispanic white, and Asian populations.

## Household Composition

Household composition and family arrangements may have significant impacts on health and well-being, particularly as family members act as sources of emotional, social, financial, and material support.[4]

**29%** of WH CBSA households included one or more people under 18 years of age.

**30%** of WH CBSA households included one or more people over 65 years of age.

Source: US Census Bureau American Community Survey, 2016-2020

# Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."[5] These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. economic insecurity, access to care/navigation issues, and other important social factors.[5]

There was limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, listening sessions and the WH Community Health Survey indicated that these issues had the greatest impact on health status and access to care in the region - especially issues related to housing, food insecurity/nutrition, and economic stability.

Interviewees, focus groups, and listening session participants shared that access to safe and affordable housing was the most significant challenge for residents in the CBSA. Participants also shared that, even among individuals and families in middle and upper-middle income brackets, housing costs can contribute to economic insecurity.

Food insecurity, food scarcity, and hunger were also identified as significant challenges, particularly for individuals and families experiencing economic insecurity. These issues were correlated to issues of job loss, inability to find employment that paid a livable wage, and living on an inadequate fixed income, which impacts the ability of individuals and families to eat a healthy diet. Interviewees, focus groups, listening session participants, and WH Community Health Survey respondents also shared that transportation was a critical factor to maintaining one's health and accessing care, especially for older adults and individuals who did not have a personal vehicle or were without caregivers, family, and social support networks.

## Economic Stability

Economic stability is affected by income/poverty, financial resources, employment and work environment, which allow people the ability to access the resources needed to lead a healthy life.[6] Lower-than-average life expectancy is highly correlated with low-income status.[7] Those who experience economic instability are also more likely not to have health insurance or to have health insurance plans with very limited benefits. Research has shown that those who are uninsured or have limited health insurance benefits are substantially less likely to access health care services.[8]

COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability.

**Percentage of Residents Living Below the Poverty Level, 2016-2020**
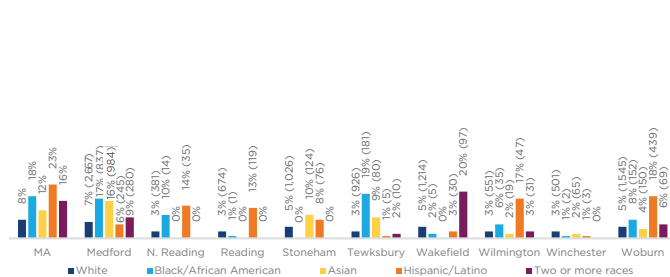


Source: US Census Bureau American Community Survey, 2016-2020

**Median Household Income, 2016-2020**
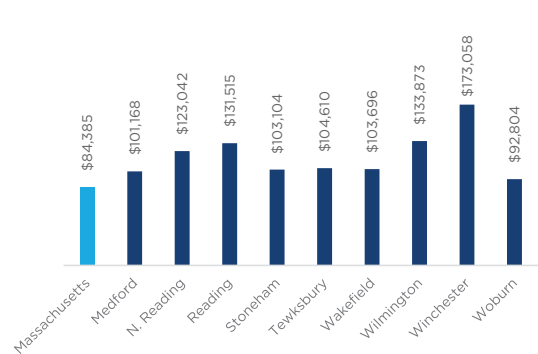


Source: US Census Bureau American Community Survey, 2016-2020

Across the CBSA, the percentage of individuals living below the poverty level tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of systemic racism, discrimination, and cumulative disadvantage over time.[9] Median household income is the total gross income before taxes, received within a one-year period by all members of a household. Median household income was higher than the Commonwealth overall in all CBSA municipalities.

The Massachusetts Department of Public Health (MDPH) conducted the COVID-19 Community Impact Survey in the fall of 2020 to assess emerging health needs, results of which indicated that community residents were concerned about their ability to pay their bills.

**Percentage\* Worried About Paying for One or More Type of Expenses/Bills in Coming Weeks (Fall 2020)**
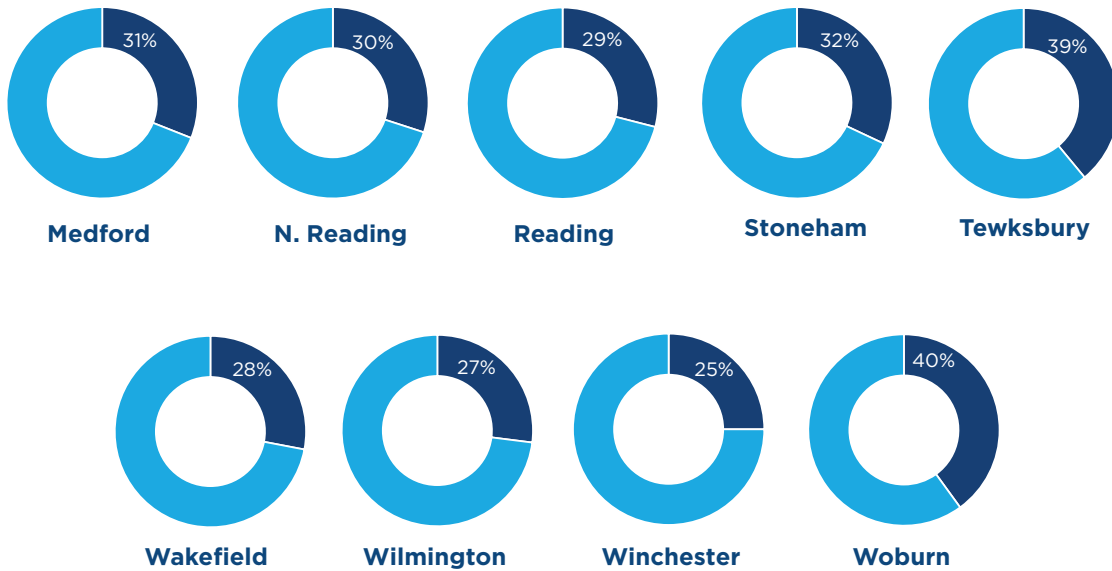
| | | | | |
|---|---|---|---|---|
| 31% | 30% | 29% | 32% | 39% |
| **Medford** | **N. Reading** | **Reading** | **Stoneham** | **Tewksbury** |

| | | | |
|---|---|---|---|
| 28% | 27% | 25% | 40% |
| **Wakefield** | **Wilmington** | **Winchester** | **Woburn** |

**\*Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

## Education

Research shows that those with more education live longer and healthier lives.[10] Patients with higher levels of educational attainment are able to better understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers.
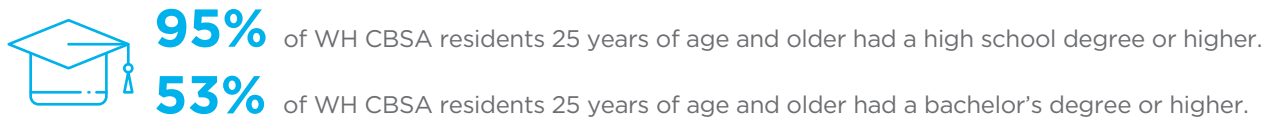
**95%** of WH CBSA residents 25 years of age and older had a high school degree or higher.

**53%** of WH CBSA residents 25 years of age and older had a bachelor's degree or higher.

Source: US Census Bureau, American Community Survey, 2016-2020

# Social Determinants of Health

## Food Insecurity and Nutrition

Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

While it is important to have grocery stores placed throughout a community to promote access, there are other factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food, and cultural appropriateness of food offerings. Food pantries and community meal programs have evolved from providing temporary or emergency food assistance to providing ongoing support for individuals, families, seniors living fixed incomes, and people living with disabilities and/or chronic health conditions.

## 5%

of WH CBSA households received SNAP benefits (formerly food stamps) within the past year. SNAP provides benefits to low-income families to help purchase healthy foods. In all CBSA communities, more than 15% of respondents to MDPH's COVID-19 Community Impact Survey reported that they were worried about getting food or groceries in the fall of 2020.

### Percentage* Worried About Getting Food or Groceries in the Coming Weeks, Fall 2020

| Medford | N. Reading | Reading | Stoneham | Tewksbury |
|---------|------------|---------|----------|-----------|
| 19% | 18% | 17% | 20% | 26% |

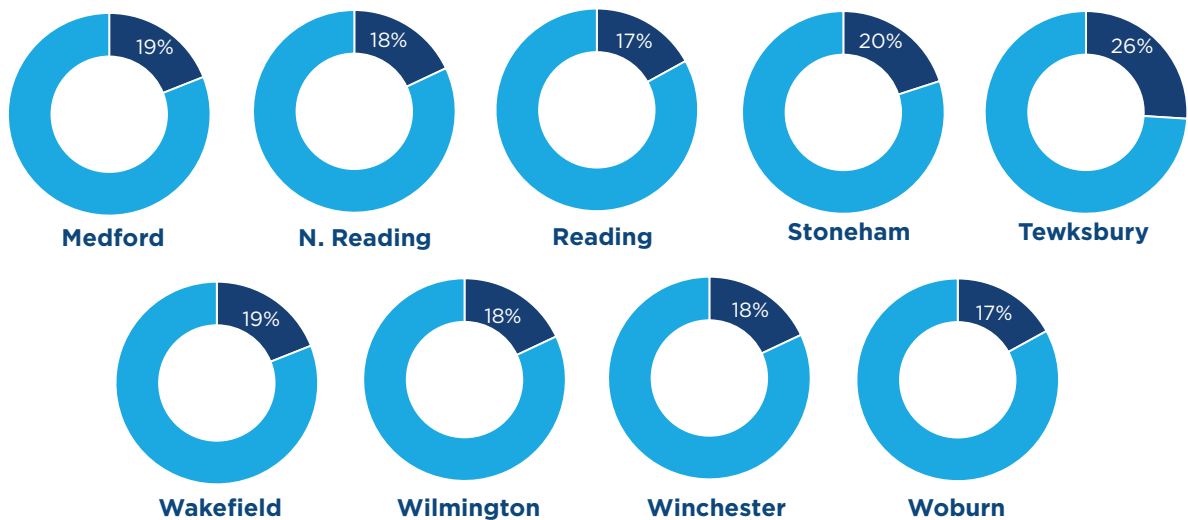| Wakefield | Wilmington | Winchester | Woburn |
|-----------|------------|------------|--------|
| 19% | 18% | 18% | 17% |

**\*Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

## Neighborhood and Built Environment

The conditions and environment in which one lives have significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks, and bike lanes improve health and quality of life.[11]

### Housing

Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases and poor mental health.[12] At the extreme are those without housing, including those who are unhoused or living in unstable or transient housing situations who are more likely to delay medical care and have mortality rates up to four times higher than those who have secure housing.[13]

Interviewees, focus groups, listening session participants, and WH Community Health Survey respondents expressed concern over the limited options for affordable housing throughout the WH CBSA.

The percentage of housing units in the WH CBSA with owner and renter costs in excess of 35% of household income was lower or similar to the Commonwealth in most communities, with the exception of Tewksbury, where percentages were higher across both owner and renter cohorts.

**Percentage of Housing Units With Monthly Owner/ Renter Costs Over 35% of Household Income**
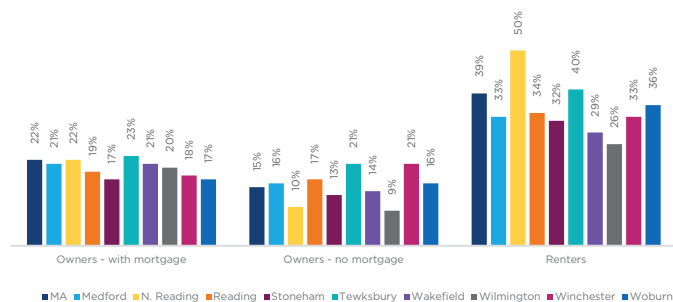


Owners - with mortgage: 22% 21% 22% 19% 17% 23% 21% 20% 18% 17%

Owners - no mortgage: 15% 16% 10% 17% 13% 21% 14% 9% 21% 16%

Renters: 39% 33% 50% 34% 32% 40% 29% 26% 33% 36%

■ MA ■ Medford ■ N. Reading ■ Reading ■ Stoneham ■ Tewksbury ■ Wakefield ■ Wilmington ■ Winchester ■ Woburn

Source: US Census Bureau American Community Survey, 2016-2020

When asked what they'd like to improve in their community,

**48%** of WH Community Health Survey respondents said "more affordable housing."

**57%** of WH Community Health Survey respondents said that housing in the community was not affordable for people with different income levels.

## Transportation

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

Transportation was identified as a significant barrier to care and needed services, especially for older adults who no longer drove or who did not have family or caregivers nearby.

When asked what they'd like to improve in their community:

**31%** of WH Survey Community Health Survey respondents wanted more access to public transportation.

**6%** of housing units in the WH CBSA did not have an available vehicle.

Source: US Census Bureau American Community Survey, 2016-2020

## Roads/Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety, and increased mobility. Sidewalks allow more space for people to walk or bike, which increases physical activity and reduces the need for vehicles on the road. Respondents to the WH Community Health Survey prioritized these improvements to the built environment.

**33%** of WH Community Health Survey respondents identified a need for better roads.

**37%** of WH Community Health Survey respondents identified a need for better sidewalks and trails.

# Systemic Factors

In the context of the health care system, systemic factors include a broad range of considerations that influence a person's ability to access timely, equitable, and high-quality services. There is a growing appreciation for the importance of these factors as they are critical to ensuring that people are able to find, access, and engage in the services they need, communicate with clinical and social service providers, and transition seamlessly from one service setting to another. The assessment gathered information related to perceptions of service gaps, barriers to access (e.g., cost of care, health insurance status, language access, cultural competence), care coordination, and information sharing. The assessment also explored issues related to diversity, equity, and inclusion and the impacts of racism and discrimination.

Systemic barriers have particularly significant impacts on people of color, non-English speakers, recent immigrants, individuals with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+.

Findings from the assessment reinforced the challenges that residents throughout the WH CBSA faced with respect to accessing care. The most common concerns were issues navigating the system due to inadequate care coordination, workforce shortages, and lack of information on where to obtain needed services. These issues led to frustration, long wait-times, and delayed care, which impacted long-term engagement in care. These issues were particularly difficult with respect to accessing primary care, behavioral health care, medical specialty care, and dental care services. Interviewees, focus groups, and listening session participants also shared challenges related to obtaining and coordinating supportive services such as transportation, housing assistance, and other non-clinical services. Interviewees, focus group, and community listening session participants discussed the need for tools to support these efforts, such as resource inventories, case managers, recovery coaches, and health care navigators.

Finally, interviewees and focus groups identified linguistic and cultural barriers to care, and the need to ensure access to interpreter services and bilingual/bicultural clinical and social service providers.

## Racial Equity

Racial equity is the condition where one's racial identity has no influence on how one fares in society.[14] Racism and discrimination influence the social, economic and physical development among Black, Indigenous and People Of Color (BIPOC), resulting in poorer social and physical conditions in those communities today.[15] Race and racial health differences are not biological in nature. However, generations of inequity creates consequences and differential health outcomes because of structural environments and unequal distribution of resources.

Interviewees reported that their communities were increasingly diverse in terms of race, ethnicity, sexual orientation, and gender identity. This diversity was identified as a strength. However, individuals expressed concerns about racism, discrimination, and varying levels of acceptance and recognition of diversity in the community.

"There are some [in the community] who commit racist acts or microaggressions and have little to no realization of how their actions impact others. If called out on it, they would become defensive and try to point out their overall positive image in the community. There are others who have advocated for policies to reflect the majority of citizens (who are mostly white), to the point of minimizing or disregarding the concerns of those who are people of color, Black, or Indigenous."

- WH Community Health Survey respondent

**Among WH Community Health Survey respondents:**
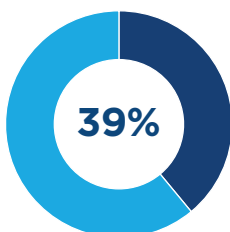
**39%** reported that built, economic, and educational environments in the community were impacted by **systemic racism.**
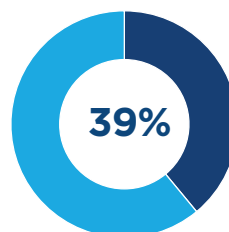
**39%** reported that environments in the community were impacted by **individual racism.**

## Accessing and Navigating the Health Care System

Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stemmed from the way in which the system did or did not function. System-level issues included providers not accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.[16]

### Populations facing barriers and disparities

- Individuals best served in a language other than English
- Older adults without caregivers
- Individuals with disabilities
- Individuals with limited economic means.

Some providers began offering care via telehealth over the course of the pandemic to mitigate COVID-19 exposure and retain continuity of care. This strategy removed barriers for some but created new hardships for those who lacked technical resources or technical savvy to take advantage of such programs.[17]

"There are no openings for mental health help at the moment. I can't begin to tell you how many wait lists I am on and have been on for about six months."
– WH Community Health Survey respondent

## Community Connections and Information Sharing

A strength of WH's CBSA were the strong community collaboratives and task forces that convened to share information and resources. Interviewees and listening session participants described a strong sense of partnership and camaraderie among community-based organizations and clinical and social service providers, borne out of a shared mission to ensure that community members had access to the services and care that they needed.

# Behavioral Factors

The nation faces a health crisis due to the increasing burden of chronic medical conditions. Underlying these health conditions are a series of behavioral risk factors that are known to help prevent illness and are the early signs or contributors of the leading causes of death (e.g., heart disease, cancer, stroke and diabetes). According to the National Centers for Disease Control and Prevention, the leading behavioral risk factors include an unhealthy diet, physical inactivity and tobacco, alcohol and marijuana use. Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being and reduces the risk of illness and death due to the chronic conditions mentioned above.[18]

When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use, and alcohol use. Those who participated in the assessment's community engagement activities were asked to identify the health issues that they felt were most important. While these issues were ultimately not selected during WH's prioritization process, the information from the assessment supported the importance of incorporating these issues into WH's IS.

## Nutrition

Adults who eat a healthy diet have increased life expectancy and decreased risk of chronic diseases and obesity; children require a healthy diet to grow and develop properly.[19] Access to affordable healthy foods is essential to a healthy diet.

**19%** of WH Community Health Survey respondents said they would like their community to have better access to healthy food.
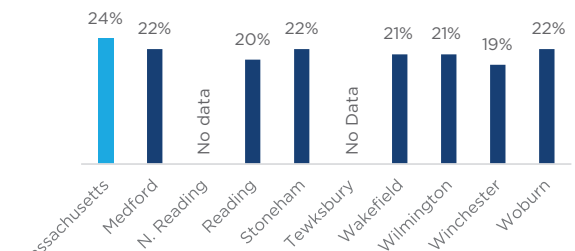
## Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the CBSA, though there was recognition that lack of physical fitness is a leading risk factor for obesity and a number of chronic health conditions.

The percentage of adults who were obese (with a body mass index over 30) was lower than the Commonwealth in all WH CBSA communities. Data was unavailable in North Reading and Tewksbury.

### Percentage of Adults Who Were Obese, 2018



| | Massachusetts | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---|---|---|---|---|---|---|---|---|---|---|
| | 24% | 22% | No data | 20% | 22% | No Data | 21% | 21% | 19% | 22% |

Source: Behavioral Risk Factor Surveillance System, 2018

## Alcohol, Marijuana and Tobacco Use

Though legal in the Commonwealth for those aged 21 and older, long-term and excessive use of alcohol, marijuana, and tobacco can lead to the development and exacerbation of chronic and complex conditions, including high blood pressure, cardiovascular disease, and cancer.

Clinical service providers reported an increase in substance use and relapse since the onset of the pandemic – potentially caused by increased stress and isolation and lapses in treatment. Interviewees and focus group participants also reported that marijuana and vaping tobacco was prevalent among youth and may be used as a coping mechanism for stress.

Among MDPH COVID-19 Community Impact Survey respondents in WH's CBSA communities who were current substance users, more than 25% reported that they used more substances in the fall of 2020 than before the pandemic.

### Percentage* of Substance Users who Said They Used More Substances Since the Start of the Pandemic, Fall 2020
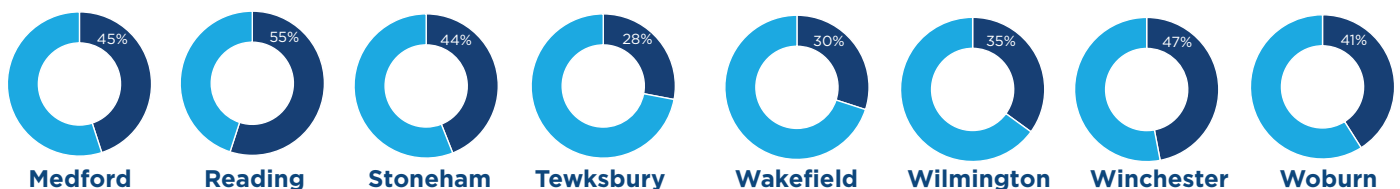


| Medford | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---|---|---|---|---|---|---|---|
| 45% | 55% | 44% | 28% | 30% | 35% | 47% | 41% |

**\*Unweighted percentages displayed**

*Data was suppressed in North Reading.*

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

# Health Conditions

The assessment gathered information related to the conditions that are known to be the leading causes of death and illness. These conditions include chronic and complex medical conditions as well as mental health and substance use disorders. As discussed in the introductory sections of this report, the assessment gathered quantitative data to assess the extent that these issues were a concern in WH's CBSA.

To augment and clarify this information, the assessment efforts included community engagement activities that asked participants to reflect on the issues that they felt

they felt had the greatest impact on community health. Efforts were made to ensure that participants reflected on a broad range of issues, including chronic and communicable medical conditions and behavioral health disorders. Given the limitations of the quantitative data, specifically that it was often old data and was not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, listening sessions, and the WH Community Health Survey was of critical importance.
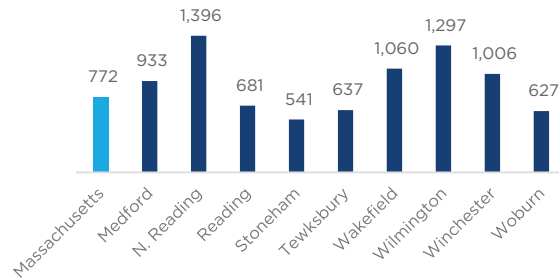
## Mental Health

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Interviewees, focus groups, and listening session participants also reflected on mental health stigma, and the shame and isolation that those with mental health challenges faced that limited their ability to access care and cope with their illness.

Youth mental health was a critical concern in the WH CBSA including the significant prevalence of chronic stress, depression, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

**Inpatient Discharge Rates (per 100,000) for Mental Health Conditions Among Those Under 18 Years of Age, 2019**



Source: Center for Health Information and Analysis, 2019

In all WH CBSA communities except North Reading, more than 20% of COVID-19 Community Impact Survey respondents reported more than 15 poor mental health days in the past month, as of fall 2020.

**Percent\* of Individuals with 15 or More Poor Mental Health Days in the Past Month (Fall 2020)**
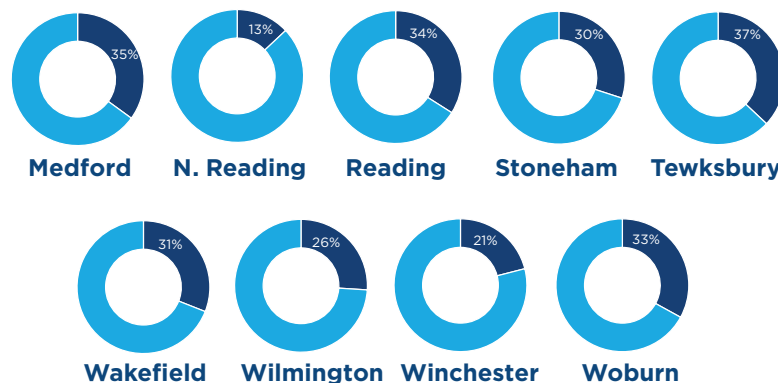


Medford 35%   N. Reading 13%   Reading 34%   Stoneham 30%   Tewksbury 37%

Wakefield 31%   Wilmington 26%   Winchester 21%   Woburn 33%

**\*Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

# Health Conditions

## Substance Use

Substance use continued to have a major impact on the CBSA the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Interviewees, focus groups, and listening session participants identified stigma as a barrier to treatment and reported a need for programs that addressed common co-occurring issues (e.g., mental health issues, homelessness). Interviewees, focus groups, and listening session participants also reflected on the need for more transitional housing and recovery support services.
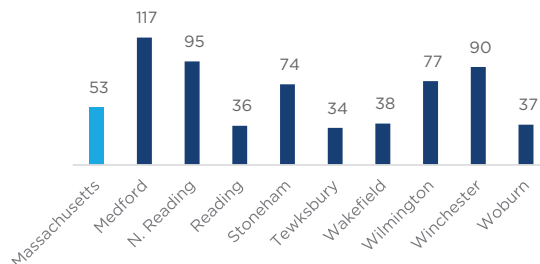
**Inpatient Discharge Rates (per 100,000) for Substance Use Disorder Among Those Under 18 Years of Age, 2017**



Source: MDPH Bureau of Substance Abuse Services, 2017

Inpatient discharge rates for substance use disorders among those under 18 years of age were higher than the Commonwealth in Medford, North Reading, Stoneham, Wilmington, and Winchester.

"People with substance use disorders need treatment facilities that don't kick them out after a few days. Substance use disorder is THE pandemic!"

- WH Community Health Survey respondent

## Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.[20]

Looking across four of the most common chronic and complex conditions, inpatient discharge rates among those 65 years of age and older were higher than the Commonwealth in many communities, particularly in Stoneham, Tewksbury, Wilmington, and Woburn.

**Inpatient Discharge Rates (per 100,000) for Chronic/Complex Conditions Among Those 65 Years of Age and Older, 2019**

| | MA | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---|---|---|---|---|---|---|---|---|---|---|
| Heart disease | 18,344 | 20,052 | 15,650 | 19,031 | 23,171 | 21,464 | 18,114 | 21,601 | 18,793 | 22,617 |
| Diabetes | 8,376 | 9,124 | 7,473 | 7,996 | 11,335 | 9,921 | 7,603 | 10,402 | 6,906 | 10,834 |
| Asthma | 1,596 | 1,516 | 1,375 | 1,806 | 2,319 | 1,403 | 1,505 | 1,372 | 1,738 | 1,955 |
| COPD | 7,130 | 6,776 | 6,591 | 6,101 | 8,097 | 8,940 | 7,302 | 8,531 | 6,084 | 9,014 |

Source: Center for Health Information and Analysis, 2019

## Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability and even death - as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees or participants at listening sessions and focus groups, it is and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

Data from the Center for Health Information and Analysis indicated that older adults in Medford, Reading, Stoneham, Tewksbury, Wilmington, and Woburn had higher inpatient discharge rates for infections and flu/pneumonia compared to the Commonwealth overall.

**Inpatient Discharge Rates (per 100,000) Among Those 65 Years of Age and Older, 2019**
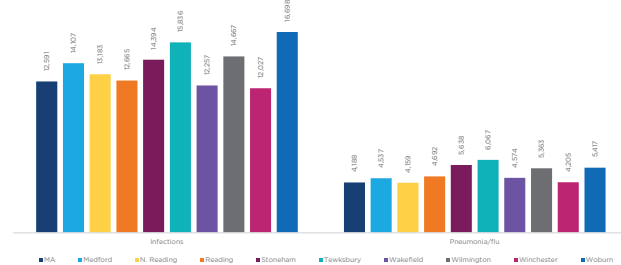


Source: Center for Health Information and Analysis, 2019

## COVID-19

On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus a global pandemic. Society and systems continue to adapt and frequently change protocols and recommendations due to new research, procedures and policies. Interviewees and focus group participants emphasized that COVID-19 is a priority concern that continues to directly impact nearly all facets of life, including economic stability, food insecurity, mental health (stress, depression, isolation, anxiety), substance use (opioids, marijuana, alcohol), and one's ability to access health care and social services.

COVID-19 presented significant risks for older adults and those with underlying medical conditions because they faced a higher risk of complications from the virus. Several interviewees described how COVID-19 exacerbated poor health outcomes, inequities, and health system deficiencies.

**Total COVID-19 Case Counts Through June 23, 2022**
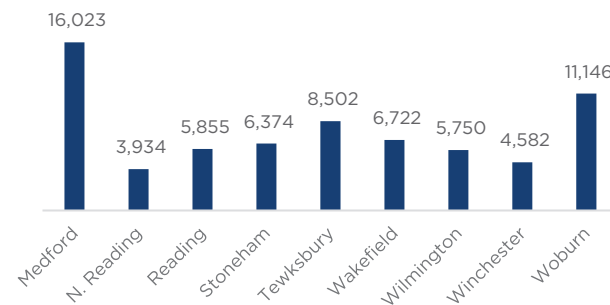


Source: Massachusetts Department of Public Health, COVID-19 Data Dashboard

In all of WH's CBSA communities, with the exception of North Reading, where data was not available, more than 10% of MDPH COVID-19Community Impact Survey respondents reported that they had not gotten the medical care they needed since July of 2020. Lapses in medical care may lead to increases in morbidity and mortality.

**Percentage\* Who Have Not Gotten the Medical Care They Need since July 2020 (as of Fall 2020)**
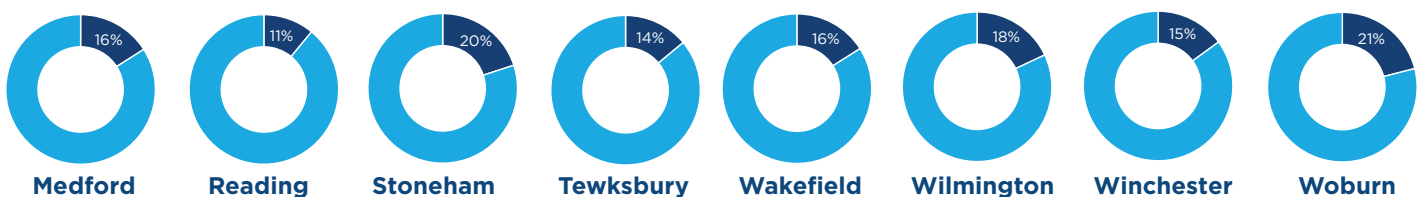


| Medford | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---------|---------|----------|-----------|-----------|------------|------------|--------|
| 16% | 11% | 20% | 14% | 16% | 18% | 15% | 21% |

**\*Unweighted percentages displayed**

*Data was suppressed in North Reading*

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

# Priorities

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities or are disproportionately impacted by systemic racism or other forms of discrimination. Accordingly, using an interactive and anonymous polling software, WH's CBAC and community residents formally prioritized the community health issues and cohorts that they believed should be the focus of WH's IS. This prioritization process helps to ensure that WH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

**Massachusetts Community Health Priorities**

| Massachusetts Attorney General's Office | Massachusetts Department of Public Health |
|---|---|
| • Chronic disease - cancer, heart disease, and diabetes<br>• Housing stability/homelessness<br>• Mental illness and mental health<br>• Substance use disorder. | • Built environment<br>• Social environment<br>• Housing<br>• Violence<br>• Education<br>• Employment. |
| *Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy* | *Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)* |

# Community Health Priorities and Priority Cohorts

WH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, WHwill work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following cohorts within the community health priority areas.

**WH Community Health Needs Assessment: Priority Cohorts**

Youth

Older Adults

Low-Resourced Populations

Racially, Ethnically and Linguistically Diverse Populations

LGBTQIA+

**WH Community Health Needs Assessment: Priority Areas**



## HEALTH EQUITY

Equitable Access to Care | Social Determinants of Health | Mental Health and Substance Use | Complex and Chronic Conditions

## Community Health Needs Not Prioritized by WH

It is important to note that there are community health needs that were identified by WH's assessment that were not prioritized for investment or included in WH's IS. Specifically, supporting education across the lifespan and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in WH's IS. While these issues are important, WH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, WH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. WH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

## Community Health Needs Addressed in WH's IS

The issues that were identified in the WH CHNA and are addressed in some way in the hospital IS are housing issues, transportation, climate change, economic insecurity, build capacity of workforce, navigation of healthcare system, linguistic access barriers, diversify provider workforce, education on domestic violence, diversifying community leadership, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, racism/discrimination, culturally appropriate/competent health and community services, cross sector partnerships/collaboration/responses, linguistic access/barriers to community resources/services, substance use stigma, substance use outreach/education/prevention, services to support long-term recovery, and opioid use/misuse.

# Implementation Strategy

WH's current 2020-2022 IS was developed in 2019 and addressed the priority areas identified by the 2019 CHNA. The 2022 CHNA provides new guidance and invaluable insight on the characteristics of WH's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed WH to develop its 2023-2025 IS.

Included below, organized by priority area, are the core elements of WH's 2023-2025 IS. The content of the strategy is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention), and disease management and treatment (tertiary prevention).

Below is a brief discussion of the resources that WH will invest to address the priorities identified by the CBAC and the hospital's senior leadership team. Following the discussion of resources are summaries of each of the selected priority areas and a listing of the goals that were established for each.

## Community Benefits Resources

WH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Recognizing that community benefits planning is ongoing and will change with continued community input, WH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. WH is committed to assessing information and updating the plan as needed.

Following are brief descriptions of each priority area, along with the goals established by WH to respond to the CHNA findings and the prioritization and planning processes. Please refer to the full IS in Appendix E for more details.

## Summary Implementation Strategy

### EQUITABLE ACCESS TO CARE

**Goal:** Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

**Strategies to address the priority:**

• Promote access to health care, health insurance, patient financial counselors, and needed medical services for patients who are uninsured or underinsured.

• Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.

• Reduce barriers to care by providing/supporting free or reduced cost transportation for homebound residents needing care.

• Provide and promote career support services and career mobility programs to hospital employees.

## SOCIAL DETERMINANTS OF HEALTH

**Goal:** Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

**Strategies to address the priority:**

- Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.
- Support impactful programs that stabilize or create access to affordable housing.
- Support impactful programs that address issues associated with the social determinants of health.
- Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.

## MENTAL HEALTH AND SUBSTANCE USE

**Goal:** Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

**Strategies to address the priority:**

- Support impactful programs that promote healthy development, support children, youth, and their families, and increase their resiliency, coping, and prevention skills.
- Build the capacity of the community to understand the importance of mental health and availability of services, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.
- Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.
- Support a model that spans the continuum of care from inpatient to outpatient and community initiatives that identify and address mental health needs and substance use disorders.
- Participate in multi-sector community coalitions to identify and advocate for policy, systems, and environmental changes that reduce and prevent substance use and promote mental health.

## COMPLEX AND CHRONIC CONDITIONS

**Goal:**

- Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

**Strategies to address the priority:**

- Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.
- Support community-based programs that increase access to free or low cost health-promoting supports to prevent chronic disease.

# Evaluation of Impact of 2020-2022 Implementation Strategy

As part of the assessment, WH evaluated its current IS. This process allowed the hospital to better understand the effectiveness of its community benefits programming and to identify which programs should or should not continue. Moving forward with the 2023-2025 IS, WH and all BILH hospitals will review community benefit programs through an objective, consistent process using the BILH Program Evaluation and Assessment Tool. Created with Community Benefits staff across BILH hospitals, the tool scores each program using criteria focused on CHNA priority alignment, funding, impact, and equity to determine fit and inclusion in the IS.

Since 2020, many of the programs that would normally be conducted in-person were postponed or canceled due to the COVID-19 pandemic. When possible, programs were delivered virtually to ensure the community was able to receive services to improve their health and wellness.

For the 2020-2022 IS process, WH planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2019 CHNA report.   These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and charity care. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2020 and 2021.   WH will continue to monitor efforts through FY 2022 to determine its impact in improving the health of the community and inform the next IS. A more detailed evaluation is included in Appendix D.

| Priority Area | Summary of Accomplishments and Outcomes |
| --- | --- |
| **Mental Health and Substance Use Disorder** | Through the Boys and Girls Club SBIRT program, over 200 youths were screened for mental health needs per year, resulting in: 91% of referred participants attending weekly mentoring sessions, 75% reporting a decreased likelihood of participating in risky behaviors, and nearly 90% reporting an increased likelihood of talking to an adult if they felt depressed or had thoughts of self-harm.<br><br>Over 100 older adults per year were served by the Mystic Valley Mobile Mental Health Clinic in FY20 and FY21 with financial support from Winchester Hospital. Services addressed isolation and environmental factors that affect mental health. |
| **Chronic/ Complex Conditions and Their Risk Factors** | Over 3,000 patients per year received free Breast Cancer Risk screenings.<br><br>Lab Services provided more than 10,000 free blood draws for homebound patients.<br><br>Over 80 children per year were enrolled in CHAMP, a pediatric asthma management program, which resulted in fewer missed school days and emergency room visits and improved overall quality of life. |
| **Social Determinants of Health and Access to Care** | The SHINE program offered over 200 free insurance coverage counseling sessions for community members at the Jenks Center in Winchester and the Winchester Hospital Center for Cancer Care.<br><br>Funding supported Metro Housing Boston's Co-Location program that provided eviction-prevention and housing-stabilization counseling services to over 100 families in Medford, Winchester, and Woburn.<br><br>With grant support, the Woburn Council of Social Concern Food Pantry program served 762 low-income individuals. The Council also established the Backpack Food Program with Woburn Public Schools, offering free food to low-resource families weekly during the school year. |

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# Appendices

# Appendix A:
# Community Engagement Summary

# Interviews

- Interview Guide
- Interview Summary

# Beth Israel Lahey Health Community Health Assessment

## Interview Guide

*Please complete this section for each interview:*

| Date: | | Start Time: | End time: |
|---|---|---|---|
| Name of Interviewee: | | | |
| Name of Organization: | | Affiliate Hospital: | |
| Facilitator Name: | | Note-taker Name: | |
| Did all participants agree to audio recording? | | | |
| Did anything unusual occur during this interview? (Interruptions, etc.) | | | |

Thank you for taking the time to speak with me today. Beth Israel Lahey Health (BILH) and [Hospital and any collaborators] are conducting a community health needs assessment and creating an implementation plan to address the prioritized needs identified.  For the first time, all 10 hospitals in the BILH system are conducting this needs assessment together.  Our hope is that we will create a plan at the individual hospital level as well as the system level that will span across the hospitals.

During this interview, we will be asking you about the strengths and challenges of the community you work in and the populations that you work with. We also want to know what BILH should focus on as we think about addressing some of the issues in the community. The data we collect during the assessment is analyzed, prioritized, and then used to create an Implementation Strategy. The Implementation Strategy outlines how the Hospital and System will address the identified priorities in partnership with community organizations. For example, if social isolation is identified as a priority, we may explore partnering with Councils on Aging on programs to engage older adults, and support policies and system changes around mental health supports.

Before we begin, I would like you to know that we will keep your individual contributions anonymous. That means no one outside of this interview will know exactly what you have said. When we report the results of this assessment, no one will be able to identify what you have said. We will be taking notes during the interview, but your name will not be associated with your responses in any way. Do you have any questions before we begin?

If you agree, we would like to record the interview for note taking purposes to ensure that we accurately capture your thoughts and obtain exact quotes to emphasize particular themes in our final report. Do you agree?"

[*if interviewee does not agree to be recorded, do not record the interview]

| Question | Direct Answer | Additional Information |
|---|---|---|
| Community Characteristics, Strengths, Challenges | | |
| What communities/populations do you mainly work with? | | |
| ● How would you describe the community (or population) served by your organization? | | |
| ● How have you seen the community/population change over the last several years? | | |
| What do you consider to be the community's (or population's) strengths? | | |
| How has COVID affected this community/population? | | |
| What are some of its biggest concerns/issues in general? What challenges does this community/population face in their day-to-day lives? | | |
| Health Priorities and Challenges | | |
| What do you think are the most pressing health concerns in the community/among the population you work with? Why? | | |
| ● How do these health issues affect the populations you work with? [Probes: In what way? Can you provide some examples?] | | |
| We understand that there are differences in health concerns, including inequalities for ethnic and | | |

| | | |
|---|---|---|
| racial minority groups **/** the impacts of racism.<br><br>Thinking about your community, do you see any disparities where some groups are more impacted than others? | | |
|    ● What contributes to these differences? | | |
| What are the biggest challenges to addressing these health issues? | | |
| What barriers to accessing resources/services exist in the community? | | |
| **Community-Based Work** | | |
| What are some of the biggest challenges your organization faces while conducting your work in the community, especially as you plan for the post-COVID period? | | |
| Do you currently partner with any other organizations or institutions in your work? | | |
| **Suggested Improvements** | | |
| When you think about the community 3 years from now, what would you like to see? | | |
|    ● What would need to happen in the short term? | | |
|    ● What would need to happen in the long term? | | |
| How can we tap into the community's/population's strengths to improve the health of the community? | | |

| | | |
|---|---|---|
| In what way can BILH and [Hospital] work toward this vision?<br><br>What should be our focus to help improve the health of the community/population? | | |
| Thank you so much for your time and sharing your opinions. Before we wrap up, is there anything you want to add that you did not get a chance to bring up earlier? | | |

I want to thank you again for your time. Once we finish conducting survey, focus groups and interviews, we will present the data back to the community to help determine what we should prioritize.  We will keep you updated on our progress and would like to invite you to the community listening sessions where we will present all of the data.  Can we add you to our contact list?  After the listening sessions, we will then create an implementation plan to address the priorities.  We want you to know that your feedback is valuable, and we greatly appreciate your assistance in this process.

*Winchester Hospital Community Health Needs Assessment 2021-2022*
*Interview Summary*

## Interviewees

- Teresa Aravena-Gonzalez , Daniela Nedbalek, Benny Wheat - Wakefield Human Rights Commission
- Marie Cassidy, Director, Medford Family Network of the Medford Public Schools
- Dean Solomon, Executive Director, and Paula Mathews, Food Pantry Director, Council for Social Concern
- Deborah Delman and Lauren Murphy (Vice President), Stoneham Community Development Corporation
- Lisa Egan, Executive Director, Reading-North Reading Chamber of Commerce
- John Feudo, Executive Director, YMCA of Greater Boston
- Dr. Allison Jekogian, Associate Director, Triumph Center, Inc.
- Jamillah Kasuswa (Coordinator) and Dinora Miranda (Case Manager), ABCD Mystic Valley Opportunity Center
- Medford Community Language Line and Medford Community Liaisons
- Medford Municipal Leaders
- North Reading Municipal Leaders
- Liora Norwich, Executive Director, Network for Social Justice
- Donny Bautz, Executive Director, Elaine Doherty, Site Director at YMCA International Learning Center, Liz Williams, Senior Regional Health Lifestyles Director, North Suburban YMCA
- Matthew Page-Shelton, Executive Director, Front Line Initiative
- Reading Municipal Leaders
- Stoneham Municipal Leaders
- Tewksbury Municipal Leaders
- Wakefield Municipal Leaders
- Wilmington Municipal Leaders
- Winchester Municipal Leaders
- Woburn Municipal Leaders
- Maria Zaroulis, Tewksbury Cares and Tewksbury Board of Health

## Key Findings

### Community characteristics

- Service area increasingly diverse in terms of race and ethnicity
- Have seen an increase in young families moving to area for strong school systems
- Residents are engaged and civic-minded

### Specific populations facing barriers

- Youth
- BIPOC
- Older adults
- Individuals with limited economic means
- LGBTQIA+
- Non English Speakers
- Immigrants

**Social Determinants of Health**

- Housing a significant issue – lack of affordable housing (both deeply affordable/subsidized and mid-range)
- Economic insecurity increasingly a concern – cost of living continues to rise. Difficult for older adults on fixed incomes
- Businesses dealing with workforce shortages
- Food insecurity

**Mental health**

- Significant prevalence of stress, anxiety, depression among youth and adults
    - Exacerbated by pandemic
    - Deep divisions over COVID restrictions, politics, impacts of racism/discrimination in communities
- Isolation a concern, especially over course of pandemic
- Youth mental health
    - Young people are stressed
    - Concerns about bullying in schools
    - Not enough providers for students with behavioral issues and needs
- Stigma a barrier to care/treatment

**Access to care**

- Many struggle to navigate the healthcare system, including health insurance
- Over the course of the pandemic, many faced difficulties accessing care because of long wait times, providers not taking on new patients
- Cost and insurance are barriers for individuals who are uninsured or underinsured
- Language is a significant barrier for many

**Diversity, Equity, Inclusion**

- Racial injustices have stoked division in community (e.g., murder of George Floyd; Anti-Asian violence). There is a denial that racism exists in service area communities
    - Has presented as a barrier to care – *"[Immigrants] are no longer seeking healthcare services because of immigration politics. Don't want service utilization to affect their status."*
- Lack of supportive services for non-English speakers and immigrants
- There need to be more services that address needs of individuals with limited economic means. Though many communities are affluent, there are a number of individuals struggling
- Need providers that reflect diversity of community – in terms of race, ethnicity, culture, language

**Resources/Assets**

- Healthcare services
- Services for seniors
- Engaged community members
- Local businesses and community organizations

# Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

# BILH Community Health Needs Assessment
## Focus Group Guide

Thank you for participating in this discussion on health in your community. I'm going to review some information about the purpose and ground rules for the discussion, then we'll begin.

We want to hear your thoughts about things that impact health in your community. The information we collect will be used by Beth Israel Lahey Health to create a report about community health. We will share the results with the community in the winter and identify ways that we can work together to improve health and wellbeing. The is used to put together a plan that outlines how the Hospital and System will address the priorities in partnership with community organizations.

We want everyone to have the chance to share their experiences. Please allow those speaking to finish before sharing your own comments. To keep the conversation moving, I may steer the group to specific topics. I may try to involve people who are not speaking up as much to share their opinions, especially if one or more people seem to be dominating the conversation. If I do this, it's to make sure everyone is included. We are here to ask questions, to listen, and to make sure you all have the chance to share your thoughts.

We will keep your identity and what you share private. We would like you all to agree as a group to keep today's talk confidential as well. We will be taking notes during the focus group, but your names will not be linked with your responses. When we report the results of this assessment, no one will be able to know what you have said. We hope you'll feel free to speak openly and honestly.

With your permission, we would like to audio record the focus group to help ensure that we took accurate notes. No one besides the project staff would have access to these recordings, and we would destroy them after the report is written. Does everyone agree with the audio recording?

*If all participants agree, you can record the Zoom. If one or more person does not agree or are hesitant, do not record the focus group.*

Does anyone have any questions before we begin?


### Section One: Community Perceptions


1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?

2. What are some of the things that make it hard for you, and your community members, to be healthy?

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?


   *If yes, move on to Section 2.*

   *If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)*

   Let's talk more deeply about these concepts.

**Section Two: Key Factors**

*In this section, ask participants to go more in depth about the factors they brought up in the previous section. For example, if they brought up the lack of affordable healthy foods, ask "are healthy foods available to some people, if so who? And why do you think they are not available to everyone?"*

*For each issue they identified:*

- Are these (things that keep you healthy) available to everyone or just a few groups of people?

- Why do you think they (things that make it hard to be healthy) exist? / Why is this a challenge?

**Section Three: Ideas and Recommendations**

4. **Ideas:** Thinking about the issues we discussed today, what ideas do you have for ways hospitals can work with other groups or services to address these challenges?
   1. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

5. **Priorities**: What do you think should be the top 3 issues that Hospitals and community organizations should focus on to make your community healthier?

**Winchester Hospital Focus Group Summary: Boys and Girls Club of Stoneham and Wakefield**

| Date: 11/3/21 | | Start Time: 6:00pm | End time: 7:00pm |
| --- | --- | --- | --- |
| Group Name and Location: Boys & Girls Club of Stoneham and Wakefield, Zoom | | | |

**What does being healthy mean to you?**
- **What does it look like?**
- **What does it feel like?**

Being in shape both physically and mentally
What you eat, nutrition
Having a healthy mindset, thinking about good things, eating good
Keeping myself active, not laying around all day. Jogging, biking, hiking.
Being active with things that you like to do. Keeping yourself busy with activities which you enjoy
Not being stressed out, having time to do stuff
Prioritizing physical and mental health equally
Understanding what stressors are in your life and how they impact your physical and mental emotions through the day

_____

**What are some of the things that help you stay healthy?**
Sports; both the social and physical aspects
Having things to do – not just laying around
Staying active, hanging out with people
Routine, going for walks, not sitting around the house
Socializing with friends who like to stay active and eat healthy – comes naturally and is influenced by your community/friends.

**Are there things in your community that help you stay healthy?**
Outdoor spaces – access to nature
Practicing sports with friends outside of school
Sports programs supported through school; e.g. cross country, track
Moving around at work – standing, steps, staying active in different ways
Working out at the Boys and Girls Club
Cross Country, Running (multiple people said this)

**Are the things that help you stay healthy available to everyone or just a few groups of people?**
More opportunities for teenage demographic over adults who only have a couple of options
Bike Path, Rock Dune in Stoneham that a lot of people use – varied age range

**Of the things that you've named as helping to keep you healthy, which would you like to see more of?**
Stoneham High School – Gym Teachers host workout programs through the summer.
Winter physical activities/gym sessions throughout the winter
Convincing friends/social circles to be active and socialize by being active. More word of mouth to get out and get active.
More avenues to find things to do – increased accessibility, resources, and pathways – consolidated location of all available programs.
Most programs created aren't directed by those participating in them. More engagement and involvement from youth to direct/create the programs would be good. This will drive up participation.
Empowering youth/teens to create their own programs.
_____

**What are some of the things that make it hard for you to be healthy?**
Quarantine, Lockdown – limitations on being outdoors and with people
Balancing a lot of things at once; school, sports, work – a lot of people struggle with doing too much or doing too little
Finding motivation to independently stay active outside of sports teams, pre-programmed activities
At younger ages – difficulty with transportation and getting to event sites / places which keep you healthy
Not knowing where to start, lack of basic information about how to begin a fitness journey
School stress, would be difficult to get outside and take a walk
Fast food, poor nutrition choices being made by community members
Occupied by a job – limitation on time

**Do these things (that make it hard for you to be healthy) affect everyone or just a few groups of people?**
Fast food and nutrition challenges are more difficult for low-income people in search of inexpensive options

**Why do you think the things that make it hard for you to be healthy exist?**
Financial inaccessibility, parents being busy with work – both parents working jobs that extend after school. Less access to getting home after activities.
Minimal public transportation, especially for teenage demographic. No particular bus available
Expensive/unaffordable to Uber everywhere

_____

**Thinking about all that we have talked about, what ideas do you have for ways that hospitals can work with other groups to help make your community healthier?**
Better identify mental health problems as the root which impacts wider community health
Fundraising for the community, developing community programs and food-access avenues, food pantry options
Inform, Educate and Advise people on how to find motivation
Awareness on stress relief options – how to relieve emotional / mental stress. Developing programs for teens to cope emotionally


**What do you think should be the top 3 issues that health service providers should focus on to make your community healthier?**
Mental Health; Depression, Anxiety
Teachers/ guidance counselor's methods to approaching problems. Current framing is that the student is expected to approach the staff for help but many are not prepared to take that step. Counselors and health-staff members at schools should be more proactive in reaching out to students, recognizing problems, extending resources.
Staff members should be actively engaging the school community interactively
        e.g. Shift away from performative support/assistance e.g. random stickers, surface level solutions
Nutrition: Positively advertising nutritious health options. Currently popular choices; pizza.
Motivation to keep active
_____

**Are there other factors that influence your health that we haven't talked about today that you feel are important?**

Healthy daily habits and developing routines to cope with emotional/physical health.
Equally prioritizing mental and physical health
Surrounding yourself with healthy people that will have a positive influence in your life

**Winchester Hospital Focus Group Summary: Medford Council on Aging**

| Date: 12/8/21 | | Start Time: 11:00am | End time: 12:00pm |
|---|---|---|---|
| Group Name and Location: Medford Council on Aging | | | |

| **Section 1: Community Perceptions** | |
|---|---|
| **Healthy:** To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy? | • Excellent health services "best in country" – hospitals, outpatient, other services<br>• Other services like gyms, food banks,<br>• Senior center – great place to go to for social program<br>    o Great people, great programs, social interactions<br>    o All the volunteers<br>    o Exercise classes<br>    o Educational programs<br>    o Emotional support<br>• Elder services outreach and 2-1-1 |
| **Unhealthy:** What are some of the things that make it hard for you to be healthy? | • Digital divide.<br>• Transportation<br>• Mental health Challenges<br>• Food security and healthy nutritional food<br>• Financial Security<br>• Substance Use -<br><br>Chronic Disease – NOT MAJOR ISSUES |

| | |
|---|---|
| Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?<br><br>*If yes, move on to Section 2.*<br><br>*If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)*<br><br>Let's talk more deeply about these concepts. | Top Factors<br>1. Transportation<br>2. Mental health<br>3. Financial Security |

<table>
<tr><td colspan="2" align="center"><b><u>Section 2: Exploring Key Factors</u></b><br><i>In this section, ask participants to go more in depth about the factors they brought up in the previous section.</i></td></tr>
<tr>
<td>Are these <b>(things that keep you healthy)</b> available to everyone or just a few groups of people?</td>
<td>• <i><b>Not discussed</b></i></td>
</tr>
<tr>
<td>Why do you think they <b>(things that make it hard to be healthy)</b> exist?<br>• Why is this a challenge?</td>
<td>• <i><b>See above. Not addressed directly</b></i></td>
</tr>
<tr>
<td>What are some examples of how these challenges impact someone's health?</td>
<td>• <b>Transportation</b><br>   o High cost<br>   o Lack of flexibility<br>   o Long wait-times<br>   o Hard to navigate<br>   o Really difficult to manage public transportation or other types of services for appointments<br>   o Don't often take the PCAs that seniors need to support them at appointments</td>
</tr>
</table>

|  | |
|---|---|
| | o The Ride is horrible<br>o COAs partnership with the City of Medford provides a transportation service that is really strong….Grant funded<br><br>• **Mental health Challenges**<br>o Lack of understanding about what MH is and what it isn't.  Perhaps its situational, grief, stress<br>o Need for screening and assessment services to diagnose<br>o Isolation and depression<br>o COVID has created a lot of grief, anxiety, uncertainty, depression<br>o Limited services in the community (screening, assessment, treatment)<br>o Need for educational and awareness programs<br>o Need for resource inventory and services to help people get the support they need<br><br>• **Financial security, Food security, Housing, etc.**<br>o For most people food security is not a major issue but for some its very serious<br>o Lots of the efforts around COVID were related to food, which was really important for many people<br>o Stigma and embarrassment related to needing services, accessing food banks<br>o Financial challenges lead to lack of food, fear, and hoarding<br>o Price of food has gone way up<br>o Paying for food and transportation can be hard financially for many<br>o Cost of medical co-pays<br>o Heat can be difficult to pay for it<br>o Medications and prescription drugs<br><br>• **Digital divide.**  It can be really difficult to access things on-line.<br>o If you don't have a computer<br>o If you are not comfortable with computers<br>o If they do not have internet sevices/"cable"<br>o Need educational programs<br>o Need to support Counsels on Aging to address issue<br><br>• **Substance Use -** |

| | |
|---|---|
| | o "Huge issue in all communities"<br><br>Chronic Disease – NOT MAJOR ISSUES |
| **Section 3: Ideas and Priorities** | |
| **Ideas:**<br>- Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time?<br>- Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of? | ● *See above* |
| **Priorities**:<br>- What do you think should be the top 3 issues service providers should focus on to make your community healthier? | ● Transportation<br>● Mental health education/stigma, screening/assessment and lack of MH services<br>● Importance of elder services, socialization, and programming to address isolation<br>● Outreach to those who are isolated, homebound, and do not come into the council on aging |
| **Section 4: Final Remarks & Closing** | |
| Are there other factors that influence your health that we have not discussed tonight that you feel are important? | *NONE* |

**Winchester Hospital Focus Group Summary: Woburn Parents**

| Date: 12/09/21 | Start Time: 7p | End time: 8p |
| --- | --- | --- |
| Group Name and Location: Parents; Meeting at Hurld-Wyman Elementary School | | |

| | Section 1: Community Perceptions |
| --- | --- |
| What does it mean to be healthy? | ● No to be ill<br>● Feel well metally and physically<br>● Eat well and healthy<br>● Get enough sleep<br>● Physical exercise<br>● Not to need meds.<br>● Have the strength to work<br>● Taking vitamins<br>● Happy/happiness<br>● Home is clean and sanitary<br>● Friends and family<br>● To be able to have fun |
| **Healthy:** To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy? | What exists:<br>1. Farmers markets, fresh veggies that are affordable<br>2. Churches<br>3. Employment<br>4. Walkable town<br>5. Food pantry<br>6. Pond and outdoor space |

| | |
|---|---|
| **Unhealthy:** What are some of the things that make it hard for you to be healthy? | What's missing:<br>1. Lack of accessible and affordable children programs in all schools<br>    a. Tutoring programs<br>    b. Afterschool programs<br>2. Transportation<br>3. Health insurance<br>4. Support systems<br>5. Lack of discrimnation in mental health programs |
| Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?<br><br>*If yes, move on to Section 2.*<br><br>*If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)*<br><br>Let's talk more deeply about these concepts. | Top Factors<br>1. Housing<br>2. Quality healthcare<br>    a. Provide masshealth application help<br>3. Outreach to community |
| <td colspan="2"><center>**Section 2: Exploring Key Factors**</center><br>*In this section, ask participants to go more in depth about the factors they brought up in the previous section.*</td> |
| Are these **(things that keep you healthy)** available to everyone or just a few groups of people? | ***N/A*** |
| Why do you think they **(things that make it hard to be healthy)** exist?<br>- Why is this a challenge? | ***N/A*** |

| | |
|---|---|
| What are some examples of how these challenges impact someone's health? | *N/A* |

| Section 3: Ideas and Priorities | |
|---|---|

| | |
|---|---|
| **Ideas:**<br>- Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time?<br>- Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of? | • **Welcoming culture** in the hospital<br>  ○ More advertising outreach to local community (multi-language outreach with specific messaging about masshealth)<br>  ○ Health education in the community<br>• Hospital to **partner** with community (like schools)<br>• Hospital could invest in creating an **affordable, accessible gym**<br>• Hospital could invest in **multilingual services** outside of Boston<br>• Hospital could invest in a **local, community health center**<br>• Hospital could invest in a **Masshealth application center**<br>• Hospital could **train and hire** more medical staff that **speak language other than English**<br>  ○ More staff training in public benefits |
| **Priorities**:<br>- What do you think should be the top 3 issues service providers should focus on to make your community healthier? | • *Housing*<br>• *Quality healthcare*<br>• *Outreach to community* |

| Section 4: Final Remarks & Closing | |
|---|---|

| | |
|---|---|
| Are there other factors that influence your health that we have not discussed tonight that you feel are important? | |

# Community Listening Sessions

- Presentation from Facilitation Training for community partners

- Facilitation guide for listening sessions

- Priority vote results and notes from January 27, 2022 listening session

- Priority vote results and notes from February 10, 2022 listening session

# AGENDA

- What is facilitation?

- Inclusive facilitation

- Creating inclusive space

- Characteristics of a good facilitator

- Let's practice!

# WHAT IS FACILITATION?

Facilitation is a dance, an artform.

# INCLUSIVE FACILITATION

*inclusive means including everyone*

## Provide space and identify ways participants can engage at the start of the meeting

Depending on the size of the group, ask participants to share their name, pronouns, and in one word describe how they're feeling today.

## Dedicate time for personal reflection

Normalize silence. It's okay if folks are quiet, don't interpret as non-participation. Encourage people to take the time to reflect on the information presented to them.

## Establish community agreements

Create common ground. This helps with addressing power dynamics that may be present in the space.

## Identify ways to make people feel welcomed

We shouldn't assume everyone feels comfortable enabling their video. Make this an option as opposed to a request.

## Design for different learning and processing styles

Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

## Consider accessibility

Some folks may join through the dial in number, so consider walking through your agenda as if you were only on the phone. Consider language interpretation and closed captioning services.

# CREATING INCLUSIVE SPACE

*move at the speed of trust*

# LET'S CONSIDER THE FOLLOWING

**1**

A participant seems to dominate the conversation.

**2**

A participant has a lot of experience in the topic but is too shy to share them in a group setting.

**3**

A participant is talking about something not related to the topic of discussion.

# THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

Feel free to send in any questions to corina_pinto@jsi.com.

**BILH Community Listening Session: Breakout Discussion Guide**

**Session name, date, time:** [Filled in by notetaker]
**Community Facilitator:** [Filled in by notetaker]
**Notetaker:** [Filled in by notetaker]

**Mentimeter link:**
**Jamboard link:**

### Ground rules and introductions (5 minutes)

**Facilitator:** "Thank you for joining the Community Listening Session today. We will be in this small breakout group for approximately 45 minutes. Let's start with brief introductions and some ground rules for our time together. I will call on each of you. If you're comfortable, please share your name, your community, and one word to describe how you're feeling today. If you don't want to share, just say pass. I'll start. I'm _____ from _____ and today I'm feeling _____."
*(Facilitator calls on each participant)*

"Thanks for sharing. I'd like to start with some ground rules to be sure we get the most out of our discussion today:
- Make space and take space. We ask that you try to speak and listen in equal measure
- Be open to learning about experiences that don't match with your own
- What is said here stays here; what is learned here leaves here. [Notetaker's name] will be taking notes during our conversation today, but will not be marking down who says what. None of the information you share will be linked back to you specifically.

Are there other ground rules people would like to add for our discussion today?"

### Question 1 (5 minutes)

**Facilitator:** What is your reaction to data and preliminary priorities we saw today?
- *Probe: Did anything from the presentation surprise you, or did this confirm what you already know?*
- *Probe: What stood out to you the most?*

***Notes:***

### Question 2 (15 minutes)

**Part 1: 10 minutes**
**Notetaker:** *List preliminary priority areas from presentation in the Zoom chat.*

**Facilitator: "**We're going to move on to Question 2. Our notetaker has listed the preliminary priority areas from the presentation in our Zoom chat. Looking at this list – are there any priority areas that you think are missing?"

***Notes on missing priority areas:***

***[After 5 minutes, the Meeting Host will pop into your Breakout Room to collect any additional priority areas.]***

## Part 2: 5 minutes

***[Meeting host will send Broadcast message when it's time to move on to Part 2]***

**Facilitator: "**We want to know what priority areas are most important to you. Right now, our notetaker is going to put a link into the Zoom chat. (Notetaker copies & pastes Mentimeter link: <<**https://www.menti.com/yqztahwt4c**>>. When you see that link, please click on it.

"Within this poll, we want you to choose the 4 priority areas that are most concerning to you. The order in which you choose is not important. We'll give you a few minutes to make your selections.

"If you're unable to access the poll, go ahead and put your top 4 priority areas into the chat, or you can say them out loud and we can cast your vote for you.

After a few minutes, the poll results will be screen shared to our group."

***[Meeting Host will pop in to your room to ensure all votes have been cast. After confirmation, Meeting Host will broadcast poll results to all Breakout Groups]***

**Facilitator:** "It looks like (A, B, C, D) are the top four priority areas for this session. Our Notetaker will type these into the Chat box so we can reference them during our next activity."

## Question 3 (25 minutes)

**Facilitator: "**Next, we'd like to discuss how issues within these priority areas might be addressed. We know that no single entity can address all of these priorities, and that it usually takes many organizations and individuals working together. For each priority area we want to know about existing resources and assets – what's already working? – and gaps and barriers – what is most needed to be able to successfully address these issues."

Let's start with [Priority Area 1].
- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 2].
- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 3].
- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 4].
- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?"

***Notetakers will be taking notes within Jamboard.***

***[Meeting Host will send a broadcast message when there are 2 minutes left in the Breakout Session]***

## Wrap Up (1 minute)

**Facilitator:** "I want to thank you all for sharing your experiences, perspectives, and knowledge. In a minute we're going to be moved back into the Main Zoom room to hear about some of the things discussed in the groups today, and to talk about the next steps in the Needs Assessment process. Is there anything else people would like to share before we're moved out of the breakout room?"

***Notes:***

# WINCHESTER HOSPITAL COMMUNITY LISTENING SESSION

**January 26, 2022**
**February 3, 2022**

Beth Israel Lahey Health

# Winchester Hospital Community Listening Session
## Agenda

| Time | Activity | Speaker/Facilitator |
|------|----------|---------------------|
| 6:00-6:05 | Opening remarks | JSI |
| 6:05-6:10 | Overview of assessment purpose, process, and guiding principles | LeighAnne Taylor, Regional Manager of Community Benefits/Community Relations, Winchester Hospital |
| 6:10-6:20 | Presentation of preliminary themes and data findings | JSI |
| 6:20-7:25 | Breakout Groups | Community Facilitators |
| 7:25-7:30 | Wrap up: Closing statements and next steps | LeighAnne Taylor |

Beth Israel Lahey Health

**Assessment Purpose and Process**

## Assessment Purpose and Process
### Purpose

Identify and prioritize the health-related and social needs of those living in the service area with an emphasis on diverse populations and those experiencing inequities.

- A **Community Health Needs Assessment (CHNA)** identifies key health needs and issues through data collection and analysis.

- An **Implementation Strategy** is a plan to address public health problems collaboratively with municipalities, organizations, and residents.

All non-profit hospitals are required to conduct a CHNA and develop an Implementation Strategy every 3 years



Beth Israel Lahey Health
Winchester Hospital

## Community Benefits Service Area

- **H**  Winchester Hospital
- **1**  Winchester Hospital Family Medical Center
- **2**  Winchester Hospital Imaging/Walk-In Urgent Care
- **3**  Winchester Hospital Orthopedics Plus at Choate Medical Center
- **4**  Imaging at Reading Health Center
- **5**  Winchester Hospital Outpatient Center
- **6**  Winchester Hospital Community Health Institute Weight Management Program and Diabetes Center

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## Assessment Purpose and Process
### FY22 CHNA and Implementation Strategy Guiding Principles

**Equity:** Work toward the systemic, fair and just treatment of all people; engage cohorts most impacted by COVID-19

**Collaboration:** Leverage resources to achieve greater impact by working with community residents and organizations

**Engagement:** Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, communities most impacted by inequities, and others

**Capacity Building:** Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation
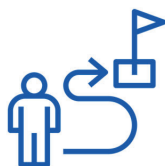
**Intentionality:** Be deliberate in our engagement and our request and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit

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# Assessment Purpose and Process
## FY22 CHNA and Implementation Strategy Process

**Kickoff**

**Report back to communities & post findings to website**

Data collection

Prioritization

Implementation strategy

Listening sessions

**Finalize reports**

| Sep 2021 | Dec 2021 | Feb 2022 | Mar 2021 | Jun 2022 | Jul 2022 | Sep 2022 |

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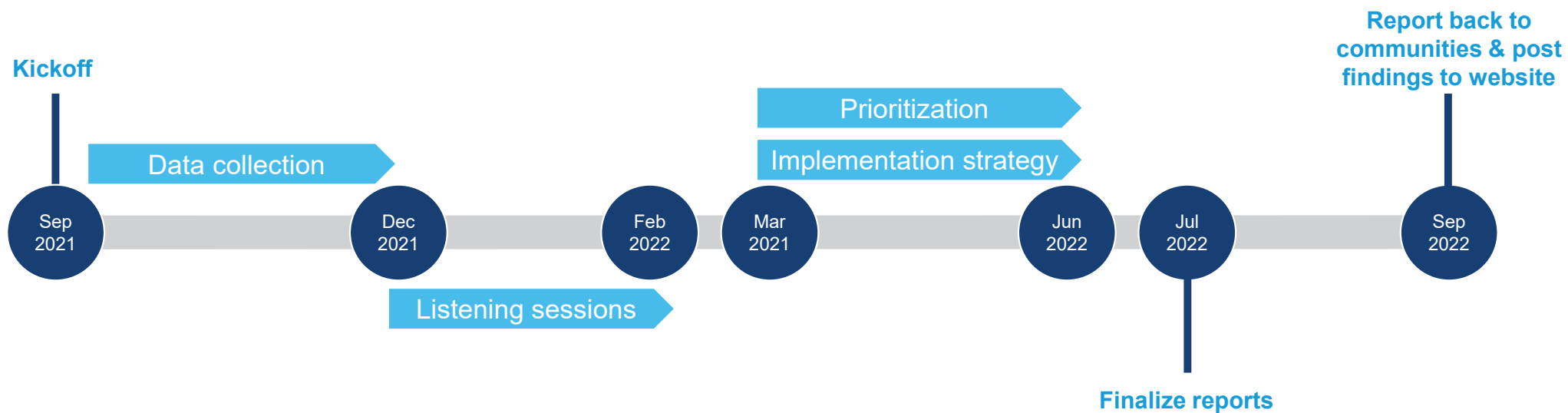
**Goals:**
- Conduct listening sessions that are *interactive, inclusive, participatory and reflective of the populations* served by Winchester Hospital
- Present data for prioritization
- Identify opportunities for *community-driven/led solutions and collaboration*



**We want to hear from you.**
Please speak up, raise your hand, or use the chat when we get to Breakout Sessions

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# Preliminary Themes & Data Findings

# CHNA Progress
## Activities to date

**Collection of secondary data, e.g.:**

✓ Massachusetts Department of Public Health

✓ Center for Health Information and Analytics (CHIA)

✓ County Health Rankings

✓ Behavioral Risk Factor Surveillance Survey

✓ Youth Risk Behavior Survey

✓ US Census Bureau

**21 Key Informant Interviews**

**822 BILH Community Health Survey Respondents**

**3 Focus Groups**
-Boys & Girls Club
-Medford Council on Aging
-Woburn Parents

# CHNA Progress
## Population Change in Community Benefits Service Area 2010-2020
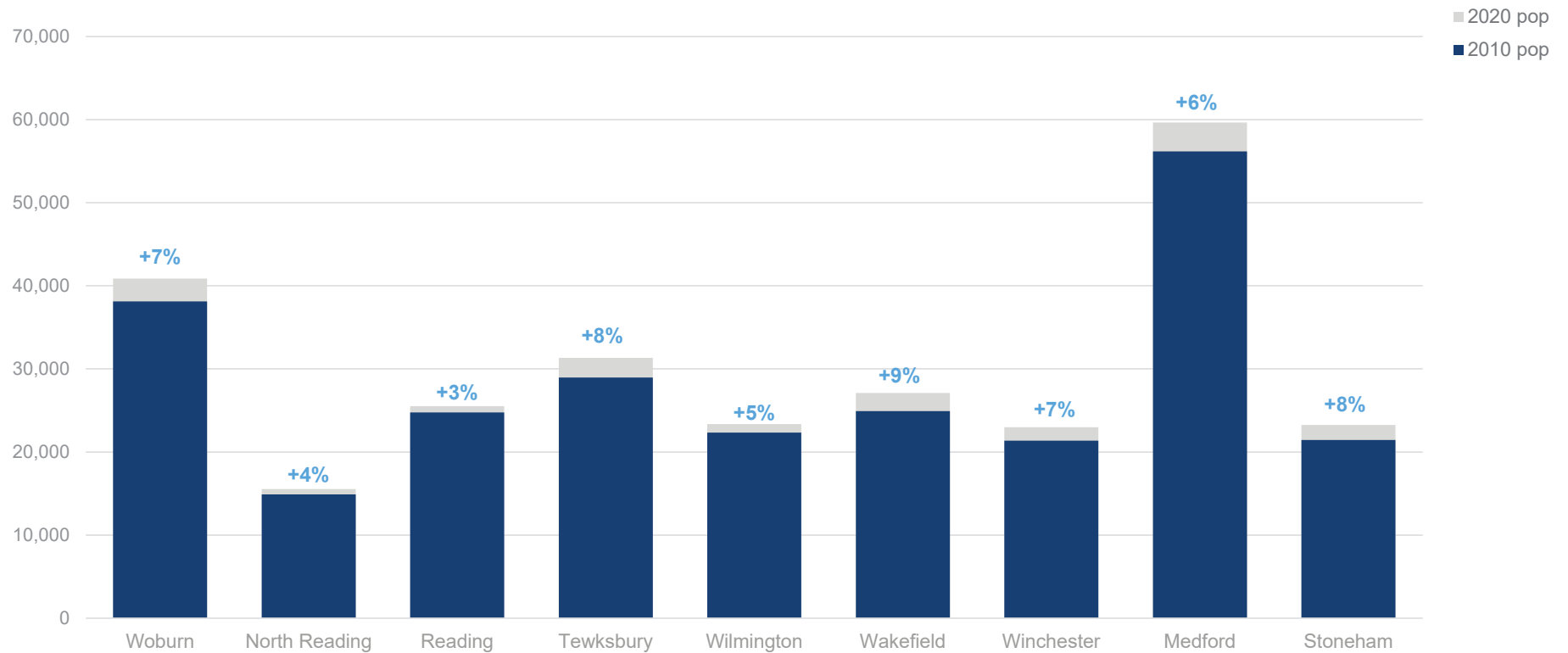
Source: 2010 & 2020 U.S. Census

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# CHNA Progress
## Race/Ethnicity Population Change in Community Benefits Service Area, 2010-2020



Net population increase of 6%

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| -15,314 -7% | 1,947 +24% | 8,102 +62% | 4,906 +66% | -28 -8% | 16 +36% | 3,070 +92% | 12,692 +293% |
| White | Black/ African American | Asian | Hispanic/ Latino (any race) | American Indian/ American Native | Native Hawaiian/ Other Pacific Islander | Some other race | Two or more races |

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# CHNA Progress
## Service Area Strengths

**FROM INTERVIEWS & FOCUS GROUPS:**

- Increasing racial and ethnic diversity in service area
- Increase in young families looking for strong school systems
- Engaged, civic-minded communities

**FROM WH COMMUNITY HEALTH SURVEY:**

**90%**
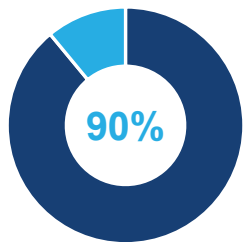
said they were **satisfied with the quality of life** in their community

**87%**
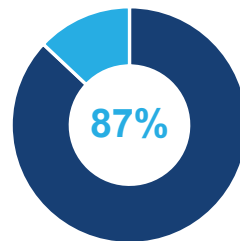
said the community has **good access to resources**
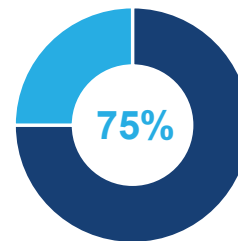
**75%**

said the community is a **good place to grow old**

**90%**

said the community is a **good place to raise kids**

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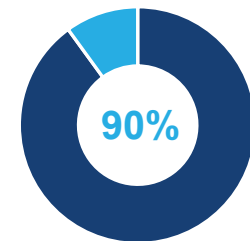
**CHNA Progress**
**Key themes**

- **Mental health**

- **Social determinants of health**

- **Diversity, equity, inclusion**

- **Access to care**

## CHNA Progress
## Key Themes: Mental Health (Youth)

- Significant prevalence of stress, anxiety, depression, behavioral issues
  - Exacerbated by Covid
- Concerns over bullying in schools
- Difficulty finding providers with availability

*"My children have ADHD and there aren't enough counselors available for regular visits. We were turned away. Nobody should be turned away.*
**– WH Community Health Survey respondent**

## Percentage High Schoolers Reporting Suicidal Ideation

| READ | STON | WAKE | WILM | WIN | WOB |
|------|------|------|------|-----|-----|
| 13% | 13% | 12% | 11% | 11% | 13% |
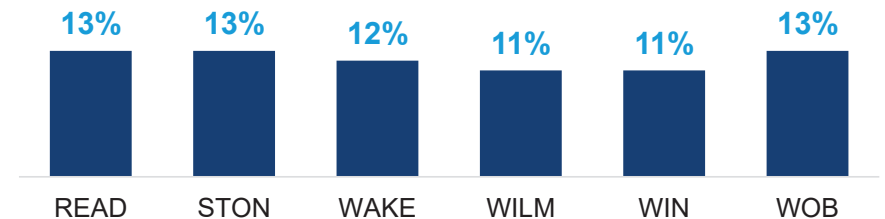
*Data Source: Youth Behavior Survey. Data not available in all CBSA communities*

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- Mental health issues exacerbated by COVID – anxiety, stress, depression, isolation

- Significant stress, anxiety, anger, and deep divisions in communities over current events (politics, COVID restrictions, recognition of racism and discrimination)

**13%** of WH Community Health Survey respondents reported that, within the past year, they needed mental health care but were not able to access it. Many cited lack of providers taking new patients, long wait times, and lack of insurance coverage as barriers

**Percentage\* with 15 or more poor mental health days in the past month (Fall 2020)**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 35% | 13% | 34% | 30% | 37% | 31% | 26% | 21% | 33% |
| MED | N READ | READ | STON | TEWK | WAKE | WILM | WIN | WOB |

*Data source: COVID-19 Community Impact Survey, MDPH*

*\*Unweighted percentages displayed*

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# CHNA Progress
## Key Themes: Social Determinants of Health

**Primary concerns:**

- Lack of affordable housing
- Economic insecurity/high cost of living
- Workforce shortages and unemployment
- Food insecurity

**Percentage\* worried about paying for one or more type of expense/bills in the coming weeks (Fall 2020)**
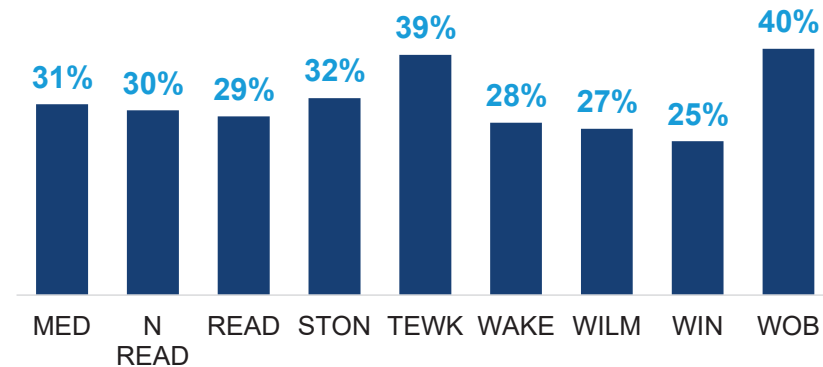


| MED | N READ | READ | STON | TEWK | WAKE | WILM | WIN | WOB |
|-----|--------|------|------|------|------|------|-----|-----|
| 31% | 30% | 29% | 32% | 39% | 28% | 27% | 25% | 40% |

When asked what they'd like to improve in their community, **48%** of WH Community Health Survey respondents reported

*"more affordable housing"*
*(#1 response)*

*"…lack of affordable housing [is a] huge problem. Love the community but will leave once kids are grown, because there are no townhouses or apartments for downsizing."* —**WH Community Health Survey respondent**

*Data source: COVID-19 Community Impact Survey, MDPH*
*\*Unweighted percentages displayed*

## CHNA Progress
## Key Themes: Diversity, Equity, and Inclusion

- Lack of support and services for non-English speakers and immigrant communities

- Impacts of racial injustices (e.g., murder of George Floyd; anti-Asian violence) deeply felt and debated. Denial that racism exists in communities

- Need housing support and social services that reflect the economic diversity in communities

**AMONG WH COMMUNITY HEALTH SURVEY RESPONDENTS:**
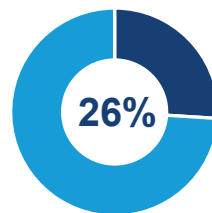
**26%** **26%** agreed that the built, economic, and educational environments in the community are impacted by systemic racism
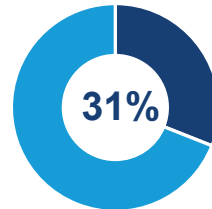
**31%** **31%** agreed that the community is impacted by individual racism

*"There is widespread denial of racism in the greater community here, and anger at the suggestion that people could be experiencing racism. However, my kids have seen racist remarks and treatment of kids at school. In addition, audits have found racist housing practices. So, it exists."*

**-WH Community Health Survey Respondent**

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## CHNA Progress
## Key Themes: Access to Care

**Difficulty accessing care because of:**
- Long wait times
- Lack of providers
- Cost/insurance barriers
- Language and cultural barriers

**Difficulties navigating and understanding healthcare system and insurance**

*"There are no openings for mental health help available at the moment. I can't begin to tell you how many waiting lists I am on and have been on for about six months."*

**-WH Community Health Survey Respondent**

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# Breakout Sessions

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# Reconvene

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**Wrap-up**
**Winchester Hospital Community Benefits**

## LeighAnne Taylor

Regional Manager, Community Benefits & Community Relations

Winchester Hospital

781-744-3131

leighanne.taylor@bilh.org

**Community Health & Community Benefits Information on website:**

Winchesterhospital.org

**Community Benefits Annual Meeting in June** (More info TBD)

## Thank you!

# Priority Area 1: Mental Health

## Resources/Assets

Training resources: Mental Health first aid training, suicide prevention training, mental health parent support training, NAM project as well

Healthy aging programs for seniors through various orgs

Interface is awesome (phone number you can call, beginning of the process)

Winchester uses Advocates for a emergency service provider

Social Capital, Inc. has several programs re youth mental health.

Woburn YMCA doing MH workshops.

Dedicated school counselors

Social worker hired at the police department

Merrill Health Care funded 3 initiatives, all related to MH.

High schools doing some programs

In Wakefield, there is a full time clinician at the police department that works closely with the hospital.

Half time social worker in Winchester at the police department.

Emergency service providers are helpful (Eliot, Tracy)

## Gaps/Barriers

Lack of providers to match individuals with (second half of interface process)

Need more funding. +1

Significant stigma attached to MH. +1

Need to add on programs to Non-profits, to increase resources beyond healthcare systems

Need on-site options

Interface is so expensive (+1)

Need to get a lot better at getting word out to all the people who need it. Sending out a flyer and a robocall aren't enough. Need people embedded in communities. +1

Lack of behavioral health beds for longer term care

Interface does not serve the entire Winchester Hospital service area

Lack of funds for training

# Priority Area 2: Access to Care

## Resources/Assets

2 years ago, WH offered a lot of free classes related to childbirth (but I had insurance)

Aunt Bertha website tells you about local resources

With the pandemic, many have moved to telehealth visits which has increased access.

At Merrill Healthcare, many people access the financial navigator.

The ability to screen and do mentorship virtually is helpful

At Merrill, we have interpreters and video interpreter devices.

Telehealth helps with access for those with digital capacity.

Shine counselors at senior centers, help navigate Medicare system.

## Gaps/Barriers

Difficulty enrolling into MassHealth

Healthcare costs are crazy, esp in the absence of insurance.

Healthcare system is confusing. Where do you go? How do you navigate? Who do you call? +1

Transportation, esp for seniors. With COVID, afraid to take Uber.

During the pandemic, people have put off seeking services due to not wanting to go to in-person services

Navigating who takes what insurance can be complicated

Getting an appointment is challenging, made worse by pandemic.

Lack of centralized places to provide information on resources

The amount of bureaucracy when going through a mental health crisis is unfair

Social services aspect: we need more people who can be the director of putting resources together or guide someone to resources they need

# Priority Area 3: Diversity, Equity, Inclusion

## Resources/Assets

Human rights commission in Stoneham

Network for Social Justice in Winchester

We have many organizations and in the school to address DEI in our community

Social Capital spearheaded Woburn's first Juneteenth celebration last year.

Social Capital program on what it means to be an ally.

Orgs are doing some best practice sharing

Y has mission to be inclusive

## Gaps/Barriers



Underscore language as a major barrier to inclusion

We need more multilingual staff within the school and throughout the community

Kids are translating for their parents

leaders are almost all whites; this is extreme barrier to inclusivity. Fire department, police, city hall, senior center, healthcare orgs. Hard to encourage people to get involved in community when don't see themselves

A group outside of government to address these issues would be helpful

Local media attacking youth and LGBTQ+ population

# Priority Area 4: Substance use

## Resources/Assets

Wake UP Wakefield.

Narcotic overdose antidote training

Programs for grandparents of substance users

Coalitions are awesome

Mystic Valley Coalition

Eastern Opioid Task Force

Recovery coaches

Recovery center in Malden

Northshore recovery high school

## Gaps/Barriers

Stigma is a big barrier.

Substance use is a result of SDOH--economics, housing, employment, etc. So, interventions need to be linked.

More recovery coaches

Support for parents and families

Long term care is missing, especially those on MassHealth

Not enough time in the day to support youth as far as prevention and intervention

# Priority Area 5: Other

## Resources/Assets

## Gaps/Barriers

Housing continues as a huge challenge, Hard to get good info to find options.

Few programs to address housing needs in area
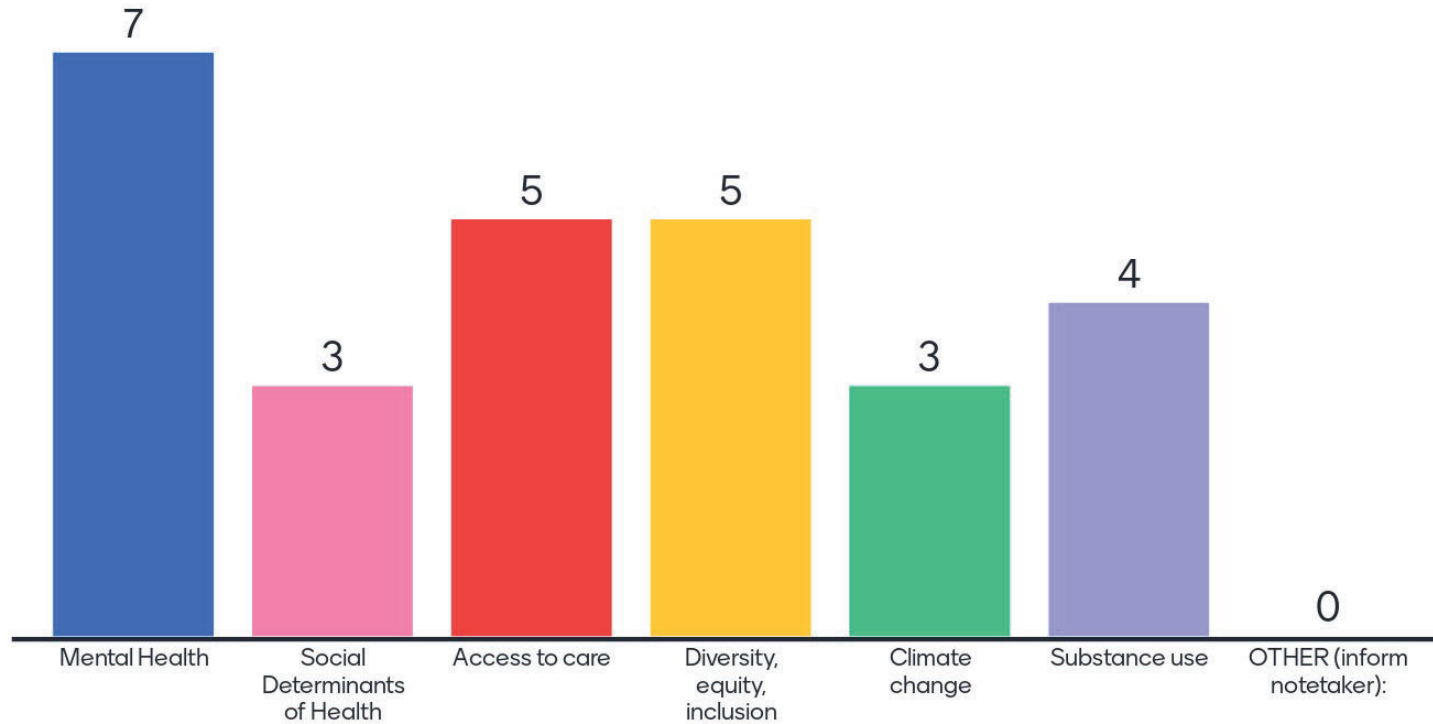
# Priority Area 1: Mental Health

## Resources/Assets

more people seeking services

school districts offer screenings

self help programs that can be helpful in the absence of professional treatment. Referring to Emotions Anonymous, AA, SMART Recovery

## Gaps/Barriers

allied mental health services is a huge need, such as physicians conducting screenings at office visits for MH/SUD

making youth services inclusive and representative, training and uplifting professionals

crisis of availability, can't train fast enough

seeing mental health as greater wellness, creating environments where there are programs and skills earlier on, reducing demand for clinicians later

long waiting lists for adolescent counseling

language access

need for more school programs, connections after need is demonstrated at schools

deaf community having difficulties getting services, therapists that use ASL

# Priority Area 2:  Access to Care

## Resources/Assets

## Gaps/Barriers

long waiting lists and lack of providers for mental health services

hospitals leading with use of pronouns, cultural humility

language access, an issue for deaf communities

# Priority Area 3: Diversity, Equity, Inclusion

## Resources/Assets

some progress being made, but more needed

use of pronouns

## Gaps/Barriers

intentional partnerships and funding choices

hospital systems being leaders in promoting EDI at institutional/systems level both externally and internally levels

both institutional and relational

cultural humility

LQBTQIA+ focus

Challenging to engage people who don't see it as an issue, how do you invite them into the conversation to educate and broaden views without being too preachy
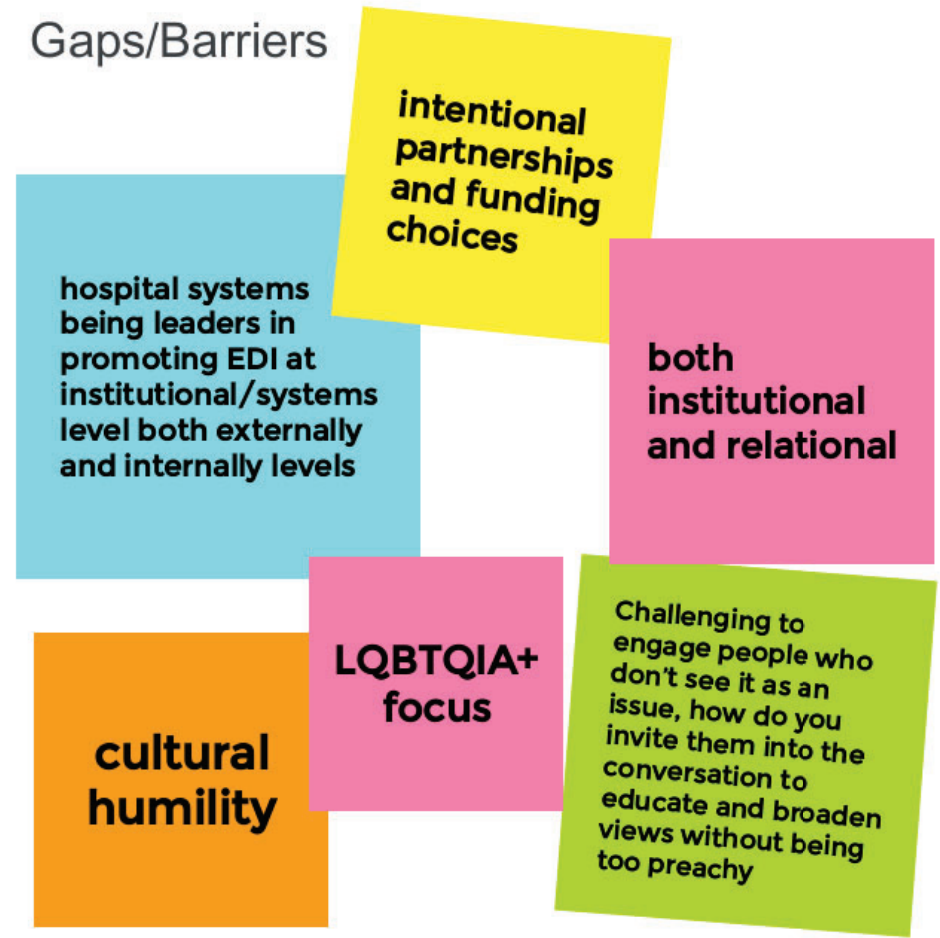
# Priority Area 4: Substance use

## Resources/Assets

**self help programs that can be helpful in the absence of professional treatment. Referring to Emotions Anonymous, AA, SMART Recovery**

**identifying concerns from the youth risk behavior survey**

**community coalitions are great at increasing awareness and education, voice in community for effective prevention strategies and policies**

**not all youth or adults misuse drugs and alcohol**

**health centers and staff need to be messengers of substance use health concerns like increases in alcoholism for women, connections between alcohol and breast cancer**

**Public health/social science research tells us that physicians and youth are the best messengers for information about substance use**

**school guidance counselors, especially those who are affirming and provide a safe environment**

## Gaps/Barriers

**working on prevention at community/municipal policies or state laws to see impactful systems change**

**conditions from COVID-19 increased substance use, also deterred healthcare priorities from substance use to COVID-19 responses**

# Appendix B:

# Data Book

# Secondary data

| | MA | Middlesex County | Community Benefits Service Area | | | | | | | | | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | |
| **Demographics** | | | | | | | | | | | | |
| **Population** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Total Population | 6,873,003 | 1,605,899 | 58,290 | 15,672 | 25,236 | 23,625 | 31,154 | 27,041 | 23,390 | 22,760 | 40,297 | |
| Male | 48.5% | 49.0% | 48.0% | 49.7% | 48.9% | 48.8% | 46.3% | 49.3% | 50.6% | 47.4% | 49.2% | |
| Female | 51.5% | 51.0% | 52.0% | 50.3% | 51.1% | 51.2% | 53.7% | 50.7% | 49.4% | 52.6% | 50.8% | |
| **Age Distribution** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Under 5 years (%) | 5.2% | 5.3% | 4.3% | 5.8% | 6.2% | 6.6% | 5.0% | 6.3% | 5.9% | 6.1% | 6.2% | |
| 5 to 9 years | 5.3% | 5.4% | 3.3% | 5.8% | 6.2% | 4.9% | 3.4% | 5.5% | 7.1% | 8.4% | 5.1% | |
| 10 to 14 years | 5.7% | 5.6% | 3.2% | 5.0% | 7.5% | 6.6% | 5.4% | 5.2% | 5.5% | 8.7% | 4.5% | |
| 15 to 19 years | 6.6% | 6.3% | 5.7% | 7.4% | 6.3% | 2.1% | 5.4% | 4.8% | 6.3% | 6.1% | 5.5% | |
| 20 to 24 years | 7.1% | 7.0% | 11.2% | 5.2% | 2.6% | 4.7% | 6.0% | 4.0% | 6.9% | 3.8% | 6.0% | |
| 25 to 34 years | 14.3% | 15.5% | 21.6% | 11.1% | 9.4% | 11.9% | 12.4% | 13.4% | 11.1% | 6.9% | 16.1% | |
| 35 to 44 years | 12.2% | 13.2% | 12.3% | 12.2% | 13.5% | 17.0% | 10.7% | 13.5% | 11.7% | 13.7% | 12.9% | |
| 45 to 54 years | 13.3% | 13.4% | 10.5% | 18.3% | 15.3% | 12.1% | 15.6% | 13.4% | 14.5% | 17.2% | 13.2% | |
| 55 to 59 years | 7.1% | 7.0% | 7.3% | 8.6% | 7.4% | 7.3% | 9.0% | 7.7% | 9.8% | 6.6% | 7.1% | |
| 60 to 64 years | 6.5% | 6.0% | 6.1% | 7.9% | 5.9% | 7.1% | 8.9% | 8.4% | 6.5% | 4.2% | 7.2% | |
| 65 to 74 years | 9.5% | 8.7% | 8.2% | 8.5% | 11.3% | 10.5% | 11.2% | 9.2% | 7.9% | 8.6% | 8.9% | |
| 75 to 84 years | 4.6% | 4.4% | 3.8% | 3.3% | 6.3% | 4.9% | 4.5% | 5.5% | 4.0% | 5.9% | 4.7% | |
| 85 years and over | 2.4% | 2.3% | 2.4% | 1.0% | 2.2% | 4.3% | 2.6% | 2.9% | 2.7% | 3.9% | 2.5% | |
| Under 18 years of age | 19.8% | 19.8% | 13.1% | 22.0% | 24.5% | 19.3% | 17.3% | 20.6% | 22.6% | 27.9% | 19.3% | |
| Over 65 years of age | 16.5% | 15.3% | 14.4% | 12.8% | 19.8% | 19.7% | 18.3% | 17.6% | 14.6% | 18.3% | 16.1% | |
| **Race/Ethnicity** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| White alone (%) | 76.6% | 75.2% | 71.9% | 92.9% | 89.8% | 88.3% | 91.5% | 94.4% | 87.0% | 78.8% | 79.5% | |
| Black or African American alone (%) | 7.5% | 5.3% | 8.9% | 0.9% | 0.7% | 2.9% | 3.2% | 1.0% | 2.9% | 0.9% | 4.7% | |
| Asian alone (%) | 6.8% | 12.4% | 11.4% | 4.3% | 5.3% | 5.4% | 2.8% | 2.6% | 5.4% | 14.5% | 10.1% | |
| Native Hawaiian and Other Pacific Islander (%) alone | 0.0% | 0.1% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | |
| American Indian and Alaska Native (%) alone | 0.2% | 0.2% | 0.1% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.6% | 0.0% | |
| Some Other Race alone (%) | 4.2% | 2.9% | 2.1% | 0.3% | 1.3% | 0.9% | 0.6% | 0.2% | 0.6% | 1.8% | 2.8% | |
| Two or More Races (%) | 4.8% | 4.0% | 5.6% | 1.7% | 2.8% | 2.5% | 1.8% | 1.8% | 4.1% | 3.4% | 2.8% | |
| Hispanic or Latino of Any Race (%) | 12.0% | 8.1% | 7.5% | 1.6% | 3.6% | 4.1% | 2.2% | 3.6% | 1.2% | 2.3% | 6.3% | |

| | MA | Middlesex County | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Community Benefits Service Area** | | | | | | | | | |
| **Race/Ethnicity of Students in Public Schools** | | | | | | | | | | | | School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021 |
| African American (%) | 9.3 | | 11.9 | 0.6 | 2.5 | 2.2 | 3.8 | 2.8 | 1.5 | 1.2 | 7.2 | |
| Asian (%) | 7.2 | | 9.5 | 4.5 | 5.3 | 5.8 | 4.1 | 3.6 | 6.0 | 18.9 | 7.6 | |
| Hispanic (%) | 22.3 | | 13.6 | 4.1 | 3.3 | 9.6 | 6.3 | 7.7 | 4.5 | 3.4 | 11.9 | |
| White (%) | 56.7 | | 59.3 | 87.4 | 86.2 | 78.0 | 83.8 | 82.5 | 84.0 | 70.0 | 69.1 | |
| Native American (%) | 0.2 | | 0.5 | 0.1 | 0.1 | 0.3 | 0.1 | 0.2 | 0.1 | 0.2 | 0.6 | |
| Native Hawaiian, Pacific Islander (%) | 0.1 | | 0.1 | 0.1 | - | - | 0.1 | 0.2 | - | - | 0.2 | |
| Multi-Race, Non-Hispanic (%) | 4.10 | | 5.1 | 3.2 | 2.5 | 4.0 | 1.8 | 3.1 | 4.0 | 6.3 | 3.6 | |
| Foreign-born | 17.0% | 21.3% | 22.1% | 9.1% | 9.4% | 13.3% | 8.4% | 7.5% | 9.9% | 9.9% | 19.2% | US Census Bureau, American Community Survey 2016-2020 |
| Naturalized U.S. Citizen | 54.2% | 50.2% | 55.1% | 61.7% | 64.4% | 65.4% | 69.5% | 66.3% | 62.5% | 62.5% | 45.1% | |
| Not a U.S. Citizen | 45.8% | 49.8% | 44.9% | 38.3% | 35.6% | 34.6% | 30.5% | 33.7% | 37.5% | 37.5% | 54.9% | |
| Region of birth: Europe | 20.0% | 18.8% | 21.8% | 35.7% | 25.7% | 27.7% | 38.6% | 37.7% | 23.1% | 23.1% | 30.2% | |
| Region of birth: Asia | 31.1% | 43.8% | 38.0% | 32.5% | 45.0% | 31.2% | 24.9% | 31.8% | 50.7% | 50.7% | 54.6% | |
| Region of birth: Africa | 9.3% | 7.2% | 3.8% | 6.5% | 6.6% | 12.7% | 17.9% | 7.0% | 7.4% | 7.4% | 2.1% | |
| Region of birth: Oceania | 0.3% | 0.5% | 0.5% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.5% | |
| Region of birth: Latin America | 36.7% | 26.9% | 33.3% | 22.4% | 16.9% | 25.9% | 12.9% | 19.6% | 8.3% | 8.3% | 10.3% | |
| Region of birth: Northern America | 2.5% | 2.8% | 2.6% | 2.9% | 5.7% | 2.5% | 5.8% | 3.9% | 10.5% | 10.5% | 2.4% | |
| **Language** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| English only | 76.1% | 73.4% | 70.6% | 90.2% | 88.8% | 82.0% | 91.2% | 90.9% | 89.9% | 78.5% | 76.9% | |
| Language other than English | 23.9% | 26.6% | 29.4% | 9.8% | 11.2% | 18.0% | 8.8% | 9.1% | 10.1% | 21.5% | 23.1% | |
| Speak English less than "very well" | 9.2% | 9.0% | 10.2% | 2.4% | 2.6% | 4.4% | 2.3% | 2.5% | 3.0% | 4.7% | 8.6% | |
| Spanish | 9.1% | 5.8% | 5.7% | 1.1% | 1.6% | 3.2% | 0.9% | 2.5% | 0.5% | 2.1% | 4.7% | |
| Speak English less than "very well" | 3.8% | 2.1% | 1.6% | 0.0% | 0.3% | 0.8% | 0.2% | 0.5% | 0.1% | 0.3% | 2.7% | |
| Other Indo-European languages | 9.0% | 11.7% | 15.7% | 6.5% | 4.9% | 8.7% | 4.5% | 4.4% | 4.8% | 10.6% | 12.0% | |
| Speak English less than "very well" | 3.0% | 3.6% | 5.2% | 1.3% | 0.9% | 1.9% | 0.9% | 1.3% | 1.7% | 2.0% | 3.9% | |
| Asian and Pacific Islander languages | 4.4% | 7.4% | 7.2% | 1.6% | 4.5% | 2.8% | 2.1% | 1.4% | 3.1% | 7.9% | 4.8% | |
| Speak English less than "very well" | 2.0% | 2.9% | 3.2% | 1.0% | 1.5% | 1.0% | 0.8% | 0.5% | 0.8% | 2.3% | 1.7% | |
| Other languages | 1.4% | 1.7% | 0.8% | 0.5% | 0.2% | 3.3% | 1.3% | 0.8% | 1.6% | 0.9% | 1.6% | |
| Speak English less than "very well" | 0.4% | 0.5% | 0.1% | 0.0% | 0.0% | 0.7% | 0.5% | 0.2% | 0.4% | 0.2% | 0.3% | |
| Percent of public school student population that are English language learners (%) | 10.5 | | 10.4 | 0.5 | 1.1 | 3.5 | 1.8 | 2.4 | 0.8 | 3.0 | 8.0 | Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations) |
| **Employment** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Unemployment rate | 5.1% | 4.2% | 3.4% | 4.9% | 2.7% | 3.5% | 4.9% | 2.7% | 4.4% | 2.8% | 5.6% | |

| | | Community Benefits Service Area | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MA | Middlesex County | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | Source |
| **Unemployment rate by race/ethnicity** | | | | | | | | | | | | |
| White alone | 4.5% | 3.9% | 3.8% | 4.7% | 3.0% | 3.3% | 5.2% | 2.3% | 4.4% | 2.8% | 5.1% | |
| Black or African American alone | 8.3% | 7.0% | 4.0% | 6.5% | 0.0% | 4.0% | 1.4% | 12.0% | 11.6% | 0.0% | 4.9% | |
| American Indian and Alaska Native alone | 10.7% | 12.1% | 0.0% | - | 0.0% | - | 0.0% | - | - | 31.5% | 0.0% | |
| Asian alone | 4.2% | 4.1% | 1.7% | 6.5% | 0.1% | 7.7% | 1.6% | 7.3% | 2.6% | 2.3% | 5.2% | |
| Native Hawaiian and Other Pacific Islander alone | 5.4% | 14.6% | 0.0% | | - | - | - | - | - | 0.0% | - | |
| Some other race alone | 8.3% | 5.7% | 0.0% | 40.4% | 0.0% | 0.0% | 6.3% | 0.0% | 0.0% | 0.0% | 25.5% | |
| Two or more races | 9.1% | 5.6% | 3.0% | 0.0% | 0.0% | 0.0% | 0.0% | 7.1% | 1.6% | 0.0% | 2.6% | |
| Hispanic or Latino origin (of any race) | 8.3% | 6.0% | 1.5% | 22.5% | 2.7% | 5.7% | 11.5% | 0.0% | 2.8% | 2.7% | 14.0% | |
| **Unemployment rate by educational attainment** | | | | | | | | | | | | |
| Less than high school graduate | 9.7% | 7.8% | 1.2% | 0.0% | 10.8% | 0.0% | 30.3% | 9.5% | 0.0% | 0.0% | 21.2% | |
| High school graduate (includes equivalency) | 5.9% | 5.1% | 2.3% | 4.6% | 0.0% | 7.2% | 4.6% | 1.9% | 5.4% | 1.3% | 5.8% | |
| Some college or associate's degree | 4.5% | 4.0% | 5.1% | 7.9% | 1.6% | 1.2% | 4.2% | 1.5% | 2.1% | 8.7% | 1.7% | |
| Bachelor's degree or higher | 2.8% | 2.7% | 2.7% | 2.4% | 1.6% | 3.6% | 1.8% | 1.8% | 3.6% | 1.6% | 3.4% | |
| **Income and Poverty** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Median household income (dollars) | 84,385 | 106,202 | 101,168 | 123,042 | 131,515 | 103,104 | 104,610 | 103,696 | 133,873 | 173,058 | 92,084 | |
| **Population living below the federal poverty line in the last 12 months** | | | | | | | | | | | | |
| Individuals | 9.8% | 7.2% | 8.6% | 2.7% | 3.0% | 5.0% | 4.0% | 5.0% | 2.8% | 2.8% | 5.7% | |
| Families | 6.6% | 4.5% | 3.3% | 1.2% | 3.1% | 2.8% | 2.1% | 3.5% | 1.4% | 2.4% | 3.7% | |
| Individuals under 18 years of age | 12.2% | 7.6% | 7.3% | 1.7% | 2.8% | 3.3% | 3.8% | 8.1% | 1.2% | 0.6% | 6.9% | |
| Individuals over 65 years of age | 8.9% | 7.5% | 5.2% | 2.8% | 4.7% | 6.7% | 5.8% | 3.1% | 5.1% | 5.5% | 7.3% | |
| Female head of household, no spouse present | 20.5% | 16.2% | 11.2% | 2.6% | 25.4% | 8.0% | 7.8% | 10.0% | 2.9% | 17.0% | 7.5% | |
| White alone | 7.9% | 6.0% | 6.6% | 2.6% | 3.0% | 4.9% | 3.3% | 4.8% | 2.8% | 2.8% | 4.9% | |
| Black or African American alone | 17.6% | 14.6% | 16.6% | 10.4% | 0.6% | 0.2% | 18.7% | 1.9% | 5.6% | 1.0% | 8.0% | |
| American Indian and Alaska Native alone | 23.3% | 26.9% | 41.7% | - | 0.0% | - | 0.0% | - | - | 17.0% | 0.0% | |
| Asian alone | 11.8% | 9.4% | 15.7% | 0.0% | 0.0% | 9.8% | 9.2% | 0.0% | 1.5% | 2.0% | 3.7% | |
| Native Hawaiian and Other Pacific Islander alone | 11.9% | 14.6% | 0.0% | - | - | - | - | - | - | 0.0% | - | |
| Some other race alone | 22.2% | 14.7% | 1.3% | 40.4% | 26.6% | 10.1% | 20.5% | 9.1% | 1.6% | 10.7% | 33.6% | |
| Two or more races | 15.5% | 8.7% | 8.8% | 0.0% | 0.0% | 0.0% | 1.8% | 20.3% | 3.2% | 0.0% | 6.0% | |
| Hispanic or Latino origin (of any race) | 23.0% | 17.3% | 5.8% | 14.0% | 13.4% | 7.8% | 0.8% | 3.2% | 17.3% | 0.6% | 17.5% | |
| Less than high school graduate | 23.2% | 18.4% | 8.6% | 6.3% | 13.3% | 17.6% | 10.7% | 14.3% | 7.0% | 39.8% | 10.9% | |

| | MA | Middlesex County | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High school graduate (includes equivalency) | 11.7% | 10.6% | 9.3% | 6.2% | 11.0% | 10.0% | 6.4% | 4.6% | 4.8% | 10.6% | 6.5% | |
| Some college, associate's degree | 8.4% | 7.1% | 7.0% | 1.0% | 2.4% | 6.0% | 4.3% | 2.8% | 6.0% | 4.4% | 6.7% | |
| Bachelor's degree or higher | 3.9% | 3.5% | 2.5% | 1.9% | 1.0% | 1.9% | 1.6% | 3.7% | 0.7% | 1.6% | 2.2% | |
| With Social Security | 30.2% | 26.3% | 23.7% | 26.1% | 31.8% | 31.4% | 33.6% | 29.6% | 27.7% | 28.9% | 29.7% | |
| With retirement income | 19.3% | 17.4% | 16.6% | 17.9% | 22.0% | 21.3% | 23.3% | 23.0% | 18.7% | 20.6% | 19.5% | |
| With Supplemental Security Income | 5.9% | 4.0% | 2.8% | 3.1% | 1.5% | 5.0% | 2.7% | 3.2% | 5.0% | 1.5% | 4.4% | |
| With cash public assistance income | 2.8% | 2.0% | 1.7% | 0.6% | 0.1% | 1.1% | 1.5% | 1.4% | 1.5% | 0.5% | 2.0% | |
| With Food Stamp/SNAP benefits in the past 12 months | 11.6% | 6.7% | 6.9% | 4.5% | 1.7% | 5.6% | 2.8% | 4.0% | 5.8% | 0.8% | 5.6% | Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations) |
| Public School Distric Students Who are Low Income (%) | 36.6 | | 34.2 | 9.5 | 8.9 | 19.3 | 17.8 | 13.8 | 11.9 | 5.7 | 32.2 | |
| **Housing** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Occupied housing units | | | | | | | | | | | | |
| Owner-occupied | 62.5% | 62.1% | 55.5% | 84.5% | 84.6% | 66.2% | 85.1% | 72.9% | 84.3% | 83.8% | 58.3% | |
| Renter-occupied | 37.5% | 37.9% | 44.5% | 15.5% | 15.4% | 33.8% | 14.9% | 27.1% | 15.7% | 16.2% | 41.7% | |
| Lacking complete plumbing facilities | 0.3% | 0.3% | 0.0% | 0.0% | 0.3% | 0.1% | 0.3% | 0.0% | 0.0% | 0.5% | 0.8% | |
| Lacking complete kitchen facilities | 0.8% | 0.8% | 0.2% | 0.3% | 0.4% | 0.3% | 1.6% | 0.2% | 0.3% | 0.5% | 0.5% | |
| No telephone service available | 1.2% | 1.0% | 0.4% | 0.2% | 0.8% | 0.8% | 1.1% | 1.3% | 0.5% | 0.7% | 1.1% | |
| Monthly housing costs <35% of total household income | | | | | | | | | | | | |
| Among owner-occupied housing units with a mortgage | 22.0% | 20.5% | 20.7% | 21.5% | 19.4% | 16.8% | 22.6% | 20.7% | 19.5% | 17.5% | 16.6% | |
| Among owner-occupied units without a mortgage | 15.2% | 15.4% | 16.3% | 9.6% | 17.3% | 13.2% | 21.3% | 14.4% | 9.2% | 20.7% | 16.3% | |
| Among occupied units paying rent | 39.1% | 35.1% | 33.2% | 49.6% | 33.8% | 31.6% | 39.7% | 29.4% | 26.0% | 33.1% | 35.5% | |
| Eviction filings, 2018 | 34,200 | 5,400 | 162 | - | 20 | 50 | - | 58 | 36 | 9 | 197 | Eviction Lab, 2018 Evictions |
| **Access to Technology** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Among households | | | | | | | | | | | | |
| Has smartphone | 83.3% | 85.9% | 86.9% | 88.0% | 83.7% | 81.9% | 81.2% | 85.9% | 88.3% | 84.9% | 82.0% | |
| Has desktop or laptop | 82.2% | 87.6% | 87.8% | 94.8% | 89.4% | 84.6% | 86.8% | 88.0% | 91.9% | 92.2% | 87.2% | |
| Has tablet or other portable wireless computer | 64.8% | 69.5% | 71.0% | 76.8% | 75.8% | 64.5% | 70.9% | 66.3% | 76.1% | 79.8% | 68.7% | |
| No computer | 7.4% | 5.8% | 5.3% | 1.1% | 4.7% | 7.6% | 7.7% | 6.1% | 3.8% | 5.5% | 6.8% | |
| With broadband internet | 88.2% | 91.3% | 92.3% | 97.3% | 93.6% | 89.0% | 91.1% | 91.5% | 95.2% | 93.3% | 90.2% | |
| **Transportation** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |

| | MA | Middlesex County | Community Benefits Service Area | | | | | | | | | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | |
| **Mode of transportation to work for workers aged 16+** | | | | | | | | | | | | |
| Car, truck, or van -- drove alone | 68.0% | 64.1% | 54.2% | 79.6% | 69.2% | 80.8% | 84.7% | 72.6% | 80.0% | 66.8% | 75.9% | |
| Car, truck, or van -- carpooled | 7.3% | 6.7% | 9.6% | 3.0% | 5.8% | 4.8% | 6.0% | 5.0% | 5.9% | 6.2% | 9.7% | |
| Public transportation (excluding taxicab) | 9.5% | 11.4% | 19.2% | 3.3% | 9.4% | 7.7% | 3.1% | 9.4% | 6.2% | 10.5% | 4.8% | |
| Walked | 4.8% | 4.9% | 5.5% | 1.9% | 0.9% | 0.4% | 1.1% | 1.9% | 0.8% | 1.2% | 1.8% | |
| Other means | 2.1% | 2.7% | 2.9% | 1.6% | 1.1% | 0.2% | 0.4% | 1.4% | 1.5% | 1.4% | 1.0% | |
| Worked from home | 8.3% | 10.2% | 8.5% | 10.6% | 13.5% | 6.1% | 4.6% | 9.7% | 5.6% | 14.1% | 6.8% | |
| Mean travel time to work (minutes) | 30 | 31.1 | 31.8 | 35.4 | 33.6 | 29.9 | 33.3 | 33 | 31.3 | 33.9 | 26.9 | |
| **Vehicles available among occupied housing units** | | | | | | | | | | | | |
| No vehicles available | 12.2% | 10.5% | 9.6% | 2.2% | 7.2% | 6.1% | 4.1% | 3.3% | 5.3% | 5.6% | 7.3% | |
| 1 vehicle available | 35.1% | 35.1% | 45.4% | 25.0% | 23.1% | 35.3% | 27.9% | 34.3% | 19.3% | 26.2% | 37.1% | |
| 2 vehicles available | 36.1% | 38.6% | 31.7% | 43.9% | 51.0% | 43.8% | 44.1% | 44.3% | 49.6% | 51.3% | 38.2% | |
| 3 or more vehicles available | 16.5% | 15.8% | 13.3% | 28.8% | 18.6% | 14.8% | 24.0% | 18.1% | 25.8% | 16.8% | 17.3% | |
| **Education** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| **Educational attainment of adults 25 years and older** | | | | | | | | | | | | |
| Less than 9th grade (%) | 4.2% | 3.2% | 3.1% | 1.1% | 1.8% | 1.4% | 1.8% | 1.6% | 1.9% | 0.9% | 2.4% | |
| 9th to 12th grade, no diploma (%) | 4.7% | 3.2% | 3.6% | 2.2% | 1.2% | 2.9% | 3.6% | 2.8% | 2.6% | 1.3% | 2.9% | |
| High school graduate (includes equivalency) (%) | 23.5% | 18.5% | 20.4% | 20.3% | 15.8% | 24.5% | 31.0% | 20.3% | 25.5% | 11.6% | 25.6% | |
| Some college, no degree (%) | 15.3% | 12.2% | 12.2% | 11.8% | 11.7% | 14.6% | 16.8% | 13.2% | 13.9% | 8.1% | 14.4% | |
| Associate's degree (%) | 7.7% | 5.9% | 6.1% | 9.6% | 6.1% | 7.5% | 8.7% | 8.5% | 7.8% | 2.8% | 7.5% | |
| Bachelor's degree (%) | 24.5% | 28.1% | 28.5% | 33.3% | 33.5% | 28.9% | 23.4% | 31.5% | 29.2% | 30.3% | 27.9% | |
| Graduate or professional degree (%) | 20.0% | 28.9% | 26.2% | 21.7% | 29.9% | 20.1% | 14.7% | 22.1% | 19.2% | 45.1% | 19.3% | |
| High school graduate or higher (%) | 91.1% | 93.7% | 93.3% | 96.8% | 97.1% | 95.7% | 94.6% | 95.6% | 95.5% | 97.9% | 94.7% | |
| Bachelor's degree or higher (%) | 44.5% | 57.1% | 54.7% | 55.0% | 63.4% | 49.0% | 38.1% | 53.6% | 48.3% | 75.3% | 47.1% | |
| **Educational attainment by race/ethnicity** | | | | | | | | | | | | |
| White alone | | | | | | | | | | | | |
| High school graduate or higher | 93.3% | 95.3% | 94.7% | 96.7% | 98.1% | 95.6% | 94.5% | 95.6% | 96.1% | 97.6% | 94.9% | |
| Bachelor's degree or higher | 46.3% | 57.7% | 55.4% | 54.1% | 63.4% | 49.3% | 36.5% | 53.3% | 47.2% | 73.6% | 45.2% | |
| Black alone | | | | | | | | | | | | |
| High school graduate or higher | 86.2% | 89.9% | 86.9% | 100.0% | 97.7% | 98.2% | 98.5% | 97.4% | 75.3% | 95.3% | 95.0% | |
| Bachelor's degree or higher | 27.6% | 36.1% | 30.4% | 32.4% | 49.1% | 33.9% | 58.7% | 21.1% | 25.5% | 86.9% | 41.2% | |
| | | | | | | | | | | | | |
| American Indian or Alaska Native alone | | | | | | | | | | | | |
| High school graduate or higher | 81.0% | 83.0% | 0.0% | - | 100.0% | - | 100.0% | 0.0% | - | 100.0% | - | |
| Bachelor's degree or higher | 21.9% | 18.5% | 0.0% | - | 100.0% | - | 100.0% | 0.0% | - | 71.1% | - | |
| Asian alone | | | | | | | | | | | | |
| High school graduate or higher | 85.7% | 90.0% | 89.9% | 96.9% | 82.1% | 93.8% | 95.0% | 96.3% | 94.7% | 98.7% | 93.3% | |

| | MA | Middlesex County | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Community Benefits Service Area** | | | | | | | | | |
| Bachelor's degree or higher | 61.8% | 70.4% | 68.1% | 68.7% | 64.8% | 59.8% | 76.0% | 82.6% | 76.1% | 89.0% | 67.1% | |
| Native Hawaiian and Other Pacific Islander alone | | | | | | | | | | | | |
| High school graduate or higher | 89.1% | 95.3% | 100.0% | - | - | - | - | - | - | 100.0% | - | |
| Bachelor's degree or higher | 36.4% | 25.5% | 100.0% | - | - | - | - | - | - | 0.0% | - | |
| Some other race alone | | | | | | | | | | | | |
| High school graduate or higher | 69.9% | 72.1% | 81.7% | 87.5% | 85.6% | 100.0% | 82.0% | 100.0% | 91.7% | 100.0% | 87.8% | |
| Bachelor's degree or higher | 15.7% | 20.2% | 34.0% | 87.5% | 74.8% | 30.0% | 22.7% | 62.2% | 0.0% | 45.2% | 24.2% | |
| Two or more races | | | | | | | | | | | | |
| High school graduate or higher | 81.3% | 89.7% | 93.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.5% | 100.0% | 100.0% | |
| Bachelor's degree or higher | 34.9% | 52.7% | 61.8% | 96.3% | 54.8% | 24.3% | 27.8% | 46.3% | 37.4% | 65.7% | 61.9% | |
| Hispanic or Latino Origin | | | | | | | | | | | | |
| High school graduate or higher | 72.4% | 77.8% | 85.5% | 96.5% | 84.8% | 89.7% | 83.9% | 95.1% | 86.1% | 100.0% | 87.6% | |
| Bachelor's degree or higher | 20.9% | 32.1% | 53.6% | 62.6% | 75.3% | 21.7% | 30.8% | 50.3% | 41.7% | 88.9% | 26.9% | |
| 4-Year Graduation Rate Among Public High School Students (%) | 89.0 | | 88.8 | 99.0 | 96.8 | 95.7 | 94.9 | 98.1 | 95.0 | 97.1 | 86.0 | Massachusetts Department of Elementary and Secondary Education, 2020 |
| **Safety/Crime** | | | | | | | | | | | | Massachusetts Crime Statistics, 2021 |
| Property Crimes Offenses (#) | | | | | | | | | | | | |
| Burglary | 9,592.0 | | 49 | 4 | 10 | 41 | 28 | 14 | 15 | 13 | 37 | |
| Larceny-theft | 55,672.0 | | 438 | 50 | 113 | 108 | 327 | 70 | 130 | 66 | 343 | |
| Motor vehicle theft | 7,045.0 | | 45 | 2 | 3 | 7 | 23 | 9 | 8 | 3 | 58 | |
| Arson | 312.0 | | 2 | 1 | 2 | 2 | 1 | 2 | 0 | 0 | 1 | |
| Crimes Against Persons Offenses (#) | | | | | | | | | | | | |
| Murder/non-negligent manslaughter | 151 | | 0 | 0 | 0 | 0 | 0 | 1 | | 0 | 1 | |
| Sex offenses | 4,171 | | 10 | 4 | 0 | 6 | 23 | 17 | 6 | 2 | 10 | |
| Assaults | 67,690 | | 309 | 38 | 38 | 92 | 306 | 115 | 102 | 15 | 157 | |
| **Access to Care** | | | | | | | | | | | | |
| Ratio of population to primary care physicians | 960 to 1 | 780 to 1 | | | | | | | | | | County Health Rankings, 2019 |
| Ratio of population to mental health providers | 140 to 1 | 160 to 1 | | | | | | | | | | County Health Rankings, 2021 |
| Ratio of population to dentists | 930 to 1 | 980 to 1 | | | | | | | | | | County Health Rankings, 2020 |
| Health insurance coverage among civilian noninstitutionalized population (%) | | | | | | | | | | | | American Community Survey (U.S. Census Bureau), 2016-2020 |
| With health insurance coverage | 97.3% | 97.4% | 96.9% | 98.8% | 99.2% | 97.9% | 98.9% | 97.5% | 99.7% | 97.9% | 98.1% | |
| With private health insurance | 74.5% | 81.0% | 82.7% | 89.8% | 89.2% | 85.8% | 86.8% | 87.0% | 88.5% | 90.2% | 80.6% | |
| With public coverage | 36.1% | 28.5% | 27.3% | 23.0% | 25.5% | 27.2% | 27.4% | 25.0% | 26.1% | 20.5% | 31.9% | |
| No health insurance coverage | 2.7% | 2.6% | 3.1% | 1.2% | 0.8% | 2.1% | 1.1% | 2.5% | 0.3% | 2.1% | 1.9% | |

| | Massachusetts | Middlesex County | Community Benefits Service Area | | | | | | | | | Source |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | |
| **Overall Health** | | | | | | | | | | | | |
| Mortality rate (age-adjusted per 100,000) | 654 | 671 | 598.7 | 504.6 | 547.6 | 559.4 | 755.1 | 664.2 | 678.6 | 406.6 | 615.2 | Massachusetts Death Report, 2019 |
| Premature mortality rate (per 100,000) | 272.8 | 271.3 | 234.2 | 195.4 | 187.5 | 205.3 | 287.5 | 209.2 | 275.6 | 118.1 | 264 | |
| Leading causes of death (counts) | | | | | | | | | | | | |
| Cancer | 12,584 | | 104 | 29 | 42 | 48 | 65 | 49 | 47 | 32 | 92 | |
| Heart Disease | 11,779 | | 105 | 19 | 43 | 47 | 65 | 48 | 52 | 22 | 84 | |
| Chronic Lower Respiratory Disease | 2,842 | | 20 | 5 | 8 | 6 | 16 | 2 | 13 | 4 | 13 | |
| Stroke | 2,463 | | 15 | 4 | 9 | 8 | 9 | 8 | 11 | 15 | 18 | |
| **Disability** | | | | | | | | | | | | US Census Bureau, American Community Survey 2016-2020 |
| Percent of population with a disability | 11.7% | 9.5% | 7.7% | 9.7% | 8.9% | 10.4% | 10.4% | 9.9% | 11.0% | 7.1% | 11.7% | |
| Under 18 | 4.7% | 3.8% | 2.0% | 2.4% | 5.7% | 1.5% | 5.2% | 3.9% | 2.5% | 2.0% | 7.4% | |
| 18-64 | 8.9% | 6.6% | 5.1% | 8.8% | 3.3% | 4.7% | 7.0% | 6.7% | 8.9% | 2.8% | 9.0% | |
| 65+ | 31.3% | 29.3% | 26.6% | 27.7% | 29.1% | 37.1% | 27.3% | 29.4% | 34.7% | 28.8% | 28.2% | |
| **Healthy Living** | | | | | | | | | | | | |
| Adults over 18 with no leisure-time physical activity (age-adjusted) (%) | 26 | 22 | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2019 |
| Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%) | 22.2 | | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2019 |
| Population with adequate access to locations for physical activity (%) | 89 | 95 | | | | | | | | | | County Health Rankings, 2021 |
| Adults who consumed fruit less than one time per day (%) | 32.7 | | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2019 |
| Adults who consumed vegetables less than one time per day (%) | 15.5 | | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2019 |
| Population with limited access to healthy foods (%) | 4 | 3 | | | | | | | | | | USDA Food Environment Atlas, 2019 |
| Total Population that Did Not Have Access to a Reliable Source of Food During Past Year (food insecurity rate) (%) | 8.2 | | | | | | | | | | | Feeding America, Map the Meal Gap, 2019 |
| Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted) (%) | 34 | 33 | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2018 |
| **Mental Health** | | | | | | | | | | | | |
| Average number of mentally unhealthy days in past 30 days (adults) | 4.2 | 4 | | | | | | | | | | County Health Rankings, 2019 |
| Youth Risk Behavior Survey (YRBS) | | | | | | | | | | | | Youth Risk Behavior Survey - Report years indicated |
| | **2019** | | | **2015** | **2021** | **2021** | | **2021** | **2021** | **2021** | **2021** | |
| % of students (grades 6-8) bullied on school property (%) | 35.3 | | | -- | 24.2 (ever) | 25.4 (ever) | | 26.5 (ever) | 26.3 (ever) | 18.9 (ever) | 30.3 (ever) | |
| % of students (grades 6-8) bullied electronically (%) | 15.2 | | | -- | 22.6 (ever) | 23.3 (ever) | | 24.8 (ever) | 23.5 (ever) | 12.7 (ever) | 27.3 (ever) | |
| % of students (grades 9-12) bullied on school property (%) | 16.3 | | | -- | 6.3 | 10.2 | | 5.7 | 4.9 | 4.7 | 6.6 | |
| % of students (grades 9-12) bullied electronically (%) | 13.9 | | | -- | 11.8 | 12.7 | | 11.9 | 12.3 | 9.2 | 11.5 | |
| % of students (grades 6-8) reporting self harm (%) | 21 | | | -- | 18.7 | 17.6 | | 17.2 | -- | -- | -- | |
| % of students (grades 6-8) reporting suicide ideation (%) | 11.3 | | | 21.2 | 17.2 | 19.9 | | 19.4 | 15.2 | 14.4 | 20.5 | |
| % of students (grades 6-8) reporting suicide attempt (%) | 5 | | | 6.6 | 3.5 | 4.9 | | 3.4 | 2.9 | 2.1 | 5.8 | |
| % of students (grades 9-12) reporting self harm (%) | 16.4 | | | 12.5 | 15.4 | 12.7 | | 16.1 | 15.3 | 14.7 | 13.0 | |
| % of students (grades 9-12) reporting suicide ideation (%) | 17.5 | | | 11.0 | 13.1 | 13.1 | | 12.0 | 11.0 | 10.6 | 12.8 | |
| % of students (grades 9-12) reporting suicide attempt (%) | 7.3 | | | 7.1 | 9.6 | 10.1 | | 2.6 | 2.4 | 7.4 | 3.4 | |
| **Substance Use** | | | | | | | | | | | | |
| Admissions to DPH-funded treatment programs (count) | 98944 | | 490 | 120 | 0-100 | 212 | 377 | 203 | 204 | 0-100 | 383 | MA DPH, Bureau of Substance Abuse Services, 2017 |
| Rate of injection drug user admissions to DPH-funded treatment program (%) | 52.4 | | 50.2 | 62.5 | 35.4 | 46.7 | 47.1 | 51.7 | 53.9 | 26.8 | 53.2 | MA DPH, Bureau of Substance Abuse Services, 2017 |
| Primary substance of use when entering treatment | | | | | | | | | | | | MA DPH, Bureau of Substance Abuse Services, 2017 |
| Alcohol (%) | 32.8 | | 32.9 | 19.2 | 46.5 | 29.7 | 23.6 | 33.5 | 29.9 | 41.1 | 25.6 | |
| Crack/Cocaine (%) | 4.1 | | - | - | - | 2.8 | - | 3 | - | - | - | |
| Heroin (%) | 52.8 | | 52.9 | 70.8 | 38.4 | 49.1 | 55.7 | 50.7 | 54.9 | 25 | 64.2 | |
| Marijuana (%) | 3.5 | | 3.3 | - | - | 9 | 2.1 | - | 3.4 | 12.5 | - | |
| Other Opioids (%) | 4.6 | | 5.7 | 5.8 | - | 7.1 | 5.8 | 8.4 | 6.4 | 10.7 | 4.2 | |
| Other Sedatives/Hypnotics (%) | 1.5 | | 2 | - | - | - | 1.9 | - | - | 10.7 | 2.9 | |
| Other Stimulants (%) | 0.5 | | - | - | - | - | - | - | - | - | - | |
| Other (%) | 0.3 | | 1.4 | - | - | - | - | - | - | - | - | |

| | Massachusetts | Middlesex County | Community Benefits Service Area | | | | | | | | | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | |
| Adults who are current smokers (age-adjusted) (%) | 12 | 12 | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2019 |
| Adults who report excessive drinking (binge or heavy drinking) (%) | 22 | 23 | | | | | | | | | | Behavioral Risk Factor Surveillance System, 2019 |
| Youth Risk Behavior Survey (YRBS) | | | | | | | | | | | | Youth Risk Behavior Survey - Report years indicated |
| | 2019 | | | 2015 | 2021 | 2021 | | 2021 | 2021 | 2021 | 2021 | |
| Students (grades 6-8) reporting lifetime alcohol use (%) | 13.6 | | | 24.2 | 11.7 | 13.9 | | 14.3 | 8.4 | 6.4 | 13.1 | |
| Students (grades 6-8) reporting current alcohol use (%) | 4.4 | | | -- | 3.2 | 5.0 | | 3.0 | 2.4 | 1.4 | 4.1 | |
| Students (grades 9-12) reporting lifetime alcohol use (%) | -- | | | 53.5 | 45.1 | 57.2 | | 48.4 | 40.8 | 45.7 | 41.3 | |
| Students (grades 9-12) reporting current alcohol use (%) | 29.8 | | | 32.2 | 14.3 | 31.3 | | 13.7 | 16.6 | 23.2 | 18.0 | |
| Students (grades 6-8) reporting current binge alcohol use (%) | 0.9 | | | -- | -- | -- | | -- | -- | -- | -- | |
| Students (grades 9-12) reporting current binge alcohol use (%) | 15.0 | | | 16.6 | 14.2 | 18.3 | | 14.6 | 7.2 | 12.3 | 8.9 | |
| Students (grades 6-8) reporting lifetime cigarette use (%) | 5.2 | | | -- | 2.0 | 3.5 | | 3.2 | 2.1 | 0.8 | 4.8 | |
| Students (grades 6-8) reporting current cigarette use (%) | -- | | | -- | 0.5 | 1.4 | | 0.9 | 0.5 | 0.2 | 0.9 | |
| Students (grades 9-12) reporting lifetime cigarette use (%) | 17.7 | | | -- | 11.5 | 15.4 | | 10.4 | 7.7 | 9.8 | 11.6 | |
| Students (grades 9-12) reporting current cigarette use (%) | 5.0 | | | -- | 6.1 | 2.8 | | 3.4 | 2.0 | 2.3 | 2.5 | |
| Students (grades 6-8) reporting lifetime marijuana use (%) | 7.0 | | | 10.4 | 2.1 | 3.8 | | 2.1 | 1.6 | 0.9 | 3.7 | |
| Students (grades 6-8) reporting current marijuana use (%) | 3.0 | | | -- | 1.1 | 3.0 | | 1.4 | 0.6 | 0.2 | 3.3 | |
| Students (grades 9-12) reporting lifetime marijuana use (%) | 41.9 | | | 30.3 | 24.6 | 36.6 | | 28.1 | 23.3 | 20.8 | 26.5 | |
| Students (grades 9-12) reporting current marijuana use (%) | 26.0 | | | 18.2 | 12.8 | 20.2 | | 15.9 | 12.0 | 9.4 | 16.7 | |
| Students (grades 6-8) reporting lifetime electronic tobacco use (%) | 14.7 | | | -- | 5.1 | 8.0 | | 7.0 | 3.7 | 1.5 | 9.0 | |
| Students (grades 6-8) reporting current electronic tobacco use (%) | -- | | | 12.9 | 20.5 | 3.3 | | 3.3 | 1.5 | 0.1 | 3.3 | |
| Students (grades 9-12) reporting lifetime electronic tobacco use (%) | 50.7 | | | -- | 27.6 | 39.9 | | 30.2 | 27.3 | 24.6 | 31.0 | |
| Students (grades 9-12) reporting current electronic tobacco use (%) | 32.2 | | | -- | 12.8 | 19.6 | | 16.0 | 23.6 | 10.3 | 13.8 | |
| **Chronic Disease (more data on CHIA data tabs)** | | | | | | | | | | | | |
| Cancer mortality (all types, age-adjusted rate per 100,000) | 149.92 | 140.37 | | | | | | | | | | Massachusetts Cancer Registry, 2014-2018 |
| Cancer incidence (age-adjusted per 100,000) | | | | | | | | | | | | |
| All sites | 498.16 | 483.79 | | | | | | | | | | |
| Breast Cancer | 176.35 | 189.2 | | | | | | | | | | |
| Cervical Cancer | 5.5 | 4.66 | | | | | | | | | | |
| Coloretal Cancer | 35.96 | 35.38 | | | | | | | | | | |
| Lung and Bronchus Cancer | 61.41 | 54.88 | | | | | | | | | | |
| Prostate Cancer | 108.84 | 106.55 | | | | | | | | | | |
| Risk factors | | | | | | | | | | | | |
| Percent of Adults who are Obese (%) | 24 | | 22.2 | | 20.2 | 21.6 | | 21.1 | 21.4 | 18.8 | 22 | Behavioral Risk Factor Surveillance System, 2018 |
| Diagnosed diabetes among adults aged >=18 years (%) | 8.6 | | 7 | | 5.8 | 6.4 | | 6.1 | 6.3 | 5.5 | 6.9 | Behavioral Risk Factor Surveillance System, 2018 |
| Age-adjusted mortality due to heart disease per 100,000 population (%) | 138.7 | | | | | | | | | | | Massachusetts Department of Public Health, Population Health Information Tool, 2015 |
| Adults ever told by doctor that they had angina or coronary heart disease (age-adjusted) (%) | 4.7 | | 4.8 | | 4.2 | 4.6 | | 4.5 | 4.7 | 3.9 | 4.8 | Behavioral Risk Factor Surveillance System, 2017 |
| Adults ever told by doctor that they had high blood pressure (age adjusted) (%) | 26.8 | | 25.7 | | 22.9 | 24.2 | | 23.9 | 24.4 | 22.1 | 25.4 | Behavioral Risk Factor Surveillance System, 2017 |
| Adults ever told by doctor that they had high cholesterol (age-adjusted) (%) | 33.1 | | 26.7 | | 25.6 | 26.2 | | 26.4 | 26.9 | 25.7 | 27.1 | Behavioral Risk Factor Surveillance System, 2017 |
| **Reproductive Health** | | | | | | | | | | | | |

| | Massachusetts | Middlesex County | Community Benefits Service Area | | | | | | | | | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | |
| Infant Mortality Rate (per 1,000 live births) | 3.7 | 2.8 | | | | | | | | | | March of Dimes, 2019 |
| Low birth weight (%) | 7.4 | 7 | | | | | | | | | | March of Dimes, 2020 |
| Mothers with late or no prenatal care (%) | 3.9% | 3.4 | | | | | | | | | | March of Dimes, 2020 |
| Births to adolescent mothers (per 1,000 females ages 15-19) | 8 | 4 | | | | | | | | | | National Center for Health Statistics, 2014-2020 |
| Percent of mothers receiving publicly funded prenatal care 2016 | 38.60% | | | | | | | | | | | Massachusetts Births 2016 |
| Women screened for postpartum depression within 6 months after delivery (%) | | | | | | | | | | | | MDPH January 2016-December 2016 |
| White (non-Hispanic) | 13.60% | | | | | | | | | | | |
| Black (non-Hispanic) | 9.70% | | | | | | | | | | | |
| Asian or Pacific Islander (non-Hispanic) | 14.60% | | | | | | | | | | | |
| American Indian/Alaska Native (non-Hispanic) | 10.30% | | | | | | | | | | | |
| Other race (non-Hispanic) | 13.30% | | | | | | | | | | | |
| Unknown race | 12.40% | | | | | | | | | | | |
| Less than a high school diploma | 8.00% | | | | | | | | | | | |
| With a high school diploma or GED | 9.30% | | | | | | | | | | | |
| Some College/Associate Degree | 11.40% | | | | | | | | | | | |
| Bachelor Degree | 14.10% | | | | | | | | | | | |
| Graduate Degrees | 15.20% | | | | | | | | | | | |
| Among individuals who had a full-term birth | 12.10% | | | | | | | | | | | |
| Among individuals who had a pre-term birth | 11.50% | | | | | | | | | | | |
| Among individuals who are not married | 9.70% | | | | | | | | | | | |
| Among individuals who are married | 13.70% | | | | | | | | | | | |
| Frequency of self-reported postpartum depressive symptoms 2017 | | | | | | | | | | | | MDPH 2019. CY18 Summary of Activities Related to Screening for Postpartum Depression |
| Rarely/Never | 61.4% | | | | | | | | | | | |
| Often/Always | 10.7% | | | | | | | | | | | |
| Sometimes | 27.9% | | | | | | | | | | | |
| **Communicable and Infectious Disease** | | | | | | | | | | | | |
| HIV prevalence (per 100,000 population 13 years and older) | 355 | 288 | | | | | | | | | | National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention, 2019 |
| STI infection cases (per 100,000) | | | | | | | | | | | | Massachusetts Population Health Information Tool, 2018 |
| Syphillis (case count) | 1,164 | | 14 | 0 | Less than 5 | Less than 5 | Less than 5 | Less than 5 | Less than 5 | 0 | 6 | |
| Gonorrhea (case count) | 7,629 | | 78 | 9 | 5 | 13 | 18 | 5 | 5 | Less than 5 | 22 | |
| Chlamydia | 30,297 | | 252 | 33 | 35 | 55 | 84 | 56 | 58 | 38 | 112 | |
| Confirmed and probable Hepatitis B cases (per 100,000 population) | 25.1 | | | | | | | | | | | Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Hepatitis B Virus Infection 2020 Surveillance Report. https://www.mass.gov/lists/infectious-disease- data-reports-and-requests. Published February 2021 |
| Rate of Hepatitis C (per 100,000) | 97.9 | | 51.4 | 48.9 | 25.7 | 31.5 | 45.7 | 56 | No data | No data | 29.2 | Massachusetts Population Health Information Tool, 2018 |
| Tuberculosis (case count) | 204 | | 1 | 0 | Less than 5 | 0 | Less than 5 | Less than 5 | 0 | 0 | Less than 5 | Massachusetts Population Health Information Tool, 2018 |
| Medicare enrollees that had annual flu vaccination (%) | 56% | 59% | | | | | | | | | | Mapping Medicare Disparities, 2019 |

*Suppressed

| | Massachusetts | Middlesex County | Community Benefits Service Area | | | | | | | | | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Medford | N. Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn | |
| **COVID-19 Community Impact Survey** | | | | | | | | | | | | MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole. |
| % very worried about getting infected with COVID-19 | | 28% | 16% | 33% | 28% | 24% | 30% | 29% | 26% | 30% | 33% | |
| % ever been tested for COVID | | 48% | 47% | 48% | 45% | 34% | 53% | 44% | 36% | 40% | 41% | |
| % who have not gotten the medical care they needed since July 2020 | | 19% | * | * | 11% | 20% | 14% | 16% | 18% | 15% | 21% | |
| % with 15 or more of poor mental health days in the past 30 days | | 32% | * | 13% | 34% | 30% | 37% | 31% | 26% | 21% | 33% | |
| % of substance users who said they are now using more substances than before the pandemic | | 42% | * | * | 55% | 44% | 28% | 30% | 35% | 47% | 41% | |
| % Worried about paying for 1 or more types of expense or bills in the coming few weeks | | 31% | 26% | 30% | 29% | 32% | 39% | 28% | 27% | 25% | 40% | |
| % Worried about getting food or groceries in the coming weeks | | 18% | 19% | 18% | 17% | 20% | 26% | 19% | 18% | 18% | 17% | |
| % Worried about getting face masks in the coming weeks | | 11% | * | * | 8% | 11% | 18% | 9% | 8% | 7% | 11% | |
| % Worried about getting medication in the coming weeks | | 10% | * | * | 12% | 8% | 21% | 10% | 8% | 9% | 16% | |
| % Worried about getting broadband in the coming weeks | | 10% | * | * | 8% | 9% | 17% | 6% | 9% | 8% | 10% | |
| % of Employed residents who experienced job loss | | 8% | * | * | * | 5% | 9% | 8% | 6% | 10% | 9% | |
| % of employed residents who experienced reduced work hours | | 12% | * | * | 9% | * | 11% | 15% | 12% | 16% | 13% | |
| % Worried about paying mortgage, rent, or utilities related expenses | | 21% | * | 13% | 18% | 24% | 32% | 22% | 17% | 13% | 30% | |
| % Worried they may have to move out of where they live in the next few months | | 17% | * | * | * | 14% | * | * | * | 17% | * | |
| **Boston Indicators: COVID Community Data Lab** | | | | | | | | | | | | Boston Indicators |
| Unemployment claims (#) reported on 10/30/21 | 5,901 | | | | | | | | | | | |
| Unemplyment rate as of 10/21/21 | 5.3% | | | | | | | | | | | |
| **COVID-19 Layoff** | | | | | | | | | | | | Metropolitian Area Planning Council, The COVID-19 Layoff Housing Gap (October 2020) |
| Estimated number of households in need of assistance with no government aid (without any unmployment benefits) | | | 701 | 136 | 205 | 226 | 263 | 260 | 184 | 107 | 426 | |
| Unemployment claims (#) | | | 2,887 | 613 | 950 | 1,144 | 1,386 | 1,320 | 968 | 561 | 2,110 | |

**Community Health Needs Assessment - Winchester Hospital**
*Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume*
*Patients aged 0-17, Winchester Hospital Community Benefits Service Area defined by BILH Community Benefits*

| | MA | Medford | North Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---|---|---|---|---|---|---|---|---|---|---|
| **All Cause** | | | | | | | | | | |
| FY19 Inpatient Discharges (all cause) rate per 100,000 | 1,735 | 1,867 | 1,491 | 1,343 | 1,255 | 1,378 | 1,722 | 1,607 | 1,204 | 1,376 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -7% | -14% | 0% | -3% | -28% | -26% | -1% | -13% | -11% | -15% |
| FY19 ED Volume (all cause) rate per 100,000 | 19,530 | 15,545 | 10,692 | 9,636 | 15,333 | 12,711 | 13,642 | 10,339 | 14,445 | 15,897 |
| Change in ED Volume Rate FY17 to FY19 | -1% | 2% | 14% | -9% | 16% | 19% | 11% | -11% | 7% | 8% |
| **Chronic Disease** | | | | | | | | | | |
| *Asthma* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 333 | 321 | 476 | 197 | 271 | 155 | 378 | 271 | 305 | 319 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -12% | -11% | 36% | 22% | -21% | -53% | -5% | -22% | 0% | 24% |
| FY19 ED Volume rate per 100,000 | 2,481 | 2,703 | 1,459 | 1,290 | 2,190 | 1,516 | 1,798 | 1,742 | 1,743 | 2,273 |
| Change in ED Volume Rate FY17 to FY19 | 2% | 40% | 119% | 85% | 128% | 57% | 83% | 96% | 111% | 78% |
| *Diabetes Mellitus* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 53 | 29 | 32 | 54 | 98 | 34 | 57 | 58 | 0 | 25 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 7% | -67% | -67% | -40% | 100% | -60% | 200% | 200% | -100% | 0% |
| FY19 ED Volume rate per 100,000 | 117 | 126 | 95 | 54 | 123 | 34 | 57 | 77 | 18 | 0 |
| Change in ED Volume Rate FY17 to FY19 | -2% | 18% | 0% | -50% | -17% | -71% | -25% | -33% | -80% | -100% |
| *Obesity* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 61 | 19 | 32 | 18 | 49 | 86 | 19 | 58 | 18 | 37 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | -67% | 0% | 0% | -33% | 67% | 0% | -25% | -50% | 0% |
| FY19 ED Volume rate per 100,000 | 81 | 262 | 32 | 0 | 123 | 52 | 57 | 19 | 18 | 111 |
| Change in ED Volume Rate FY17 to FY19 | 0% | 42% | 0% | -100% | 400% | 200% | 0% | 0% | 0% | 50% |
| **Injuries and Infections** | | | | | | | | | | |
| *Allergy* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 125 | 126 | 286 | 197 | 49 | 103 | 265 | 97 | 180 | 197 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | 63% | 80% | 10% | -78% | 20% | 100% | -29% | 25% | 100% |
| FY19 ED Volume rate per 100,000 | 1,874 | 2,372 | 2,126 | 1,791 | 2,658 | 1,292 | 2,479 | 1,762 | 2,228 | 2,310 |
| Change in ED Volume Rate FY17 to FY19 | -1% | 17% | 97% | 79% | 135% | 92% | 147% | 90% | 61% | 68% |
| *HIV Infection* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 18% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in ED Volume Rate FY17 to FY19 | -23% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| *Infections* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 767 | 768 | 508 | 788 | 295 | 482 | 833 | 639 | 395 | 491 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -2% | 8% | 23% | 42% | -57% | -33% | 26% | 22% | -15% | -37% |
| FY19 ED Volume rate per 100,000 | 7,457 | 6,115 | 2,665 | 2,346 | 4,529 | 3,755 | 3,992 | 2,749 | 3,288 | 5,700 |
| Change in ED Volume Rate FY17 to FY19 | 4% | 2% | 20% | -4% | 3% | 31% | -2% | 13% | 11% | 13% |
| *Injuries* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 345 | 262 | 127 | 161 | 172 | 327 | 322 | 136 | 162 | 221 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -4% | -39% | -33% | -25% | 0% | 46% | 31% | -42% | -31% | 20% |
| FY19 ED Volume rate per 100,000 | 7,024 | 5,230 | 4,600 | 3,779 | 6,473 | 4,513 | 6,225 | 3,814 | 7,007 | 5,455 |
| Change in ED Volume Rate FY17 to FY19 | -8% | -7% | 4% | -28% | 14% | -1% | 9% | -24% | -3% | -5% |
| *Poisonings* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 85 | 78 | 63 | 18 | 172 | 155 | 19 | 58 | 36 | 12 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -30% | -20% | 0% | -83% | 17% | 50% | -86% | 50% | 100% | -83% |
| FY19 ED Volume rate per 100,000 | 501 | 428 | 159 | 197 | 541 | 327 | 189 | 348 | 305 | 381 |
| Change in ED Volume Rate FY17 to FY19 | 32% | 29% | -29% | -35% | 100% | 19% | -23% | 64% | 42% | 41% |
| *Pneumonia/Influenza* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 213 | 262 | 254 | 125 | 123 | 138 | 303 | 136 | 126 | 258 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 3% | -4% | 14% | -13% | 67% | -64% | 45% | -30% | -22% | 200% |
| FY19 ED Volume rate per 100,000 | 1,098 | 690 | 539 | 519 | 689 | 758 | 530 | 387 | 611 | 921 |
| Change in ED Volume Rate FY17 to FY19 | 38% | 51% | 42% | 45% | 100% | 63% | 22% | 43% | 36% | 83% |
| *Sexually Transmitted Diseases* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 4 | 10 | 0 | 18 | 0 | 0 | 0 | 0 | 0 | 12 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 7% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 35 | 19 | 63 | 0 | 0 | 0 | 0 | 0 | 18 | 25 |
| Change in ED Volume Rate FY17 to FY19 | 15% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| **Other** | | | | | | | | | | |
| *Attention Deficit Hyperactivity Disorder* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 141 | 136 | 222 | 18 | 98 | 224 | 132 | 174 | 126 | 98 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -3% | 17% | 40% | -86% | -73% | 117% | -13% | -47% | -30% | -38% |
| FY19 ED Volume rate per 100,000 | 588 | 525 | 571 | 430 | 541 | 723 | 322 | 697 | 539 | 811 |
| Change in ED Volume Rate FY17 to FY19 | 17% | 86% | 200% | 50% | 144% | 200% | 240% | 57% | 329% | 128% |
| *Learning Disorders* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 135 | 97 | 63 | 90 | 98 | 103 | 208 | 77 | 72 | 98 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 12% | -57% | 0% | 67% | 33% | -40% | 120% | 0% | 0% | -11% |
| FY19 ED Volume rate per 100,000 | 103 | 78 | 63 | 36 | 74 | 52 | 114 | 58 | 72 | 49 |
| Change in ED Volume Rate FY17 to FY19 | 84% | 60% | 0% | 0% | 50% | 50% | 500% | 200% | 300% | -20% |
| *Mental Health* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 772 | 933 | 1,396 | 681 | 541 | 637 | 1,060 | 1,297 | 1,006 | 627 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -5% | -10% | 57% | -33% | -48% | 23% | 60% | -18% | 17% | -29% |
| FY19 ED Volume rate per 100,000 | 2,592 | 1,575 | 2,221 | 1,684 | 2,314 | 2,980 | 1,779 | 2,807 | 2,102 | 2,604 |
| Change in ED Volume Rate FY17 to FY19 | 5% | -17% | 52% | -15% | 45% | 70% | 29% | 12% | 23% | 30% |
| *Substance Use Disorders* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 53 | 117 | 95 | 36 | 74 | 34 | 38 | 77 | 90 | 37 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -8% | 0% | 0% | -60% | 50% | 0% | -50% | 33% | 400% | -50% |
| FY19 ED Volume rate per 100,000 | 343 | 224 | 190 | 161 | 320 | 362 | 95 | 271 | 323 | 491 |
| Change in ED Volume Rate FY17 to FY19 | -5% | 130% | 0% | -18% | -24% | 24% | -58% | -75% | -14% | 135% |
| *Complication of Medical Care* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 229 | 282 | 63 | 143 | 148 | 224 | 170 | 368 | 72 | 98 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -4% | -19% | -60% | 0% | -25% | -28% | -18% | 111% | -33% | -47% |
| FY19 ED Volume rate per 100,000 | 208 | 204 | 0 | 143 | 172 | 155 | 57 | 155 | 144 | 123 |
| Change in ED Volume Rate FY17 to FY19 | 3% | -22% | -100% | 33% | 17% | 80% | -50% | -33% | 300% | -29% |

**Community Health Needs Assessment - Winchester Hospital**
*Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume*
*Patients aged 18-44, Winchester Hospital Community Benefits Service Area defined by BILH Community Benefits*

| | MA | Medford | North Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Winchester Hospital Community Benefits Service Area | | | | | |
| **All Cause** | | | | | | | | | | |
| FY19 Inpatient Discharges (all cause) rate per 100,000 | 6,072 | 4,354 | 5,171 | 5,175 | 6,341 | 6,125 | 6,350 | 6,053 | 4,654 | 6,525 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 0% | 5% | -6% | 11% | 11% | 7% | -6% | 7% | 6% | 1% |
| FY19 ED Volume (all cause) rate per 100,000 | 25,053 | 16,117 | 12,373 | 11,228 | 18,379 | 16,859 | 17,225 | 14,429 | 11,829 | 21,228 |
| Change in ED Volume Rate FY17 to FY19 | -1% | 2% | 11% | 17% | 9% | 10% | 4% | 7% | 18% | 1% |
| **Cancer** | | | | | | | | | | |
| Breast Cancer | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 32 | 7 | 55 | 49 | 55 | 10 | 33 | 36 | 16 | 100 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -10% | -50% | 50% | -50% | 100% | -92% | -70% | -25% | -50% | 25% |
| FY19 ED Volume rate per 100,000 | 27 | 19 | 18 | 25 | 14 | 10 | 0 | 36 | 0 | 47 |
| Change in ED Volume Rate FY17 to FY19 | 25% | 25% | 0% | 100% | 0% | -50% | -100% | 0% | -100% | 250% |
| Colorectal Cancer | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 15 | 7 | 0 | 0 | 0 | 0 | 11 | 73 | 16 | 0 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 17% | 0% | -100% | -100% | 0% | -100% | -50% | 0% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 4 | 11 | 0 | 0 | 0 | 0 | 11 | 0 | 0 | 0 |
| Change in ED Volume Rate FY17 to FY19 | 21% | 0% | 0% | 0% | -100% | 0% | 0% | 0% | -100% | 0% |
| GYN Cancer | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 41 | 15 | 18 | 37 | 178 | 0 | 22 | 61 | 62 | 40 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 11% | -56% | 0% | 200% | 550% | -100% | 0% | 150% | 300% | 200% |
| FY19 ED Volume rate per 100,000 | 30 | 19 | 0 | 0 | 14 | 0 | 0 | 0 | 0 | 33 |
| Change in ED Volume Rate FY17 to FY19 | 23% | 400% | 0% | 0% | 0% | -100% | -100% | 0% | 0% | 400% |
| Lung Cancer | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 26 | 11 | 0 | 0 | 27 | 10 | 22 | 61 | 78 | 7 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 3% | -25% | -100% | -100% | 0% | -50% | -78% | 0% | 150% | -50% |
| FY19 ED Volume rate per 100,000 | 7 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 16 | 0 |
| Change in ED Volume Rate FY17 to FY19 | 47% | 0% | 0% | 0% | 0% | 0% | -100% | 0% | 0% | -100% |
| Prostate Cancer | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -15% | 0% | 0% | 0% | 0% | 0% | 0% | -100% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in ED Volume Rate FY17 to FY19 | 150% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Other Cancer | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 304 | 183 | 129 | 247 | 370 | 315 | 352 | 303 | 296 | 388 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | 11% | -56% | -33% | 4% | -8% | -42% | 108% | 6% | 41% |
| FY19 ED Volume rate per 100,000 | 142 | 104 | 74 | 99 | 41 | 76 | 66 | 97 | 156 | 114 |
| Change in ED Volume Rate FY17 to FY19 | 29% | 75% | 33% | 33% | -50% | -27% | -40% | 300% | 67% | 113% |
| **Chronic Disease** | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 745 | 413 | 499 | 642 | 548 | 763 | 857 | 714 | 389 | 602 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -5% | -15% | -23% | 93% | 3% | 67% | -9% | 13% | 79% | -10% |
| FY19 ED Volume rate per 100,000 | 2,649 | 1,948 | 1,404 | 1,248 | 2,013 | 1,422 | 1,780 | 1,695 | 1,012 | 2,554 |
| Change in ED Volume Rate FY17 to FY19 | 3% | 30% | 9% | 66% | 71% | 32% | 22% | 97% | 55% | 18% |
| Congestive Heart Failure | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 124 | 60 | 18 | 62 | 27 | 124 | 55 | 61 | 47 | 67 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 14% | 220% | 0% | 400% | -85% | -19% | 0% | 67% | 0% | 100% |
| FY19 ED Volume rate per 100,000 | 56 | 37 | 18 | 0 | 14 | 67 | 22 | 24 | 0 | 13 |
| Change in ED Volume Rate FY17 to FY19 | 42% | 233% | 0% | -100% | -50% | 133% | 0% | 0% | 0% | 0% |
| COPD and Lung Disease | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 136 | 63 | 129 | 124 | 68 | 95 | 77 | 73 | 62 | 167 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -5% | 143% | 40% | 400% | 25% | -44% | -42% | 50% | 33% | 14% |
| FY19 ED Volume rate per 100,000 | 127 | 56 | 55 | 12 | 55 | 95 | 55 | 36 | 31 | 100 |
| Change in ED Volume Rate FY17 to FY19 | 16% | 36% | 0% | -50% | 0% | 25% | 150% | 0% | 0% | 50% |
| Diabetes Mellitus | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 478 | 242 | 148 | 124 | 178 | 429 | 341 | 496 | 109 | 374 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 23% | 60% | -17% | 18% | 29% | 0% | 156% | 250% | -16% |
| FY19 ED Volume rate per 100,000 | 1,167 | 581 | 554 | 482 | 561 | 821 | 395 | 460 | 218 | 682 |
| Change in ED Volume Rate FY17 to FY19 | 7% | 3% | 76% | 26% | -15% | 25% | -8% | 36% | 0% | -33% |
| Heart Disease | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 445 | 220 | 92 | 222 | 178 | 420 | 143 | 303 | 233 | 361 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 48% | -67% | 38% | -63% | -28% | -41% | 56% | 200% | -14% |
| FY19 ED Volume rate per 100,000 | 375 | 183 | 92 | 148 | 192 | 258 | 286 | 278 | 249 | 247 |
| Change in ED Volume Rate FY17 to FY19 | 31% | -6% | -50% | 300% | -13% | 17% | 225% | 188% | 300% | 23% |
| Hypertension | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 606 | 283 | 388 | 346 | 329 | 658 | 615 | 496 | 218 | 655 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 1% | -7% | 11% | 65% | -17% | 35% | 24% | 32% | 250% | 9% |
| FY19 ED Volume rate per 100,000 | 1,838 | 976 | 831 | 865 | 1,205 | 1,011 | 1,780 | 872 | 420 | 1,805 |
| Change in ED Volume Rate FY17 to FY19 | 8% | 17% | -2% | 35% | 52% | -13% | 95% | -1% | -18% | 0% |
| Liver Disease | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 427 | 302 | 203 | 346 | 411 | 343 | 363 | 436 | 280 | 548 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 15% | 35% | 10% | 180% | -9% | 13% | 22% | -10% | 157% | -10% |
| FY19 ED Volume rate per 100,000 | 185 | 127 | 148 | 148 | 164 | 229 | 88 | 230 | 140 | 160 |
| Change in ED Volume Rate FY17 to FY19 | 25% | 48% | 100% | 71% | 71% | 118% | -27% | 138% | 0% | -27% |
| Obesity | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 919 | 495 | 462 | 581 | 657 | 868 | 758 | 835 | 233 | 776 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 6% | -26% | 18% | -6% | 15% | -12% | -3% | 67% | -6% |
| FY19 ED Volume rate per 100,000 | 530 | 622 | 277 | 333 | 507 | 611 | 264 | 399 | 249 | 635 |
| Change in ED Volume Rate FY17 to FY19 | 11% | 17% | 67% | 238% | 106% | 60% | -38% | 120% | 100% | 48% |
| Stroke and Other Neurovascular Diseases | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 71 | 41 | 55 | 62 | 82 | 95 | 33 | 145 | 0 | 40 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 9% | 57% | -25% | 150% | 100% | 67% | -63% | 140% | 0% | 20% |
| FY19 ED Volume rate per 100,000 | 28 | 11 | 18 | 0 | 27 | 29 | 11 | 0 | 31 | 13 |
| Change in ED Volume Rate FY17 to FY19 | 11% | 200% | -67% | 0% | 100% | 200% | 0% | -100% | 0% | 0% |

## Injuries and Infections

### Allergy

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 553 | 533 | 757 | 581 | 1,013 | 658 | 1,186 | 811 | 280 | 669 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 13% | 6% | 52% | 42% | 72% | 64% | 1% | 52% | -18% | 54% |
| FY19 ED Volume rate per 100,000 | 3,482 | 4,187 | 3,250 | 3,286 | 4,916 | 2,233 | 6,437 | 4,285 | 3,004 | 5,409 |
| Change in ED Volume Rate FY17 to FY19 | 44% | 61% | 329% | 322% | 322% | 255% | 384% | 763% | 239% | 291% |

### Hepatitis

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 344 | 212 | 148 | 148 | 178 | 439 | 209 | 206 | 156 | 234 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -4% | 21% | -38% | 0% | -54% | 84% | -21% | -19% | 67% | -39% |
| FY19 ED Volume rate per 100,000 | 195 | 63 | 222 | 124 | 274 | 191 | 154 | 145 | 93 | 328 |
| Change in ED Volume Rate FY17 to FY19 | 1% | -35% | 20% | 67% | 33% | -29% | 0% | 33% | 0% | 40% |

### HIV Infection

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 44 | 22 | 18 | 0 | 14 | 19 | 55 | 36 | 0 | 33 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | 500% | 0% | 0% | 0% | -33% | 150% | 50% | 0% | 67% |
| FY19 ED Volume rate per 100,000 | 102 | 45 | 37 | 0 | 0 | 48 | 110 | 36 | 0 | 53 |
| Change in ED Volume Rate FY17 to FY19 | 11% | 100% | -33% | -100% | 0% | -29% | 400% | 50% | 0% | 0% |

### Infections

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 1,534 | 816 | 1,090 | 976 | 1,287 | 1,832 | 1,208 | 1,574 | 763 | 1,658 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | 2% | 31% | 16% | -2% | 35% | 22% | 0% | 17% | 15% |
| FY19 ED Volume rate per 100,000 | 5,547 | 3,393 | 2,087 | 1,989 | 3,218 | 3,225 | 3,318 | 2,227 | 1,930 | 3,844 |
| Change in ED Volume Rate FY17 to FY19 | -6% | -8% | 5% | 23% | -10% | 6% | 1% | -16% | -5% | -6% |

### Injuries

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 1,103 | 626 | 1,200 | 605 | 794 | 1,135 | 868 | 1,392 | 716 | 1,150 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 14% | 16% | -2% | 12% | 4% | -8% | 47% | 31% | 13% |
| FY19 ED Volume rate per 100,000 | 7,762 | 4,809 | 3,453 | 2,927 | 5,423 | 4,961 | 4,801 | 3,983 | 3,689 | 6,365 |
| Change in ED Volume Rate FY17 to FY19 | -4% | -4% | -6% | -12% | -6% | -6% | -11% | -7% | 1% | 3% |

### Poisonings

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 189 | 123 | 129 | 124 | 205 | 181 | 198 | 242 | 93 | 274 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -7% | -6% | -42% | -23% | -12% | 19% | -22% | 25% | 200% | 11% |
| FY19 ED Volume rate per 100,000 | 693 | 495 | 591 | 309 | 561 | 706 | 560 | 412 | 280 | 682 |
| Change in ED Volume Rate FY17 to FY19 | -8% | -2% | -9% | -34% | -16% | 3% | -30% | -26% | -28% | -10% |

### Pneumonia/Influenza

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 286 | 175 | 185 | 272 | 247 | 487 | 187 | 242 | 202 | 234 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 8% | 9% | -17% | 175% | 50% | 34% | -39% | 67% | 117% | -13% |
| FY19 ED Volume rate per 100,000 | 588 | 350 | 203 | 247 | 520 | 305 | 384 | 206 | 420 | 501 |
| Change in ED Volume Rate FY17 to FY19 | 27% | 49% | 10% | 18% | 90% | 23% | 35% | -32% | 23% | 27% |

### Sexually Transmitted Diseases

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 80 | 63 | 74 | 49 | 96 | 67 | 66 | 61 | 31 | 67 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -9% | 21% | 0% | -20% | -22% | -36% | 100% | 25% | -60% | -33% |
| FY19 ED Volume rate per 100,000 | 262 | 97 | 37 | 62 | 68 | 38 | 44 | 121 | 78 | 127 |
| Change in ED Volume Rate FY17 to FY19 | 15% | 37% | 0% | 400% | 0% | -20% | -20% | 233% | 67% | 111% |

### Tuberculosis

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 9 | 7 | 0 | 25 | 0 | 10 | 0 | 0 | 16 | 13 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -3% | -33% | -100% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 5 | 0 | 0 | 0 | 0 | 19 | 0 | 0 | 16 | 7 |
| Change in ED Volume Rate FY17 to FY19 | 0% | -100% | 0% | 0% | 0% | 100% | -100% | -100% | 0% | 0% |

## Other

### Dementia and Cognitive Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 177 | 138 | 74 | 148 | 274 | 172 | 110 | 218 | 78 | 181 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 9% | 118% | -33% | 33% | 82% | 13% | -55% | 50% | 67% | -27% |
| FY19 ED Volume rate per 100,000 | 201 | 194 | 55 | 111 | 55 | 210 | 165 | 266 | 62 | 241 |
| Change in ED Volume Rate FY17 to FY19 | -11% | 6% | -57% | 0% | -71% | 29% | 7% | 120% | -20% | 44% |

### Mental Health

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 4,382 | 3,054 | 3,453 | 3,063 | 3,273 | 3,368 | 5,119 | 4,273 | 2,195 | 3,945 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 19% | 6% | 32% | 4% | 22% | 1% | 31% | 26% | 1% |
| FY19 ED Volume rate per 100,000 | 7,907 | 4,440 | 5,762 | 5,114 | 6,108 | 7,079 | 6,108 | 5,193 | 4,420 | 7,268 |
| Change in ED Volume Rate FY17 to FY19 | 16% | 25% | 70% | 78% | 52% | 45% | 13% | 29% | 70% | 28% |

### Parkinsons and Movement Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 41 | 11 | 37 | 49 | 27 | 105 | 44 | 24 | 16 | 53 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -2% | -50% | 100% | 33% | 100% | 267% | -43% | -33% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 95 | 112 | 55 | 86 | 55 | 57 | 88 | 121 | 62 | 114 |
| Change in ED Volume Rate FY17 to FY19 | -4% | 20% | 50% | 75% | 33% | -40% | -20% | 100% | 100% | 42% |

### Substance Use Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 2,012 | 1,162 | 1,163 | 877 | 1,548 | 1,756 | 1,593 | 1,743 | 732 | 1,852 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -2% | 9% | -7% | 6% | -16% | 19% | -4% | 13% | 42% | 0% |
| FY19 ED Volume rate per 100,000 | 8,347 | 4,548 | 3,675 | 2,927 | 5,683 | 6,183 | 4,416 | 4,987 | 2,895 | 7,522 |
| Change in ED Volume Rate FY17 to FY19 | 0% | 0% | 11% | 13% | 2% | 37% | -14% | 5% | 56% | -8% |

### Complication of Medical Care

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 2,698 | 2,294 | 2,807 | 2,964 | 3,547 | 2,939 | 3,318 | 3,268 | 2,895 | 3,376 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 4% | -4% | 7% | 20% | 7% | -1% | 13% | -2% | 7% |
| FY19 ED Volume rate per 100,000 | 582 | 454 | 388 | 321 | 438 | 382 | 494 | 484 | 249 | 521 |
| Change in ED Volume Rate FY17 to FY19 | 14% | 33% | 200% | 44% | -6% | 14% | 29% | 43% | 78% | 81% |

# Community Health Needs Assessment - Winchester Hospital

*Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume*
*Patients aged 45-64, Winchester Hospital Community Benefits Service Area defined by BILH Community Benefits*

| | | | | | Winchester Hospital Community Benefits Service Area | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MA | Medford | North Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
| **All Cause** | | | | | | | | | | |
| FY19 Inpatient Discharges (all cause) rate per 100,000 | 9,762 | 8,284 | 7,232 | 6,797 | 9,976 | 9,301 | 9,369 | 7,013 | 4,999 | 10,702 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 0% | -1% | 8% | 6% | 0% | -3% | 9% | -16% | 5% | 5% |
| FY19 ED Volume (all cause) rate per 100,000 | 24,003 | 17,928 | 12,080 | 10,569 | 19,209 | 16,450 | 18,620 | 12,077 | 11,549 | 21,284 |
| Change in ED Rate FY17 to FY19 | 2% | -5% | 17% | 5% | 15% | 18% | 30% | 15% | 22% | 7% |
| **Cancer** | | | | | | | | | | |
| *Breast Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 258 | 170 | 166 | 253 | 404 | 298 | 263 | 111 | 142 | 367 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -5% | -29% | -64% | -18% | -4% | -13% | -17% | -53% | -40% | 11% |
| FY19 ED Volume rate per 100,000 | 195 | 102 | 83 | 99 | 145 | 165 | 131 | 250 | 237 | 266 |
| Change in ED Volume Rate FY17 to FY19 | 18% | -29% | 300% | 75% | -36% | 150% | 25% | 125% | 275% | 222% |
| *Colorectal Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 116 | 75 | 166 | 14 | 129 | 110 | 145 | 139 | 79 | 46 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 0% | -42% | 33% | -93% | 33% | 400% | 267% | 67% | -50% | -58% |
| FY19 ED Volume rate per 100,000 | 27 | 14 | 0 | 0 | 0 | 11 | 0 | 28 | 16 | 0 |
| Change in ED Volume Rate FY17 to FY19 | 12% | -67% | -100% | -100% | 0% | -67% | 0% | 0% | 0% | -100% |
| *GYN Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 182 | 204 | 124 | 155 | 355 | 177 | 79 | 195 | 95 | 156 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -3% | 25% | -25% | 57% | 175% | -20% | -45% | -53% | -14% | -53% |
| FY19 ED Volume rate per 100,000 | 82 | 48 | 62 | 28 | 48 | 121 | 13 | 56 | 63 | 110 |
| Change in ED Volume Rate FY17 to FY19 | 21% | 17% | 200% | -33% | -50% | 83% | 0% | 100% | 33% | 300% |
| *Lung Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 358 | 354 | 269 | 267 | 355 | 331 | 460 | 181 | 79 | 560 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | -19% | -13% | 12% | 22% | 15% | 133% | -13% | -77% | 11% |
| FY19 ED Volume rate per 100,000 | 97 | 41 | 62 | 56 | 32 | 88 | 13 | 0 | 32 | 83 |
| Change in ED Volume Rate FY17 to FY19 | 21% | -45% | 50% | 33% | -33% | 0% | -75% | -100% | 100% | 125% |
| *Prostate Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 133 | 102 | 186 | 169 | 16 | 210 | 145 | 28 | 79 | 73 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -5% | 25% | 125% | 71% | -86% | 36% | -35% | -71% | -17% | -64% |
| FY19 ED Volume rate per 100,000 | 60 | 34 | 62 | 0 | 0 | 11 | 79 | 0 | 16 | 28 |
| Change in ED Volume Rate FY17 to FY19 | 30% | -17% | 200% | -100% | -100% | -67% | 100% | 0% | -50% | 200% |
| *Other Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,984 | 1,816 | 1,906 | 2,069 | 2,954 | 2,030 | 2,208 | 1,280 | 949 | 2,875 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 3% | -13% | -16% | -25% | 50% | 3% | 26% | -41% | -46% | 6% |
| FY19 ED Volume rate per 100,000 | 597 | 394 | 642 | 310 | 597 | 519 | 315 | 487 | 443 | 698 |
| Change in ED Volume Rate FY17 to FY19 | 27% | 123% | 94% | -15% | 208% | 114% | 60% | 119% | 211% | 192% |
| **Chronic Disease** | | | | | | | | | | |
| *Asthma* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,051 | 891 | 953 | 858 | 1,049 | 838 | 1,275 | 584 | 538 | 1,102 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -17% | -11% | 44% | 7% | 0% | -21% | 24% | -14% | 10% | -17% |
| FY19 ED Volume rate per 100,000 | 1,944 | 1,768 | 932 | 1,055 | 1,808 | 1,147 | 1,919 | 1,071 | 870 | 2,241 |
| Change in ED Volume Rate FY17 to FY19 | 0% | 30% | 22% | 97% | 93% | 53% | 103% | 20% | 15% | 18% |
| *Congestive Heart Failure* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,292 | 1,251 | 1,077 | 661 | 1,227 | 1,192 | 1,353 | 877 | 585 | 1,653 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 10% | 1% | 68% | 9% | 7% | 19% | 69% | -18% | 16% | 17% |
| FY19 ED Volume rate per 100,000 | 396 | 204 | 124 | 197 | 291 | 165 | 342 | 181 | 79 | 459 |
| Change in ED Volume Rate FY17 to FY19 | 41% | 3% | 0% | 40% | 260% | 50% | 73% | 86% | 0% | 163% |
| *COPD and Lung Disease* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,994 | 1,666 | 953 | 816 | 1,324 | 1,125 | 2,037 | 1,141 | 364 | 2,342 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 1% | -27% | 5% | 9% | -16% | -18% | 35% | -15% | -26% | 11% |
| FY19 ED Volume rate per 100,000 | 1,388 | 789 | 497 | 239 | 823 | 508 | 657 | 404 | 142 | 1,203 |
| Change in ED Volume Rate FY17 to FY19 | 10% | 14% | 167% | 42% | 16% | -27% | 67% | 4% | 0% | -2% |
| *Diabetes Mellitus* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 2,808 | 2,476 | 1,368 | 1,548 | 1,856 | 2,240 | 2,273 | 2,073 | 902 | 2,875 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 3% | 9% | 20% | 24% | -35% | -9% | 14% | -17% | -5% | 22% |
| FY19 ED Volume rate per 100,000 | 4,109 | 3,176 | 1,741 | 1,351 | 3,132 | 2,173 | 2,746 | 1,711 | 1,361 | 3,426 |
| Change in ED Volume Rate FY17 to FY19 | 10% | 16% | 42% | 26% | 26% | 29% | 90% | 28% | 51% | 1% |
| *Heart Disease* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 3,609 | 2,999 | 3,087 | 2,477 | 3,600 | 3,376 | 3,219 | 3,033 | 1,898 | 4,180 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 4% | -9% | 22% | -4% | -3% | 9% | 28% | -12% | 32% | 9% |
| FY19 ED Volume rate per 100,000 | 1,448 | 721 | 601 | 732 | 1,356 | 883 | 815 | 751 | 570 | 1,387 |
| Change in ED Volume Rate FY17 to FY19 | 17% | -27% | 0% | 18% | 29% | 11% | 13% | -2% | 6% | 8% |
| *Hypertension* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 4,045 | 3,237 | 2,694 | 2,730 | 3,697 | 3,464 | 3,995 | 2,838 | 1,804 | 4,529 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -2% | 5% | -11% | 7% | -11% | -18% | 7% | -16% | 23% | 5% |
| FY19 ED Volume rate per 100,000 | 7,878 | 5,584 | 3,813 | 3,152 | 6,457 | 5,042 | 5,480 | 4,369 | 2,832 | 7,082 |
| Change in ED Volume Rate FY17 to FY19 | 10% | 18% | 19% | -6% | 19% | 29% | 79% | 15% | 6% | -10% |
| *Liver Disease* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,562 | 1,285 | 1,886 | 802 | 1,550 | 1,037 | 1,708 | 918 | 649 | 1,442 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | -10% | 168% | 43% | -44% | -1% | 29% | 10% | 46% | 11% |
| FY19 ED Volume rate per 100,000 | 404 | 245 | 207 | 239 | 339 | 375 | 381 | 195 | 301 | 303 |
| Change in ED Volume Rate FY17 to FY19 | 19% | 38% | 11% | 13% | -13% | 42% | 164% | -33% | 171% | -3% |
| *Obesity* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 2,410 | 1,932 | 1,596 | 1,534 | 2,244 | 1,931 | 2,063 | 1,837 | 712 | 2,287 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 2% | 28% | 28% | -3% | -13% | 7% | -2% | -12% | 6% |
| FY19 ED Volume rate per 100,000 | 675 | 667 | 477 | 464 | 1,114 | 629 | 342 | 710 | 316 | 974 |
| Change in ED Volume Rate FY17 to FY19 | 17% | 3% | 77% | 267% | 156% | 46% | 0% | 183% | 54% | 77% |
| *Stroke and Other Neurovascular Diseases* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 443 | 326 | 373 | 324 | 420 | 419 | 355 | 390 | 111 | 625 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | -8% | 6% | 15% | -10% | 12% | 13% | 8% | -30% | 48% |
| FY19 ED Volume rate per 100,000 | 119 | 82 | 62 | 141 | 129 | 132 | 118 | 70 | 79 | 92 |
| Change in ED Volume Rate FY17 to FY19 | 6% | 0% | -25% | 67% | 33% | 140% | 350% | -29% | 67% | -17% |

## Injuries and Infections

### Allergy

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 1,314 | 1,571 | 1,264 | 1,252 | 2,002 | 1,015 | 2,628 | 1,030 | 791 | 2,094 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 20% | -18% | 56% | 93% | 28% | 37% | 23% | 37% | 61% | 66% |
| FY19 ED Volume rate per 100,000 | 4,000 | 5,543 | 4,165 | 3,912 | 6,166 | 2,957 | 7,976 | 4,007 | 3,037 | 7,174 |
| Change in ED Volume Rate FY17 to FY19 | 59% | 96% | 1082% | 1109% | 607% | 458% | 848% | 1008% | 449% | 530% |

### Hepatitis

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 492 | 299 | 249 | 84 | 339 | 177 | 315 | 153 | 16 | 276 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -19% | -36% | 33% | -25% | -32% | -43% | 20% | 267% | -50% | -38% |
| FY19 ED Volume rate per 100,000 | 211 | 34 | 21 | 0 | 32 | 66 | 26 | 42 | 32 | 193 |
| Change in ED Volume Rate FY17 to FY19 | -11% | -62% | 0% | 0% | 100% | 20% | 100% | 200% | 100% | 425% |

### HIV Infection

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 157 | 109 | 21 | 42 | 65 | 88 | 118 | 70 | 0 | 46 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -7% | -20% | 0% | 0% | 0% | -58% | 13% | 150% | 0% | 150% |
| FY19 ED Volume rate per 100,000 | 236 | 68 | 83 | 14 | 16 | 44 | 13 | 14 | 0 | 28 |
| Change in ED Volume Rate FY17 to FY19 | -3% | -29% | 0% | 0% | -75% | 33% | -86% | 0% | 0% | -57% |

### Infections

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 3,824 | 3,156 | 2,383 | 2,083 | 4,149 | 4,490 | 3,824 | 2,254 | 1,392 | 4,088 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 3% | 8% | 15% | 19% | 22% | 3% | 46% | -30% | -10% | 9% |
| FY19 ED Volume rate per 100,000 | 3,618 | 2,938 | 2,072 | 1,576 | 2,470 | 2,118 | 2,129 | 1,517 | 1,756 | 3,077 |
| Change in ED Volume Rate FY17 to FY19 | -4% | -2% | 0% | 12% | 1% | -2% | -7% | -8% | 16% | 30% |

### Injuries

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 3,425 | 3,061 | 2,818 | 2,843 | 3,648 | 3,255 | 3,456 | 2,658 | 1,455 | 3,913 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 0% | 10% | 54% | 11% | 7% | 29% | -3% | -2% | 22% |
| FY19 ED Volume rate per 100,000 | 7,959 | 5,938 | 4,455 | 3,518 | 6,651 | 6,278 | 5,414 | 4,160 | 4,445 | 7,432 |
| Change in ED Volume Rate FY17 to FY19 | -2% | -17% | 31% | -13% | 14% | 9% | -5% | 18% | 2% | 3% |

### Poisonings

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 232 | 143 | 228 | 197 | 307 | 254 | 145 | 195 | 127 | 331 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -7% | -28% | 120% | 133% | -14% | -12% | 83% | 17% | -11% | -14% |
| FY19 ED Volume rate per 100,000 | 395 | 238 | 269 | 99 | 420 | 199 | 368 | 237 | 127 | 266 |
| Change in ED Volume Rate FY17 to FY19 | 5% | -10% | 86% | -42% | 86% | -33% | 100% | 6% | 14% | 4% |

### Pneumonia/Influenza

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 1,135 | 932 | 1,015 | 732 | 969 | 1,478 | 1,183 | 654 | 316 | 1,350 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 8% | 10% | 40% | 6% | -27% | 17% | 48% | -28% | -33% | 5% |
| FY19 ED Volume rate per 100,000 | 555 | 354 | 373 | 267 | 468 | 364 | 447 | 376 | 253 | 459 |
| Change in ED Volume Rate FY17 to FY19 | 11% | 0% | 50% | 46% | 53% | 10% | 70% | 50% | -27% | -2% |

### Sexually Transmitted Diseases

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 24 | 34 | 21 | 0 | 0 | 0 | 0 | 0 | 0 | 37 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -3% | 25% | 0% | -100% | 0% | -100% | -100% | 0% | -100% | 0% |
| FY19 ED Volume rate per 100,000 | 38 | 34 | 21 | 0 | 0 | 11 | 0 | 28 | 0 | 9 |
| Change in ED Volume Rate FY17 to FY19 | 5% | 0% | 0% | 0% | -100% | 0% | -100% | 100% | -100% | 0% |

### Tuberculosis

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 18 | 41 | 0 | 0 | 0 | 0 | 13 | 0 | 16 | 28 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -3% | 500% | 0% | 0% | 0% | 0% | 0% | 0% | -50% | 200% |
| FY19 ED Volume rate per 100,000 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| Change in ED Volume Rate FY17 to FY19 | 7% | -100% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

## Other

### Dementia and Cognitive Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 868 | 619 | 932 | 647 | 872 | 850 | 920 | 473 | 253 | 836 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 10% | -11% | 50% | 59% | -11% | 1% | 27% | 0% | 0% | -3% |
| FY19 ED Volume rate per 100,000 | 325 | 224 | 124 | 113 | 145 | 287 | 250 | 153 | 127 | 175 |
| Change in ED Volume Rate FY17 to FY19 | -5% | -34% | 50% | 167% | -36% | 18% | 12% | 450% | 14% | -14% |

### Mental Health

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 7,268 | 5,965 | 4,890 | 3,631 | 7,700 | 6,289 | 7,806 | 3,451 | 2,721 | 6,834 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 4% | 0% | 21% | 16% | 12% | 23% | 22% | -19% | 12% | 3% |
| FY19 ED Volume rate per 100,000 | 6,209 | 3,496 | 3,564 | 2,252 | 5,246 | 4,722 | 4,954 | 2,992 | 2,879 | 5,934 |
| Change in ED Volume Rate FY17 to FY19 | 17% | 40% | 107% | 34% | 92% | 62% | 86% | 49% | 176% | 47% |

### Parkinsons and Movement Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 252 | 265 | 249 | 127 | 226 | 386 | 197 | 125 | 127 | 184 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 8% | 34% | 100% | 50% | 17% | 35% | 50% | 0% | 33% | -29% |
| FY19 ED Volume rate per 100,000 | 185 | 129 | 62 | 84 | 178 | 88 | 145 | 139 | 79 | 101 |
| Change in ED Volume Rate FY17 to FY19 | 5% | -42% | 0% | 100% | 450% | -38% | -21% | 150% | 0% | -35% |

### Substance Use Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 3,820 | 2,952 | 2,300 | 1,435 | 3,277 | 2,460 | 3,403 | 2,171 | 1,392 | 3,858 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 0% | -9% | 29% | 13% | -7% | 0% | 21% | -7% | 17% | 2% |
| FY19 ED Volume rate per 100,000 | 7,619 | 4,747 | 2,611 | 1,464 | 4,730 | 4,755 | 4,402 | 2,922 | 2,515 | 5,686 |
| Change in ED Volume Rate FY17 to FY19 | 3% | -3% | 50% | 4% | 23% | 36% | 38% | 21% | 109% | 12% |

### Complication of Medical Care

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 1,870 | 1,605 | 1,658 | 1,168 | 2,437 | 1,931 | 1,932 | 1,336 | 744 | 2,223 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 7% | -9% | 33% | 9% | 54% | 0% | 32% | -23% | -29% | 21% |
| FY19 ED Volume rate per 100,000 | 472 | 374 | 290 | 239 | 549 | 375 | 460 | 292 | 190 | 478 |
| Change in ED Volume Rate FY17 to FY19 | 8% | 8% | 8% | 6% | 79% | 36% | 94% | 62% | -20% | 49% |

**Community Health Needs Assessment - Winchester Hospital**
*Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume*
*Patients aged 65+, Winchester Hospital Community Benefits Service Area defined by BILH Community Benefits*

| | MA | Medford | North Reading | Reading | Stoneham | Tewksbury | Wakefield | Wilmington | Winchester | Woburn |
|---|---|---|---|---|---|---|---|---|---|---|
| **All Cause** | | | | | | | | | | |
| FY19 Inpatient Discharges (all cause) rate per 100,000 | 25,473 | 26,214 | 22,771 | 27,357 | 31,048 | 30,117 | 25,155 | 28,960 | 26,380 | 31,116 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 2% | 7% | 10% | 4% | 2% | 12% | 7% | 14% | 8% |
| FY19 ED Volume (all cause) rate per 100,000 | 26,010 | 24,232 | 16,814 | 23,216 | 25,730 | 22,309 | 23,711 | 20,404 | 21,846 | 24,029 |
| Change in ED Rate FY17 to FY19 | 10% | 16% | 26% | 14% | 14% | 3% | 30% | 14% | 6% | 2% |
| **Cancer** | | | | | | | | | | |
| *Breast Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,253 | 1,456 | 1,093 | 1,652 | 2,139 | 1,200 | 1,464 | 1,771 | 1,550 | 2,145 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 10% | 0% | -17% | 10% | -1% | 11% | 15% | 5% | 41% |
| FY19 ED Volume rate per 100,000 | 480 | 248 | 352 | 793 | 600 | 338 | 522 | 624 | 564 | 638 |
| Change in ED Volume Rate FY17 to FY19 | 42% | 0% | 100% | 112% | 173% | 100% | 100% | 733% | 85% | 213% |
| *Colorectal Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 271 | 376 | 247 | 220 | 240 | 237 | 221 | 125 | 188 | 299 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | 73% | 0% | -41% | 0% | -36% | -21% | -75% | -11% | 10% |
| FY19 ED Volume rate per 100,000 | 42 | 30 | 35 | 0 | 20 | 51 | 0 | 0 | 23 | 27 |
| Change in ED Volume Rate FY17 to FY19 | 9% | 0% | 0% | -100% | -67% | 200% | -100% | -100% | -50% | 0% |
| *GYN Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 508 | 545 | 388 | 661 | 460 | 490 | 421 | 1,122 | 705 | 652 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | -19% | 10% | 67% | -18% | -12% | -25% | 246% | -6% | 41% |
| FY19 ED Volume rate per 100,000 | 145 | 69 | 282 | 220 | 280 | 101 | 100 | 224 | 211 | 136 |
| Change in ED Volume Rate FY17 to FY19 | 47% | 250% | 0% | 400% | 0% | 100% | 67% | 200% | 80% | 233% |
| *Lung Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,347 | 1,833 | 1,375 | 1,101 | 1,579 | 1,944 | 1,625 | 1,422 | 1,339 | 1,575 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 9% | 27% | 3% | 19% | 44% | 13% | 7% | -20% | 36% | 0% |
| FY19 ED Volume rate per 100,000 | 282 | 208 | 141 | 176 | 320 | 287 | 261 | 75 | 305 | 272 |
| Change in ED Volume Rate FY17 to FY19 | 26% | 17% | 100% | 167% | 45% | 31% | 30% | -70% | 30% | 43% |
| *Prostate Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,270 | 1,417 | 1,093 | 1,630 | 1,519 | 1,352 | 1,023 | 1,522 | 1,268 | 1,548 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 34% | 24% | 14% | 25% | -7% | 21% | 15% | 2% | 13% |
| FY19 ED Volume rate per 100,000 | 434 | 297 | 388 | 352 | 460 | 473 | 140 | 549 | 517 | 529 |
| Change in ED Volume Rate FY17 to FY19 | 36% | 200% | 175% | 167% | 156% | 75% | -13% | 144% | 340% | 86% |
| *Other Cancer* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 7,146 | 8,332 | 7,684 | 9,780 | 8,916 | 8,078 | 7,422 | 8,656 | 8,457 | 9,883 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 13% | 17% | 31% | 43% | 2% | 13% | -3% | -1% | 14% | 28% |
| FY19 ED Volume rate per 100,000 | 1,519 | 1,050 | 1,304 | 1,938 | 1,719 | 1,589 | 1,244 | 1,621 | 1,879 | 2,091 |
| Change in ED Volume Rate FY17 to FY19 | 33% | 28% | 85% | 203% | 169% | 65% | 19% | 160% | 95% | 202% |
| **Chronic Disease** | | | | | | | | | | |
| *Asthma* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,596 | 1,516 | 1,375 | 1,806 | 2,319 | 1,403 | 1,505 | 1,372 | 1,738 | 1,955 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -16% | -22% | -25% | 3% | 8% | -7% | -21% | -36% | 28% | -7% |
| FY19 ED Volume rate per 100,000 | 1,257 | 1,119 | 952 | 1,079 | 1,259 | 761 | 1,404 | 773 | 1,198 | 1,371 |
| Change in ED Volume Rate FY17 to FY19 | 8% | 57% | 13% | 26% | 40% | 32% | 133% | -16% | 76% | 15% |
| *Congestive Heart Failure* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 8,161 | 9,164 | 7,543 | 8,348 | 10,796 | 9,870 | 7,262 | 9,529 | 7,846 | 10,223 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 9% | 5% | 27% | 4% | 14% | 16% | 5% | 6% | 16% | 14% |
| FY19 ED Volume rate per 100,000 | 1,705 | 1,793 | 1,128 | 2,137 | 1,679 | 1,572 | 1,565 | 1,497 | 1,433 | 2,091 |
| Change in ED Volume Rate FY17 to FY19 | 34% | 113% | 88% | 76% | 163% | 52% | 129% | 71% | 126% | 25% |
| *COPD and Lung Disease* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 7,130 | 6,776 | 6,591 | 6,101 | 8,097 | 8,940 | 7,302 | 8,531 | 6,084 | 9,014 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 0% | 27% | -2% | -8% | 19% | 17% | -3% | 42% | 9% |
| FY19 ED Volume rate per 100,000 | 2,422 | 1,872 | 1,339 | 1,586 | 2,439 | 1,842 | 1,846 | 3,043 | 1,175 | 2,362 |
| Change in ED Volume Rate FY17 to FY19 | 18% | 91% | 46% | -3% | 63% | -7% | 100% | 63% | 9% | 14% |
| *Diabetes Mellitus* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 8,376 | 9,124 | 7,473 | 7,996 | 11,335 | 9,921 | 7,603 | 10,402 | 6,906 | 10,834 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | 4% | 13% | 7% | 20% | 4% | 22% | 14% | 7% | 21% |
| FY19 ED Volume rate per 100,000 | 5,867 | 6,043 | 3,490 | 4,317 | 6,178 | 4,512 | 5,015 | 4,714 | 3,805 | 5,702 |
| Change in ED Volume Rate FY17 to FY19 | 18% | 52% | 32% | 14% | 51% | -12% | 160% | 27% | 0% | -3% |
| *Heart Disease* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 18,344 | 20,052 | 15,650 | 19,031 | 23,171 | 21,464 | 18,114 | 21,601 | 18,793 | 22,617 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 11% | 9% | 4% | 11% | 7% | 14% | 7% | 14% | 15% |
| FY19 ED Volume rate per 100,000 | 3,975 | 3,586 | 2,397 | 4,119 | 3,818 | 3,887 | 2,788 | 4,240 | 4,487 | 4,779 |
| Change in ED Volume Rate FY17 to FY19 | 16% | 61% | 3% | 27% | 19% | 1% | 10% | 42% | 65% | 25% |
| *Hypertension* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 10,397 | 9,947 | 9,905 | 11,344 | 13,055 | 12,337 | 11,133 | 11,025 | 10,218 | 13,006 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -1% | -4% | 4% | 8% | 5% | -6% | 21% | -10% | 4% | 2% |
| FY19 ED Volume rate per 100,000 | 12,665 | 12,542 | 7,896 | 11,454 | 12,955 | 10,647 | 12,718 | 10,676 | 10,571 | 12,178 |
| Change in ED Volume Rate FY17 to FY19 | 14% | 51% | 12% | 2% | 6% | -5% | 91% | -6% | -10% | -17% |
| *Liver Disease* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 1,956 | 1,892 | 1,551 | 1,806 | 2,099 | 2,451 | 1,505 | 2,569 | 1,621 | 1,643 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 16% | -9% | 52% | 61% | 21% | 11% | -15% | 49% | 77% | -8% |
| FY19 ED Volume rate per 100,000 | 258 | 178 | 176 | 220 | 340 | 287 | 160 | 224 | 329 | 149 |
| Change in ED Volume Rate FY17 to FY19 | 36% | -14% | 0% | 67% | 240% | 55% | 33% | 80% | 250% | 22% |
| *Obesity* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 3,869 | 3,576 | 3,102 | 3,612 | 4,058 | 3,583 | 3,290 | 4,240 | 2,373 | 3,720 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 14% | -5% | 7% | 33% | 6% | -7% | 3% | 29% | 29% | 12% |
| FY19 ED Volume rate per 100,000 | 367 | 426 | 564 | 705 | 720 | 524 | 441 | 624 | 329 | 570 |
| Change in ED Volume Rate FY17 to FY19 | 26% | 48% | 300% | 191% | 112% | 55% | 340% | 150% | 100% | 100% |
| *Stroke and Other Neurovascular Diseases* | | | | | | | | | | |
| FY19 Inpatient Discharges rate per 100,000 | 2,064 | 1,862 | 1,727 | 2,159 | 2,699 | 2,924 | 2,327 | 2,220 | 1,997 | 3,231 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 5% | -20% | -9% | -11% | 50% | 27% | 41% | 6% | 15% | 38% |
| FY19 ED Volume rate per 100,000 | 380 | 327 | 423 | 308 | 500 | 304 | 341 | 150 | 305 | 448 |
| Change in ED Volume Rate FY17 to FY19 | 10% | -3% | 71% | -36% | 39% | -14% | 6% | -63% | -13% | 120% |

## Injuries and Infections

### Allergy

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 3,711 | 6,311 | 5,358 | 5,573 | 7,757 | 2,873 | 8,405 | 4,739 | 4,957 | 4,914 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 32% | -1% | 81% | 61% | 18% | 49% | 38% | 43% | 83% | 55% |
| FY19 ED Volume rate per 100,000 | 5,138 | 8,203 | 6,027 | 9,163 | 9,436 | 3,397 | 9,789 | 7,633 | 6,695 | 8,403 |
| Change in ED Volume Rate FY17 to FY19 | 88% | 304% | 2343% | 1709% | 1473% | 814% | 1643% | 1813% | 850% | 949% |

### Hepatitis

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 273 | 327 | 0 | 176 | 260 | 101 | 201 | 150 | 141 | 163 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -3% | 74% | -100% | 167% | 30% | -57% | 11% | -33% | -25% | -8% |
| FY19 ED Volume rate per 100,000 | 70 | 40 | 0 | 44 | 20 | 34 | 40 | 0 | 23 | 41 |
| Change in ED Volume Rate FY17 to FY19 | 36% | 100% | 0% | 0% | 0% | 100% | -50% | 0% | 0% | 0% |

### HIV Infection

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 53 | 59 | 0 | 22 | 20 | 0 | 20 | 25 | 0 | 14 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 2% | 200% | 0% | 0% | 0% | 0% | -50% | 0% | 0% | 0% |
| FY19 ED Volume rate per 100,000 | 47 | 89 | 0 | 44 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in ED Volume Rate FY17 to FY19 | 34% | 350% | 0% | 0% | 0% | 0% | -100% | 0% | 0% | -100% |

### Infections

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 12,591 | 14,107 | 13,183 | 12,665 | 14,394 | 15,836 | 12,257 | 14,667 | 12,027 | 16,698 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 10% | 36% | 5% | -5% | 17% | 24% | 20% | 14% | 7% |
| FY19 ED Volume rate per 100,000 | 4,213 | 3,576 | 3,208 | 3,304 | 4,138 | 3,650 | 3,711 | 3,193 | 3,265 | 3,706 |
| Change in ED Volume Rate FY17 to FY19 | 3% | -4% | 44% | 2% | 34% | 21% | 23% | 41% | -3% | 5% |

### Injuries

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 11,877 | 13,840 | 10,857 | 15,639 | 16,194 | 13,520 | 13,761 | 13,994 | 12,755 | 17,078 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 15% | 6% | 12% | 37% | 9% | 32% | 23% | 31% | 15% | 32% |
| FY19 ED Volume rate per 100,000 | 10,393 | 11,145 | 7,191 | 10,529 | 11,955 | 10,529 | 11,013 | 8,930 | 10,453 | 11,092 |
| Change in ED Volume Rate FY17 to FY19 | 11% | 21% | 42% | 16% | 21% | 2% | 25% | 30% | 31% | 28% |

### Poisonings

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 281 | 238 | 282 | 529 | 500 | 304 | 401 | 399 | 329 | 638 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 7% | -29% | -11% | 243% | 108% | 20% | 150% | 33% | 75% | 114% |
| FY19 ED Volume rate per 100,000 | 185 | 168 | 35 | 242 | 40 | 152 | 120 | 175 | 141 | 122 |
| Change in ED Volume Rate FY17 to FY19 | 27% | 325% | -67% | 10% | -33% | 0% | 100% | 75% | 50% | -10% |

### Pneumonia/Influenza

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 4,188 | 4,537 | 4,159 | 4,692 | 5,638 | 6,067 | 4,574 | 5,363 | 4,205 | 5,417 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 0% | -6% | 3% | 6% | -2% | 17% | 47% | 0% | -11% | -8% |
| FY19 ED Volume rate per 100,000 | 569 | 535 | 529 | 441 | 460 | 389 | 522 | 424 | 446 | 421 |
| Change in ED Volume Rate FY17 to FY19 | 1% | -11% | 150% | 100% | 10% | 21% | 13% | 31% | -17% | 19% |

### Sexually Transmitted Diseases

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 30 | 10 | 0 | 22 | 40 | 0 | 40 | 25 | 23 | 27 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 9% | -80% | -100% | 0% | 100% | -100% | 100% | 0% | 0% | -33% |
| FY19 ED Volume rate per 100,000 | 5 | 0 | 0 | 22 | 0 | 0 | 0 | 0 | 23 | 0 |
| Change in ED Volume Rate FY17 to FY19 | 0% | -100% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

### Tuberculosis

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 52 | 69 | 0 | 0 | 60 | 0 | 40 | 50 | 47 | 109 |
| Change in Inpatient Discharge Rate FY17 to FY19 | -11% | 0% | -100% | -100% | 0% | 0% | 0% | 100% | -67% | 33% |
| FY19 ED Volume rate per 100,000 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| Change in ED Volume Rate FY17 to FY19 | 13% | -100% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

## Other

### Dementia and Cognitive Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 6,264 | 7,093 | 5,569 | 6,652 | 9,176 | 7,166 | 6,540 | 7,309 | 6,507 | 8,594 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 6% | 10% | 5% | 3% | 13% | 2% | 23% | 11% | 7% | 10% |
| FY19 ED Volume rate per 100,000 | 2,053 | 1,496 | 1,339 | 1,630 | 1,879 | 2,890 | 1,224 | 1,596 | 1,973 | 1,996 |
| Change in ED Volume Rate FY17 to FY19 | 11% | -9% | 41% | -14% | 7% | 0% | -25% | -18% | 5% | -5% |

### Mental Health

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 10,900 | 12,265 | 8,601 | 11,872 | 13,635 | 12,388 | 11,374 | 11,275 | 10,218 | 13,006 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 15% | 11% | 11% | 35% | 30% | 19% | 15% | 27% | 58% | 25% |
| FY19 ED Volume rate per 100,000 | 3,500 | 2,368 | 3,102 | 3,370 | 4,458 | 3,532 | 3,230 | 3,592 | 4,275 | 4,032 |
| Change in ED Volume Rate FY17 to FY19 | 35% | 77% | 159% | 99% | 135% | 32% | 130% | 106% | 153% | 69% |

### Parkinsons and Movement Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 1,523 | 1,605 | 1,304 | 1,806 | 2,079 | 2,129 | 1,284 | 1,746 | 1,950 | 1,996 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 10% | 37% | 3% | 17% | 11% | 38% | 14% | 21% | 20% | 7% |
| FY19 ED Volume rate per 100,000 | 602 | 545 | 564 | 529 | 660 | 828 | 441 | 499 | 916 | 394 |
| Change in ED Volume Rate FY17 to FY19 | 11% | 25% | 167% | 26% | 83% | 40% | -8% | 186% | 86% | 32% |

### Substance Use Disorders

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 2,956 | 2,338 | 2,291 | 2,357 | 2,799 | 3,143 | 2,668 | 3,467 | 1,856 | 3,842 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 13% | -7% | 25% | 18% | 8% | 28% | 19% | 22% | 16% | 42% |
| FY19 ED Volume rate per 100,000 | 2,258 | 1,565 | 1,057 | 1,123 | 1,579 | 1,386 | 1,665 | 1,671 | 1,151 | 2,023 |
| Change in ED Volume Rate FY17 to FY19 | 22% | 70% | 58% | 11% | 61% | 64% | 32% | 52% | 36% | 37% |

### Complication of Medical Care

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY19 Inpatient Discharges rate per 100,000 | 4,867 | 5,805 | 5,464 | 5,463 | 6,357 | 5,442 | 5,316 | 7,184 | 5,661 | 6,815 |
| Change in Inpatient Discharge Rate FY17 to FY19 | 13% | 27% | 49% | 23% | 33% | 8% | 46% | 62% | 58% | 42% |
| FY19 ED Volume rate per 100,000 | 835 | 763 | 1,022 | 1,013 | 820 | 541 | 722 | 873 | 564 | 747 |
| Change in ED Volume Rate FY17 to FY19 | 9% | -14% | 123% | 84% | 52% | -30% | 9% | 106% | -25% | 20% |

**Notes:**

Population counts: Sg2 Claritas Demographic Data, 2021.

Data is broken out into four age groupings (0-17, 18-44, 45-64, 65+). One age group per tab.

Included data is a calculated  rate of inpatient discharge or ED volume per 100,000 population, by town. Inpatient discharge and ED data retrieved from CHIA FY17 and FY19.

Categorization of the Health Conditions listed above determined by Sg2 CARE Family (ICD-9 and -10 diagnosis code to disease grouping)

Percent change based on rate per 100,000 in FY17 compared to rate per 100,000 in FY19, using identical Sg2 CARE Family definitions. Please note the % change in rate for some health conditions is large, likely due to small volumes or coding changes.

Volumes noted as <11 are supressed per CHIA cell suppression guidelines.

# Community Health Survey

- Survey
- Survey output
- Survey Distribution Channels

Community Health Survey for Beth Israel Lahey Health
2022 Community Health Needs Assessment

Beth Israel Lahey Health and its member hospitals are conducting a Community Health Needs Assessment to better understand the most pressing health-related issues for residents in the communities we serve. It is important that each hospital gather input from people living, working, and learning in the community. The information gathered will help each hospital to improve its patient and community services.

Please take about 15 minutes to complete this survey. Your responses will be private.  If you do not feel comfortable answering a question, you may skip it. Taking this survey will not affect any services that you receive. Findings from this survey that are shared back with the community will be combined across all respondents. It will not be possible to identify you or your responses. Thank you for completing this survey.

You will have the option at the end of the survey to enter a drawing for a $100 gift card

We have shared this survey widely. Please complete this survey only once.

# Time in Community

1. We are interested in your experiences in the community where you spend the most time. This may be the place where you live, work, play, or learn.
   Please enter the zip code of the community in which you spend the most time.
   Zip code: _____

1. How many years have you lived in the selected community?
   - ❏ Less than 1 year
   - ❏ 1-5 years
   - ❏ 6-10 years
   - ❏ Over 10 years but not all my life
   - ❏ I have lived here all my life
   - ❏ I used to live here, but not anymore
   - ❏ I have never lived here

2. How many years have you worked in the selected community?
   - ❏ Less than 1 year
   - ❏ 1-5 years
   - ❏ 6-10 years
   - ❏ Over 10 years
   - ❏ I do not work here

3. If you do not live or work in the selected community, how are you connected to it?
   _____

## Your Community

4. Please check the response that best describes how much you agree or disagree with each statement about your community.

| | Strongly Disagree | Disagree | Agree | Strongly Agree | Don't Know |
|---|---|---|---|---|---|
| I feel like I belong in my community. | | | | | |
| Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.) | | | | | |
| My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play) | | | | | |
| My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support) | | | | | |
| My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). | | | | | |

5. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

- ☐ Better access to good jobs
- ☐ Better access to health care
- ☐ Better access to healthy food
- ☐ Better access to internet
- ☐ Better access to public transportation
- ☐ Better parks and recreation

- ☐ Better roads
- ☐ Better schools
- ☐ Better sidewalks and trails Cleaner environment
- ☐ Lower crime and violence
- ☐ More affordable childcare
- ☐ More affordable housing
- ☐ More arts and cultural events

- ☐ More effective city services (like water, trash, fire department, and police)
- ☐ More inclusion for diverse members of the community
- ☐ Stronger community leadership
- ☐ Stronger sense of community
- ☐ Other (_____)

## Social + Cultural Environment

6. We are interested to know about your experiences finding support in your community. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

| | Strongly Disagree | Disagree | Agree | Strongly Agree | Don't Know |
|---|---|---|---|---|---|
| There are people and/or organizations in my community that support me during times of stress and need. | | | | | |
| I believe that all residents, including myself, can make the community a better place to live. | | | | | |
| During COVID-19, information I need to stay healthy and safe has been readily available in my community. | | | | | |
| During COVID-19, resources I need to stay healthy and safe have been readily available in my community. | | | | | |

## Natural + Built Environment

7. The natural and built environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

| | True | Somewhat true | Not at all true | I don't know |
|---|---|---|---|---|
| My community feels safe. | | | | |
| People like me have access to safe, clean parks and open spaces. | | | | |
| People like me have access to reliable transportation. | | | | |
| People like me have housing that is safe and good quality. | | | | |
| The air in my community is healthy to breathe. | | | | |
| The water in my community is safe to drink. | | | | |
| My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards. | | | | |
| During extreme heat, people like me have access to options for staying cool. | | | | |

## Economic + Educational Environment

8. The economic and educational environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

| | True | Somewhat true | Not at all true | I don't know |
|---|---|---|---|---|
| People like me have access to good local jobs with living wages and benefits. | | | | |
| People like me have access to local investment opportunities, such as owning homes or businesses. | | | | |
| Housing in my community is affordable for people with different income levels. | | | | |
| People like me have access to affordable childcare services. | | | | |
| People like me have access to good education for their children. | | | | |

9. How much do you agree or disagree with the statements below?

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
|---|---|---|---|---|---|
| The built, economic, and educational environments in my community are impacted by **systemic racism**. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. | | | | | |
| The built, economic, and educational environments in my community are impacted by **individual racism**. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. | | | | | |

## Health + Access to care

10. The healthcare environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

|  | True | Somewhat true | Not at all true | I don't know |
|---|---|---|---|---|
| Health care in my community meets the physical health needs of people like me. |  |  |  |  |
| Health care in my community meets the mental health needs of people like me. |  |  |  |  |

11. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

|  | I needed this type of care and was able to access it. | I needed this type of care but was not able to access it. | I did not need this type of care. |
|---|---|---|---|
| Routine medical care |  |  |  |
| Dental (mouth) care |  |  |  |
| Mental health care |  |  |  |
| Reproductive health care |  |  |  |
| Emergency care for a mental health crisis, including suicidal thoughts |  |  |  |
| Treatment for a substance use disorder |  |  |  |
| Vision care |  |  |  |
| Medication for a chronic illness |  |  |  |

12. For any types of care that you needed but were not able to access, select the reason(s) why you were unable to access care.

|  | Concern about COVID exposure | Unable to afford the costs | Unable to get transportation | Hours did not fit my schedule | Fear or distrust of health care system | No providers speak my language | Another reason not listed |
|---|---|---|---|---|---|---|---|
| Routine medical care |  |  |  |  |  |  |  |
| Dental care |  |  |  |  |  |  |  |
| Mental health care |  |  |  |  |  |  |  |
| Reproductive health care |  |  |  |  |  |  |  |
| Emergency care for a mental health crisis, including suicidal thoughts |  |  |  |  |  |  |  |
| Treatment for a substance use disorder |  |  |  |  |  |  |  |
| Vision care |  |  |  |  |  |  |  |
| Medication for a chronic illness |  |  |  |  |  |  |  |

If you selected "Another reason not listed" in the table above, please explain why you were unable to get the care you needed:

_____

13. How much do you agree with the following statements?

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
|---|---|---|---|---|---|
| Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color.  This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. | | | | | |
| Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. | | | | | |

## Experiences with Discrimination

14.  It has been shown that experiencing discrimination negatively impacts the health and well-being of individuals and communities. In order to better understand these impacts, BILH would like to hear about your lived experience regarding discrimination. In the following questions, we are interested in the ways you are treated. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

| | Never | Less than once a year | A few times a year | A few times a month | At least once a week | Almost every day |
|---|---|---|---|---|---|---|
| You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise. | | | | | | |
| You are unfairly stopped, searched, questioned, threatened, or abused by the police. | | | | | | |
| You receive worse service than other people at stores, restaurants, or service providers. | | | | | | |
| Landlords or realtors refused to rent or sell you an apartment or house. | | | | | | |
| Healthcare providers treat you with less respect or provide worse services to you compared to other people. | | | | | | |

15. If you answered a few times a year or more, what do you think is the main reason for these experiences? You may select more than one.

☐ Ableism (discrimination on the basis of disability)
☐ Ageism (discrimination on the basis of age)
☐ Discrimination based on income or education level
☐ Discrimination based on the basis of religion
☐ Discrimination based on the basis of weight or body size
☐ Homophobia (discrimination against gay, lesbian, bisexual, or queer people)
☐ Racism (discrimination on the basis of racial or ethnic group identity)

☐ Sexism (discrimination on the basis of sex)
☐ Transphobia (discrimination against transgender or gender non-binary people)
☐ Xenophobia (discrimination against people born in another country)
☐ Don't know
☐ Prefer not to answer

16.  Is there anything else you would like to share about the community you selected in the first question? If not, leave blank.

_____
_____
_____

**Beth Israel Lahey Health**

## About You

The following questions help us to better understand how people of diverse identities and life experiences may have similar or different experiences of the community. You may skip any question you prefer not to answer.

**17. What is your age?**

- ☐ Under 18
- ☐ 18-24
- ☐ 25-44
- ☐ 45-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and over
- ☐ Prefer not to answer

**18. What is your current gender identity?**

- ☐ Genderqueer or gender non-conforming
- ☐ Man
- ☐ Transgender
- ☐ Woman
- ☐ Prefer to self-describe:

  _____

**19. What is your sexual orientation?**

- ❏ Bisexual
- ❏ Gay or lesbian
- ❏ Straight/heterosexual
- ❏ Prefer to self-describe:

  _____
- ❏ Prefer not to answer

**20. Which of these groups best represents your race? You will have space to enter ethnicity in the next question. (Please check all that apply.)**

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Not listed above/Other: _____
- ☐ Prefer not to answer

**21. What is your ethnicity? (You can specify one or more)**

- ☐ African (specify_____)
- ☐ African American
- ☐ American
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander (specify_____)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban

- ☐ Dominican
- ☐ European (specify_____)
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian

- ☐ Mexican, Mexican-American, Chicano
- ☐ Middle Eastern (specify_____)
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other (specify_____)
- ☐ Unknown/not specified

**22. What is the primary language(s) spoken in your home? (Please check all that apply.)**

- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (including Mandarin and Cantonese)
- ☐ English
- ☐ Haitian Creole
- ☐ Hindi

- ☐ Khmer
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other: _____
- ☐ Prefer not to answer

23. What is the highest grade or level of school that you have completed?
    ☐ Never attended school
    ☐ Grades 1 through 8
    ☐ Grades 9 through 11/ Some high school
    ☐ Grade 12/Completed high school or GED
    ☐ Some college, Associates Degree, or Technical Degree
    ☐ Bachelor's Degree
    ☐ Any post graduate studies
    ☐ Prefer not to answer

24. Are you currently:
    ☐ Employed full-time (40 hours or more per week)
    ☐ Employed part-time (Less than 40 hours per week)
    ☐ Self-employed (Full- or part-time)
    ☐ A stay at home parent
    ☐ A student (Full- or part-time)
    ☐ Unemployed
    ☐ Unable to work for health reasons
    ☐ Retired
    ☐ Other (specify_____)
    ☐ Prefer not to answer

25. How long have you lived in the United States?
    ☐ Less than one year
    ☐ 1 to 3 years
    ☐ 4 to 6 years
    ☐ More than 6 years, but not my whole life
    ☐ I have always lived in the United States
    ☐ Prefer not to answer

26. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?
    ☐ Never served in the military
    ☐ On active duty now (in any branch)
    ☐ On active duty in the past, but not now (includes retirement from any branch)
    ☐ Prefer not to answer

27. Do you identify as a person with a disability?
    ☐ Yes
    ☐ No
    ☐ Prefer not to answer

28. How would you describe your current housing situation?
    ☐ I rent my home
    ☐ I own my home
    ☐ I am staying with another household
    ☐ I am experiencing homelessness or staying in a shelter
    ☐ Other (specify_____)
    ☐ Prefer not to answer

29. Are you the parent or caregiver of a child under the age of 18?
    ☐ Yes (Please answer question 30)
    ☐ No
    ☐ Prefer not to answer

30. If you are the parent or caregiver for a child under 18, please indicate the age(s) of the child(ren) you care for. (Please check all that apply.)
    ☐ 0-3 years
    ☐ 4-5 years
    ☐ 6-10 years
    ☐ 11-14 years
    ☐ 15-17 years

31. Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? (Select all that apply)
☐ My neighborhood or building
☐ Faith community (*such as a church, mosque, temple, or faith-based organization)*
☐ School community *(such as a college or education program that you attend, or a school that you child attends)*
☐ Work community *(such as your place of employment, or a professional association)*
☐ A shared identity or experience *(such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)*
☐ A shared interest group *(such as a club, sports team, political group, or advocacy group)*
☐ Another city or town where I do not live
☐ Other (Feel free to share: _____)

If you would like to be entered into the drawing to win a $100 gift card, please enter your name and the best way to contact you in the box (phone number or email). This information will not be used to identify your answers to the survey in any way.  Please detach this sheet, and return the survey and this sheet to the place you picked it up.

| **First Name and Email or Phone:** |
|---|

If you would like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities, please enter your email address below. This information will not be used to identify your answers to the survey in any way.  Please detach this sheet, and return the survey and this sheet to the place you picked it up.

| **Email:** |
|---|

Thank you so much for your help in improving your community!

Next
Back
Done

**C. Precision Audio**

GVC streamed :30 audio spots across multiple platforms (iHeart, NPF, PODcasts, Pandora, Spotify, etc.). GVC served up audio commercial voiceover for each hospital using zip codes. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

Sample audio script. Note: Script was customized for each of the 10 hospitals.

*Winchester Hospital wants to hear what you think the most important health-related priorities are in our community. Please take an online survey at bilh.org/chna. Your responses will help to inform innovative solutions to improve the health of our community. Simply go to bilh.org/chna and fill out the survey. That's b-i-l-h.org/c-h-n-a.*

Note: For social media and precision audio, this campaign is people based, so GVC is following each audience member and serving ad messaging where ever and whenever they are consuming online content (within the set frequency for the campaign).

For example, one person could be more active online early mornings – reading articles when he/she/they wake up; listening to streamed music while he/she/they commute – so GVC would then be sure to serve Mike his daily ad frequency during the times he is more active online, increasing the likelihood for click conversion with display ads – or in the case of audio, listening to the ad through to 100% completion. So basically going off of the targets media consumption.

# Winchester Hospital Community Health Survey Output

## Response Counts

| | | |
|---|---|---|
| **Completion Rate:** | 100% | |
| | Complete | 822 |

**Totals: 822**

## 1. Select a language.

| Value | | Percent | Responses |
|---|---|---|---|
| Take the survey in English | | 96.1% | 787 |
| 参加简体中文调查 | | 0.6% | 5 |
| Participe da pesquisa em português | | 2.6% | 21 |
| Responda la encuesta en español | | 0.7% | 6 |

**Totals: 819**

## 3. How many years have you lived in the selected community?

| Value | | Percent | Responses |
|---|---|---|---|
| Less than 1 year | | 2.1% | 17 |
| 1-5 years | | 15.4% | 126 |
| 6-10 years | | 14.8% | 121 |
| Over 10 years but not all my life | | 48.0% | 393 |
| I have lived here all my life | | 16.1% | 132 |
| I used to live here, but not anymore | | 0.9% | 7 |
| I have never lived here | | 2.8% | 23 |

Totals: 819

## 4. How many years have you worked in the selected community?

| Value | | Percent | Responses |
|---|---|---|---|
| Less than 1 year | | 5.8% | 47 |
| 1-5 years | | 14.5% | 118 |
| 6-10 years | | 8.1% | 66 |
| Over 10 years | | 21.4% | 174 |
| I do not work here | | 50.2% | 409 |

**Totals: 814**

## 6. Please check the response that best describes how much you agree or disagree with each statement about your community.

| | Strongly Disagree | Disagree | Agree | Strongly Agree | Don't Know | Responses |
|---|---|---|---|---|---|---|
| I feel like I belong in my community. <br> Count <br> Row % | 20 <br> 2.5% | 62 <br> 7.6% | 416 <br> 51.0% | 291 <br> 35.7% | 26 <br> 3.2% | 815 |
| Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.) <br> Count <br> Row % | 19 <br> 2.3% | 51 <br> 6.2% | 430 <br> 52.6% | 305 <br> 37.3% | 12 <br> 1.5% | 817 |
| My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play) <br> Count <br> Row % | 14 <br> 1.7% | 25 <br> 3.1% | 350 <br> 42.7% | 389 <br> 47.5% | 41 <br> 5.0% | 819 |
| My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support) <br> Count <br> Row % | 22 <br> 2.7% | 130 <br> 15.9% | 401 <br> 49.1% | 210 <br> 25.7% | 54 <br> 6.6% | 817 |
| My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). <br> Count <br> Row % | 16 <br> 2.0% | 58 <br> 7.1% | 423 <br> 52.0% | 286 <br> 35.2% | 30 <br> 3.7% | 813 |
| Totals <br> Total Responses | | | | | | 819 |

## 7. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

| Value | | Percent | Responses |
|---|---|---|---|
| Better access to good jobs | | 9.4% | 76 |
| Better access to health care | | 14.6% | 118 |
| Better access to healthy food | | 18.5% | 149 |
| Better access to internet | | 6.0% | 48 |
| Better access to public transportation | | 31.3% | 252 |
| Better parks and recreation | | 20.1% | 162 |
| Better roads | | 32.6% | 263 |
| Better schools | | 16.9% | 136 |
| Better sidewalks and trails | | 37.1% | 299 |
| Cleaner environment | | 17.5% | 141 |
| Lower crime and violence | | 5.8% | 47 |
| More affordable childcare | | 19.0% | 153 |
| More affordable housing | | 48.3% | 389 |
| More arts and cultural events | | 22.2% | 179 |
| More effective city services (like water, trash, fire department, and police) | | 8.6% | 69 |
| More inclusion for diverse members of the community | | 32.6% | 263 |
| Stronger community leadership | | 12.7% | 102 |
| Stronger sense of community | | 18.7% | 151 |
| Other | | 6.9% | 56 |

8. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

| | Strongly Disagree | Disagree | Agree | Strongly Agree | Don't Know | Responses |
|---|---|---|---|---|---|---|
| There are people and/or organizations in my community that support me during times of stress and need. Count Row % | 15 1.8% | 101 12.4% | 412 50.6% | 146 17.9% | 140 17.2% | 814 |
| I believe that all residents, including myself, can make the community a better place to live. Count Row % | 8 1.0% | 20 2.4% | 399 48.8% | 379 46.3% | 12 1.5% | 818 |
| During COVID-19, information I need to stay healthy and safe has been readily available in my community. Count Row % | 10 1.2% | 41 5.0% | 413 50.5% | 335 41.0% | 19 2.3% | 818 |
| During COVID-19, resources I need to stay healthy and safe have been readily available in my community. Count Row % | 14 1.7% | 76 9.3% | 421 51.5% | 276 33.7% | 31 3.8% | 818 |

Totals
Total Responses                                                                                                          818

# 9. For each statement below, check the response that best describes how true you think the statement is.

| | True | Somewhat True | Not At All True | Don't Know | Responses |
|---|---|---|---|---|---|
| My community feels safe.<br>Count<br>Row % | 634<br>77.5% | 167<br>20.4% | 10<br>1.2% | 7<br>0.9% | 818 |
| People like me have access to safe, clean parks and open spaces.<br>Count<br>Row % | 614<br>75.2% | 180<br>22.1% | 15<br>1.8% | 7<br>0.9% | 816 |
| People like me have access to reliable transportation.<br>Count<br>Row % | 413<br>50.4% | 304<br>37.1% | 61<br>7.4% | 41<br>5.0% | 819 |
| People like me have housing that is safe and good quality.<br>Count<br>Row % | 587<br>71.8% | 182<br>22.3% | 24<br>2.9% | 24<br>2.9% | 817 |
| The air in my community is healthy to breathe.<br>Count<br>Row % | 586<br>71.6% | 176<br>21.5% | 12<br>1.5% | 44<br>5.4% | 818 |
| The water in my community is safe to drink.<br>Count<br>Row % | 502<br>61.6% | 190<br>23.3% | 65<br>8.0% | 58<br>7.1% | 815 |
| My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards.<br>Count<br>Row % | 281<br>34.4% | 297<br>36.4% | 45<br>5.5% | 194<br>23.7% | 817 |
| During extreme heat, people like me have access to options for staying cool.<br>Count<br>Row % | 482<br>59.1% | 203<br>24.9% | 46<br>5.6% | 85<br>10.4% | 816 |

Totals
Total Responses | | | | | 819

**10. For each statement below, check the response that best describes how true you think the statement is.**

| | True | Somewhat True | Not At All True | Don't Know | Responses |
|---|---|---|---|---|---|
| People like me have access to good local jobs with living wages and benefits. Count Row % | 338 41.3% | 307 37.5% | 62 7.6% | 111 13.6% | 818 |
| People like me have access to local investment opportunities, such as owning homes or businesses. Count Row % | 327 40.2% | 318 39.1% | 71 8.7% | 97 11.9% | 813 |
| Housing in my community is affordable for people with different income levels. Count Row % | 63 7.7% | 226 27.7% | 467 57.2% | 61 7.5% | 817 |
| People like me have access to affordable childcare services. Count Row % | 103 12.7% | 293 36.0% | 162 19.9% | 256 31.4% | 814 |
| People like me have access to good education for their children. Count Row % | 506 62.1% | 228 28.0% | 18 2.2% | 63 7.7% | 815 |
| Totals Total Responses | | | | | 818 |

## 11. How much do you agree or disagree with the statements below?

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Responses |
|---|---|---|---|---|---|---|
| The built, economic, and educational environments in my community are impacted by **systemic racism.** This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row % | 96 11.9% | 148 18.4% | 248 30.8% | 210 26.1% | 103 12.8% | 805 |
| The built, economic, and educational environments in my community are impacted by **individual racism.** This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row % | 96 12.0% | 147 18.3% | 243 30.3% | 249 31.0% | 67 8.4% | 802 |

Totals
Total Responses                                                                 805

12. For each statement below, check the response that best describes how true you think the statement is.

| | True | Somewhat True | Not at all True | Don't Know | Responses |
|---|---|---|---|---|---|
| Health care in my community meets the physical health needs of people like me.<br>Count<br>Row % | 498<br>61.3% | 226<br>27.8% | 51<br>6.3% | 38<br>4.7% | 813 |
| Health care in my community meets the mental health needs of people like me.<br>Count<br>Row % | 223<br>27.7% | 279<br>34.6% | 154<br>19.1% | 150<br>18.6% | 806 |

Totals
Total Responses                                                                                           813

13. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

| | I needed this type of care and was able to access it. | I needed this type of care but was not able to access it. | I did not need this type of care. | Responses |
|---|---|---|---|---|
| Routine medical care<br>Count<br>Row % | 720<br>88.1% | 35<br>4.3% | 62<br>7.6% | 817 |
| Dental (mouth) care<br>Count<br>Row % | 693<br>85.3% | 57<br>7.0% | 62<br>7.6% | 812 |
| Mental health care<br>Count<br>Row % | 174<br>21.5% | 107<br>13.2% | 528<br>65.3% | 809 |
| Reproductive health care<br>Count<br>Row % | 170<br>21.1% | 21<br>2.6% | 616<br>76.3% | 807 |
| Emergency care for a mental health crisis, including suicidal thoughts<br>Count<br>Row % | 34<br>4.2% | 33<br>4.1% | 746<br>91.8% | 813 |
| Treatment for a substance use disorder<br>Count<br>Row % | 15<br>1.9% | 12<br>1.5% | 778<br>96.6% | 805 |
| Vision care<br>Count<br>Row % | 536<br>65.9% | 51<br>6.3% | 226<br>27.8% | 813 |
| Medication for a chronic illness<br>Count<br>Row % | 296<br>36.7% | 14<br>1.7% | 496<br>61.5% | 806 |
| Totals<br>Total Responses | | | | 817 |

## 14. For any types of care that you needed but were not able to access, select the reason(s) why you were unable to access care.

| | Concern about COVID exposure | Unable to afford the costs | Unable to get transportation | Hours did not fit my schedule | Fear or distrust of health care system | No providers speak my language | Another reason not listed | Responses |
|---|---|---|---|---|---|---|---|---|
| Routine medical care Count Row % | 81 36.5% | 22 9.9% | 9 4.1% | 31 14.0% | 5 2.3% | 3 1.4% | 71 32.0% | 222 |
| Dental care Count Row % | 79 35.4% | 56 25.1% | 5 2.2% | 23 10.3% | 6 2.7% | 3 1.3% | 51 22.9% | 223 |
| Mental health care Count Row % | 31 13.0% | 26 10.9% | 4 1.7% | 24 10.0% | 10 4.2% | 6 2.5% | 138 57.7% | 239 |
| Reproductive health care Count Row % | 25 16.2% | 7 4.5% | 4 2.6% | 10 6.5% | 6 3.9% | 5 3.2% | 97 63.0% | 154 |
| Emergency care for a mental health crisis, including suicidal thoughts Count Row % | 22 14.7% | 7 4.7% | 2 1.3% | 6 4.0% | 10 6.7% | 3 2.0% | 100 66.7% | 150 |
| Treatment for a substance use disorder Count Row % | 21 15.6% | 9 6.7% | 3 2.2% | 5 3.7% | 4 3.0% | 4 3.0% | 89 65.9% | 135 |
| Vision care Count Row % | 45 26.3% | 21 12.3% | 6 3.5% | 18 10.5% | 1 0.6% | 2 1.2% | 78 45.6% | 171 |
| Medication for a chronic illness Count Row % | 25 17.9% | 12 8.6% | 2 1.4% | 14 10.0% | 2 1.4% | 1 0.7% | 84 60.0% | 140 |

| | Concern about COVID exposure | Unable to afford the costs | Unable to get transportation | Hours did not fit my schedule | Fear or distrust of health care system | No providers speak my language | Another reason not listed | Responses |
|---|---|---|---|---|---|---|---|---|
| Totals | | | | | | | | |
| Total Responses | | | | | | | | 239 |

## 16. How much do you agree with the following statements?

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Responses |
|---|---|---|---|---|---|---|
| Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row % | 150 18.8% | 172 21.5% | 279 34.9% | 142 17.8% | 56 7.0% | 799 |
| Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row % | 143 18.0% | 180 22.7% | 314 39.5% | 124 15.6% | 33 4.2% | 794 |

**Totals**

Total Responses · 799
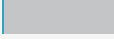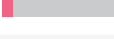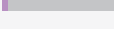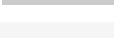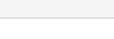
## 17. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

| | Never | Less than once a year | A few times a year | A few times a month | At least once a week | Almost every day | Responses |
|---|---|---|---|---|---|---|---|
| You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise.<br>Count<br>Row % | 643<br>84.6% | 83<br>10.9% | 28<br>3.7% | 1<br>0.1% | 2<br>0.3% | 3<br>0.4% | 760 |
| You are unfairly stopped, searched, questioned, threatened, or abused by the police.<br>Count<br>Row % | 731<br>94.0% | 38<br>4.9% | 5<br>0.6% | 2<br>0.3% | 0<br>0.0% | 2<br>0.3% | 778 |
| You receive worse service than other people at stores, restaurants, or service providers.<br>Count<br>Row % | 637<br>82.2% | 75<br>9.7% | 49<br>6.3% | 8<br>1.0% | 4<br>0.5% | 2<br>0.3% | 775 |
| Landlords or realtors refused to rent or sell you an apartment or house.<br>Count<br>Row % | 718<br>94.1% | 23<br>3.0% | 14<br>1.8% | 2<br>0.3% | 1<br>0.1% | 5<br>0.7% | 763 |
| Healthcare providers treat you with less respect or provide worse services to you compared to other people.<br>Count<br>Row % | 685<br>89.0% | 52<br>6.8% | 24<br>3.1% | 5<br>0.6% | 1<br>0.1% | 3<br>0.4% | 770 |
| Totals<br>Total Responses | | | | | | | 778 |

## 18. What do you think is the main reason for these experiences? You may select more than one.

| Value | | Percent | Responses |
|---|---|---|---|
| Ableism (discrimination on the basis of disability) | | 9.6% | 10 |
| Ageism (discrimination on the basis of age) | | 28.8% | 30 |
| Discrimination based on income or education level | | 25.0% | 26 |
| Discrimination based on the basis of religion | | 2.9% | 3 |
| Discrimination based on the basis of weight or body size | | 27.9% | 29 |
| Homophobia (discrimination against gay, lesbian, bisexual, or queer people) | | 4.8% | 5 |
| Racism (discrimination on the basis of racial or ethnic group identity) | | 27.9% | 29 |
| Sexism (discrimination on the basis of sex) | | 27.9% | 29 |
| Transphobia (discrimination against transgender or gender non-binary people) | | 4.8% | 5 |
| Xenophobia (discrimination against people born in another country) | | 13.5% | 14 |
| Don't know | | 12.5% | 13 |
| Prefer not to answer | | 10.6% | 11 |

## 20. What is your age?

| Value | | Percent | Responses |
|---|---|---|---|
| Under 18 | | 12.7% | 103 |
| 18-24 | | 1.7% | 14 |
| 25-44 | | 29.0% | 235 |
| 45-64 | | 37.0% | 300 |
| 65-74 | | 11.2% | 91 |
| 75-84 | | 5.9% | 48 |
| 85 and over | | 1.4% | 11 |
| Prefer not to answer | | 1.0% | 8 |

**Totals: 810**

## 21. What is your current gender identity?

| Value | | Percent | Responses |
|---|---|---|---|
| Genderqueer or gender non-conforming | | 1.0% | 8 |
| Man | | 16.0% | 130 |
| Transgender | | 0.2% | 2 |
| Woman | | 82.3% | 668 |
| Prefer to self-describe: | | 0.5% | 4 |

**Totals: 812**

## 22. What is your sexual orientation?

| Value | | Percent | Responses |
|---|---|---|---|
| Bisexual | | 3.2% | 26 |
| Gay or lesbian | | 3.6% | 29 |
| Straight/heterosexual | | 84.3% | 679 |
| Prefer to self-describe: | | 1.2% | 10 |
| Prefer not to answer | | 7.6% | 61 |

**Totals: 805**

## 23. Which of these groups best represents your race? You will have space to enter ethnicity in the next question. Please select all that apply.

| Value | | Percent | Responses |
|---|---|---|---|
| American Indian or Alaska Native | | 0.4% | 3 |
| Asian | | 8.2% | 66 |
| Black or African American | | 1.4% | 11 |
| Hispanic/Latino | | 5.8% | 47 |
| White | | 83.0% | 670 |
| Not listed above/Other: | | 1.6% | 13 |
| Prefer not to answer | | 4.6% | 37 |

## 24. What is your ethnicity? Please select all that apply.

| Value | | Percent | Responses |
|---|---|---|---|
| American | | 53.0% | 403 |
| Brazilian | | 3.7% | 28 |
| Chinese | | 4.2% | 32 |
| European (specify): | | 27.7% | 211 |
| Other (specify): | | 6.8% | 52 |
| Unknown/Not specified | | 4.6% | 35 |
| African (specify): | | 0.4% | 3 |
| African American | | 0.7% | 5 |
| Cape Verdean | | 0.1% | 1 |
| Colombian | | 0.4% | 3 |
| Dominican | | 0.1% | 1 |
| Filipino | | 0.5% | 4 |
| Guatemalan | | 0.5% | 4 |
| Haitian | | 0.3% | 2 |
| Honduran | | 0.3% | 2 |
| Indian | | 1.8% | 14 |
| Japanese | | 0.3% | 2 |
| Korean | | 0.8% | 6 |
| Mexican, Mexican-American, Chicano | | 0.5% | 4 |
| Middle Eastern (specify): | | 1.3% | 10 |
| Portuguese | | 2.8% | 21 |
| Puerto Rican | | 0.5% | 4 |
| Russian | | 1.1% | 8 |
| Salvadoran | | 0.1% | 1 |
| Vietnamese | | 0.5% | 4 |

## 25. What is the primary language(s) spoken in your home? Please select all that apply.

| Value | | Percent | Responses |
|---|---|---|---|
| Armenian | | 2.9% | 23 |
| Chinese (including Mandarin and Cantonese) | | 2.9% | 23 |
| English | | 88.9% | 716 |
| Haitian Creole | | 0.1% | 1 |
| Hindi | | 0.5% | 4 |
| Portuguese | | 4.0% | 32 |
| Russian | | 0.2% | 2 |
| Spanish | | 1.6% | 13 |
| Vietnamese | | 0.2% | 2 |
| Other (specify): | | 4.5% | 36 |
| Prefer not to answer | | 0.6% | 5 |

## 26. What is the highest grade or level of school that you have completed?

| Value | | Percent | Responses |
|---|---|---|---|
| Grades 1 through 8 | | 2.5% | 20 |
| Grades 9 through 11/ Some high school | | 10.0% | 81 |
| Grade 12/Completed high school or GED | | 7.3% | 59 |
| Some college, Associates Degree, or Technical Degree | | 17.4% | 141 |
| Bachelor's Degree | | 23.0% | 186 |
| Any post graduate studies | | 37.8% | 306 |
| Prefer not to answer | | 2.0% | 16 |

Totals: 809

## 27. Are you currently:

| Value | | Percent | Responses |
|---|---|---|---|
| Employed full-time (40 hours or more per week) | | 44.0% | 355 |
| Employed part-time (Less than 40 hours per week) | | 14.7% | 119 |
| Self-employed (Full- or part-time) | | 5.6% | 45 |
| A stay at home parent | | 4.5% | 36 |
| A student (Full- or part-time) | | 11.2% | 90 |
| Unemployed | | 2.4% | 19 |
| Unable to work for health reasons | | 1.6% | 13 |
| Retired | | 14.0% | 113 |
| Other (specify): | | 1.4% | 11 |
| Prefer not to answer | | 0.7% | 6 |

**Totals: 807**

## 28. How long have you lived in the United States?

| Value | | Percent | Responses |
|---|---|---:|---:|
| Less than one year | | 0.2% | 2 |
| 1 to 3 years | | 2.3% | 19 |
| 4 to 6 years | | 2.0% | 16 |
| More than 6 years, but not my whole life | | 8.6% | 70 |
| I have always lived in the United States | | 86.2% | 700 |
| Prefer not to answer | | 0.6% | 5 |
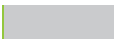
**Totals: 812**

## 29. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?

| Value | | Percent | Responses |
|---|---|---|---|
| Never served in the military | | 95.2% | 769 |
| On active duty now (in any branch) | | 0.1% | 1 |
| On active duty in the past, but not now (includes retirement from any branch) | | 2.5% | 20 |
| Prefer not to answer | | 2.2% | 18 |

Totals: 808

## 30. Do you identify as a person with a disability?

| Value | | Percent | Responses |
|---|---|---|---|
| Yes | | 8.9% | 72 |
| No | | 88.2% | 711 |
| Prefer not to answer | | 2.9% | 23 |
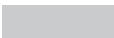
Totals: **806**

## 31. How would you describe your current housing situation?

| Value | | Percent | Responses |
|---|---|---|---|
| I rent my home | | 14.7% | 118 |
| I own my home | | 73.9% | 594 |
| I am staying with another household | | 4.0% | 32 |
| I am experiencing homelessness or staying in a shelter | | 0.1% | 1 |
| Other (specify): | | 4.5% | 36 |
| Prefer not to answer | | 2.9% | 23 |
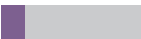
**Totals: 804**

## 32. Are you the parent or caregiver of a child under the age of 18?

| Value | | Percent | Responses |
|---|---|---|---|
| Yes | | 40.0% | 324 |
| No | | 59.0% | 478 |
| Prefer not to answer | | 1.0% | 8 |

Totals: 810

## 33. Please indicate the age(s) of the child(ren) you care for.  Please select all that apply.

| Value | | Percent | Responses |
|---|---|---|---|
| 0-3 years | | 17.2% | 55 |
| 4-5 years | | 15.7% | 50 |
| 6-10 years | | 50.5% | 161 |
| 11-14 years | | 40.8% | 130 |
| 15-17 years | | 31.7% | 101 |

## 34. Which of the following communities do you feel you belong to? Please select all that apply.

| Value | | Percent | Responses |
|---|---|---|---|
| My neighborhood or building | | 67.8% | 527 |
| Faith community (such as a church, mosque, temple, or faith-based organization) | | 28.8% | 224 |
| School community (such as a college or education program that you attend, or a school that you child attends) | | 40.8% | 317 |
| Work community (such as your place of employment, or a professional association) | | 47.9% | 372 |
| A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity) | | 13.6% | 106 |
| A shared interest group (such as a club, sports team, political group, or advocacy group) | | 39.6% | 308 |
| Another city or town where I do not live | | 16.3% | 127 |
| Other (Feel free to share): | | 4.4% | 34 |

**Survey Distribution Channels: Global View Communications (GVC)**

*Engaging with Diverse Communities*

**Survey Campaign Dates: November 1, 2021 – November 15, 2021.**

Connecting with our diverse communities to understand and address the most pressing health-related concerns for residents is priority for BILH. GVC have deployed a marketing campaign to reach our target populations through a three-phase approach. First is an online survey which is followed by a listening session and then an annual meeting.

**Our Approach**

Research was conducted to determine the diverse target audiences based on zip codes surrounding our 10 hospitals and then cross-referenced with the top 2-to-3 diverse populations and languages based on the largest cohorts. That research indicated the following audiences: Hispanic, Black/African American, Chinese, Haitian, Indian, and Cape Verdean.
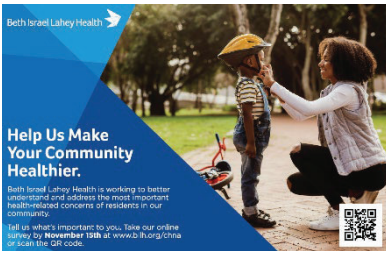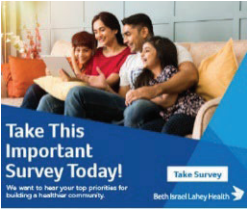
| Winchester Hospital | Beverly/Addison Gilbert Hospital | Lahey Hospital and Medical Center | Anna Jaques Hospital | Beth Israel Deaconess Medical Center |
|---|---|---|---|---|
| 01801 01806 01807 01808 01813 01815 01864 01867 01876 01880 01887 01888 01889 01890 02155 02156 02180 02153 | 01901 01902 01903 01904 01905 01910 01915 01923 01929 01930 01931 01937 01938 01944 01965 01966 01949 | 02420 02421 02474 02475 02476 01850 01851 01852 01853 01854 01960 01961 01730 01731 01803 01805 01821 01822 01862 01865 01940 | 01830 01831 01832 01833 01834 01835 01860 01913 01950 01951 01952 01985 01969 | 02445 02446 02447 02173 02492 02467 |
| **Mt. Auburn Hospital** | **New England Baptist** | **BID – Milton Hospital** | **BID - Needham Hospital** | **BID – Plymouth Hospital** |
| 02138 02139 02140 02141 02142 02143 02144 02145 02238 02239 02451 02452 02453 02454 02455 02474 02472 02474 02475 02476 02477 02478 02479 | 02445 02446 02447 02467 02026 02027 | 02169 02170 02171 02186 02187 02269 02368 | 02492 02494 02026 02027 02030 02090 | 02330 02331 02332 02345 02355 02360 02361 02362 02364 02366 02381 |

**Channels**

GVC utilized three types of marketing channels to expand our reach. Diverse print publications, precision audio, and digital advertising.

1. **Print**
   The following print publications were selected based on reach or hyper targeted audiences. Translation was used if the publication publishes in languages other than English.
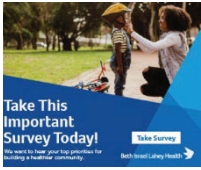
| | |
|---|---|
| **A. El Mundo – Spanish Translation**<br> | **B. Sampan – Chinese Translation**<br> |
| **C. Thang Long – Vietnamese Translation**<br> | **D. Bay State Banner – Black/African American, Cape Verdean/English**<br> |
| **E. Chelsea Record – Hispanic/English**<br> | **F. Indian New England – English (online only)**<br> |
| **G. Haitian Reporter – English (online only)**<br> | |

For the printed newspapers the publish dates are as follows:

| | |
|---|---|
| Bay State | 4-Nov |
| El Mundo | 4-Nov |
| Sampan | 5-Nov |
| Haitian Report (digital only) | 2 weeks |
| Thang Long | 2-Nov |
| India New England (digital only) | 2 weeks |
| Chelsea | 4-Nov |

## 2. Digital Advertising

Digital ads will be served across various websites. GVC utilized a people-based marketing approach. The digital ads will be served up based on the zip codes provided and will include both English and translations based on user preferences.  For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

| A. African American/Black, Haitian, Cape Verdean | B. Hispanic | C. Chinese |
|---|---|---|
|  |  |  |
| **D. Indian** | **E. Vietnamese** | |
|  |  | |

**C. Precision Audio**

GVC streamed :30 audio spots across multiple platforms (iHeart, NPF, PODcasts, Pandora, Spotify, etc.). GVC served up audio commercial voiceover for each hospital using zip codes. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

Sample audio script. Note: Script was customized for each of the 10 hospitals.

*Winchester Hospital wants to hear what you think the most important health-related priorities are in our community. Please take an online survey at bilh.org/chna. Your responses will help to inform innovative solutions to improve the health of our community. Simply go to bilh.org/chna and fill out the survey. That's b-i-l-h.org/c-h-n-a.*

Note: For social media and precision audio, this campaign is people based, so GVC is following each audience member and serving ad messaging where ever and whenever they are consuming online content (within the set frequency for the campaign).

For example, one person could be more active online early mornings – reading articles when he/she/they wake up; listening to streamed music while he/she/they commute – so GVC would then be sure to serve Mike his daily ad frequency during the times he is more active online, increasing the likelihood for click conversion with display ads – or in the case of audio, listening to the ad through to 100% completion. So basically going off of the targets media consumption.

# Survey Distribution Channels: Winchester Hospital Community Partners

| Organization | Contact Person/Name | Title (if Applicable) |
|---|---|---|
| Action for Boston Community Development (ABCD), Mystic Valley Opportunity Center | Jamillah Kasuswa | Operations Manager |
| Albion Cultural Exchange Committee | albionculturalexchange@wakefield.ma.us | N/A |
| Blair House of Tewksury Assisted living | Katie Houle | Resident Services Coordinator |
| Boys & Girls Club of Woburn | Julie Gage | Executive Director |
| Burbank YMCA | Donny Bautz | Executive Director |
| Connect the Tots | Lindsey Hoyme | Secretary |
| Council of Autism Service Providers | Lorri Unumb, Esq. | CEO |
| Crawford memorial united methodist Church | Rev. Ann Robertson | Minister |
| First Baptist Church of Wakefield | Pastor Peter Brown | Minister |
| Housing Families, Inc | Kelly Hollis | Director |
| I'm Still Here Foundation | Mary Anne Grant | Executive Director |
| Islamic Cultural Center of Medford | Nichole Mossalam | Director |
| Jenks Center | Phillip Beltz | Executive Director |
| Korean American Citizens League | Sophie Park | Executive Director |
| Mass Hire | Lee-Ann Johnson | Manager |
| Massachusetts Partnership for Youth Inc | Margie Daniels | Executive Director |
| Medford Board of Health | MaryAnn O'Connor | Director |
| Medford Council on Aging | Pamela Kelly | N/A |
| Medford Community Liasons | Darline Raymond | Community Liason |
| Medford Diversity Equity Inclusion Task Force | Neil Osborne | Director of Diversity |
| Medford Family Network | Marie Cassidy | Director |
| Medford Farmers Market | Heather Meeker-Green | Market Manager |
| Medford Head Start | Kristina Cates | Operations Manager |
| Medford Health Department | Penelope Funaiole | Prevention and Outreach Manager |
| Medford High School Gay-Straight Alliance | Michael Skorker and Nicole Chalifoux | teachers |
| Medford Housing Authority | Lisa Tonello | ROSS Coordinator |
| Medford Mass in Motion | Syrah McGivern | MiM Coordinator |
| Medford Mayor | Breanna Lungo-Koehn | Mayor |
| Medford Office of Planning, Development, and Sustainability | Alicia Hunt | Director |
| Medford Police Department | Jack Buckley | Chief of Police |
| Medford Public Library | Barabara Kerr | Director |
| Medford Public Schools | Dr. Marice Edouard-Vincent | School Superintendent |
| Medford Recreation Department | Kevin Bailey | Director |
| Medford Wayside Youth and Family Support Network | Andrea Salzman | VP of Community Services |
| Melrose Wakefield Mass in Motion | Kara Showers | Coordinator |
| Melrose-Wakefield Hospital | Barabara Kauffman | Community Benefits Manager |
| Middlesex County District Attorney (DA) | Nora Mann | Director of Community Partnerships |
| Mission of Deeds | Sharon Petersen | Director of Development |
| Mom's Club of Reading | membership@readingmomsclub.org | general email |
| Mystic Valley Elder Services | Lauren Reid | Director of Community programs |
| Mystic Valley Public Health Committee | Liz Parsons | Coordinator |
| Network for Social Justice | Liora Norwich | Executive Drector |
| New Hope Chapel | Tami Edson | Director |
| North Burbank YMCA | John Fuedo | Exectuive Director |
| North Reading Community Impact Team | Amy Luckiewicz | Drug Free Communities Director |
| North Reading Council On Aging (COA) | Mary Prenney | Director |
| North Reading Food Pantry | Christian Community Services of North Reading | N/A |
| North Reading Health Department | Robert Bracey | Director |
| North Reading Housing Authority | Aaron Beineke | Executive Director |
| North Reading Library | Sharin Kelleher | Director |
| North Reading Planning Department | Danielle McKnight | Town Planner |
| North Reading Police Department | Laura Miranda | Mental Health Clinician |
| North Reading Recreation Department | Lynne Clemens | Director |
| NuPath | Daniel Harrison, President | President |
| Old South United Methodist Church | Carol Rogerson | Secretary |
| Parents of Tots | Nina Fielder | Director |
| PEER Servants | Carol Mostrom | Director |
| Reading Coalition for Prevention and Support | Erica McNamara | Director |
| Reading Council on Aging | Amy O'Brien | Director |
| Reading Department of Planning | Andrew MacNichol | Staff Planner |
| Reading Department of Recreation | Genevieve Fiorente | Director |
| Reading Health Services | Laura Vlasuk | Director |
| Reading Housing Authority | Kathryn Gallant | Executive Director |
| Reading Police Department | David J. Clark | chief of police |
| Reading Public Library | Amy Lannon | Director |
| Reading Public Schools | Dr. Thomas Milaschewski | Superintendent of Schools |
| Reading Town Manager | Bob LeLacheur | Town Manager |
| Reading Veterans Services | Kevin Bohmiller | Veterans Services Officer |
| Reading-North Reading Chamber of Commerce | Lisa Egan | Executive Drietor |
| Riverside Family Support Center | Kristen D'Andrea | Program Director |

| | | |
|---|---|---|
| Social Capital Inc. | David Crowley | Executive Director |
| St. Athanasius Church (alanon/alateen) | Stephen B. Rock | Reverend |
| St. Eulalia's Church | Laura MacMullin | Parish Secretary |
| St. Williams Church | Donna Bell | Administrative Assistant |
| Stoneham Board of Health | Martin Fralik | Health Agent |
| Stoneham Community Development Corporation | Judy Bousquin | Program Manager |
| Stoneham Council on Aging | Kristen Spence | Director |
| Stoneham Department of Parks and Recreation | Brian Blumsack | Director |
| Stoneham Department of Planning and Economic Development | Erin Wortman | Town Planner |
| Stoneham Department of Veterans of Affairs | Melanie Mendel | Veterans Services Officer |
| Stoneham Health Department | Erin Hull | Health Agent |
| Stoneham Housing Authority | Lisalana Cappuccio | Tenant Coordinator |
| Stoneham Library | Nicole Langley | Director |
| Stoneham Police Deparrtment | James T. McIntyre | Chief of Police |
| Stoneham Public Schools | John Macero | Superintendent of Schools |
| Stoneham Substance Abuse Coalition | Shelly Macneill | Coordinator |
| Stoneham Town Administrator | Dennis Sheehan | Town Administrator |
| Stoneham/Wakefield Boys and Girls Club | Anthony Guardia | Director of Development |
| Tewksbury Cares | Maria Zaroulis | Director |
| Tewksbury Community Pantry, Inc. | info@tewksburypantry.org | N/A |
| Tewksbury Community Roundtable | Robert Hayes | Community Outreach/Technical Services Librarian |
| Tewksbury Council on Aging (COA) | Jan Conole | Director |
| Tewksbury Frontline Initiative | Matthew Page-Shelton | Regional Director |
| Tewksbury Housing Authority | Melissa Maniscalco | Director |
| Tewksbury Planning & Conservation Department | Alex Lowder | Town Planner |
| Tewksbury Public Library | Robert Hayes | Community Outreach/Technical Services Librarian |
| The Dwelling Place Soup Kitchen | thedwellingplace1987@gmail.com | N/A |
| Thom Anne Sullivan Center (Mystic Valley) | Anne Marsh | Director |
| Triumph Center | Alison Jekogian | Assistant Director |
| Unitarian Universalist Church (food program and Alanon/Alateen) | Brenda Bonetti | Secretary |
| Unitarian Universalist Church of Reading | Linda Snow Dockser | Office Administrator |
| Unitarian Universalist Church of Wakefield | Rev. Elizabeth Assenza | Minister |
| Universalist Unitarian Church of Reading | Melissa Martin | Secretary |
| Vida Real Internacional (church) | info@vidareal.net | N/A |
| Wakefield Center Neighborhood Association | info@wcna.org | N/A |
| Wakefield Department of Community & Economic Development | Erin Kokinda | Director |
| Wakefield Department of Recreation | Dan McGrath | Director |
| Wakefield Deprtment of Public Schools | Douglas Lyons | Superintendent |
| Wakefield Farmers Market | AnnMarie Gallivan | Market Manager |
| Wakefield Health Department | Anthony Chui | Director |
| Wakefield Housing Authority | Maureen Hickey | Executive Director |
| Wakefield Human Rights Commission | Benny Wheat | Chair |
| Wakefield Interfaith Food Pantry | Maureen Miller | Executive Director |
| Wakefield Library | Catherine McDonald | Director |
| Wakefield Lynnfield Chamber of Commerce | John Smolinsky | Director |
| Wakefield Lynnfield United Methodist Church | Rev. Glenn Mortimer | Minister |
| Wakefield Main Streets | info@wakefieldmainstreets.org | N/A |
| Wakefield Police Department | Steven Skory | Police Chief |
| Wakefield Public Health Nurse | Melissa Lowry | Public Health Nurse |
| Wakefield Senior Center/Council on Aging (COA) | Judy Luciano | Director |
| Wakefield Town Administrator | Stephen P. Maio | Town Adminstrator |
| Wakefield Veterans Services | Dave Mangan | Veterans Services Officer |
| Wake-Up (Wakefield Unified Prevention Coalition) | Catherine Dhringa | Drug Free Communities Coordinator |
| West Medford Community Center | Nathalie Jean | Executive Director |
| Wilmington Community Fund | wilmcf@verizon.net | N/A |
| Wilmington Community Roundtable | Tina Stewart | Library Director |
| Wilmington Council on Aging (COA) | Terri Marciello | Director |
| Wilmington Department of Recreation | Karen Campbell | Director |
| Wilmington Department of Veterans Affairs | Louis Cimaglia IV | Director |
| Wilmington Health Dept | Tracy Mello | Director |
| Wilmington Housing Authority | Emily LaMacchia | Executive Director |
| Wilmington Library | Charlotte Wood | Director |
| Wilmington Planning Department | Valerie Gingrich | Director |
| Wilmington Police Department | Joseph Desmond | Police Chief |
| Wilmington Public Schools | Glenn Brand | Superintendent of Schools |
| Wilmington Select Board | Lilia Maselli | Chairman |
| Wilmington Substnace Abuse Coalition | Samantha Reif | Coordinator |
| Wilmington Town Manager | Jeffrey Hull | Town Manager |
| Wilmington/Tewksbury Chamber of Commerce | Nancy Vallee | Executive Director |
| Wincheser Hospital Center for Healthy Living | Angeline Brady | Program Director |
| Winchester Council on Aging (COA)/Jenks Center | Phillip Beltz | Executive Director |
| Winchester Coalition for a Safer Community | Dot Butler | Director |
| Winchester Department of Parks & Recreation | Nick Cacciolfi | Director |
| Winchester Foundation for Educational Excellence | Caren Connolly | Executive Director |

| | | |
|---|---|---|
| Winchester Health Department | Jen Murphy | Director |
| Winchester Housing Authority | Sue Cashell | Director |
| Winchester Jenks Center Social Worker | Suzanne Norton | Social Worker |
| Winchester Network for Social Justice | Liora Norwich | Executive Director |
| Winchester Police Department | Daniel O'Connell | Police Chief |
| Winchester Public Library | Ann Wirtanen | Director |
| Winchester Public Schools | Frank Hackett | Superintendent |
| Winchester School of Chinese Culture | Jennifer Zhang | President |
| Winchester Town Manager | Lisa Wong | Town Manager |
| Winchester Town Planner | Brian Szekely | Town Planner |
| Woburn Board of Health | John Fralick | Director |
| Woburn Chamber of Commerce | Chris Kisiel | Executive Director |
| Woburn Coalition Against Substance Abuse | Rick Jolly | Coordinator |
| Woburn Council of Social Concern | Jessie Bencosme | Executive Director |
| Woburn Deparmtent of Parks & Recreation | Rory Lindstrom | Director |
| Woburn Department of Veterans Services | Larry Guiseppe | Veterans Services Officer |
| Woburn Housing Authority | Leslie Gangi | Resident Coordinator |
| Woburn Lion's Club | Chris Kisiel | President |
| Woburn Mayor | Scott Galvin | Mayor |
| Woburn Planning Board | Tina Cassidy | Director |
| Woburn Police Department | Robert F. Rufo, Jr. | Chief |
| Woburn Public Library | Hermayne Gordon | Director |
| Woburn Public School Parents | Adriana Mendes-Sheldon | Family & Community Engagement Liaison |
| Woburn Public Schools | Michael Baldassare | Assistant Superintendent of Schools |
| Woburn Senior Center/Council on Aging (COA) | Marie Lingblom | Director |
| Woburn Veterans Services | Larry Guiseppe | Director |
| YMCA International School | Elaine Dougherty | Director |

# Appendix C:
# Resource Inventory

# Winchester Hospital Corporation Community Resource List

**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| **Statewide Resources** | Department of Mental Health- Handhold program | Provides tips, tools, and resources to help families navigate children's mental health journey. | | | www.handholdma.org |
| | Executive Office of Elder Affairs | Provides access to the resources for older adults to live healthy in every community in the Commonwealth. | 1 Ashburton Place 5th Floor Boston | 617.727.7750 | www.mass.gov/orgs/executive-office-of-elder-affairs |
| | MA 211 | Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community. | | 211 or 877.211.6277 | www.mass211.org |
| | Massachusetts Elder Abuse Hotline | Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community. | 1 Ashburton Place 5th Floor Boston | 800.922.2275 | www.mass.gov/orgs/executive-office-of-elder-affairs |
| | MA Women, Infants and Children (WIC) Nutrition Program | Provides free nutrition, health education and other services to families who qualify. | | 800.942.1007 | www.mass.gov/orgs/women-infants-children-nutrition-program |
| | MassOptions | Provides connection to services for older adults and persons with disabilities. | | 800.243.4636 | www.massoptions.org |
| | Massachusetts Substance Use Helpline | 24/7 Free and confidential public resource for finding substance use treatment and recovery services. | | 800.327.5050 | www.helplinema.org |
| | National Suicide Prevention Lifeline | Provides 24/7, free and confidential support. | | 800.273.8255 | www.suicidepreventionlifeline.org |

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**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| **Statewide Resources** | Network of Care Massachusetts | Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts. | | | www.massachusetts.networkofcare.org |
| | Project Bread Foodsource Hotline | Provides information about food resources in the community and assistance with SNAP applications by phone. | | 1.800.645.8333 | www.projectbread.org/get-help |
| | SafeLink | Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence. | | 877.785.2020 | www.casamyrna.org/get-support/safelink |
| | SAMHSA's National Helpline | Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders. | | 800.662.HELP (4357) | www.samhsa.gov/find-help/national-helpline |
| | Supplemental Nutritional Assistance Program (SNAP) | Provides nutrition benefits to individuals and families to help subsidize food costs. | | 877.382.2363 | www.mass.gov/snap-benefits-formerly-food-stamps |
| | Veteran Crisis Hotline | Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges. | | 800.273.8255 | www.veteranscrisisline.net |
| **Domestic violence** | Boston Area Rape Crisis Center | Provides free, confidential support and services to survivors of sexual violence. | 989 Commonwealth Ave Boston | 617.492.8306 24/7 Hotline: 800.841.8371 | www.barcc.org |

# Winchester Hospital Corporation Community Resource List

**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| **Domestic Violence** | REACH Beyond Domestic Violence | Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement. | PO Box 540024 Waltham | 781.891.0724 Hotline: 800.899.4000 | www.reachma.org |
| **Food Assistance** | Council of Social Concern | Provides food assistance to residents of Woburn and Winchester. | 2 Merrimac St Woburn | 781.935.6495 | www.socialconcern.org |
| | First Church Stoneham Food Pantry | Provides food assistance to residents of Stoneham. | 1 Church St Stoneham | 781.438.0097 | www.firstchurchstoneham.org/outreach/ |
| | North Reading Food Pantry | Provides food assistance to residents of North Reading. | 150 Haverhill St North Reading | 978.276.0040 | www.nrfoodpantry.org |
| | Old South United Methodist Church | Provides food assistance to residents of Reading. | 6 Salem St Reading | 781.944.8486 | www.oldsouthumc.org/foodpantry |
| | Tewksbury Community Pantry | Provides food assistance to residents of Tewksbury. | 999 Whipple Rd Tewksbury | 978.858.2273 | www.tewksburypantry.org |
| | Unitarian Universalist Church of Medford | Provides food assistance to residents of Medford and other surrounding towns. | 147 High St Medford | 781.396.4549 | www.uumedford.org/connection/food-pantry |
| | Wakefield Food Pantry | Provides food assistance to residents of Wakefield. | 467 Main St Wakefield | 781.245.2510 | www.wakefieldfoodpantry.org |
| | Wilmington Food Pantry | Provides food assistance to residents of Wilmington. | 142 Chestnut St Wilmington | 978.658.7425 | www.commfund.org/food-pantry.html |
| **Housing Support** | Heading Home | Provides emergency shelter, transitional, and permanent housing for extremely low-resource families and individuals. | 529 Main St Ste 100 Charlestown | 617.864.8140 | www.headinghomeinc.org |

# Winchester Hospital Corporation Community Resource List

**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| Housing Support | Metro Housing Boston | Provides information and resources for low and moderate resource families and individuals. | 1411 Tremont St Boston | 617.859.0400 | www.MetroHousingBoston.org |
| | Mission of Deeds | Provides basic home essentials to those in need of assistance. | 6 Chapin Ave Reading | 781.944.9797 | www.missionofdeeds.org |
| | North Reading Housing Authority | Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities. | 41 Peabody Court North Reading | 978.664.2982 | www.northreadingha.org |
| | Reading Housing Authority | Provides affordable, subsidized rental housing for low-resource residents of Reading. | 22 Frank D Tanner Dr Reading | 781.944.6755 | www.readinghousing.org |
| | Stoneham Housing Authority | Provides affordable, subsidized rental housing for low-resource residents of Stoneham. | 11 Parker Chase Rd Stoneham | 781.438.0734 | www.stonehamha.org |
| | Tewksbury Housing Authority | Provides affordable, subsidized rental housing for low-resource residents of Tewksbury. | Saunders Circle Tewksbury | 978.851.7392 | www.tewksburyhousing.com |
| | Wakefield Housing Authority | Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities. | 26 Crescent St Wakefield | 781.245.7328 | www.wakefieldhousing.org |
| | Wilmington Housing Authority | Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities. | 41 Deming Way Wilmington | 978.658.8531 | www.wilmingtonha.org |
| | Winchester Housing Authority | Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities. | 13 Westley St Winchester | 781.721.5718 | www.winchesterha.org |
| | Woburn Housing Authority | Provides housing assistance programs to low-resource residents of Woburn. | 59 Campbell St Woburn | 781.935.0818 | www.woburnhousing.org |

## Winchester Hospital Corporation Community Resource List

**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| Mental Health and Substance Use | Beth Israel Lahey Health (BILH) Behavioral Services | Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services. | | 978.968.1700 | ww.nebhealth.org |
| | Eliot Community Human Services | Provides services for people of all ages throughout Massachusetts through a continuum of services includes diagnostic evaluation, 24-hour emergency services, and crisis stabilization, outpatient and court-mandated substance-use prevention services; individual, group and family outpatient counseling, early intervention, specialized psychological testing; day, residential, social and vocational programs for individuals with developmental disabilities, outreach and support services for people experiencing homelessness. | 125 Hartwell Ave Lexington | 781.861.0890 | www.eliotchs.org |
| | Riverside Outpatient Center | Offers comprehensive mental health services for children and families. | 6 Kimball Ln Ste 310 Lynnfield | 781.246.2010 | www.riversidecc.org |
| | Tewksbury Treatment Center | Offers a 32-bed inpatient detoxification service that treats and cares for men and women aged 18 and older in need of medical detoxification from alcohol, opiates and benzodiazepines. | 365 East St Tewksbury | 978.259.7000 | www.nebhealth.org |
| | Triumph Center | Provides counseling, social skills groups, summer programming and psychological evaluation services for children, adolescents, young adults and families, as well as consultation and evaluations for schools and other institutions. | 36 Woburn St Reading | 781.942.9277 | www.triumphcenter.net |

# Winchester Hospital Corporation Community Resource List

**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| Mental Health and Substance Use | Wilmington Family Counseling Service, Inc. | Provides quality mental health and substance use disorder treatment. | 5 Middlesex Ave Unit 11 Wilmington | 978.658.9889 | www.wilmingtonfamilycounseling.com |
| Senior Services | Medford Council on Aging | Provides services for older adults in Medford including fitness, education, social services, and recreation. | 101 Riverside Ave Medford | 781.396.6010 | www.medfordma.org/departments/council-on-aging/ |
|  | Minuteman Senior Services | Provide supportive services for older adults and persons with disabilities. | 26 Crosby Dr Bedford | 781.272.7177 | www.minutemansenior.org |
|  | Mystic Valley Elder Services | Provides programs for older adults or people with disabilities and caregivers for communities North of Boston. | 300 Commercial St #19 Malden | 781.324.7705 | www.mves.org |
|  | North Reading Council on Aging | Provides services for older adults in North Reading including fitness, education, social services, and recreation. | 157 Park St North Reading | 978.664.5600 | www.northreadingma.gov/elder-services |
|  | Reading Council on Aging | Provides services for older adults in Reading including fitness, education, social services, and recreation. | 49 Pleasant St Reading | 781.942.6658 | www.northreadingma.gov/council-aging |
|  | Stoneham Council on Aging | Provides services for older adults in Stoneham including fitness, education, social services, and recreation. | 136 Elm St Stoneham | 781.438.1157 | www.stonehamseniorcenter.org |
|  | Tewksbury Senior Center | Provides services for older adults in Tewksbury including fitness, education, social services, and recreation. | 175 Chandler St Tewksbury | 978.640.4480 | www.tewksbury-ma.gov/council-on-aging |
|  | Wakefield Council on Aging | Provides services for older adults in Wakefield including fitness, education, social services, and recreation. | 30 Converse St Wakefield | 781.245.3312 | www.wakefield.ma.us/senior-center |
|  | Wilmington Senior Center | Provides services for older adults in Wilmington including fitness, education, social services, and recreation. | 15 School St Wilmington | 978.657.7595 | www.wilmingtonma.gov/elderly-services |

# Winchester Hospital Corporation Community Resource List

**Community Benefits Service Area includes: Reading, North Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn**

| Health Issue | Organization | Brief Description | Address | Phone | Website |
|---|---|---|---|---|---|
| **Senior Services** | Winchester Council on Aging | Provides services for older adults in Winchester including fitness, education, social services, and recreation. | 109 Skillings Rd Winchester | 781.721.7136 | www.jenkscenter.org |
| | Woburn Council on Aging | Provides services for older adults in Woburn including fitness, education, social services, and recreation. | 144 School St Woburn | 781.897.5960 | www.woburnma.gov/government/senior |
| **Transportation** | Lowell Regional Transit Authority (LRTA) | Provides public transportation to the Greater Lowell area. | 115 Thorndike St Lowell | 978.459.0164 | www.lrta.com |
| | MBTA Commuter Rail Service | Provides local bus service to Boston. | | | www.mbta.com |
| | MBTA Bus | Lowell Line stops in Lowell, North Billerica, Wilmington, Woburn, Winchester, and Medford. | | | www.mbta.com |
| **Additional Resources** | Burbank YMCA / YMCA of Greater Boston | Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities. | 36 Arthur B Lord Dr Reading | 781.944.9622 | www.ymcaboston.org/burbank |
| | North Suburban YMCA / YMCA of Greater Boston | Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities. | 137 Lexington St Woburn | 781.935.3270 | www.ymcaboston.org/northsuburban |

# Appendix D:

# Evaluation of 2020–2022 Implementation Strategy

# Winchester Hospital (WH)

## Evaluation of 2020-2022 Implementation Strategy

Below are highlights of the work that has been accomplished since the last Implementation Strategy. For full reports, please see submissions to the Massachusetts Attorney General Community Benefits office (https://massago.onbaseonline.com/massago/1801CBS/annualreport.aspx).

**Priority: Mental Health and Substance Use Disorders**

| Goal 1: Address the prevalence and impact, stigma, risk/protective factors, and access issues associated with mental health and substance use disorder | | | |
|---|---|---|---|
| Population | Objectives | Activities | Progress, Outcomes, and Impact |
| -Older adults<br>-Individuals with chronic/complex conditions<br>-Low-resource individuals and families<br>-Youth and adolescents | -Reduce isolation and depression<br><br>-Reduce environmental risk factors associated with developing mental health issues<br><br>-Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners | -Organize and support initiatives that increase opportunities for social engagement<br><br>-Organize and support initiatives that reduce environmental risk factors associated with developing mental health issues<br><br>-Support and participate in task forces and community collaboratives that discuss strategies to address mental health and substance use issues | -Over 100 older adults per year were served by the Mystic Valley Mobile Mental health clinic in FY20 and FY21 with financial support from Winchester Hospital. Services addressed isolation and environmental factors that affect mental health.<br><br>-Funding supported three local councils on aging to purchase iPads to continue social programming, increase connectedness, and support access to virtual mental health services amongst older adults.<br><br>-Prior to the start of the COVID-19 pandemic, Winchester Hospital partnered with local senior centers to provide two social events and one educational program reaching approximately 400 seniors in the hospital's service area.<br><br>-Winchester Hospital is an active members of the Mystic Valley Public Health Committee and the District Attorney's Opioid Task Force, two cross-sector regional collaboratives working on mental health and substance use issues. |

| Goal 1: Address the prevalence and impact, stigma, risk/protective factors, and access issues associated with mental health and substance use disorder | | | |
|---|---|---|---|
| Population | Objectives | Activities | Progress, Outcomes, and Impact |
| -Older adults<br>-Individuals with chronic/complex conditions<br>--Low-resource individuals and families<br>-Youth and adolescents | -Increase awareness of the impacts and risk factors for developing substance use disorders<br><br>-Increase awareness of the signs, symptoms, risks, and stigma of developing mental health issues and promote access to treatment<br><br>-Increase access to appropriate mental health and substance use treatment and support services | -Organize and support community based initiatives that increase awareness, prevent, and identify individuals at risk for developing substance use disorders, including vaping.<br><br>-Organize and support initiatives in clinical and community based settings that reduce stigma, increase awareness about the signs and symptoms of mental health issues and/or identify individuals at risk for developing mental health issues and refer to treatment<br><br>-Enhance access to integrated behavioral health services<br><br>-Provide support to individuals with mental health and substance use issues within the Emergency Department | -Through the Boys and Girls Club SBIRT program, over 200 youths were screened for mental health needs per year, resulting in: 91% of referred participants attended weekly mentoring sessions, 75% reporting a decreased likelihood of participating in risky behaviors, and nearly 90% reporting an increased likelihood of talking to an adult if they felt depressed or had thoughts of self-harm.<br><br>-Funding supported the establishment and maintenance of Interface Referral Services in two communities. This free service utilizes counselors to connect residents directly with mental health providers. In both communities, an average of 80 residents utilized the services to connect with mental health providers to address mental health concerns including anxiety, depression, and COVID-19-related stress.<br><br>-The Collaborative Care Model led to mental health integration and direct care across 6 primary care sites, now serving over 1,300 patients.<br><br>-The Centralized Bed Management Program supports ED patients experiencing mental health and substance use disorders via a centralized bed placement system that monitors progress through the ED and coordinates inpatient placement based on the patient's needs. |

**Priority: Chronic/Complex Conditions and Risk Factors**

| Goal 1: Prevent, detect and manage chronic disease and complex conditions and enhance access to treatment and support services | | | |
|---|---|---|---|
| Population | Objectives | Activities | Progress, Outcomes, and Impact |
| -Older adults<br>-Individuals with chronic/complex conditions<br>-Low-resource individuals and families<br>-Youth and adolescents | -Create awareness of/educate community members about the preventable risk factors associated with chronic and complex health conditions<br><br>-Help community members detect chronic disease and provide linkages to associated services<br><br>-Engage individuals in evidence-based/evidence-informed programs that help them better manage their chronic disease | -Organize and support programs and activities in clinical or community-based settings to provide education<br><br>-Organize and support health screenings in clinical or nonclinical settings to detect chronic conditions and refer to and coordinate care.<br><br>-Support programs and activities that refer, educate and support individuals in better managing their chronic conditions. | -Over 3,000 patients per year received free Breast Cancer Risk screenings.<br><br>-Lab Services provided more than 10,000 free blood draws for homebound patients.<br><br>-The hospital's Healthy State website provided health information to educate and influence healthy behavior change. In FY20, there were 72,205 page views, including more than 8,700 views from returning users.<br><br>T-he Chronic Disease Management program supported 72 adults with chronic diseases to help them better manage their health and overall quality of life.<br><br>-Over 80 children per year were enrolled in CHAMP, a pediatric asthma management program, which resulted in fewer missed school days and emergency room visits and improved overall quality of life.<br><br>-In FY 2020, a monthly average of 85 people participated in the weight management program.<br><br>-The 12-week Fighting Fatigue program for cancer patients served an average of 10 patients per year and resulted in decreases in fatigue and pain amongst nearly half of the participants. |

| | | | -Funding supported the establishment of the Jenks Center Mobile Anemia and Cholesterol clinic for individuals living in affordable housing. 44 individuals participated in the program and have connected with the Jenks Center nurse for ongoing support and management.<br><br>-The Mount Vernon Resident Health program provided over 700 treatments to Winchester residents to address chronic pain and arthritis, resulting in over half of participants reporting reductions in pain and improvement in mood. |
| --- | --- | --- | --- |

| Goal 1: Prevent, detect and manage chronic disease and complex conditions and enhance access to treatment and support services | | | |
| --- | --- | --- | --- |
| Population | Objectives | Activities | Progress, Outcomes, and Impact |
| -Older adults<br>-Individuals with chronic/complex conditions<br>-Low-resource individuals and families<br>-Youth and adolescents | -Educate individuals about achieving a healthy diet<br><br>-Increase access to supportive services that reduce the stress and anxiety associated with chronic illness | -Organize and/or support programs in clinical and nonclinical settings that educate on how to choose and/or prepare healthy foods<br><br>-Provide or support programs and services that help individuals and family members alleviate the burden(s) associated with chronic/complex conditions | -The Oncology Nurse Navigator dedicated an average of 2,000 hours providing 6,500 consultations assisting more than 2,000 patients.<br><br>-Winchester Hospital provided 584 free integrative therapy sessions to more than 500 patients undergoing cancer treatment. |

**Priority: Social Determinants of Health and Access to Care**

| Goal 1: Address social determinants of health and barriers to care | | | |
|---|---|---|---|
| Population | Objectives | Activities | Progress, Outcomes, and Impact |
| -Older adults<br>-Individuals with chronic/complex conditions<br>-Low-resource individuals and families<br>-Youth and adolescents | -Increase access to affordable and safe transportation options<br><br>-Educate providers and community members about hospital and/or public assistance programs that can help them identify and enroll in appropriate health insurance plans and/or reduce their financial burden<br><br>-Enhance awareness about hospital/community resources that address health issues and social determinants of health | -Provide support for programs/initiatives that address issues associated with transportation.<br><br>-Provide counseling, support, and referral services to community members to enroll and remain in appropriate programs.<br><br>-Distribute information at community events and to physicians, clinical staff, and community partners. | -Funding supported two councils on aging van transportation programs in Tewksbury and Winchester to increase access to free rides to medical appointment for older adults and people with disabilities.<br><br>-The hospital provided free taxi rides to medical appointments for an average of 100 low-income patients per year.<br><br>-Patient Financial Services staff provided free counseling for 24,000 patients with Medicaid coverage who completed an application with a Financial Navigator or who qualified for upgraded MassHealth coverage.<br><br>-The SHINE program offered over 200 free insurance coverage counseling sessions for community members at the Jenks Center in Winchester and the Winchester Hospital Center for Cancer Care. |

| Goal 1: Address social determinants of health and barriers to care | | | |
|---|---|---|---|
| Population | Objectives | Activities | Progress, Outcomes, and Impact |
| -Older adults<br>-Individuals with chronic/complex conditions<br>-Low-resource individuals and families<br>-Youth and adolescents | -Explore ways to reduce/address housing instability<br><br>-Increase access to clinical services for homebound patients<br><br>-Increase access to affordable and nutritious foods and affordable physical activity<br><br>-Increase awareness about how to create a healthy and safe environment for babies and families, and promote healthy child development | Develop relationships with community partners and organizations that address issues associated with housing instability.<br><br>-Provide or support programs that enhance access to clinical services<br><br>-Organize and support programs that provide access to free or low-cost healthy foods and physical activity.<br><br>-Organize and support programs that promote a healthy and safe environment and foster healthy growth and development for infants and babies. | -Funding supported Metro Housing Boston's Co-Location program that provided eviction-prevention and housing-stabilization counseling services to over 100 families in Medford, Winchester, and Woburn.<br><br>-Funding supported the establishment of the Network for Social Justice regional Housing Stability Coalition, working on housing policy change initiatives to reduce housing cost burdens in Winchester.<br><br>-Hospital's kitchen staff, under the direction of registered dietitians, prepared and packed 4,500 meals to meet the dietary needs of participants of the hospital's home meal delivery program.<br><br>-Funding supported the establishment of a 20-week fresh fruit and vegetable farm share at two Winchester Housing Authority locations, serving 3,430 pounds of fresh produce to residents, free of charge.<br><br>-With grant support, the Woburn Council of Social Concern Food Pantry program served 762 low-income individuals. The Council also established the Backpack Food Program with Woburn Public Schools, offering free food to low-resource families weekly during the school year. |

| | | | -The Wilmington Elder Services Meals and More program provided 300 older adults with free, fresh produce bimonthly in partnership with local grocery stores and farms.<br><br>-15 Healing Yoga classes were offered to cancer patients in treatment or recovery, reaching 40 participants.<br><br>-550 couples completed the free Winchester Hospital Breastfeeding Classes.<br><br>-In FY20, sleep sacks were provided to infants of mothers delivered at Winchester Hospital to promote a safe sleeping environment at home. |
| --- | --- | --- | --- |

# Appendix E:

# 2023–2025 Implementation Strategy

# Beth Israel Lahey Health
# Winchester Hospital

# 2022 Implementation Strategy

# Implementation Strategy

## About the 2022 Hospital and Community Health Needs Assessment Process

Winchester Hospital (WH), founded in 1912, is a 229-bed community hospital located in Winchester, Massachusetts, that serves nearly half a million people a year and is one of the leading providers of comprehensive health care services in the area northwest of Boston. In addition to acute-care inpatient services, WH provides an extensive range of primary care, outpatient medical, surgical, and obstetrical services as well as specialized care in bariatrics, cardiology, cardiac surgery, orthopedics, neurology, vascular surgery, and oncology. WH's mission is "To Care. To Heal. To Excel. In Service to Our Community."

The Community Health Needs Assessment (CHNA) and planning work for this 2022 report was conducted between September 2021 and September 2022.  In conducting this assessment and planning process, it would be difficult to overstate WH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. WH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage WH's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

WH collected a wide range of quantitative data to characterize the communities served across its Community Benefits Service Area (CBSA). The hospital also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs of specific communities. The data were tested for statistical significance whenever possible and compared against data at the regional, Commonwealth and national level to support analysis and the prioritization process. The assessment also included

data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Between October 2021 and February 2022, the hospital conducted 21 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 800 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 1,000 community residents, clinical and social service providers, and other key community partners.

## Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that faces health-related disparities or are disproportionately impacted by systemic racism or other forms of discrimination. Accordingly, using an interactive, anonymous polling software, WH's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of WH's IS. This prioritization process helps to ensure that WH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

WH's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary

prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute to the systemic, fair and just treatment of all people.
- Could be scaled to other BILH hospitals.
- Are flexible to respond to emerging community needs.

Recognizing that community benefits planning is ongoing and will change with continued community input, WH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues that may arise, which may require a change in the IS or the strategies documented within it. WH is committed to assessing information and updating the plan as needed.

## Community Benefits Service Area

WH's CBSA includes the nine municipalities of Medford, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn located in northwest suburban Boston, Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs.

There are segments of the WH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. WH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. WH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

WH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, WH focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved. By prioritizing these cohorts, WH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

## Prioritized Community Health Needs and Cohorts

WH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.
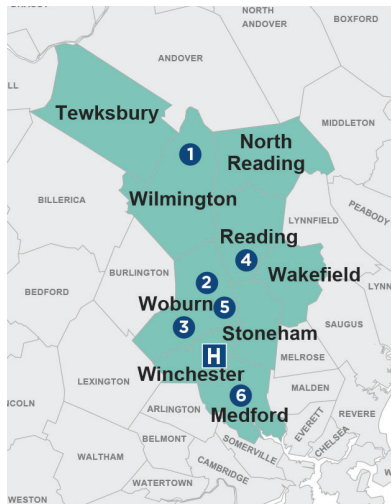
Beth Israel Lahey Health
Winchester Hospital

## Community Benefits Service Area

- **H** Winchester Hospital
- **1** Winchester Hospital Family Medical Center
- **2** Winchester Hospital Imaging/Walk-In Urgent Care
- **3** Winchester Hospital Orthopedics Plus at Choate Medical Center
- **4** Imaging at Reading Health Center
- **5** Winchester Hospital Outpatient Center
- **6** Winchester Hospital Community Health Institute Weight Management Program and Diabetes Center

## WH Priority Cohorts

Youth
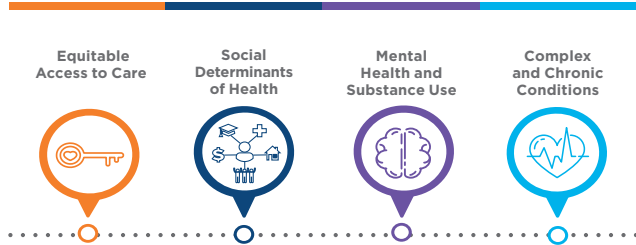
Low-Resourced Populations

Older Adults

Racially, Ethnically and Linguistically Diverse Populations

LGBTQIA+

## WH Community Health Priority Areas

### HEALTH EQUITY

| Equitable Access to Care | Social Determinants of Health | Mental Health and Substance Use | Complex and Chronic Conditions |
|---|---|---|---|

## Community Health Needs Not Prioritized by WH

It is important to note that there are community health needs that were identified by WH's assessment that were not prioritized for investment or included in WH's IS. Specifically, supporting education across the lifespan and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in WH's IS. While these issues are important, WH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, WH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. WH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

## Community Health Needs Addressed in WH's IS

The issues that were identified in the WH CHNA and are addressed in some way in the hospital IS are housing issues, transportation, climate change, economic insecurity, build capacity of workforce, navigation of healthcare system, linguistic access barriers, diversify provider workforce, education on domestic violence, diversifying community leadership, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, racism/discrimination, culturally appropriate/competent health and community services, cross sector partnerships/collaboration/responses, linguistic access/barriers to community resources/services, substance use stigma, substance use outreach/education/prevention, services to support long-term recovery, and opioid use/misuse.

# Implementation Strategy Details

## Priority: Equitable Access to Care

Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers are at the system level and stem from the way in which the system does or does not function. System-level issues include providers not accepting new patients, long wait lists, and an inherently complicated health care system that is difficult for many to navigate.

There are also individual-level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

**Resources/Financial Investment:** WH expends substantial resources on its community benefits program to achieve the goals and objectives of its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

**Goal:** Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/ WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Promote access to health care, health insurance, patient financial counselors, and needed medical services for patients who are uninsured or underinsured. | • Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations | • Patient financial counselors<br>• Home Blood Draw program<br>• Serving the Health Insurance Needs of Everyone (SHINE) Program<br>• Primary Care Support | • # patients and clients assisted and their demographics<br>• # referrals to services<br>• participant responses to Social Determinants of Health Screening tool | • Minuteman Senior Services<br>• BILH Primary Care | Economic stability |
| Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers. | • Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Interpreter Services<br>• Formation and integration of hospital Diversity, Equity, and Inclusion (DEI) council | • # of patients assisted<br>• # of languages provided<br>• # of staff DEI trainings | WH Interpreter Services Department | Not Applicable |

**Goal:** Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/ WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Reduce barriers to care by providing/ supporting free or reduced cost transportation for homebound residents needing care. | • Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Medical appointment transportation voucher program<br>• Jenks Center transportation program | • # patients assisted<br>• # rides provided | • Woburn Checker Cab<br>• Jenks Center | Transportation |
| Provide and promote career support services and career mobility programs to hospital employees. | WH employees | • Career and academic advising<br>• Hospital-sponsored community college courses<br>• Hospital-sponsored English Speakers of Other Languages (ESOL) classes<br>• Diverse talent promotion and acquisition | • # of employees who participated<br>• # of employees who were promoted | BILH Workforce Development | Economic stability |

# Priority: Social Determinants of Health

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define the quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, and other important social factors.

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, listening sessions, and the BID Needham Community Health Survey reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food insecurity/nutrition, transportation, and economic instability.

**Resources/Financial Investment**: WH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

**Goal:** Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations | • Council of Social Concern food pantry program<br>• Woburn Public Schools Backpack Food Program<br>• Winchester Housing Authority free farmer's market<br>• Farmer's market SNAP Gap matching funds and programs<br>• Winchester Hospital Meals on Wheels Program | • # clients assisted and their demographics<br>• # pounds of food served<br>• # of residents reached<br>• # of meals prepared | • Council of Social Concern<br>• Woburn Public School System<br>• Winchester Housing Authority<br>• Area Farmer's Markets<br>• City of Medford<br>• Jenks Center<br>• Local Councils on Aging<br>• New Entry Sustainable Farming Project | Chronic & Complex Conditions |
| Support impactful programs that stabilize or create access to affordable housing. | Low-resourced populations | Metro Housing Boston housing security and stability program | • # clients assisted and their demographics<br>• # of referrals made<br>• # of Families prevented from homelessness | Metro Housing Boston | Not Applicable |

**Goal:** Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Support impactful programs that address issues associated with the social determinants of health. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Provide community grants to address emerging needs<br>• Work with BILH Diversity, Equity, and Inclusion Council to expand contracts with diverse suppliers and vendors | • # of grantees<br>• Length of grant period<br>• # of new partnerships established<br>• $ amount invested<br>• Grant outcomes<br>• Supplier diversity spend | To be identified | Not Applicable |
| Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Network for Social Justice Housing Coalition<br>• Medford Food Policy Council<br>• Middlesex Regional Food Security Coalition | • Hospital representation on community coalitions<br>• Support of coalition-sponsored policy, system, and environmental changes<br>• # of policies considered<br>• # of policies adopted | • Network for Social Justice<br>• City of Medford<br>• Local and regional elected officials | Not Applicable |

# Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues on youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Interviewees, focus group, and community listening session participants also discussed the stigma, shame, and isolation that those with mental health challenges face that limit their ability to access care and cope with their illness.

Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Interviewees, focus groups, and community listening session participants

engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness). Those participating in interviews, focus groups, listening sessions, and other meetings also reflected on the need for transitional housing and other recovery support services.

**Resources/Financial Investment:** WH expends substantial resources on its community benefits program to achieve the goals and objectives of its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

**Goal:** Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Support impactful programs that promote healthy development, support children, youth, and their families, and increase their resiliency, coping, and prevention skills. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | School-based mental health and substance use prevention programs and after school youth programs | • # participating students<br>• Self-reported changes in knowledge and behaviors | Public school systems | Equitable access to care |
| Build the capacity of the community to understand the importance of mental health and availability of services, and reduce negative stereotypes, bias, and stigma around mental illness and substance use. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | Screening, Brief Intervention, Referral to Treatment (SBIRT) & Question, Persuade, Refer (QPR) programs at Boys and Girls Club of Stoneham & Wakefield | • # staff trained<br>• # referrals made<br>• # youth matched to treatment<br>• # youth matched to mentors | Boys and Girls Club of Stoneham & Wakefield | Equitable access to care |

**Goal:** Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment. | • Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Centralized Bed Management<br>• Detoxification Services<br>• Behavioral Health Emergency Department technicians<br>• BILH Collaborative Care Model<br>• Mobile Mental Health Clinic<br>• Mystic Valley Elder Services (MVES)<br>• | • # of patients served<br>• # of therapy sessions<br>• # of integrated behavioral health consultations<br>• # of practices | • Winchester affiliated primary care practices<br>• Winchester Emergency Department<br>• BILH Behavioral Health Services<br>• Mystic Valley Elder Services | Equitable access to care |
| Support a model that spans the continuum of care from inpatient to outpatient and community initiatives that identify and address mental health needs and substance use disorders. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Healing and Recovering Together (HART) House Tewksbury<br>• Transitional Support Services - Tewksbury<br>• Town of Winchester social worker<br>• Council on Aging programs for older adults mental health promotion and substance use prevention<br>• Interface Referral Service – Winchester and Stoneham<br>• Provide community health grants to address this need | • # participants and their demographics<br>• # of referrals made<br>• Self-reported changes in mood and behavior<br>• # of police officers who complete 40-hour Crisis Intervention Training<br>• Top reasons for referral<br>• Caller demographics<br>• Amount awarded<br>• # of grantees<br>• Length of grant period<br>• # of new partnerships established | • HART House<br>• Local Councils on Aging<br>• Town of Winchester<br>• Town of Stoneham | Equitable access to care |

**Goal:** Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

| STRATEGIES | COHORT(S) | INITIATIVES TO ADDRESS THE PRIORITY | METRICS/WHAT WE ARE MEASURING | IDENTIFIED PARTNERS | SECONDARY PRIORITY |
|---|---|---|---|---|---|
| Participate in multi-sector community coalitions to identify and advocate for policy, systems, and environmental changes that reduce and prevent substance use and promote mental health. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Mystic Valley Public Health Committee<br>• Mystic Valley Behavioral Health Coalition<br>• Middlesex District Attorney (DA) Opioid Task Force<br>• Local substance use prevention coalitions | • Hospital participation in coalition meetings<br>• Support of coalition-sponsored policy, system, and environmental changes<br>• # of new partnerships established<br>• # of policies considered<br>• # of policies adopted<br>• Programs offered | • Mystic Valley Public Health Committee staff lead, based in Medford Public Health Department<br>• Tufts Medicine<br>• Melrose Wakefield Hospital<br>• Middlesex DA | Not Applicable |

# Priority: Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

**Resources/Financial Investment:** WH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

| **Goal:** Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources. | | | | | |
|---|---|---|---|---|---|
| **STRATEGIES** | **COHORT(S)** | **INITIATIVES TO ADDRESS THE PRIORITY** | **METRICS/WHAT WE ARE MEASURING** | **IDENTIFIED PARTNERS** | **SECONDARY PRIORITY** |
| Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs. | • Low-resourced population<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+<br>• Youth | • Breast Cancer Risk Assessment<br>• Oncology Nurse Navigator<br>• Center for Healthy Living Health Education Programs<br>• CHAMP Pediatric Asthma program<br>• Fighting Fatigue Program<br>• A Caring Place wig donation program<br>• Mount Vernon House Resident Health Program<br>• Patient support groups | • # clients assisted and their demographics<br>• changes in health status<br>• self-reported changes in knowledge and behavior<br>• # of support group meetings<br>• # of support group participants<br>• Staff time | • Winchester Hospital Center for Healthy Living<br>• Mount Vernon House<br>• Winchester Center for Cancer Care | Equitable Access to Care |
| Support community-based programs that increase access to free or low-cost health-promoting supports to prevent chronic disease. | • Youth<br>• Low-resourced populations<br>• Racially, ethnically, and linguistically diverse populations<br>• LGBTQIA+ | • Integrative Therapies for Cancer Patients<br>• Outpatient Lactation Program<br>• Diabetes Management Program monthly clinic | • # clients assisted and their demographics<br>• Changes in health status<br>• Self-reported changes in knowledge and behavior | • Winchester Hospital Center for Healthy Living<br>• Mount Vernon House | Equitable Access to Care |

## General Regulatory Information

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|---|---|
| **Contact Person:** | LeighAnne Taylor, Regional Manager, Community Benefits & Community Relations |
| **Date of written plan:** | June 30, 2022 |
| **Date written plan was adopted by authorized governing body:** | September 13, 2022 |
| **Date written plan was required to be adopted** | February 15, 2023 |
| **Authorized governing body that adopted the written plan:** | Winchester Hospital Board of Trustees |
| **Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?** | ☑ Yes      ☐ No |
| **Date facility's prior written plan was adopted by organization's governing body:** | September 17, 2019 |
| **Name and EIN of hospital organization operating hospital facility:** | Winchester Hospital 04-2104434 |
| **Address of hospital organization:** | 41 Highland Ave, Winchester, MA 01890 |