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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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.

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.

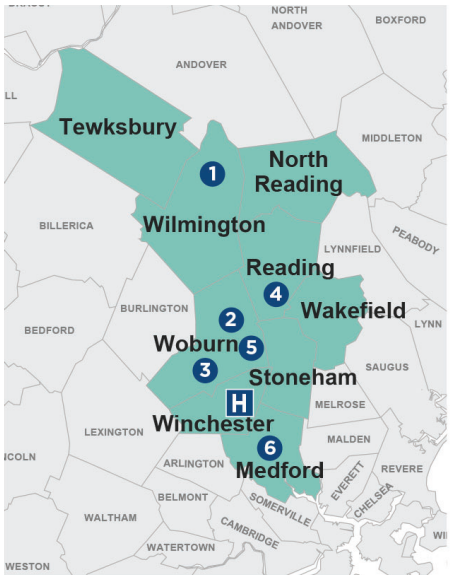
The assessment and planning work for this current report was conducted between September 2021 and September 2022 and WH's Board of Trustees approved the 2022 report and adopted the 2023-2025 IS, included as Attachment E, on September 13, 2022.

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



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

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.

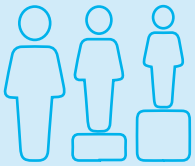
WH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within the CBSA. The activities that will be implemented as a result of this assessment will support all of the people who live in the CBSA. However, in recognition of the health disparities 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.

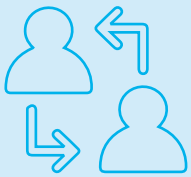


Equity:

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

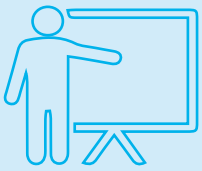
Collaboration:

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: Preliminary Assessment & Engagement	Phase II: Focused Engagement	Phase III: 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

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:

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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.

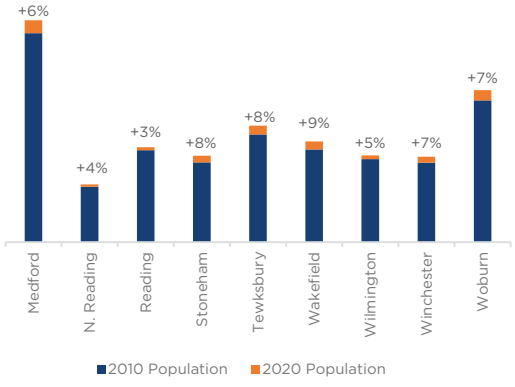
There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers were most likely to have poor health status and face systemic challenges accessing needed services. While relatively small, these segments of the population 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



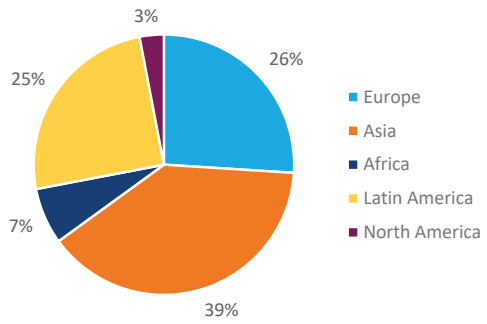
Source: US Census Bureau, 2010 and 2020 Decennial Census

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



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.

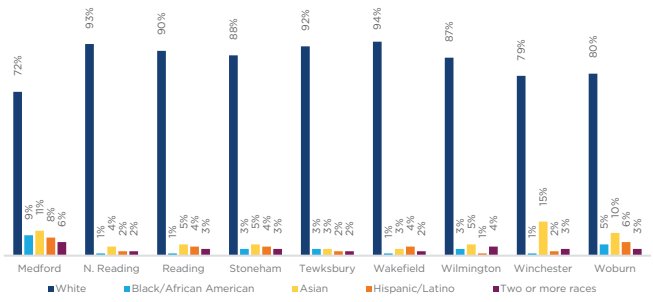
21% of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

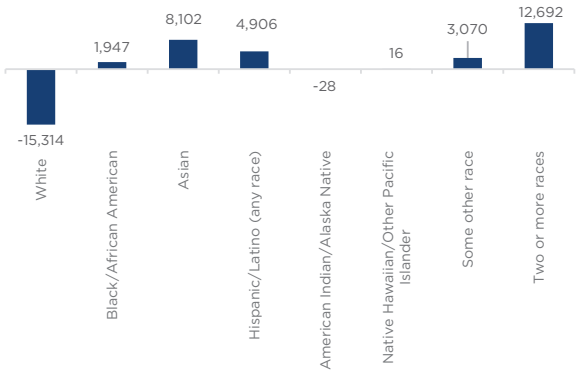
In the WH CBSA overall, the number of residents who identified as white and American Indian/Alaska Native has decreased since 2010, while there was an increase in other census categories. Individuals who participated in the assessment reported that they felt the CBSA was increasingly diverse, though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

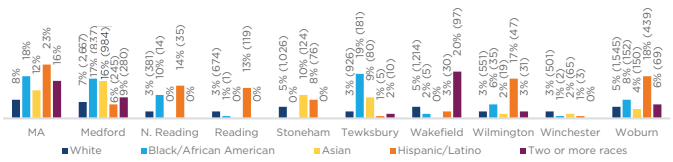
Food insecurity, food scarcity, and hunger were also identified as significant challenges, particularly for individuals and families experiencing economic insecurity. These issues were correlated to issues of job loss, inability to find employment that paid a livable wage, and living on an inadequate 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]

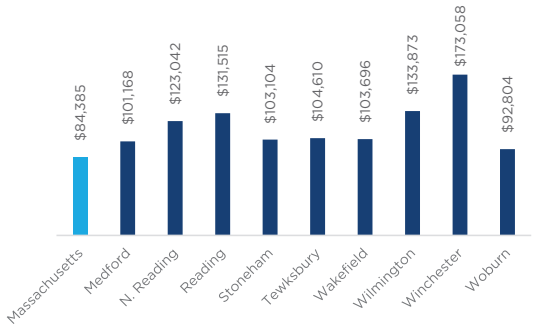
COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability.

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



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

Median Household Income, 2016-2020

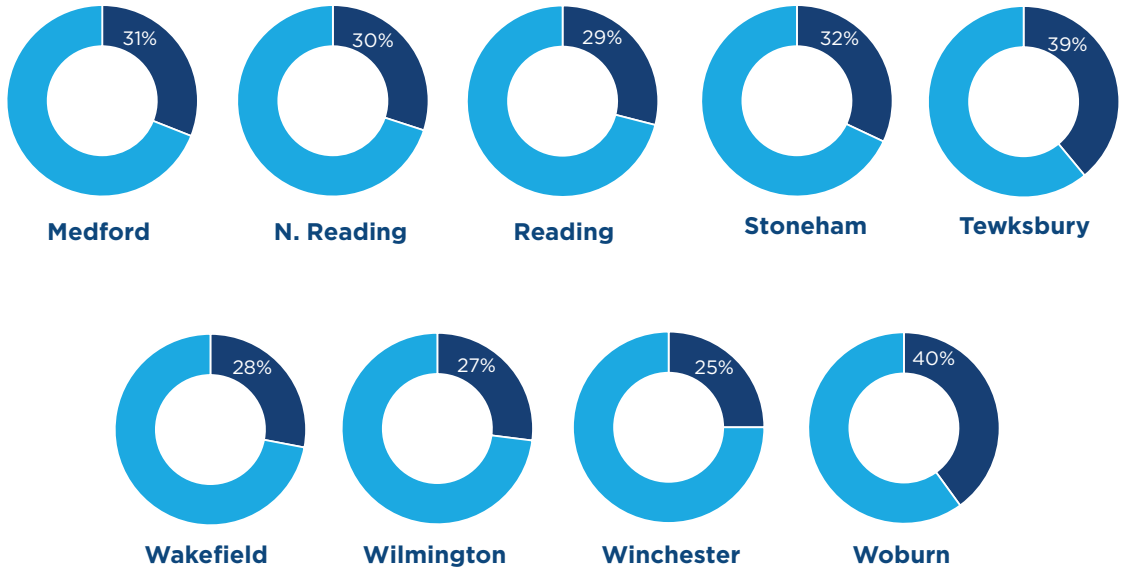


Source: US Census Bureau American Community Survey, 2016-2020

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)



***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

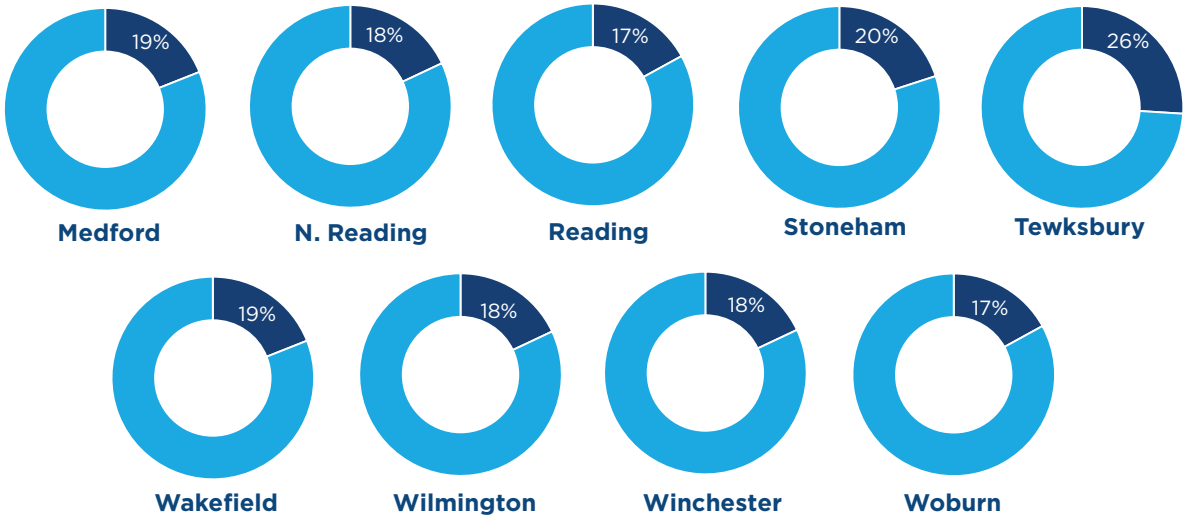
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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



***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]

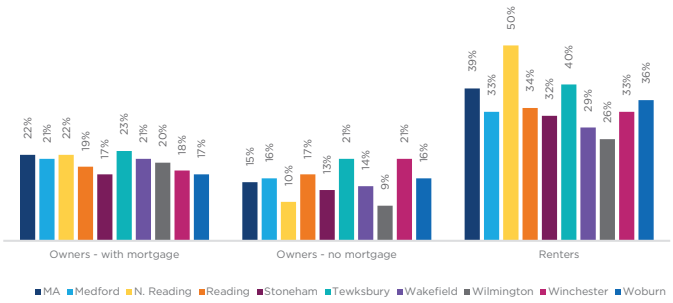
Housing

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



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.

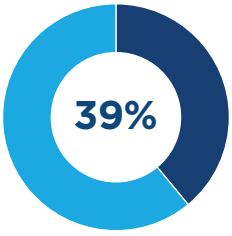
Racial Equity

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.

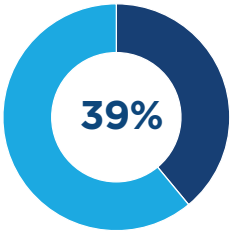
Interviewees reported that their communities were increasingly diverse in terms of race, ethnicity, sexual orientation, and gender identity. This diversity was identified as a strength. However, individuals expressed concerns about racism, discrimination, and varying levels of acceptance and recognition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



reported that built, economic, and educational environments in the community were impacted by **systemic racism.**



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.

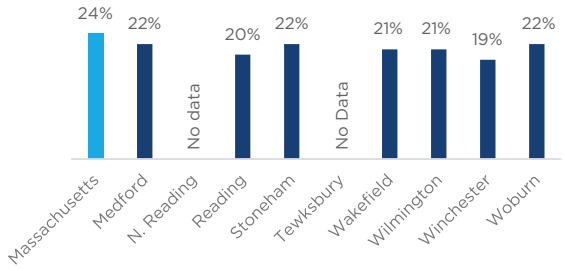
19% of WH Community Health Survey respondents said they would like their community to have better access to healthy food.

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 Readingand Tewksbury.

Percentage of Adults Who Were Obese, 2018



Source: Behavioral Risk Factor Surveillance System, 2018

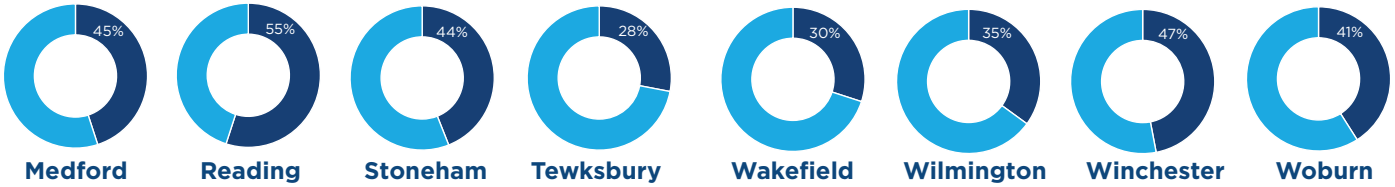
Alcohol, Marijuana and Tobacco Use

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



***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.

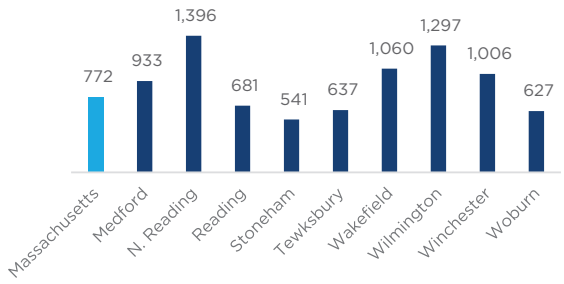
Mental Health

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.

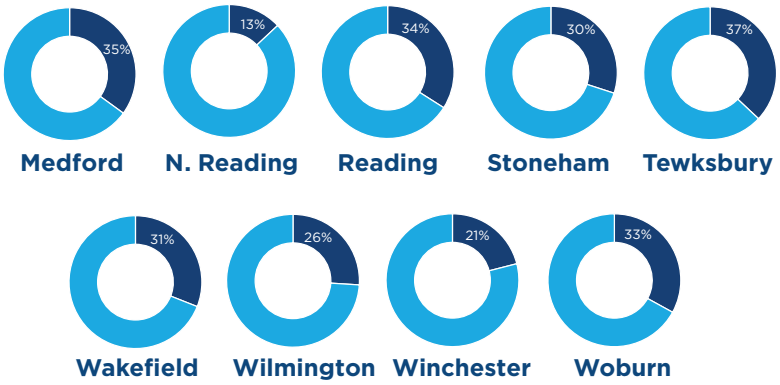
Inpatient Discharge Rates (per 100,000) for Mental Health Conditions Among Those Under 18 Years of Age, 2019



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)



***Unweighted percentages displayed**

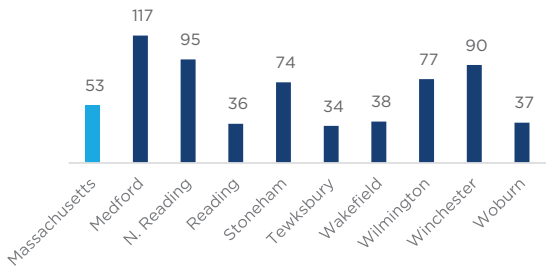
Source: MDPH COVID-19 Community Impact Survey, Fall 2020

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

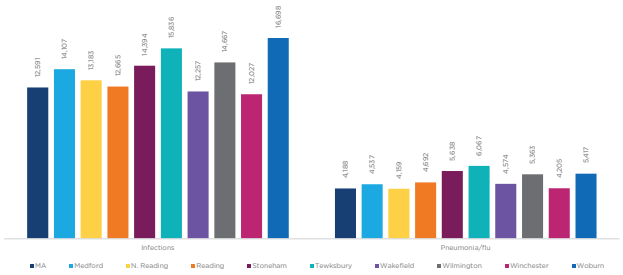
Source: Center for Health Information and Analysis, 2019

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



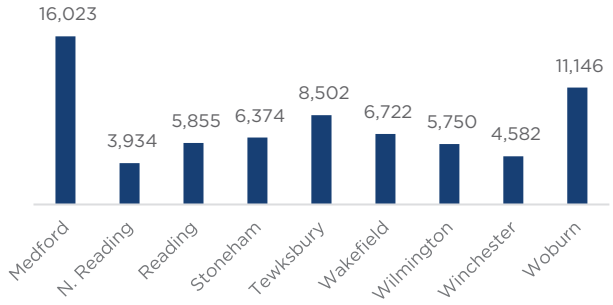
Source: Center for Health Information and Analysis, 2019

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.

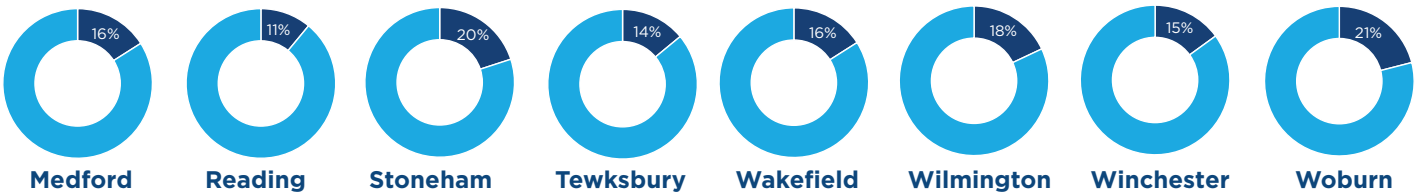
Total COVID-19 Case Counts Through June 23, 2022



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)



Data was suppressed in North Reading

***Unweighted percentages displayed**

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 • Housing stability/homelessness • Mental illness and mental health • Substance use disorder.	• Built environment • Social environment • Housing • Violence • Education • Employment.
Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy	*Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)*

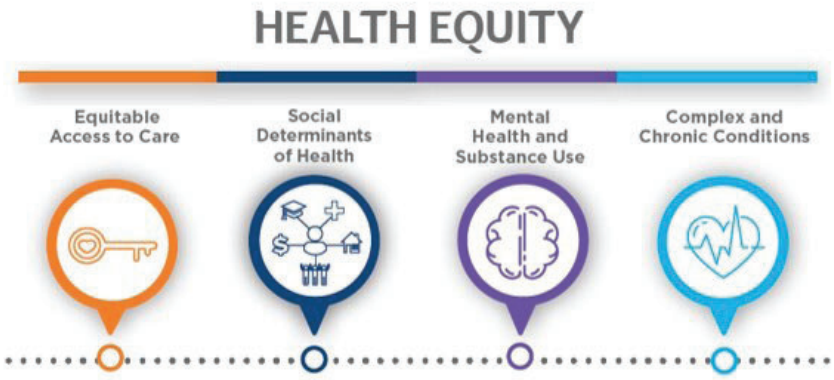
Community Health Priorities and Priority Cohorts

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



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. 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. Lab Services provided more than 10,000 free blood draws for homebound patients. 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. 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. 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

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2020-2022 Implementation Strategy

Appendix E: 2023-2025 Implementation Strategy

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?"

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

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. 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? 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

Winchester Hospital Community Health Needs Assessment 2021-2022

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

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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
	• Other services like gyms, food banks,
	• Senior center – great place to go to for social program
	  ○ Great people, great programs, social interactions
	  ○ All the volunteers
	  ○ Exercise classes
	  ○ Educational programs
	  ○ Emotional support
	• 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. • Transportation • Mental health Challenges • Food security and healthy nutritional food • Financial Security • Substance Use - 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? *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.	Top Factors 1. Transportation 2. Mental health 3. Financial Security
<u>Section 2: Exploring Key Factors</u> *In this section, ask participants to go more in depth about the factors they brought up in the previous section.*	
Are these **(things that keep you healthy)** available to everyone or just a few groups of people?	• ***Not discussed***
Why do you think they **(things that make it hard to be healthy)** exist? • Why is this a challenge?	• ***See above. Not addressed directly***
What are some examples of how these challenges impact someone's health?	• **Transportation** ○ High cost ○ Lack of flexibility ○ Long wait-times ○ Hard to navigate ○ Really difficult to manage public transportation or other types of services for appointments ○ Don't often take the PCAs that seniors need to support them at appointments

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

	○ "Huge issue in all communities" Chronic Disease – NOT MAJOR ISSUES
<u>Section 3: Ideas and Priorities</u>	
Ideas: - 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? - 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: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	• Transportation • Mental health education/stigma, screening/assessment and lack of MH services • Importance of elder services, socialization, and programming to address isolation • Outreach to those who are isolated, homebound, and do not come into the council on aging
<u>Section 4: Final Remarks & Closing</u>	
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 ● Feel well metally and physically ● Eat well and healthy ● Get enough sleep ● Physical exercise ● Not to need meds. ● Have the strength to work ● Taking vitamins ● Happy/happiness ● Home is clean and sanitary ● Friends and family ● 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: 1. Farmers markets, fresh veggies that are affordable 2. Churches 3. Employment 4. Walkable town 5. Food pantry 6. Pond and outdoor space

Unhealthy: What are some of the things that make it hard for you to be healthy?	What's missing: 1. Lack of accessible and affordable children programs in all schools a. Tutoring programs b. Afterschool programs 2. Transportation 3. Health insurance 4. Support systems 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? *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.	Top Factors 1. Housing 2. Quality healthcare a. Provide masshealth application help 3. Outreach to community
<u>Section 2: Exploring Key Factors</u> *In this section, ask participants to go more in depth about the factors they brought up in the previous section.*	
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? - Why is this a challenge?	***N/A***

What are some examples of how these challenges impact someone's health?	***N/A***
<u>Section 3: Ideas and Priorities</u>	
Ideas: - 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? - 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 ○ More advertising outreach to local community (multi-language outreach with specific messaging about masshealth) ○ Health education in the community ● Hospital to **partner** with community (like schools) ● Hospital could invest in creating an **affordable, accessible gym** ● Hospital could invest in **multilingual services** outside of Boston ● Hospital could invest in a **local, community health center** ● Hospital could invest in a **Masshealth application center** ● Hospital could **train and hire** more medical staff that **speak language other than English** ○ More staff training in public benefits
Priorities: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	● ***Housing*** ● ***Quality healthcare*** ● ***Outreach to community***
<u>Section 4: Final Remarks & Closing</u>	
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

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

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.

CREATING INCLUSIVE SPACE

move at the speed of trust

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.

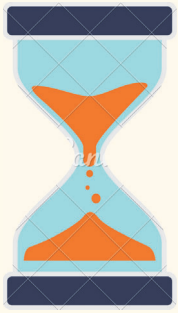
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial

Active listener

Authentic

Patient



Enthusiastic

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

Acknowledgements

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

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

Assessment Purpose and Process

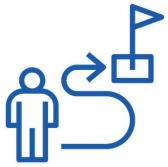
FY22 CHNA and Implementation Strategy Guiding Principles

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

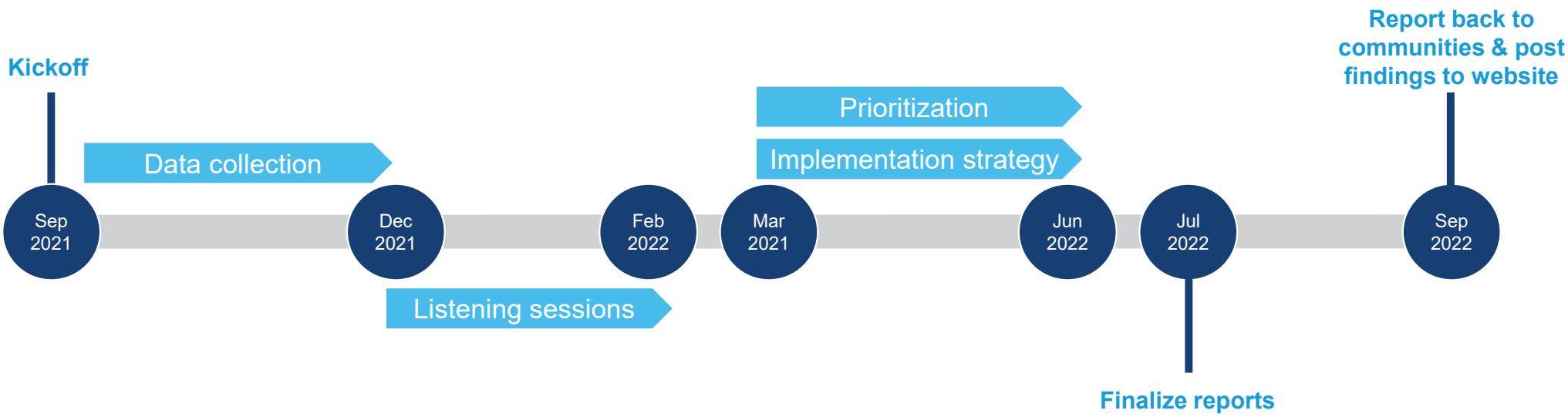
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



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

Assessment Purpose and Process

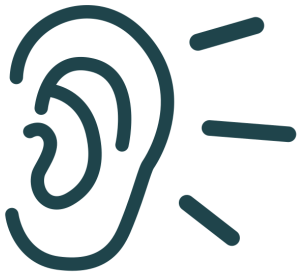
FY22 CHNA and Implementation Strategy Process



Assessment Purpose and Process
Meeting goals

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

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**

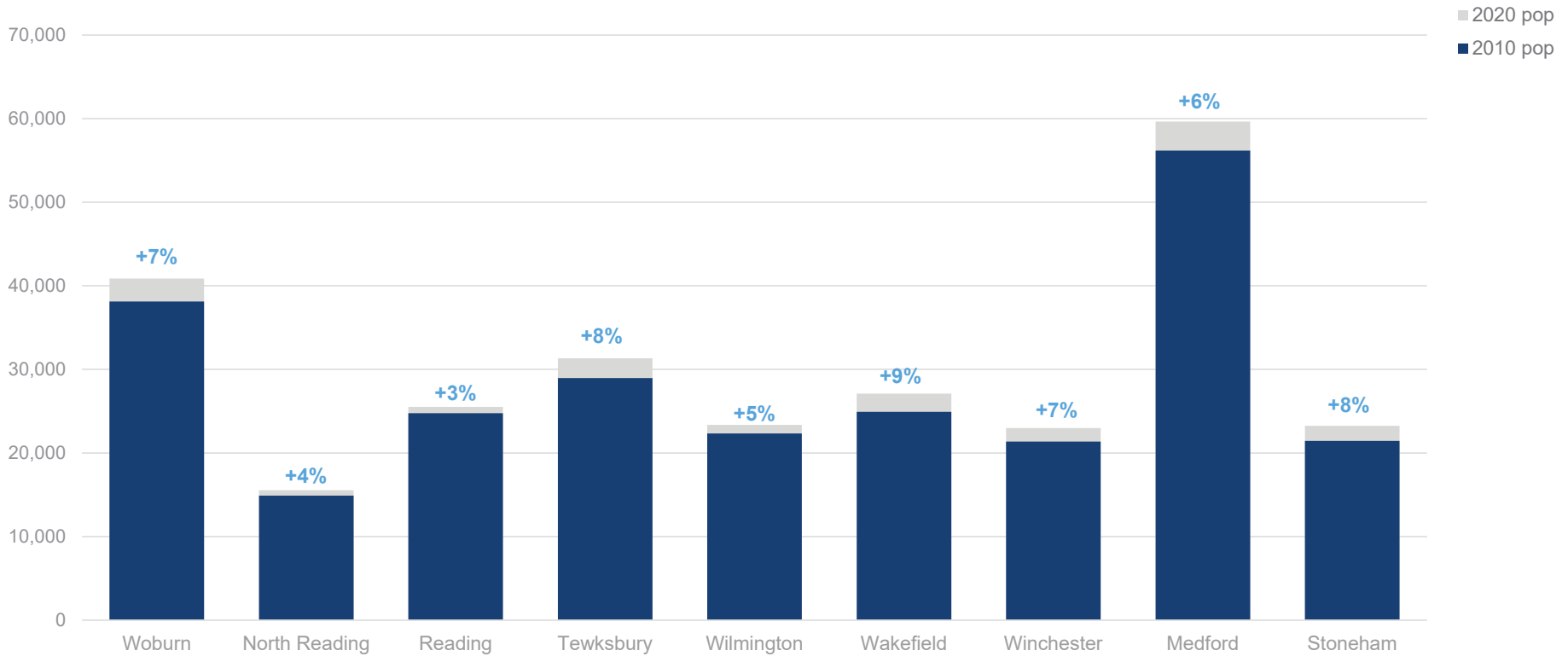
-Boys & Girls Club

-Medford Council on Aging

-Woburn Parents

CHNA Progress

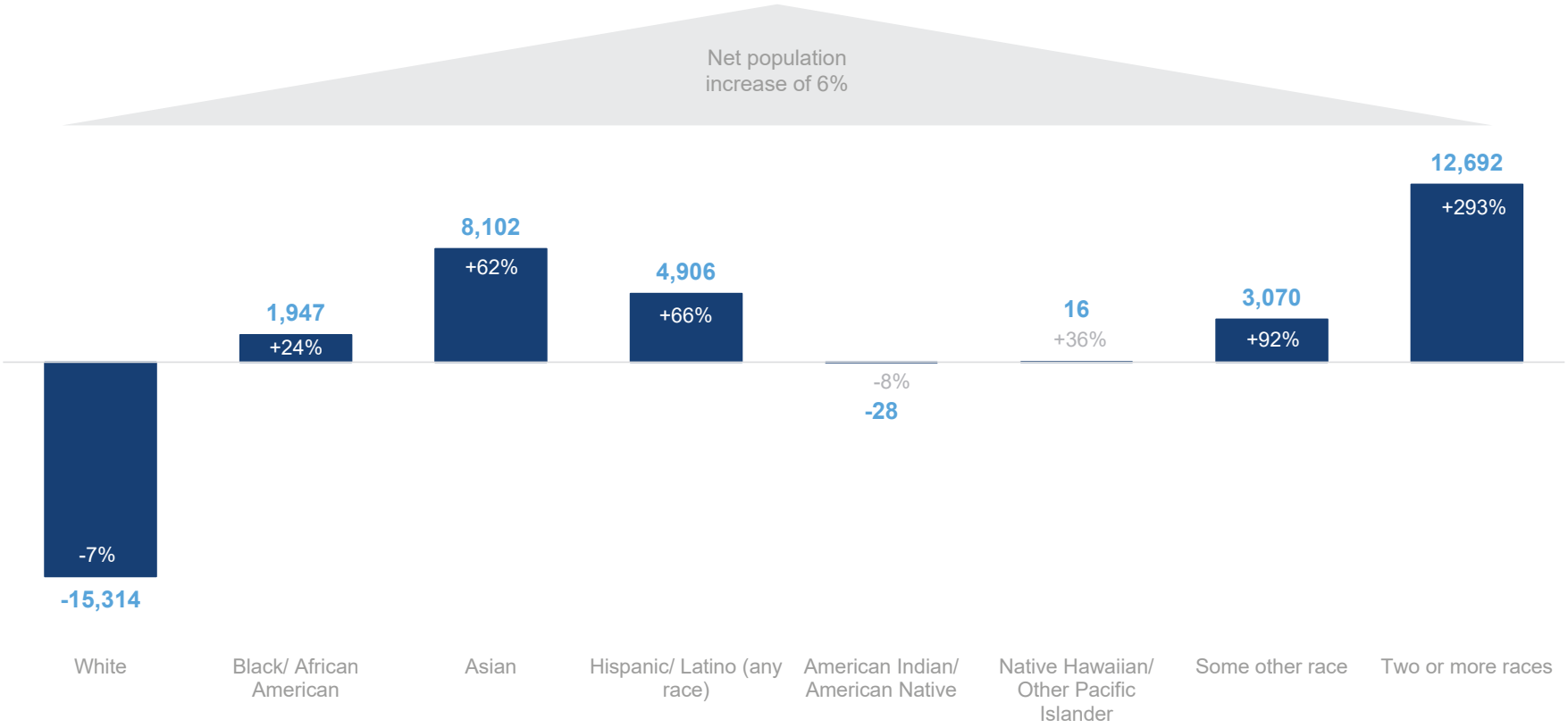
Population Change in Community Benefits Service Area 2010-2020



Source: 2010 & 2020 U.S. Census

CHNA Progress

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



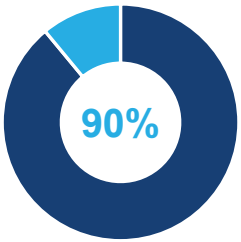
Source: 2010 & 2020 U.S. Census

CHNA Progress
Service Area Strengths

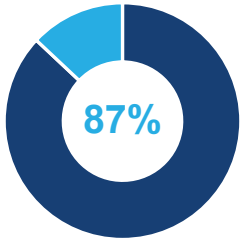
FROM INTERVIEWS & FOCUS GROUPS:

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

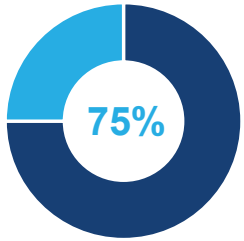
FROM WH COMMUNITY HEALTH SURVEY:



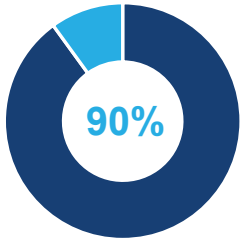
said they were **satisfied with the quality of life** in their community



said the community has **good access to resources**



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



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

CHNA Progress
Key themes

- **Mental health**
- **Social determinants of health**
- **Diversity, equity, inclusion**
- **Access to care**

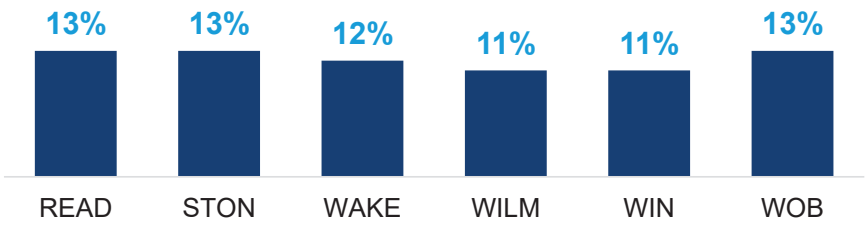
CHNA Progress
Key Themes: Mental Health (Youth)

- 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



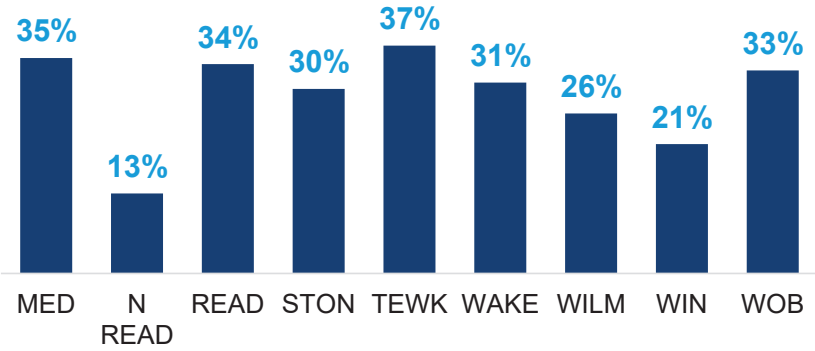
Data Source: Youth Behavior Survey. Data not available in all CBSA communities

CHNA Progress
Key Themes: Mental Health (Adult)

- 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)



Data source: COVID-19 Community Impact Survey, MDPH

**Unweighted percentages displayed*

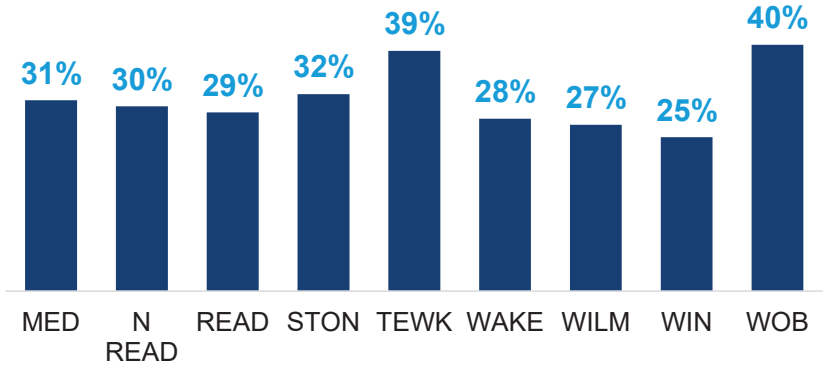
CHNA Progress

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)



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***

Beth Israel Lahey Health

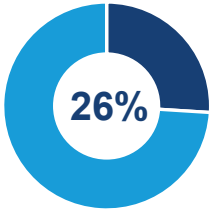
Data source: COVID-19 Community Impact Survey, MDPH
**Unweighted percentages displayed*

CHNA Progress

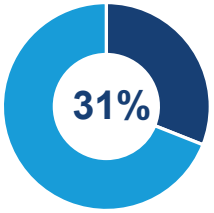
Key Themes: Diversity, Equity, and Inclusion

- 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% agreed that the built, economic, and educational environments in the community are impacted by systemic racism



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

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

Breakout Sessions

Reconvene

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

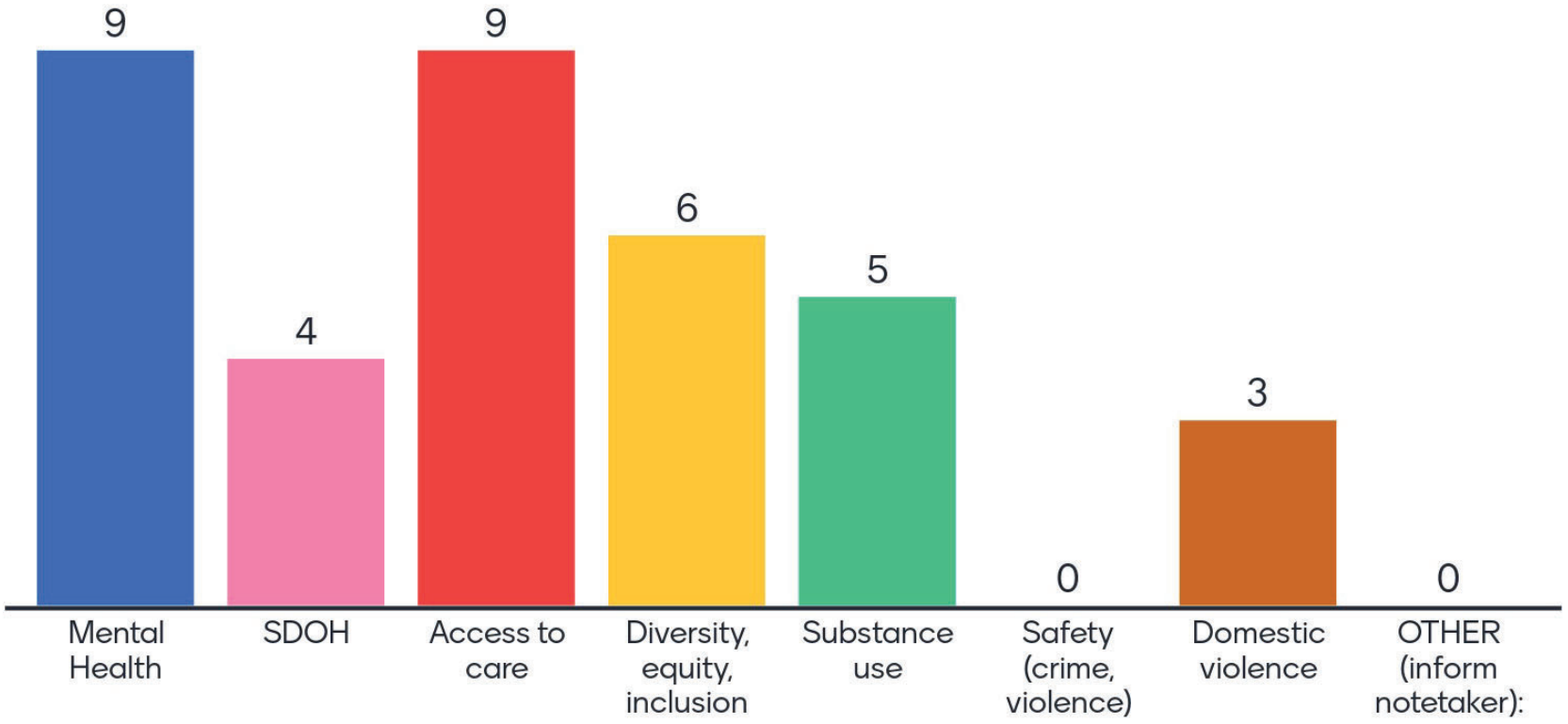
Community Benefits Annual Meeting in June (More info TBD)

Thank you!

Choose your top 4 priority areas.

Mentimeter

Priority vote results from January 26, 2022 Listening Session



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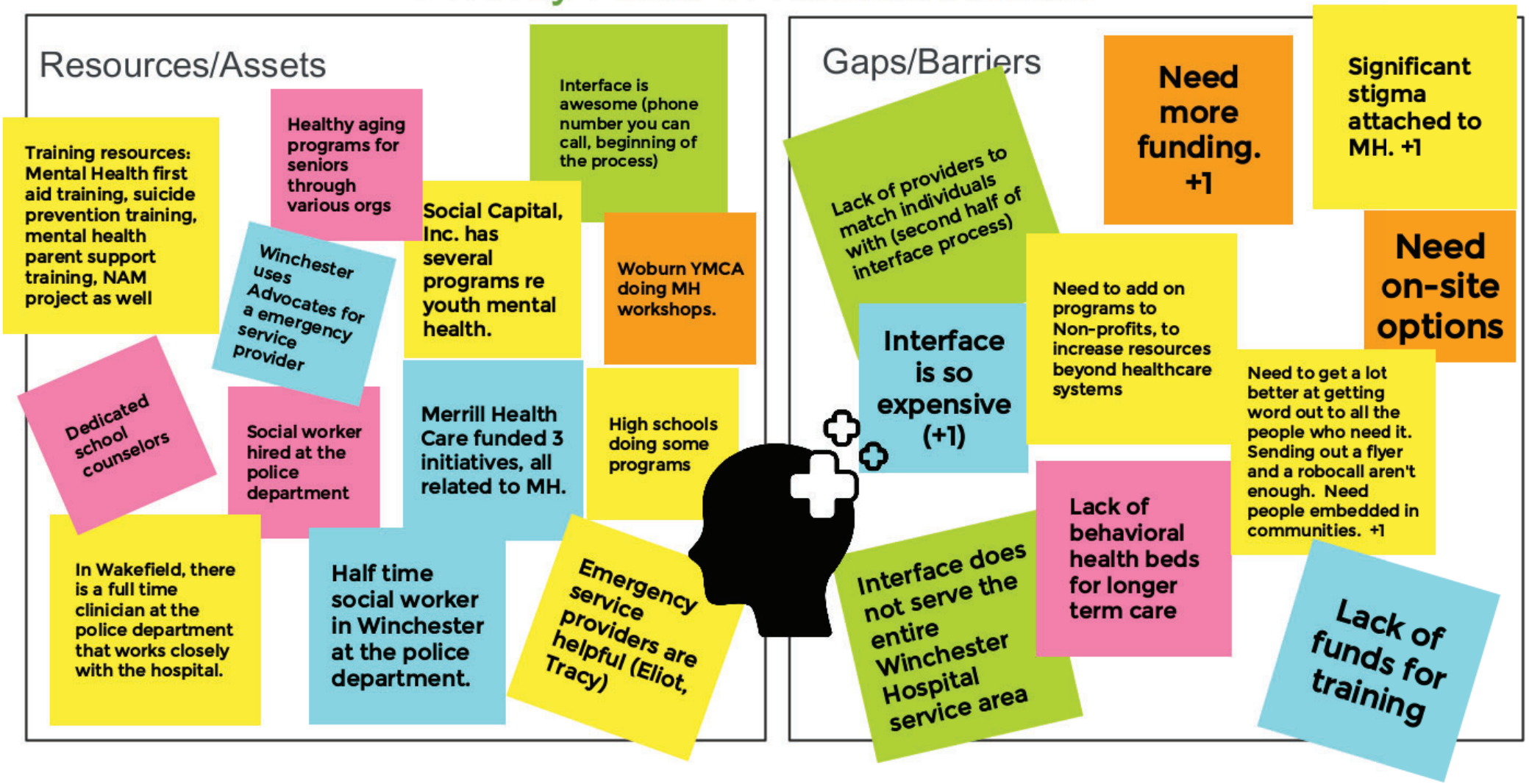
Notes from January 26, 2022 session

Priority Area 1: Mental Health



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

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

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

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

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

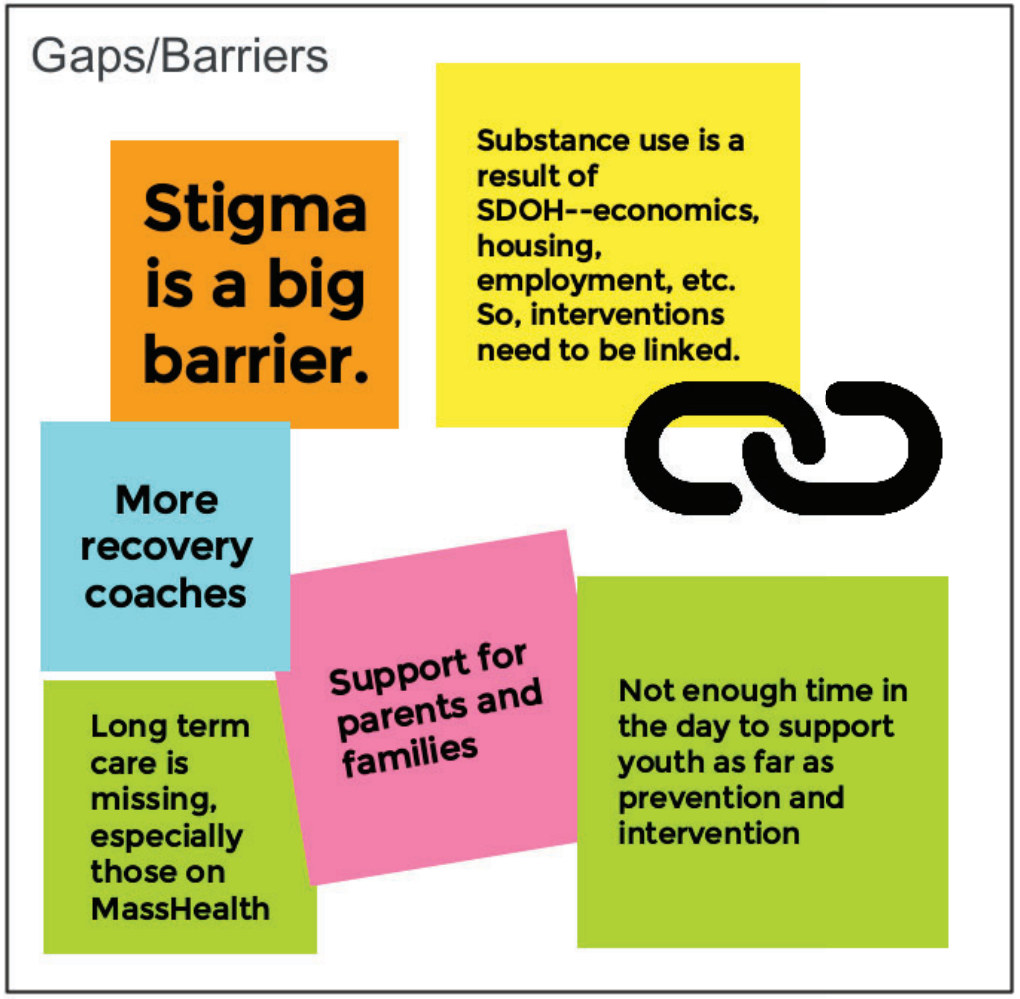
Kids are translating for their parents

leaders are almost all whites; this is extreme barrier to inclusivity. Fire department, police, city hall, senior center, healthcare orgs. Hard to encourage people t 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



Priority Area 5: Other

Resources/Assets

Gaps/Barriers

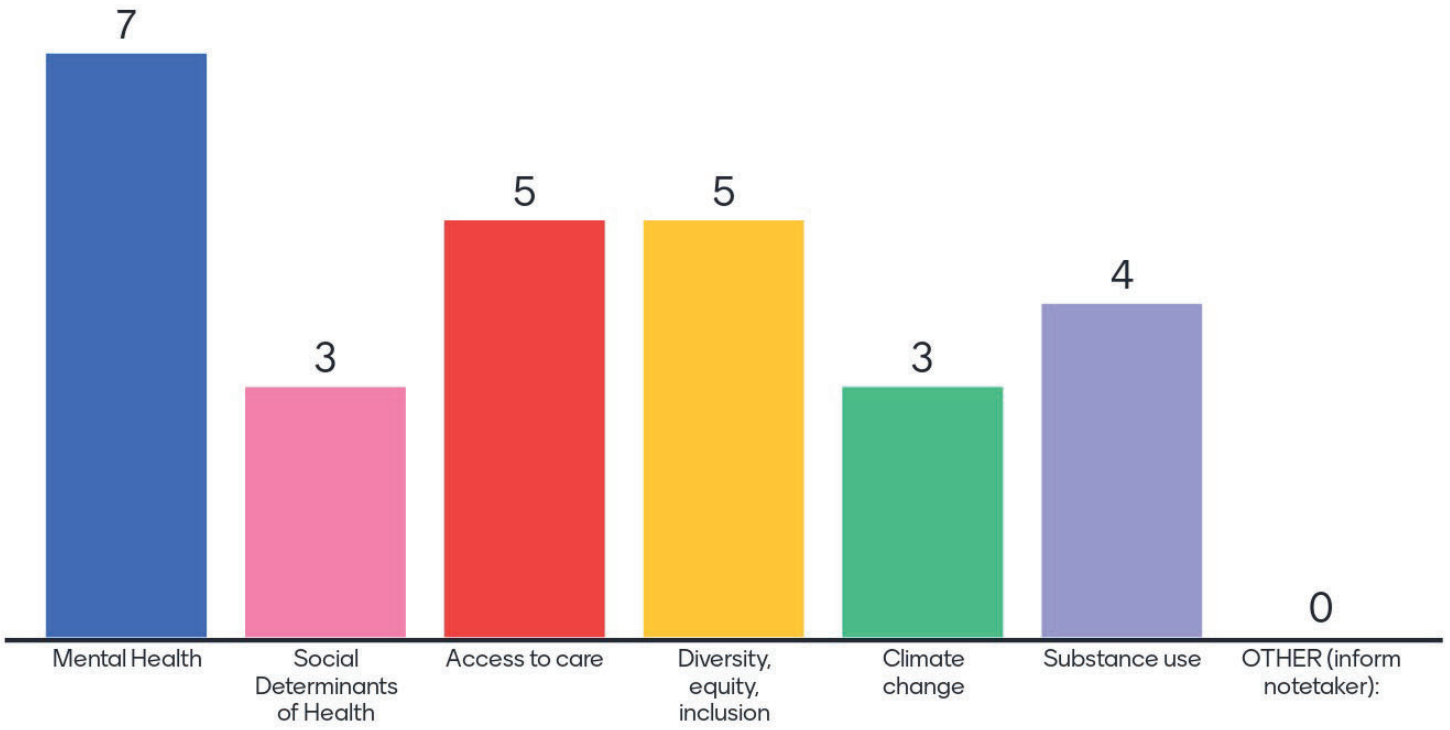
Few programs to address housing needs in area

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

Choose your top 4 priority areas.

Mentimeter

Priority vote results from February 3, 2022 Listening Session



7

Notes from February 3, 2022 session

Priority Area 1: Mental Health

Priority Area 2: Access to Care

Resources/Assets

Gaps/Barriers

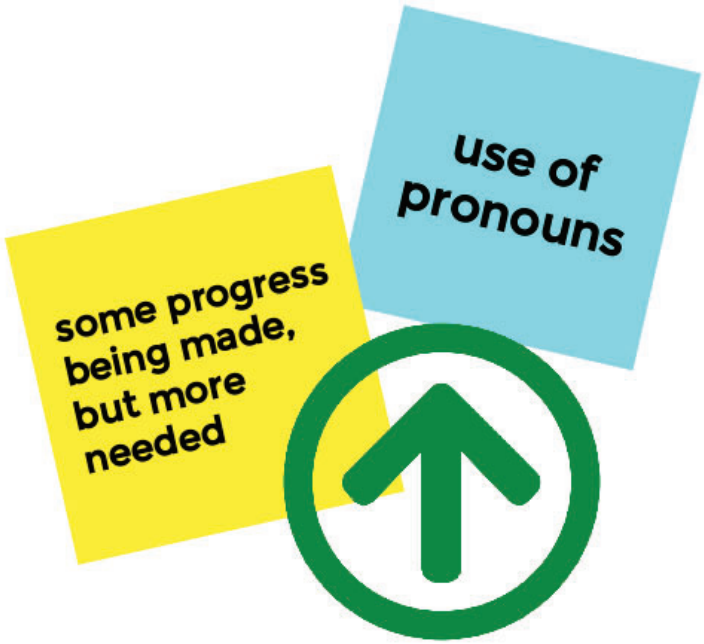
long waiting lists and lack of providers for mental health services

hospitals leading with use of pronouns, cultural humility

language access, an issue for deaf communities

Priority Area 3: Diversity, Equity, Inclusion

Resources/Assets



Gaps/Barriers

intentional partnerships and funding choices

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

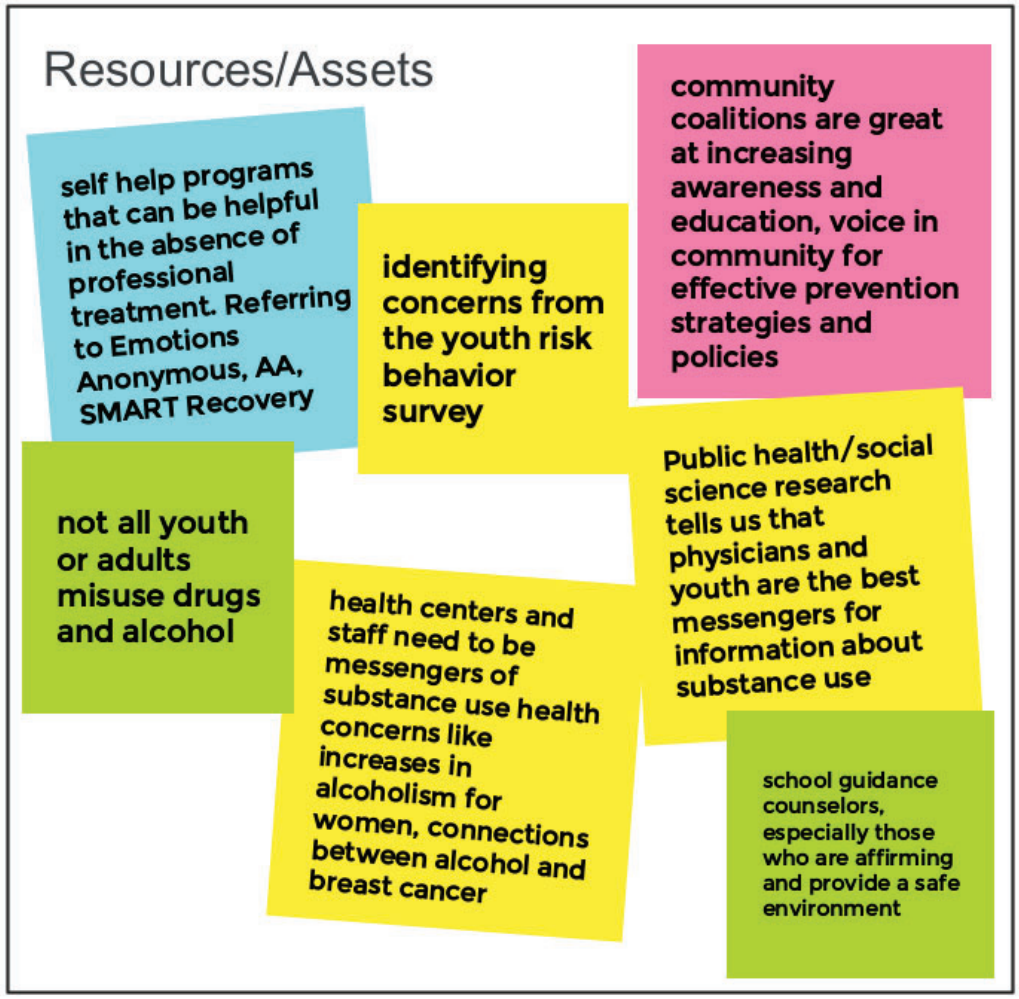
both institutional and relational

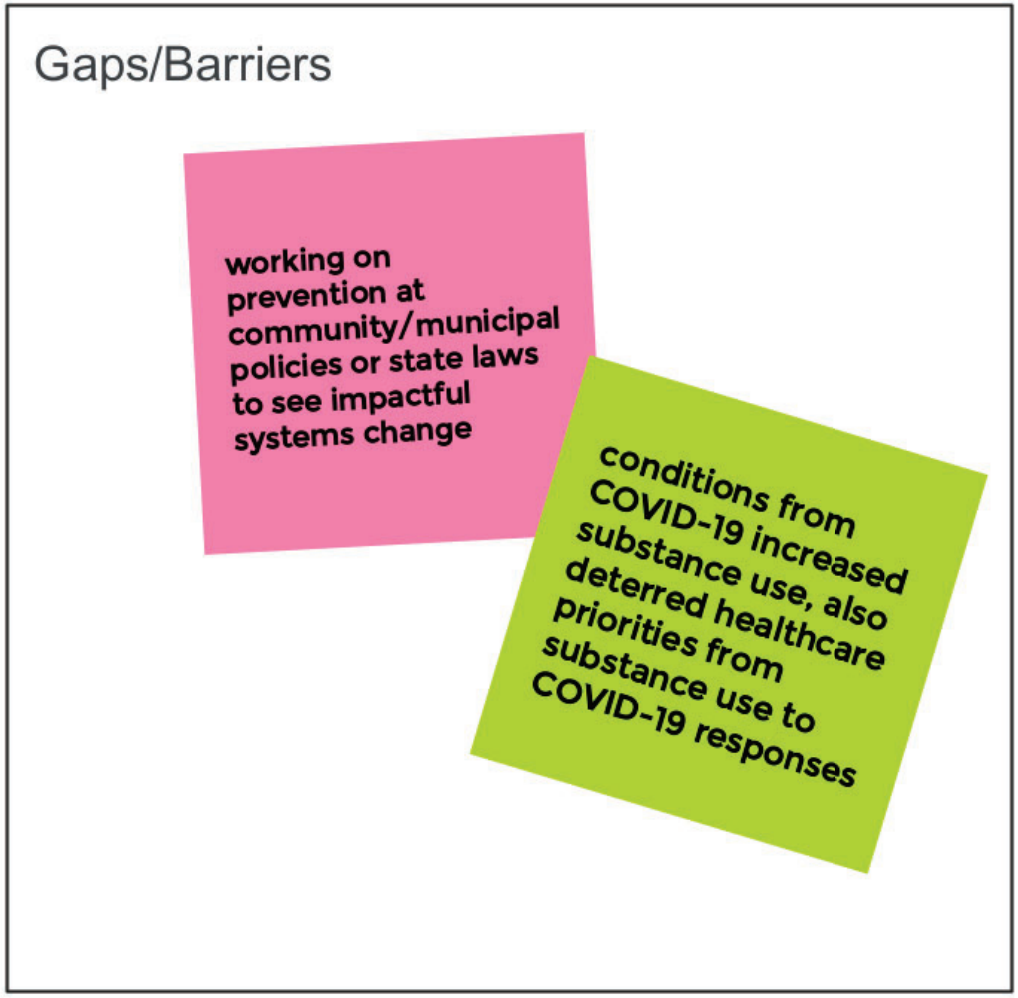
cultural humility

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





Appendix B:
Data Book

Secondary data

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

			Community Benefits Service Area									
	MA	**Middlesex County**	**Medford**	**N. Reading**	**Reading**	**Stoneham**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
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%	

			Community Benefits Service Area									
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
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%	

			Community Benefits Service Area									
	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%	
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	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
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

			Community Benefits Service Area									
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
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%	

			Community Benefits Service Area									
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
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%	

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

			Community Benefits Service Area									
	Massachusetts	Middlesex County	Medford	N. Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
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	-	-	-	-	-	-	-	-	

			Community Benefits Service Area									
	Massachusetts	Middlesex County	Medford	N. Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
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												

			Community Benefits Service Area									
	Massachusetts	**Middlesex County**	**Medford**	**N. Reading**	**Reading**	**Stoneham**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	Source
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: Medford	N. Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
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

		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	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

		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	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 Volume 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

		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	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 Volume 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

Beth Israel Lahey Health

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?
   _____

Beth Israel Lahey Health

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 <u>but were not able to access</u>, 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. Count Row %	20 2.5%	62 7.6%	416 51.0%	291 35.7%	26 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.) Count Row %	19 2.3%	51 6.2%	430 52.6%	305 37.3%	12 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) Count Row %	14 1.7%	25 3.1%	350 42.7%	389 47.5%	41 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) Count Row %	22 2.7%	130 15.9%	401 49.1%	210 25.7%	54 6.6%	817
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). Count Row %	16 2.0%	58 7.1%	423 52.0%	286 35.2%	30 3.7%	813
Totals 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. Count Row %	634 77.5%	167 20.4%	10 1.2%	7 0.9%	818
People like me have access to safe, clean parks and open spaces. Count Row %	614 75.2%	180 22.1%	15 1.8%	7 0.9%	816
People like me have access to reliable transportation. Count Row %	413 50.4%	304 37.1%	61 7.4%	41 5.0%	819
People like me have housing that is safe and good quality. Count Row %	587 71.8%	182 22.3%	24 2.9%	24 2.9%	817
The air in my community is healthy to breathe. Count Row %	586 71.6%	176 21.5%	12 1.5%	44 5.4%	818
The water in my community is safe to drink. Count Row %	502 61.6%	190 23.3%	65 8.0%	58 7.1%	815
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards. Count Row %	281 34.4%	297 36.4%	45 5.5%	194 23.7%	817
During extreme heat, people like me have access to options for staying cool. Count Row %	482 59.1%	203 24.9%	46 5.6%	85 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. Count Row %	498 61.3%	226 27.8%	51 6.3%	38 4.7%	813
Health care in my community meets the mental health needs of people like me. Count Row %	223 27.7%	279 34.6%	154 19.1%	150 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 Count Row %	720 88.1%	35 4.3%	62 7.6%	817
Dental (mouth) care Count Row %	693 85.3%	57 7.0%	62 7.6%	812
Mental health care Count Row %	174 21.5%	107 13.2%	528 65.3%	809
Reproductive health care Count Row %	170 21.1%	21 2.6%	616 76.3%	807
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	34 4.2%	33 4.1%	746 91.8%	813
Treatment for a substance use disorder Count Row %	15 1.9%	12 1.5%	778 96.6%	805
Vision care Count Row %	536 65.9%	51 6.3%	226 27.8%	813
Medication for a chronic illness Count Row %	296 36.7%	14 1.7%	496 61.5%	806
Totals 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	81	22	9	31	5	3	71	222
Count	36.5%	9.9%	4.1%	14.0%	2.3%	1.4%	32.0%	
Row %								
Dental care	79	56	5	23	6	3	51	223
Count	35.4%	25.1%	2.2%	10.3%	2.7%	1.3%	22.9%	
Row %								
Mental health care	31	26	4	24	10	6	138	239
Count	13.0%	10.9%	1.7%	10.0%	4.2%	2.5%	57.7%	
Row %								
Reproductive health care	25	7	4	10	6	5	97	154
Count	16.2%	4.5%	2.6%	6.5%	3.9%	3.2%	63.0%	
Row %								
Emergency care for a mental health crisis, including suicidal thoughts	22	7	2	6	10	3	100	150
Count	14.7%	4.7%	1.3%	4.0%	6.7%	2.0%	66.7%	
Row %								
Treatment for a substance use disorder	21	9	3	5	4	4	89	135
Count	15.6%	6.7%	2.2%	3.7%	3.0%	3.0%	65.9%	
Row %								
Vision care	45	21	6	18	1	2	78	171
Count	26.3%	12.3%	3.5%	10.5%	0.6%	1.2%	45.6%	
Row %								
Medication for a chronic illness	25	12	2	14	2	1	84	140
Count	17.9%	8.6%	1.4%	10.0%	1.4%	0.7%	60.0%	
Row %								

	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. Count Row %	643 84.6%	83 10.9%	28 3.7%	1 0.1%	2 0.3%	3 0.4%	760
You are unfairly stopped, searched, questioned, threatened, or abused by the police. Count Row %	731 94.0%	38 4.9%	5 0.6%	2 0.3%	0 0.0%	2 0.3%	778
You receive worse service than other people at stores, restaurants, or service providers. Count Row %	637 82.2%	75 9.7%	49 6.3%	8 1.0%	4 0.5%	2 0.3%	775
Landlords or realtors refused to rent or sell you an apartment or house. Count Row %	718 94.1%	23 3.0%	14 1.8%	2 0.3%	1 0.1%	5 0.7%	763
Healthcare providers treat you with less respect or provide worse services to you compared to other people. Count Row %	685 89.0%	52 6.8%	24 3.1%	5 0.6%	1 0.1%	3 0.4%	770
Totals 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

Beth Israel Lahey Health

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

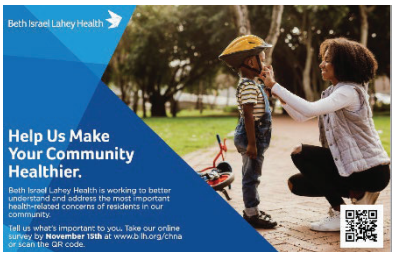
The following print publications were selected based on reach or hyper targeted audiences. Translation was used if the publication publishes in languages other than English.

A. El Mundo – Spanish Translation

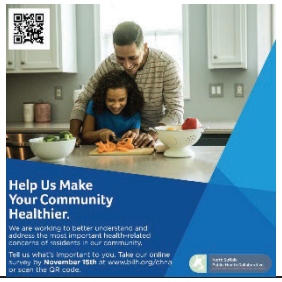
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

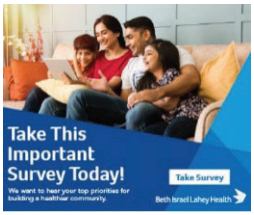
D. Bay State Banner – Black/African American, Cape Verdean/English



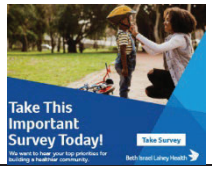
E. Chelsea Record – Hispanic/English



F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



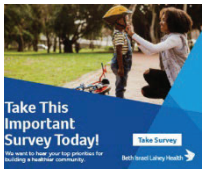
For the printed newspapers the publish dates are as follows:

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

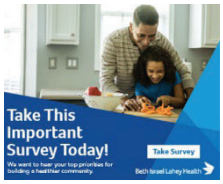
2. Digital Advertising

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.

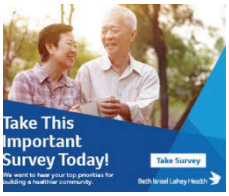
A. African American/Black, Haitian, Cape Verdean



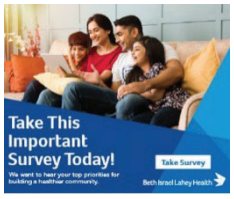
B. Hispanic



C. Chinese



D. Indian



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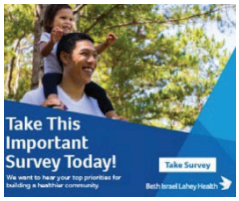


C. Precision Audio

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 Driector
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 Driector
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

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	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 -Individuals with chronic/complex conditions -Low-resource individuals and families -Youth and adolescents	-Reduce isolation and depression -Reduce environmental risk factors associated with developing mental health issues -Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners	-Organize and support initiatives that increase opportunities for social engagement -Organize and support initiatives that reduce environmental risk factors associated with developing mental health issues -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. -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. -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. -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 -Individuals with chronic/complex conditions --Low-resource individuals and families -Youth and adolescents	-Increase awareness of the impacts and risk factors for developing substance use disorders -Increase awareness of the signs, symptoms, risks, and stigma of developing mental health issues and promote access to treatment -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. -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 -Enhance access to integrated behavioral health services -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. -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. -The Collaborative Care Model led to mental health integration and direct care across 6 primary care sites, now serving over 1,300 patients. -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 -Individuals with chronic/complex conditions -Low-resource individuals and families -Youth and adolescents	-Create awareness of/educate community members about the preventable risk factors associated with chronic and complex health conditions -Help community members detect chronic disease and provide linkages to associated services -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 -Organize and support health screenings in clinical or nonclinical settings to detect chronic conditions and refer to and coordinate care. -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. -Lab Services provided more than 10,000 free blood draws for homebound patients. -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. T-he Chronic Disease Management program supported 72 adults with chronic diseases to help them better manage their health and overall quality of life. -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. -In FY 2020, a monthly average of 85 people participated in the weight management program. -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. -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 -Individuals with chronic/complex conditions -Low-resource individuals and families -Youth and adolescents	-Educate individuals about achieving a healthy diet -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 -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. -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 -Individuals with chronic/complex conditions -Low-resource individuals and families -Youth and adolescents	-Increase access to affordable and safe transportation options -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 -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. -Provide counseling, support, and referral services to community members to enroll and remain in appropriate programs. -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. -The hospital provided free taxi rides to medical appointments for an average of 100 low-income patients per year. -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. -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.

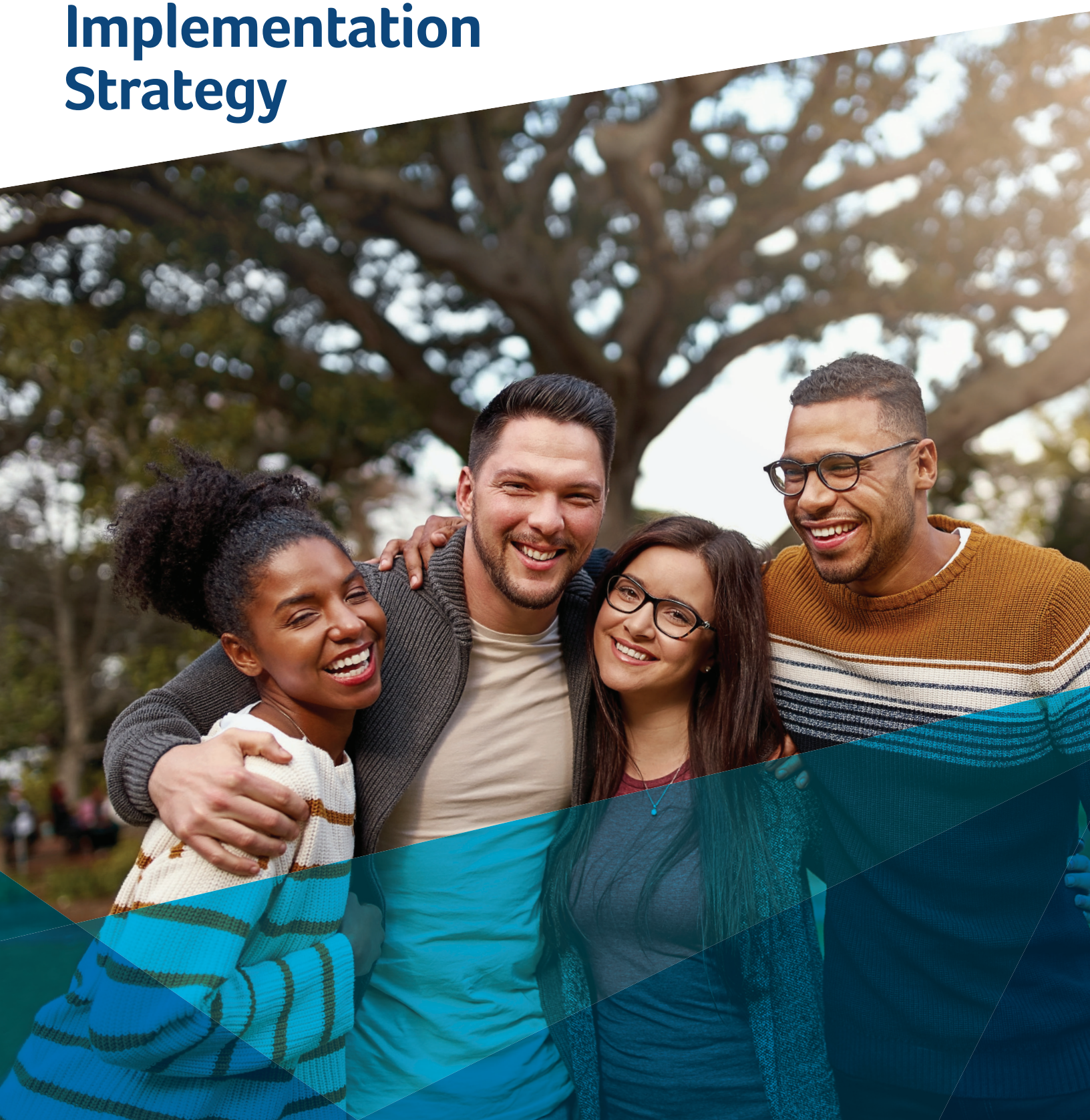
Goal 1: Address social determinants of health and barriers to care			
Population	Objectives	Activities	Progress, Outcomes, and Impact
-Older adults -Individuals with chronic/complex conditions -Low-resource individuals and families -Youth and adolescents	-Explore ways to reduce/address housing instability -Increase access to clinical services for homebound patients -Increase access to affordable and nutritious foods and affordable physical activity -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. -Provide or support programs that enhance access to clinical services -Organize and support programs that provide access to free or low-cost healthy foods and physical activity. -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. -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. -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. -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. -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. -15 Healing Yoga classes were offered to cancer patients in treatment or recovery, reaching 40 participants. -550 couples completed the free Winchester Hospital Breastfeeding Classes. -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

FY23-FY25 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. 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

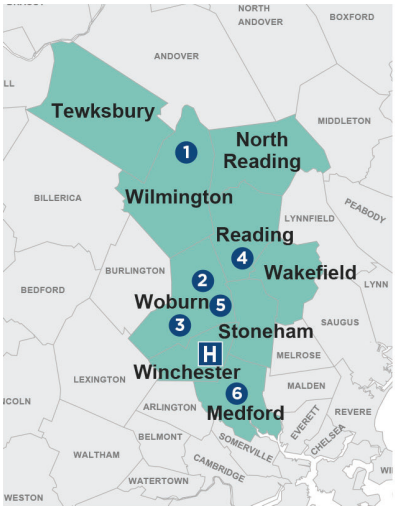
WH's CBSA includes the nine municipalities of Medford, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn located in northwest suburban Boston, Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics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

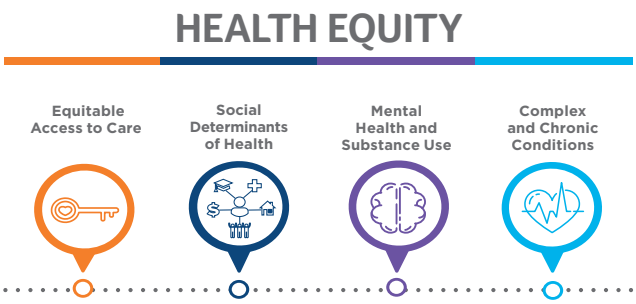
Low-Resourced Populations

Older Adults

Racially, Ethnically and Linguistically Diverse Populations

LGBTQIA+

WH Community Health Priority Areas



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 • Racially, ethnically, and linguistically diverse populations	• Patient financial counselors • Home Blood Draw program • Serving the Health Insurance Needs of Everyone (SHINE) Program • Primary Care Support	• # patients and clients assisted and their demographics • # referrals to services • participant responses to Social Determinants of Health Screening tool	• Minuteman Senior Services • BILH Primary Care	Economic stability
Promote equitable care, health equity, health literacy for patients, especially those who face cultural and linguistic barriers.	• Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Interpreter Services	• # of patients assisted • # of languages provided	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 • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Medical appointment transportation voucher program • Jenks Center transportation program	• # patients assisted • # rides provided	• Woburn Checker Cab • Jenks Center	Transportation
Provide and promote career support services and career mobility programs to hospital employees.	WH employees	• Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes	• # of employees who participated	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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Council of Social Concern food pantry program • Woburn Public Schools Backpack Food Program • Winchester Housing Authority free farmer's market • Farmer's market SNAP Gap matching funds and programs • Winchester Hospital Meals on Wheels Program	• # clients assisted and their demographics • # pounds of food served • # of residents reached • # of meals prepared	• Council of Social Concern • Woburn Public School System • Winchester Housing Authority • Area Farmer's Markets • City of Medford • Jenks Center • Local Councils on Aging • 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 • # of referrals made • # 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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Provide community grants to address emerging needs	• # of grantees • Length of grant period • # of new partnerships established • $ amount invested • Grant outcomes	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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Network for Social Justice Housing Coalition • Medford Food Policy Council • Middlesex Regional Food Security Coalition	• Hospital representation on community coalitions • Support of coalition-sponsored policy, system, and environmental changes • # of policies considered • # of policies adopted	• Network for Social Justice • City of Medford • 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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	School-based mental health and substance use prevention programs and after school youth programs	• # participating students • 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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	Screening, Brief Intervention, Referral to Treatment (SBIRT) & Question, Persuade, Refer (QPR) programs at Boys and Girls Club of Stoneham & Wakefield	• # staff trained • # referrals made • # youth matched to treatment • # 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 • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Centralized Bed Management • Detoxification Services • Behavioral Health Emergency Department technicians • BILH Collaborative Care Model • Mobile Mental Health Clinic • Mystic Valley Elder Services (MVES) •	• # of patients served • # of therapy sessions • # of integrated behavioral health consultations • # of practices	• Winchester affiliated primary care practices • Winchester Emergency Department • BILH Behavioral Health Services • 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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Healing and Recovering Together (HART) House Tewksbury • Transitional Support Services - Tewksbury • Town of Winchester social worker • Council on Aging programs for older adults mental health promotion and substance use prevention • Interface Referral Service – Winchester and Stoneham • Provide community health grants to address this need	• # participants and their demographics • # of referrals made • Self-reported changes in mood and behavior • # of police officers who complete 40-hour Crisis Intervention Training • Top reasons for referral • Caller demographics • Amount awarded • # of grantees • Length of grant period • # of new partnerships established	• HART House • Local Councils on Aging • Town of Winchester • 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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Mystic Valley Public Health Committee • Mystic Valley Behavioral Health Coalition • Middlesex District Attorney (DA) Opioid Task Force • Local substance use prevention coalitions	• Hospital participation in coalition meetings • Support of coalition-sponsored policy, system, and environmental changes • # of new partnerships established • # of policies considered • # of policies adopted • Programs offered	• Mystic Valley Public Health Committee staff lead, based in Medford Public Health Department • Tufts Medicine • Melrose Wakefield Hospital • 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 • Racially, ethnically, and linguistically diverse populations • LGBTQIA+ • Youth	• Breast Cancer Risk Assessment • Oncology Nurse Navigator • Center for Healthy Living Health Education Programs • CHAMP Pediatric Asthma program • Fighting Fatigue Program • A Caring Place wig donation program • Mount Vernon House Resident Health Program • Patient support groups	• # clients assisted and their demographics • changes in health status • self-reported changes in knowledge and behavior • # of support group meetings • # of support group participants • Staff time	• Winchester Hospital Center for Healthy Living • Mount Vernon House • 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 • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Integrative Therapies for Cancer Patients • Outpatient Lactation Program • Diabetes Management Program monthly clinic	• # clients assisted and their demographics • Changes in health status • Self-reported changes in knowledge and behavior	• Winchester Hospital Center for Healthy Living • Mount Vernon House	Equitable Access to Care

General Regulatory Information

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

Beth Israel Lahey Health
Winchester Hospital