Beth Israel Lahey Health
Winchester Hospital

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for Winchester Hospital (WH) is the culmination of a collaborative process that began in June 2024. 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 stakeholders 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 historically underserved populations.

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 a community listening session. This assessment and planning work 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.

Winchester Hospital Community Benefits Senior Leadership Team 2025

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Catherine Robertson, Vice President of Ambulatory Services

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Introduction

Background

Winchester Hospital (WH) is a leading regional provider of comprehensive healthcare services in northwest suburban Boston. The hospital has 229 licensed inpatient beds with more than 2,400 employees and over 850 clinicians on active medical staff. Winchester Hospital offers acute care inpatient services and an extensive range of outpatient services that includes integrated home care. The hospital provides care in major clinical areas, including surgery, pediatrics, cancer care, obstetrics and gynecology, and newborn care.

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 2025 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 WH's success now and in the future. The assessment engaged more than 1,400 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, 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 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 2022 and the report, along with the associated 2023-2025 IS, was approved by the WH Board of Trustees on September 13, 2022. The 2022 CHNA report was posted on WH's website before September 30, 2022 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 June 2024 and September 2025 and WH's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 9, 2025.

Definition of Community Served

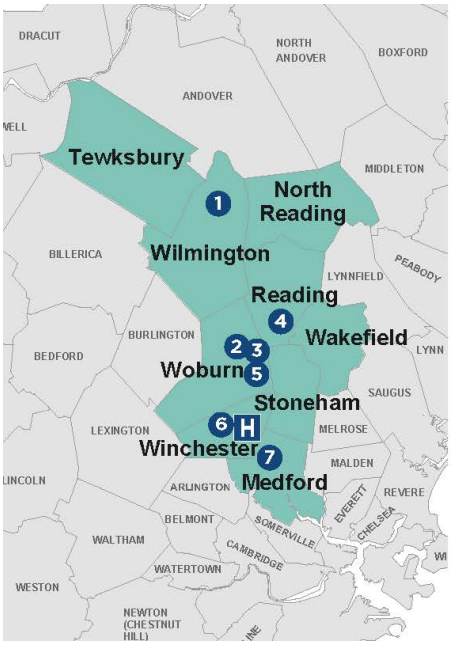
The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within WH's CBSA.

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. 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 the 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.



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
- 2 Winchester Hospital Sleep Disorder Center
- 3 Winchester Hospital Rehabilitation Services
- 4 Winchester Hospital Rehabilitation Services at Reading Health Center
- 5 Winchester Hospital Outpatient Center
- 6 Winchester Hospital Pain Management Center
- 6 Ambulatory Surgery Center
- 6 Radiation Oncology Center
- 7 Wound Healing Center

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 most of its community benefits activities to improve the health status of those who face health disparities, experience poverty, or 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 the hospital'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 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.

The CHNA and IS development process was guided by the following principles: equity, accountability, community engagement, and impact.

Equity:

Apply an equity lens to achieve fair and just treatment so that all communities and people can achieve their full health and overall potential.

Accountability:

Hold each other to efficient, effective and accurate processes to achieve our system, department and communities' collective goals.

Community Engagement:

Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

Impact:

Employ evidence-based and evidence-informed strategies that align with system and community priorities to drive measurable change in health outcomes.

The assessment and planning process was conducted between June 2024 and September 2025 in three phases:

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 a community listening session to present and prioritize findings	Presentation to hospital's Board of Trustees
Preliminary analysis of key themes	Compilation of resource inventory	Distribution of results via hospital website

In April of 2024, BILH hired JSI Research & Training Institute, 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, language spoken, national origin, religion, gender identity, sexual orientation, 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	MDPH Community Health Equity 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 as well as ensures that there is a direct link between the hospital and many of the community's leading health and community-based organizations. The CBAC meets quarterly to support WH's community benefits work and met five times during the course of the assessment. 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 in 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 also 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 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 and 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 June 2024 and February 2025, WH conducted 16 one-on-one or group interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,300 residents, and organized a community listening session. In total, the assessment process collected information from nearly 1,500 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 copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

16 interviews
with community leaders

1,388 survey respondents

5 focus groups

- Youth
- Older adults
- Men of color
- Chinese older adults
- Medford Community Liaisons

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across a 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 includes a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify available community resources in the CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

The WH CBAC was engaged at the outset of the strategic planning and reporting phase of the project. The CBAC was updated on assessment progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in a prioritization process using a set of 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 WH developed its IS.

After prioritization with the CBAC, a community listening session was 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. Using the same set of anonymous polls, community listening session participants were asked to prioritize the issues that they believed were most important. The session also allowed participants to share their ideas on existing community strengths and assets, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the prioritization process, a CHNA report was developed and WH's existing IS was augmented, revised, and tailored. When developing the IS, WH's Community Benefits staff retained community health initiatives that worked well and aligned with the priorities from the 2025 CHNA.

After drafts of the CHNA report and IS were developed, they were shared with WH's senior leadership team for input and comment. The hospital's Community Benefits staff then reviewed these inputs and incorporated elements, as appropriate, before the final 2025 CHNA Report and 2026-2028 IS were submitted to WH's Board of Trustees for approval.

After the Board of Trustees formally approved the 2025 CHNA report and adopted 2026-2028 IS, these documents were posted on WH's website, alongside the 2022 CHNA report and 2023-2025 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 the hospital'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 2025 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 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, community listening session prioritization, 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 segments 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.

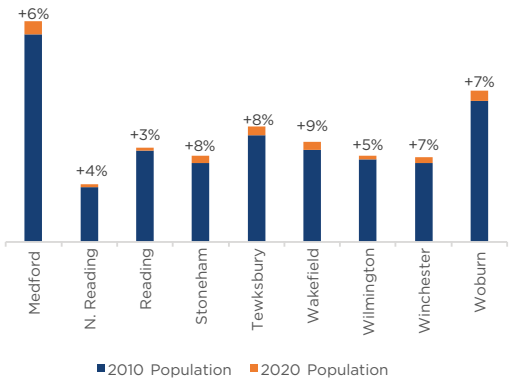
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the WH CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were people of color, individuals who speak a language other than English, and foreign-born populations in all communities. Interviewees and focus group participants reported that these populations faced systemic challenges that limited their ability to access health care services. Some segments of the population were impacted by language and cultural barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have led to 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 community or municipal level. Research shows that those who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning experience health disparities and challenges accessing services.[2]

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



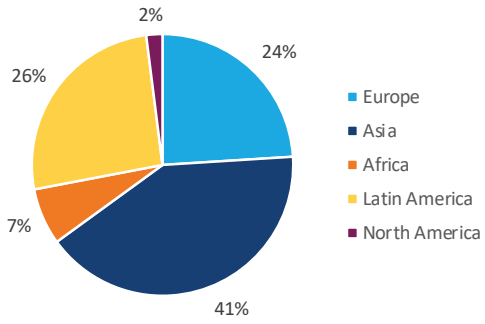
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

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.[3]

15% of the WH CBSA population was foreign born.

Region of Origin Among Foreign-Born Residents in the CBSA, 2019-2023



Source: US Census Bureau American Community Survey, 2019-2023

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.[4]

19% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

32% speak English less than "very well."

Source: US Census Bureau American Community Survey, 2019-2023

Age

Age is a fundamental factor to consider when assessing individual and community health status. Older adults are at a higher risk of experiencing physical and mental health challenges and are more likely to rely on immediate and community resources for support compared to young people.[5]

17%

of residents in the CBSA are 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.

19%

of residents in the CBSA are under 18 years of age.

Source: US Census Bureau American Community Survey, 2019-2023

Gender Identity and Sexual Orientation

Massachusetts has the tenth largest percentage of lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA+) adults, by state. LGBTQIA+ individuals face issues of disproportionate violence, socioeconomic inequality and health disparities.[6]

7%

of adults in Massachusetts identify as LGBTQIA+

Source: Gallup/Wiliams, 2023

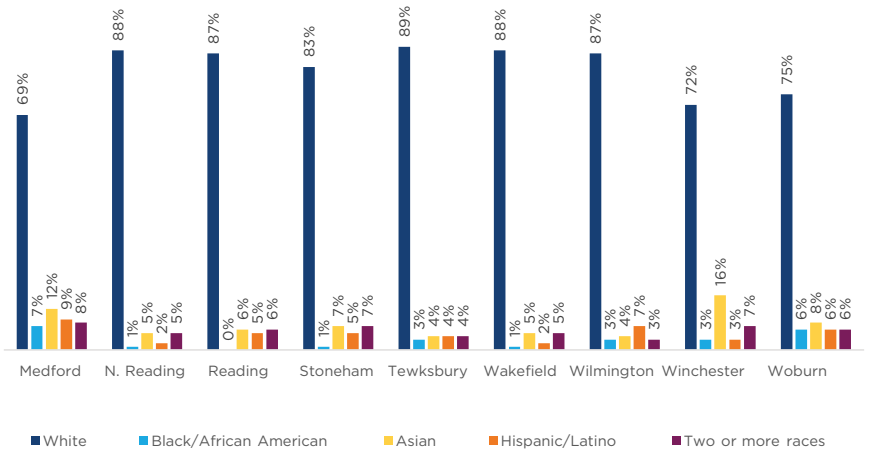
21% of LGBTQIA+ adults in Massachusetts are raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

WH's CBSA is diverse. Compared to the Commonwealth overall, the percentage of residents who identify as Asian is significantly higher than the Commonwealth in Medford, Reading, Wakefield, Wilmington, and Woburn. The percentage of residents who identify as two or more races is significantly higher than the Commonwealth in Woburn.

Race/Ethnicity by Municipality, 2019-2023



Source: US Census Bureau American Community Survey, 2019-2023

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.[7]

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

31% of WH CBSA households included one or more people over 65 years of age.

Source: US Census Bureau American Community Survey, 2019-2023

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 quality of life for many segments of the population in WH's 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.[8]

Information gathered through interviews, focus groups, the listening session, and the 2025 WH Community Health Survey reinforced that these issues impact health status and access to care in the region - especially issues related to housing, economic insecurity, food insecurity/nutrition, transportation, and language and cultural barriers to services.

Interviewees, focus groups, and listening session participants reported that housing costs were having a widespread impact across nearly all segments of the CBSA population. These effects were particularly pronounced for older adults and those living on fixed incomes, who faced heightened economic insecurity. Even individuals and families in middle and upper-middle income brackets reported experiencing financial strain due to the high cost of housing.

Lack of access to affordable healthy foods was identified as a challenge, especially for individuals and families under economic strain. Factors such as job loss, difficulty finding livable-wage employment, or reliance on inadequate fixed incomes all contribute to food insecurity, making it harder for people to afford healthy diets. Interviewees, focus group, and listening session participants emphasized that living costs continue to rise at a faster pace than wages, exacerbating the financial burden on households.

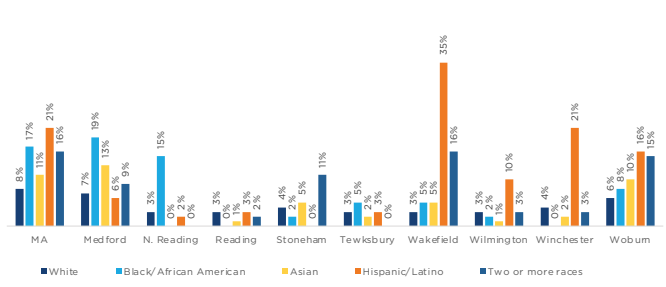
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

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.[9] Lower-than-average life expectancy is highly correlated with low-income status.[10] 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.[11]

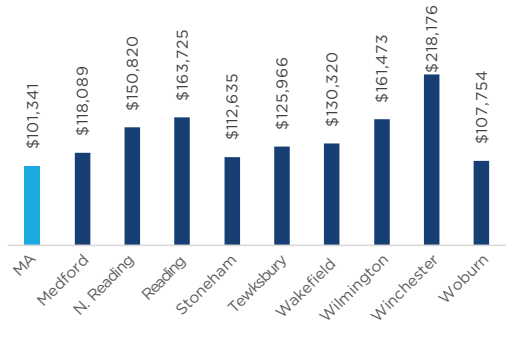
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains essential for meeting basic needs and preventing further economic insecurity.

Percentage of Residents Living Below the Poverty Level, 2019-2023



Source: US Census Bureau American Community Survey, 2019-2023

Median Household Income, 2019-2023

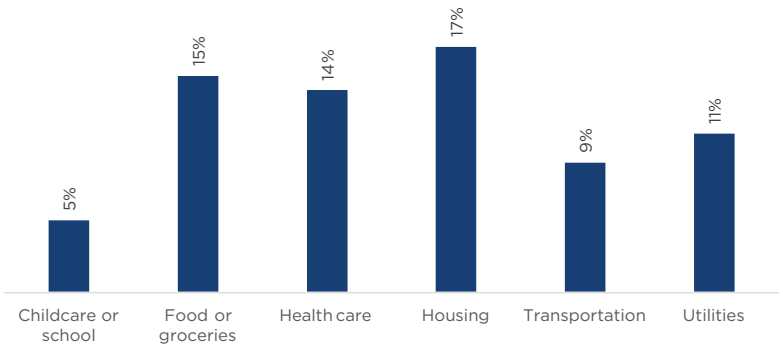


Source: US Census Bureau American Community Survey, 2019-2023

Across the WH 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 cumulative disadvantage over time.[12] 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 in all CBSA communities.

In the 2025 WH Community Health Survey, survey respondents reported trouble paying or certain expenses in the past 12 months. Costs associated with housing, health care, and food/groceries emerged as most problematic among survey respondents.

Percentage Who Had Trouble Paying for Expenses in the Past 12 Months



Source: 2025 WH Community Health Survey

Education

Research shows that those with more education live longer, healthier lives. Patients with a higher level 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.[13]

95% of CBSA residents 25 years of age and older have a high school degree or higher.

55% of CBSA residents 25 years of age and older have a Bachelor's degree or higher.

Source: US Census Bureau, American Community Survey, 2019-2023

Social Determinants of Health

Food Insecurity and Nutrition

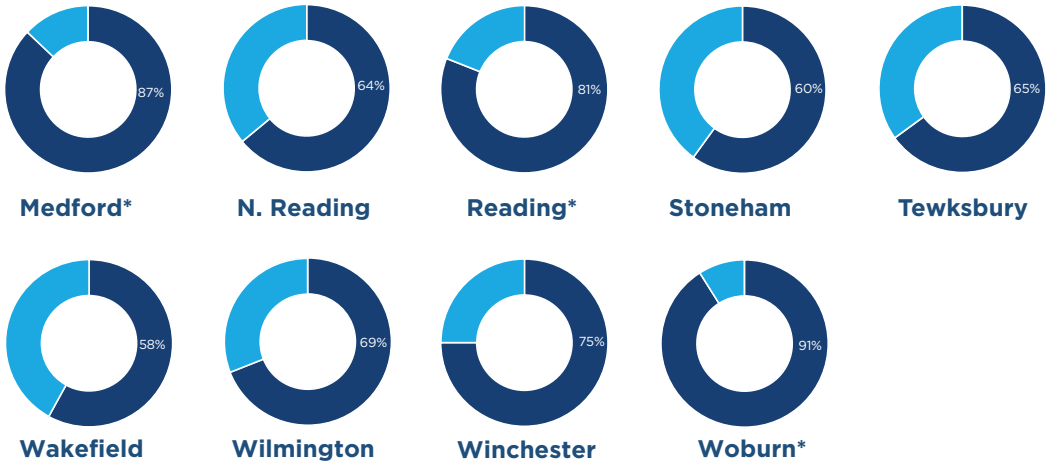
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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, older adults living on fixed incomes, and people living with disabilities and/or chronic health conditions.

6%

of CBSA households received Supplemental Nutrition Assistance Program (SNAP) benefits within the past year. SNAP provides benefits to low-income families to help purchase healthy foods. The data below shows the percentage of residents who are eligible for SNAP benefits but not enrolled, highlighting a gap in food assistance access that may reflect barriers related to awareness, enrollment processes, or other inequities.

Percentage of Residents Who Are Likely Eligible for SNAP but Aren't Receiving Benefits, 2023



*Percentage shown is an average of the percentages across all zip codes in the municipality

Source: The Food Bank of Western Massachusetts and the Massachusetts Law Reform Institute

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.[14]

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. 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.[15]

Interviewees, focus groups, and 2025 WH Community Health Survey respondents expressed concern over the limited options for affordable housing throughout the CBSA.

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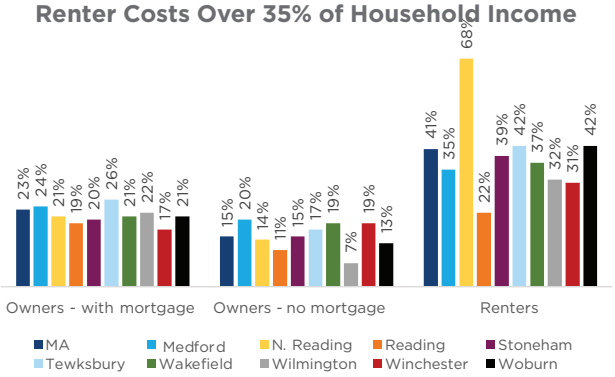
The percentage of owner-occupied housing units with housing costs in excess of 35% of household income was lower than the Commonwealth in most municipalities. Among renters, percentages were higher than the Commonwealth in North Reading, Tewksbury, and Woburn.

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



Source: US Census Bureau American Community Survey, 2019-2023

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

45% of 2025 WH Community Health Survey respondents said "more affordable housing."

17% of 2025 WH Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 WH Community Health Survey

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 basic resources. 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 may no longer drive or who don't have family or caregivers nearby.

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

31% of 2025 WH Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 WH Community Health Survey

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

Source: US Census Bureau American Community Survey, 2019-2023

Roads/Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety and increased mobility. Sidewalks and bike lanes 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 2025 WH Community Health Survey prioritized these improvements to the built environment.

34% of 2025 WH Community Health Survey respondents identified a need for better roads.

38% of 2025 WH Community Health Survey respondents identified a need for better sidewalks and trails.

Source: 2025 WH Community Health Survey

Systemic Factors

In the context of the health care system, systemic factors include a broad range of different considerations that influence a person's ability to access timely, equitable, accessible, and high quality services. There is a growing appreciation for the importance of these factors as they are seen as 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.

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of color, people whose first language is not English, foreign-born individuals, people living 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 long wait-times, language and cultural barriers, and navigating a complex health care system. This was true with respect to primary care, behavioral health, and medical specialty care.

Interviewees, focus groups, and listening session participants also reflected on the high costs of care, including prescription medications, particularly for those who were uninsured or who had limited health insurance benefits.

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 ways in which the system did or did not function. System-level issues included full provider panels, which prevented providers from 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]

> "Some folks just don't have the resources to access the care they need. A lot of older adults don't have a phone. There's a digital divide. What if you are poor, or homeless, and your phone gets cut off?"
>
> -Interviewee

Populations facing barriers and disparities

- Low-resourced individuals
- Racially, ethnically, and linguistically diverse populations
- Individuals living with disabilities
- Older adults
- Youth
- LGBTQIA+

Community Connections and Information Sharing

A great strength of the WH CBSA were the strong community-based organizations and task forces that worked to meet the needs of CBSA residents. However, interviewees, focus groups, and listening session participants reported that community-based organizations sometimes worked in silos, and there was a need for more partnership, information sharing, and leveraging of resources between organizations. Interviewees and focus group participants also reported that it was difficult for some community members to know what resources were available to them, and how to access them.

"Coming out of the pandemic, we've learned that there is strength in numbers. The more brain power and resources we can gather around a table, the more likely we are able to address issues."

-Interviewee

Behavioral Factors

The nation, including the residents of Massachusetts and WH's CBSA, 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). The leading behavioral risk factors include an unhealthy diet, physical inactivity and tobacco, alcohol, and marijuana use.[17]

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 previously. 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 also asked to identify the health issues that they felt were most important. The information from the assessment supports 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.[18] Access to affordable healthy foods is essential to a healthy diet.

19% of 2025 WH Community Health Survey respondents said they would like. their community to have better access to healthy food.

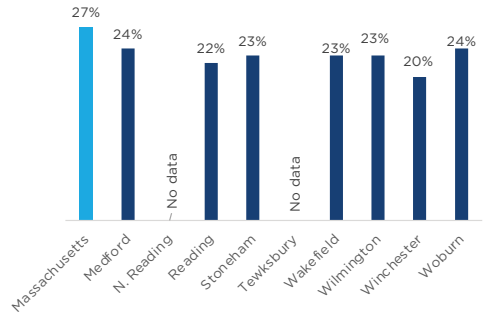
Source: 2025 WH Community Health Survey

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the WH 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 CBSA municipalities.

Percentage of Adults Who are Obese, 2022



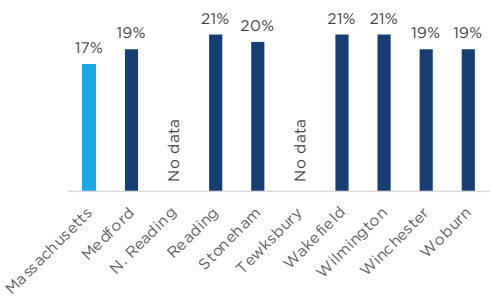
Source: CDC PLACES, 2022

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 linkages between substance use and mental health concerns, noting that individuals may use substances such as alcohol or marijuana as a way to cope with stress. Interviewees and focus group participants also identified vaping as a concern particularly affecting youth.

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC PLACES, 2022

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 and specific requests for participants to reflect on the issues that 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 issues.

Given the limitations of the quantitative data, specifically that it was often out of date and was not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, listening session, and the 2025 WH Community Health Survey was of critical importance.

Mental Health

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

In addition to the overall burden and prevalence of mental health issues, residents also identified a need for more behavioral health providers and treatment options, including inpatient and outpatient services and specialty care. Interviewees, focus groups, and listening session participants also reflected on the need to support individuals in navigating care options within the behavioral health system.

61% of Winchester High School students reported that their mental health was not good sometimes, most of the time, or always in the past 30 days.

Source: 2023 Winchester Public Schools Youth Health Survey

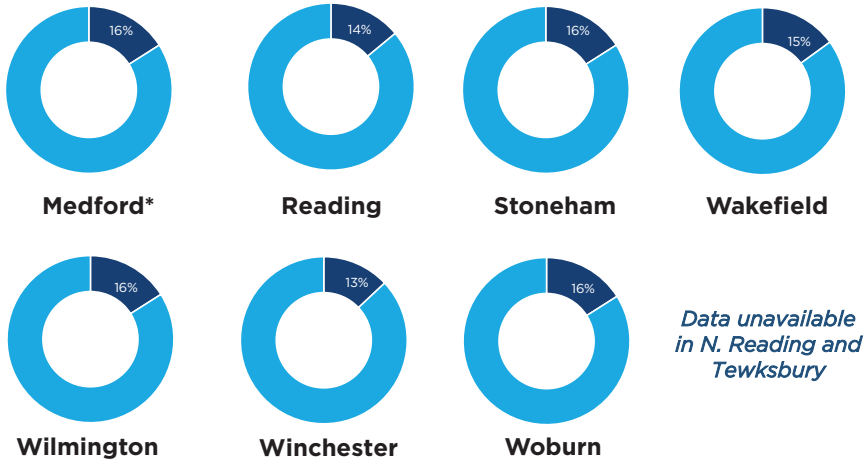
32% of 2025 WH Community Health Survey respondents said health care in the community does not meet people's mental health needs.

Source: 2025 WH Community Health Survey

57%

of 2025 WH Community Health Survey respondents identified mental health as a health issue that matters most in their community.

Percent of Adults Who Experienced Frequent Mental Distress Within the Past 30 Days, 2022



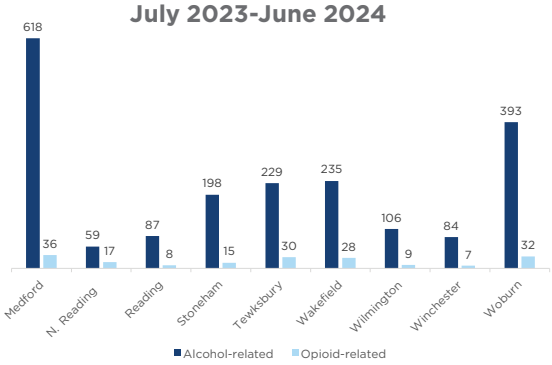
Source: CDC PLACES, 2022

Health Conditions

Substance use remained a major issue in the CBSA, with ongoing concern about opioids and alcohol. It was also recognized as closely connected to other community health challenges like mental health and economic insecurity.

Looking across the service area, there were more alcohol-related emergency visits than there were opioid-related visits. The highest number of visits for both substances were in Medford.

Alcohol and Opioid Related Emergency Room Visits, July 2023-June 2024



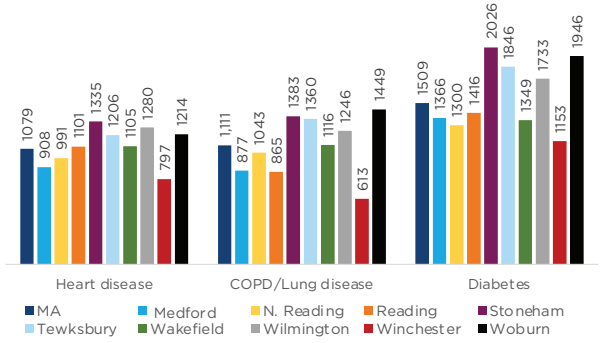
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for three of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.[19]

Looking across four of the more common chronic/complex conditions, inpatient discharge rates among adults 65 years of age and older were consistently higher than the Commonwealth in Stoneham, Tewksbury, Wilmington, and Woburn.

Inpatient Discharge Rates Per 100,000 Among Those 65 and Older, 2024



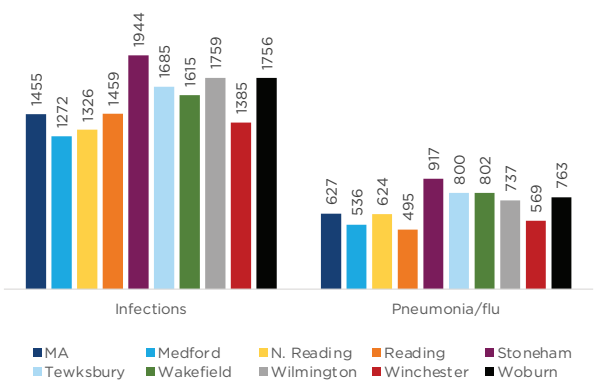
Source: Center for Health Information and Analysis, 2024

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 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 Stoneham, Tewksbury, Wakefield, Wilmington, and Woburn had higher inpatient discharge rates for infections and pneumonia/flu compared to the Commonwealth.

Inpatient Discharge Rates Per 100,000 Among Those 65 and Older, 2024



Source: Center for Health Information and Analysis, 2024

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. Accordingly, using an interactive, anonymous polling software, WH's CBAC and community residents, through the community listening session, formally prioritized the community health issues and the 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 • Maternal health equity	• 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)*

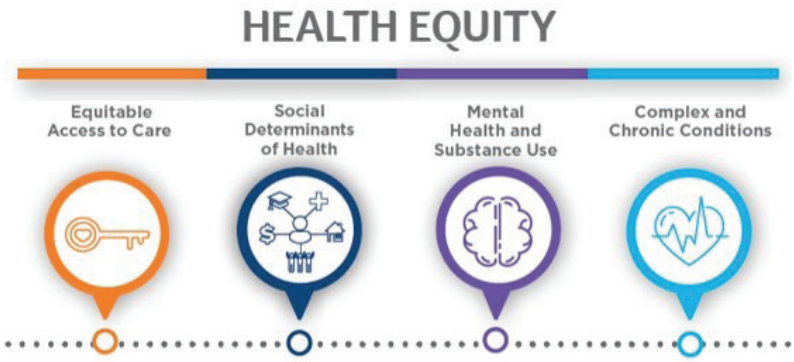
Community Health Priorities and Priority Cohorts

WH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, WH 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 cohorts within the community health priority areas.

WH Community Health Needs Assessment: Priority Cohorts

- **Youth**
- **Older Adults**
- **Low-Resourced Populations**
- **LGBTQIA+**
- **Individuals Living with Disabilities**
- **Racially, Ethnically, and Linguistically Diverse Populations**

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, issues related to the built environment (i.e., improving roads/sidewalks) 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's IS are housing issues, transportation, food insecurity, language and cultural barriers to services, economic insecurity, issues related to digital access, long wait times for care, health insurance and cost barriers, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive/navigation services for individuals with substance use disorder, community-based behavioral health education and prevention, conditions associated with aging, healthy eating/active living, community-based chronic disease education and prevention, maternal health equity, and caregiver support.

Implementation Strategy

WH's current 2023-2025 IS was developed in 2022 and addressed the priority areas identified by the 2022 CHNA. The 2025 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 2026-2028 IS.

Included below, organized by priority area, are the core elements of WH's 2026-2028 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. WH supports residents in its CBSA by providing financial assistance to individuals who are low-resourced and are unable to pay for care and services. Moving forward, WH will continue to provide free or discounted health services to persons who meet the organization's eligibility criteria.

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:

- Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.
- Support community/regional programs and partnerships to enhance access to affordable and safe transportation.
- Advocate for and support policies and systems that improve access to care.

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 programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.
- Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.
- Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.
- Advocate for and support policies and systems that address 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 mental health and substance use education, awareness, and stigma reduction initiatives.
- Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.
- Advocate for and support policies and programs that address mental health and substance use.

CHRONIC AND COMPLEX 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:

- Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with chronic and complex conditions and/or their caregivers.
- Support programs and partnerships that advance maternal health equity by expanding access to culturally responsive care, addressing social determinants of health, and reducing disparities in maternal and infant outcomes.
- Advocate for and support policies and systems that address those with chronic and complex conditions.

Evaluation of Impact of 2023-2025 Implementation Strategy

As part of the assessment, WH evaluated its current IS. This process allowed WH to better understand the effectiveness of it's community benefits programming and to identify which programs should or should not continue. Moving forward with the 2026-2028 IS, WH and all BILH hospitals will review community benefit programs through an objective, consistent process.

For the 2023-2025 IS process, WH planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2022 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and financial assistance. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2023 and 2024. WH will continue to monitor efforts through FY 2025 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
Social Determinants of Health	Efforts to address social determinants included meal delivery, food pantries, school backpack programs, and SNAP matching at farmers markets—reaching hundreds of families and homebound residents. Housing stability was supported through counseling services, with most participants achieving stability. Nine multi-year community grants were awarded. Winchester Hospital remained active in several regional coalitions focused on housing and food security.
Equitable Access to Care	Winchester Hospital expanded access to care by offering financial counseling to nearly 14,000 patients and providing thousands of home blood draws to reduce barriers for homebound individuals. The SHINE program supported hundreds of residents with health insurance navigation, including low-income and older adults. Interpreter services were used in over 3,000 encounters annually, with language access expanding to Haitian Creole. The hospital also provided over 800 transportation rides and vouchers and supported workforce development with community college courses and ESOL classes.
Mental Health and Substance Use	The hospital strengthened mental health supports through youth-focused programs, staff and teen Mental Health First Aid trainings, and mentor matching for at-risk youth. Programs like SBIRT, QPR, and LGBTQ+ inclusion events further expanded outreach. Behavioral health techs provided over 2,000 hours of care, and the Collaborative Care Model served over 1,600 patients. Winchester also partnered on older adult-focused mobile mental health clinics and maintained services like the Interface Referral program and town social workers. Community grants supported local events, youth internships, and mental health education campaigns, while hospital staff participated in key regional coalitions and policy advocacy efforts.
Complex and Chronic Conditions	Winchester Hospital provided nearly 3,000 free breast cancer screenings and offered navigation and support through its Oncology Nurse Navigator. Programs like CHAMP assisted children with asthma, while classes at the Center for Healthy Living promoted chronic disease prevention. A wig donation program supported cancer patients, and lactation services helped hundreds of mothers meet breastfeeding goals. Although some programs had decreased participation or data availability,the hospital sustained critical access to screening, self-management education, and support services for populations at risk for chronic illness.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: 2026-2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

Introduction:
Thank you for agreeing to participate in this interview. As you may know, Beth Israel Lahey Health, including [name of Hospital] are conducting a Community Health Needs Assessment to better understand community health priorities in their region. The results of this needs assessment are used to create and Implement Strategy that the hospital will use to address the needs that are identified.

During this interview, we will be asking you about the assets, strengths, and challenges in the community you work in. We will also ask about the populations that you work with, to understand whether there are particular segments that face significant barriers to getting the care and services that they need. We want to know about the social factors and community health issues that your community faces, and get your perspective on opportunities for the hospital to collaborate with partners to address these issues.

The data we collect during this interview will be analyzed along with the other information we're collecting during this assessment. We are gathering and analyzing quantitative data on demographics, social determinants of health, and health behaviors/outcomes, conducting focus groups, and we conducted a robust Community Health Survey that you may have seen and/or helped us to distribute.

Before we begin, I want you to know that we will keep your individual contributions anonymous. That means no one outside of our Project Team will know exactly what you have said. When we report the results of this assessment, we will not attribute information to anyone directly. We will be taking notes during the interview, but if you'd like to share something "off the record", please let me know and I will remove it from our notes.

Are there any questions before we begin?

1. **Please tell me a bit about yourself. What is your role at your organization, how long have you been in that position, and do you participate in any community or regional collaboratives or task forces? Do you also live in the community?**

2. **In [name of Hospital's] last assessment, we identified [4-5] community health priority areas [list them]. When you think about the large categories of issues that people struggle with the most in your community, do these seem like the right priorities to you?**

    a. Would you add any additional priority areas?
    b. I'd like to ask you about the specific issues within each of these areas that are most relevant to your community. For example, in the area of Social Determinants of Health, which issues do people struggle with the most (e.g., housing, transportation, access to job training)?

i. In the area of [Social Determinants of Health] – what specific issues are most relevant to your community?
ii. In the area of [Access to Care] – what specific issues are most relevant to your community?
iii. In the area of [Mental Health and Substance Use] – what specific issues are most relevant to your community?
iv. In the area of [Complex and Chronic Conditions] – what specific issues are most relevant to your community?

3. **In the last assessment, [name of Hospital] identified priority cohorts – or populations that face significant barriers to getting the care and services they need. The priority cohorts that were identified are [list them]. When you think about the specific segments of the population in your community that face barriers, do these populations resonate with you?**
    a. Are there specific segments that I did not list that you would add for your community?
    b. What specific barriers do these populations face that make it challenging to get the services they need?

LHMC, MAH, Winchester: Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/Linguistically Diverse Populations, LGBTQIA+

BIDMC: Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/Linguistically Diverse Populations, LGBTQIA+, Families Impacted by Violence and Incarceration

BH/AGH, Needham, : Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/Linguistically Diverse Populations

AJH, NEBH, Milton, Plymouth: Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/ Linguistically Diverse Populations, Individuals living with disabilities

Exeter: Older adults, Individuals Living with Disabilities, LGBTQIA+, Low resource populations

4. **I want to ask you about community assets and partnerships.**
    a. What is the partnership environment in your community? Are organizations, collaboratives/task forces, municipal leadership, and individuals open to working with one another to address community issues?
        i. Are there specific multi-sector collaboratives that are particularly strong?
    b. Are there specific organizations that you think of as the "backbone" of your community – who work to get individuals the services and support that they need?

5. **Thank you so much for your time, and sharing your perspectives. Before we hang up, is there anything I didn't ask you about that you'd like us to know?**

Winchester Hospital
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Medford Municipal Leaders
- North Reading Municipal Leaders
- Stoneham Municipal Leaders
- Tewksbury Municipal Leaders
- Wakefield Municipal Leaders
- Wilmington Municipal Leaders
- Winchester Municipal Leaders
- Woburn Municipal Leaders
- Nelida Alonge, Community Liaison, City of Woburn
- Adetonkunbo Solarin, Director of Public Health, Town of Reading
- John Fuedo, Executive Director at Burbank YMCA, and Donny Bautz, Executive Director, North Suburban YMCA
- Janis Mamyek and Marie Traniello, Inspire Cafe
- Jessie Bencosme, Executive Director, and Paula Matthews, Food Pantry Director, Council of Social Concern
- Renata Ivnitskaya, Director of Residential Nursing, Northeast Arc
- Birgitta Damon, CEO, LEO, Inc.
- Faith-based leaders

Community Health Priority Areas

Social Determinants of Health

- Housing
    - Older adults have difficultly finding safe and affordable housing in the community
        - Unable to move to smaller housing due to lack of housing stock available
    - Long wait times for affordable housing, additionally some housing lists require sobriety, which can be a barrier for individuals with substance use disorder
    - Increase in overcrowded, temporary, and unstable housing (hotels, cars, shelters, street)
    - Lack of resources to help people maintain their homes and reduce hoarding
- Food insecurity
    - Rise in food costs and an increase in individuals using food resources (pantries, etc.)
        - Lack of access to produce is a major issue
    - Schools provide free breakfast and lunch to students which helps ease the impact
- Economic Insecurity and Employment
    - People whose first language is not English, individuals with substance use disorder, and individuals living with disabilities face additional barriers when seeking employment
    - Childcare is expensive and requires children to have a recent physical and vaccinations, which can be a barrier for parents without medical care access
- Transportation

    - While some transportation resources exist outside of buses, they often need to be scheduled well in advance, limiting their use for last minute or frequent appointments
    - The MBTA connects communities to Boston, but many towns are left out and there is little in-town transportation available

Access to Care

- Some members of the community are afraid to seek medical care due to personal history, immigration status, or fear of a language barrier
    - Could be improved through additional community outreach
- Provider Access
    - Need for medical providers who have experience serving individuals living with disabilities
    - Need for culturally inclusive medical providers and increased language access
    - Need for more providers who have experience working with LGBTQIA+ populations; many individuals currently travel to Boston for care where there are more experienced providers
    - Lack of providers for veteran care and outside providers may not accept VA insurance
    - Lack of providers, especially specialists, who accept MassHealth had led to overuse of emergency rooms and urgent cares
    - Lack of mental health providers has led to long waiting lists for care especially for pediatrics
- Health system navigation is a challenge for new Americans and people who do not have insurance
- Lack of digital literacy is a barrier, particularly for older adults, as providers switch to scheduling appointments online and providing telehealth services

Mental Health and Substance Use

- Mental Health
    - Lasting impact of COVID-19
    - Impact of trauma
    - Youth mental health and emotional regulation/coping skills
        - School avoidance
        - Challenge to find care outside of the school setting
        - Lack of family support for LBGTQIA+ youth
    - Anxiety, depression, OCD
    - Isolation and loss of support systems in older adults
- Substance Use
    - Nicotine, vaping
    - Underage alcohol use

Chronic and Complex Conditions

- Diabetes, dementia, COPD, and asthma were identified as common chronic conditions
- Lack of patient knowledge about their condition, treatment plan, medication, and aftercare
    - Especially diabetes and educating on healthy lifestyles (diet, exercise, etc.)
- Need for additional caregiver supports and resources
- Supply chain challenges have limited medication access, especially for ADHD and diabetes

Priority Populations

- Agreement across interviewees that the following populations should continue to be the priority, as they face the most significant barriers to care and services:
    - Youth
    - Older Adults
    - Racially/ethnically/linguistically diverse (including immigrants and refugees – primarily those that have newly arrived)
    - Low-resourced/low-income populations
    - LGBTQIA+
- Interviewees also identified concerns for veterans, individuals with substance use disorder, individuals who are homeless/unstably housed, caregivers, and individuals living with disabilities

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout the Winchester region.
    - Specific organizations identified as critical resources: YMCA, Substance Use Disorder Task Forces, Boys and Girls Club, The Arc of MA, Autism Housing Pathways, Special Olympics, Best Buddies, Woburn Senior Center, Woburn Council of Social Concern and Social Capital Inc., Youth Engaged in Service (YES), Wakefield Food Pantry, Mystical Valley Elder Services, Eliot Community Services, Rental Assistance for Families in Transition
      (RAFT), Jenks Center, Outreach Worker Task Force, Hoarding Task Force, Greater Lowell Health Alliance, Wellness Coalitions, Reading Coalition for Prevention and Support
- Youth coalitions, small business organizations, food banks, senior centers, town/municipal government, school districts, religious organizations, local departments of health, veteran's services, food pantries, and emergency services were identified as common organization and sources of partnerships across interviews
- Interviewees noted good collaboration between organizations and with the hospital
- Limited funding available for organizations and partnerships to access and apply for

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

Name of group:
Hospital:
Date/time and location:
Facilitator(s):
Note taker(s):
Language(s):

Instructions for Facilitators/Note Takers (Review before focus group)

- This focus group guide is specifically designed for focus group facilitators and note-takers, and should not be distributed to participants. It is a comprehensive tool that will equip you with the necessary knowledge and skills to effectively carry out your roles in the focus group process.
- As a **facilitator**, your role is to guide the conversation so that everyone can share their opinions. This requires you to manage time carefully, create an environment where people feel safe to share, and manage group dynamics.
    - Participants are not required to share their names. If participants want to introduce themselves, they can.
    - Use pauses and prompts to encourage participants to reflect on their experiences. For example: "Can you more about that?" "Can you give me an example?" "Why do you think that happened?"
    - While all participants are not required to answer each question, you may want to prompt quieter individuals to provide their opinions. If they have not yet shared, you may ask specific people – "Is there anything you'd like to share about this?"
    - You may have individuals that dominate the conversation. It is appropriate to thank them for their contributions but encourage them to give time for others to share. For example, you may say, "Thank you for sharing your experiences. Since we have limited time together, I want to make sure we allow other people to share their thoughts."
- As a **notetaker**, your role is to document the discussion. This requires you to listen carefully, to document key themes from the discussion, and to summarize appropriately.
    - Do not associate people's names with their comments. You can say, "One participant shared X. Two other participants agreed."
    - Responses such as "I don't know" are still important to document.
    - At the end of the focus group, notetakers should take the time to review and edit their notes. The notetaker should share the notes with the facilitator to review them and ensure accuracy.
    - After focus group notes have been reviewed and finalized, notes should be emailed to Madison_Maclean@jsi.com

Opening Script

- Thank you for participating in this discussion about community health. We are grateful to [Focus group host] for helping to pull people together and for allowing the use of this space. Before we get started, I am going to tell you a bit more about the purpose of this meeting, and then we'll discuss some ground rules.
- My name is [Facilitator name] and I will be leading the discussion today. I am also joined by [any co-facilitators] who will be helping me, and [notetaker] who will be taking notes as we talk.
- Every three years, [name of Hospital] conducts a community health needs assessment to understand the factors that affect health in the community. The information we collect today will be used by the Hospital and their partners to create a report about community health. We will share the final report back with the community in the Fall of 2025.
- We will not be sharing your name – you can introduce yourself if you'd like, but it is not necessary. When we share notes back with the Hospital, we will keep your identity and the specific things you share private. We ask that you all keep today's talk confidential as well. We hope you'll feel comfortable to discuss your honest opinions and experiences. After the session, we would like to share notes with you so that you can be sure that our notes accurately captured your thoughts. After your review, if there is something you want removed from the notes, or if you'd like us to change something you contributed, we are happy to do so.
- Let's talk about some ground rules.
    - **We encourage everyone to listen and share in equal measure.** We want to be sure everyone here has a chance to share. The discussion today will last about an hour. Because we have a short amount of time together, I may steer the group to specific topics. We want to hear from everyone, so if you're contributing a lot, I may ask that you pause so that we can hear from others. If you haven't had the chance to talk, I may call on you to ask if you have anything to contribute.
    - **It's important that we respect other people's thoughts and experiences.** Someone may share an experience that does not match your own, and that's ok.
    - **Since we have a short amount of time together, it's important that we keep the conversation focused on the topic at hand.** Please do not have side conversations, and please also try to stay off your phone, unless it is an emergency.
    - **Are there any other ground rules people would like to establish before we get started?**
- Are there any questions before we begin?

Question 1

We want to start by talking about <u>physical health</u>. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
b. **What stops you from being as physically healthy as you'd like to be?**

Summarize: Based on what you shared, it sounds like [list to 3-4 themes] have the biggest impact on your physical health. Is that correct, or do we want to add some more?

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?
b. What stops you from being as mentally healthy as you'd like to be?

Summarize: Based on what you shared, it sounds like [list to 3-4 themes] have the biggest impact on your mental health. Is that correct, or do we want to add some more?

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health." What social factors are most problematic in your community?

a. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others?
    a. What sorts of barriers do they face in getting the resources they need?

Summarize:

- It sounds like people struggle with [list top social factors/social determinants]. Is this a good summary, or are there other factors you'd like to add to this list?
- It sounds like [list segments of the population identified] may struggle to get their needs met, due to things like [list reasons why]. Are there other populations or barriers you'd like to add to this list?

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?
b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

Summarize: It sounds like some of the key community resources include [list top responses]. I also heard that you'd like to see more [list resource needs]. Did I miss anything?

Question 5

- Is there anything we did not ask you about, that you were hoping to discuss today?
- Are there community health issues in your community that we didn't identify?
- Are there any other types of resources or supports you'd like to see available in your community?

Thank you

Thank you so much for participating in our discussion today. This information will be used to help ensure that Hospitals are using their resources to help residents get the services they need.

After we leave today, we will clean up notes from the discussion and would like to share them back with you, so that you can be sure that we captured your thoughts accurately. If you'd like to receive a copy of the notes, please be sure you wrote your email address on the sign-in sheet.

We also have $25 gift cards for you, as a small token of our appreciation for the time you took to participate. [*If emailing, let them know they will receive it via email. If giving in person, be sure you check off each person who received a gift card, for our records*].

Winchester Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Men of color
Location: Front Line of Fresh (Medford) Barbershop
Date, time: 10/2/2024
Facilitator: JSI
Approximate number of participants: 9

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Trying to be intentional and take the stairs in my build or park far away when out and about
    ii. A gentleman who lives around the corner walks a lot, he averages about 3/4k steps. A lot of folks do a lot of walking, running, biking
    iii. In college one gentleman says he would run, and says he currently does a lot of walking, biking, and going on the treadmill at home. The family is not in the habit as much and he don't want to shame folks
    iv. Go to the gym a lot, but they have a stressful job so it is hard
    v. Blink Fitness, Planet Fitness, Crossfit, Lifetime, and Reimagine are the most consistent gyms that folks go to. Some people also go to Mystic Valley YMCA LiveFit, or go swimming at the school
    vi. Want to make the education building available in the community
    vii. Some people do the VOLO sports, or organized team sports for adults, all kinds of sports
    viii. People go to assembly row for tennis
    ix. Go to the gym, if a busy day and a nice day, go for a walk
    x. People go to play basketball at some of the parks
    xi. Wouldn't consider doing things at work, being on feet all day, as being active
    xii. A lot of access to stuff on the internet now, how do you do it correctly, what's the best way

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Would love for a gym in West Medford, but there is so much traffic in the area
    ii. Definitely hard to be consistent
    iii. Hard to do intense things, or organized sports, don't want to get hurt
        1. It is hard to have coverage if hurt
    iv. Too tired to go to the gym after work; there is so much to do

v. Busy at work
vi. Getting sick
vii. Being tired from life
viii. You should start a physical journey as a kid and learn structure at a young age, so that you can keep doing it in life or at least have a regiment
ix. People hurt themselves working out and it stops them from going back
x. Prioritizing family and work/life over yourself, it is really hard
xi. Food insecurity is huge, how can I work out when I don't know where my food is going to come next
xii. Finances, it's expensive to work out, expensive to find a good gym, better ones cost a lot of money
    1. Even $10 at Planet Fitness can be a lot
xiii. Accessibility of transportation in the community. It is hard to get to some of these places. A huge block of time for some to get there, especially if you work a lot of hours

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?
    a. Outpour of optimism, try and be optimistic, not naïve or optimistic, but try and think positive to set the tone. Try to do everything in that headspace, try not to allow myself to kick myself in the ass for something. I just apply what I might have missed to the next thing
    b. Don't watch the news
    c. Some folks have taken breaks from social media
        i. Social media is chasing you; it will show you so many bad things, so I try to cut things out
        ii. Deleting Instagram
    d. Trying to stay in the moment, those things aren't real
        i. Two ways of handling my own mental health: finding time to be alone and just be in the moment, whether it's in the moment, just existing, being able to quiet the mind and brain. I have had the privilege to share with someone
    e. Everyone feels like they can generally talk to someone in their lives
    f. Coming here to the shop helps him a lot, eases the mind a lot
        i. A lot agree the barbershop is a safe place
        ii. Barber agrees that it's building a relationship
        iii. Authentic here
        iv. Barbershop/beauty shop a haven for black men/women to come and share, historically, and currently. We are able to chat with someone and

maybe look up to people, good role models, one gentlemen has seen a huge positive in his life for coming

g. Mental health has to do with regular health
h. Walking is wonderful for one person to relieve their mental health
i. Most small business don't have insurance, this person's does, and insurance helps pay for the gym, they wish that was standard

b. What stops you from being as mentally healthy as you'd like to be?

a. When I am unemployed I can scroll for hours, the algorithms are bad for you, not mentally healthy
b. Tend to put everyone else before themselves
c. Negative stigma attached to mental health
    i. When you hear cancer, you associate death. When you hear autism, you don't consider the whole person, when you hear mental health, you think bad. You can be mentally healthy but strong, it's a negative stigma, a lot agree
    ii. Growing up in a household that stigmatized mental health
    iii. The "you should just deal with it" generation made things hard (others agreed)
    iv. Parents are from Haiti, if you said you needed mental health care you were crazy, or you should pray things away
    v. If the parents don't know, then they don't know, it's hard when they pass down that stigma
d. People forget their training about what to do when things get tough; they don't always practice what they preach
e. Competitive atmosphere with peers, a lot of comparing to what others are doing. Social media makes people feel like they're not doing enough, or the right thing, or someone is better. It is super easy to see what others do and think you're not good enough
    i. With social media you might see someone who is putting out a false image, smoke and mirrors, to make it look like they're doing more than they really are. Then you go back to comparing yourself to others which hurts
    ii. Social media aspect born into it, no training
f. If talking about mental health is not common, there's not a lot of places to go to; you're not supposed to tell people your business
g. "Kill the comparison", try and not focus around you, and stay clear headed into what you're doing
    i. "Comparison is the killer of joy," need to remember that
    ii. Overall, this is a huge barrier on mental health
h. A job is just a job
i. It takes conditioning to try and build these resiliency skills, to be able to move on to the next piece, condition oneself to be mentally strong
j. Hard to sometimes feel

k. Some folks who were children of immigrants felt pressure to do well
    i. There's more pressure not to fail, then there is to succeed at the highest level, don't want to let parents down in general
l. Different generations in general have their own barriers

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. What social factors are most problematic in your community?

a. Affordable housing impacts so much
    i. Grew up here as a kid and they moved to West Medford in the early 70's. The kids they grew up with couldn't afford to live here
    ii. Insular community gets stretched, hard to stay living in the community that they're used to. Finding enough starter homes for the community that's lived and breathed it for a while is hard
    iii. 110% agree, housing affordability and food affordability are huge stressors. People can assume everyone who lives around here can afford it, they can't, people are being pushing out of neighborhoods
    iv. Housing is the number one
    v. Condos are crazy expensive, everything expensive, their daughter had to move to Framingham, away from where they grew up, it's where they can afford
    vi. Affordable housing isn't affordable, wages do not meet what people can live
    vii. So many people living together with either family, or lots of roommates, only way to be able to afford things
    viii. Affordable housing is not affordable
    ix. Pressure that folks feel to move out from home but can't afford to do it, there's a stigma to that
    x. If you don't have to leave home, don't leave. In some circumstances you have no choice and have to, but just contribute around the house then go pay market rate
    xi. It makes people get into relationships (lack of affordable housing)
b. The T is a massive problem, they can't get to housing, hospitals, work, anything
c. Mental health goes into all these things
    i. Goes back to mental health, it turns into physical health
d. School, aka college, is really expensive, are kids going to want to go college?
e. What people are making to the cost of living is not relative at all
    i. These programs are barely affordable for the standards they set
    ii. Economics can't even save you
f. It is hard to have a core group of people on the same page as you, some people stigmatize you for not living on your own, having a car, etc.
g. Not enough translators on staff

h. Scarcity mindset, if you're expecting growth around you, someone else doing it won't affect you. People make it seem like because if they eat, I won't eat, which isn't true

b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others?

a. Haitians
b. Women of color

c. What sorts of barriers do they face in getting the resources they need?

a. Language is definitely a huge barrier and hindrance. A lot of folks in Medford seem to want to have more inclusion or coming together, but there's not translation services available
    i. Medical facilities need more translators on staff in general, they can't keep using regular employees to do these services, they are focused on their own jobs
b. Most immediate way to communicate in medicine but not able to get feedback? Why even bother to go?
c. A lot of folks don't have a great relationship with their medical partners for various reasons
    i. There is a trust barrier, especially for people of color
    ii. Beth Israel needs to bring back these trust barriers and have things seem genuine
    iii. The human side of people needs to be considered more, just because they're a doctor may not mean they have your best interest.
    iv. Would be helpful in the trust community
    v. Stigma historically going to the hospital, like the Tuskegee Studies in Alabama
    vi. If you walk in with an accent and they think you're dumb, they treat you like you're dumb
    vii. Normalize having doctors that look more like the populations they serve
d. A few people have had a few bad experiences at BILH
e. Doctors need to be better at being human, explain as thorough as possible
    i. If they have not explained it well, I will ask them to repeat it and say it again
    ii. One person was an Emergency Medical Technician and felt they had a little bit of better care, because they kind of understood language. Providers need to have that mindset with everyone

iii. We can understand that everyone is burnt out, but just talk through it again after the first time. Patients don't always have the knowledge competency at their (provider's) level, (the providers) need to walk it through at a more retainable level

f. Too many apps; when getting results you need to know what they mean
g. Need more visual representation in these services
h. Having the hospital invest in the community invest more in their community
i. Having an advocate to speak on behalf of them who gets the culture, translate properly
j. Medical person may have a lot of people they see
k. What's happening in my body is my fear, my diagnosis, and that's a lot to carry with you. You need to be told what you should do, you can't rush through with people, especially if you're a person of color

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?

a. West Medford Community Center is the local diversity hub for young adults, seniors
b. At Bunker Hill people go to them for student pieces who are enrolled here
c. People go to Chelsea for Market Basket because it's cheaper

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

a. You need a car to get to these places (existing resources)
b. Local affordable grocery store
c. More resources in general. Finance resources to help people, information for health, things for youth, we need a YMCA/Boys and Girls Club, the kids need places to go
d. Pop-up clinics, we need more of these for people to get care. People would feel more comfortable doing that than going to a hospital
e. Would love to see that with affordable food as well, more options
f. Telehealth appointments, translators
    i. Get the universities involved with translators, use them for credit work
g. Shoutout to the recreation community, build it up even more

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?
Are there community health issues in your community that we didn't identify?
Are there any other types of resources or supports you'd like to see available in your community?

- Equitable education about these things, more or less everyone has access to things, there are so many levels

- Bring more things from the hospital into the schools, talk about basic health check-ups, primary care provider type services, and shots
    - Having people come to the schools who look like them, bring diverse people into school to show that healthcare is diverse. It doesn't have to just be a doctor, they can be a nurse, there are other roles, just show young people they can do these things
- Younger generation
- Stop stigmatizing community colleges, reach out to them more for partnerships, they have a nursing program utilize them
- These youth have a little more gusto, give everyone a fair shot

Winchester Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: City of Medford Community Liaisons
Location: Medford City Hall
Date, time: 10/9/2024
Facilitator: JSI
Approximate number of participants: 10

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. My husband had a recent operation and he goes to rehab. My family is healthier than us. They play basketball, go hiking, walk, and do treasure hunts.
    ii. In our family we have risk factors for heart disease, so we have to do aerobic exercise to keep the blood flowing.
    iii. Trying to eat better, trying to be more conscious of what I am eating. Because of my job, I walk around the store all day long so I get the steps in. What keeps me healthy is my new baby nephew who gives me great joy.
        1. Eating better means trying to cut out some of the sugar. I'm personally trying to figure out what things are causing inflammation. I'm trying to eat more plant-based foods to lower my cholesterol.
    iv. I try to get to the gym. I got the tik tok stepper, "they got me." I am trying to eat cleaner
    v. I try to exercise as much as I can. I get my bike and go to the minuteman bike path.
    vi.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Right now I do nothing. But I need to get back to it. The goal that I set for myself I haven't been able to. I want to go to the gym but I haven't had the energy to do it.
    ii. My kids are healthy, but my husband and I are not doing a good job of taking care of ourselves.
    iii. I find myself making choices that are cheaper
        1. Why is it that salads cost so much more than cheap burgers?
    iv. The environment we live in, our lives are so fast paced and the processed foods are so much easier for our fast lives. The healthier foods take more time.

America is really bad, they add way more ingredients that add so much more (calories)

v. My health issues make it hard. The cold weather is also a barrier. It's better if there are gyms. Every city should have a free place where you can play for free.
    1. In Everett it's $15 a month to have a family gym membership. You just need to be an Everett resident
vi. The side effects from the medication that I'm taking are having an impact. Last week I went to the hospital because I was not feeling well. He hadn't taken the blood test yet, but the doctor said, "I don't mean to scare you but this could be cancer". It scared me and the stress that caused me was traumatic.

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?
    a. Drink Michelob Ultra
    b. We get together and be social
    c. Listen to music and work in my garden
    d. Hobbies are really important, dedicating a few hours a week to something that makes you happy. For me, it's video games. Changing your environment too and going out to the country.
    e. My prayer routine. Sharing how we feel with friends and family and eating ice cream
    f. Travelling for me, it helps me stay happy
    g. Therapy
        i. I used to go to therapy
    h. Another thing that I do, I don't know if it's cultural, but humming a song calms me.

b. What stops you from being as mentally healthy as you'd like to be?
    a. I started having a margarita every day, but then I realized that it was a habit so I turned to sweets.
    b. Responsibilities
    c. Phone, distractions, watching the news
    d. Taking other people's issues and feeling them in your heart
    e. Always helping others and your family. The responsibility of it all

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

- **a. What social factors are most problematic in your community?**
    - a. Feeling ashamed for having needs. Not being able to pack your fridge. Having to ask for assistance. Other people having to know you are struggling. Money, finances. If you can't buy food. You can't dress in the way you need.
    - b. As an immigrant myself, it's more inclusive than it was 20 years ago when I came. A huge factor that is getting worse every year is housing. If you are paying this much money for rent, you don't have much money left for rent.
    - c. Cost of living and housing
        - i. Even lottery tickets have gone up
    - d. Some people see that immigrants are getting resources faster than people that have been there. People are seeing the needs of neighbors not being met while immigrants (have their needs met). Even as an immigrant myself.
- **b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?**
    - a. The elderly population breaks my heart
        - i. Transportation barriers
        - ii. The system fails them
        - iii. Loneliness
        - iv. Seniors are getting scammed. They aren't used to the rapid advancement of technology
    - b. Language barriers

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

- **a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    - a. I am surprised how many activities happen at the Senior Center, I wish people were more aware of what
    - b. Here in Medford, we have the luxury of having a HS that also has a tech school in there

- **b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    - a. At our age (50's) it's hard to find people, where we connect with others
    - b. More job opportunities for teens to explore future jobs.

i. Something we heard a lot was that there were a lot of young people, especially those without jobs.

c. More businesses connecting with local young people to get them involved work

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?

Are there community health issues in your community that we didn't identify?

Are there any other types of resources or supports you'd like to see available in your community?

- Police leave their cars running. They leave them running. I don't understand why the cars are running the whole time. Why is it running for 4 hours?

Winchester Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Chinese older adults
Location: Jenks Center
Date, time: 10/17/2024
Facilitator: JSI and Jenks Center Staff
Approximate number of participants: 16

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. I meditate every day. I started meditating in 1996 to maintain my physical health. Through meditation, I feel very open-minded and have no anxiety.
    ii. I retired five years ago. Before that, I walked to work every day, then I learned to play table tennis and went hiking weekly. After meals, I walk. I have abnormal sugar metabolism, which I manage through diet and exercise. For the past 5 or 6 years, my levels have remained stable and have not increased. I plan to exercise at the center in the future.
    iii. I retired this year. Before retiring, I had a five-year transition period to adjust from a busy work life to retirement. Good living habits, safe food, and health for both body and mind are essential. The body and mind interact. I do annual health check-ups, using the check-up results as a reference for my health status. Medication intervention is also important. Additionally, mental health is crucial—don't be anxious about the future and ensure sufficient sleep.
    iv. Moderate exercise is beneficial; exercising helps me sleep well. As long as I exercise enough to sweat a little, don't stay up late, and eat wisely, I'm good.
    v. I enjoy exercising, but my preferences have changed with age. I used to like tennis, but high-intensity sports are no longer suitable for me as I've aged. I then chose tai chi, but after coming to the U.S., I couldn't find an environment for tai chi, so I struggled to maintain my exercise routine. I want to go to bed early, but it's hard to stick to it.
    vi. After retiring, I worked for another 13 years. I think working is the best way to maintain physical and mental health. I worked in many places, focusing on health checks. I didn't have time to exercise, but my blood pressure and cholesterol were all normal, with slightly elevated triglycerides. Now, I play table tennis at the senior center.

b. **What stops you from being as physically healthy as you'd like to be?**

i. Aging
ii. Busy lifestyles
iii. Environmental limitation

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?

a. Mental health requires having faith. There are many things we can't control ourselves. Because I believe in Christianity, I leave everything to God, which relieves my worries and helps me sleep well.
    i. I also believe that faith is very important. I practice Falun Gong, and I am now very healthy, with no issues related to high blood pressure, high cholesterol, or high blood sugar.
b. I have high blood pressure, which I've managed with medication for many years. I'm maintaining it quite well. My secret to keeping my blood pressure stable is having a good mindset. When I feel lively, I play sports, including table tennis, which I started learning after retirement. Additionally, having companionship helps.
c. I also read a book called "Zhuan Falun." I used to have a terrible temper, but through reading, I learned to look inward when I encounter problems. This has made me happier. Practicing Falun Gong exercises also improved my health, benefiting both my body and mind.
d. A cheerful mood is a friend to physical and mental health; good sleep is the best remedy. When I sleep well, my mood improves. In my youth, I used to play mahjong all night, but now I go to bed at 9 PM and wake up at 5 AM—very regularly.

b. What stops you from being as mentally healthy as you'd like to be?

a. My sleep isn't very good. The reason for my poor sleep is that, as I age, I find it harder to sleep. It might also be due to having too much on my mind; when I think too much, I can't sleep, but things might be better if I had less on my mind.
b. My sleep is poor because of anxiety.

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. What social factors are most problematic in your community?

a. The air here is quite good, but there are a lot of tissues and masks littering the streets, which aren't as clean as those in China.
b. Winchester has older houses, and we often smell gas. Is it possible to check this? Also, with the old pipes from over 100 years ago, are there any safety concerns? What can be done to ensure the safety of the pipes in our home?
c. Living in the U.S. is great in terms of the environment, but the language barrier brings a lot of inconvenience.
    i. In terms of general transportation and food, everyone is fine, but language remains a significant barrier
    ii. Last March, I had an ultrasound at Winchester Hospital. I entered through East Gate 41, and they only gave me a guidance form before letting me in. Once inside, the whole floor was empty, like a maze, and I couldn't find the ultrasound department. It caused me a lot of inconvenience. When I got to the Winchester hospital, there was no one who spoke Chinese. Even though I know a little English, it was still very difficult. That's why we need a translator. It's not just Winchester Hospital—at public service areas, I can't find a translator either. There are very few family doctors who speak Chinese here. I feel everything is good, but seeing a doctor is really difficult.
    iii. Especially for Chinese seniors, the language barrier is very challenging. There are relatively many Chinese seniors in Winchester. and among them, about 80% or even 90% of seniors do not speak English at all. They don't know how to enjoy welfare benefits, public health policies, or the available services.
    iv. Currently, there aren't many Chinese people at Winchester Hospital because we go elsewhere to find hospitals with Chinese-speaking staff. If Winchester Hospital had translators, we'd be more than willing to go there. Especially for annual health check-ups for the elderly—from blood tests to colonoscopies—we have to go to different places to find Chinese-speaking doctors. I had to go to Cambridge for a colonoscopy, and go to Quincy for blood tests. We rely on our children to take us far away to see a doctor, which is very inconvenient. I know at least hundreds of elderly people in Winchester who would prefer to stay at Winchester Hospital, but because of the language issue, we have to go outside the area to see a doctor. And since these seniors don't drive, they have to wait for their children to find time to take them to a place with Chinese-speaking doctors.
d. I feel comfortable here. I came to Boston in 1995 and moved to Winchester in 1999. But I have some anxieties because the overall education environment has deteriorated. Winchester is quite good in Massachusetts, but as the overall quality drops, Winchester is also declining. The difference between the past and present education is significant. As a parent and from my work experience, I see that education is now more laissez-faire, which wasn't the case before. A Chinese school has built an elementary school in town. We hope our children can gain knowledge, while also enjoying a happy environment and receiving proper values. We have integrated the advantages of both Chinese and American education systems. This has alleviated some of my anxiety.

e. I feel pretty good. Compared to China, it's better here, and we are very satisfied. In China, it's impossible to even get an appointment, and you spend most of the day waiting to see a doctor for three minutes.
f. I think it's quite difficult. It's even harder for the elderly. I'm 59 this year, and for my mother, seeing a doctor requires me to accompany her. Thinking about the other seniors, if their children are not retired or are busy with work, it's extremely hard for the elderly to see a doctor.

b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?

a. Chinese speakers due to lack of translation access at the hospital

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?

a. Moving to Winchester has been great. The senior center here brings us a lot of convenience and joy. With so many friends, it's less lonely, and both body and mind are uplifted.

Winchester Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Youth from Boys & Girls Club Stoneham, Boys and Girls Club Wakefield, Social Capital Inc., Network for Social Justice, Mystic Valley Public Health Coalition
Location: Boys & Girls Club Stoneham
Date, time: 10/19/2024
Facilitator: JSI
Approximate number of participants: 14

Question 1

We want to start by talking about <u>physical health</u>. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

- **a. How have you been able to support your physical health to stay healthy?**
    - i. Physical health is more than just physically being present
    - ii. A participant mentioned how their school allows them to go to the nurse if they're feeling tired (not just for feeling sick)
        1. They're able to take a power nap and it allows the student to recharge and reset for the rest of the day
    - iii. Another student echoed that sentiment by explaining how the school allows time for breaks outside to let free of the stresses of school
        1. Do students feel comfortable to have the break?
            a. Yes, a student said, but they explained that the administration of the school isn't promoting it as much because they don't want kids to skip classes
    - iv. Another student added that the guidance department is another great resource to support physical health
    - v. Many classrooms have a couch or a place to relax
- **b. What stops people from being physically healthy?**
    - i. A student mentioned stress and how the pressures of class content incentivized students to stay in class despite being tired
    - ii. Taking harder classes like AP classes are preventing some students from being physically healthy
    - iii. Someone mentioned that some students go to school despite being sick
        1. Society has an expectation that even if you're sick, you shouldn't skip school or any important event
    - iv. Physical well-being is often overshadowed by mental health or physical health is just solely thought of as lifting/exercising
- **c. What are some things people do to stay physically healthy?**
    - i. A student said playing a sport or going to the gym helped them relax and brought their energy back
        1. Made them feel more physically healthy after working out

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

- **a. How do you and your loved ones stay mentally healthy?**
    - a. Guidance counselors are a great resource
        - i. Some students talk for a long time, and it can be difficult to reach them since they're always booked.
            1. There four guidance counselors for a student population of 600 people
    - b. On the flip side, being too busy and having too many things on your plate often inhibits students from being mentally healthy
        - i. Sports, homework, college applications,
            1. There is a two semester athletic requirement
            2. 14 hours of a sport, then going home to face so much homework
        - ii. There is a fine balance between being busy to not wasting time during the day, but also not overwhelming themselves.
        - iii. Time is like a pie and slicing it up between each activity and expectation can be difficult
- **b. How do you support your mental health while you have so many other commitments in your life?**
    - a. Trying to stay on top of work was mentioned
    - b. It can be hard but it is necessary!
- **c. What can be helpful during times of stress?**
    - a. Talking to a family member or someone that you trust
    - b. Are kids often comfortable talking to their guidance counselor?
        - i. The consensus was that it really depends on the situation because it can be different for each student
    - c. A student mentioned that their guidance department is like a "revolving door" making it hard to form a close connection

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

- **a. What are some social factors in your community that you think are most problematic that affect your well-being? Ex. transportation**
    - a. Money! In Winchester particularly, wealth is very prominent in the community
        - i. If you don't have money, your social reputation is diminished
    - b. Language! Woburn has recently had a lot of students that don't understand each other.

i. It can be frustrating to form connections with others because they don't speak the same language
ii. Especially as a Senior, where college applications have exacerbated the isolation

c. The school administration is trying to help them, but they don't have the adequate transportation
i. Some students at WMHS have to walk home 2 miles if they miss the bus

b. How is peer pressure affecting youth health?

a. Bullying is still an issue a student mentioned
i. Has now recently not been as extreme as it used to be (during previous generations)
ii. Sometimes friends can peer pressure each other into doing something they don't want to do

b. Peer pressure and bullying come in different forms
i. The movies and TV shows can be different from what happens in real life
ii. Cyberbullying is people are directly saying mean things in media
1. Sometimes there's a disconnect between how cyberbullying is portrayed
2. Often, people can be passive-aggressive through text, not as overt as the media portrays it as

c. Peer pressure in real life is driven by FOMO (fear of missing out)
i. Social dynamics that push people to try to feel cool
ii. Peer pressure is often internalized sometimes
1. The mind in your head forces you to feel isolated from the rest of the group or grade
2. The societal need to FIT IN!

d. Sports! You must do a sport to find friends and be involved in things

c. Is there a community that you feel doesn't offer enough resources to support the social factors of health?

a. Food availability based on the stores in your community etc.
b. Transportation in Stoneham is difficult for students
i. Some Kindergarteners have to walk around Stone Zoo to get to school
c. There are only three elementary schools in Stoneham
d. The classrooms are very big and the ratios of student to teacher ratios
i. A student mentioned how their class size is over 30 people (one class is 32) and it has affected their learning environment
ii. Large classes are due to layoffs or budget contractions
iii. In Stoneham, the class size issues has been ballooning and people have begun to notice it

d. What would help with the barriers/challenges that relate to social issues?

a. Melrose has a bus fee, but it would be waived if they cannot afford it. They never deny a student access to transportation
b. Woburn has a peer tutoring program at the high school
i. Middle School has also begun to bring it to the school

e. What are your thoughts on more peer to peer interactions?

a. A student thought it would work well if it was structured well
b. Need a more formal system
c. Another student said that it can be nerve-wracking to go to the peer tutoring because they don't want to be seen getting help

f. Are community hubs for teens or other health centers helpful?

a. Sports centers are a great location to support communities

g. Are there any specific groups in the community, outside of teens, that would benefit from support?

a. Parent support! A student mentioned that they have a big family and the pressure for parents to manage their kids and balance their jobs etc.
    i. It can be stressful to see your child stressed and it can bubble up within the family

h. Any other comments or concerns? Health or mental health concerns?

a. Sleep schedules! A student explained how some people only get 3-4 hours of sleep a day, and the school isn't doing a good job advocating for better sleep schedules
b. Students associate their self-worth and their grades as a reflection of how much you value yourself, or how well you perform in a sport
    i. Academic or performance validation
c. School and sports takes up most of the day
    i. Not much time for people to forge hobbies

Winchester Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Older adults
Location: Wakefield Senior Center
Date, time: 9/17/2024
Facilitator: JSI and Merrimack Valley Elder Services
Approximate number of participants: 20

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Zumba
    ii. There are many classes at the senior center; most classes and social opportunities are at the senior center(s)
    iii. Have a support system
    iv. Go to the Winchester pain clinic
    v. Socialize with friends
    vi. Go to support groups for caregivers
    vii. Tai chi, seated yoga, walking – all this helps physically.
    viii. Malden YMCA offers a program "performance fitness" which helps with balance by using light weights, the class is free.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. The stress of caregiving
    ii. Having your own health issues (heart attack) and caregiving
    iii. Lack of respite care – I would like to do things to care for myself but have limited time available, and need someone to watch my loved one.
    iv. It would be nice if exercise classes were free, some classes at the senior centers are $5/each and if you are on a fixed income paying makes it difficult. Gym memberships are expensive.

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?**

a. Support groups (caregiver and AA)
b. Taking medication(s) – antidepressants are important to maintain mental health.
c. Find ways to reduce/manage stress, positive thinking and being grateful, using a meditation app.
d. Going to the senior center, socializing, and staying active.
e. Being upfront with friends/people about your mental health and getting help if you need it.
f. Alzheimer's association offers online support for caregivers to deal with stressors their website is easy to navigate.

b. What stops you from being as mentally healthy as you'd like to be?

a. Weather can cause issues, being able to get out can be difficult.
b. There is no longer a sense of community in my neighborhood where people help one another. We don't have relationships with neighbors.
c. Feeling overwhelmed and can't do everything.
d. More support groups for caregivers are needed and/or support groups that meet more frequently.
e. Some people stated they used zoom during winter or when unable to get out of the house. Others stated they did not like or did not know how to use a computer; they would prefer to socialize in-person.

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. What social factors are most problematic in your community?

a. Transportation
    i. Very difficult, especially for medical procedures that involve the need for someone else to drop you off and pick you up.
    ii. If you don't have immediate family or don't want to bother someone, how do you get to these appointments?
    iii. This is very stressful, particularly appointments in Boston.
    iv. Transportation should also be free – it should be determined by a person's needs and not by a person's income. Hospitals should offer pick up / drop off services since they require you to have someone drop you off and pick you up.
    v. Can usually get "the Ride", "uber", or "senior center van" to get to a doctor's appointment, but none of those are allowed if you are having cataract surgery or colonoscopy.
b. Housing Costs and Maintenance
    i. It is very difficult to find affordable contractors or landscapers if you need work done at your home. It's all very overpriced even for basic maintenance. Having

yard work done is very expensive and if you can't do it yourself what are your choices?

ii. One person stated when the upkeep of living in a home got too much/too difficult they sold their home and moved to something smaller.

b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others?

a. Elderly people and seniors, especially those that are caregivers

c. What sorts of barriers do they face in getting the resources they need?

a. Fixed income, they can't afford to pay for things around the home or pay for social events or even exercise classes to maintain health.
b. Help around the home is non-existent unless you can afford it.
c. Technology is too advanced – using zoom or a computer is not for everyone. Wakefield senior center offers no free classes, other centers do have free classes.
d. Someone suggested inquiring at the local high school for students to help out shoveling snow or doing yardwork.
e. Someone else suggested branching out to different senior centers to find free classes – all of Malden's classes are free.

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?

a. MVES
b. Church and church friendships
c. AA support groups
d. Caregiver support groups
e. The VA office is very helpful
f. Senior centers
g. Friends and family.

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

a. A resource guide
b. More senior centers offering free classes – having to pay stops many people from being able to attend more classes in a month.

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?
Are there community health issues in your community that we didn't identify?
Are there any other types of resources or supports you'd like to see available in your community?
Participants felt everything was addressed.

Community Listening Sessions

- Presentation from Facilitation Training for Community Facilitators
- Facilitation guide for listening sessions
- Presentation and voting results from February 2025 Listening Session

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

- What is a Community Listening Session?
- Event Agenda
- Role of the Community Facilitator
- Review Breakout Discussion Guide
- Q&A
- Characteristics of a good facilitator (if time permits!)

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

- Closed captioning is available at all sessions
- Interpretation available based on requests made during registration

Goals:

- Interactive, inclusive, participatory sessions that reflect populations served by each Hospital
- Present community health needs assessment data
- Prioritize community health issues
- Identify opportunities for community-driven/led solutions and collaboration

EVENT AGENDA

- Orientation to meeting/Zoom (JSI): 5 minutes
- Welcome and overview of assessment process (BILH): 5 minutes
- Presentation of Key Themes from Data Collection (JSI): 15 minutes
- Breakout Groups (Community Facilitators + Notetakers): ~50 minutes
- Next steps and closing statements (BILH): 1-2 minutes

BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

Each group will have 1 Community Facilitator, 1 JSI Notetaker, and up to 8 participants

Participants will be asked to:

- Prioritize community health issues based on their personal and professional experiences
- Share reaction to key themes from data
- Share ideas on community-based solutions

ROLE OF COMMUNITY FACILITATOR

Establish ground rules

Initiate and guide discussion

Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

JSI will email your event-specific guide 2 days prior to event date

Provides a "script" for the questions you'll ask in the Breakout Sessions

Will include a list of Community Facilitator/Notetaker pairings and contact info for all event staff

LET'S REVIEW.

REMEMBER: YOU HAVE SUPPORT.

YOUR NEXT STEPS

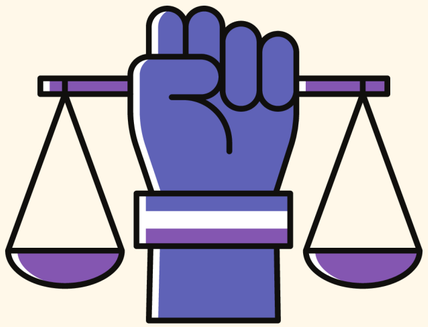
Be sure to register for your Listening Session (both in-person and virtual). For Zoom meetings, registration is required to join and you will be sent your link to join the meeting after you register

Plan to arrive at the meeting 30 minutes prior to start time

Look for an email with your Breakout Discussion Guide 2 days prior to the event

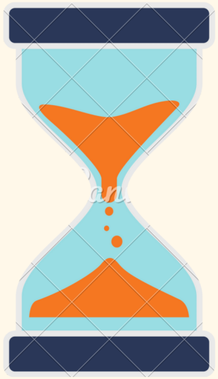
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

INCLUSIVE FACILITATION

inclusive means including everyone

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

Ask participants to share their name, where they're from, and if they're from a particular community organization. Make sure they know that this is optional and if its ok if they'd rather not share

Dedicate time for personal reflection

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

Establish group 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

Maintain eye contact; Pay attention to non-verbal cues that someone may want to share (or doesn't); Thank them for their input

Consider accessibility

Be aware that some folks may be using the dial-in number to join the meeting (if via Zoom). Consider asking for their thoughts directly. Be sure to ask if they're able to see the Mentimeter poll (if not, the notetaker can log their votes for them)

THANK YOU!

Feel free to send in any questions to Madison

madison_maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

Session name, date, time: [filled in before session]
Community Facilitator: [filled in before session]
Notetaker: [filled in before session]
Mentimeter link: [filled in before session]
Miro board: [filled in before session]

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 about 50 minutes. Before we begin, I want to make sure that everybody was able to access the Mentimeter poll. Did anyone run into issues?" *If participants are having trouble logging in, the JSI Notetaker can help get them to the right screen.*

"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, what community you're from, and if you're part of any local community organizations. I'll start. I'm [name], from [community name], and I also work at [organization]." *(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 to our discussion today?"

Priority Area 1: Social Determinants of Health (12 minutes)

Facilitator: "We're going to have a chance to prioritize the issues that were presented during the earlier part of our meeting. First, we will start with the Social Determinants of Health. The priorities in this category are listed here on the screen. Using Mentimeter, **we want you to prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community.** Go ahead and vote now. If you run into issues, let us know and we can help make sure your vote is logged." *[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" [*Notetaker reports to Madison when all votes are logged, and polling results are shared back to all groups]*

Facilitator: "Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- Possible probes (if needed): Are there any issues in the area of social determinants that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 2: Access to Care (12 minutes)

Facilitator: "We're now going to go through the same exercise for our second priority area – Access to Care. Priorities in this category are listed here on the screen. Again, using Mentimeter, please prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community. Go ahead and vote now."*[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" *[Notetaker reports to Madison when all votes are logged. Polling results are then shared back to all groups].*

"Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- **Possible probes (if needed):** Are there any issues in the area of Access to Care that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues than others?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 3: Mental Health and Substance Use (12 minutes)

Facilitator: "We're now going to go through the same exercise for our third priority area – Mental Health and Substance Use. Priorities in this category are listed here on the screen. Again, using Mentimeter, please prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community. Go ahead and vote now."*[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" *[Notetaker reports to Madison when all votes are logged. Polling results are then shared back to all groups].*

"Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- **Possible probes (if needed):** Are there any issues in the area of social determinants that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 4: Chronic and Complex Conditions (12 minutes)

Facilitator: "We're now going to go through the same exercise for our fourth and final priority area – Chronic and Complex Conditions. Priorities in this category are listed here on the screen. Again, using Mentimeter, please prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community. Go ahead and vote now."*[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" *[Notetaker reports to Madison when all votes are logged. Polling results are then shared back to all groups].*

"Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- **Possible probes (if needed):** Are there any issues in the area of Chronic and Complex Conditions that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Wrap up (1 minute)

"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 the next steps in the Needs Assessment process."

Winchester Hospital Community Listening Session

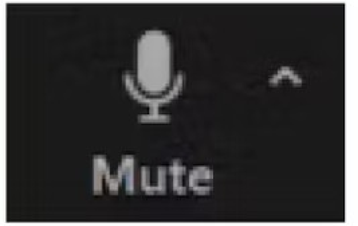
February 13, 2025 | 10:00-11:30am

Beth Israel Lahey Health

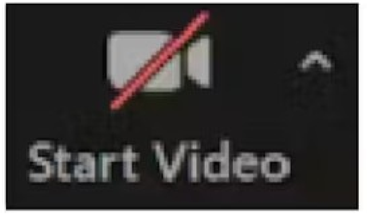
Winchester Hospital Community Listening Session

Meeting Guidelines

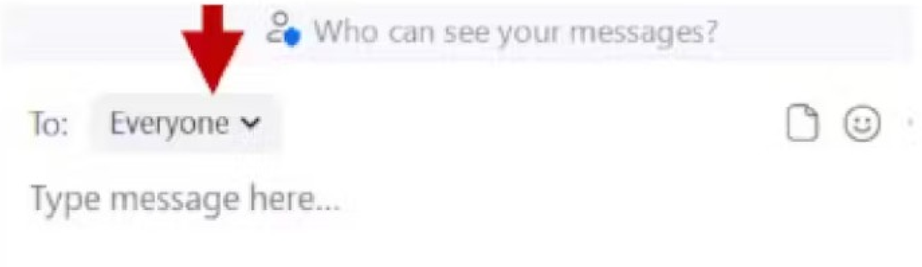
- Please remain on **mute** until we move to Breakout Sessions



- Start your **video** if possible



- **Tech Support** is available – chat with “Tech Support” in Chat



Winchester Hospital Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Winchester Hospital

Winchester Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
10:00-10:05	Zoom orientation and Welcome	JSI
10:05-10:10	President's Welcome Overview of assessment purpose, process, and guiding principles	Al Campbell, President, Winchester Hospital JSI
10:10-10:25	Presentation of preliminary themes and data findings	JSI
10:25-10:30	Transition to Breakout Groups	JSI
10:30-11:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
11:25-11:30	Wrap up and Next Steps	JSI

Assessment Purpose and Process

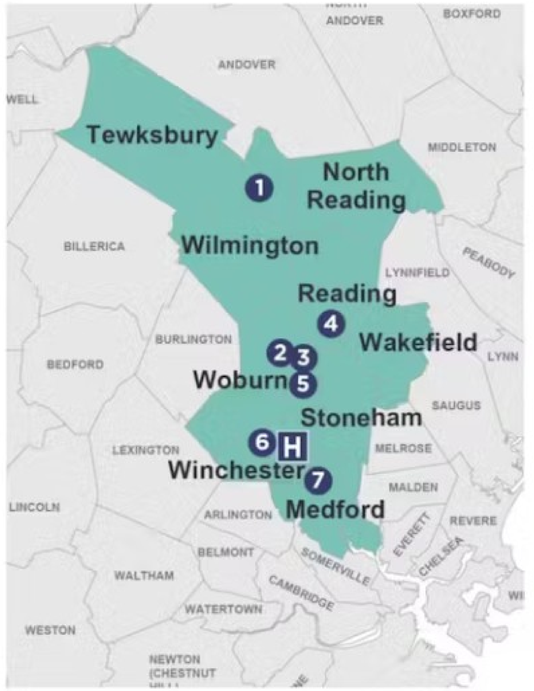
Assessment Purpose and Process

Purpose

Identify and prioritize the community health 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
- 2 Winchester Hospital Sleep Disorder Center
- 3 Winchester Hospital Rehabilitation Services
- 4 Winchester Hospital Rehabilitation Services at Reading Health Center
- 5 Winchester Hospital Outpatient Center
- 6 Winchester Hospital Pain Management Center
- 6 Ambulatory Surgery Center
- 6 Center for Cancer Care
- 6 Radiation Oncology Center
- 7 Wound Healing Center

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

Accountability: Hold each other to efficient, effective and accurate processes to achieve our system, department and communities' collective goals.

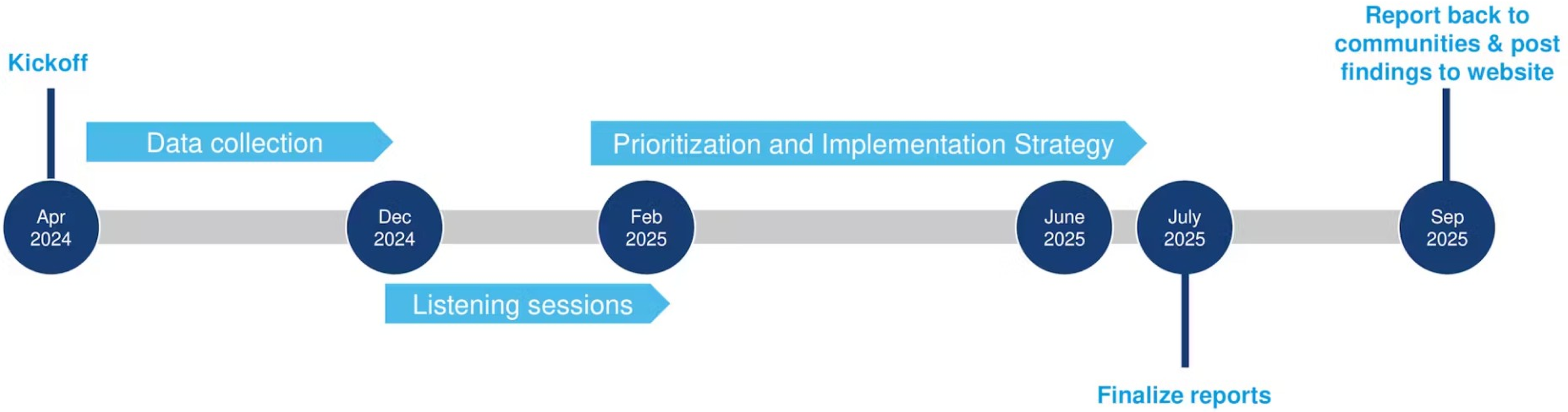
Community Engagement: Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

Equity: Apply an equity lens to achieve fair and just treatment so that ***all*** communities and people can achieve their full health and overall potential.

Impact: Employ evidence-based and evidence-informed strategies that align with system and community priorities to drive measurable change in health outcomes.

Assessment Purpose and Process

FY25 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

Mentimeter

Key Themes & Data Findings

Beth Israel Lahey Health

FY25 CHNA Progress

Activities to date

Collection of secondary data, e.g.:

- US Census Bureau
- Center for Health Information and Analytics (CHIA)
- County Health Rankings
- Behavioral Risk Factor Surveillance Survey
- Youth Risk Behavior Surveys
- CDC and National Vital Statistics
- Other local sources of data

16 Interviews

1,388 FY25 Winchester Hospital Community Health Survey Respondents

5 Focus Groups

- Youth (Mystic Valley Public Health Committee, Social Capital Inc., Boys and Girls Club)
- *Older adults (Wakefield Council on Aging)*
- *Men of color (Front Line of Fresh Barbershop)*
- *Chinese older adults (The Jenks Center)*
- *Medford Community Liaisons (City of Medford)*

FY25 CHNA Progress

FY25 Winchester Hospital Community Health Survey Responses

1,388 responses

(Represents a 69% increase from 822 responses FY22)

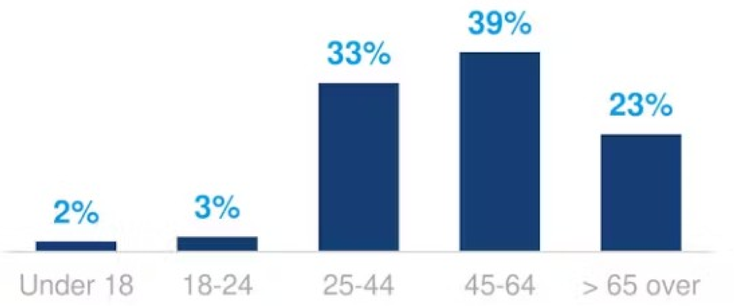
11% of respondents report a language other than English as the primary language spoken in their home **(same in FY22)**

78% of the respondents are women **(down from 82% in FY22)**

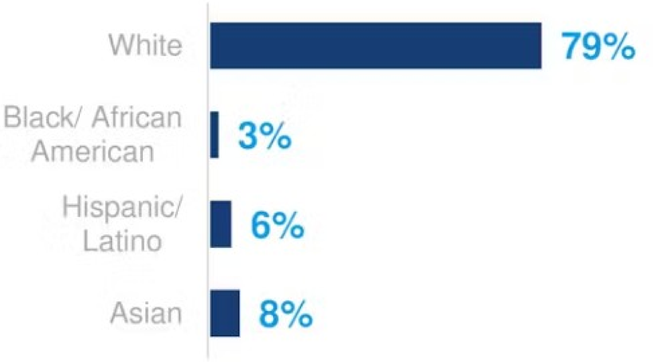
12% of the respondents identify as having a disability **(up from 9% in FY22)**

7% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(same in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 130 in FY25 compared to 32 in FY22
- **Black/African American respondents:** 3% in FY25 compared to 1% in FY22
- **Hispanic respondents:** 6% in FY25 compared to 6% in FY22
- **Asian respondents:** 8% in FY25 compared to 8% in FY22

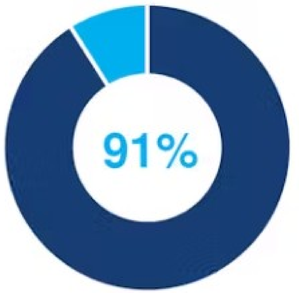
FY25 CHNA Progress

Community Benefits Service Area Strengths

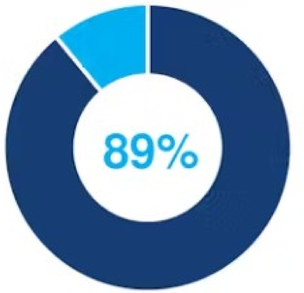
FROM INTERVIEWS & FOCUS GROUPS:

- Partnerships between community-based organizations, and between community-based organizations and municipal government, have remained strong
- Strong school systems and many collaborative and engaged youth-focused organizations
- Walkable communities

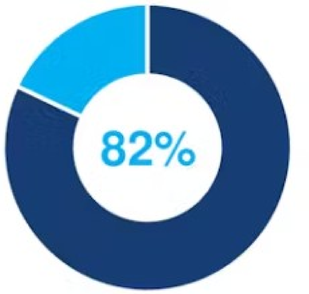
FROM FY25 WINCHESTER HOSPITAL COMMUNITY HEALTH SURVEY:



said they **feel like they belong** in their community
(compared to 87% in FY22)



said they are **satisfied with quality of life in their community**
(compared to 90% in FY22)



said the community **has good access to resources**
(compared to 87% in FY22)

FY25 CHNA Progress

Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

Interviews and survey results show that community health concerns remained remarkably consistent between FY22 and FY25, with the same 4 categories emerging as the preliminary priority areas. Information from focus groups reinforced findings from interviews and survey results.

FY25 CHNA Progress
Social Determinants of Health

Primary concerns:

- Housing issues
- Transportation
- Food insecurity
- Language and cultural barriers to services
- Economic insecurity and high cost of living

"Food insecurity is [a] huge [barrier] to being physically healthy. How can I work out when I don't know where my food is going to come from next?" ***– Focus group participant***

When asked what they'd like to improve in their community, **45%** of FY25 WH Community Health Survey respondents reported **more affordable housing – the #1 response** **(down from 48% in FY22)**

When asked what they'd like to improve in their community, **31%** of FY25 WH Community Health Survey respondents reported **better access to public transportation** **(same as FY22)**

15% of FY25 WH Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

FY25 CHNA Progress

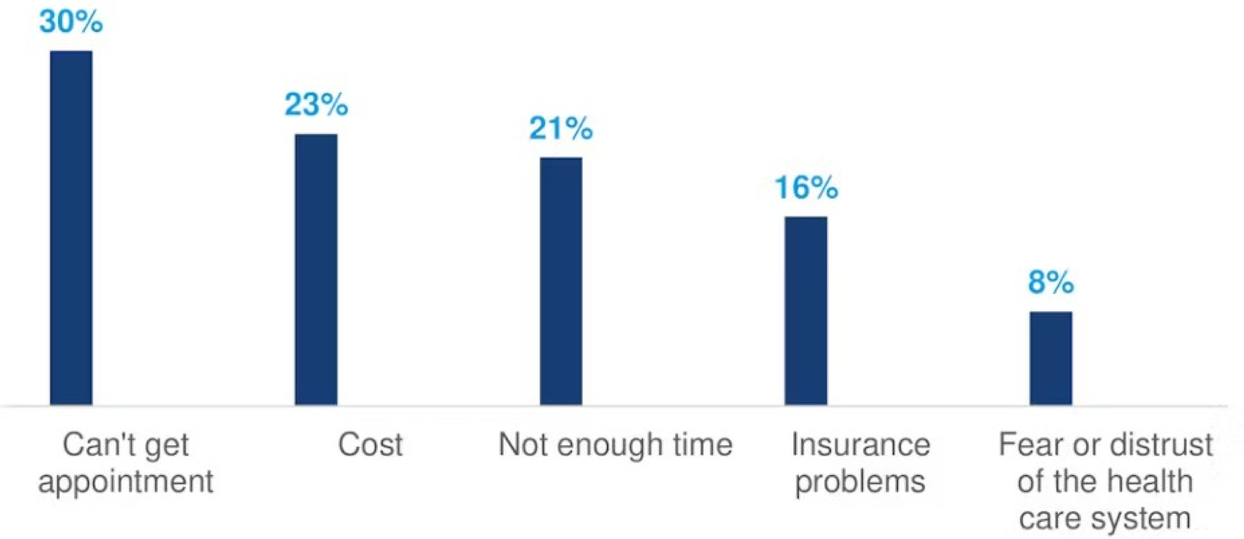
Preliminary Themes: Equitable Access to Care

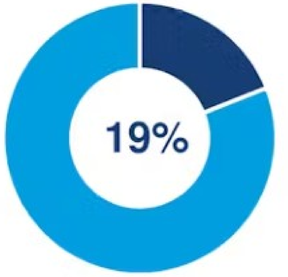
Primary concerns:

- Long wait times for primary, behavioral, and specialty care
- Language and cultural barriers to care
- Health insurance and cost barriers
- Navigating a complex health care system
- Digital divide for telehealth and care navigation

"Some folks just don't have the resources to access the care they need. A lot of older adults don't have a phone. There's a digital divide. What if you are poor, or homeless, and your phone gets cut off?"
*- **Interviewee***

What barriers keep you from getting needed health care?
(Top 5 responses from FY25 Winchester Hospital Community Health Survey)





19% of FY25 WH Community Health Survey respondents reported that health care in their community does not meet people's physical health needs

FY25 CHNA Progress

Preliminary Themes: Mental Health and Substance Use

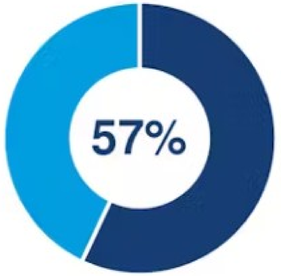
Primary Concerns:

- Youth mental health
- Social isolation (especially for older adults)
- Lack of behavioral health providers (mental health and substance use)
- Lack of supportive and navigation services for individuals with SUD
- Need for community-based education and prevention programs

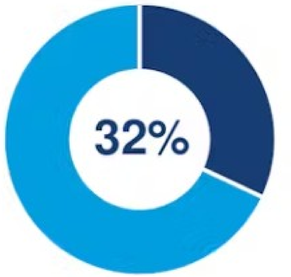
Factors that affect youth mental health (as identified by teens participating in a focus group):

- Pressure and stress of balancing academics, school work, and athletics and being successful in all areas
- Maintaining social reputations and relationships
- Bullying/cyberbullying
- Peer pressure

AMONG FY25 WINCHESTER HOSPITAL COMMUNITY HEALTH SURVEY RESPONDENTS:



57% identified mental health as a heath issue that matters most in their community (#1 response)



32% reported that mental health care in the community does not meet people's needs

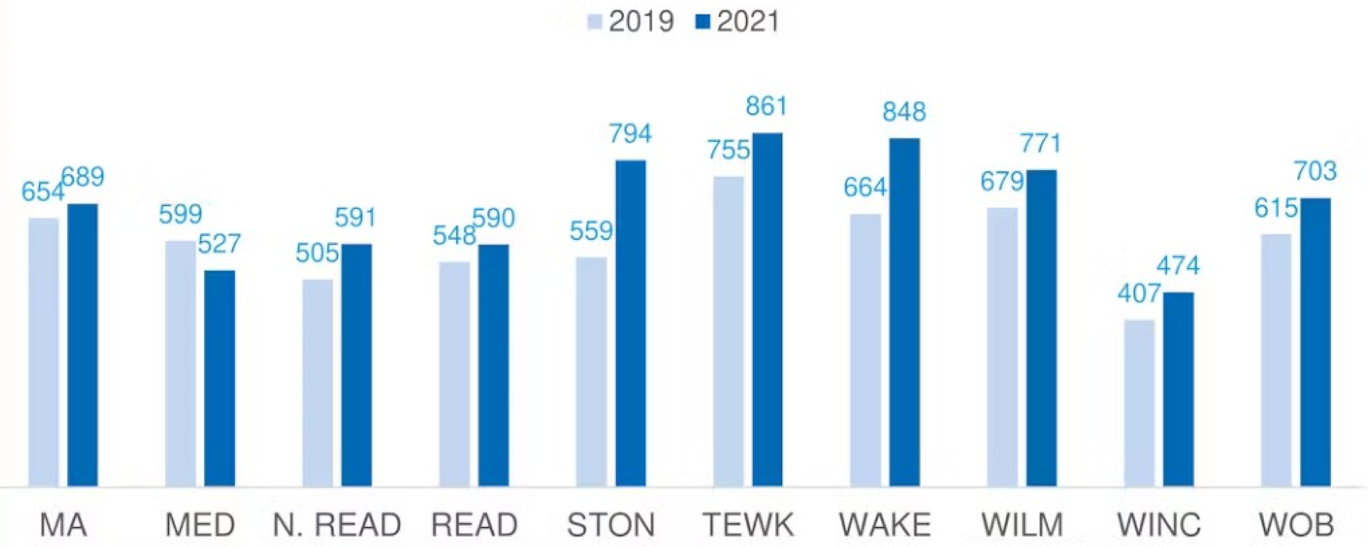
FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

Primary Concerns:

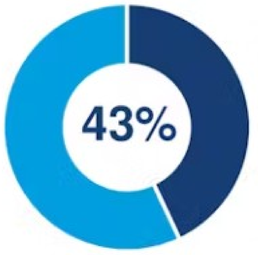
- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Healthy eating/active living
- Need for more community-based education and prevention
- Caregiver support

Age-adjusted All-Cause Mortality Rate, 2019 vs 2021 (rates per 100,000)



Data Source: MDPH, Massachusetts Deaths, 2021

AMONG FY25 WH COMMUNITY HEALTH SURVEY RESPONDENTS:



43% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community (#2 response)

"I'm pleasantly surprised to see more people trying to be knowledgeable about health and how to manage their conditions. I've heard people at dinners refusing foods that are unhealthy. There is an interest." ***- Interviewee***

Instructions

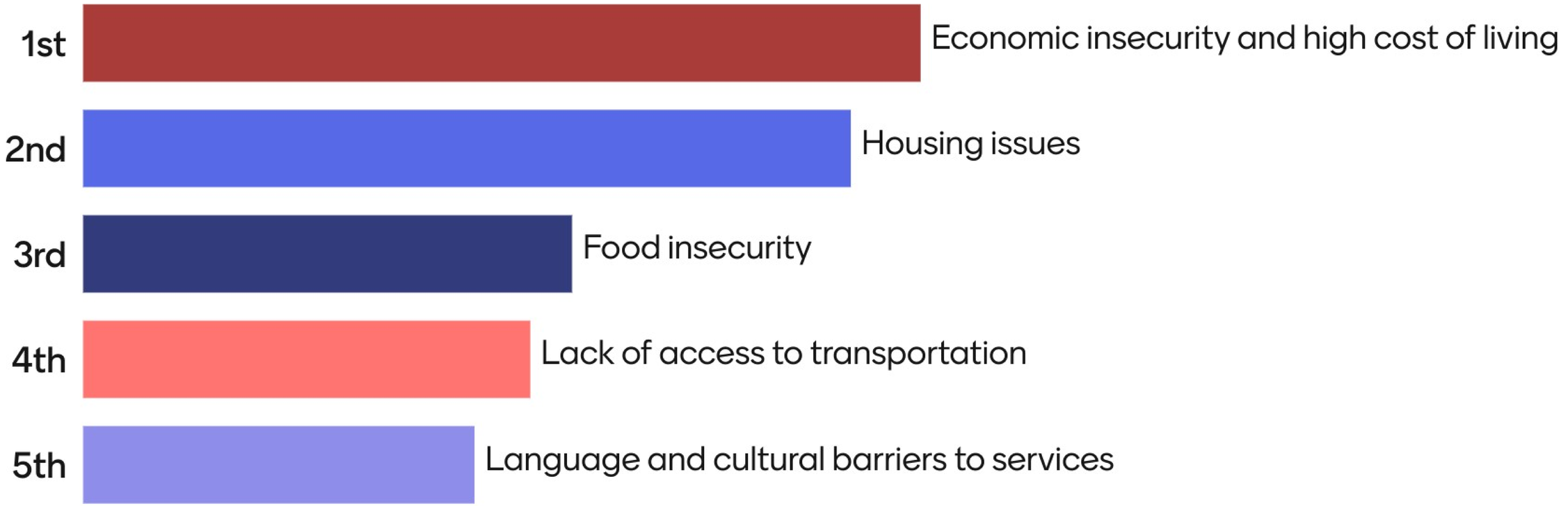
Mentimeter

Breakout Sessions

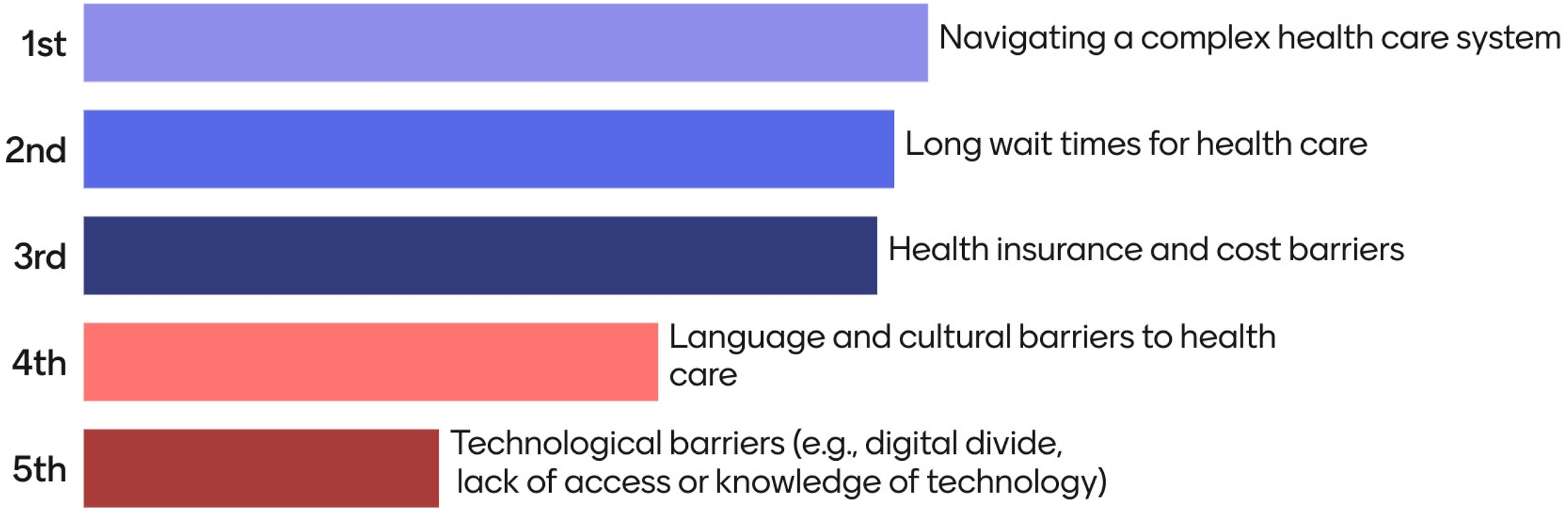
Beth Israel Lahey Health

7

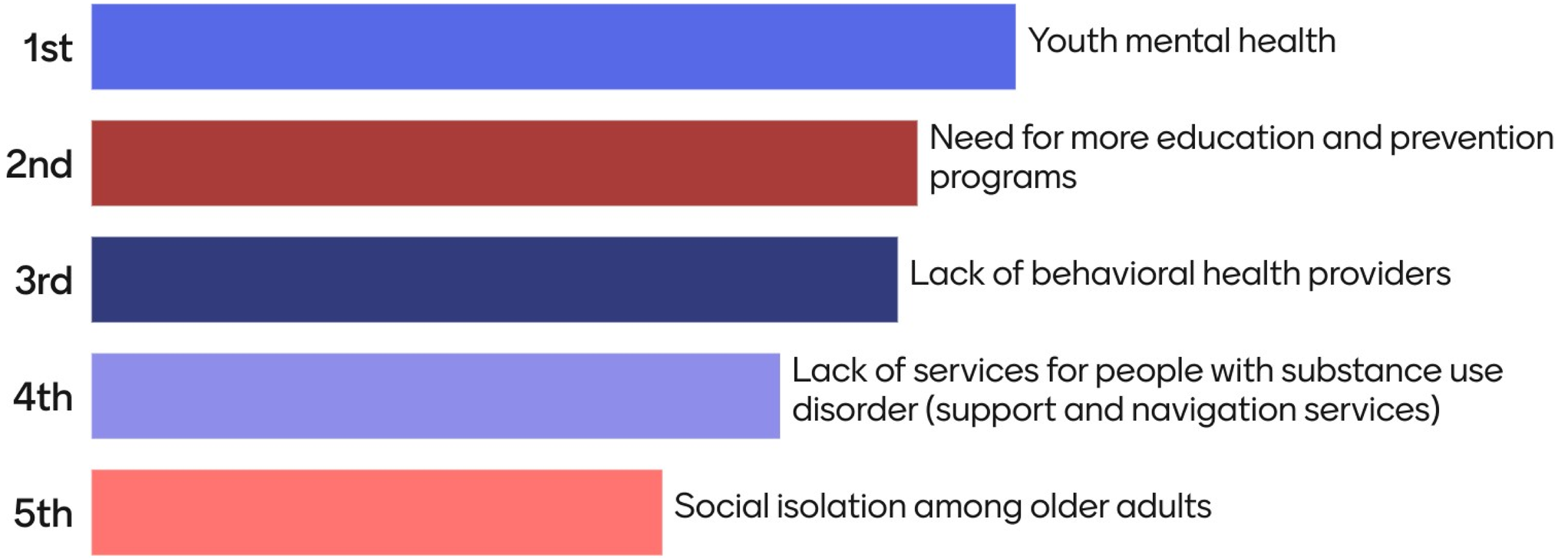
Social Determinants: Rank the following in order of what you feel should be the highest priority, based on needs in your community



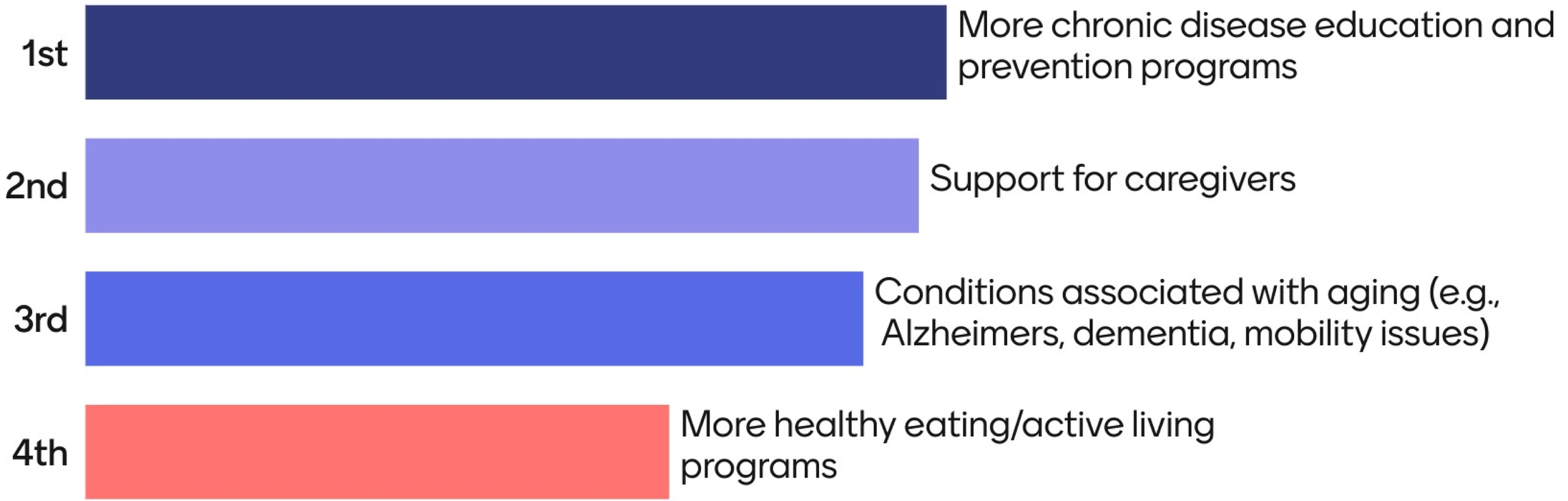
Access to Care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



Mental Health and Substance Use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



Chronic and Complex Conditions: Rank the following in order of what you feel should be the highest priority, based on needs in your community



Mentimeter

Reconvene

Beth Israel Lahey Health

Wrap-up
Winchester Hospital Community Benefits

Questions or Comments on CHNA

Laureane Marquez
Manager, Community Benefits & Community Relations
laureane_marquez@bidmilton.org

Community Health & Community Benefits Information on website:
https://winchesterhospital.org/about/community-benefits-needs

Community Benefits Annual Meeting in September (More info TBD)

Thank you!

Appendix B:
Data Book

Secondary Data

Demographics

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
Demographics							
Population							US Census Bureau, American Community Survey 2019-2023
Total population	6992395	1622896	59062	15634	25448	22986	
Male	48.9%	49.4%	48.1%	49.9%	48.0%	47.8%	
Female	51.1%	50.6%	51.9%	50.1%	52.0%	52.2%	
Age Distribution							US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.1%	3.7%	4.3%	5.8%	6.9%	
5 to 9 years	5.2%	5.4%	3.4%	5.8%	6.5%	5.3%	
10 to 14 years	5.7%	5.6%	3.7%	6.8%	6.8%	5.7%	
15 to 19 years	6.5%	6.3%	6.2%	6.4%	6.2%	3.1%	
20 to 24 years	6.8%	6.8%	8.8%	5.3%	4.1%	3.8%	
25 to 34 years	14.1%	15.1%	22.4%	11.3%	9.4%	13.0%	
35 to 44 years	12.9%	13.8%	12.8%	12.7%	12.7%	17.0%	
45 to 54 years	12.6%	12.8%	11.4%	17.2%	13.8%	11.4%	
55 to 59 years	7.0%	6.8%	6.5%	7.7%	5.2%	6.8%	
60 to 64 years	6.8%	6.2%	5.4%	8.2%	9.1%	6.4%	
65 to 74 years	10.3%	9.3%	9.2%	8.5%	12.2%	10.8%	
75 to 84 years	4.9%	4.6%	3.9%	4.6%	5.9%	6.3%	
85 years and over	2.2%	2.1%	2.6%	1.2%	2.3%	3.6%	
Under 18 years of age	19.6%	19.6%	13.1%	22.0%	23.3%	20.3%	
Over 65 years of age	17.5%	16.0%	15.8%	14.3%	20.5%	20.7%	
Race/Ethnicity							US Census Bureau, American Community Survey 2019-2023

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
White alone (%)	70.70%	69.0%	69.4%	88.1%	87.1%	83.0%	
Black or African American alone (%)	7.0%	5.0%	6.6%	0.5%	0.3%	0.9%	
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.0%	0.0%	0.1%	0.0%	
Asian alone (%)	7.1%	13.2%	12.0%	5.4%	6.2%	7.1%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	4.2%	3.9%	0.7%	0.8%	2.3%	
Two or More Races (%)	9.5%	8.4%	8.1%	5.3%	5.6%	6.6%	
Hispanic or Latino of Any Race (%)	12.9%	9.0%	8.9%	2.1%	4.6%	4.6%	
Foreign-born							US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	366,954	14,267	1,125	2,277	2,919	
Naturalized U.S. citizen	54.5%	51.0%	53.4%	67.8%	66.0%	50.2%	
Not a U.S. citizen	45.5%	49.0%	46.6%	32.2%	34.0%	49.8%	
Region of birth: Europe	18.1%	16.9%	22.7%	24.1%	26.5%	17.9%	
Region of birth: Asia	30.5%	42.9%	41.8%	51.6%	48.4%	46.1%	
Region of birth: Africa	9.5%	7.6%	4.0%	1.8%	5.4%	8.1%	
Region of birth: Oceania	0.3%	0.5%	0.1%	0.6%	1.3%	0.0%	
Region of birth: Latin America	39.4%	29.7%	29.9%	18.1%	12.3%	26.1%	
Region of birth: Northern America	2.2%	2.4%	1.5%	3.7%	6.1%	1.8%	
Language							US Census Bureau, American Community Survey 2019-2023
English only	75.2%	71.7%	70.0%	90.6%	88.7%	82.1%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
Language other than English	24.8%	28.3%	30.0%	9.4%	11.3%	17.9%	
Speak English less than "very well"	9.7%	9.9%	10.0%	1.7%	3.1%	6.3%	
Spanish	9.6%	6.4%	6.8%	1.6%	1.4%	2.8%	
Speak English less than "very well"	4.1%	2.4%	2.2%	0.2%	0.3%	1.1%	
Other Indo-European languages	9.2%	12.2%	14.6%	5.6%	5.5%	8.5%	
Speak English less than "very well"	3.2%	4.1%	4.7%	0.4%	1.3%	2.7%	
Asian and Pacific Islander languages	4.4%	7.8%	7.7%	2.2%	4.4%	4.1%	
Speak English less than "very well"	1.9%	2.9%	2.8%	1.1%	1.5%	1.9%	
Other languages	1.6%	2.0%	0.8%	0.0%	0.0%	2.6%	
Speak English less than "very well"	0.4%	0.5%	0.3%	0.0%	0.0%	0.6%	
Employment							US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	4.2%	4.4%	4.2%	3.0%	3.1%	
Unemployment rate by race/ethnicity							
White alone	4.5%	4.0%	4.5%	3.5%	2.8%	3.0%	
Black or African American alone	7.9%	6.4%	6.8%	-	0.0%	5.2%	
American Indian and Alaska Native alone	6.9%	5.5%	0.0%	-	0.0%	0.0%	
Asian alone	4.0%	3.5%	2.0%	6.5%	5.1%	6.0%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
Native Hawaiian and Other Pacific Islander alone	4.8%	10.9%	0.0%	-	-	-	
Some other race alone	8.0%	6.4%	5.6%	11.7%	13.8%	0.0%	
Two or more races	7.9%	5.4%	5.4%	13.5%	3.5%	1.3%	
Hispanic or Latino origin (of any race)	8.1%	6.2%	4.1%	6.1%	7.3%	0.0%	
Unemployment rate by educational attainment							
Less than high school graduate	9.1%	8.1%	11.3%	0.0%	0.0%	13.6%	
High school graduate (includes equivalency)	6.4%	5.9%	3.5%	6.4%	4.5%	4.4%	
Some college or associate's degree	5.2%	4.9%	3.9%	4.3%	1.4%	1.1%	
Bachelor's degree or higher	2.7%	2.7%	3.7%	1.5%	2.4%	2.8%	
Income and Poverty							US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	126,779	118,089	150,820	163,725	112,635	
Population living below the federal poverty line in the last 12 months							
Individuals	10.0%	7.5%	8.2%	2.8%	2.7%	4.6%	
Families	6.6%	6.7%	11.1%	3.3%	1.2%	6.5%	
Individuals under 18 years of age	11.8%	7.4%	7.0%	0.7%	0.5%	3.3%	
Individuals over 65 years of age	10.2%	8.6%	10.6%	3.4%	5.3%	9.5%	
Female head of household, no spouse	19.1%	15.4%	5.9%	2.5%	13.0%	8.3%	

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Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
White alone	7.6%	6.0%	6.5%	3.1%	2.8%	4.2%	
Black or African American alone	17.1%	15.4%	19.0%	15.3%	0.0%	1.5%	
American Indian and Alaska Native alone	19.1%	12.7%	54.5%	-	0.0%	0.0%	
Asian alone	11.0%	8.6%	12.5%	0.0%	0.9%	5.0%	
Native Hawaiian and Other Pacific Islander alone	21.7%	4.7%	-	-	-	-	
Some other race alone	20.1%	14.2%	3.8%	6.4%	15.2%	0.0%	
Two or more races	15.7%	10.5%	9.3%	0.0%	1.5%	10.5%	
Hispanic or Latino origin (of any race)	20.6%	15.1%	6.0%	2.1%	2.9%	0.2%	
Less than high school graduate	24.4%	20.4%	16.3%	20.6%	17.7%	21.7%	
High school graduate (includes equivalency)	12.7%	12.1%	12.3%	8.6%	8.2%	9.0%	
Some college, associate's degree	9.2%	8.2%	6.6%	2.4%	4.8%	6.7%	
Bachelor's degree or higher	4.0%	3.4%	3.2%	1.0%	1.3%	1.7%	
With Social Security	29.8%	25.8%	24.8%	27.4%	32.0%	33.8%	
With retirement income	22.9%	20.9%	20.2%	22.6%	28.7%	26.4%	
With Supplemental Security Income	5.6%	3.9%	3.6%	5.7%	1.6%	3.8%	
With cash public assistance income	3.5%	2.8%	3.1%	2.1%	1.4%	1.3%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.6%	8.5%	8.5%	1.3%	6.3%	

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Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
Housing							US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	95.5%	94.9%	98.9%	96.9%	96.8%	
Owner-occupied	62.6%	61.6%	53.1%	83.8%	83.1%	71.1%	
Renter-occupied	37.4%	38.4%	46.9%	16.2%	16.9%	28.9%	
Lacking complete plumbing facilities	0.3%	0.3%	0.1%	0.4%	0.7%	0.1%	
Lacking complete kitchen facilities	0.8%	0.9%	0.2%	0.4%	1.2%	0.3%	
No telephone service available	0.8%	0.6%	0.2%	0.7%	0.9%	0.9%	
Monthly housing costs <35% of total household income							
Among owner-occupied units with a mortgage	22.7%	20.7%	24.4%	20.8%	18.9%	19.5%	
Among owner-occupied units without a mortgage	15.4%	15.2%	20.0%	14.0%	11.3%	14.7%	
Among occupied units paying rent	41.3%	37.4%	34.9%	67.9%	21.6%	38.8%	
Access to Technology							US Census Bureau, American Community Survey 2019-2023
Among households							
Has smartphone	89.2%	91.5%	90.7%	90.6%	89.2%	87.6%	
Has desktop or laptop	83.2%	88.4%	85.9%	94.8%	87.9%	88.6%	
With a computer	95.1%	96.5%	96.0%	99.4%	95.3%	96.5%	
With a broadband Internet subscription	91.8%	94.2%	92.7%	96.7%	95.6%	93.6%	

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Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
Transportation							US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	56.0%	50.1%	68.7%	59.6%	70.5%	
Car, truck, or van -- carpooled	6.9%	6.4%	6.2%	3.4%	6.3%	4.7%	
Public transportation (excluding taxicab)	7.0%	8.0%	14.1%	1.2%	5.1%	4.1%	
Walked	4.2%	4.2%	4.4%	1.8%	1.2%	0.5%	
Other means	2.5%	3.2%	3.0%	0.8%	0.1%	0.4%	
Worked from home	16.7%	22.2%	22.2%	24.1%	27.7%	19.7%	
Mean travel time to work (minutes)	29.3	30.0	30.8	32.9	30.6	28.9	
Vehicles available among occupied housing units							
No vehicles available	11.8%	10.4%	12.2%	4.4%	4.5%	4.5%	
1 vehicle available	35.8%	36.5%	41.5%	24.4%	27.0%	36.9%	
2 vehicles available	35.8%	37.8%	34.4%	44.7%	49.7%	43.0%	
3 or more vehicles available	16.6%	15.3%	12.0%	26.5%	18.7%	15.5%	
Education							US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older							
Less than 9th grade	4.2%	3.3%	3.6%	1.0%	2.7%	0.9%	
9th to 12th grade, no diploma	4.4%	3.2%	3.7%	2.1%	1.1%	3.2%	

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Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
High school graduate (includes equivalency)	22.8%	17.5%	18.5%	20.1%	15.8%	23.5%	
Some college, no degree	14.4%	11.2%	11.4%	12.7%	9.6%	12.1%	
Associate's degree	7.5%	5.7%	5.2%	8.5%	5.7%	6.3%	
Bachelor's degree	25.3%	28.8%	30.3%	33.2%	34.3%	31.7%	
Graduate or professional degree	21.4%	30.2%	27.3%	22.3%	30.8%	22.3%	
High school graduate or higher	91.4%	93.4%	92.7%	96.9%	96.2%	95.9%	
Bachelor's degree or higher	46.6%	59.0%	57.6%	55.5%	65.1%	54.0%	
Educational attainment by race/ethnicity							
White alone							
High school graduate or higher	94.6%	96.0%	94.6%	97.0%	96.9%	96.1%	
Bachelor's degree or higher	49.4%	60.9%	56.4%	55.8%	65.8%	55.2%	
Black alone							
High school graduate or higher	87.1%	89.6%	83.8%	92.0%	97.3%	93.1%	
Bachelor's degree or higher	30.7%	40.0%	46.4%	0.0%	41.3%	20.8%	
American Indian or Alaska Native alone							
High school graduate or higher	75.2%	69.1%	0.0%	-	100.0%	-	
Bachelor's degree or higher	24.4%	31.3%	0.0%	-	0.0%	-	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
Asian alone							
High school graduate or higher	86.6%	90.3%	91.4%	95.8%	86.4%	97.3%	
Bachelor's degree or higher	64.0%	71.3%	74.5%	72.7%	59.6%	60.0%	
Native Hawaiian and Other Pacific Islander alone							
High school graduate or higher	86.6%	98.5%	-	-	-	-	
Bachelor's degree or higher	40.0%	20.9%	-	-	-	-	
Some other race alone							
High school graduate or higher	71.6%	73.6%	80.2%	81.1%	99.0%	73.9%	
Bachelor's degree or higher	20.0%	27.1%	44.3%	54.7%	62.9%	18.1%	
Two or more races							
High school graduate or higher	80.6%	85.6%	89.1%	98.4%	96.9%	100.0%	
Bachelor's degree or higher	33.6%	46.1%	57.6%	27.0%	63.0%	42.4%	
Hispanic or Latino Origin							
High school graduate or higher	73.4%	77.6%	83.6%	92.7%	100.0%	82.7%	
Bachelor's degree or higher	23.3%	34.9%	54.9%	45.5%	73.5%	19.7%	
Health insurance coverage among civilian							US Census Bureau, American Community Survey 2019-2023

Key

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Demographics: Medford - Stoneham

			Areas of Interest				
	Massachusetts	**Middlesex County**	**Medford**	**North Reading**	**Reading**	**Stoneham**	**Source**
noninstitutionalized population (%)							US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	97.6%	96.6%	99.3%	98.0%	98.4%	
With private health insurance	73.8%	80.0%	81.3%	86.5%	89.5%	85.0%	
With public coverage	37.1%	29.9%	27.7%	25.5%	25.0%	29.0%	
No health insurance coverage	2.6%	2.4%	3.4%	0.7%	2.0%	1.6%	
Disability							
Percent of population With a disability	12.1%	9.8%	9.2%	10.9%	8.6%	10.5%	
Under 18 with a disability	4.9%	4.1%	3.1%	6.5%	4.4%	2.0%	
18-64	9.4%	7.1%	6.0%	10.5%	5.2%	5.9%	
65+	30.2%	27.9%	29.7%	19.7%	22.8%	32.4%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Demographics								
Population								US Census Bureau, American Community Survey 2019-2023
Total population	6992395	1622896	31168	27284	23195	22862	41205	
Male	48.9%	49.4%	47.6%	50.6%	52.1%	47.5%	48.6%	
Female	51.1%	50.6%	52.4%	49.4%	47.9%	52.5%	51.4%	
Age Distribution								US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.1%	5.3%	6.8%	5.9%	5.4%	5.6%	
5 to 9 years	5.2%	5.4%	4.3%	5.2%	6.0%	8.6%	4.7%	
10 to 14 years	5.7%	5.6%	5.0%	4.8%	6.8%	8.4%	4.1%	
15 to 19 years	6.5%	6.3%	4.5%	4.8%	6.7%	7.8%	5.7%	
20 to 24 years	6.8%	6.8%	5.3%	4.1%	5.8%	2.8%	7.7%	
25 to 34 years	14.1%	15.1%	12.2%	12.6%	9.1%	6.2%	16.4%	
35 to 44 years	12.9%	13.8%	11.4%	14.7%	13.5%	13.4%	12.5%	
45 to 54 years	12.6%	12.8%	14.7%	12.3%	14.0%	16.6%	13.4%	
55 to 59 years	7.0%	6.8%	8.3%	7.2%	9.8%	8.0%	6.6%	
60 to 64 years	6.8%	6.2%	8.9%	8.2%	7.9%	5.0%	7.8%	
65 to 74 years	10.3%	9.3%	11.3%	10.3%	9.2%	9.1%	9.0%	
75 to 84 years	4.9%	4.6%	6.0%	6.2%	4.1%	5.6%	4.0%	
85 years and over	2.2%	2.1%	2.8%	2.8%	1.5%	3.0%	2.7%	
Under 18 years of age	19.6%	19.6%	17.4%	20.0%	22.9%	28.3%	17.7%	
Over 65 years of age	17.5%	16.0%	20.1%	19.3%	14.7%	17.7%	15.6%	
Race/Ethnicity								US Census Bureau, American Community Survey 2019-2023

Key

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
White alone (%)	70.70%	69.0%	88.7%	88.0%	86.8%	72.4%	75.4%	
Black or African American alone (%)	7.0%	5.0%	2.5%	0.8%	1.3%	3.0%	5.9%	
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.1%	0.1%	0.3%	0.1%	
Asian alone (%)	7.1%	13.2%	3.9%	4.9%	4.4%	15.7%	8.2%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	
Some Other Race alone (%)	5.4%	4.2%	0.7%	1.3%	0.5%	1.5%	4.0%	
Two or More Races (%)	9.5%	8.4%	4.2%	5.0%	7.0%	7.1%	6.3%	
Hispanic or Latino of Any Race (%)	12.9%	9.0%	4.2%	2.4%	2.5%	3.2%	5.9%	
Foreign-born								US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	366,954	3,205	2,779	1,638	4,624	8,316	
Naturalized U.S. citizen	54.5%	51.0%	67.3%	66.5%	66.5%	68.0%	53.3%	
Not a U.S. citizen	45.5%	49.0%	32.7%	33.5%	33.5%	32.0%	46.7%	
Region of birth: Europe	18.1%	16.9%	30.3%	25.9%	28.7%	30.5%	20.6%	
Region of birth: Asia	30.5%	42.9%	27.0%	41.5%	44.6%	53.3%	30.0%	
Region of birth: Africa	9.5%	7.6%	12.1%	5.0%	4.6%	4.2%	12.7%	
Region of birth: Oceania	0.3%	0.5%	0.0%	0.0%	0.0%	0.0%	0.2%	
Region of birth: Latin America	39.4%	29.7%	28.0%	25.0%	15.0%	10.6%	36.1%	
Region of birth: Northern America	2.2%	2.4%	2.7%	2.6%	7.1%	1.4%	0.4%	
Language								US Census Bureau, American Community Survey 2019-2023
English only	75.2%	71.7%	86.6%	87.1%	91.4%	73.1%	76.1%	

Key

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Language other than English	24.8%	28.3%	13.4%	12.9%	8.6%	26.9%	23.9%	US Census Bureau, American Community Survey 2019-2023
Speak English less than "very well"	9.7%	9.9%	4.8%	3.5%	1.9%	6.0%	9.1%	
Spanish	9.6%	6.4%	2.7%	2.0%	1.3%	2.4%	3.8%	
Speak English less than "very well"	4.1%	2.4%	1.6%	0.4%	0.1%	0.2%	2.3%	
Other Indo-European languages	9.2%	12.2%	7.2%	7.2%	4.3%	13.5%	14.2%	
Speak English less than "very well"	3.2%	4.1%	2.1%	2.3%	1.4%	2.3%	5.4%	
Asian and Pacific Islander languages	4.4%	7.8%	2.4%	2.7%	2.6%	10.5%	2.8%	
Speak English less than "very well"	1.9%	2.9%	0.9%	0.3%	0.3%	3.4%	1.3%	
Other languages	1.6%	2.0%	1.1%	1.0%	0.5%	0.4%	3.0%	
Speak English less than "very well"	0.4%	0.5%	0.2%	0.4%	0.0%	0.0%	0.2%	
Employment								
Unemployment rate	5.1%	4.2%	4.0%	4.5%	5.1%	3.0%	7.4%	
Unemployment rate by race/ethnicity								
White alone	4.5%	4.0%	4.3%	4.2%	4.8%	3.5%	6.8%	
Black or African American alone	7.9%	6.4%	3.4%	17.6%	26.3%	0.0%	8.0%	
American Indian and Alaska Native alone	6.9%	5.5%	-	0.0%	0.0%	46.5%	0.0%	
Asian alone	4.0%	3.5%	0.7%	0.0%	3.8%	1.5%	6.0%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Native Hawaiian and Other Pacific Islander alone	4.8%	10.9%	-	-	-	-	0.0%	
Some other race alone	8.0%	6.4%	4.0%	14.0%	0.0%	0.0%	24.9%	
Two or more races	7.9%	5.4%	2.7%	8.9%	4.8%	1.8%	3.2%	
Hispanic or Latino origin (of any race)	8.1%	6.2%	1.4%	11.6%	1.3%	0.0%	16.6%	
Unemployment rate by educational attainment								
Less than high school graduate	9.1%	8.1%	27.3%	0.0%	0.0%	0.0%	26.0%	
High school graduate (includes equivalency)	6.4%	5.9%	4.3%	5.4%	6.6%	1.5%	12.7%	
Some college or associate's degree	5.2%	4.9%	3.0%	5.8%	6.1%	9.8%	3.7%	
Bachelor's degree or higher	2.7%	2.7%	0.7%	3.7%	3.6%	1.8%	3.3%	
Income and Poverty								US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	126,779	125,966	130,320	161,473	218,176	107,754	
Individuals	10.0%	7.5%	3.0%	4.6%	3.0%	3.9%	7.8%	
Families	6.6%	6.7%	3.8%	1.0%	2.6%	2.0%	3.1%	
Individuals under 18 years of age	11.8%	7.4%	1.5%	4.3%	1.1%	2.6%	8.3%	
Individuals over 65 years of age	10.2%	8.6%	5.3%	6.0%	2.8%	7.6%	10.3%	
Female head of household, no spouse	19.1%	15.4%	1.2%	7.6%	4.3%	19.8%	14.5%	

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
White alone	7.6%	6.0%	3.0%	3.4%	3.0%	3.7%	6.2%	
Black or African American alone	17.1%	15.4%	5.0%	5.2%	1.6%	0.1%	8.3%	
American Indian and Alaska Native alone	19.1%	12.7%	100.0%	0.0%	0.0%	27.4%	0.0%	
Asian alone	11.0%	8.6%	2.1%	4.9%	0.9%	2.0%	10.3%	
Native Hawaiian and Other Pacific Islander alone	21.7%	4.7%	-	-	-	-	0.0%	
Some other race alone	20.1%	14.2%	9.3%	44.1%	21.1%	44.9%	21.6%	
Two or more races	15.7%	10.5%	0.0%	16.4%	2.9%	3.2%	14.5%	
Hispanic or Latino origin (of any race)	20.6%	15.1%	2.7%	34.5%	9.6%	20.8%	15.9%	
Less than high school graduate	24.4%	20.4%	6.4%	16.8%	7.6%	38.6%	21.0%	
High school graduate (includes equivalency)	12.7%	12.1%	5.5%	7.8%	2.8%	14.1%	10.3%	
Some college, associate's degree	9.2%	8.2%	3.9%	6.6%	7.2%	1.6%	7.4%	
Bachelor's degree or higher	4.0%	3.4%	1.0%	1.9%	2.2%	2.6%	2.9%	
With Social Security	29.8%	25.8%	34.7%	31.7%	29.1%	28.5%	26.5%	
With retirement income	22.9%	20.9%	29.9%	26.3%	21.6%	24.8%	22.6%	
With Supplemental Security Income	5.6%	3.9%	5.0%	2.9%	4.1%	2.0%	4.0%	
With cash public assistance income	3.5%	2.8%	3.4%	1.2%	2.8%	1.6%	3.4%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.6%	5.7%	5.5%	4.9%	1.7%	9.7%	

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			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Housing								US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	95.5%	96.9%	96.0%	98.0%	97.2%	96.3%	
Owner-occupied	62.6%	61.6%	85.0%	70.4%	86.9%	83.4%	57.6%	
Renter-occupied	37.4%	38.4%	15.0%	29.6%	13.1%	16.6%	42.4%	
Lacking complete plumbing facilities	0.3%	0.3%	0.1%	0.2%	0.2%	0.2%	0.7%	
Lacking complete kitchen facilities	0.8%	0.9%	1.3%	0.4%	0.5%	0.6%	1.2%	
No telephone service available	0.8%	0.6%	0.9%	0.3%	0.8%	0.4%	0.7%	
Monthly housing costs <35% of total household income								
Among owner-occupied units with a mortgage	22.7%	20.7%	26.1%	20.6%	22.3%	16.7%	21.0%	
Among owner-occupied units without a mortgage	15.4%	15.2%	17.1%	19.2%	6.7%	18.7%	13.1%	
Among occupied units paying rent	41.3%	37.4%	42.4%	37.1%	32.1%	30.6%	41.8%	
Access to Technology								US Census Bureau, American Community Survey 2019-2023
Among households								
Has smartphone	89.2%	91.5%	89.8%	90.6%	93.1%	90.5%	90.1%	
Has desktop or laptop	83.2%	88.4%	88.4%	87.3%	92.4%	93.2%	85.6%	
With a computer	95.1%	96.5%	95.9%	95.0%	98.3%	96.0%	96.1%	
With a broadband Internet subscription	91.8%	94.2%	94.5%	93.0%	96.4%	95.2%	93.3%	

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Transportation								US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	56.0%	80.1%	62.9%	71.2%	52.3%	68.9%	
Car, truck, or van -- carpooled	6.9%	6.4%	5.2%	5.0%	4.2%	4.4%	9.3%	
Public transportation (excluding taxicab)	7.0%	8.0%	1.3%	6.9%	3.7%	7.1%	3.7%	
Walked	4.2%	4.2%	0.6%	2.4%	0.9%	2.7%	1.5%	
Other means	2.5%	3.2%	0.6%	0.6%	2.1%	1.9%	1.5%	
Worked from home	16.7%	22.2%	12.2%	22.2%	17.9%	31.6%	15.1%	
Mean travel time to work (minutes)	29.3	30.0	31.4	31.8	29.9	30.8	25.9	
Vehicles available among occupied housing units								
No vehicles available	11.8%	10.4%	2.4%	4.1%	4.9%	5.7%	6.3%	
1 vehicle available	35.8%	36.5%	29.9%	37.2%	19.6%	26.3%	36.3%	
2 vehicles available	35.8%	37.8%	42.3%	43.4%	51.8%	52.0%	38.3%	
3 or more vehicles available	16.6%	15.3%	25.4%	15.3%	23.8%	16.0%	19.1%	
Education								US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	3.3%	2.7%	1.8%	1.2%	1.4%	2.4%	
9th to 12th grade, no diploma	4.4%	3.2%	4.3%	2.4%	1.8%	1.3%	3.2%	

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
High school graduate (includes equivalency)	22.8%	17.5%	28.9%	21.0%	24.2%	9.0%	26.0%	
Some college, no degree	14.4%	11.2%	15.7%	11.5%	15.6%	6.9%	13.6%	
Associate's degree	7.5%	5.7%	8.0%	6.3%	7.9%	2.9%	7.4%	
Bachelor's degree	25.3%	28.8%	26.0%	31.9%	30.8%	27.6%	27.4%	
Graduate or professional degree	21.4%	30.2%	14.4%	25.1%	18.4%	50.8%	19.9%	
High school graduate or higher	91.4%	93.4%	93.0%	95.8%	97.0%	97.3%	94.4%	
Bachelor's degree or higher	46.6%	59.0%	40.3%	57.0%	49.2%	78.4%	47.3%	
Educational attainment by race/ethnicity								
White alone								
High school graduate or higher	94.6%	96.0%	93.2%	96.0%	96.9%	97.8%	95.7%	
Bachelor's degree or higher	49.4%	60.9%	39.0%	56.9%	48.3%	78.1%	47.2%	
Black alone								
High school graduate or higher	87.1%	89.6%	99.1%	93.9%	92.9%	89.5%	93.9%	
Bachelor's degree or higher	30.7%	40.0%	71.2%	56.7%	26.7%	63.1%	40.2%	
American Indian or Alaska Native alone								
High school graduate or higher	75.2%	69.1%	100.0%	76.5%	100.0%	87.0%	100.0%	
Bachelor's degree or higher	24.4%	31.3%	0.0%	76.5%	0.0%	43.5%	100.0%	

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Asian alone								
High school graduate or higher	86.6%	90.3%	90.8%	92.2%	99.6%	96.9%	89.9%	
Bachelor's degree or higher	64.0%	71.3%	74.2%	69.4%	83.0%	86.2%	67.2%	
Native Hawaiian and Other Pacific Islander alone								
High school graduate or higher	86.6%	98.5%	-	-	-	-	100.0%	
Bachelor's degree or higher	40.0%	20.9%	-	-	-	-	0.0%	
Some other race alone								
High school graduate or higher	71.6%	73.6%	95.5%	90.0%	100.0%	91.3%	84.1%	
Bachelor's degree or higher	20.0%	27.1%	76.8%	49.3%	45.9%	62.5%	28.8%	
Two or more races								
High school graduate or higher	80.6%	85.6%	85.5%	100.0%	96.5%	97.1%	87.6%	
Bachelor's degree or higher	33.6%	46.1%	13.9%	43.8%	38.5%	73.0%	35.8%	
Hispanic or Latino Origin								
High school graduate or higher	73.4%	77.6%	80.3%	91.0%	95.3%	91.6%	78.3%	
Bachelor's degree or higher	23.3%	34.9%	16.1%	39.3%	55.8%	72.0%	38.2%	
Health insurance coverage among civilian								US Census Bureau, American Community Survey 2019-2023

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Demographics: Tewksbury - Woburn

			Areas of Interest					
	Massachusetts	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
noninstitutionalized population (%)								US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	97.6%	99.1%	97.6%	99.1%	98.4%	98.3%	
With private health insurance	73.8%	80.0%	83.9%	84.8%	88.8%	89.5%	76.2%	
With public coverage	37.1%	29.9%	32.0%	27.7%	25.8%	19.9%	35.7%	
No health insurance coverage	2.6%	2.4%	0.9%	2.4%	0.9%	1.6%	1.7%	
Disability								
Percent of population With a disability	12.1%	9.8%	10.8%	10.9%	10.5%	6.7%	11.7%	
Under 18 with a disability	4.9%	4.1%	3.3%	5.1%	4.9%	3.2%	6.2%	
18-64	9.4%	7.1%	7.8%	6.2%	8.2%	3.1%	9.0%	
65+	30.2%	27.9%	27.2%	32.9%	30.0%	24.4%	29.9%	

Health Status

Health Status: Medford - Stoneham

			Areas of interest				
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Source
Access to Care							
Ratio of population to primary care physicians	103.5	128.3	128.3	128.3	128.3	128.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.2	145.4	145.3	145.7	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	6.7	0.0	3.9	0.0	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health							
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	13.8		11.8	no data	10.1	12.0	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9					CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0					Massachusetts Death Report, 2021
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	4.8	0.0	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	7.6	6.5	No data	4.3	5.0	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	4.2	53.0	33.2	8.2	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	22.9	no data	22.2	23.4	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	24.2	no data	27.6	28.8	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	30.4	no data	35.3	25.4	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	16.4	no data	14.0	16.8	BRFSS, 2022
Chronic Conditions							
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	11.4		10.8	11.2	BRFSS, 2022

Health Status: Medford - Stoneham

			Areas of interest				
	MA	**Middlesex County**	**Medford**	**N. Reading**	**Reading**	**Stoneham**	**Source**
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	7.3		7.7	8.3	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	4.8		3.9	4.7	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	5.0		4.5	4.7	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6		2.5		2.6	2.9	BRFSS, 2022
Cancer							
Mammography screening among women 50-74 (%), age-adjusted	84.9		83.9	no data	83.9	83.4	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5		72.5	no data	74.3	74.8	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)							
All sites	449.4	426.6	426.1	429.1	425.8	427.1	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	52.3	54.2	52.9	50.8	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	109.0	111.0	110.0	107.6	State Cancer Profiles, 2016-2020
Prevention and Screening							
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0		3.1	no data	2.3	3.1	
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	18.2	15.5	16.4	15.2	15.0	15.9	Behavioral Risk Factor Surveillance System, 2021
Adults age 18+ with poor or fair general health (crude %)	12.9	10.6	11.0	10.0	8.9	10.9	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data		86.6	no data	91.0	90.0	
Communicable and Infectious Disease							
STI infection cases (per 100,000)							
Chlamydia	385.8	264.0	293.2	293.2	293.2	293.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021

Health Status: Medford - Stoneham

			Areas of interest				
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Source
Syphilis	10.6	9.8	9.9	9.9	9.9	9.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	84.2	84.2	84.2	84.2	84.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	288.2	288.2	288.2	288.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	2.7	2.7	2.7	2.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19							
Percent of Adults Fully Vaccinated	78.1	87.7	87.0	87.0	87.0	87.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.0	4.0	4.0	4.0	4.0	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use							
Current cigarette smoking (%), age-adjusted	10.4		9.4	no data	7.8	9.5	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2		19.0	no data	18.1	17.7	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	22.2	22.2	22.2	22.2	22.2	CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)	17.9	18.2					Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6					
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0					
Substance-related deaths (Age-adjusted rate per 100k)							MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance	61.9	41.1	36.2	48.7	35.8	32.8	
Opioid-related deaths	33.7	20.1	23.8	37.5	31.6	*	
Alcohol-related deaths	29.1	20.4	14.4	*	*	*	
Stimulant-related deaths	23.0	13.6	12.5	*	*	21.1	
Substance-related ER visits (age-adjusted rate per 100K)							MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	1353.6	778.3	603.3	1164.0	

Health Status: Medford - Stoneham

			Areas of interest				
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Source
Opioid-related ER visits	169.3	102.9	74.5	148.2	35.7	62.3	
Opioid-related EMS Incidents	248.8	176.3	157.6	199.3	39.2	103.3	
Alcohol-related ER visits	1235.6	962.1	1091.2	466.7	428.9	901.4	
Stimulant-related ER visits	15.7	13.6	*	*	*	*	
Substance Addiction Services							MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	243.0	289.3	246.9	271.0	
Number of BSAS providers		201.0	4.0	2.0	2.0	0.0	
Number of clients of BSAS services (residents)		3702.0	92.0	33.0	48.0	44.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	16.0	17.0	17.0	22.0	
Buprenorphine RX's filled	9982.0	6002.1	7269.6	7882.2	3577.9	8879.7	
Individuals who received buprenorphine RX's		508.3	675.5	630.1	286.1	701.3	
Naloxone kits received		35323.0	342.0	112.0	84.0	95.0	
Naloxone kids: Opioid deaths Ratio		78.0	25.0	20.0	6.0	*	
Fentanyl test strips received		50130.0	500.0	0.0	400.0	600.0	
Environmental Health							
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	72.4	100.0	0.0	58.9	100.0	Population in Neighborhoods Meeting Environmental Justice Health Criteria , Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead Screening %	68.0		85.0	72.0	73.0	94.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6		13.2	4.1	3.8	4.8	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0		77.0	57.0	73.0	73.0	ACS 5-year estimates for housing, 2017 - 2021

Health Status: Medford - Stoneham

			Areas of interest				
	MA	Middlesex County	Medford	N. Reading	Reading	Stoneham	Source
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		16.7	17.4	11.6	20.4	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9		9.5	8.5	4.9	8.2	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	5.5	NS	NS	0.0	NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3					EPA - National Air Toxics Assessment, 2018
Mental Health							
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	36.9	36.9	36.9	36.9	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6		24.6	No data	23.4	24.1	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data		34.5	No data	31.0	32.0	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data		23.4	No data	20.0	21.5	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6		15.8	No data	12.8	14.3	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.0	0.0	0.1	0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health							
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.1	7.1	7.1	7.1	County Health Rankings, 2016-2022
Safety/Crime							
Property Crimes Offenses (#)							Massachusetts Crime Statistics, 2023
Burglary	10028.0		60.0	4.0	23.0	42.0	
Larceny-theft	60647.0		498.0	45.0	136.0	150.0	

Health Status: Medford - Stoneham

			Areas of interest				
	MA	**Middlesex County**	**Medford**	**N. Reading**	**Reading**	**Stoneham**	**Source**
Motor vehicle theft	7224.0		72.0	10.0	2.0	9.0	
Arson	377.0		0.0	0.0	0.0	1.0	
Crimes Against Persons Offenses (#)							
Murder/non-negligent manslaughter	162.0		1.0	0.0	0.0	0.0	
Sex offenses	4365.0		16.0	0.0	0.0	10.0	
Assaults	72086.0		392.0	58.0	31.0	107.0	
Human trafficking	0.0		0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)							
Race/Ethnicity/Ancestry Bias	222.0		2.0	1.0	1.0		
Religious Bias	88.0		1.0	0.0	0.0		
Sexual Orientation Bias	80.0		0.0	0.0	0.0		
Gender Identity Bias	22.0		0.0	0.0	0.0		
Gender Bias	2.0		0.0	0.0	0.0		
Disability Bias	0.0		0.0	0.0	0.0		

Health Status: Tewksbury-Woburn

			Areas of interest					
	MA	Middlesex County	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
Access to Care								
Ratio of population to primary care physicians	103.5	128.3	128.3	128.3	128.3	128.3	128.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.1	145.1	145.5	144.9	145.1	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	86.2	3.7	8.6	0.0	78.3	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health								
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	13.8		no data	10.8	11.5	9.5	13.3	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9						CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0						Massachusetts Death Report, 2021
Risk Factors								
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	4.8	0.0	0.0	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	7.6	7.2	4.6	6.0	2.2	7.0	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	65.6	19.8	52.1	24.9	34.7	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	no data	23.1	23.5	20.4	14.2	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	no data	27.1	27.3	26.9	27.9	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	no data	35.5	34.6	35.5	34.1	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	no data	15.0	15.6	13.7	18.0	BRFSS, 2022
Chronic Conditions								

Health Status: Tewksbury-Woburn

			Areas of interest					
	MA	Middlesex County	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable		11.1	11.2	10.2	11.5	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable		7.7	7.9	7.8	8.4	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable		5.0	5.3	4.2	5.9	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable		5.9	6.0	5.6	6.1	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6			2.6	2.7	2.4	2.9	BRFSS, 2022
Cancer								
Mammography screening among women 50-74 (%), age-adjusted	84.9		no data	84.7	82.0	84.2	82.6	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5		no data	74.9	72.1	71.6	71.8	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)								
All sites	449.4	426.6	425.9	426.5	425.0	424.8	427.1	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	51.1	52.9	50.6	51.4	51.6	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	106.7	111.6	110.4	107.9	107.1	State Cancer Profiles, 2016-2020
Prevention and Screening								
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0		no data	78.6	77.8	80.0	77.4	
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	18.2	15.5	16.0	15.6	15.3	14.2	15.8	Behavioral Risk Factor Surveillance System, 2021
Adults age 18+ with poor or fair general health (crude %)	12.9	10.6	11.3	10.1	10.9	8.3	11.4	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data		no data	90.5	90.0	91.9	88.5	
Communicable and Infectious Disease								

Health Status: Tewksbury-Woburn

			Areas of interest					
	MA	Middlesex County	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
STI infection cases (per 100,000)								
Chlamydia	385.8	264.0	293.2	293.2	293.2	293.2	293.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	9.8	9.9	9.9	9.9	9.9	9.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	84.2	84.2	84.2	84.2	84.2	84.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	288.2	288.2	288.2	288.2	288.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	2.7	2.7	2.7	2.7	2.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19								
Percent of Adults Fully Vaccinated	78.1	87.7	87.0	87.0	87.0	87.0	87.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.0	4.0	4.0	4.0	4.0	4.0	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use								
Current cigarette smoking (%), age-adjusted	10.4		no data	8.4	9.8	6.7	11.0	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2		no data	18.6	18.6	16.6	17.8	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	22.2	22.2	22.2	22.2	22.2	22.2	CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)	17.9	18.2						Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6						
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0						
Substance-related deaths (Age-adjusted rate per 100k)								MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance	61.9	41.1	28.6	45.1	29.1	24.2	56.5	
Opioid-related deaths	33.7	20.1	*	17.4	*	0.0	27.6	
Alcohol-related deaths	29.1	20.4	18.0	24.2	*	*	31.1	
Stimulant-related deaths	23.0	13.6	*	*	*	*	23.8	

Health Status: Tewksbury-Woburn

			Areas of interest					
	MA	Middlesex County	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
Substance-related ER visits (age-adjusted rate per 100K)								MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	891.2	1123.0	664.3	652.5	1289.9	
Opioid-related ER visits	169.3	102.9	101.2	110.5	*	48.2	89.8	
Opioid-related EMS Incidents	248.8	176.3	258.4	155.0	171.3	43.5	159.0	
Alcohol-related ER visits	1235.6	962.1	630.1	801.9	499.6	485.9	977.3	
Stimulant-related ER visits	15.7	13.6	*	*	*	0.0	*	
Substance Addiction Services								MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	1123.1	287.9	252.7	87.1	352.3	
Number of BSAS providers		201.0	9.0	4.0	4.0	0.0	12.0	
Number of clients of BSAS services (residents)		3702.0	252.0	51.0	33.0	14.0	97.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	12.0	21.0	19.0	29.0	20.0	
Buprenorphine RX's filled	9982.0	6002.1	12586.9	10826.9	8188.8	1889.4	11126.3	
Individuals who received buprenorphine RX's		508.3	1375.2	897.0	890.8	178.5	917.4	
Naloxone kits received		35323.0	278.0	320.0	140.0	55.0	4481.0	
Naloxone kids: Opioid deaths Ratio		78.0	*	36.0	*	-	154.0	
Fentanyl test strips received		50130.0	1100.0	2400.0	500.0	200.0	1200.0	
Environmental Health								
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	72.4	100.0	63.5	100.0	72.6	81.1	Population in Neighborhoods Meeting Environmental Justice Health Criteria , Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead Screening %	68.0		78.0	79.0	66.0	71.0	73.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6		1.7	4.4	1.8	5.8	10.4	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual

			Areas of interest					
	MA	Middlesex County	Tewksbury	Wakefield	Wilmington	Winchester	Woburn	Source
								average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0		46.0	71.0	52.0	77.0	64.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		13.6	13.3	14.0	15.8	17.2	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9		10.9	7.1	7.8	6.6	7.9	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	5.5	NS	NS	NS	NS	NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3						EPA - National Air Toxics Assessment, 2018
Mental Health								
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	36.9	36.9	36.9	36.9	36.9	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6		no data	24.3	24.7	21.3	24.6	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data		no data	31.8	32.6	30.0	33.5	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data		no data	20.5	21.9	19.7	23.5	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6		no data	13.9	14.6	11.6	15.4	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.3	0.0	0.0	0.0	0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health								
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.1	7.1	7.1	7.1	7.1	County Health Rankings, 2016-2022
Safety/Crime								

Health Status: Tewksbury-Woburn

			Areas of interest					
	MA	**Middlesex County**	**Tewksbury**	**Wakefield**	**Wilmington**	**Winchester**	**Woburn**	**Source**
Property Crimes Offenses (#)								Massachusetts Crime Statistics, 2023
Burglary	10028.0		23.0	11.0	20.0	7.0	36.0	
Larceny-theft	60647.0		321.0	93.0	171.0	52.0	332.0	
Motor vehicle theft	7224.0		18.0	22.0	12.0	2.0	47.0	
Arson	377.0		1.0	1.0	0.0	0.0	2.0	
Crimes Against Persons Offenses (#)								
Murder/non-negligent manslaughter	162.0		0.0	0.0	0.0	0.0	0.0	
Sex offenses	4365.0		25.0	18.0	11.0	1.0	16.0	
Assaults	72086.0		243.0	99.0	106.0	17.0	185.0	
Human trafficking	0.0		0.0	0.0	0.0	0.0	1.0	
Hate Crimes Offenses (#)								
Race/Ethnicity/Ancestry Bias	222.0			1.0	1.0			
Religious Bias	88.0			0.0	0.0			
Sexual Orientation Bias	80.0			0.0	0.0			
Gender Identity Bias	22.0			0.0	0.0			
Gender Bias	2.0			0.0	0.0			
Disability Bias	0.0			0.0	0.0			

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

Note 1: Sample sizes (N) and percentages are displayed below for each survey question. The percentages are weighted by statewide age, race and gender identity distributions. See data notes for more information.

Note 2: The CHES was not designed to be a representative survey of all MA residents and percentages displayed may not be representative of the state.

			MASSACHUSETTS		Middlesex		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	1908	1.30%	528	1.10%	*	*
		Worried about losing	1908	2.60%	528	2.70%	218	2.80%
Housing	Current living situation	Steady place	1908	95.10%	528	95.80%	218	95.90%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	510	22.00%	210	16.20%
		Never	1963	87.80%	546	90.80%	228	90.40%
		Sometimes	1963	9.90%	546	7.00%	228	7.90%
Basic Needs	Food insecurity, past month	A lot	1963	2.30%	546	2.20%	*	*
		No internet	1938	1.30%	538	0.90%	*	*
		Does not work well	1938	6.60%	538	5.20%	222	6.80%
Basic Needs	Current internet access	Works well	1938	92.20%	538	93.90%	222	93.20%
		Somewhat or strongly disagree	1864	2.50%	516	1.60%	*	*
		Somewhat agree	1864	14.60%	516	10.30%	212	9.00%
Neighborhood	Able to get where you need to go	Strongly agree	1864	82.80%	516	88.20%	212	90.10%
		Never	1833	65.00%	504	73.80%	205	76.60%
		Rarely	1833	22.80%	504	19.20%	205	17.10%
		Somewhat often	1833	8.50%	504	4.60%	205	4.90%
Neighborhood	Experienced neighborhood violence, lifetime	Very often	1833	3.70%	504	2.40%	*	*
		No	1739	3.90%	469	3.20%	187	2.70%
		Yes, adult in home	1739	80.50%	469	83.80%	187	85.60%
		Yes, adult outside home	1739	37.30%	469	36.20%	187	41.20%
Safety & Support	Have someone to talk to if needed help	Yes, friend or non-adult family	1739	43.00%	469	44.80%	187	46.50%

			MASSACHUSETTS		Middlesex		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Feel safe with my family/caregivers	Not at all	1768	1.00%	473	1.70%	*	*
		Somewhat	1768	7.70%	473	6.80%	187	7.00%
		Very much	1768	91.30%	473	91.50%	187	93.00%
Safety & Support	Feel I belong at school	Not at all	1760	5.90%	472	5.50%	187	4.30%
		Somewhat	1760	29.10%	472	28.60%	187	28.30%
		Very much	1760	65.00%	472	65.90%	187	67.40%
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	467	3.20%	*	*
		Somewhat	1745	17.10%	467	15.40%	185	15.70%
		Very much	1745	80.50%	467	81.40%	185	82.70%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	471	66.50%	188	61.20%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	471	5.30%	188	6.40%
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	471	18.30%	188	17.00%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	471	13.40%	188	12.80%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	471	6.40%	188	8.50%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	471	13.00%	188	15.40%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	471	72.20%	188	68.60%
Safety & Support	Experienced intimate partner violencea	Ever	1589	13.10%	442	8.60%	177	9.60%
		In past year	1567	7.80%	440	5.20%	176	5.70%
Safety & Support	Experienced household violenceb	Ever	1536	14.20%	420	11.00%	168	8.30%
		In past year	1519	5.50%	417	5.30%	168	3.00%
Safety & Support	Experienced sexual violencec	Ever	1558	9.20%	430	7.70%	172	8.70%
		In past year	1551	3.10%	428	2.10%	171	2.90%
Safety & Support	Experienced discrimination	Ever	1674	45.20%	446	44.80%	175	40.60%
		In past year	1674	19.60%	446	19.50%	175	12.60%

			MASSACHUSETTS		Middlesex		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		No	1652	51.50%	433	56.10%	168	60.10%
		Yes, <10 hours per week	1652	18.10%	433	21.70%	168	14.30%
		Yes, 11-19 hours per week	1652	13.30%	433	12.20%	168	18.50%
		Yes, 20-34 hours per week	1652	10.30%	433	6.50%	168	5.40%
Employment	Worked for pay, past year	Yes, >35 hours per week	1652	6.80%	433	3.50%	*	*
		None of these	1484	66.80%	386	67.60%	147	70.70%
		Frequent absences	1484	7.60%	386	8.30%	147	8.20%
		Needed more support in school	1484	7.00%	386	6.50%	147	3.40%
		Needed more support outside school	1484	6.30%	386	8.00%	147	6.10%
		Safety concerns	1484	5.10%	386	5.20%	147	3.40%
Education	Educational challenges, past year	Temperature in classroom	1484	18.50%	386	16.60%	147	18.40%
		Never	1503	87.70%	391	90.50%	151	90.70%
		Once or twice	1503	9.10%	391	6.90%	151	6.60%
		Monthly	1503	1.60%	391	1.30%	*	*
Education	Hurt or harrassed by school staff, past year	Daily	1503	1.60%	391	1.30%	*	*
		College-preparation	1459	57.90%	382	61.30%	147	62.60%
		Extracurricular activities	1459	74.40%	382	82.20%	147	74.10%
		Guidance conselour	1459	58.80%	382	59.40%	147	59.20%
Education	Helpful school resources provided	Programs to reduce bullying, violence, etc.	1459	19.10%	382	24.30%	147	25.90%
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	139	5.00%	*	*
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	106	5.70%	*	*
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	*	*	*	*

			MASSACHUSETTS		Middlesex		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	72	20.80%	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those needing care)	Yes	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those needing care)	Yes	62	7.90%	*	*	*	*
Healthcare Access	ANY unmet heath care need, past year (among those needing any care)	Yes	857	10.30%	234	10.70%	84	7.10%
Mental Health	Psychological distress, past month	Low	1376	22.10%	362	22.10%	138	22.50%
		Medium	1376	33.00%	362	34.00%	138	31.90%
		High	1376	18.40%	362	20.20%	138	20.30%
		Very high	1376	26.60%	362	23.80%	138	25.40%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	394	14.70%	150	12.70%
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%	352	12.80%	130	12.30%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	390	6.70%	149	9.40%
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	382	8.40%	147	6.80%
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	382	7.30%	147	8.80%
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	383	9.40%	147	9.50%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*	*	*

			MASSACHUSETTS		Middlesex		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	376	8.00%	143	6.30%
		Not sure	1445	5.70%	376	6.40%	143	6.30%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%	190	22.10%	70	22.90%
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%	190	7.40%	70	10.00%
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%	190	20.50%	70	20.00%
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%	190	26.80%	70	18.60%
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%	190	38.90%	70	35.70%
Emerging Issues	Unable to work due to weather, past 5 years1	Yes	767	7.60%	190	6.80%	70	8.60%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years1	Yes	767	33.30%	190	28.90%	70	21.40%
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%	*	*	*	*

			MASSACHUSETTS		Middlesex		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%	190	56.30%	70	52.90%

Community Health Equity Survey (CHES) – Adult

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	3353	1.70%	*	*	*	*	*	*	*	*
		Worried about losing	14888	8.00%	3353	6.50%	84	9.50%	58	8.60%	*	*	*	*
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	84	90.50%	58	87.90%	35	91.40%	47	87.20%
Housing	Issues in current housing 2	Yes, at least one	11103	37.00%	2437	39.10%	60	56.70%	36	38.90%	*	*	35	37.10%
Basic Needs	Trouble paying for childcare/school1	Yes	7486	4.60%	1689	4.70%	*	*	*	*	*	*	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food)1	Yes	7486	18.80%	1689	12.20%	42	19.00%	*	*	*	*	*	*
Basic Needs	Trouble paying for health care1	Yes	7486	15.00%	1689	13.30%	42	31.00%	*	*	*	*	*	*
Basic Needs	Trouble paying for housing1	Yes	7486	19.40%	1689	15.60%	42	19.00%	*	*	*	*	*	*
Basic Needs	Trouble paying for technology1	Yes	7486	8.40%	1689	6.00%	42	11.90%	*	*	*	*	*	*
Basic Needs	Trouble paying for transportation1	Yes	7486	12.60%	1689	9.40%	42	11.90%	*	*	*	*	*	*
Basic Needs	Trouble paying for utilities1	Yes	7486	17.20%	1689	11.90%	42	11.90%	*	*	*	*	*	*
Basic Needs	Trouble paying for ANY basic needs1	Yes	7486	35.20%	1689	27.10%	42	40.50%	*	*	*	*	*	*
Basic Needs	Applied for/received economic assisstance	Yes	14928	20.30%	3366	12.40%	86	14.00%	60	16.70%	*	*	49	18.40%
		Not enough money	13814	16.50%	3141	11.00%	79	8.90%	53	22.60%	35	17.10%	42	14.30%
Basic Needs	End of month finances	Just enough money	13814	31.10%	3141	24.90%	79	26.60%	53	28.30%	35	17.10%	42	23.80%

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Money left over	13814	52.40%	3141	64.10%	79	64.60%	53	49.10%	35	65.70%	42	61.90%
Basic Needs	Current internet access2	No internet	11425	3.00%	2514	1.60%	*	*	*	*	*	*	*	*
		Does not work well	11425	9.30%	2514	7.00%	*	*	39	12.80%	*	*	38	15.80%
		Works well	11425	87.70%	2514	91.50%	62	88.70%	39	84.60%	*	*	38	84.20%
Neighborhood	Able to get where you need to go2	Somewhat or strongly disagree	11064	7.00%	2521	5.50%	*	*	*	*	*	*	*	*
		Somewhat agree	11064	22.00%	2521	21.70%	60	21.70%	44	27.30%	*	*	41	14.60%
		Strongly agree	11064	71.00%	2521	72.80%	60	76.70%	44	65.90%	30	86.70%	41	80.50%
Neighborhood	Experienced neighborhood violence, lifetime2	Never	11008	58.60%	2509	63.50%	60	50.00%	44	63.60%	30	60.00%	41	63.40%
		Rarely	11008	28.90%	2509	28.60%	60	46.70%	44	34.10%	30	23.30%	41	29.30%
		Somewhat often	11008	9.10%	2509	5.80%	*	*	*	*	*	*	*	*
		Very often	11008	3.40%	2509	2.10%	*	*	*	*	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	3236	83.50%	82	87.80%	56	83.90%	33	90.90%	44	77.30%
		Not sure	14393	6.50%	3236	6.60%	82	8.50%	*	*	*	*	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	3233	75.50%	82	74.40%	57	77.20%	33	75.80%	44	70.50%
		Not sure	14366	10.20%	3233	10.80%	82	18.30%	*	*	*	*	44	13.60%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	3226	72.50%	82	73.20%	57	63.20%	33	72.70%	43	67.40%
		Not sure	14325	12.90%	3226	11.60%	82	19.50%	57	10.50%	*	*	43	14.00%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	3222	82.70%	81	82.70%	56	82.10%	33	87.90%	43	83.70%
		Not sure	14336	7.00%	3222	6.80%	81	11.10%	*	*	*	*	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	3212	66.10%	79	60.80%	56	62.50%	33	75.80%	43	58.10%
		Not sure	14247	16.30%	3212	17.40%	79	27.80%	*	*	*	*	43	18.60%
		Ever	13621	29.70%	3068	26.50%	76	25.00%	57	28.10%	31	35.50%	38	31.60%

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Experienced intimate partner violencea	In past year	13359	4.50%	3029	3.20%	*	*	*	*	*	*	*	*
Safety & Support	Experienced sexual violenceb	Ever	13628	21.00%	3073	22.60%	76	27.60%	56	28.60%	*	*	40	30.00%
		In past year	13593	1.40%	3070	1.20%	*	*	*	*	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	3160	59.10%	80	66.30%	55	58.20%	32	65.60%	41	48.80%
		In past year	14130	18.00%	3160	17.20%	80	18.80%	55	20.00%	*	*	*	*
Employment	Have multiple jobs (among all workers)2	Yes	6896	20.90%	1542	19.30%	49	20.40%	*	*	*	*	*	*
Employment	Location of work (among all workers)	At home only	9173	7.50%	2091	10.40%	64	9.40%	*	*	*	*	*	*
		Outside home only	9173	54.60%	2091	42.40%	64	40.60%	31	51.60%	*	*	*	*
		Both at home/outside home	9173	37.40%	2091	46.60%	64	46.90%	31	38.70%	*	*	*	*
Employment	Paid sick leave at work (among all workers)2	Yes	6903	75.30%	1543	76.80%	49	77.60%	*	*	*	*	*	*
		Not sure	6903	4.20%	1543	3.60%	*	*	*	*	*	*	*	*
Healthcare Access	Reported chronic condition 1	Yes	6821	65.20%	1509	63.00%	39	76.90%	*	*	*	*	*	*
Healthcare Access	Unmet need for short-term illness care (among those who needed this care)2	Yes	3455	7.60%	849	5.90%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care)2	Yes	1674	9.00%	443	7.70%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	713	6.60%	*	*	*	*	*	*	*	*

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	69	34.80%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	596	17.40%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)2	Yes	998	7.00%	243	6.60%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care)2	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	174	11.50%	*	*	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)2	Yes	6941	15.20%	1655	12.60%	48	10.40%	*	*	*	*	*	*
Healthcare Access	Telehealth visit, past year1	One or more visit	6747	51.20%	1504	58.80%	38	65.80%	*	*	*	*	*	*
		Offered, didn't have	6747	7.00%	1504	7.60%	*	*	*	*	*	*	*	*
		Not offered	6747	22.10%	1504	19.00%	38	26.30%	*	*	*	*	*	*

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No healthcare visits	6747	20.30%	1504	14.80%	*	*	*	*	*	*	*	*
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	1016	19.20%	*	*	*	*	*	*	*	*
		Not sure	4184	3.80%	1016	3.60%	*	*	*	*	*	*	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	3024	38.70%	79	22.80%	51	41.20%	30	40.00%	36	36.10%
		Medium	13267	32.00%	3024	34.30%	79	39.20%	51	35.30%	30	23.30%	36	30.60%
		High	13267	13.90%	3024	13.70%	79	22.80%	51	15.70%	30	20.00%	36	22.20%
		Very high	13267	17.30%	3024	13.40%	79	15.20%	*	*	30	16.70%	*	*
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	*	*	*	*	*	*	*	*
Mental Health	Suicide ideation, past yearc	Yes	13036	7.40%	2981	7.00%	*	*	*	*	*	*	*	*
Substance Use	Tobacco use, past month2	Yes	10305	14.10%	2294	8.40%	63	14.30%	*	*	*	*	*	*
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	78	60.30%	52	55.80%	30	50.00%	37	37.80%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	80	8.80%	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	80	10.00%	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	79	21.50%	*	*	*	*	38	15.80%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	80	25.00%	52	13.50%	30	20.00%	38	18.40%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	3061	0.40%	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	*	*	*	*	*	*

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Ecstasy/MDMA/LSD/ Ketamine use, past year	Yes	13626	0.80%	3061	0.80%	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, pasy year	Yes	13626	0.60%	*	*	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	3061	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	*	*	*	*	*	*	*	*
Emerging Issues	COVID-19 vaccinatination, past year1	Yes	6729	67.80%	1506	76.40%	38	92.10%	*	*	*	*	*	*
		Not sure	6729	3.60%	1506	3.30%	*	*	*	*	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)2	Yes	6196	22.00%	1445	17.90%	37	13.50%	*	*	*	*	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies , past 5 years2	Yes	10422	37.40%	2312	40.00%	64	57.80%	38	47.40%	*	*	*	*
Emerging Issues	Flooding in home or on street, past 5 years2	Yes	10422	11.00%	2312	11.90%	64	14.10%	38	23.70%	*	*	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years2	Yes	10422	32.20%	2312	35.20%	64	29.70%	38	36.80%	*	*	*	*

			MASSACHUSETTS		MIDDLESEX		Medford		Tewksbury		Wakefield		Woburn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	Power outages, past 5 years2	Yes	10422	24.50%	2312	25.60%	64	29.70%	38	34.20%	*	*	*	*
Emerging Issues	School cancellation due to weather, past 5 years2	Yes	10422	17.60%	2312	19.20%	64	25.00%	38	15.80%	*	*	*	*
Emerging Issues	Unable to work due to weather, past 5 years2	Yes	10422	14.80%	2312	14.60%	64	26.60%	38	15.80%	*	*	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years2	Yes	10422	28.30%	2312	32.40%	64	39.10%	38	31.60%	*	*	*	*
Emerging Issues	Other climate impact, past 5 years2	Yes	10422	1.70%	2312	1.70%	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years2	Yes	10422	67.20%	2312	72.30%	64	78.10%	38	73.70%	*	*	*	*

Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume

CHIA Ages 0-17

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
All Causes										
FY24 ED Volume (all cause) rate per 100,000	4923	3311	2801	2655	3379	2872	3193	2949	3888	4303
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1350	1294	1388	1417	1286	1485	1349	1214	1717
Allergy										
FY24 ED Volume rate per 100,000	293	281	425	354	400	225	384	448	587	392
FY24 Inpatient Discharges rate per 100,000	29	21	6	23	13	22	18	25	26	31
Asthma										
FY24 ED Volume rate per 100,000	347	234	264	129	217	176	255	284	306	263
FY24 Inpatient Discharges rate per 100,000	67	74	64	78	39	57	92	73	78	78
Attention Deficit Hyperactivity Disorder										
FY24 ED Volume rate per 100,000	77	50	83	59	78	138	55	77	96	92
FY24 Inpatient Discharges rate per 100,000	27	8	6	43	4	22	36	4	56	26
Complication of Medical Care										
FY24 ED Volume rate per 100,000	33	14	19	27	39	9	40	17	17	24
FY24 Inpatient Discharges rate per 100,000	49	35	38	15	17	16	18	64	26	24
Diabetes										
FY24 ED Volume rate per 100,000	21	19	25	11	39		7	17	4	9
FY24 Inpatient Discharges rate per 100,000	8	3	6	11		6		8		7

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
HIV/AIDS										
FY24 ED Volume rate per 100,000	0									
FY24 Inpatient Discharges rate per 100,000	0									
Infection										
FY24 ED Volume rate per 100,000	1314	979	553	503	808	669	683	607	727	1178
FY24 Inpatient Discharges rate per 100,000	131	102	77	66	117	73	92	90	78	109
Injuries										
FY24 ED Volume rate per 100,000	922	618	682	649	761	656	691	702	1201	831
FY24 Inpatient Discharges rate per 100,000	49	35	45	11	30	61	44	17	30	39
Learning Disorders										
FY24 ED Volume rate per 100,000	22	19	19	7	13	12	11	34	13	24
FY24 Inpatient Discharges rate per 100,000	24	25	12	7	8	19	36	17	13	19
Mental Health										
FY24 ED Volume rate per 100,000	292	179	218	275	234	347	170	370	355	290
FY24 Inpatient Discharges rate per 100,000	75	63	51	78	60	83	59	30	131	68
Obesity										
FY24 ED Volume rate per 100,000	7	6		3						7
FY24 Inpatient Discharges rate per 100,000	12	6		7		16	7	4		2
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	150	76	83	94	126	80	118	99	78	151

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	32	19	25	31	34	38	40	8	26	36
Poisonings										
FY24 ED Volume rate per 100,000	59	42	19	51	39	35	40	43	35	48
FY24 Inpatient Discharges rate per 100,000	6	9	6			3	3		4	7
STIs										
FY24 ED Volume rate per 100,000	4	4					3	4	4	7
FY24 Inpatient Discharges rate per 100,000	1					3	3			2
Substance Use										
FY24 ED Volume rate per 100,000	48	27	25	59	21	38	48	99	70	36
FY24 Inpatient Discharges rate per 100,000	11	8		23	8	9	11	8	13	14
Age 0-17 Total	4923	3311	2801	2655	3379	2872	3193	2949	3888	4303

CHIA Ages 18-44

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
All Causes										
FY24 ED Volume (all cause) rate per 100,000	11106	7778	4726	4678	7533	6622	6712	5665	4734	9614
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	1998	1680	1605	2096	1987	2051	1910	1315	2685
Allergy										
FY24 ED Volume rate per 100,000	952	1064	1075	1062	1417	923	1290	1086	828	1805
FY24 Inpatient Discharges rate per 100,000	206	199	186	114	252	170	269	215	87	204
Asthma										
FY24 ED Volume rate per 100,000	552	275	289	236	317	257	299	219	153	373
FY24 Inpatient Discharges rate per 100,000	266	199	154	145	213	151	214	280	70	285
Breast Cancer										
FY24 ED Volume rate per 100,000	7	4	6		8	3				7
FY24 Inpatient Discharges rate per 100,000	9	8			4	9				9
CHF										
FY24 ED Volume rate per 100,000	14	12		3		6			8	7
FY24 Inpatient Discharges rate per 100,000	50	27		7	34	45	14	47	26	36
Complication of Medical Care										
FY24 ED Volume rate per 100,000	120	97	64	74	86	70	81	60	52	104
FY24 Inpatient Discharges rate per 100,000	645	636	573	539	578	685	598	664	451	846

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
COPD and Lung Disease										
FY24 ED Volume rate per 100,000	30	17	19	7	4	12	11	21	17	36
FY24 Inpatient Discharges rate per 100,000	40	34	25	7	26	41	33	8	8	26
Diabetes										
FY24 ED Volume rate per 100,000	309	132	231	141	178	122	199	73	96	246
FY24 Inpatient Discharges rate per 100,000	173	152	90	74	91	151	107	73	65	187
GYN Cancer										
FY24 ED Volume rate per 100,000	2									
FY24 Inpatient Discharges rate per 100,000	4	1			4				17	2
Heart Disease										
FY24 ED Volume rate per 100,000	12	4	6		4	9	3	25	8	19
FY24 Inpatient Discharges rate per 100,000	56	50	25	15	60	32	33	47	21	58
Hepatitis										
FY24 ED Volume rate per 100,000	26	6	12	3	17	3	14	4	8	24
FY24 Inpatient Discharges rate per 100,000	70	45	32	23	52	51	44	64	4	73
HIV/AIDS										
FY24 ED Volume rate per 100,000	24	4	19		13	9	3			14
FY24 Inpatient Discharges rate per 100,000	14	11	6		4	19	3			7
Hypertension										
FY24 ED Volume rate per 100,000	447	202	199	157	243	283	306	211	214	348

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	210	170	77	82	100	157	121	181	70	253
Infection										
FY24 ED Volume rate per 100,000	1595	1106	586	535	1078	858	827	676	727	1285
FY24 Inpatient Discharges rate per 100,000	338	223	199	129	295	366	188	271	149	324
Injuries										
FY24 ED Volume rate per 100,000	1775	1115	856	664	1248	1074	1212	827	758	1527
FY24 Inpatient Discharges rate per 100,000	237	184	186	86	221	209	181	146	118	285
Liver Disease										
FY24 ED Volume rate per 100,000	99	69	51	47	104	93	85	43	61	107
FY24 Inpatient Discharges rate per 100,000	191	194	83	110	143	151	136	125	35	217
Mental Health										
FY24 ED Volume rate per 100,000	1310	881	837	834	1100	1077	1119	901	719	1378
FY24 Inpatient Discharges rate per 100,000	834	723	624	483	765	736	735	720	407	1058
Obesity										
FY24 ED Volume rate per 100,000	135	68	83	66	113	86	48	43	48	95
FY24 Inpatient Discharges rate per 100,000	324	212	96	153	182	218	221	185	61	329
Other Cancer										
FY24 ED Volume rate per 100,000	12	6		3	13	12	7		8	4
FY24 Inpatient Discharges rate per 100,000	23	24	12	3	21	12	25	21	17	14
Pneumonia/Influenza										

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 ED Volume rate per 100,000	122	76	64	59	95	86	59	68	96	119
FY24 Inpatient Discharges rate per 100,000	85	68	51	31	91	144	66	94	48	73
Poisonings										
FY24 ED Volume rate per 100,000	182	116	115	59	121	138	99	159	100	197
FY24 Inpatient Discharges rate per 100,000	33	24	12	15	43	16	25	17	8	51
Prostate Cancer										
FY24 ED Volume rate per 100,000	0									
FY24 Inpatient Discharges rate per 100,000	0					3		4		
STIs										
FY24 ED Volume rate per 100,000	77	37	12	15	13	16	7		17	31
FY24 Inpatient Discharges rate per 100,000	37	35	32	7	43	25	29	12	13	48
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	8	8			4	9		17	4	14
FY24 Inpatient Discharges rate per 100,000	19	17	12	3	13	22	11	21		19
Substance Use										
FY24 ED Volume rate per 100,000	2079	1057	843	802	1265	1360	1208	1250	771	1807
FY24 Inpatient Discharges rate per 100,000	588	425	270	200	413	437	395	431	192	600
Tuberculosis										
FY24 ED Volume rate per 100,000	2	4					3			

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	8	14		3	4	3		4		4
Age 18-44 Total	11106	7778	4726	4678	7533	6622	6712	5665	4734	9614

CHIA– Ages 45-64

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
All Causes										
FY24 ED Volume (all cause) rate per 100,000	6844	4673	4398	3808	5345	4857	5208	4769	3520	5737
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	1692	1635	1447	2148	2325	1899	1949	1201	2395
Allergy										
FY24 ED Volume rate per 100,000	797	837	1320	1050	1317	717	1386	1500	732	1488
FY24 Inpatient Discharges rate per 100,000	330	307	302	208	382	241	380	228	162	361
Asthma										
FY24 ED Volume rate per 100,000	299	127	173	129	187	131	199	185	166	168
FY24 Inpatient Discharges rate per 100,000	254	161	186	157	208	186	214	194	105	263
Breast Cancer										
FY24 ED Volume rate per 100,000	40	24	38	23	30	45	22	17	21	31
FY24 Inpatient Discharges rate per 100,000	57	34	83	31	69	70	44	81	52	90
CHF										
FY24 ED Volume rate per 100,000	78	34	32	15	43	80	40	30		46
FY24 Inpatient Discharges rate per 100,000	344	187	225	141	260	347	218	237	74	400
Complication of Medical Care										
FY24 ED Volume rate per 100,000	100	71	32	27	56	106	73	60	35	65

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	428	357	218	220	408	395	321	418	206	495
COPD and Lung Disease										
FY24 ED Volume rate per 100,000	239	90	83	47	91	186	195	34	26	180
FY24 Inpatient Discharges rate per 100,000	415	296	199	149	308	373	299	211	105	485
Diabetes										
FY24 ED Volume rate per 100,000	759	387	399	283	521	550	421	366	153	580
FY24 Inpatient Discharges rate per 100,000	688	511	328	385	548	640	439	487	219	731
GYN Cancer										
FY24 ED Volume rate per 100,000	4	1	6	3		6	3		4	2
FY24 Inpatient Discharges rate per 100,000	16	19	19	19	26	16	14	17		17
Heart Disease										
FY24 ED Volume rate per 100,000	37	24	32	23	39	22	22	34	26	19
FY24 Inpatient Discharges rate per 100,000	280	225	231	137	217	299	210	215	153	265
Hepatitis										
FY24 ED Volume rate per 100,000	23	1			8	9	11	8		4
FY24 Inpatient Discharges rate per 100,000	83	72	19	23	47	25	48	34	30	46
HIV/AIDS										
FY24 ED Volume rate per 100,000	34	9	6	7	4	3	11			
FY24 Inpatient Discharges rate per 100,000	34	22	19	15	4			4	4	17
Hypertension										

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 ED Volume rate per 100,000	1377	749	611	578	869	1026	1005	793	482	1002
FY24 Inpatient Discharges rate per 100,000	918	651	553	546	843	948	735	776	420	970
Infection										
FY24 ED Volume rate per 100,000	813	573	437	421	700	505	609	491	337	565
FY24 Inpatient Discharges rate per 100,000	627	463	379	361	478	701	462	491	324	670
Injuries										
FY24 ED Volume rate per 100,000	1351	1007	746	763	1048	849	1108	892	806	1166
FY24 Inpatient Discharges rate per 100,000	534	429	360	338	530	508	443	349	236	507
Liver Disease										
FY24 ED Volume rate per 100,000	113	63	103	70	86	109	129	155	74	112
FY24 Inpatient Discharges rate per 100,000	383	276	276	236	334	292	336	280	179	417
Mental Health										
FY24 ED Volume rate per 100,000	703	524	540	452	695	559	735	439	306	634
FY24 Inpatient Discharges rate per 100,000	1042	871	631	562	956	1026	964	720	381	1107
Obesity										
FY24 ED Volume rate per 100,000	138	63	77	74	147	122	96	142	65	131
FY24 Inpatient Discharges rate per 100,000	619	432	386	287	482	649	406	478	201	614
Other Cancer										
FY24 ED Volume rate per 100,000	30	29	38		60	35	14	30	8	41

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	100	68	77	90	104	115	51	112	61	117
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	73	35	45	19	78	48	59	38	35	82
FY24 Inpatient Discharges rate per 100,000	228	132	141	98	191	247	147	163	43	251
Poisonings										
FY24 ED Volume rate per 100,000	82	64	51	31	78	48	59	77	30	63
FY24 Inpatient Discharges rate per 100,000	36	22	19	3	34	35	44	47	13	29
Prostate Cancer										
FY24 ED Volume rate per 100,000	12	3	19	7	8	6	3	4	4	14
FY24 Inpatient Discharges rate per 100,000	28	24	19	7	17	41	29	12	21	36
STIs										
FY24 ED Volume rate per 100,000	10	4								
FY24 Inpatient Discharges rate per 100,000	6	6	12			3				4
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	24	17	25	19	21	32	25	17	21	21
FY24 Inpatient Discharges rate per 100,000	92	63	51	35	65	102	70	34	30	121
Substance Use										
FY24 ED Volume rate per 100,000	1492	1075	727	464	961	958	905	862	377	1280
FY24 Inpatient Discharges rate per 100,000	858	571	515	330	808	643	669	564	249	939

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
Tuberculosis										
FY24 ED Volume rate per 100,000	1	1								
FY24 Inpatient Discharges rate per 100,000	11	3		11		6				12
Age 45-64 Total	6844	4673	4398	3808	5345	4857	5208	4769	3520	5737

CHIA– Ages 65+

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
All Causes										
FY24 ED Volume (all cause) rate per 100,000	5485	4097	3767	4607	5810	5423	5315	4350	4485	5222
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	3815	4250	4674	6154	5580	4827	5131	4191	5627
Allergy										
FY24 ED Volume rate per 100,000	798	898	1249	1609	1578	778	1615	1552	1223	1893
FY24 Inpatient Discharges rate per 100,000	671	746	579	810	1191	517	1057	814	683	890
Asthma										
FY24 ED Volume rate per 100,000	155	55	51	78	91	96	181	81	109	100
FY24 Inpatient Discharges rate per 100,000	314	228	244	302	452	289	369	288	227	378
Breast Cancer										
FY24 ED Volume rate per 100,000	69	34	77	82	95	51	40	38	74	82
FY24 Inpatient Discharges rate per 100,000	216	202	135	310	369	286	218	301	311	317
CHF										
FY24 ED Volume rate per 100,000	270	140	160	153	217	250	218	163	210	207
FY24 Inpatient Discharges rate per 100,000	1445	1195	1056	1310	1826	1923	1434	1655	1131	1888
Complication of Medical Care										
FY24 ED Volume rate per 100,000	158	170	148	137	182	135	147	150	135	165
FY24 Inpatient Discharges rate per 100,000	809	699	824	924	1165	1106	853	1060	749	1061

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
COPD and Lung Disease										
FY24 ED Volume rate per 100,000	350	212	193	177	217	488	269	215	118	261
FY24 Inpatient Discharges rate per 100,000	1111	877	1043	865	1383	1360	1116	1246	613	1449
Diabetes										
FY24 ED Volume rate per 100,000	860	553	592	582	917	829	657	633	416	744
FY24 Inpatient Discharges rate per 100,000	1509	1366	1300	1416	2026	1846	1349	1733	1153	1946
GYN Cancer										
FY24 ED Volume rate per 100,000	7			3	4	6	3	12	4	4
FY24 Inpatient Discharges rate per 100,000	27	17	19	19	52	32	22	17	48	36
Heart Disease										
FY24 ED Volume rate per 100,000	90	68	45	110	56	54	66	51	56	90
FY24 Inpatient Discharges rate per 100,000	1079	908	991	1101	1335	1206	1105	1280	797	1214
Hepatitis										
FY24 ED Volume rate per 100,000	7				13	6		4	4	4
FY24 Inpatient Discharges rate per 100,000	51	64	32	51	60	28	22	47	8	51
HIV/AIDS										
FY24 ED Volume rate per 100,000	7	6		7		6				
FY24 Inpatient Discharges rate per 100,000	14	12		7		6	18	4		4
Hypertension										
FY24 ED Volume rate per 100,000	1774	1201	1049	1160	1809	1682	1840	944	1148	1251

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	1758	1566	1841	1983	2513	2229	1881	2087	1801	2273
Infection										
FY24 ED Volume rate per 100,000	718	514	502	598	817	720	639	470	618	604
FY24 Inpatient Discharges rate per 100,000	1455	1272	1326	1459	1944	1685	1615	1759	1385	1756
Injuries										
FY24 ED Volume rate per 100,000	1257	984	850	1172	1513	1151	1260	940	1174	1217
FY24 Inpatient Discharges rate per 100,000	1365	1279	1146	1573	1831	1515	1545	1500	1275	1778
Liver Disease										
FY24 ED Volume rate per 100,000	65	46	25	59	82	41	103	51	48	53
FY24 Inpatient Discharges rate per 100,000	421	317	309	369	561	408	454	444	263	414
Mental Health										
FY24 ED Volume rate per 100,000	347	255	321	393	374	366	465	362	403	373
FY24 Inpatient Discharges rate per 100,000	1456	1285	1081	1263	1687	1865	1548	1526	1030	1668
Obesity										
FY24 ED Volume rate per 100,000	72	51	109	55	100	61	81	73	56	65
FY24 Inpatient Discharges rate per 100,000	764	639	714	609	878	919	676	836	460	790
Other Cancer										
FY24 ED Volume rate per 100,000	58	35	45	55	52	48	36	25	48	58
FY24 Inpatient Discharges rate per 100,000	285	231	347	322	313	350	328	349	206	331
Pneumonia/Influenza										

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 ED Volume rate per 100,000	79	46	90	62	56	102	48	73	39	82
FY24 Inpatient Discharges rate per 100,000	627	536	624	495	917	800	802	737	569	763
Poisonings										
FY24 ED Volume rate per 100,000	30	9	19	27	8	16	29	30	17	24
FY24 Inpatient Discharges rate per 100,000	44	37	64	43	60	70	44	68	39	75
Prostate Cancer										
FY24 ED Volume rate per 100,000	62	42	32	39	52	28	51	43	83	58
FY24 Inpatient Discharges rate per 100,000	221	119	264	173	321	189	240	293	179	297
STIs										
FY24 ED Volume rate per 100,000	1		6							2
FY24 Inpatient Discharges rate per 100,000	7	12	6	3		6		8		4
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	63	55	25	47	86	77	66	47	35	70
FY24 Inpatient Discharges rate per 100,000	290	239	206	263	369	263	314	280	267	302
Substance Use										
FY24 ED Volume rate per 100,000	391	191	238	196	313	337	395	362	162	322
FY24 Inpatient Discharges rate per 100,000	552	369	502	350	543	482	447	526	241	670
Tuberculosis										
FY24 ED Volume rate per 100,000	1	1								

	Winchester Hospital Community Benefits Service Area									
	MA	Medford	North Reading	Reading	Stoneham	Tewksbury	Wakefield	Wilmington	Winchester	Woburn
FY24 Inpatient Discharges rate per 100,000	15	17	6	7	13		3	4	8	29
Age 65+ Total	5485	4097	4250	4674	6154	5580	5315	5131	4485	5627

Community Health Survey

- FY25 WH Community Health Survey
  - Survey output

Beth Israel Lahey Health

Community Health Survey for Beth Israel Lahey Health
2025 Community Health Needs Assessment

Beth Israel Lahey Health and its member hospitals are conducting a Community Health Needs Assessment to better understand the most important health-related issues for community residents. Each hospital must gather input from people living, working, and learning in the community. The information collected will help each hospital 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.

At the end of the survey, you will have the option to enter a drawing for a $100 gift card.

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

Select a language

About Your Community

1. We want to know about your experiences in the community where you spend the most time. This may be where you live, work, play, pray or worship, or learn.

Please enter the zip code of the community where you spend the most time.

Zip code: _____

2. Please select the response(s) that best describes your relationship to the community:

- ☐ I live in this community
- ☐ I work in this community
- ☐ Other (specify: _____)

3. 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 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, daycare, after-school programs, housing, and places to play)	☐	☐	☐	☐	☐

Beth Israel Lahey Health

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.).	☐	☐	☐	☐	☐
My community feels safe.	☐	☐	☐	☐	☐
My community has housing that is safe and of good quality	☐	☐	☐	☐	☐
My community is prepared for climate disasters like flooding, hurricanes, or blizzards.	☐	☐	☐	☐	☐
My community offers people options for staying cool during extreme heat.	☐	☐	☐	☐	☐
My community has services that support people during times of stress and need.	☐	☐	☐	☐	☐
I believe that all residents, including myself, can make the community a better place to live.	☐	☐	☐	☐	☐

4. What are the things you want 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 (_____)

Health and Access to care

5. Please check the response that best describes how much you agree or disagree with each statement about your access to health care in your community.

	Strongly Agree	Agree	Disagree	Strongly Disagree
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.	☐	☐	☐	☐

6. Where do you primarily receive your routine health care? Please choose one.

- ☐ A doctor's or nurse's office
- ☐ A public health clinic or community health center
- ☐ Urgent care provider
- ☐ A hospital emergency room
- ☐ No usual place
- ☐ Other, please specify: _____

7. What barriers, if any, keep you from getting needed health care? Please select all that apply.

- ☐ Fear or distrust of the health care system
- ☐ Not enough time
- ☐ Insurance problems
- ☐ No providers or staff speak my language
- ☐ Can't get an appointment
- ☐ Cost
- ☐ Concern about COVID or other disease exposure
- ☐ Transportation
- ☐ Other, please specify: _____
- ☐ No barriers

8. What health issues matter the most in your community? Please select up to 5 issues from the list below.

- ☐ Aging problems (like arthritis, falls, hearing/vision loss)
- ☐ Alcohol or drug misuse
- ☐ Asthma
- ☐ Cancer
- ☐ Child abuse/neglect
- ☐ Diabetes
- ☐ Domestic violence
- ☐ Environment (like air quality, traffic, noise)
- ☐ Heart disease and stroke
- ☐ Hunger/malnutrition
- ☐ Homelessness
- ☐ Housing
- ☐ Infant death
- ☐ Mental health (anxiety, depression, etc.)
- ☐ Obesity
- ☐ Poor diet/inactivity
- ☐ Poverty
- ☐ Rape/sexual assault
- ☐ Sexually transmitted infections (STIs)
- ☐ Smoking
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Trauma
- ☐ Underage drinking
- ☐ Vaping/E-cigarettes
- ☐ Violence
- ☐ Youth use of social media

About You

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

9. What is the highest grade or school year you have finished?

- ☐ 12th grade or lower (no diploma)
- ☐ High school (including GED, vocational high school)
- ☐ Started college but not finished
- ☐ Vocational, trade, or technical program after high school
- ☐ Associate degree (for example, AA, AS)
- ☐ Bachelor's degree (for example, BA, BS, AB)
- ☐ Graduate degree (for example, master's, professional, doctorate)
- ☐ Other (specify below)
- ☐ Prefer not to answer

10. What is your race or ethnicity? *Select all that apply*.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latine/a/o
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other (specify below)
- ☐ Not sure
- ☐ Prefer not to answer
- ☐ Other: _____

11. What is your sexual orientation?

- ☐ Asexual
- ☐ Bisexual and/or Pansexual
- ☐ Gay or Lesbian
- ☐ Straight (Heterosexual)
- ☐ Queer
- ☐ Questioning/I am not sure of my sexuality
- ☐ I use a different term (specify: _____)
- ☐ I do not understand what this question is asking
- ☐ I prefer not to answer

12. What is your current gender identity?

- ☐ Female, Woman
- ☐ Male, Man
- ☐ Nonbinary, Genderqueer, not exclusively male or female
- ☐ Questioning/I am not sure of my gender identity
- ☐ I use a different term (specify: _____)
- ☐ I do not understand what this question is asking
- ☐ I prefer not to answer

13. In the **past 12 months**, did you have trouble paying for any of the following? *Select all that apply*.

- ☐ Childcare or school
- ☐ Food or groceries
- ☐ Formula or baby food
- ☐ Health care (appointments, medicine, insurance)
- ☐ Housing (rent, mortgage, taxes, insurance)
- ☐ Technology (computer, phone, internet)
- ☐ Transportation (car payment, gas, public transit)
- ☐ Utilities (electricity, water, gas)
- ☐ Other (specify: _____)
- ☐ None of the above

14. What is your age?

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

15. 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 (specify _____)
- ☐ Prefer not to answer

16. 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
☐ Prefer not to answer
☐ Other (specify_____)

17. Do you identify as a person with a disability?

☐ Yes
☐ No
☐ Prefer not to answer

18. I currently:

☐ Rent my home
☐ Own my home (with or without a mortgage)
☐ Live with parent or other caretakers who pay for my housing
☐ Live with family or roommates and share costs
☐ Live in a shelter, halfway house, or other temporary housing
☐ Live in senior housing or assisted living
☐ I do not currently have permanent housing
☐ Other

19. How long have you lived in the United States?

☐ I have always 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
☐ Prefer not to answer

20. 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 your 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 (_____)

May14, 2024

Beth Israel Lahey Health

Enter to Win a $100.00 Gift Card!

To enter the drawing to win a $100 gift card, please:

- Complete the form below by providing your contact information.
- Detach this sheet from your completed survey.
- Return both forms (completed survey and drawing entry form) to the location that you picked up the survey.

---

1. Please enter your first name and the best way to contact you. This information will not be used to identify your answers to the survey in any way.

   First Name: _____

   Email: _____

   Daytime Phone #: _____

2. Would you like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities? ☐ Yes ☐ No
   (If yes, please be sure you have listed your email address above).

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

FY25 BILH CHNA Survey - Winchester Hospital

Response Counts

Completion Rate:	**92.1%**		
	Complete		1,278
	Partial		110

Totals: 1,388

1. Select a language.

Value	Percent	Responses
Take the survey in English	90.3%	1,215
شارك في الاستطلاع باللغة العربية	0.2%	3
参加简体中文调查	4.8%	64
參加繁體中文調查	0.2%	3
Reponn sondaj la nan lang kreyòl ayisyen	0.7%	10
हिंदी में सर्वेक्षण में भाग लें	0.3%	4
Participe da pesquisa em português	1.9%	25
Пройдите анкету на русском языке	0.4%	5
Responda la encuesta en español	1.2%	16

Totals: 1,345

2. Please select the response(s) that best describes your relationship to the community. You can choose more than one answer.

Value	Percent	Responses
I live in this community	93.9%	1,296
I work in this community	22.2%	307
Other, please specify:	1.7%	24

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

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
I feel like I belong in my community. Count Row %	462 33.6%	782 56.9%	76 5.5%	20 1.5%	34 2.5%	1,374
Overall, I am satisfied with the quality of life in my community. *(Think about health care, raising children, getting older, job opportunities, safety, and support.)* Count Row %	391 28.8%	823 60.5%	99 7.3%	21 1.5%	26 1.9%	1,360
My community is a good place to raise children. *(Think about things like schools, daycare, after-school programs, housing, and places to play)* Count Row %	516 37.7%	681 49.8%	82 6.0%	20 1.5%	68 5.0%	1,367
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 %	282 20.6%	700 51.1%	229 16.7%	48 3.5%	110 8.0%	1,369
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	333 24.9%	791 59.1%	129 9.6%	22 1.6%	64 4.8%	1,339
My community feels safe. Count Row %	558 40.7%	727 53.0%	58 4.2%	15 1.1%	13 0.9%	1,371

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	448 32.9%	734 54.0%	97 7.1%	19 1.4%	62 4.6%	1,360
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	181 13.3%	598 43.9%	164 12.0%	30 2.2%	390 28.6%	1,363
My community offers people options for staying cool during extreme heat. Count Row %	201 14.7%	607 44.4%	195 14.3%	26 1.9%	337 24.7%	1,366
My community has services that support people during times of stress and need. Count Row %	168 12.4%	656 48.3%	169 12.5%	27 2.0%	337 24.8%	1,357
I believe that all residents, including myself, can make the community a better place to live. Count Row %	558 41.1%	749 55.1%	24 1.8%	9 0.7%	19 1.4%	1,359
Totals Total Responses						1374

4. What are the things you want to improve about your community? Please select up to 5 items from the list below.

Value	Percent	Responses
Better access to good jobs	14.9%	203
Better access to health care	17.8%	242
Better access to healthy food	18.6%	252
Better access to internet	6.1%	83
Better access to public transportation	31.4%	426
Better parks and recreation	21.0%	285
Better roads	34.2%	464
Better schools	20.1%	273
Better sidewalks and trails	38.4%	521
Cleaner environment	14.1%	191
Lower crime and violence	9.9%	135
More affordable childcare	28.1%	381
More affordable housing	44.5%	604
More arts and cultural events	21.3%	289
More effective city services (like water, trash, fire department, and police)	13.7%	186
More inclusion for diverse members of the community	23.2%	315

Value	Percent	Responses
Stronger community leadership	13.1%	178
Stronger sense of community	14.9%	203
Other, please specify:	5.5%	75

5. Please check the response that best describes how much you agree or disagree with each statement about your access to health care in your community.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	95 7.2%	159 12.1%	749 57.1%	240 18.3%	69 5.3%	1,312
Health care in my community meets the mental health needs of people like me. Count Row %	99 7.6%	310 23.9%	524 40.4%	107 8.2%	258 19.9%	1,298
Totals Total Responses						1312

6. Where do you primarily receive your routine health care? Please choose one.

Value	Percent	Responses
A doctor's or nurse's office	83.9%	1,091
A public health clinic or community health center	7.7%	100
Urgent care provider	2.9%	38
A hospital emergency room	1.8%	24
No usual place	2.2%	29
Other, please specify:	1.5%	19

Totals: 1,301

7. What barriers, if any, keep you from getting needed health care? You can choose more than one answer.

Value	Percent	Responses
Fear or distrust of the health care system	8.3%	106
Not enough time	21.2%	271
Insurance problems	15.9%	204
No providers or staff speak my language	3.0%	38
Can’t get an appointment	29.6%	378
Cost	23.1%	295
Concern about COVID or other disease exposure	4.3%	55
Transportation	6.6%	85
Other, please specify:	6.6%	84
No barriers	38.2%	489

8. What health issues matter the most in your community? Please select up to 5 issues from the list below.

Value	Percent	Responses
Aging problems (like arthritis, falls, hearing/vision loss)	43.0%	530
Alcohol or drug misuse	29.0%	357
Asthma	4.5%	56
Cancer	23.3%	287
Child abuse/neglect	5.5%	68
Diabetes	10.6%	131
Domestic violence	7.4%	91
Environment (like air quality, traffic, noise)	19.1%	236
Heart disease and stroke	16.1%	199
Hunger/malnutrition	6.8%	84
Homelessness	8.8%	108
Housing	26.1%	322
Mental health (anxiety, depression, etc.)	56.6%	698
Obesity	15.9%	196
Poor diet/inactivity	14.8%	183
Poverty	5.2%	64

Value	Percent	Responses
Smoking	6.1%	75
Suicide	9.2%	113
Trauma	6.1%	75
Underage drinking	13.3%	164
Vaping/E-cigarettes	19.2%	237
Violence	3.7%	46
Youth use of social media	35.4%	437
Infant death	0.8%	10
Rape/sexual assault	2.4%	30
Sexually transmitted infections (STIs)	2.7%	33
Teenage pregnancy	1.2%	15

9. What is the highest grade or school year you have finished?

Value	Percent	Responses
12th grade or lower (no diploma)	4.6%	59
High school (including GED, vocational high school)	7.1%	92
Started college but not finished	7.6%	98
Vocational, trade, or technical program after high school	3.4%	44
Associate degree (for example, AA, AS)	6.9%	89
Bachelor's degree (for example, BA, BS, AB)	33.5%	434
Graduate degree (for example, master's, professional, doctorate)	34.9%	452
Other, please specify:	0.6%	8
Prefer not to answer	1.5%	20

Totals: 1,296

10. What is your race or ethnicity? You can choose more than one answer.

Value	Percent	Responses
American Indian or Alaska Native	1.3%	17
Asian	8.0%	102
Black or African American	3.1%	39
Hispanic or Latine/a/o	6.2%	79
Middle Eastern or North African	0.6%	8
Native Hawaiian or Pacific Islander	0.2%	2
White	78.6%	1,001
Other, please specify:	1.3%	16
Not sure	0.2%	3
Prefer not to answer	4.2%	54

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.2%	15
Bisexual and/or Pansexual	2.9%	37
Gay or Lesbian	1.9%	24
Straight (Heterosexual)	84.4%	1,081
Queer	0.7%	9
Questioning/I am not sure of my sexuality	0.3%	4
I use a different term, please specify:	0.4%	5
I do not understand what this question is asking	1.7%	22
I prefer not to answer	6.6%	84

Totals: 1,281

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	78.3%	1,008
Male, Man	17.8%	229
Nonbinary, Genderqueer, not exclusively male or female	0.9%	11
Questioning/I am not sure of my gender identity	0.1%	1
I use a different term, please specify:	0.2%	3
I do not understand what this question is asking	0.5%	6
I prefer not to answer	2.3%	30

Totals: 1,288

13. In the past 12 months, did you have trouble paying for any of the following? You can choose more than one answer.

Value	Percent	Responses
Childcare or school	4.9%	62
Food or groceries	15.3%	193
Formula or baby food	1.7%	21
Health care (appointments, medicine, insurance)	14.2%	179
Housing (rent, mortgage, taxes, insurance)	17.4%	220
Technology (computer, phone, internet)	5.1%	64
Transportation (car payment, gas, public transit)	8.8%	111
Utilities (electricity, water, gas)	11.3%	143
Other, please specify:	2.6%	33
None of the above	66.5%	838

14. What is your age?

Value	Percent	Responses
Under 18	1.5%	20
18-24	2.5%	33
25-44	33.0%	428
45-64	39.0%	506
65-74	12.5%	162
75-84	7.9%	102
85 and over	2.7%	35
Prefer not to answer	0.8%	11

Totals: 1,297

15. What is the primary language(s) spoken in your home? You can choose more than one answer.

Value	Percent	Responses
Armenian	2.9%	38
Chinese (including Mandarin and Cantonese)	4.4%	57
English	87.6%	1,130
Haitian Creole	2.1%	27
Hindi	0.9%	11
Portuguese	2.9%	37
Russian	0.8%	10
Spanish	2.9%	37
Vietnamese	0.1%	1
Other, please specify:	2.7%	35
Prefer not to answer	1.1%	14

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	49.3%	636
Employed part-time (Less than 40 hours per week)	14.3%	184
Self-employed (Full- or part-time)	4.5%	58
A stay-at-home parent	5.4%	70
A student (Full- or part-time)	1.6%	21
Unemployed	2.5%	32
Unable to work for health reasons	1.9%	24
Retired	18.5%	239
Other, please specify:	1.2%	15
Prefer not to answer	0.9%	12

Totals: 1,291

17. Do you identify as a person with a disability?

Value	Percent	Responses
Yes	12.1%	156
No	84.4%	1,084
Prefer not to answer	3.5%	45

Totals: 1,285

18. I currently:

Value	Percent	Responses
Rent my home	15.7%	203
Own my home (with or without a mortgage)	70.3%	906
Live with parent or other caretakers who pay for my housing	5.6%	72
Live with family or roommates and share costs	3.4%	44
Live in a shelter, halfway house, or other temporary housing	0.8%	10
Live in senior housing or assisted living	2.2%	28
I do not currently have permanent housing	0.9%	12
Other	1.1%	14

Totals: 1,289

19. How long have you lived in the United States?

Value	Percent	Responses
I have always lived in the United States	81.3%	1,049
Less than one year	1.8%	23
1 to 3 years	2.1%	27
4 to 6 years	1.9%	24
More than 6 years, but not my whole life	11.9%	153
Prefer not to answer	1.2%	15

Totals: 1,291

20. 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? You can choose more than answer.

Value	Percent	Responses
My neighborhood or building	55.6%	700
Faith community (such as a church, mosque, temple, or faith-based organization)	23.6%	297
School community (such as a college or education program that you attend or a school that your child attends)	29.5%	371
Work community (such as your place of employment or a professional association)	39.6%	498
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)	12.6%	159
A shared interest group (such as a club, sports team, political group, or advocacy group)	30.0%	378
Another city or town where I do not live	13.1%	165
Other, please feel free to share:	4.9%	62

21. Would you like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities? If yes, please be sure you have listed your email address above.

Value	Percent	Responses
Yes	27.5%	269
No	72.5%	709

Totals: 978

Appendix C:
Resource Inventory

Winchester Hospital Corporation Community Resource List

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

Health Issue	Organization	Brief Description	Address	Phone	Website
	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
	Executive Office of Aging & Independence	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	Find Help	Provides resources for financial assistance, food pantries, medical care, and other free or reduced-cost help.			www.findhelp.org
	Mass 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 Behavioral Health Help Line	Available 24 hours a day, 7 days a week, connects individuals and families to the full range of treatment services for mental health and substance use.		833.773.2445	www.masshelpline.com
	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 10th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-aging-independence
	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

Statewide Resources	Massachusetts Behavioral Health Help Line (BHHL) Treatment Connection	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.		833.773.2445	www.masshelpline.com/MABHHLTreatmentConnectionResourceDirectory
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for substance use treatment, recovery, and problem gambling services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		988	www.988lifeline.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	
	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)	
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		988	www.veteranscrisisline.net
Domestic Violence	Boston Area Rape Crisis Center-Family Justice Center	Provides free, confidential support and services to survivors of sexual violence.		617.492.8306 24/7 Hotline: 800.841.8371	www.barcc.org
	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
	Council of Social Concern	Provides food assistance to residents of Woburn and Winchester.	2 Merrimac St Woburn	781.935.6495	www.socialconcern.org

Food Assistance	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
Housing Support	Heading Home	Provides emergency shelter, transitional, and permanent housing for extremely low-resource families and individuals.	186 Massachusetts Ave Boston	617.864.8140	www.headinghomeinc.org
	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.tewksbury-ma.gov/492/Housing-Authority
	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
	Advocates Community Behavioral Health Centers	Provides routine appointments, same-day access for urgent issues, and 24/7 crisis intervention for people of all ages.	675 Main St Waltham	781.893.2003	www.advocates.org/services/cbhc
	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	www.bilhbehavioral.org
	Cambridge Community Behavioral Health Center	Provides treatment for mental health and substance use disorders.	1493 Cambridge St Cambridge	833.222.2030	www.challiance.org/sandbox-area/psych-about-the-cbhc
	Eliot Community Behavioral Health Centers	Provides substance use and mental health treatment programs including urgent and emergency services, crisis stabilization, individual and family therapy services and care coordination for youth, families and adults.	95 Pleasant St Lynn	800.988.1111	www.eliotchs.org/cbhc/
Mental Health and Substance Use	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	978.381.4286	www.bilhbehavioral.org
	Triumph Center	Provides counseling, social skills groups, summer programming and psychological evaluation services for children, adolescents, young adults	36 Woburn St Reading	781.942.9277	www.triumphcenter.net
	Vinfen Community Behavioral Health Center	Provides urgent and routine outpatient services; crisis intervention services to support individuals and families.	40 Church St Lowell	978.674.6744	www.vinfen.org/services/cbhc/
	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
	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.	1 Burlington Woods Dr Ste 101 Burlington		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	781.942.6794	www.readingma.gov/205/Elder-Human-Services
Senior Services	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/459/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 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 Bus	Provides local bus service to Boston.			www.mbta.com
	MBTA Commuter Rail Service	Lowell Line stops in Lowell, North Billerica, Wilmington, Woburn, Winchester, and Medford.			www.mbta.com
	Stoneham Shuttle	Provide free local on-demand shuttle service to Stoneham residents.			www.stoneham-ma.gov/1060/Stoneham-Shuttle
	Boys & Girls Clubs of Stoneham	Offers programs in sports & recreation, education, arts, health & wellness, technology, and character & leadership.	15 Dale Court Stoneham	781.438.6770	www.bgcwakefield.org/stoneham-clubhouse/
	Boys & Girls Clubs of Wakefield	Offers programs in sports & recreation, education, arts, health & wellness, technology, and character & leadership.	467 Main St Wakefield	781.246.1343	www.bgcwakefield.org/wakefield-clubhouse/
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
	James L. McKeown Boys & Girls Club of Woburn	Offers programs in sports & recreation, education, arts, health & wellness, technology, and character & leadership.	Charles Gardner Ln Woburn	781.935.3777	www.bgcwoburn.org
	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 2023-2025 Implementation Strategy

Winchester Hospital

Evaluation of 2023-2025 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.

Priority: Equitable Access to Care

Goal: Provide equitable and comprehensive access to high-quality health care services for those who face economic barriers.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	Promote access to health care, health insurance, patient financial counselors, and needed medical services for patients who are uninsured or underinsured.	● Patient financial counselors ● Home Blood Draw program ● Serving the Health Insurance Needs of Everyone (SHINE) Program ● Primary Care Support	● 13,802 patients received financial counseling/screening (FY23) ● 6,488 (FY23) and 1,341 (FY24) home blood draws ○ Patients reported reduced feelings of isolation, as the visit with the phlebotomist provided them with a social opportunity ● 639 consumers served (FY23) by SHINE ○ 171 consumers in Winchester ● 579 consumers served (FY24) by SHINE ○ Consumers resided in Arlington, Burlington, and Winchester ○ 64 consumers in Arlington or WInchester were below low-income subsidy

			● MMS referred 3 people to home delivered meals services and 1 to transportation services (FY24)
● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	Promote equitable care, health equity, and health literacy for patients, especially those who face cultural and linguistic barriers	● Interpreter Services	● 3,275 interpreter services encounters (FY23) ○ Top three languages requested were Spanish, Portuguese, and Chinese Mandarin ● 1,498 interpreter encounters in the outpatient setting and 1,661 interpreter services encounters in the ED setting (FY24) ○ Total of 3,159 interpreter services encounters ○ The top three language requests were Spanish, Portuguese, and Haitian Creole
● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	Reduce barriers to care by providing/ supporting free or reduced cost transportation for homebound residents needing care.	● Medical appointment transportation voucher program ● Jenks Center transportation program	● In FY23, Winchester Hospital provided 130 rides to patients as well as vouchers for 240 medical appointment rides ● In FY24, WInchester Hospital provided over 700 rides as well as vouchers for 120 one way medical appointment rides
● WH Employees	Provide and promote career support services and career mobility programs to hospital employees.	● Career and academic advising ● Hospital-sponsored community college courses	● In FY23, 54 community members placed in internships across BILH hospitals to learn

		● Hospital-sponsored English Speakers of Other Languages (ESOL) classes	● valuable skills. Winchester Hospital participated in offering these internships. In FY23, 22 interns were hired permanently in BILH hospitals. Winchester Hospital participated in these hirings. ● In FY23, ○ 20 BILH employees attended citizenship classes, ○ 135 BILH employees attended career development workshops and ○ 189 BILH employees attended financial literacy classes. Winchester Hospital employees participated in these offerings. ● In FY23, 45 employees across BILH were enrolled in ESOL classes. Winchester Hospital employees participated in these classes

Priority: 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.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	● 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	● Winchester Hospital Meals on Wheels Program: ○ Baseline (FY23): Packed and delivered 4,780 meals to homebound residents; Year 1 (FY24): Packed and delivered 5,143 meals to homebound residents ● Winchester Housing Authority free farmer's market: ○ Baseline (FY23): Provided more than 3,200 pounds of fresh produce to participating residents. Year 1 (FY24): Provided more than 3,200 pounds of fresh produce to participating residents ● Woburn Public Schools Backpack Food Program: ○ Baseline (FY23): Provided backpacks with healthy food and snacks to 5 students from the Woburn Public Schools weekly. Year 1 (FY24): Provided backpacks with healthy food and snacks to 35-50 students from the Woburn Public Schools weekly. ● Farmer's market SNAP Gap matching funds and programs:

			○ Baseline (FY23):15 families were served during the 17-week market season and a total of nearly $2,500 dollars in SNAP match dollars were distributed; Year 1 (FY24): 116 families served; ○ As of October 31, 2024 this project increased the healthy food budgets by $48 for an average of 5 families per week, for 18 weeks during the season
● Low-resourced populations	Support impactful programs that stabilize or create access to affordable housing.	● Metro Housing Boston housing security and stability program	● Metro Housing Boston: ○ Baseline (FY23): Counseling to 18 low- to moderate-income individuals and families to prevent eviction, increase housing stability and economic self-sufficiency; Year 1 (FY24): Counseling to 18 participants who presented with a housing concern or crisis. ○ Over 60% of participants stabilized their housing situation and reported an increased knowledge of the housing search process

● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	Support impactful programs that address issues associated with the social determinants of health.	● Provide community grants to address emerging needs	● # of community grants provided ○ Baseline (FY23): 9 grants; Year 1 (FY24): 9 grants, all 3-year
● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	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.	● Network for Social Justice Housing Coalition ● Medford Food Policy Council ● Middlesex Regional Food Security Coalition	● Participate in community coalitions ○ Baseline (FY23): Participated as a coalition member in the Mystic Valley Public Health Committee; Year 1 (FY24): Participated as a coalition member in the Mystic Valley Public Health Committee ● Network for Social Justice Housing Coalition o Baseline (FY23): Participated as a coalition member in the Network for Social Justice Housing Coalition; Year 1 (FY24): Participated as a coalition member in the Network for Social Justice Housing Coalition. ● Middlesex Regional Food Security Coalition o Baseline (FY23): N/A; Year 1 (FY24): BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for 9 bills that supported access to services to address the root causes of poor health outcomes for all Massachusetts residents.

Priority: 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.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	Support impactful programs that promote healthy development, support children, youth, and their families, and increase their resiliency, coping, and prevention skills.	● School-based mental health and substance use prevention programs and after school youth programs	● School-based mental health and substance use prevention programs and after school youth programs; Burbank YMCA Grant: ○ Baseline (FY23): Three Mental Health First Aid Trainings were held and 15 staff were trained; Year 1 (FY24): Implemented our Youth Healthy Habits program and our Mental Health First Aid trainings for teens.
● Youth ● low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	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.	● Screening, Brief Intervention, Referral to Treatment (SBIRT) & Question, Persuade, Refer (QPR) programs at Boys and Girls Club of Stoneham & Wakefield	● SBIRT; Number screened; # of teens paired with mentors and number of workshops/events conducted ○ Baseline (FY23): Over 300 Stoneham youth were screened. Year 1 (FY24): n/a ○ Baseline (FY23): 48 at-risk youth were paired with mentors; Year 1 (FY24): 105 at-risk youth were paired with mentors ○ Baseline (FY23): Four campaign events and workshops conducted; Year 1 (FY24): 2 campaign events and workshops included: hosted a training for all staff called Supporting LGBTQ+ Youth in School and Community Settings.

● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	● Centralized Bed Management ● Detoxification Services ● Behavioral Health Emergency Department technicians ● BILH Collaborative Care Model ● Mobile Mental Health Clinic – Mystic Valley Elder Services (MVES) ● Collaborative Care Model	● Behavioral Health Emergency Department technicians: ○ Baseline (FY23): Two behavioral health technicians provided a total of 1,005 hours of behavioral health patient care. Year 1 (FY24): Two behavioral health technicians provided a total of 2,047 hours of behavioral health patient care ● BILH Collaborative Care Model: ○ Baseline (FY23): 1,308 patients were seen through the Collaborative Care model in 12 primary care practices. Year 1 (FY24): Served 1,607 patients in 11 primary care practices. ● Mystic Valley Elder Services (MVES): ○ Baseline (FY23):135 new consumers enrolled. Year 1 (FY24): 120 new consumers enrolled. ○ Baseline (FY23): 73% of MVES Mobile Mental Health Program consumers indicated that they were coping better with their daily problems; Year 1 (FY24): 71% of MVES Mobile Mental Health Program consumers indicated that they were coping better with their daily problems.
● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically	Support a model that spans the continuum of care from inpatient to outpatient and community initiatives that identify and address mental	● Healing and Recovering Together (HART) House Tewksbury ● Transitional Support Services - Tewksbury	● Healing and Recovering Together (HART) House Tewksbury: ○ Baseline (FY23): Provided 5,155 bed days of care to program pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder to 67

diverse populations ● LGBTQIA+	health needs and substance use disorders.	● Town of Winchester social worker ● Council on Aging programs for older adult mental health promotion and substance use prevention ● Interface Referral Service – Winchester and Stoneham ● Provide community health grants to address this need	women and 108 children. Year 1 (FY24): Data unavailable as site moved from CBSA ● Town of Winchester social worker: ○ Baseline(FY23): 46 cases and 20 referrals made to community services and programs. Year 1 (FY24): 44 cases and 14 referrals made to community services and programs. ● Interface Referral Service: ○ Baseline (FY23): 47 Stoneham residents were served by INTERFACE; Year 1(FY24): 37 Stoneham residents were served by INTERFACE. ○ Baseline (FY23): 86%, were seeking individual therapy. Year 1 (FY24): 87%, were seeking individual therapy. ● Provide community health grants to address this need: ○ Baseline(FY23): 10 youth engaged as interns. Year 1(FY24): 13 youth engaged as interns ○ Baseline(FY23): 5 community events held. Year 1(FY24): 6 community events held. ○ Baseline(FY23): Attendance at these events totaled 131. Year 1(FY24): Attendance at these events totaled 303 ○ Baseline(FY23): The website received 592 visitors and 216 visits to the mental health event listings on the site. Year 1(FY24): The website received 622 visitors and 1099 visits to the mental health event listings on the site ○ Baseline(FY23): 6 blog posts added and over 100 calendar events. Year 1(FY24): N/A

			● Resiliency skills building opportunities in Tewksbury: o Baseline(FY23): Two listening sessions were conducted; Year 1(FY24): Held two workshops, two events and meditation classes o Baseline(FY23): N/A; Year 1(FY24): Overdose vigil with 200 participants, a PRIDE event picnic with 35 participants and a weekly meditation class at the library with an average of 20 to 45 people per week.
● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	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.	● Mystic Valley Public Health Committee ● Mystic Valley Behavioral Health Coalition ● Middlesex District Attorney (DA) Opioid Task Force ● Local substance use prevention coalitions	● Hospital president letter of support for adoption of Nicotine Free Generation policy in Medford, North Reading, and Winchester ● Hospital president letter of support continuation of the Mystic Valley Elder Services' (MVES) Elder Mental Health Outreach Team (EMHOT) program ● Mystic Valley Public Health Committee o Baseline(FY23): Participated as a coalition member; Year 1(FY24): Participated as a coalition member ● Middlesex District Attorney (DA) Opioid Task Force o Baseline(FY23): Participated as a coalition member; Year 1(FY24): Participated as a coalition member

Priority: 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.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+ ● Youth	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.	● Breast Cancer Risk Assessment ● Oncology Nurse Navigator ● Center for Health Living Health Education Programs ● CHAMP Pediatric Asthma program ● Fighting Fatigue Program ● A Caring Place Wig donation program ● Patient support groups	● Breast Cancer Risk Assessment: ○ Baseline(FY23): 4,216 free breast cancer risk screenings; Year 1(FY24): 2,989 free breast cancer risk screenings. ● Oncology Nurse Navigator: ○ Baseline(FY23): 1744 hours, serving 2324 new patients; Year 1(FY24): 1680 hours providing serving 1890 patients ● Center for Healthy Living Health Education Programs: ○ Baseline(FY23): 3,702 class registrations; Year 1(FY24): 1,078 class registrations ● CHAMP Pediatric Asthma program: ○ Baseline(FY23): 117 children participated in CHAMP; Year 1(FY24): 109 children participated in CHAMP. ○ Baseline(FY23): 146 home visits; Year 1(FY24): 108 home visits ○ Baseline(FY23): One school training session was held via Zoom ○ Baseline(FY23): 218 Asthma Action Plans completed; Year

			1(FY24): 139 Asthma Action Plans completed ● A Caring Place¸Wig donation program: ○ Baseline(FY23): Served 795 patients with compression products, cold caps, and wigs or head coverings. Year 1(FY24): 359 patients were with compression products, cold caps, and wigs or head coverings.
● Youth ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● LGBTQIA+	Support community-based programs that increase access to free or low-cost health-promoting supports to prevent chronic disease.	● Integrative Therapies for Cancer Patients ● Outpatient Lactation Program ● Diabetes Management Program monthly clinic	● Outpatient Lactation Program: ○ Baseline(FY23): 848 mothers participated in the program. Year 1(FY24): 615 mothers participated in the program. ○ Baseline(FY23): 89% of the new mothers surveyed after the program reported meeting the breastfeeding goal; Year

			1(FY24): 80% of the new mothers surveyed after the program reported meeting the breastfeeding goal. ○ Baseline(FY23): 88% reported successfully breastfeeding for six months or more; Year 1(FY24):73% reported successfully breastfeeding for six months or more.

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Winchester Hospital

FY26-FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Winchester Hospital (WH) is a leading regional provider of comprehensive healthcare services in northwest suburban Boston. The hospital has 229 licensed inpatient beds with more than 2,400 employees and over 850 clinicians on active medical staff. Winchester Hospital offers acute care inpatient services and an extensive range of outpatient services that includes integrated home care. The hospital provides care in major clinical areas, including surgery, pediatrics, cancer care, obstetrics and gynecology, and newborn care.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. 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 are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are are in substance use recovery, and persons experiencing 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 the hospital's Community Benefits Service Area (CBSA). WH 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 for specific communities. The data was 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 Implementation Strategy (IS.). Between June 2024 and February 2025, WH conducted 16 one-on-one interviews with key collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,300 residents, and organized a community listening session. In total, the assessment process collected information from more than 1,400 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, WH's CBAC and community residents, through the community listening session, 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 WH'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:

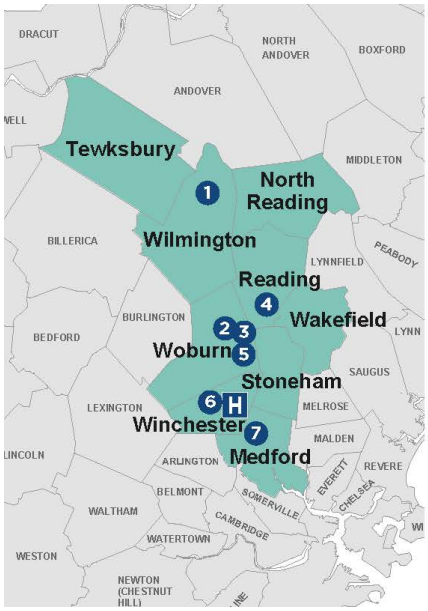
- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the 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. 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 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 populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities. 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.



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
- 2 Winchester Hospital Sleep Disorder Center
- 3 Winchester Hospital Rehabilitation Services
- 4 Winchester Hospital Rehabilitation Services at Reading Health Center
- 5 Winchester Hospital Outpatient Center
- 6 Winchester Hospital Pain Management Center
- 6 Ambulatory Surgery Center
- 6 Radiation Oncology Center
- 7 Wound Healing Center

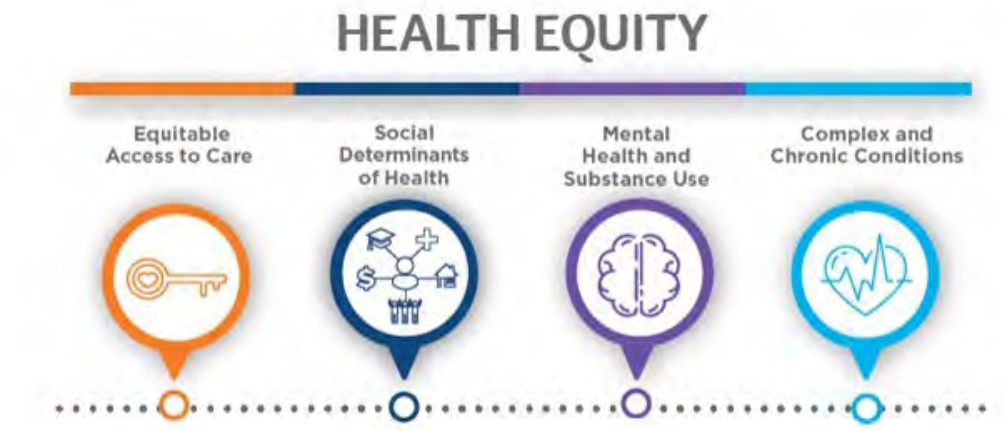
Prioritized Community Health Needs and Cohorts

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.

WH Priority Cohorts

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically, and Linguistically Diverse Populations
- Individuals Living with Disabilities
- 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, issues related to the built environment (i.e., improving roads/sidewalks) 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's IS are housing issues, transportation, food insecurity, language and cultural barriers to services, issues related to digital access, economic insecurity, long wait times for care, health insurance and cost barriers, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive/navigation services for individuals with substance use disorder, community-based behavioral health education and prevention, conditions associated with aging, healthy eating/active living, community-based chronic disease education and prevention, maternal health equity, and caregiver support.

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 were at the system level, and stem from the way in which the system does or does not function. System-level issues included full provider panels, which prevented providers from 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.

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 free or discounted 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, or leveraged 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	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations • Older adults	• Health insurance eligibility and enrollment assistance services • Financial counseling activities • Programs and activities to support culturally/ linguistically competent care and interpreter services • Expanded primary care and medical specialty care services for Medicaid-covered, insured, and underinsured populations	• # of people served • # of referrals made • # of community workshops organized • # of clinical practices supported	• Older adult services agencies • Hospital-based activities
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation	• Low-resourced populations	• Transportation and rideshare assistance programs	• # of rides provided	• Hospital-based activities
Advocate for and support policies and systems that improve access to care	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

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 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.

Information gathered through interviews, focus groups, listening session, and the 2025 WH Community Health Survey reinforced that these issues have considerable impacts 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 free or discounted 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, or leveraged 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	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• Low-resourced populations • Older adults	• Food access, nutrition support, and educational programs and activities	• # of people served • # of meals provided	• Private, non-profit, and health-related agencies • Older adult services agencies • Hospital-based activities
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• Low-resourced populations	• Housing assistance, navigation, and resident support activities	• # of people served	• Housing support and community development agencies

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	SAMPLE METRICS	IDENTIFIED PARTNERS
Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.	• All priority populations	• Career advancement and mobility programs	• # of people served • # of people hired • # of programs or classes organized	• Hospital-based activities
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation.	• Low-resourced populations	• Transportation and rideshare assistance programs	• # of rides provided	• Hospital-based activities

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 for youth and young adults, and social isolation among older adults.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options. Those who participated in the assessment also reflected on the difficulties individuals face when navigating the behavioral health system.

Substance use remained a major issue in the CBSA, with ongoing concern about opioids and alcohol. It was also recognized as closely connected to other community health challenges like mental health and economic insecurity.

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 free or discounted 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, or leveraged 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	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• Youth • Older adults	• Health education, awareness, and wellness activities for youth • Health education, awareness, and wellness activities for older adults	• # of people served • # of programs	• Private, non-profit, health-related agencies • Older adult services agencies
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Patient care navigator programs • Expand access to mental health and substance use services for individuals and families • Primary care and behavioral health integration and collaborative care programs • Health education, awareness, and wellness activities (all age groups) • Crisis intervention and early response programs and activities • Outreach, support, and navigation programs and activities • Participation in community coalitions	• # of people served • # of classes/ programs organized • # of clinical practices supported	• Local public agencies • Hospital-based activities
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital -based activities

Priority: Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. 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 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 free or discounted 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, or leveraged 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/o 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	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	• All priority populations	• Fitness, nutrition, and healthy living programs and activities • Cancer, education, wellness, navigation, and peer support programs • Support groups (peer and professional-led)	• # of classes offered • # of participants • # of people reached/ attendees • # of sessions held per group • # of screenings • # of referrals	• Private, non-profit, and health-related agencies • Hospital-based activities
Support programs and partnerships that advance maternal health equity by expanding access to culturally responsive care, addressing social determinants of health, and reducing disparities in maternal and infant outcomes.	• All priority populations	• Perinatal support groups (including breastfeeding support) • Elective participation in Perinatal-Neonatal Quality Improvement Network (PNQIN) bundles to improve maternal health equity	• # people served • # of classes or groups organized	• To be determined
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activity

General Regulatory Information

Contact Person:	LeighAnne Taylor, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 9, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 9, 2025
Date written plan was required to be adopted	February 15, 2026
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 13, 2022
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