COMMUNITY HEALTH NEEDS ASSESSMENT

Beth Israel Lahey Health
Lahey Hospital & Medical Center

Beth Israel Lahey Health
Lahey Medical Center
Peabody

LAHEY CLINIC HOSPITAL, INC. 2019
Executive Summary

Background and Purpose
Lahey Clinic Hospital, Inc. includes both Lahey Hospital & Medical Center (LHMC) and Lahey Medical Center – Peabody. Together, they are referred to as LHMC/LMCP throughout this report. Both hospitals are part of the Beth Israel Lahey Health (BILH) system.

Lahey Hospital & Medical Center is a world-renowned tertiary medical center known for its innovative technology, pioneering medical treatment, and leading-edge research. A teaching hospital of Tufts University School of Medicine, the hospital provides quality health care in virtually every specialty and subspecialty, from primary care to cancer diagnosis and treatment to kidney and liver transplantation. It is a national leader in a number of health care areas, including stroke, weight management, and lung screenings. For more information on Lahey Hospital & Medical Center, please visit www.laheyhospital.org.

Lahey Medical Center – Peabody (LMCP) is a full-service community-based hospital and medical center, serving patients in the Peabody and North Shore regions. The hospital features a 24-hour Emergency Department, an Ambulatory Surgery Center, and 39 medical and surgical specialties for patients aged 18 and older. The hospital has a 10-bed inpatient unit for overnight hospitalizations, a full range of diagnostic imaging services, a lab for bloodwork, an on-site pharmacy, eye care, a hearing aid center, primary care providers, cancer treatment, a continence center, and orthopedic care. Leading-edge services and technology at Lahey Medical Center – Peabody, include an advanced CT scanner, on-site MRI, 3-D mammography, radiation oncology, and a state-of-the-art neurophysiology lab. The hospital also offers specialty services, including a Weight-Loss Center, Cancer Center, Spine Center, Pain Center, and Sleep Disorders Center.

LHMC/LMCP is committed to fulfilling Massachusetts Attorney General’s Office Community Benefit and federal Internal Revenue Service (IRS) requirements to assess and prioritize health needs in its community benefits service area (CBSA). LHMC/LMCP’s CBSA includes eight communities: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell, Lynnfield, and Peabody. Given
that LHMC/LMCP operates multiple buildings under a single state license and serves different geographic areas and populations. The CBSA does not exclude medically underserved, low-income, or minority populations. For this assessment, LHMC/LMCP made every effort to identify the health needs of all residents within its community benefits service area, regardless of whether they use or have used services at its facilities.

LHMC/LMCP acknowledges its role as a critical community resource, but it also recognizes the value in collaborating with community partners to identify, educate, prevent, and address issues that prevent community residents from accessing the health and social services they need. This Community Health Needs Assessment (CHNA) and the associated Implementation Strategy 2020-2022 were done in close collaboration with LHMC/LMCP’s leadership, staff, health and social services partners, and the community at large. This assessment involved input from nearly 1,000 community residents, stakeholders, and service providers. This assessment, including the process that was applied to develop the Implementation Strategy, exemplifies the spirit of collaboration and community engagement that is such a vital part of LHMC/LMCP’s mission.

This CHNA provides information that will be used to make sure that LHMC/LMCP’s services and programs are appropriately focused, are delivered in ways that are responsive to those in its CBSA, and are conducted to address leading barriers to health and well-being. This CHNA and the Implementation Strategy allow LHMC/LMCP to meet commonwealth and federal Community Benefits requirements, per the Massachusetts Attorney General’s Office and the IRS as part of the Affordable Care Act.

**Approach and Methods**

The assessment began in December 2018 and was conducted in three phases, which allowed for the collection of an extensive amount of quantitative and qualitative data (Phase 1); engagement of community residents, key stakeholders, and service providers (Phase 2); and analysis and prioritization of findings for use in developing a data-driven Implementation Strategy (Phase 3).
### 2019 CHNA and Implementation Strategy: Project Phases

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<thead>
<tr>
<th>Phase 1 – Preliminary Assessment and Engagement</th>
<th>Phase 2 – Targeted Engagement</th>
<th>Phase 3 – Strategic Planning and Reporting</th>
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<tr>
<td><strong>Identify health needs</strong></td>
<td><strong>Engage key stakeholders</strong></td>
<td><strong>Develop Community Health Needs Assessment and Implementation Strategy</strong></td>
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<tr>
<td>• Collection and analysis of quantitative data to characterize community characteristics, health needs, and barriers to care.</td>
<td>• Focus groups with target populations and service providers.</td>
<td>• Meetings with the Community Benefits Advisory Committee and Project Advisory Committee to present CHNA findings, prioritize community health issues, identify vulnerable populations, and discuss potential responses.</td>
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<td>• Qualitative data collection through key informant interviews with hospital leaders, local service providers, town leaders, and community stakeholders.</td>
<td>• Community forums with community residents and service providers.</td>
<td>• Creation of a Resource Inventory to catalog local organizations, service providers, and community assets that have the potential to address identified needs.</td>
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<td>• Evaluation of the hospital’s current portfolio of community benefits activities.</td>
<td>• Dissemination and analysis of a Community Health Survey to capture residents’ perceptions of barriers to good health, leading health issues, vulnerable populations, accessibility of health services, and opportunities for the hospital to improve the services it offers to the community.</td>
<td>• Literature review of evidence-based strategies and identification of successful strategies being conducted by community-based organizations to respond to identified health priorities.</td>
</tr>
<tr>
<td>• Synthesis of findings from quantitative and qualitative research to identify themes and areas of consensus.</td>
<td>• Literature review of evidence-based strategies and identification of successful strategies being conducted by community-based organizations to respond to identified health priorities.</td>
<td>• Development of a final CHNA report and Implementation Strategy.</td>
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</table>

Steering Committee meetings to plan and manage project activities.

Hundreds of individuals from across LHMC/LMCP’s CBSA were engaged in the assessment and planning process, including:

- Health and social services providers
- Town administrators/elected officials
- Public health officials
- Public school nurses and administrators
- Community organizers and advocates/community residents
- Beth Israel Lahey Health senior leadership and staff
- LHMC/LMCP senior leadership, staff, and board members

These individuals were invited to provide input through key informant interviews, focus groups, community listening sessions, and a widely distributed Community Health Survey. While it was not
possible for this assessment to involve all community stakeholders, LHMC/LMCP made every effort to be as inclusive as possible and to provide a broad range of opportunities for participation over the course of several months.

Key Findings
Below is a high-level summary of health-related findings that were identified after a comprehensive review of all the quantitative and qualitative information that was collected as part of the CHNA. A detailed and in-depth discussion of key findings is included in the full CHNA report.

- **The social determinants of health (e.g., transportation, economic stability, access to care, housing, food insecurity) affect many segments of the population.** A key theme from the assessment’s key informant interviews, focus groups, listening sessions, and Community Health Survey was the continued impact that the social determinants of health have on residents of LHMC/LMCP’s service area, especially those who are low to moderate income, frail or homebound, have mental health or substance use issues, or lack a close support system.

- **Certain populations are more vulnerable to health care disparities and barriers to care.** Despite the fact that Massachusetts has one of highest rates of health insurance enrollment and the communities that make up LHMC/LMCP’s service area have strong, robust safety net systems, there are still substantial numbers of low-income, Medicaid-covered, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical and behavioral services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care medical, medical specialty, and behavioral health services.

- **Mental health issues (e.g., depression, anxiety/stress, access to treatment, stigma) underlie many health and social concerns.** Nearly every key informant interview, focus group, and listening session included discussions on the impact of mental health issues. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading concerns. There were particular concerns about the impact of depression, anxiety, and e-cigarette/vaping on youth and social isolation among older adults.

- **Substance dependency continues to affect individuals, families, and communities.** The opioid epidemic continues to be an area of focus. Beyond opioids, key informants were also concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and e-cigarette/vaping among adolescents.

- **Chronic diseases (e.g., cardiovascular disease, cancer, diabetes, asthma) require more education, screening/early intervention, and management – and a focus on risk factors.** Although there was major emphasis on behavioral health issues, many key informants, focus group participants, and listening session participants identified a need to address the many risk factors associated with chronic and complex health conditions. Physical inactivity and poor nutrition/lifestyle were discussed by many, with some of these issues being associated with age (mobility issues among older adults), education/health literacy (lack of understanding about healthy eating), and
socioeconomic status (fresh foods being expensive, and gyms and health centers unaffordable). Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

Community Health Priorities

The CHNA was designed as a population-based assessment, meaning the goal was to identify the full range of community health issues across all demographic and socioeconomic segments of the population. The issues identified were framed in a broad context to ensure that the breadth of unmet needs and community health issues was recognized.

An integrated analysis of all assessment activities framed the leading community health issues into three priority areas: mental health and substance use disorder, chronic/complex conditions and risk factors, and social determinants of health and access to care.

Priority Populations

All segments of the population face challenges that may limit the ability to access health services, regardless of age, race/ethnicity, income, family history, or health status. In the body of this report, there is a comprehensive review of the full breadth of quantitative and qualitative data that was compiled as part of this assessment effort; this review includes findings that touch on common challenges cited among community residents throughout the service area.

To target community benefits efforts and to comply with commonwealth and federal guidelines, there was an effort to prioritize segments of the population with complex health needs or that face significant barriers to care. With this in mind, four population segments were prioritized: low-resource individuals and families, older adults, youth/adolescents, and individuals and families with chronic/complex conditions.

2020-2022 LHMC/LMCP priority populations

- Low-resource individuals and families
- Older adults
- Youth/adolescents
- Individuals and families with chronic/complex conditions
Summary Implementation Strategy

The following is a list of the goals and objectives that have been established for each priority area in LHMC/LMCP’s Implementation Strategy.

<table>
<thead>
<tr>
<th>Priority Area 1: Mental health and substance use disorder</th>
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<tr>
<td><strong>Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder</strong></td>
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<tr>
<td>• Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners</td>
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<tr>
<td>• Explore opportunities for partnerships with community-based organizations to identify, screen, assess, and refer those with mental health issues and substance use disorder to treatment</td>
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<tr>
<td>• Reduce environmental risk factors associated with mental health or substance use issues</td>
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<tr>
<td>• Increase access to appropriate mental health and substance use treatment and support services</td>
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<tr>
<td>• Enhance the ability of local service providers and community partners to understand, anticipate, and respond to health needs and social determinants of health</td>
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<th>Priority Area 2: Chronic/complex conditions and risk factors</th>
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<tr>
<td><strong>Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings</strong></td>
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<tr>
<td>• Increase awareness of and education about the risks and protective factors associated with chronic and complex conditions</td>
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<tr>
<td>• Support programs/activities in clinical and nonclinical settings that screen, educate, and refer patients for chronic/complex conditions and their risk factors</td>
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<tr>
<td>• Enhance access and promote equitable care for vulnerable individuals with chronic/complex conditions</td>
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<tr>
<td><strong>Goal 2: Support individuals with or recovering from chronic/complex conditions and their caregivers</strong></td>
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<tr>
<td>• Increase access to supportive services to reduce stress and anxiety, reduce negative symptoms and side effects, and increase overall well-being</td>
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<th>Priority Area 3: Social determinants of health and access to care</th>
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<tr>
<td><strong>Goal 1: Address the social determinants of health and access to care</strong></td>
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<tr>
<td>• Increase partnerships and collaboration with community-based organizations to address the social determinants of health</td>
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<tr>
<td>• Increase access to affordable and safe transportation options</td>
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<tr>
<td>• Educate providers and community members about hospital and/or public assistance programs that can help them identify and enroll in appropriate health insurance plans and/or reduce their financial burden</td>
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<tr>
<td>• Work to help strengthen the local workforce</td>
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<tr>
<td>• Increase awareness of domestic violence and promote links to services</td>
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<tr>
<td>• Promote resilience and emergency preparedness</td>
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<tr>
<td>• Increase access to affordable and nutritious foods</td>
<td></td>
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<tr>
<td>• Increase access to affordable and free opportunities for physical activity</td>
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Acknowledgements

This Community Health Needs Assessment (CHNA) and its associated Implementation Strategy are the results of a collaborative process between Lahey Hospital & Medical Center and Lahey Medical Center – Peabody (LHMC/LMCP), including hospital leadership and clinical staff, and many community-based organizations, municipal leaders, advocates, and community residents throughout its service area. At the foundation of this endeavor was a desire to meaningfully engage community residents and service providers to share their thoughts on barriers to good health, leading community health issues, local assets and resources, and opportunities to improve the delivery of health care services and the overall health of the community.

This assessment was overseen by the:

- **Beth Israel Lahey Health – North: Steering Committee 2019**, composed of Community Relations staff from LHMC/LMCP, Winchester Hospital, Beverly Hospital and Addison Gilbert Hospital, and Beth Israel Lahey Health (formerly Lahey Health).

- **Lahey Hospital & Medical Center Community Benefits Advisory Committee 2019 (CBAC)**, which included hospital leadership, clinical providers, and representatives from community-based organizations, advocacy groups, and other sectors. This body recommended the Implementation Strategy for board approval on August 2, 2019.

- **Beth Israel Lahey Health – North: Project Advisory Committee 2019 (PAC)**, composed of representatives from LHMC/LMCP, Winchester Hospital, Beverly Hospital and Addison Gilbert Hospital, Lahey Health at Home, Beth Israel Lahey Health (BILH) Behavioral Services, local public health officials, community stakeholders, and Community Relations staff.

LHMC/LMCP hired John Snow, Inc. (JSI), a public health research and consulting firm, to assist in the completion of this work. The hospital appreciates the contributions that JSI has made in collecting and analyzing data, engaging the community, and conducting research throughout the CHNA and Implementation Strategy development process.

Finally, LHMC/LMCP would like to thank the many residents who contributed to this process. Since the beginning of the assessment in December 2018, hundreds of individuals shared their needs, experiences, and expertise through interviews, focus groups, surveys, and community listening sessions.

*The Board of Trustees, which is the authorized body of Lahey Hospital & Medical Center and Lahey Medical Center – Peabody, approved this Community Health Needs Assessment and adopted the Implementation Strategy on September 16, 2019.*
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Introduction and Purpose

Introduction

Lahey Clinic Hospital, Inc. includes both Lahey Hospital & Medical Center (LHMC) and Lahey Medical Center, Peabody (LMCP). Together, they are referred to as LHMC/LMCP throughout this report. Both hospitals are part of the Beth Israel Lahey Health (BILH) system.

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LHMC/LMCP is committed to fulfilling Massachusetts Attorney General’s Office Community Benefits and federal Internal Revenue Service (IRS) requirements to assess and prioritize health needs in its community benefits service area (CBSA). LHMC/LMCP’s CBSA includes eight communities: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell, Lynnfield, and Peabody. Given that LHMC/LMCP operates multiple buildings under a single state license and serves different geographic areas and populations, the communities that are part of the CBSA are an aggregate of these communities.
areas and populations. The CBSA does not exclude medically underserved, low-income, or minority populations. For this assessment, LHMC/LMCP made every effort to identify the health needs of all residents within its CBSA, regardless of whether they use or have used services at its facilities.

LHMC/LMCP strives to create and support opportunities for residents of the service area to lead healthy and productive lives through community benefits programming. The hospital acknowledges its role as a critical community resource, but it also recognizes the value in collaborating with community partners to identify, educate, prevent, and address issues that prevent community residents from accessing the health and social services they need. This CHNA and the associated Implementation Strategy were done in close collaboration with LHMC/LMCP’s leadership, staff, health and social services partners, and the community at large. This assessment involved input from nearly 1,000 community residents, stakeholders, and service providers. This assessment, including the process that was applied to develop the Implementation Strategy, exemplifies the spirit of collaboration and community engagement that is such a vital part of LHMC/LMCP’s mission.

Purpose

Not-for-profit hospitals and health maintenance organizations enjoy a range of benefits, including commonwealth and federal tax-exempt status. With these benefits come fiduciary and public obligations, including periodic assessments of community health needs, barriers to care, and vulnerable populations. From these community health needs assessments, hospitals and health maintenance organizations develop implementation strategies that outline the ways in which the entities will address the identified health needs, otherwise known as “community benefits” activities.

Conducted through a collaborative process engaging hospital leaders and clinical staff from LHMC/LMCP, along with leaders, organizations, service providers, and residents from the CBSA, the CHNA is a population-based assessment that considers the needs of the entire population, regardless of whether individuals are or were patients at the hospital. Per the community benefits guidelines that govern the CHNA, special efforts were made to assess the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed vulnerable or at risk.
The primary goals for the CHNA and this report are to:

**Assess**
Community health needs, defined broadly to include health status, social determinants, environmental factors, and service system strengths/weaknesses

**Engage**
Members of the community, including local health departments, service providers, and community residents, as well as LHMC/LMCP leadership and staff

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

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

This CHNA may be used as a source of information and guidance to:

- Clarify issues related to community characteristics, barriers to care, existing service gaps, unmet community need, and other health-related factors
- Prioritize and promote community health investment
- Inform and guide a comprehensive, collaborative community health improvement planning process
- Facilitate discussion within and across sectors regarding community need, community health improvement, and health equity
- Serve as a resource to others working to address health inequities

LHMC/LMCP is committed 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 societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout the assessment process, efforts were made to understand the needs of populations that are disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable or at risk. As a result of this approach, LHMC/LMCP’s Implementation Strategy will focus on the geographic, demographic, and socioeconomic segments of the population most at risk, as well as those with physical and behavioral health needs.
Approach and Methods

Approach
The assessment began with the creation of a Steering Committee composed of representatives from the former Lahey Health system, including LHMC/LMCP, Winchester Hospital, and Beverly Hospital-Addison Gilbert Hospital. The hospital hired JSI, a public health research and consulting firm in Boston, to complete the CHNA and Implementation Strategy. The Steering Committee provided vital oversight of the CHNA approach, methods, and reporting process. This committee met monthly, in person and via conference call, to review project activities, vet preliminary findings, address challenges, and ensure alignment in CHNA approach and methods across the BILH system.

LHMC/LMCP engaged its CBAC, made up of hospital leadership and clinical staff, local service providers, and key community stakeholders, extensively throughout this process. This group met three times over the course of the assessment and provided input on the assessment approach, vetted preliminary findings, and helped prioritize community health issues and vulnerable populations. The CBAC also reviewed and provided feedback on the associated Implementation Strategy. Meeting dates and agendas are included in Table 1.

Finally, the PAC was convened to provide input and feedback from a system wide perspective. The PAC was composed of representatives from clinical and administrative leadership and local public health officials, along with Community Relations staff. The PAC met three times over the course of the project and provided broad-based feedback on the approach and vetted preliminary findings relative to identified priority community health issues and vulnerable populations. Meeting dates and agendas are included in Table 1.

- LHMC/LMCP engagement
  - 36 community stakeholders and leaders participated in interviews
  - 18 interviews with LHMC/LMCP and BILH leaders and staff
  - 5 focus groups with social workers, older adults, families and community residents, high school students, and residents of low-to-moderate-income housing
  - 2 community listening sessions with 40+ participants
  - 6 total meetings with the CBAC and PAC
Table 1: CBAC and PAC meeting dates and agendas

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<tr>
<th>LHMC/LMCP CBAC</th>
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<tr>
<td><strong>Meeting Date</strong></td>
<td><strong>Agenda</strong></td>
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| May 6, 2019 | • Overview of CHNA requirements and process, including distribution of Community Health Survey  
• Gather feedback on initial data findings  
• Identify initial priority areas and populations |
| June 25, 2019 | • Review data findings, including initial Community Health Survey results  
• Review refined priority areas and populations  
• Initial review of Implementation Strategy |
| August 5, 2019 | • Review and provide feedback on Implementation Strategy |

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<tr>
<th>PAC</th>
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<tr>
<td><strong>Meeting Date</strong></td>
<td><strong>Agenda</strong></td>
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| February 12, 2019 | • Overview of CHNA requirements and process  
• Define role of PAC  
• Gather input on Community Health Survey instrument and distribution |
| June 13, 2019 | • Inform PAC on information gathering and synthesis  
• Share key findings  
• Gather input on strategies to address needs |
| August 12, 2019 | • Present final results of needs assessment and implementation strategies for the hospital  
• Gather feedback on process – what worked well, what to improve  
• Gather input on opportunities for systemwide initiatives |

LHMC/LMCP’s Community Relations staff, CBAC, and hospital leadership reviewed this CHNA report and Implementation Strategy before it was submitted to the Board of Trustees for approval on September 16, 2019.

The assessment was completed in three phases. A summary of each phase and its associated activities are included in Table 2. A detailed description of LHMC/LMCP’s approach to community engagement is included in Appendix A.
### Methods

#### Quantitative Data Collection and Analysis

Quantitative data from a broad range of sources was collected and analyzed to characterize communities in LHMC/LMCP’s CBSA, measure health status, and inform a comprehensive understanding of the health-related issues. Sources included:

- Massachusetts Department of Elementary and Secondary Education: School and District Profiles (2017 and 2018-2019)
- FBI Uniform Crime Reports (2017)
- Massachusetts Department of Public Health, Bureau of Substance Abuse Services (2017)
- Massachusetts Department of Public Health, Annual Reports on Births (2016)
- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Profiles (FY 2013-2017)
• Massachusetts Center for Health Information Analysis (CHIA) Hospital Discharges (2017)
• Massachusetts Healthy Aging Collaborative, Community Profiles (2018)
• Youth Risk Behavior Surveys (2017 and 2018)

JSI, working in collaboration with staff from BILH and CHIA, obtained federal fiscal year 2017 hospital discharge data for municipalities within the commonwealth. JSI analyzed the discharge data for the hospital’s CBSA based on patient residence. JSI also developed statewide averages for comparative purposes. CHIA aggregates hospital discharge data from all hospitals in Massachusetts and makes it available to hospitals and researchers to evaluate morbidity, access to care, and health services utilization trends.

The data allowed for hospital-specific analyses based on where the patient was hospitalized within Massachusetts and patient origin analyses based on the patient’s address of residence. Related to the CHNA activities, this data was used to:

• Measure hospitalization rates for major health issues as identified by stakeholders in the qualitative research
• Gauge access to high-quality primary and outpatient services for residents within the CBSA using the Agency for Health Research and Quality (AHRQ) Quality Indicators Prevention Quality Indicators (PQI) software

PQI rates were developed for eight chronic PQI measures, four of which are related to diabetes (Table 3). PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality primary or outpatient care. The PQIs are population based and, therefore, can help public health agencies, health care systems, and others interested in improving health care quality in their communities.1

JSI compared municipal-level PQI rates with Massachusetts’ statewide average.

---

1 AHRQ Prevention Quality Indicators v2019 ICD-10-CM Benchmark Data Tables
Table 3: PQI measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Label</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI 1</td>
<td>Diabetes short-term complications admission rate</td>
<td>Over age 18</td>
</tr>
<tr>
<td>PQI 3</td>
<td>Diabetes long-term complications admission rate</td>
<td>Over age 18</td>
</tr>
<tr>
<td>PQI 5</td>
<td>Chronic obstructive pulmonary disease (COPD) or asthma in older adults</td>
<td>Over age 45*</td>
</tr>
<tr>
<td>PQI 7</td>
<td>Hypertension admission rate</td>
<td>Over age 18</td>
</tr>
<tr>
<td>PQI 8</td>
<td>Heart failure admission rate</td>
<td>Over age 18</td>
</tr>
<tr>
<td>PQI 14</td>
<td>Uncontrolled diabetes admission rate</td>
<td>Over age 18</td>
</tr>
<tr>
<td>PQI 15</td>
<td>Asthma in younger adults</td>
<td>Ages 20 to 44</td>
</tr>
<tr>
<td>PQI 93</td>
<td>Prevention quality diabetes composite</td>
<td>Over age 18</td>
</tr>
</tbody>
</table>

*JSI’s age group varied slightly from those used by AHRQ to align with U.S. Census Bureau groupings used for the discharge analysis.

JSI produced rates per 100,000 population, as defined for the measure. Results from the discharge data analysis are included in the Key Findings: Behavioral Risk Factors and Health Status section of this report.

Quantitative Data Limitations
Relative to most states, Massachusetts does an exemplary job at making comprehensive data available at the commonwealth, county, and municipal levels through the Massachusetts Department of Public Health (MDPH). Historically, this data has been made available through the Massachusetts Community Health Information Profile (MassCHIP) data system, an automated and interactive resource provided by MDPH; MassCHIP is no longer updated. To replace this system, MDPH is creating the Population Health Information Tool (PHIT), which will include municipal-level data stratified by demographic and socioeconomic variables (e.g., gender/sex, age, race/ethnicity, poverty level). At the time this report was produced, community profiles were not available via the PHIT. The most significant limitation this caused was the availability of timely data related to morbidity, mortality, and service utilization. The data sets used in this report are the most up to date provided by MDPH. This data was still valuable and allowed for identification of health needs relative to the commonwealth and specific communities; however, these data sets may not reflect recent trends in health statistics.

Additionally, quantitative data was not stratified by age, race/ethnicity, income, or other characteristics, which limited the ability to identify health disparities in an objective way. Qualitative activities allowed for exploration of these issues, but the lack of objective quantitative data constrained this effort.

Qualitative Data Collection and Analysis
LHMC/LMCP recognizes that authentic community engagement is critical to assessing community needs, identifying health priorities and vulnerable populations, and creating a robust implementation strategy. The hospital was committed to engaging the community throughout this process. Using the community engagement continuum included in MDPH’s Community Engagement Standards for Community Health Planning as a guide (Figure 2), LHMC/LMCP employed a variety of approaches to ensure that community members were informed, consulted, and involved throughout the assessment process, and that they
were collaborators in ensuring that the Implementation Strategy addressed priority issues and vulnerable populations.

**Figure 2: Community engagement continuum**

![Community Engagement Continuum Diagram](image)

**Informed:** LHMC/LMCP informed the community of:

- Assessment activities (e.g., Community Health Survey, focus groups, and listening sessions)
- Summary quantitative and qualitative data findings in public meetings

**Consulted:** LHMC/LMCP consulted the community by:

- Presenting its current CHNA to town leadership and stakeholder groups
- Hosting focus groups with community stakeholders and residents
- Conducting key informant interviews
- Conducting a Community Health Survey
- Holding two community listening sessions to solicit opinions and ideas directly from community residents

**Involved:** LHMC/LMCP involved its advisory bodies, including the CBAC and the PAC, to provide input and feedback on the assessment approach and to vet preliminary findings. These bodies included community residents and stakeholders. Local health and public health directors were also key members of the PAC. LHMC further engaged with the community by co-hosting its public forums with the two CHNAs in its service area.

**Collaborated:** Members of the CBAC and PAC were key collaborators in helping prioritize health needs and vulnerable populations. These advisory bodies were also consulted in the drafting of the Implementation Strategy.

The following are descriptions of the approach to community engagement activities. Associated tools, lists of participants, and other materials are included in the Detailed Community Engagement Summary in Appendix A.
Key Informant Interviews (28 individuals; four meetings with town leadership) – JSI conducted key informant interviews with community stakeholders from LHMC/LMCP’s entire service area. These interviews were done to confirm and refine findings from secondary data analysis, to provide community context, and to clarify needs and priorities within specific communities. Individual interviews were conducted by phone using a structured interview guide developed by JSI and the Steering Committee. JSI worked with LHMC/LMCP to identify a representative group of interviewees that included hospital administrators, clinical providers, and representatives from community-based organizations that worked across the health and social services spectrum (e.g., community coalitions, recreation, elder health/healthy aging, homelessness and housing, health centers).

JSI also conducted four group interviews with municipal leadership, including mayors or town administrators and representatives from various municipal offices (e.g., health and/or public health, senior services, police, fire, planning). These interviews were done to understand municipal-level needs, to identify potential community partners, and to set a foundation for a more impactful and relevant Implementation Strategy. Detailed notes were taken for each interview. For a list of interviewees, sectors represented, interview dates, and the interview guide, please see Appendix A: Detailed Community Engagement Summary. Key themes and findings from these interviews are included in the narrative sections of this report.

Focus groups (five) – Focus groups were conducted for three target populations: high school students (Burlington High School), older adults (Billerica Council on Aging), and individuals in public housing (Arlington Housing Authority). They were also conducted with two service provider populations – social workers at LHMC/LMCP and with Mill City Grows, a community-based organization working on issues of food insecurity in greater Lowell. Focus groups were held at locations that were considered safe and accessible for participants. JSI facilitated all focus groups using a guide that was similar to the one used for key informant interviews to ensure consistent data collection. Focus groups allowed for the collection of more nuanced information to augment findings from secondary data and key informant interviews, and for the exploration of strategic and programmatic options to address identified health issues, service gaps, and/or barriers to care. JSI and LHMC/LMCP worked with leadership or representatives at each location to identify focus group participants. For a list of focus group locations, target populations, dates, and the focus group guide, please see Appendix A: Detailed Community Engagement Summary.

Community listening sessions (two) – LHMC/LMCP partnered with the two CHNAs in its service area to co-host the listening sessions. One session was held in collaboration with CHNA 15 and Emerson Hospital in Bedford and one in collaboration with CHNA 13/14 in Peabody. CHNA 15 and 13/14 included representatives from municipalities within both LHMC/LMCP’s and Beverly Hospital-Addison Gilbert Hospital’s service areas, making this session relevant for both assessment processes. These sessions allowed for the capture of information directly from community residents, staff from community-based organizations, and local service providers. LHMC/LMCP staff also provided information about community benefits and the needs assessment process to attendees. Participants were asked to react to
a set of preliminary data findings and to share thoughts on community health needs, barriers to care, vulnerable populations, and community assets and resources. These sessions also served as open public meetings for the hospitals to share current community benefits programming and solicit feedback on activities.

Both sessions were held in locations that were easily accessible, safe, and well-known. For a list of locations, dates/times, approximate number of attendees, and a discussion guide, please see Appendix A: Detailed Community Engagement Summary.

Community Health Survey (591 responses) – JSI worked with the Steering Committee and the PAC to develop a Community Health Survey to solicit information directly from community residents. Respondents were asked to provide their opinions and perceptions of leading social determinants of health and barriers to care, clinical health issues, vulnerable populations, access to health care services, and opportunities for the hospital to improve community health programming.

Surveys were available online, through the SurveyGizmo platform, in English and seven other languages: Spanish, Portuguese, Italian, Haitian-Creole, Khmer, Hindi, and traditional Chinese. Surveys were also made available in hard copy for distribution; hard-copy surveys were collected and the responses were included in the final analysis. LHMC worked in close collaboration with local community organizations, businesses, and stakeholders to distribute the survey to community residents, including those who are typically hard to reach (e.g., non-English speakers, diverse populations). Appendix A includes a copy of the Community Health Survey and a list of survey distribution channels.

Responses were received from residents from all towns within LHMC/LMCP’s CBSA, with the most responses coming from Peabody (28.9%) and the fewest coming from Lowell (3.6%) (Figure 3).

Findings from the survey are integrated into the narrative sections of this report; a summary of top responses for selected questions is included in Table 4.
Table 4: Summary of Community Health Survey results

<table>
<thead>
<tr>
<th>Question</th>
<th>Top 3 responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think about your community. Choose the top three (3) issues</td>
<td>• Physical inactivity or sedentary lifestyle (58.6%)</td>
</tr>
<tr>
<td>that you think prevent people from being able to live a</td>
<td>• Housing is expensive or unsafe (39.1%)</td>
</tr>
<tr>
<td>healthy life.</td>
<td>• Social isolation, lack of support, loneliness (31.8%)</td>
</tr>
<tr>
<td></td>
<td>• Mental health (46.4%)</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular conditions (e.g., hypertension/high blood pressure, heart</td>
</tr>
<tr>
<td></td>
<td>disease, stroke) (46.3%)</td>
</tr>
<tr>
<td></td>
<td>• Physical inactivity, nutrition, and/or obesity (45.9%)</td>
</tr>
<tr>
<td>Think about your community. Choose the top three (3) issues</td>
<td>• Older adults (65+) (65.4%)</td>
</tr>
<tr>
<td>that you think people struggle with the most.</td>
<td>• Those with disabilities (physical, cognitive, developmental, emotional) (50.7%)</td>
</tr>
<tr>
<td></td>
<td>• Low-income populations (45.7%)</td>
</tr>
<tr>
<td>Think about your community. Choose the top three (3)</td>
<td>• Outpatient mental health treatment (e.g., community mental health centers,</td>
</tr>
<tr>
<td>populations that you think have the greatest health needs.</td>
<td>mental health counseling) (45.6%)</td>
</tr>
<tr>
<td></td>
<td>• Inpatient or residential drug and alcohol treatment (e.g., rehabilitation and</td>
</tr>
<tr>
<td></td>
<td>detoxification) (44.5%)</td>
</tr>
<tr>
<td></td>
<td>• Long-term care (e.g., assisted living, skilled nursing facilities/nursing homes)</td>
</tr>
<tr>
<td></td>
<td>(43.2%)</td>
</tr>
</tbody>
</table>

Community Benefits Evaluation

JSI reviewed the fiscal year 2017/2018 Community Benefits Reports to the Attorney General (AG Report) submitted by LHMC/LMCP to help the hospital evaluate strategies and programs addressing needs identified in the 2016 CHNA and plan for community benefits activities over the next three years. Activities reported in the AG Report, defined as “actions undertaken in accordance to the community benefits which contributed to achieving the strategic objective of supporting community health,” were abstracted from this report and individually scored by an evaluator at JSI. JSI determined the intensity of each activity by coding three specific attributes:

- Behavioral intention (providing information, enhancing skills, modifying policy)
- Duration (one time or ongoing)
- Reach (proportion of population involved)

Examples of the types of strategies and programs that were analyzed as part of the evaluation are presented in the table below. Community Relations staff used evaluation results to inform the 2020-2022 Implementation Strategy.
<table>
<thead>
<tr>
<th>Health Priority Area</th>
<th>Program</th>
<th>Program Highlights</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness, prevention, and chronic disease management</td>
<td>Free breast cancer risk assessments</td>
<td>Free assessment screening tool to help community residents determine whether they may be at risk for breast cancer. Using an electronic tablet, people are able to confidentially answer questions that help determine whether they may be at a higher risk for breast cancer. The assessment, evaluation, and follow-up are all provided at no cost to participants. Results are given to their physicians, who can help them determine whether they might benefit from a higher level of screening beyond regular checkups and mammograms.</td>
<td>In FY18, LHMC screened 25,005 people and identified 1,033 patients who had a high-risk mutation and 2,358 patients who had a high lifetime risk of breast cancer.</td>
</tr>
<tr>
<td>Elder health</td>
<td>Serving Health Information Needs of Everyone (SHINE) program</td>
<td>LHMC/LMCP collaborates with Minuteman Senior Services to provide SHINE counselors for the Arlington, Burlington, and Winchester Councils on Aging (COAs) to assist Medicare beneficiaries with navigating their insurance options and finding financial assistance programs.</td>
<td>In FY18, 700 people were helped through the program, which was an 11% increase over FY17, and 49 people were served by an on-site counselor at the LHMC campus, which was a 22% increase from FY17. In FY18, approximately 18% of the consumers served through the LHMC partnership with the SHINE program had incomes below 150% of the federal poverty level.</td>
</tr>
<tr>
<td>Behavioral health (mental health and substance use)</td>
<td>Medication disposal box</td>
<td>As part of our commitment to helping address the need of prescription drug misuse, LHMC is now providing a medication disposal kiosk to safely dispose of expired or unwanted medications. Medications can be dropped off 24 hours a day, 7 days a week and are safely disposed of in accordance with DEA regulations.</td>
<td>In FY18, LHMC collected and disposed of 471 pounds of medications.</td>
</tr>
</tbody>
</table>
Resource Inventory
Community Relations staff created a Resource Inventory to inform what services are available to address community needs and to determine the extent to which there are gaps in health-related services. Community Relations staff compiled a list of resources across the broad continuum of services, including:

- Access to health care
- Child, parent, and family support
- Disabilities and special needs
- Domestic violence
- Food assistance
- Transportation services
- Veterans services
- Housing and homelessness
- Mental health and substance use
- Senior services
- Sexual/reproductive health
- Support groups

The Resource Inventory was compiled using information from existing resource inventories and partner lists from LHMC/LMCP. Community Relations staff reviewed the hospital’s prior annual report of community benefits activities to the Massachusetts AG, which included a listing of partners, as well as publicly available lists of local resources. JSI supported this effort further by collecting information about community resources during CHNA interviews, focus groups, and community listening sessions. The goal of this process was to identify key partners who may or may not be already collaborating with the hospital. The resource inventory can be found in Appendix C.

Prioritization, Implementation Strategy, and Reporting
During Phase 2, JSI synthesized and integrated findings from the quantitative and qualitative research, including key findings from secondary data and information from key informant interviews, focus groups, listening sessions, and the Community Health Survey. Through this analysis, JSI developed a set of preliminary priority areas and vulnerable populations.

LHMC/LMCP facilitated a meeting with the CBAC to present findings and to propose priority areas and vulnerable populations. During this meeting, JSI guided the CBAC through a process to refine sub-priorities in each priority area. Using the results of this meeting as a guide, JSI worked with LHMC/LMCP’s Community Relations staff to draft and refine the 2020-2022 Implementation Strategy. This Implementation Strategy, including goals, objectives, strategies, sample measures, and community partners, was further refined and finalized through two subsequent meetings with the CBAC. Finally, JSI worked with LHMC/LMCP’s Community Relations staff in drafting and finalizing the CHNA report.

Approval/Adoption and Public Comment
The final CHNA and Implementation Strategy were presented to the Board of Trustees for approval and adoption in September 2019. LHMC/LMCP will be responsible for reporting on, and if necessary, updating and resubmitting, its Implementation Strategy to the Massachusetts AG’s office on an annual basis until the next assessment cycle in 2022.

As with every CHNA report, this document will be posted on LHMC/LMCP’s website and is available free of charge in hard copy by request. Community members and service providers were encouraged to
share their thoughts, concerns, and questions throughout the CHNA process; they are encouraged to continue to share their thoughts and ideas moving forward.

There has been no written feedback on LHMC/LMCP’s previous CHNA since its posting in 2016, but LHMC/LMCP did present the findings to the community, stakeholders, and community organizations at several in-person meetings. There was no feedback on the Massachusetts AG’s website, which publishes the hospital’s community benefits reports and provides an opportunity for public comment. Any feedback received is welcome and will be taken into account when updates and changes are made to the Implementation Strategy or to inform future CHNA processes.

For more information, please contact:

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Lahey Hospital & Medical Center
781-744-7907
Michelle.Snyder@Lahey.org
Demographic Profile

To understand community needs and health status for LHMC/LMCP’s service area, we begin with a description of the population’s geographic and demographic characteristics. This information is critical to recognizing inequities, identifying vulnerable populations and health-related disparities, and targeting strategic responses. Conclusions were drawn from an integrated analysis of quantitative and qualitative data findings. More expansive data tables are included in the LHMC/LMCP Data Book (Appendix B).

Population and Age Distribution

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

Many key informants and focus group/listening session participants identified concerns around the ability of the health and social services systems to adequately meet the needs of older adults. While there are many active COAs, senior centers, and organizations dedicated to serving this population, some identified that it is often difficult for vulnerable residents to take advantage of their services because of transportation issues and frailty.

- The municipality with the largest population was Lowell (110,964); the smallest was Lynnfield (12,732).
- In nearly all municipalities in LHMC/LMCP’s service area, the median age was significantly high compared with the commonwealth overall (39.4). The median age was significantly low in Lowell (33.3) and similar to the commonwealth in Billerica (40.5).
- The percentage of the population under 18 was significantly high in Arlington (21.5%), Bedford (24.8%), Lexington (26.1%), Lowell (22.7%), and Lynnfield (23.7%) compared with the commonwealth overall (20.4%). The percentage was significantly low in Peabody (17.4%) and similar in Billerica and Burlington.
- The percentage of the population over 65 was significantly high in Bedford (18.3%), Burlington (19.5%), Lexington (18.7%), Lynnfield (20.6%), and Peabody (20.9%) compared with the commonwealth overall (15.5%). The percentage was significantly low in Lowell (10.5%) and similar to the commonwealth in Arlington and Billerica.

<table>
<thead>
<tr>
<th></th>
<th>Population (#)</th>
<th>Median age (years)</th>
<th>Under 18 (%)</th>
<th>Ages 20-24 (%)</th>
<th>Ages 45-54 (%)</th>
<th>Ages 55-59 (%)</th>
<th>Ages over 65 (%)</th>
<th>Ages over 85 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>6,789,319</td>
<td>39.4</td>
<td>20.4</td>
<td>7.2</td>
<td>14.3</td>
<td>7.1</td>
<td>15.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Essex County</td>
<td>775,860</td>
<td>40.8</td>
<td>21.8</td>
<td>6.6</td>
<td>14.9</td>
<td>7.5</td>
<td>15.9</td>
<td>2.5</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>1,582,857</td>
<td>38.5</td>
<td>20.3</td>
<td>6.9</td>
<td>14.4</td>
<td>6.9</td>
<td>14.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Arlington</td>
<td>44,992</td>
<td>41.4</td>
<td>21.5</td>
<td>3.4</td>
<td>15.8</td>
<td>6.3</td>
<td>16.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Bedford</td>
<td>14,105</td>
<td>43.3</td>
<td>24.8</td>
<td>3.3</td>
<td>17.0</td>
<td>7.8</td>
<td>18.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Billerica</td>
<td>42,791</td>
<td>40.5</td>
<td>19.6</td>
<td>5.8</td>
<td>16.6</td>
<td>6.6</td>
<td>14.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Burlington</td>
<td>26,103</td>
<td>42.2</td>
<td>20.4</td>
<td>5.4</td>
<td>15.2</td>
<td>6.1</td>
<td>19.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Lexington</td>
<td>33,339</td>
<td>45.0</td>
<td>26.1</td>
<td>3.3</td>
<td>18.5</td>
<td>6.9</td>
<td>18.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Lowell</td>
<td>110,964</td>
<td>33.3</td>
<td>22.7</td>
<td>9.5</td>
<td>13.0</td>
<td>6.1</td>
<td>10.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>12,732</td>
<td>46.0</td>
<td>23.7</td>
<td>4.7</td>
<td>17.2</td>
<td>7.7</td>
<td>20.6</td>
<td>3.8</td>
</tr>
<tr>
<td>Peabody</td>
<td>52,610</td>
<td>44.3</td>
<td>17.4</td>
<td>6.7</td>
<td>13.2</td>
<td>7.8</td>
<td>20.9</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

**Race, Ethnicity, and Foreign-Born**

An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. According to the Centers for Disease Control and Prevention (CDC), non-Hispanic blacks have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites.² Hispanics have the highest uninsured rates of any racial or ethnic group in the United States.³ Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index.⁴ These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes.

The LHMC/LMCP service area is quite diverse. While many municipalities are predominantly white, there are significant populations of Asian and Hispanic/Latino residents throughout the service area. Several key informants identified immigrants, refugees, and undocumented individuals as segments of the population that face extreme barriers to accessing health and social services. Fear around immigration status, inability to navigate the health system, and lack of health literacy are often prohibitive factors that affect if and when these individuals seek out or maintain preventive care.

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• The percentage of Asian residents was significantly high in most municipalities compared with the commonwealth overall (6.3%) – Arlington (11.5%), Bedford (14.6%), Burlington (16.0%), Lexington (27.3%), and Lowell (21.0%).
• The percentage of Hispanic/Latino residents was significantly high in Lowell (20.3%) compared with the commonwealth overall (11.2%), and significantly low in all other municipalities.
• The percentage of foreign-born residents was significantly high in Arlington (18.6%), Burlington (21.7%), Lexington (25.9%), and Lowell (26.7%), and significantly low in Billerica (11.0%) and Lynnfield (8.5%).

Table 7: Race, ethnicity, and foreign-born (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>White alone (%)</th>
<th>Black or African American alone (%)</th>
<th>Asian alone (%)</th>
<th>Hispanic or Latino of any race (%)</th>
<th>Foreign-born (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>78.9</td>
<td>7.4</td>
<td>6.3</td>
<td>11.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Essex County</td>
<td>80.6</td>
<td>4.0</td>
<td>3.4</td>
<td>19.6</td>
<td>16.2</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>77.9</td>
<td>5.2</td>
<td>11.2</td>
<td>7.7</td>
<td>20.5</td>
</tr>
<tr>
<td>Arlington</td>
<td>81.7</td>
<td>1.9</td>
<td>11.5</td>
<td>4.3</td>
<td>18.6</td>
</tr>
<tr>
<td>Bedford</td>
<td>79.1</td>
<td>3.3</td>
<td>14.6</td>
<td>4.0</td>
<td>16.2</td>
</tr>
<tr>
<td>Billerica</td>
<td>86.6</td>
<td>3.4</td>
<td>6.2</td>
<td>4.3</td>
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</tr>
<tr>
<td>Burlington</td>
<td>76.2</td>
<td>5.1</td>
<td>16.0</td>
<td>2.0</td>
<td>21.7</td>
</tr>
<tr>
<td>Lexington</td>
<td>68.3</td>
<td>0.8</td>
<td>27.3</td>
<td>2.1</td>
<td>25.9</td>
</tr>
<tr>
<td>Lowell</td>
<td>60.8</td>
<td>7.3</td>
<td>21.0</td>
<td>20.3</td>
<td>26.7</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>92.6</td>
<td>0.6</td>
<td>5.0</td>
<td>2.8</td>
<td>8.5</td>
</tr>
<tr>
<td>Peabody</td>
<td>87.7</td>
<td>3.4</td>
<td>1.4</td>
<td>9.3</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

Language

Language barriers pose significant challenges to providing effective and high-quality health and social services. While many health care institutions, including LHMC/LMCP, have medical interpreter services available at their facilities, research has found that the health care provider’s language and cultural competency are key to reducing racial and ethnic health disparities.5 Some key informants and focus group/listening session participants reported that language and cultural barriers were major barriers to accessing health and social services and navigating the health system.

• The percentage of the population (age 5+) who spoke a language other than English in the home was significantly high in Lexington (31.1%) and Lowell (43.8%) and significantly low in Arlington

---

(20.6%), Billerica (13.5%), and Lynnfield (12.2%) compared with the commonwealth overall (23.1%).

- The percentage of the population who spoke Spanish was significantly high in Lowell (15.3%) compared with the commonwealth (8.8%) overall. Percentages were similar to or significantly low in all other municipalities.
- The percentage of the population who spoke Asian/Pacific Islander languages was significantly high in most municipalities compared with the commonwealth overall, with the exception of Billerica, Peabody, and Lynnfield, which were low or significantly low.

### Table 8: Percent of population age 5+ who speak a language other than English in the home (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>Language other than English (%)</th>
<th>Spanish (%)</th>
<th>Other Indo-European languages (%)</th>
<th>Asian/Pacific Islander languages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>23.1</td>
<td>8.8</td>
<td>8.8</td>
<td>4.2</td>
</tr>
<tr>
<td>Essex County</td>
<td>25.6</td>
<td>16.5</td>
<td>5.7</td>
<td>2.3</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>26.0</td>
<td>5.9</td>
<td>11.3</td>
<td>7.0</td>
</tr>
<tr>
<td>Arlington</td>
<td>20.6</td>
<td>2.7</td>
<td>10.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Bedford</td>
<td>19.9</td>
<td>1.8</td>
<td>8.6</td>
<td>9.5</td>
</tr>
<tr>
<td>Billerica</td>
<td>13.5</td>
<td>3.3</td>
<td>7.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Burlington</td>
<td>25.1</td>
<td>2.0</td>
<td>11.9</td>
<td>6.8</td>
</tr>
<tr>
<td>Lexington</td>
<td>31.1</td>
<td>2.0</td>
<td>10.5</td>
<td>16.6</td>
</tr>
<tr>
<td>Lowell</td>
<td>43.8</td>
<td>15.3</td>
<td>10.4</td>
<td>15.1</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>12.2</td>
<td>2.2</td>
<td>6.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Peabody</td>
<td>21.9</td>
<td>6.4</td>
<td>13.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**Source:** U.S. Census Bureau, American Community Survey, 2013-2017

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.
Key Findings: Social Determinants of Health

The social determinants of health are the conditions in which people live, work, learn, and play. These conditions influence and define quality of life for many segments of the population in the CHNA service area.

It is important to note that there is limited data to characterize the social determinants of health at the community level. To augment the lack of quantitative data, the key informant interviews, focus groups, community forums, and the Community Health Survey, specifically, solicited feedback on the social determinants of health and barriers to care. A dominant theme from key informant interviews and community forums was the tremendous impact that the underlying social determinants, particularly housing, transportation, and income/employment, have on residents in LHMC/LMCP’s service area.

Socioeconomic Characteristics

Socioeconomic status, as measured by income, employment status, occupation, education, and the extent to which one lives in areas of economic disadvantage, is closely linked to morbidity, mortality, and overall well-being. Lower-than-average life expectancy is highly correlated with low-income status.

Education

Higher education is associated with improved health outcomes and social development at the individual and community levels. Compared with individuals with more education, people with less education are more likely to experience health issues, such as obesity, substance use, and injury. The health benefits of higher education typically include better access to resources, safer and more stable housing, and better engagement with providers. Proximate factors associated with low education that affect health outcomes include the inability to navigate the health care system, educational disparities in personal health behaviors, and exposure to chronic stress. It is important to note that, while education affects health, poor health status may also be a barrier to education.

- The percentage of residents with less than a high school degree was significantly high in Lowell (20.2%) compared with the commonwealth overall (9.7%). Percentages were similar to or significantly low compared with the commonwealth overall in all other municipalities.
- In most municipalities, the percentage of residents with a bachelor’s degree or higher was significantly high in most municipalities compared with the commonwealth overall. Percentages were significantly low in Billerica (33.7%), Lowell (22.6%), and Peabody (30.8%).

---

10 Zimmerman, Population Health
Table 9: Educational attainment (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>Less than a high school degree (%)</th>
<th>Bachelor’s degree or higher (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>9.7</td>
<td>42.1</td>
</tr>
<tr>
<td>Essex County</td>
<td>10.6</td>
<td>38.8</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>7.2</td>
<td>54.1</td>
</tr>
<tr>
<td>Arlington</td>
<td>3.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Bedford</td>
<td>2.4</td>
<td>70.1</td>
</tr>
<tr>
<td>Billerica</td>
<td>7.4</td>
<td>33.7</td>
</tr>
<tr>
<td>Burlington</td>
<td>4.8</td>
<td>53.6</td>
</tr>
<tr>
<td>Lexington</td>
<td>2.1</td>
<td>81.6</td>
</tr>
<tr>
<td>Lowell</td>
<td>20.2</td>
<td>22.6</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>3.6</td>
<td>53.1</td>
</tr>
<tr>
<td>Peabody</td>
<td>10.2</td>
<td>30.8</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

The Massachusetts Department of Elementary and Secondary Education provides data on public school enrollment, attendance, retention, and student characteristics:

- The dropout rate was higher than the commonwealth overall in Billerica (6.5%), Lowell (6.5%), and Peabody (6.5%).
- In Lexington (30.8%) and Lowell (28.6%), the percentage of students whose first language was not English was higher than the commonwealth overall (21.9%).
- The percentage of students with disabilities* was similar to or lower than the commonwealth overall across municipalities.
- Over half of students in Lowell were economically disadvantaged (53.8%)** compared with the commonwealth overall; the percentage was also higher than the commonwealth overall in Peabody (30.3%).
Among those who responded to the Community Health Survey, 46% identified “low-income populations” as a segment with the greatest health needs.

### Employment, Income, and Poverty

Lack of gainful and reliable employment is linked to several barriers to care, including lack of health insurance, inability to pay for health care services and copays, and inability to pay for transportation to enable individuals to receive services. In key informant interviews and focus groups, participants stressed that while unemployment may be low across the service area, many live on fixed incomes or are underemployed. Certain populations struggle to find and retain employment for a variety of reasons – from mental and physical health issues to lack of child care to transportation issues and other factors.

Like education, income impacts all aspects of an individual’s life, including the ability to secure housing, needed goods (e.g., food, clothing), and services (e.g., transportation, health care, child care). It may also affect one’s ability to maintain good health. While almost all the municipalities in LHMC/LMCP’s CBSA had median household incomes that were significantly higher than the commonwealth overall, key informant interviewees and focus group participants reported that there were pockets of poverty throughout the service area, even in towns that were considered affluent.

- The unemployment rate among the civilian labor force was significantly high in Lowell (8.4%) and significantly low in Arlington (3.6%) and Billerica (4.9%) compared with the commonwealth overall (6.0%).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>4.9</td>
<td>21.9</td>
<td>10.5</td>
<td>18.1</td>
<td>31.2</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington</td>
<td>1.0</td>
<td>12.0</td>
<td>4.3</td>
<td>15.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Bedford</td>
<td>0.5</td>
<td>18.2</td>
<td>6.6</td>
<td>16.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Billerica</td>
<td>6.5</td>
<td>8.5</td>
<td>1.5</td>
<td>17.0</td>
<td>15.6</td>
</tr>
<tr>
<td>Burlington</td>
<td>0.4</td>
<td>18.3</td>
<td>4.2</td>
<td>13.7</td>
<td>11.4</td>
</tr>
<tr>
<td>Lexington</td>
<td>0.2</td>
<td>30.8</td>
<td>8.8</td>
<td>14.1</td>
<td>5.4</td>
</tr>
<tr>
<td>Lowell</td>
<td>6.5</td>
<td>28.6</td>
<td>23.7</td>
<td>17.3</td>
<td>53.8</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>0.0</td>
<td>7.4</td>
<td>2.1</td>
<td>17.7</td>
<td>7.2</td>
</tr>
<tr>
<td>Peabody</td>
<td>6.5</td>
<td>14.0</td>
<td>8.9</td>
<td>19.7</td>
<td>30.3</td>
</tr>
</tbody>
</table>

*Students with disabilities include those who have an Individualized Educational Plan
**Student participation in one or more of the following: Supplemental Nutrition Assistance Program, Traditional Aid to Families with Dependent Children, Department of Children and Families foster care program, and MassHealth

Source: Massachusetts Department of Elementary and Secondary Education School and District Profiles
Source: MA Department of Elementary and Secondary Education, 2018-2019
• Median household income was significantly high in all municipalities except Lowell and Peabody, where the median income was significantly low compared with the commonwealth overall.
• The percentage of individuals living below 200% of the federal poverty line was higher than the commonwealth overall in Lowell (41.6). This data point did not include confidence intervals, so figures could not be tested for statistical significance.

Table 11: Employment, income, and poverty (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>Unemployment rate (%)</th>
<th>Median household income ($)</th>
<th>Below 200% poverty (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>6.0</td>
<td>74,167</td>
<td>23.7</td>
</tr>
<tr>
<td>Essex County</td>
<td>6.0</td>
<td>73,533</td>
<td>24.2</td>
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<td>Middlesex County</td>
<td>4.8</td>
<td>92,878</td>
<td>17.9</td>
</tr>
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<td>Arlington</td>
<td>3.6</td>
<td>103,594</td>
<td>11.9</td>
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<td>4.8</td>
<td>125,208</td>
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<td>Billerica</td>
<td>4.9</td>
<td>99,453</td>
<td>11.4</td>
</tr>
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<td>Burlington</td>
<td>4.9</td>
<td>99,254</td>
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<td>Lexington</td>
<td>4.9</td>
<td>162,083</td>
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</tr>
<tr>
<td>Lowell</td>
<td>8.4</td>
<td>48,581</td>
<td>41.6</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>7.2</td>
<td>117,706</td>
<td>5.5</td>
</tr>
<tr>
<td>Peabody</td>
<td>5.3</td>
<td>65,085</td>
<td>22.9</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

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 homeless or living in unstable or transient housing situations. They are more likely to delay medical care and have mortality rates up to four times higher than those who have secure housing.

Adults who are homeless or living in unstable situations are more likely to experience mental health issues, substance use, intimate partner violence, and trauma; children in similar situations have difficulty in school and are more likely to exhibit antisocial behavior. Many key informants and focus group/forum participants expressed concern over the limited options for affordable housing throughout the service

39% of Community Health Survey respondents identified expensive/unsafe housing as an issue that prevents people from being able to live a healthy life.

---

13 Kottke, Access to Affordable Housing
area. This was particularly an issue for older adults, who often bear the burden of household costs (e.g., taxes, maintenance, adaptabilities) while living on fixed incomes.

- The percentage of owner-occupied housing units was significantly high in most communities compared with the commonwealth overall (62.4%), with the exception of Lowell, which was exceptionally low (42.2%). The percentage of owner-occupied households in which ownership costs exceed 30% of total household income, representing a major financial burden, was significantly high in Peabody (37.0%) and significantly low in Arlington (26.1%) compared with the commonwealth overall (31.5%).
- The percentage of renter-occupied housing units was significantly low or similar to the commonwealth overall (37.6%) in all communities, with the exception of Lowell, where the percentage was significantly high (57.8%). The percentage of renter-occupied households whose gross rent exceeds 30% of total household income was significantly high in Lowell (57.7%), Lynnfield (74.6%), and Peabody (58.5%) compared with the commonwealth overall (50.1%).

Housing insecurity was a common theme across key informant interviews, focus groups, and community forums. Specific concerns included the ability of seniors on fixed incomes to remain in their homes – continued increases in housing prices in the Greater Boston area are pushing more people into the suburbs (thus driving up home prices).

Table 12: Housing (2013-2017)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Owner-occupied (%)</th>
<th>Monthly owner costs &gt;30% of household income (%)</th>
<th>Renter-occupied (%)</th>
<th>Gross rent &gt;30% of total household income (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>62.4</td>
<td>31.5</td>
<td>37.6</td>
<td>50.1</td>
</tr>
<tr>
<td>Essex County</td>
<td>63.8</td>
<td>33.0</td>
<td>36.2</td>
<td>53.0</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>62.6</td>
<td>29.2</td>
<td>37.4</td>
<td>46.0</td>
</tr>
<tr>
<td>Arlington</td>
<td>60.9</td>
<td>26.1</td>
<td>39.1</td>
<td>37.7</td>
</tr>
<tr>
<td>Bedford</td>
<td>74.0</td>
<td>33.5</td>
<td>26.0</td>
<td>53.0</td>
</tr>
<tr>
<td>Billerica</td>
<td>80.9</td>
<td>29.7</td>
<td>19.1</td>
<td>43.4</td>
</tr>
<tr>
<td>Burlington</td>
<td>70.2</td>
<td>31.0</td>
<td>29.8</td>
<td>40.7</td>
</tr>
<tr>
<td>Lexington</td>
<td>80.8</td>
<td>29.7</td>
<td>19.2</td>
<td>38.2</td>
</tr>
<tr>
<td>Lowell</td>
<td>42.2</td>
<td>35.1</td>
<td>57.8</td>
<td>57.7</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>87.9</td>
<td>33.9</td>
<td>12.1</td>
<td>74.6</td>
</tr>
<tr>
<td>Peabody</td>
<td>64.5</td>
<td>37.0</td>
<td>35.5</td>
<td>58.5</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, American Community Survey, 2013-2017

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

“Several agencies provide assistance with accessing services, including housing. However, there is a lack of affordable housing in our region for low-to-moderate-income families and individuals.”

– Survey respondent
Transportation

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

There is very limited quantitative data to characterize issues related to transportation. Many interviewees, focus group participants, and survey respondents felt that lack of transportation was a critical barrier to accessing care and community and social services (e.g., senior centers and COAs, grocery stores, other stores) and the ability to socialize, especially for older adults without access to a personal vehicle.

- Mean commuting times were significantly high in Arlington (32.3 minutes) and Lexington (31.6 minutes) compared with the commonwealth overall (29.3 minutes). Data was not reported for Bedford or Lynnfield.
- A significantly low percentage of the population work outside the county in which they reside in Bedford, Billerica, Burlington, Lexington, and Lowell compared with the commonwealth overall (30.8%). A significantly high percentage travel outside their county in Lynnfield (53.2%).

Table 13: Transportation (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>Mean commute time (minutes)</th>
<th>Works outside county of residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>29.3</td>
<td>30.8</td>
</tr>
<tr>
<td>Essex County</td>
<td>29.8</td>
<td>32.3</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>30.8</td>
<td>30.4</td>
</tr>
<tr>
<td>Arlington</td>
<td>32.3</td>
<td>29.9</td>
</tr>
<tr>
<td>Bedford</td>
<td>N/A</td>
<td>18.6</td>
</tr>
<tr>
<td>Billerica</td>
<td>29.2</td>
<td>19.1</td>
</tr>
<tr>
<td>Burlington</td>
<td>29.2</td>
<td>21.2</td>
</tr>
<tr>
<td>Lexington</td>
<td>31.6</td>
<td>25.7</td>
</tr>
<tr>
<td>Lowell</td>
<td>25.8</td>
<td>16.5</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>N/A</td>
<td>53.2</td>
</tr>
<tr>
<td>Peabody</td>
<td>26.5</td>
<td>32.6</td>
</tr>
</tbody>
</table>

*Source*: U.S. Census Bureau, American Community Survey, 2013-2017

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.
Built Environment

The built environment – buildings, streets, parks, open spaces, and other forms of physical infrastructure – has a major influence on physical activity and lifestyle. Creating safe outdoor spaces for people to exercise, relax, and commute is an important component in establishing healthy lifestyle habits that protect against poor health outcomes. While concerns related to the built environment were not key themes of this assessment, these issues can work to either prevent or contribute to disease and disability in the community. There are a number of valuable community resources in the service area, including playgrounds, parks, athletic fields, walking trails, bike paths, dog parks, waterways, and recreational centers.

Food Access

There is an overwhelming body of evidence to show that many families, particularly low-income families of color, struggle to access food that is affordable, high-quality, and healthy. While it is important to have grocery stores placed throughout a community to promote access, research shows that there are a number of factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food, and cultural appropriateness of food offerings. Pantries and community meal programs have evolved from providing temporary or emergency food assistance to providing ongoing support for individuals, families, seniors living on fixed incomes, people with disabilities, and adults working multiple low-wage jobs to make ends meet.

In LHMC/LMCP’s service area, issues related to food insecurity, food scarcity, and hunger were discussed as risk factors for poor physical and mental health for both children and adults. The Supplemental Nutrition Assistance Program (SNAP) Gap is the difference between the number of low-income Massachusetts residents receiving MassHealth who are likely SNAP eligible and the number of people actually receiving SNAP (those qualifying for MassHealth are also likely to qualify for SNAP benefits).

- The percentage of residents who had received SNAP (food stamp) benefits in the past 12 months was similar to or significantly low compared with the commonwealth overall (12.3%) in all municipalities, with the exception of Lowell (24.1%), where the percentage was significantly high.

16 Massachusetts Legal Services, www.masslegalservices.org
• SNAP Gap percentages were higher than the commonwealth overall in all communities in the service area with the exception of Lowell, indicating that there are many residents who are eligible to receive the benefits but don’t. Percentages were particularly high (>70%) in Lynnfield and Lexington.

Table 14: SNAP enrollment and SNAP Gap

<table>
<thead>
<tr>
<th></th>
<th>Received SNAP (food stamps) in the past 12 months (%)</th>
<th>SNAP Gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>12.3</td>
<td>48.0</td>
</tr>
<tr>
<td>Essex County</td>
<td>14.1</td>
<td>N/A</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>7.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington</td>
<td>4.6</td>
<td>64.0</td>
</tr>
<tr>
<td>Bedford</td>
<td>3.9</td>
<td>64.0</td>
</tr>
<tr>
<td>Billerica</td>
<td>4.3</td>
<td>69.0</td>
</tr>
<tr>
<td>Burlington</td>
<td>4.1</td>
<td>67.0</td>
</tr>
<tr>
<td>Lexington</td>
<td>3.5</td>
<td>73.0</td>
</tr>
<tr>
<td>Lowell</td>
<td>24.1</td>
<td>42.0</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>1.8</td>
<td>72.0</td>
</tr>
<tr>
<td>Peabody</td>
<td>12.6</td>
<td>55.0</td>
</tr>
</tbody>
</table>

*Source (SNAP enrollment): U.S. Census Bureau, American Community Survey, 2013-2017*

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

Crime/Violence

Crime and violence are public health issues that influence health status on many levels, from death and injury to emotional trauma, anxiety, isolation, and absence of community cohesion. Those who participated in the assessment process did not identify crime and violence as major issues.

• Violent crime (e.g., murder/non-negligent manslaughter, forcible rape, robbery, aggravated assault) rates were lower than the commonwealth overall (353.1 per 100,000) in all municipalities.

• Property crime (e.g., burglary, larceny/theft, motor vehicle theft, arson) rates were higher than the commonwealth overall (1,398.1 per 100,000) in Burlington (1,818.0 per 100,000) and Lowell (1,974.9 per 100,000).
Table 15: Violent and property crime, rates per 100,000 (2017)

<table>
<thead>
<tr>
<th></th>
<th>Violent crime rate (per 100,000)</th>
<th>Property crime rate (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>353.1</td>
<td>1,398.1</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington</td>
<td>83.6</td>
<td>565.5</td>
</tr>
<tr>
<td>Bedford</td>
<td>61.6</td>
<td>403.9</td>
</tr>
<tr>
<td>Billerica</td>
<td>92.7</td>
<td>565.8</td>
</tr>
<tr>
<td>Burlington</td>
<td>198.7</td>
<td>1818.0</td>
</tr>
<tr>
<td>Lexington</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Lowell</td>
<td>289.3</td>
<td>1974.9</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>53.7</td>
<td>797.4</td>
</tr>
<tr>
<td>Peabody</td>
<td>290.2</td>
<td>1183.6</td>
</tr>
</tbody>
</table>

Source: FBI Uniform Crime Statistics, 2017. Rates were not available for counties or Lexington.
Key Findings: Behavioral Risk Factors and Health Status

At the core of the CHNA process is understanding access-to-care issues, leading causes of morbidity and mortality, and the extent to which populations and communities participate in certain risky behaviors. This information is critical to assessing health status, clarifying health-related disparities, and identifying health priorities. This assessment captures a wide range of quantitative data from federal and municipal data sources. Qualitative information gathered from key informant interviews, focus groups, and the Community Health Survey informed this section of the report by providing perspectives on the confounding and contributing factors of illness, health priorities, barriers to care, service gaps, and possible strategic responses to the issues identified. This data augmented the quantitative data and allowed for the identification of vulnerable population cohorts.

Health Insurance and Access to Care

Whether an individual has health insurance – and the extent to which it helps pay for needed acute services and access to a full continuum of high-quality, timely, and accessible preventive and disease management or follow-up services – has been shown to be critical to overall health and well-being. Access to a usual source of primary care is particularly important, since it greatly affects the individual’s ability to receive regular preventive, routine, and urgent care and to manage chronic diseases.

While Massachusetts has one of the highest health insurance coverage rates in the U.S., there are still pockets of individuals without coverage, including young people, immigrants and refugees, and those who are unemployed. Many key informants and focus group/forum participants identified issues around navigating the health system, including health insurance, as a critical issue. This was especially an issue for older adults attempting to navigate Medicaid eligibility, costs, and coverage; low-to-moderate-income populations, those who do not meet eligibility requirements for public insurance and/or public assistance programs and struggle to afford the rising costs of health care premiums; and non-English speakers who may face language and cultural barriers.

“The most important [barrier] is cost. Even as a teacher, my insurance wasn’t very good. People don’t seek preventive medicine because they can’t afford it. Visiting specialists and hospitalizations are even worse.” – Survey respondent

• The percentage of the population that was uninsured was significantly high in Lowell (5.3%) compared with the commonwealth overall (3.0%); percentages were similar to or significantly low compared with the commonwealth overall in all other municipalities in the CBSA.
• The percentage with public insurance (e.g., MassHealth, Medicare) was significantly high in Lowell (47.7%) and Peabody (41.4%) compared with the commonwealth overall (35.5%); percentages were significantly low in all other municipalities.
• The percentage of the population with private insurance was significantly high in all municipalities compared with the commonwealth overall (74.2%), with the exception of Lowell (56.1%), where the percentage was significantly low, and Peabody (73.9%), where the percentage was similar.

Table 16: Health insurance (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>Uninsured (%)</th>
<th>Public health insurance (%)</th>
<th>Private health insurance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>3.0</td>
<td>35.5</td>
<td>74.2</td>
</tr>
<tr>
<td>Essex County</td>
<td>3.3</td>
<td>38.4</td>
<td>71.6</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>2.8</td>
<td>28.4</td>
<td>80.4</td>
</tr>
<tr>
<td>Arlington</td>
<td>1.1</td>
<td>23.8</td>
<td>88.0</td>
</tr>
<tr>
<td>Bedford</td>
<td>0.7</td>
<td>27.7</td>
<td>87.2</td>
</tr>
<tr>
<td>Billerica</td>
<td>2.5</td>
<td>27.8</td>
<td>82.1</td>
</tr>
<tr>
<td>Burlington</td>
<td>2.1</td>
<td>30.3</td>
<td>85.1</td>
</tr>
<tr>
<td>Lexington</td>
<td>1.0</td>
<td>22.3</td>
<td>90.1</td>
</tr>
<tr>
<td>Lowell</td>
<td>5.3</td>
<td>47.7</td>
<td>56.1</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>0.4</td>
<td>26.8</td>
<td>88.1</td>
</tr>
<tr>
<td>Peabody</td>
<td>2.7</td>
<td>41.4</td>
<td>73.9</td>
</tr>
</tbody>
</table>

*Source:* U.S. Census Bureau, American Community Survey, 2013-2017

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

**Physical Activity, Nutrition, and Weight**

Lack of physical fitness and poor nutrition are among the leading risk factors associated with obesity and chronic health issues. Adequate nutrition helps prevent disease and is essential for the healthy growth and development of children and adolescents, while overall fitness and the extent to which people are physically active reduce the risk for many chronic conditions and are linked to good emotional health. Over the past two decades, obesity rates in the United States have doubled for adults and tripled for children. Overall, these trends have spanned all segments of the population, regardless of age, sex, race, ethnicity, education, income, or geographic region.

Focus group participants and listening session attendees identified lack of physical activity, poor nutrition, and obesity as key risk factors for chronic and complex conditions.
According to the Middlesex School League Youth Risk Behavior Survey (YRBS) results:

- Over 20% of middle school and high school students in all municipalities described themselves as slightly or very overweight.
- High school students were less active than middle school students; over 10% of students in both Arlington and Burlington reported that they were not physically active for at least 60 minutes in the week prior to taking the survey.

**Table 17: Youth physical activity (2019)**

<table>
<thead>
<tr>
<th></th>
<th>Described themselves as slightly or very overweight (%)</th>
<th>Not physically active at least 60 minutes per day at least one day in past week (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Middle School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington (2018)</td>
<td>20.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Bedford (2018)</td>
<td>21.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Burlington (2018)</td>
<td>25.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Lexington (2017)</td>
<td>24.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Lynnfield (2017)</td>
<td>24.6</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>High School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>28.1</td>
<td>15.1</td>
</tr>
<tr>
<td>Arlington (2018)</td>
<td>24.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Bedford (2018)</td>
<td>24.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Burlington (2018)</td>
<td>27.8</td>
<td>14.0</td>
</tr>
<tr>
<td>Lexington (2017)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Lynnfield (2017)</td>
<td>25.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

*Source: Middlesex League Youth Risk Behavior Survey (2019)*

For older adults, physical activity and proper nutrition may reduce the risk of premature death and delay, prevent, or manage many chronic/complex conditions. As many key informants and focus group/listening session participants shared, social isolation, mobility issues, and other barriers may prevent older adults from accessing nutritious foods and getting adequate exercise. LHMC/LMCP has historically focused many of its Community Benefits programs on promoting healthy activities and reducing barriers for older adults.

Data from the Massachusetts Healthy Aging Collaborative includes several data points on physical activity and nutrition/diet for those 65 or older:

> “Social media plays a big role [in obesity]. Kids are not getting outside for exercise – they’re indoors on video games or social media. Participation in youth sports is down.” – Key informant

---

• The percentage of adults 60+ with any reported physical activity in the past month was significantly higher than the commonwealth overall (73.3%) in Bedford (88.4%) and Lexington (88.4%), and significantly lower in Lowell (62.3%) and Peabody (64.6%).

• The percentage of adults 60+ who consumed five or more fruits and vegetables a day was lower than the commonwealth overall (21.5%) in Billerica (19.3%), Burlington (19.3%), Lowell (19.1%), and Lynnfield (21.3%).

• The percentage of the population who self-reported as obese was significantly lower than the commonwealth overall (23.1%) in Arlington (15.3%), Bedford (16.2%), and Lexington (16.2%).

• The percentage of adults 65+ who had been clinically diagnosed as obese was significantly higher than the commonwealth overall (19.0%) in Billerica (21.8%), Lowell (21.8%), and Peabody (23.6%), and significantly lower in Arlington (16.5%), Bedford (15.4%), and Lexington (12.0%).

Table 18: Physical activity and nutrition/weight among older adults

<table>
<thead>
<tr>
<th></th>
<th>Self-reported any physical activity in past month (60+) (%)</th>
<th>Five or more fruits and vegetables a day (60+) (%)</th>
<th>Self-reported as obese (60+) (%)</th>
<th>Clinically diagnosed as obese (65+) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>73.3</td>
<td>21.5</td>
<td>23.1</td>
<td>19.0</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington</td>
<td>77.8</td>
<td>22.4</td>
<td>15.3</td>
<td>16.5</td>
</tr>
<tr>
<td>Bedford</td>
<td>88.4</td>
<td>27.6</td>
<td>16.2</td>
<td>15.4</td>
</tr>
<tr>
<td>Billerica</td>
<td>69.8</td>
<td>19.3</td>
<td>30.1</td>
<td>21.8</td>
</tr>
<tr>
<td>Burlington</td>
<td>69.8</td>
<td>19.3</td>
<td>30.1</td>
<td>19.9</td>
</tr>
<tr>
<td>Lexington</td>
<td>88.4</td>
<td>27.6</td>
<td>16.2</td>
<td>12.0</td>
</tr>
<tr>
<td>Lowell</td>
<td>62.3</td>
<td>19.1</td>
<td>27.9</td>
<td>21.8</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>68.6</td>
<td>21.3</td>
<td>21.2</td>
<td>18.6</td>
</tr>
<tr>
<td>Peabody</td>
<td>64.6</td>
<td>22.7</td>
<td>24.5</td>
<td>23.6</td>
</tr>
</tbody>
</table>

Source: Massachusetts Healthy Aging Collaborative, 2018

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

All-Cause Mortality and Premature Mortality

The all-cause and premature mortality rates do not indicate that all residents of a municipality have equal or similar access to care based simply on proximity to services. For example, not all residents in Burlington and Peabody have better access to health services, and therefore lower rates, than do those in other municipalities simply because they live closer to hospitals.

• All-cause mortality rates were significantly high in Billerica (903.4) and Burlington (821.5) and significantly low in Arlington (614.6) and Lexington (425.6) compared with the commonwealth overall (684.5).

---

19 All-cause mortality rate is an aggregation of all deaths of any cause. The premature mortality rate is a measure of unfulfilled life expectancy; it is the deaths among residents under the age of 75.
Premature mortality rates were significantly high in Lowell (479.1) and significantly low in Lexington (146.5) and Lynnfield (209.5) compared with the commonwealth overall (279.6).

Table 19: All-cause and premature mortality, age-adjusted rates per 100,000 (2015)

<table>
<thead>
<tr>
<th></th>
<th>All causes mortality rate</th>
<th>Premature mortality rate (&lt; 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>684.5</td>
<td>279.6</td>
</tr>
<tr>
<td>Essex County</td>
<td>691.9</td>
<td>284.4</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>616.5</td>
<td>227.7</td>
</tr>
<tr>
<td>Arlington</td>
<td>614.6</td>
<td>233.3</td>
</tr>
<tr>
<td>Bedford</td>
<td>663.0</td>
<td>265.8</td>
</tr>
<tr>
<td>Billerica</td>
<td>903.4</td>
<td>315.4</td>
</tr>
<tr>
<td>Burlington</td>
<td>821.5</td>
<td>272.9</td>
</tr>
<tr>
<td>Lexington</td>
<td>425.6</td>
<td>146.5</td>
</tr>
<tr>
<td>Lowell</td>
<td>917.9</td>
<td>479.1</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>607.7</td>
<td>209.5</td>
</tr>
<tr>
<td>Peabody</td>
<td>731.3</td>
<td>295.8</td>
</tr>
</tbody>
</table>

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

Chronic and Complex Conditions

Chronic conditions such as heart disease, cancer, stroke, Alzheimer’s disease, and diabetes are the leading causes of death and disability in the United States and are the leading drivers of the nation’s $3.3 trillion annual health care costs. Over half of American adults have at least one chronic condition, while 40% have two or more. Perhaps most significant, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society. This underscores the need to focus on health risk factors, primary care engagement, and evidence-based chronic disease management. There was broad, if not universal, acknowledgement and awareness of these pervasive health issues among interviewees and forum participants.

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21 “Chronic Diseases in America,” CDC
Cardiovascular and Cerebrovascular Diseases

Cardiovascular and cerebrovascular diseases, such as heart disease and stroke, are affected by a number of health and behavioral risk factors, including obesity and physical inactivity, tobacco use, and alcohol use. Hypertension, or high blood pressure, increases the risk of more serious health issues, including heart failure, stroke, and other forms of major cardiovascular disease.

- Across the service area, the PQI rates for hypertension were higher than the commonwealth overall (47.5) in Burlington (52.9), Lynnfield (61.7), and Peabody (73.7). A higher PQI rate indicates that there may be room to improve the quality of primary care services offered – and patient engagement – to better manage the condition.

Figure 4: Hypertension PQI rates per 100,000 population (2017)

Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017
• The PQI rates for heart failure were higher than the commonwealth overall (459.4) in Burlington (481.3), Lowell (591.9), Lynnfield (493.8) and Peabody (736.6).

Figure 5: Heart failure PQI rates per 100,000 population (2017)

Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017

• The major cardiovascular disease hospitalization rate was higher than the commonwealth overall (1,771.2) in Burlington (1,785.6), Lowell (1,841.0), and Peabody (2,520.4).
• The heart disease mortality rate was significantly high in Billerica (193.1) compared with the commonwealth overall (138.7). It should be noted that the mortality rates included in this report are limited to one year of data; rates that include multiple years of data would provide a more accurate representation of disease burden.
• The coronary heart disease mortality rate was significantly high in Billerica (125.7) and Lowell (104.9), and significantly low in Arlington (53.0) and Lexington (46.0) compared with the Commonwealth overall (82.3).
• The cerebrovascular disease mortality rate was significantly low in Lexington (10.7) compared with the commonwealth overall (28.4).
Table 20: Cardiovascular disease inpatient hospitalizations and mortality

<table>
<thead>
<tr>
<th></th>
<th>Major cardiovascular disease inpatient hospitalizations</th>
<th>Heart disease mortality*</th>
<th>Coronary heart disease mortality*</th>
<th>Cerebrovascular disease (stroke) mortality*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>1,771.2</td>
<td>138.7</td>
<td>82.3</td>
<td>28.4</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>141.0</td>
<td>83.3</td>
<td>29.0</td>
</tr>
<tr>
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<td>N/A</td>
<td>121.6</td>
<td>74.6</td>
<td>25.3</td>
</tr>
<tr>
<td>Arlington</td>
<td>1,392.7</td>
<td>104.4</td>
<td>53.0</td>
<td>18.9</td>
</tr>
<tr>
<td>Bedford</td>
<td>1,545.6</td>
<td>94.1</td>
<td>60.3</td>
<td>24.0</td>
</tr>
<tr>
<td>Billerica</td>
<td>1,206.6</td>
<td>193.1</td>
<td>125.7</td>
<td>31.2</td>
</tr>
<tr>
<td>Burlington</td>
<td>1,785.6</td>
<td>162.3</td>
<td>89.0</td>
<td>21.5</td>
</tr>
<tr>
<td>Lexington</td>
<td>1,302.4</td>
<td>82.8</td>
<td>46.0</td>
<td>10.7</td>
</tr>
<tr>
<td>Lowell</td>
<td>1,841.0</td>
<td>159.1</td>
<td>104.9</td>
<td>32.7</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>1,749.0</td>
<td>121.9</td>
<td>66.1</td>
<td>‡</td>
</tr>
<tr>
<td>Peabody</td>
<td>2,520.4</td>
<td>144.0</td>
<td>78.3</td>
<td>24.1</td>
</tr>
</tbody>
</table>

*Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017

*Source: MDPH Registry of Vital Records and Statistics, age-adjusted rates per 100,000, 2015

‡ Data suppressed because of small numbers.

Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

Cancer

The most common risk factors for cancer are well-known: age, family history of cancer, alcohol and tobacco use, diet, exposure to cancer-causing substances, chronic inflammation, and hormones. Key informants and focus group/listening session participants identified several needs for individuals with cancer and their caregivers, including more support groups and pain management therapies, assistance with care navigation and management, and respite services.

- The cancer (all types) inpatient hospitalization rate was higher than the commonwealth overall (456.3) in Arlington (478.4), Lexington (486.9), Lynnfield (524.7), and Peabody (610.0).
- The mortality rate for all types of invasive cancers was significantly low in Lexington (101.9) compared with the commonwealth overall (152.8). The rates were similar to the commonwealth in all other municipalities.
- There were no recorded breast cancer (female) deaths in Lexington in 2015. Rates were similar to the commonwealth or suppressed because of small numbers in all other municipalities.
- The lung cancer mortality rate was significantly high in Burlington (57.0) and significantly low in Lexington (9.7) compared with the commonwealth overall (39.0). Rates were similar to the commonwealth in all other municipalities.
- The prostate cancer mortality rate was significantly high in Arlington (36.9) and Peabody (24.3) compared with the commonwealth overall (7.0). There were no recorded prostate cancer
deaths in Lexington and Lynnfield in 2015. Rates were suppressed because of small numbers in all other municipalities.

Table 21: Cancer inpatient hospitalizations and mortality

<table>
<thead>
<tr>
<th></th>
<th>Cancer inpatient hospitalizations (all types)</th>
<th>Cancer mortality (all types)*</th>
<th>Breast cancer mortality (female)*</th>
<th>Lung cancer mortality*</th>
<th>Prostate cancer mortality*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>456.3</td>
<td>152.8</td>
<td>9.8</td>
<td>39.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Essex County</td>
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<td>146.4</td>
<td>16.9</td>
<td>37.3</td>
<td>19.6</td>
</tr>
<tr>
<td>Middlesex County</td>
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<td>16.2</td>
<td>35.2</td>
<td>14.8</td>
</tr>
<tr>
<td>Arlington</td>
<td>478.4</td>
<td>160.1</td>
<td>19.8</td>
<td>28.7</td>
<td>36.9</td>
</tr>
<tr>
<td>Bedford</td>
<td>395.8</td>
<td>153.0</td>
<td>50.3</td>
<td>38.7</td>
<td>‡</td>
</tr>
<tr>
<td>Billerica</td>
<td>331.5</td>
<td>168.1</td>
<td>23.2</td>
<td>43.7</td>
<td>‡</td>
</tr>
<tr>
<td>Burlington</td>
<td>413.9</td>
<td>182.8</td>
<td>‡</td>
<td>57.0</td>
<td>‡</td>
</tr>
<tr>
<td>Lexington</td>
<td>486.9</td>
<td>101.9</td>
<td>0.0</td>
<td>9.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Lowell</td>
<td>357.7</td>
<td>174.7</td>
<td>14.8</td>
<td>41.5</td>
<td>‡</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>524.7</td>
<td>121.3</td>
<td>‡</td>
<td>35.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Peabody</td>
<td>610.0</td>
<td>158.8</td>
<td>21.1</td>
<td>43.1</td>
<td>24.3</td>
</tr>
</tbody>
</table>

Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017
*Source: MDPH Registry of Vital Records and Statistics, age-adjusted rates per 100,000, 2015
‡ Data suppressed because of small numbers.
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

Respiratory Diseases

Respiratory diseases such as asthma and COPD are exacerbated by behavioral, environmental, and location-based risk factors, including smoking, diet and nutrition, substandard housing, and environmental exposures (e.g., air pollution, secondhand smoke). They are the third leading cause of death in the United States. In many scenarios, quality of life for those with respiratory diseases can improve with proper care and management.22

- Across the service area, the PQI rate for COPD was higher than the commonwealth overall (700.6) in Lowell (1113.9) and Peabody (838.3). A higher PQI rate indicates that there may be room to improve the quality of primary care services offered – and patient engagement – to better manage the condition.
- The PQI rate for asthma among younger adults (ages 20-44) was higher than the commonwealth overall (50.3) in Lowell (88.7).

The rate of chronic lower respiratory disease (CLRD) inpatient hospitalizations was higher than the commonwealth overall (428.3) in Lowell (580.3) and Peabody (547.8).

The CLRD mortality rate was significantly high in Billerica (60.6) and Lowell (50.1) and significantly low in Lexington (13.1) compared with the commonwealth overall (33.0). Across other municipalities, rates were similar to the commonwealth overall.

Table 22: CLRD inpatient hospitalization and mortality

<table>
<thead>
<tr>
<th></th>
<th>CLRD inpatient hospitalizations</th>
<th>CLRD mortality*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>428.3</td>
<td>33.0</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>33.8</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>N/A</td>
<td>27.6</td>
</tr>
<tr>
<td>Arlington</td>
<td>220.8</td>
<td>24.8</td>
</tr>
<tr>
<td>Bedford</td>
<td>254.5</td>
<td>29.3</td>
</tr>
<tr>
<td>Billerica</td>
<td>186.1</td>
<td>60.6</td>
</tr>
<tr>
<td>Burlington</td>
<td>336.9</td>
<td>49.4</td>
</tr>
<tr>
<td>Lexington</td>
<td>113.6</td>
<td>13.1</td>
</tr>
<tr>
<td>Lowell</td>
<td>580.3</td>
<td>50.1</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>267.5</td>
<td>33.4</td>
</tr>
<tr>
<td>Peabody</td>
<td>547.8</td>
<td>39.2</td>
</tr>
</tbody>
</table>

*Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017

*Source: MDPH Registry of Vital Records and Statistics, age-adjusted rate per 100,000, 2015
Diabetes

Over the course of a lifetime, approximately 40% of adults in the U.S. are expected to develop type 2 diabetes – this number increases to over 50% for Hispanic men and women.\(^23\) Several factors increase the risk of developing type 2 diabetes, including being overweight, physical inactivity, age, and family history. Having diabetes increases the risk of cardiovascular comorbidities (e.g., hypertension, atherosclerosis), may limit the ability to engage in physical activity, and may have negative impacts on metabolism.\(^24\) A recent study published by Massachusetts General Hospital’s Diabetes Unit and Center for Genomic Medicine found that the onset of type 2 diabetes can be reduced with healthy eating, including for those with genetic risk factors.\(^25\) While very few key informants and focus group/listening session participants identified diabetes as an issue, there was significant discussion about many of the risk factors for diabetes: poor nutrition, physical inactivity, and obesity.

- Across the service area, the PQI rate for diabetes was higher than the commonwealth overall (200.3) in Burlington (235.8), Lowell (315.8), and Peabody (207.2).
- The diabetes mortality rate was significantly low in Billerica (30.2) compared with the commonwealth overall (16.8). Rates were similar to the commonwealth overall or were suppressed because of small numbers in all other municipalities.

Table 23: Diabetes PQI rates and mortality

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Diabetes PQI rate</th>
<th>Mortality rate (age-adjusted)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>200.3</td>
<td>16.8</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>15.1</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>N/A</td>
<td>15.5</td>
</tr>
<tr>
<td>Arlington</td>
<td>84.9</td>
<td>12.8</td>
</tr>
<tr>
<td>Bedford</td>
<td>84.8</td>
<td>‡</td>
</tr>
<tr>
<td>Billerica</td>
<td>104.7</td>
<td>30.2</td>
</tr>
<tr>
<td>Burlington</td>
<td>235.8</td>
<td>16.3</td>
</tr>
<tr>
<td>Lexington</td>
<td>85.2</td>
<td>9.6</td>
</tr>
<tr>
<td>Lowell</td>
<td>315.8</td>
<td>26.9</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>92.6</td>
<td>‡</td>
</tr>
<tr>
<td>Peabody</td>
<td>207.2</td>
<td>10.0</td>
</tr>
</tbody>
</table>

*Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017


‡ Data suppressed because of small numbers.

---


\(^{25}\) Merino, Jordi. "Quality of Dietary Fat and Genetic Risk of Type 2 Diabetes: Individual Participant Data Meta-Analysis." *BMJ*, 10 June 2019, [https://www.bmj.com/content/bmj/366/bmj.l4292.full.pdf](https://www.bmj.com/content/bmj/366/bmj.l4292.full.pdf)
Mental Health

Mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified in stakeholder feedback as one of the leading health issues for residents of LHMC/LMCP’s service area. Individuals from across the health services spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety.

Many key informants and focus group/listening session participants identified social isolation as an issue for older adults. Participants suggested several reasons for this isolation – a lack of friends or family, inability to leave the home due to frailty or limited access to transportation, or unwillingness to leave the home for unknown reasons. While there are many active senior centers and COAs in LHMC/LMCP’s service area, participants reported that it was difficult for some older adults to attend activities or utilize services because of transportation or mobility issues.

- The mental health disorder inpatient hospitalization rate was higher than the commonwealth overall (5,957.6) in Lowell (6,436.4) and Peabody (7,605.0).
- The mental health mortality rate was significantly high in Peabody (104.2) and significantly low in Lexington (37.1) compared with the commonwealth overall (62.9). Rates were similar to or lower than the commonwealth in all other municipalities. As explained above, it is important to understand that this data set is limited to only one year of data and that these rates are not a true reflection of the burden of mental health issues in the CBSA; while mental health disorders underlie many other medical conditions, including substance misuse, they are often not the primary cause of death.
- There were no recorded deaths by suicide in Lynnfield in 2015. Rates were suppressed because of small numbers in all other municipalities with the exceptions of Arlington, Lexington, and Lowell, where the rates were similar to the commonwealth overall.
Table 24: Mental health mortality, age-adjusted rates per 100,000 (2015)

<table>
<thead>
<tr>
<th></th>
<th>Mental health disorder inpatient hospitalizations*</th>
<th>Mental health disorder mortality*</th>
<th>Death by suicide*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>5,957.6</td>
<td>62.9</td>
<td>9.0</td>
</tr>
<tr>
<td>Essex County</td>
<td>N/A</td>
<td>80.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>N/A</td>
<td>60.1</td>
<td>8.4</td>
</tr>
<tr>
<td>Arlington</td>
<td>4,520.6</td>
<td>58.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Bedford</td>
<td>4,570.7</td>
<td>57.8</td>
<td>‡</td>
</tr>
<tr>
<td>Billerica</td>
<td>4,053.2</td>
<td>72.9</td>
<td>‡</td>
</tr>
<tr>
<td>Burlington</td>
<td>5,174.0</td>
<td>64.3</td>
<td>‡</td>
</tr>
<tr>
<td>Lexington</td>
<td>3,347.4</td>
<td>37.1</td>
<td>13.5</td>
</tr>
<tr>
<td>Lowell</td>
<td>6,436.4</td>
<td>77.9</td>
<td>8.0</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>4,784.0</td>
<td>55.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Peabody</td>
<td>7,605.0</td>
<td>104.2</td>
<td>‡</td>
</tr>
</tbody>
</table>

Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017

*Source: MDPH Registry of Vital Records and Statistics, age-adjusted rates per 10,000, 2015

‡ Data suppressed because of small numbers.
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

While mental health was an issue across demographic and socioeconomic segments of the population, there were specific issues identified for youth and for older adults. For youth, key informants and focus group/listening session participants were most concerned about chronic stress/anxiety, depression, and suicidality. In a focus group with students at Burlington High School, students spoke at length about the immense pressures to maintain grades, participate in activities, and attend a prestigious college. One student reported that she could not think of a single friend who had not experienced major anxiety issues. According to YRBS data:

- In Arlington, Bedford, Burlington, and Lexington, over 25% of high school students reported that they had felt sad or hopeless almost every day for over two weeks sometime within the past 12 months, and over 10% had ever seriously considered suicide.
- In Arlington, Bedford, Burlington, and Lexington, over 10% of middle school students reported having seriously considered suicide.
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Community Health Survey respondents identified inpatient substance use services as the second hardest health service for community residents to access.

### Substance Use

Along with mental health, substance use was named as a leading health issue among key informants and focus group/listening session participants and Community Health Survey respondents. Behavioral health providers reported that individuals continue to struggle to access care services, including rehabilitation and detox, outpatient treatment, and medication-assisted treatment. As with mental health services, there are a number of community partners working to fill service gaps and address the needs of both individuals and the community at-large, although individuals continue to face delays or barriers to care due to limited providers and specialists, limited treatment beds, and social determinants that impede access to care (e.g., insurance coverage, transportation, employment, health literacy). Many participants also discussed the co-morbidity that often occurs between mental health and substance use issues.

The opioid epidemic continues to be a critical concern, not only for individuals but also for families, communities, and society. Key informants and focus group/listening session participants were particularly concerned about the traumatic effect opioid use has on family units – including the children of parents with opioid issues, and grandparents or other family members who struggle to access the resources needed to care for these children.

---

### Figure 7: Youth mental health, from YRBS data

<table>
<thead>
<tr>
<th></th>
<th>Felt sad/hopeless almost every day for two+ weeks in past 12 months (%)*</th>
<th>Ever seriously considered suicide (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Middle School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington (2018)</td>
<td>N/A</td>
<td>15.0</td>
</tr>
<tr>
<td>Bedford (2018)</td>
<td>15.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Burlington (2018)</td>
<td>N/A</td>
<td>12.1</td>
</tr>
<tr>
<td>Lexington (2017)</td>
<td>N/A</td>
<td>15.4</td>
</tr>
<tr>
<td>Lynnfield (2017)</td>
<td>N/A</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>High School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>27.4</td>
<td>12.4</td>
</tr>
<tr>
<td>Arlington (2018)</td>
<td>25.7</td>
<td>11.0</td>
</tr>
<tr>
<td>Bedford (2018)</td>
<td>28.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Burlington (2018)</td>
<td>27.6</td>
<td>12.0</td>
</tr>
<tr>
<td>Lexington (2017)</td>
<td>27.1</td>
<td>17.2</td>
</tr>
<tr>
<td>Lynnfield (2017)</td>
<td>16.2</td>
<td>7.6</td>
</tr>
</tbody>
</table>

*Full question reads: “During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?”

Source: Youth Risk Behavior Surveys, multiple years
- The opioid-related inpatient hospitalization rate was higher than the Commonwealth overall (781.3) in Lowell (906.5).
- The rate of fatal opioid overdoses was significantly high in Lowell (54.6) compared to the Commonwealth overall (24.6). Rates were similar or suppressed due to small numbers in all other municipalities.
- Among those treated in facilities licensed by the Massachusetts Bureau of Substance Abuse Services (BSAS) with residence in municipalities in LHMC/LMCP’s service area, heroin was the primary substance of use.

Table 25: Substance use

<table>
<thead>
<tr>
<th></th>
<th>Fatal opioid overdose (rate)*</th>
<th>Opioid-related inpatient hospitalizations*</th>
<th>Opioid death count (by city/town of residence) **</th>
<th>Admissions to BSAS licensed facilities (#)***</th>
<th>Of BSAS admissions: Alcohol as primary substance of use (%)***</th>
<th>Of BSAS admissions: Heroin as primary substance of use (%)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>24.6</td>
<td>781.3</td>
<td>1,945</td>
<td>98,948</td>
<td>32.8</td>
<td>52.8</td>
</tr>
<tr>
<td>Essex County</td>
<td>30.3</td>
<td>N/A</td>
<td>N/A</td>
<td>10,545</td>
<td>34.2</td>
<td>49.5</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>19.4</td>
<td>N/A</td>
<td>N/A</td>
<td>12,528</td>
<td>35.8</td>
<td>49.9</td>
</tr>
<tr>
<td>Arlington</td>
<td>15.6</td>
<td>376.5</td>
<td>3</td>
<td>202</td>
<td>34.2</td>
<td>44.6</td>
</tr>
<tr>
<td>Bedford</td>
<td>‡</td>
<td>377.0</td>
<td>3</td>
<td>0-100</td>
<td>25.4</td>
<td>57.6</td>
</tr>
<tr>
<td>Billerica</td>
<td>27.4</td>
<td>514.6</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burlington</td>
<td>‡</td>
<td>356.2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lexington</td>
<td>‡</td>
<td>211.0</td>
<td>3</td>
<td>0-100</td>
<td>26.9</td>
<td>48.1</td>
</tr>
<tr>
<td>Lowell</td>
<td>54.6</td>
<td>906.5</td>
<td>64</td>
<td>2,659</td>
<td>31.3</td>
<td>56.4</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>‡</td>
<td>390.9</td>
<td>5</td>
<td>0-100</td>
<td>31.8</td>
<td>47.0</td>
</tr>
<tr>
<td>Peabody</td>
<td>20.2</td>
<td>734.3</td>
<td>13</td>
<td>730</td>
<td>28.0</td>
<td>53.3</td>
</tr>
</tbody>
</table>

Source: Massachusetts Department of Public Health Registry of Vital Records and Statistics, age-adjusted rate per 100,000; 2015
*Source: Massachusetts Acute Hospital Case Mix data; hospital discharges as provided by CHIA, crude rates per 100,000, 2017
**Source: Massachusetts Department of Public Health Registry of Vital Records and Statistics, age-adjusted rate per 100,000; 2017
***Source: Massachusetts Bureau of Substance Abuse Services (BSAS), 2017
‡ Data suppressed due to small numbers
Shading represents statistical significance compared to the Commonwealth. Figures highlighted in orange are statistically higher compared to the Commonwealth overall, while figures highlighted in blue are significantly lower.

Vaping, or e-cigarette use, was a primary concern for youth. Key informants referred to e-cigarette use as an epidemic and were not only concerned with education and prevention efforts, but also treating those who had developed nicotine addictions. In a focus group, Burlington High School students corroborated the severity of the issue, describing e-cigarette use as commonplace and generally accepted among their peers. Changing community norms around marijuana and its health impacts,
especially in light of legalization in Massachusetts, was also identified as a concern for younger populations.

- On the YRBS, the percentage of middle school students who had ever used or currently use an electronic vapor product was similar to the commonwealth overall in both Arlington and Burlington.
- The percentage of high school students who had ever used an electronic vapor product was lower than the commonwealth in both Arlington and Burlington, while the percentage that currently uses the products was higher.

Table 26: Substance use by school district, YRBS

<table>
<thead>
<tr>
<th></th>
<th>Ever used electronic vapor product (%)*</th>
<th>Used electronic vapor product in past 30 days (%)</th>
<th>Used marijuana in past 30 days (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Middle School</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>8.8</td>
<td>3.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington (2018)</td>
<td>7.4</td>
<td>3.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Bedford (2018)</td>
<td>11.0</td>
<td>7.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Burlington (2018)</td>
<td>8.4</td>
<td>3.9</td>
<td>N/A</td>
</tr>
<tr>
<td>Lexington (2017)</td>
<td><strong>1.8</strong></td>
<td><strong>0.6</strong></td>
<td>0.6</td>
</tr>
<tr>
<td>Lynnfield (2017)</td>
<td>3.2</td>
<td>1.8</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>High School</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>41.1</td>
<td>20.1</td>
<td>24.1</td>
</tr>
<tr>
<td>Arlington (2018)</td>
<td>37.7</td>
<td>22.6</td>
<td>21.5</td>
</tr>
<tr>
<td>Bedford (2018)</td>
<td>34.2</td>
<td>27.9</td>
<td>18.6</td>
</tr>
<tr>
<td>Burlington (2018)</td>
<td>40.4</td>
<td>24.3</td>
<td>20.5</td>
</tr>
<tr>
<td>Lexington (2017)</td>
<td>N/A</td>
<td>*6.6</td>
<td>11.5</td>
</tr>
<tr>
<td>Lynnfield (2017)</td>
<td>29.6</td>
<td>22.3</td>
<td>11.6</td>
</tr>
</tbody>
</table>

*Electronic vapor product defined as e-cigarette, e-cigar, e-pipe, vape pipe, vaping pen, e-hookah, or hookah pen

**Question asks about use of ENDD (electronic nicotine delivery device) products, such as e-cigarettes and vaping pens

Source: YRBS

Older Adult Health/Healthy Aging

As discussed in previous sections, key informants and focus group/forum participants were concerned about social isolation and depression among older adults, especially frail elders who live alone or who did not have a regular caregiver. Other concerns for the older adult population included issues around chronic disease management and navigation of the health system (including health insurance), neurological issues (e.g., Alzheimer’s, dementia), and mobility/falls.

According to community profiles put together by the Massachusetts Healthy Aging Collaborative:
• The percentage of older adults (65+) living alone was similar to the commonwealth overall in all municipalities.
• The percentage of older adults (65+) with depression was significantly high in Lowell (35.4%) and Peabody (34.3%) and significantly low in Billerica (29.0%), Burlington (29.5%), and Lynnfield (28.3%) compared with the commonwealth overall (31.5%).
• The percentage of older adults (65+) with an anxiety disorder was significantly high in Lowell (28.3%) and Peabody (29.2%) and significantly low in Billerica (23.4%) and Lexington (21.9%) compared with the commonwealth overall (25.4%).
• The percentage of older adults (65+) with Alzheimer’s disease or a related dementia was significantly high in Lexington (15.1%), Lowell (16.4%), and Peabody (14.9%) and significantly low in Billerica (11.9%) and Lynnfield (12.0%) compared with the commonwealth overall (13.6%).
• The percentage of older adults (60+) who had been injured in a fall in the past 12 months was significantly high in Arlington (17.6%) compared with the commonwealth overall (10.6%).
• The percentage of older adults (65+) with osteoporosis was significantly high in Arlington (22.9%), Lexington (24.9%), Lynnfield (23.3%), and Peabody (25.2%) compared to the commonwealth overall (20.7%).

“[Social isolation] is at the root of many people's health issues...people tend not to share feelings or issues with others and are hesitant to seek services or assistance.” – Key informant

Table 27: Older adult health (2018)

<table>
<thead>
<tr>
<th></th>
<th>65+ living alone (%)</th>
<th>65+ with depression (%)</th>
<th>65+ with anxiety disorders (%)</th>
<th>65+ with Alzheimer’s or a related dementia (%)</th>
<th>60+ injured in a fall past 12 months (%)</th>
<th>65+ with osteoporosis (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>29.2</td>
<td>31.5</td>
<td>25.4</td>
<td>13.6</td>
<td>10.6</td>
<td>20.7</td>
</tr>
<tr>
<td>Essex County</td>
<td>29.3</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>28.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington</td>
<td>33.1</td>
<td>32.8</td>
<td>25.7</td>
<td>12.8</td>
<td>17.6</td>
<td>22.9</td>
</tr>
<tr>
<td>Bedford</td>
<td>21.8</td>
<td>32.2</td>
<td>24.6</td>
<td>13.4</td>
<td>9.4</td>
<td>20.7</td>
</tr>
<tr>
<td>Billerica</td>
<td>16.5</td>
<td>29.0</td>
<td>23.4</td>
<td>11.9</td>
<td>9.5</td>
<td>18.8</td>
</tr>
<tr>
<td>Burlington</td>
<td>22.1</td>
<td>29.5</td>
<td>24.3</td>
<td>13.5</td>
<td>9.5</td>
<td>21.6</td>
</tr>
<tr>
<td>Lexington</td>
<td>23.0</td>
<td>30.6</td>
<td>21.9</td>
<td>15.1</td>
<td>9.4</td>
<td>24.9</td>
</tr>
<tr>
<td>Lowell</td>
<td>34.5</td>
<td>35.4</td>
<td>28.3</td>
<td>16.4</td>
<td>10.4</td>
<td>19.5</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>24.3</td>
<td>28.3</td>
<td>24.7</td>
<td>12.0</td>
<td>11.7</td>
<td>23.3</td>
</tr>
<tr>
<td>Peabody</td>
<td>34.5</td>
<td>34.3</td>
<td>29.2</td>
<td>14.9</td>
<td>14.0</td>
<td>25.2</td>
</tr>
</tbody>
</table>

Source: Massachusetts Healthy Aging Collaborative, Massachusetts Healthy Aging Community Profiles, 2018
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.
Maternal and Infant Health

The well-being of children and their mothers has implications for future generations. Though maternal and child health issues were not identified as priorities through the assessment process, it is important to track data to identify trends over time. It is important to note that many factors may affect maternal and child health outcomes, including the mother’s health status preconception, age, socioeconomic status, and access to adequate health care and support services.26

Table 28: Infant mortality (2015)

<table>
<thead>
<tr>
<th>Location</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>4.3</td>
</tr>
<tr>
<td>Essex County</td>
<td>4.8</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>3.1</td>
</tr>
<tr>
<td>Arlington</td>
<td>‡</td>
</tr>
<tr>
<td>Bedford</td>
<td>‡</td>
</tr>
<tr>
<td>Billerica</td>
<td>‡</td>
</tr>
<tr>
<td>Burlington</td>
<td>‡</td>
</tr>
<tr>
<td>Lexington</td>
<td>0.0</td>
</tr>
<tr>
<td>Lowell</td>
<td>6.4</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>0.0</td>
</tr>
<tr>
<td>Peabody</td>
<td>‡</td>
</tr>
</tbody>
</table>

‡ Data suppressed because of small numbers.

Infectious Disease

Though great strides have been made to control the spread of infectious diseases in the U.S., they remain a major cause of illness, disability, and even death. Sexually transmitted infections, diseases transmitted through drug use, vector-borne illnesses, tuberculosis, pneumonia, and influenza are among the infectious diseases that have the greatest impact on modern American populations. Though not named as a major health concern by interviewees or participants of forums and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality. Young children, older adults, individuals with compromised immune systems, injection drug users, and those having unprotected sex are most at risk for contracting infectious diseases.

Table 29: Infectious disease

<table>
<thead>
<tr>
<th></th>
<th>Chlamydia cases (lab confirmed)</th>
<th>Gonorrhea cases (lab confirmed)</th>
<th>Syphilis cases (probable and confirmed)</th>
<th>Hepatitis C cases (probable and confirmed)</th>
<th>Pneumonia/influenza mortality (age-adjusted per 100,000)*</th>
<th>Adults 60+ with flu shot in past year (%)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>29,203</td>
<td>7,307</td>
<td>1,091</td>
<td>7,765</td>
<td>17.1</td>
<td>60.8</td>
</tr>
<tr>
<td>Essex County</td>
<td>5,162</td>
<td>1,069</td>
<td>234</td>
<td>1,239</td>
<td>18.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>3,330</td>
<td>580</td>
<td>86</td>
<td>710</td>
<td>13.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Arlington</td>
<td>83</td>
<td>20</td>
<td>5</td>
<td>24</td>
<td>20.2</td>
<td>69.8</td>
</tr>
<tr>
<td>Bedford</td>
<td>26</td>
<td>&lt;5</td>
<td>0</td>
<td>8</td>
<td>20.0</td>
<td>65.8</td>
</tr>
<tr>
<td>Billerica</td>
<td>128</td>
<td>18</td>
<td>&lt;5</td>
<td>103</td>
<td>35.9</td>
<td>51.5</td>
</tr>
<tr>
<td>Burlington</td>
<td>42</td>
<td>10</td>
<td>&lt;5</td>
<td>12</td>
<td>31.6</td>
<td>51.5</td>
</tr>
<tr>
<td>Lexington</td>
<td>34</td>
<td>6</td>
<td>&lt;5</td>
<td>11</td>
<td>‡</td>
<td>65.8</td>
</tr>
<tr>
<td>Lowell</td>
<td>757</td>
<td>144</td>
<td>20</td>
<td>213</td>
<td>24.1</td>
<td>58.8</td>
</tr>
<tr>
<td>Lynnfield</td>
<td>32</td>
<td>&lt;5</td>
<td>0</td>
<td>7</td>
<td>‡</td>
<td>62.3</td>
</tr>
<tr>
<td>Peabody</td>
<td>130</td>
<td>48</td>
<td>8</td>
<td>49</td>
<td>14.6</td>
<td>59.8</td>
</tr>
</tbody>
</table>

*Source: MDPH Bureau of Infectious Disease and Laboratory Services, 2017
**Source: MDPH Registry of Vital Records and Statistics, 2015
‡ Data suppressed because of small numbers.
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.
Summary of Priorities and Implementation Strategy

This section provides a summary of the priority issues and priority populations that were identified through the assessment process, based on an integrated analysis of quantitative and qualitative data and results of a prioritization process with the CBAC. A full Implementation Strategy, with goals, priority populations, objectives, strategies, sample measures, and potential community partners, can be found in Appendix D.

Implementation Strategy Planning Principles and Commonwealth Priorities

In developing the Implementation Strategy, care was taken to ensure that LHMC/LMCP’s community health priorities were aligned with the Commonwealth of Massachusetts priorities as set by the MDPH and the Massachusetts Health Policy Commission (MHPC) (Table 30). LHMC/LMCP also made efforts to ensure that the Implementation Strategy was aligned with broader principles drawn from the commonwealth’s Community Benefit Guidelines and the literature on how to best promote community health improvement and prevention efforts.

Table 30: Massachusetts community health priorities

<table>
<thead>
<tr>
<th>MDPH: Community Benefit Priorities</th>
<th>Massachusetts Health Policy Commission: Determination of Need Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Housing stability and homelessness</td>
<td>• Built environments</td>
</tr>
<tr>
<td>• Mental illness and mental health</td>
<td>• Social environments</td>
</tr>
<tr>
<td>• Substance use disorders</td>
<td>• Housing</td>
</tr>
<tr>
<td>• Chronic disease, with a focus on cancer, heart disease, and diabetes</td>
<td>• Violence</td>
</tr>
<tr>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Employment</td>
</tr>
</tbody>
</table>

Priority Populations

LHMC/LMCP is committed to improving the health status and well-being of all residents living throughout its service area – certainly all geographic, demographic, and socioeconomic segments of the population face challenges that may impede their ability to access care or maintain good health. With this in mind, LHMC/LMCP’s Implementation Strategy includes activities that will support residents throughout its service area across all segments of the population.

However, based on the assessment’s quantitative and qualitative findings, there was broad agreement that LHMC/LMCP’s Implementation Strategy should prioritize certain demographic and socioeconomic segments of the population that face significant barriers to care, have complex health issues, or are more impacted by the social determinants of health. The assessment identified low-resource individuals
and families, older adults, youth/adolescents, and individuals with chronic/complex conditions as priority populations to be included in the Implementation Strategy.

Figure 8: LHMC/LMCP priority populations, 2020-2022

Low-Resource Individuals and Families

Key informants, focus group/listening session participants, and survey respondents discussed the challenges that individuals and families face when they are forced to decide between paying for housing, food, health care services, child care, transportation, and other essentials. The root of this dilemma is often the inability to find or maintain employment that pays a livable wage. The term “low resource” rather than “low income” was used to underscore the idea that many individuals and families in the service area – not just those in low-income brackets – struggle to access the resources that allow them to achieve and maintain a good quality of life. Many participants spoke of the intense challenges that moderate-income individuals and families face since they are not eligible for public assistance programs like Medicaid, SNAP, Healthy Start, and other subsidized services. Further, those who may be eligible for certain benefits may not know how to access them or may not apply because of the stigma of accepting public assistance.

LHMC/LMCP is committed to working with community-based organizations and partners to enhance access to local resources, including health care, transportation, low-cost, healthy foods, and safe and accessible spaces to exercise. Furthermore, LHMC/LMCP is committed to collaborating with partners to strengthen the local workforce by supporting job-training programs.

Older Adults

In the U.S. and the commonwealth, older adults are among the fastest-growing age groups. Chronic and complex conditions are the leading cause of death among older adults, and older adults are more likely to develop chronic illnesses and conditions such as hypertension, diabetes, COPD, congestive heart failure, depression, anxiety, Alzheimer’s disease, Parkinson’s disease, and dementia than are younger adult cohorts. By 2030, the CDC and the Healthy People 2020 Initiative estimate that 37 million people nationwide, or 60% of the older adult population aged 65 and over, will need to manage more than one chronic medical condition. Significant proportions of this group experience hospitalizations, are admitted to nursing homes, and receive home health services and other social supports in home and community settings.

The challenges faced by older adults came up in nearly every interview, focus group, and community listening session. Older adults were also identified as the segment of the population with the most significant health needs in the Community Health Survey. Older adults living alone and those without dedicated family or caregivers were seen as particularly vulnerable.
LHMC/LMCP recognizes that addressing these concerns demands a service system that is robust, diverse, and responsive. LHMC/LMCP has historically supported a number of initiatives aimed at improving health and health care access for older adults, and it will continue to do so. LHMC/LMCP will work with partners and community-based organizations to explore programs that address social isolation, chronic disease management/navigation, access to care, food insecurity, and transportation issues for older adults in its service area.

**Youth/Adolescents**
Key informants and focus group/listening session participants identified a range of issues for youth and adolescents – namely, in the realms of mental health and substance use (e.g., depression, anxiety/chronic stress, and vaping and e-cigarette use). It is important to reduce the stigma associated with these conditions, especially for young people – breaking down this stigma will encourage open dialogue between youth/adolescents, parents, educators, and providers.

LHMC/LMCP will continue to work with community partners, including public school districts, to enhance access to services for youth and adolescents in its service area. LHMC/LMCP will also continue to support efforts to enhance screening and education.

**Individuals with Chronic/Complex Conditions**
Though substance use and mental health were the leading priority issues for many key informants, providers, and residents, one cannot ignore that cardiovascular disease, stroke, and cancer are the leading causes of death in the nation and the commonwealth. Along with other conditions, including asthma and diabetes, these conditions are considered to be chronic and complex – they may strike early in one’s life and persist for many years, may be incurable or irreversible, and may be difficult to manage. It is also important to note that the risk factors for many chronic/complex conditions are the same: lack of physical activity, poor nutrition, and obesity.

LHMC/LMCP is committed to enhancing access to health education, screening, and referral services in clinical and nonclinical settings.

**Community Health Priorities**
LHMC/LMCP’s CHNA is a population-based assessment – the goal being to identify the full range of community health issues affecting individuals in the CBSA. The priority issues have been framed in a broad context to ensure that the breadth of unmet needs and community health issues is recognized. LHMC/LMCP is confident that these priorities reflect the sentiments of the vast majority of those who were involved in the assessment and prioritization process; they were determined through an integrated and thorough analysis of quantitative and qualitative data and a prioritization process with the CBAC. Within these priority areas, goals and objectives will be determined to maximize impact, focus the hospital’s efforts, and leverage existing resources and partnerships.
Table 31 includes a comparison of priority issues that were chosen from the 2016 and 2019 community health needs assessments.

Table 31: Priority areas from community health needs assessments, 2016 and 2019

<table>
<thead>
<tr>
<th>2016 LHMC/LMCP Community Health Priority Areas</th>
<th>2019 LHMC/LMCP Community Health Priority Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wellness, prevention, and chronic disease management</td>
<td>• Mental health and substance use disorder</td>
</tr>
<tr>
<td>• Elder health</td>
<td>• Chronic/complex conditions and their risk factors</td>
</tr>
<tr>
<td>• Behavioral health (mental health and substance use)</td>
<td>• Social determinants of health and access to care</td>
</tr>
</tbody>
</table>

Below is a brief description of LHMC/LMCP’s 2019 community health priority areas.

Mental Health and Substance Use Disorder
As it is throughout the commonwealth and the nation, the burden of mental health and substance use on individuals, families, communities, and service providers in LHMC/LMCP’s CBSA is overwhelming. Nearly every key informant interview, focus group, and listening session included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading issues in this domain. There were particular concerns regarding the impact of depression, anxiety, and e-cigarette use/vaping on youth and social isolation among older adults.

LHMC/LMCP recognizes the importance of primary prevention – the hospital will continue to work with community partners to offer educational programs around mental health and substance misuse. The hospital will also enhance partnerships with community-based organizations to identify, screen, and
refer youth with mental health and substance use issues to treatment. LHMC/LMCP will continue to partner and collaborate with community-based organizations that work with older adults to reduce social isolation and enhance access to supportive services.

Chronic/Complex Conditions and Risk Factors
Heart disease, stroke, and cancer continue to be the leading causes of death in the nation and the commonwealth and place a significant burden on communities. Approximately six in 10 deaths can be attributed to these three conditions combined. If respiratory disease (e.g., asthma, COPD) and diabetes, which are two of the top 10 leading causes of death across all geographies, are included, one can account for the vast majority of causes of death.

Many of the risk factors for these conditions are the same – physical inactivity, poor nutrition, obesity, and tobacco/alcohol use. LHMC/LMCP has a long history of working with community partners to create awareness of and education about risk factors and their links to chronic and complex health conditions. The hospital will continue to support programs that provide opportunities for people to access low-cost, healthy foods and opportunities for safe and affordable physical activity. Beyond addressing the risk factors, LHMC/LMCP is also committed to providing screening and educational opportunities, supporting individuals and caregivers throughout the service area to engage in chronic disease management programs and supportive services (e.g., integrative therapies, support groups), and providing links to care.

Social Determinants of Health and Access to Care
The social determinants of health, particularly housing, transportation, and food insecurity, have a tremendous impact on residents within LHMC/LMCP’s CBSA, especially those who are low to moderate income. The social determinants of health are often the drivers of or underlying factors that create or exacerbate mental health issues, substance misuse, and chronic/complex conditions. These social determinants of health, particularly poverty, also underlie many of the access-to-care issues that were prioritized in the assessment: navigating the health system (including health insurance), chronic disease management, and affording care.

LHMC/LMCP is committed to addressing social determinants and breaking down barriers to care. The hospital will continue to collaborate with community-based organizations to engage individuals in services, reduce financial burdens, increase access to appropriate primary and specialty care services, and support healthy families and communities. LHMC/LMCP is also committed to strengthening the local workforce and addressing unemployment by supporting job-training programs.

Community Health Needs Not Prioritized by LHMC/LMCP
It is important to note that there are community health needs that were identified through LHMC/LMCP’s assessment that were not prioritized for inclusion in the Implementation Strategy for a number of reasons:

- Feasibility of LHMC/LMCP having an impact in the short or long term
- Clinical expertise of the organization
• Limited burden on residents of the service area
• The issue is currently being addressed by community partners in a way that does not warrant additional support

Though maternal and child health is not a priority area included in LHMC/LMCP’s Implementation Strategy, LHMC/LMCP partners with its affiliated local community hospitals with clinical expertise in this area to address issues in this domain.

Lack of affordable housing was identified as a community health issue in the assessment, but this issue was deemed by the CBAC to be outside LHMC/LMCP’s primary sphere of influence. This is not to say that LHMC/LMCP will not support efforts in this area; the hospital remains open and willing to work with hospitals across BILH’s network and with other public and private partners to address this issue collaboratively.

Community Benefits Resources

Over the past year, LHMC/LMCP has contributed direct, in-kind, and grant funding to support community initiatives operated by the hospital and its community partners to improve the health of individuals in its service area. LHMC/LMCP has leveraged grants and other funds to address health disparities and health inequities, and it has provided uncompensated “charity care” to low-income individuals who were unable to pay for care and services at the hospital.

This year, LHMC/LMCP will commit a comparable amount, if not more, through charity care, direct community health program investments, and in-kind resources of staff time, materials, and programs. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services and on behalf of its community partners.

Recognizing that community benefits planning is ongoing and will change with continued community input, LHMC/LMCP’s Implementation Strategy will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues that may require a change in the Implementation Strategy or the strategies documented within it.
Summary Implementation Strategy

The following is a list of the goals and objectives that have been established for each priority area in LHMC/LMCP’s Implementation Strategy.

Table 32: LHMC/LMCP Summary Implementation Strategy, 2020-2022

<table>
<thead>
<tr>
<th>Priority Area 1: Mental health and substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder</strong></td>
</tr>
<tr>
<td>• Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners</td>
</tr>
<tr>
<td>• Explore opportunities for partnerships with community-based organizations to identify, screen, assess, and refer those with mental health issues and substance use disorder to treatment</td>
</tr>
<tr>
<td>• Reduce environmental risk factors associated with mental health or substance use issues</td>
</tr>
<tr>
<td>• Increase access to appropriate mental health and substance use treatment and support services</td>
</tr>
<tr>
<td>• Enhance the ability of local service providers and community partners to understand, anticipate, and respond to health needs and social determinants of health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Area 2: Chronic/complex conditions and risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings</strong></td>
</tr>
<tr>
<td>• Increase awareness of and education about the risks and protective factors associated with chronic and complex conditions</td>
</tr>
<tr>
<td>• Support programs/activities in clinical and nonclinical settings that screen, educate, and refer patients for chronic/complex conditions and their risk factors</td>
</tr>
<tr>
<td>• Enhance access and promote equitable care for vulnerable individuals with chronic/complex conditions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Area 3: Social determinants of health and access to care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Address the social determinants of health and access to care</strong></td>
</tr>
<tr>
<td>• Increase partnerships and collaboration with community-based organizations to address the social determinants of health</td>
</tr>
<tr>
<td>• Increase access to affordable and safe transportation options</td>
</tr>
<tr>
<td>• Educate providers and community members about hospital and/or public assistance programs that can help them identify and enroll in appropriate health insurance plans and/or reduce their financial burden</td>
</tr>
<tr>
<td>• Work to help strengthen the local workforce</td>
</tr>
<tr>
<td>• Increase awareness of domestic violence and promote links to services</td>
</tr>
<tr>
<td>• Promote resilience and emergency preparedness</td>
</tr>
<tr>
<td>• Increase access to affordable and nutritious foods</td>
</tr>
<tr>
<td>• Increase access to affordable and free opportunities for physical activity</td>
</tr>
</tbody>
</table>
Appendix A:
Detailed Community Engagement Approach
### Key Informant Interviews

#### BILH-Northern Region (formerly Lahey Health) Internal Interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Affiliation</th>
<th>Sectors(s) Represented/Population Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Nesto, MD</td>
<td>Chief Medical Officer, Beth Israel Lahey Health</td>
<td>Health System Leadership</td>
</tr>
<tr>
<td>Deborah Costello</td>
<td>Chief Operating Officer, Home Health and Hospice, Lahey Health at Home</td>
<td>Home Health</td>
</tr>
<tr>
<td>Hilary Jacobs</td>
<td>President, Beth Israel Lahey Health Behavioral Health Services</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Leslie Sebba, MD</td>
<td>President and Chief Medical Officer, Lahey Clinical Performance Network</td>
<td>Health System Leadership</td>
</tr>
<tr>
<td>Theresa Giove</td>
<td>Executive Director, Urgent Care</td>
<td>Health System Leadership; Clinical Care</td>
</tr>
<tr>
<td>Linda Willer-Newcomb</td>
<td>Vice President, Lahey Health Cancer Institute</td>
<td>Health System Leadership; Chronic/Complex Conditions</td>
</tr>
<tr>
<td>Richard Iseke</td>
<td>Chief Quality Officer, Lahey Health System</td>
<td>Health System Leadership</td>
</tr>
<tr>
<td>Pauline Lodge</td>
<td>Senior Vice President, Business Dev/Marketing &amp; Communications</td>
<td>Health System Leadership</td>
</tr>
<tr>
<td>Wayne Saltsman, MD</td>
<td>Chief Medical Officer, Lahey Health Continuing Care</td>
<td>Health System Leadership</td>
</tr>
</tbody>
</table>

#### LHMC Internal Key Informant Interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Affiliation</th>
<th>Sectors(s) Represented/Population Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Longworth, MD</td>
<td>Interim Chair, Beth Israel Lahey Health Primary Care Network</td>
<td>Hospital leadership</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Officer, Lahey Hospital &amp; Medical Center</td>
<td></td>
</tr>
<tr>
<td>Stathos Antoniades</td>
<td>Chief Operating Officer, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership</td>
</tr>
<tr>
<td>Andrew Villanueva, MD</td>
<td>Chief of Quality and Safety, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership</td>
</tr>
<tr>
<td>Patrick Aquino, MD</td>
<td>Psychiatry, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership; Behavioral health</td>
</tr>
<tr>
<td>Michelle McCool Heatley</td>
<td>Assistant Chief Nursing Officer, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership; Clinical services</td>
</tr>
<tr>
<td>Lars Reinhold, MD</td>
<td>Interim Chief of Primary Care, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership; Primary care</td>
</tr>
<tr>
<td>Sandi Mackey</td>
<td>Trauma Service Nurse Director, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership; Clinical services</td>
</tr>
<tr>
<td>Brenda Joseph and committee</td>
<td>Cancer Committee, Lahey Hospital &amp; Medical Center</td>
<td>Hospital-based; Chronic/complex conditions</td>
</tr>
<tr>
<td>committee members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ursala Tice and council</td>
<td>Diversity Council, Lahey Hospital &amp; Medical Center</td>
<td>Hospital-based; Diversity</td>
</tr>
<tr>
<td>members</td>
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<td></td>
</tr>
<tr>
<td>Jane Edmonds</td>
<td>Board of Directors, Lahey Hospital &amp; Medical Center</td>
<td>Hospital leadership; Higher education</td>
</tr>
<tr>
<td></td>
<td>Vice President for Programming &amp; Community Outreach Babson, College</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

<table>
<thead>
<tr>
<th>External Key Informant Interviewees</th>
<th>Old Healthcare/Healthy Aging</th>
<th>Municipal Leadership</th>
<th>Public Health</th>
<th>Municipal Leadership</th>
<th>Human Services</th>
<th>Food Insecurity</th>
<th>Substance Abuse Prevention</th>
<th>Healthy Communities; Children and Families</th>
<th>Education; Youth and Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelly Magee-Wright</td>
<td>Executive Director, Minuteman Senior Services</td>
<td>Old Healthcare/Healthy Aging</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
<tr>
<td>Alison Cservenchi</td>
<td>Director, Bedford Council on Aging</td>
<td>Older Healthcare/Healthy Aging</td>
<td>Municipal Leadership</td>
<td>Healthy Communities</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
<tr>
<td>Heidi Porter</td>
<td>Director, Bedford Board of Health</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Old Healthcare/Healthy Aging</td>
<td>Healthy Communities; Children and Families</td>
<td>Education; Youth and Adolescents</td>
</tr>
<tr>
<td>Kathy Fox</td>
<td>Health Agent, Public Health, Town of Lexington</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Old Healthcare/Healthy Aging</td>
<td>Healthy Communities; Children and Families</td>
<td>Education; Youth and Adolescents</td>
</tr>
<tr>
<td>David Neylon</td>
<td>Health Agent, Public Health, Town of Lexington</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Old Healthcare/Healthy Aging</td>
<td>Healthy Communities; Children and Families</td>
<td>Education; Youth and Adolescents</td>
</tr>
<tr>
<td>Melissa Interess</td>
<td>Acting Director, Human Services Department, Town of Lexington</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Old Healthcare/Healthy Aging</td>
<td>Healthy Communities; Children and Families</td>
<td>Education; Youth and Adolescents</td>
</tr>
<tr>
<td>Amy Pessia</td>
<td>Executive Director, Merrimack Valley Food Bank</td>
<td>Food Insecurity</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
<tr>
<td>Peg Sallade</td>
<td>Director, A Healthy Lynnfield Coalition</td>
<td>Substance Abuse Prevention</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
<tr>
<td>John Feudo</td>
<td>Executive Director, Burbank YMCA</td>
<td>Healthy Communities; Children and Families</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
<tr>
<td>Bill Petryszyn</td>
<td>Executive Director, North Suburban YMCA</td>
<td>Healthy Communities; Children and Families</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
<tr>
<td>Kevin Cyr</td>
<td>Director of Teaching and Learning, Lynnfield Public Schools</td>
<td>Education; Youth and Adolescents</td>
<td>Municipal Leadership</td>
<td>Public Health</td>
<td>Municipal Leadership</td>
<td>Human Services</td>
<td>Food Insecurity</td>
<td>Substance Abuse Prevention</td>
<td>Healthy Communities; Children and Families</td>
</tr>
</tbody>
</table>

**Municipal Leadership**

| Burlington Town Leaders            | Paul Sagarino, Town Administrator | John Curran, Mayor | Jean Bushnell, Director, Billerica Council on Aging | Marie O'Rourke, Veteran's Office | Richard Berube, Director of Public Health, Billerica Board of Health | Chris Reilly, Planning Director | Mike Higgins, Substance Abuse Coordinator | Ed Bettencourt, Mayor | Chris Ryder, Chief of Staff, Office of the Mayor | Captain Scott Wlasuk, Police | Cara Murtagh, Superintendent of Schools, Peabody Public Schools | Sharon Cameron, Health Director, City of Peabody | Adam Chapdelaine Town Manager, Fire Chief Robert Jefferson, Police Captain James Curran, Public Health Director Natash Waden, Youth Counseling Center Director Colleen Leger, Veterans Services Director Jeff Chunglo, Council on Aging Director Susan Carp, Youth Coalition Substance Use Prevention Director Karen Koresky |
|------------------------------------|----------------------------------|-------------------|-----------------------------------------------------|---------------------------------|---------------------------------------------------------------|-----------------------------|-----------------------------------------|---------------------------------|---------------------------------|---------------------------------|--------------------------------|----------------------------------; mandate an approach to address the identified needs. This approach should focus on building partnerships and involving community members in decision-making processes. The Hospital will work closely with these groups and stakeholders to ensure that the recommendations are culturally relevant and responsive to community needs. The key informant interviews conducted as part of this process have provided valuable insights into the priorities and concerns of the community. The findings from these interviews will be integrated into the Community Health Needs Assessment (CHNA) and used to develop a comprehensive Implementation Strategy. These strategies will be designed to address the identified needs and align with the mission of the Hospital as a community-focused institution. 

**Key Informant Interview Guide**

**Introduction:** As you may know, the Hospital is conducting a Community Health Needs Assessment (CHNA) to better understand the health needs of those living in its service area. This assessment, and a subsequent Implementation Strategy, is required of all non-profit hospitals to meet state Attorney General and Federal IRS
requirements. The Implementation Strategy will outline how the hospital will work to address health needs and factors leading to poor health, as well as ways in which it will build on the community’s strengths. It is therefore extremely important that the Hospital hear from a broad range of people living, working, and learning in the community. JSI has been contracted by the Hospital to conduct the assessment, which will include interviews, a Community Health Survey, and focus groups. This interview is part of the data collection and should take between 30-60 minutes. To ensure our data reflect your community or the community you serve, it is important that you speak openly and honestly. We will be taking notes during the conversation, but will not link your name or personal information to your quotes without your permission. Do you have any questions before I get started?

- **Question 1 (External):** Could you tell me more about yourself? How long have you worked at [name of organization]? Are you also a resident of a community within the service area? **(Internal):** What is your role at the hospital and how long have you worked there?
  - **Probe for information on programs/services offered through their organization, populations they work with, etc.**

- **Question 2:** The assessment is looking at health defined broadly – beyond clinical health issues, we are also looking at the root causes most commonly associated with ill health (e.g. housing, transportation, employment/workforce, etc.) What do you see as the major barriers to care for those in the service area?
  - **Try to identify top 2-3**

- **Question 3:** What clinical health issues (e.g. substance use, mental health, cancer, overweight/obesity, etc.) do you think are having the biggest impact on those in the service area?
  - **Try to identify top 2-3**

- **Question 4:** What segments of the population have the most significant health needs or are most vulnerable? (e.g. young children, low-income, non-English speakers, older adults, etc.)
  - **Do you see this changing in the future? Improving? Getting worse?**

- **Question 5 (External interviewees):** Are there programs of services offered by other community organizations that you think are working well to address the needs of the community? **(Internal interviewees):** How effectively do you think the Hospital is currently meeting the needs of the community? Are there specific programs or services offered by the Hospital that stand out to you as working well to address community health?
  - **Mention that we will be compiling a list of community organizations/resources for the Resource Inventory**

- **Question 6:** As we explained at the beginning of the interview, we will be making an effort to gather input from community residents as part of this assessment. Can you recommend any strategies to engage hard-to-reach populations?
  - **Any coalitions or advocacy groups that work with hard-to-reach populations?**

- **Question 7:** Finally, we are working to gather quantitative data to characterize health status – this includes demographic and socioeconomic data, and disease-specific incidence, hospitalization, emergency department, and mortality data wherever it is available. Do you know of, or use, any local data sources (e.g. reports, other needs assessments, etc.)?

*Additional questions for internal interviewees:*

- Where do you see opportunities for the Hospital to implement programs and services to address community health needs?
• Are there any community organizations that you would identify as a strong partner to the Hospital?
### Focus Groups

<table>
<thead>
<tr>
<th>Name of group</th>
<th>Population/Sector Represented</th>
<th>Date</th>
<th>Location</th>
<th>Number of attendees (approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHMC Social Workers</td>
<td>Those who work to support patients and families in need of assistance</td>
<td>March 20, 2019</td>
<td>LHMC - Peabody</td>
<td>20</td>
</tr>
<tr>
<td>Arlington Housing Corporation tenants</td>
<td>Individuals who live in low-to-moderate income housing; primarily older adults</td>
<td>March 28, 2019</td>
<td>Arlington Housing Authority</td>
<td>10</td>
</tr>
<tr>
<td>Billerica Council on Aging members</td>
<td>Older adults</td>
<td>April 3, 2019</td>
<td>Billerica Senior Center</td>
<td>10</td>
</tr>
<tr>
<td>Burlington High School students</td>
<td>Youth/adolescents (two classes with mixed ages)</td>
<td>April 3, 2019</td>
<td>Burlington High School</td>
<td>30</td>
</tr>
<tr>
<td>Mill City Grows patrons and employees</td>
<td>Families and residents of Lowell</td>
<td>April 25, 2019</td>
<td>Mill City Grows</td>
<td>5</td>
</tr>
</tbody>
</table>

**Focus Group Guide**

**Introduction & Purpose of Focus Group:** The Hospital is conducting a Community Health Needs Assessment (CHNA) to better understand the health needs of those living in its service area. This assessment, and a subsequent Implementation Strategy (IS) are required of all non-profit hospitals to meet state Attorney General and Federal IRS requirements.

The IS will outline how the hospital will work to address health needs and factors leading to poor health, as well as ways in which it will build on the community’s strengths. It is therefore extremely important that the Hospital hear from a broad range of people living, working, and learning in the community. To ensure our data reflect your community or the community you serve, it is important that you speak openly and honestly. We will be taking notes during the conversation, but will not link your name or personal information to your quotes without your permission.

- **Question 1:** The assessment is looking at health defined broadly – beyond clinical health issues, we are also looking at the root causes of ill health (e.g. housing, transportation, employment/workforce, poverty), also called the “social determinants of health.” What social determinants do people struggle with the most in your community? *Try to identify top 2-3*

- **Question 2:** What clinical health issues (e.g. substance use, mental health, cancer, overweight/obesity) are having the biggest impact on those in your community? *Try to identify top 2-3*

- **Question 3:** What segments of the population have the most significant health needs or are most vulnerable for poor health? (e.g. young children, low-income, non-English speakers, older adults, racial/ethnic minorities) *Do you see this changing in the future? Improving? Getting worse?*
Question 4: How effectively do you think the Hospital is currently meeting the needs of your community?

Question 5: Where do you see opportunities for the Hospital to implement programs/services to address community health needs?

Question 6: Are there programs or services offered by other community organizations that you think are working well to address the needs of the community?

Question 7: We will be making an effort to gather input from community residents as part of this assessment. Can you recommend any strategies to engage hard-to-reach populations?
APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

Community Listening Sessions

<table>
<thead>
<tr>
<th>Name of group</th>
<th>Population/Sectors Represented</th>
<th>Date</th>
<th>Location</th>
<th>Number of attendees (approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community session - Bedford</td>
<td>Community Coalition (Community Health Network Area 15); includes residents and representatives from across the health and social service spectrum (e.g., housing, municipal health/public health departments, youth/adolescents, elder health, substance misuse, mental health, etc.)</td>
<td>March 7, 2019</td>
<td>Minuteman Senior Services, Bedford</td>
<td>25</td>
</tr>
<tr>
<td>Community session - Peabody</td>
<td>Community Coalition (Community Health Network Area 13/14); includes residents and representatives from across the health and social service spectrum (e.g., housing, municipal health/public health departments, youth/adolescents, elder health, substance misuse, mental health, etc.)</td>
<td>May 2, 2019</td>
<td>Peabody Senior Center</td>
<td>12</td>
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</tbody>
</table>

JSI facilitated a community forum with residents and service providers throughout the Hospital’s service area. JSI facilitated the community listening sessions by presenting a high-level overview of quantitative data findings from the Hospital’s Community Health Needs Assessment and then soliciting feedback and input from participants on leading health issues, vulnerable populations, barriers to care, community assets/resources, and opportunities for the hospital to improve its services and outreach. Questions were discussed in plenary sessions and in small groups. JSI documented the results of these sessions and used the information gathered to inform the assessment and development of the Implementation Strategy.

Community Listening Discussion Questions

1. Think of the data you’ve seen, and your own knowledge/experiences. What are the most pressing barriers to good health for those in your community?
2. Think of the data you’ve seen, and your own knowledge/experiences. What health issues do you think people struggle with the most in your community?
3. Think of the data you’ve seen and your own knowledge/experiences. What populations do you think are vulnerable or at-risk for poor health in your community?
4. What resources are available in your community to help address the issues discussed today?
Community Health Survey

Translated into Chinese, Spanish, Portuguese, Haitian Creole, Khmer, Hindi, and Italian

Distribution channels:

Internal LHMC contacts
Women’s Leadership Committee
Community Health Network Area 15
YMCAs: Torigian
Chambers of Commerce: Wakefield/Lynnfield, Burlington
Boys & Girls Clubs: Billerica, Arlington
Billerica Neighborhood Brigade
Burlington Recreation Department
Lexington Community Center
Citizen’s Inn, Peabody
Libraries: Burlington, Arlington, Bedford, Billerica, Lexington, Lynnfield
Arlington Housing Authority
Lynnfield Mom’s Facebook Group
Healthy Lynnfield newsletter
Councils on Aging/Senior Centers: Burlington, Billerica, Arlington, Peabody
Billerica Health and Wellness Fair
African Center of the Merrimack Valley
Asian Task Force Against Domestic Violence
Bethany Christian Services
Cambodian Mutual Assistance Association
Christ Jubilee International Ministries
Massachusetts Alliance of Portuguese Speakers

Community Health Survey Questions

Beverly Hospital and Addison Gilbert, Lahey Hospital and Medical Center, and Winchester Hospital are conducting Community Health Needs Assessments to better understand the most pressing health-related issues for residents in the communities we serve. The information gathered will help us develop health improvement plans that address these issues, and guide our decisions on investments in community programs and services. Your input is extremely important to us.

Please take about 10 minutes to complete this survey. Your responses will be anonymous.

This survey has been shared widely. Please complete this survey only once.

Please email Madison MacLean (madison_maclean@jsi.com) with questions.

Question 1: What town do you live in?
APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

Question 2: How old are you?
__ Under 18 __ 18 to 24 __ 23 to 34 __ 35 to 44
__ 45 to 54 __ 55 to 64 __ 65 to 74 __ 75 or older

Question 3: Are you Hispanic, Latino/a, or of Spanish origin? __ Yes __ No

Question 4: Which of these best describes your face? Choose all that apply.
__ White __ Black or African American __ Asian
__ Native Hawaiian or Pacific Islander __ American Indian or Alaska Native __ Other (please specify)

Question 5: Think about your community. Choose the top three (3) issues that you think prevent people from being able to live a healthy life.
__ Housing is expensive or unsafe __ Unsafe streets (bad roads or sidewalks)
__ Transportation issues __ Physical inactivity or sedentary lifestyle
__ Cannot find or afford healthy foods __ Social isolation, lack of support, loneliness
__ No or limited health insurance __ Long commute to/from work or school
__ No or limited education __ Discrimination, racism, distrust
__ Poverty, low wages, no jobs __ Crime or violence
__ Other (please specify)

Question 6: Read the following statements. Check all that you agree with.
__ Expensive co-payments for care and medication stop me from seeking care or filling prescriptions
__ It is hard to find health care providers that understand my (or others’) language, culture, religion
__ It is hard to find doctors that are taking new patients
__ It is hard to find appointments that work with my schedule
__ Health care is too expensive
APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

Question 7: Think about your community. Choose the top three (3) populations that you think have the greatest health needs.

- Young children (0-5 years of age)
- Non-English Speakers
- School age children (6-11 years of age)
- Homeless/housing insecure
- Adolescents (12-17 years of age)
- Low-income populations
- Young adults (18-24 years of age)
- Those with disabilities (physical, cognitive, developmental)
- Older Adults (older than 65 years of age)
- Lesbian, gay, bisexual, transgender, queer/questioning
- Immigrants/Refugees
- Racial/ethnic minorities
- Other (please specify)

Question 7: Think about your community. Choose the top three (3) health issues that you think people struggle with the most.

- Cancer
- Cardiovascular conditions (e.g. hypertension/high blood pressure, heart disease, stroke)
- Respiratory diseases (e.g. asthma, chronic obstructive pulmonary disease [COPD], emphysema)
- Physical inactivity, nutrition, and/or obesity
- Maternal and child health issues (e.g., prenatal care, teen pregnancy, infant mortality)
- Diabetes
- Dental care
- Infectious disease (e.g. influenza, HIV/AIDS, sexually transmitted infections, hepatitis C)
- Neurological disorders (e.g. Alzheimer’s, Parkinson’s, dementia)
- Mobility impairments (e.g. falls, arthritis, fibromyalgia)

- Mental health
  - If chosen: __ Depression __ Anxiety/Stress __ Other mental illness

- Substance use
  - If chosen: __ Alcohol __ Marijuana __ Opioids/Prescription drugs __ Nicotine (including e-cigarettes)

Question 9: What programs or services offered by organizations in your community stand out as working well to address your community’s health needs? Please specify.
APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

Question 10: Think about your community. What health services are hard for people to access? (Check all that apply)

___ Primary care (e.g. family, general practice, internal medicine physicians)
___ Emergency care
___ Urgent care (e.g. immediate care centers, Minute Clinics)
___ Oral health care (e.g. dentists, oral surgeons)
___ Specialty care (e.g. cardiology, dermatology, oncology, endocrinology)
___ OB/GYN (e.g. female reproductive system, maternity care)
___ Pharmacies
___ Inpatient or residential drug and alcohol treatment (e.g. rehabilitation and detoxification)
___ Outpatient drug and alcohol treatment (e.g. medication-assisted treatment, outpatient clinics)
___ Inpatient mental health treatment (e.g. residential treatment, psychiatric hospitals, hospital inpatient units)
___ Outpatient mental health treatment (e.g. community mental health centers, mental health counseling)
___ Long-term care (e.g. assisted living, skilled nursing facilities/nursing homes, convalescent homes)
___ Other (please specify)

Question 11: What programs or services should the Hospital offer to improve community health? Please specify.

Question 12: Please provide additional thoughts on community health issues, or how the Hospital could better improve health in your community.

Thank you for your input. Please contact Madison MacLean (Madison_Maclean@jsi.com) with questions.
Appendix B:
Data Book
### Demographics

#### MA

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Age</th>
<th>Race / Ethnicity / Culture</th>
<th>Language Spoken at Home by Population 5 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essex County</td>
<td>381,800</td>
<td>51%</td>
<td>76%</td>
<td>25%</td>
</tr>
<tr>
<td>Middlesex County</td>
<td>718,800</td>
<td>52%</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>Newton</td>
<td>118,000</td>
<td>53%</td>
<td>78%</td>
<td>22%</td>
</tr>
<tr>
<td>Brookline</td>
<td>140,000</td>
<td>54%</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td>Belmont</td>
<td>145,000</td>
<td>55%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Back Bay</td>
<td>165,000</td>
<td>56%</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>Lexington</td>
<td>175,000</td>
<td>57%</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>Medford</td>
<td>190,000</td>
<td>58%</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Cambridge</td>
<td>205,000</td>
<td>59%</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>Somerville</td>
<td>225,000</td>
<td>60%</td>
<td>85%</td>
<td>15%</td>
</tr>
<tr>
<td>Arlington</td>
<td>245,000</td>
<td>61%</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td>Watertown</td>
<td>265,000</td>
<td>62%</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>Waltham</td>
<td>285,000</td>
<td>63%</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>Newton Center</td>
<td>305,000</td>
<td>64%</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>Newton Upper</td>
<td>325,000</td>
<td>65%</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

#### Key

- **Statistically higher than statewide rate**
- **Statistically lower than statewide rate**

### Source

### DEMOGRAPHICS

**Key**
- Statistically higher than statewide rate
- Statistically lower than statewide rate

#### Sources
- Census Bureau, 2013-2017 ACS 5-Year Estimates
- Massachusetts Department of Elementary and Secondary Education and District Profiles

<table>
<thead>
<tr>
<th>Demographic</th>
<th>MA</th>
<th>Essex County</th>
<th>Middlesex County</th>
<th>Arlington</th>
<th>Bedford</th>
<th>Billerica</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lowell</th>
<th>Lynnfield</th>
<th>Peabody</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of households, no husband present, family (%)</td>
<td>12.3</td>
<td>13.6</td>
<td>9.7</td>
<td>7.9</td>
<td>6.6</td>
<td>11.6</td>
<td>9.2</td>
<td>6</td>
<td>20.4</td>
<td>4.8</td>
<td>11.3</td>
</tr>
<tr>
<td>% of female household, no husband present, family - With own children of the household under 18 years (%)</td>
<td>8.3</td>
<td>7.4</td>
<td>4.7</td>
<td>3.4</td>
<td>3.8</td>
<td>2.2</td>
<td>4.2</td>
<td>3</td>
<td>11.5</td>
<td>2.3</td>
<td>6.8</td>
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<td>% of nonfamily households (%)</td>
<td>36.3</td>
<td>33.1</td>
<td>35.3</td>
<td>38.3</td>
<td>28.2</td>
<td>21.4</td>
<td>26.8</td>
<td>21.3</td>
<td>37.4</td>
<td>22.3</td>
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<tr>
<td>Average family size</td>
<td>3.13</td>
<td>3.19</td>
<td>3.14</td>
<td>3.09</td>
<td>3.12</td>
<td>3.22</td>
<td>3.2</td>
<td>3.21</td>
<td>3.36</td>
<td>3.27</td>
<td>3.1</td>
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<tr>
<td>Income/Poverty</td>
<td>6</td>
<td>6</td>
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<td>90.1</td>
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<td>Vacant housing units (%)</td>
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<td>Ag household owner-occupied (%)</td>
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<td>Monthly owner costs exceed 10% of household income (%)</td>
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<td>Renter-occupied (%)</td>
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<td>Gross rent exceeds 30% of household income (%)</td>
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<td>97.6</td>
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<td>Graduation rate(%), 2017</td>
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<td>Dropout rate(%), 2017</td>
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<td>English language learners(%), 2018-19</td>
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**Key**
- Statistically higher than statewide rate
- Statistically lower than statewide rate

**Source**
- Massachusetts Department of Elementary and Secondary Education School and District Profiles
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### TABLE C16001: LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH FOR THE POPULATION 5 YEARS AND OLDER, 2013-2017 AMERICAN COMMUNITY SURVEY 5-YEAR ESTIMATES

**DEMOGRAPHICS**

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<tr>
<td>Spanish or Spanish Creole</td>
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<td>French (excluding Quebec)</td>
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<td>Other Asian and Pacific Island Languages</td>
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</tr>
<tr>
<td><strong>Speak English less than &quot;very well&quot;</strong></td>
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</table>
### DEMOGRAPHICS

**TOP 5 ANCESTRIES BY TOWN - all data from US Census Bureau American Community Survey, 2013-2017 5-Year Estimates; B04006: People Reporting Ancestry**

**MASSACHUSETTS**

<table>
<thead>
<tr>
<th>Ancestry</th>
<th>Estimate</th>
<th>MOE</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Pop</td>
<td>6,789,319</td>
<td>11,116</td>
<td>20.67</td>
</tr>
<tr>
<td>Irish</td>
<td>1,403,567</td>
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</tr>
<tr>
<td>Italian</td>
<td>647,855</td>
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<td>437,190</td>
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<tr>
<td>German</td>
<td>400,519</td>
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**ARLINGTON**

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<thead>
<tr>
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<tbody>
<tr>
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**BEDFORD**

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<tr>
<td>Total Pop</td>
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<td>American</td>
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**BILLERICA**

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<tr>
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<tbody>
<tr>
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**BURLINGTON**

<table>
<thead>
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<tbody>
<tr>
<td>Total Pop</td>
<td>26,103</td>
<td>26</td>
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<tr>
<td>Total Pop</td>
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**LYNNFIELD**

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<tr>
<td>Total Pop</td>
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**PEABODY**

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**LOWELL**

<table>
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<tr>
<td>Total Pop</td>
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<tr>
<td>English</td>
<td>4,717</td>
<td>563</td>
<td>4.2509282</td>
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### CLINICAL INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>Opioid-Related EMS Incidents (count, by occurrence), 2017</td>
<td>Office of Emergency Medical Services, Bureau of Health Care Safety and Quality, MDPH</td>
</tr>
<tr>
<td>Opioid-Related EMS Incidents (count, by occurrence), 2018</td>
<td>Office of Emergency Medical Services, Bureau of Health Care Safety and Quality, MDPH</td>
</tr>
<tr>
<td>Fatal opioid overdoses (count, by residence), 2017</td>
<td>Massachusetts Registry of Vital Records and Statistics, MDPH, May 2019</td>
</tr>
<tr>
<td>Deaths, 2015</td>
<td>MDPH Registry of Vital Records and Statistics</td>
</tr>
<tr>
<td>Prevention quality Diabetes Composite, Crude Rate per 100,000 Population (among 18+ years)(PQI-93)</td>
<td>Center for Health Information and Analysis Hospital Discharge Data 2017</td>
</tr>
<tr>
<td>Inpatient hospitalizations (crude rate per 100,000)</td>
<td>Center for Health Information and Analysis Hospital Discharge Data 2017</td>
</tr>
<tr>
<td>Uncontrolled Diabetes Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-14)</td>
<td>Center for Health Information and Analysis Hospital Discharge Data 2017</td>
</tr>
<tr>
<td>Diabetes Short Term Complications Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-01)</td>
<td>Center for Health Information and Analysis Hospital Discharge Data 2017</td>
</tr>
<tr>
<td>Diabetes Long Term Complications Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-03)</td>
<td>Center for Health Information and Analysis Hospital Discharge Data 2017</td>
</tr>
<tr>
<td>Total Inpatient Hospitalization, Discharge rate per 100,000:</td>
<td>这种医院的感染率（某种疾病的发病率）</td>
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### Infectious Disease

<table>
<thead>
<tr>
<th>Disease</th>
<th>Rate or Cases</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>HIV/AIDS (age-adjusted rate per 100,000)</td>
<td>2.2</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Pneumonia/Influenza</td>
<td>21.4</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Hepatitis C cases (confirmed and probable), 2017</td>
<td>111.4</td>
<td>2005-2017</td>
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<tr>
<td>Syphilis cases (probable and confirmed), 2017</td>
<td>103.4</td>
<td>2005-2017</td>
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<tr>
<td>Gonorrhea cases (lab confirmed), 2017</td>
<td>25.4</td>
<td>2005-2017</td>
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<tr>
<td>Chlamydia cases (lab confirmed), 2017</td>
<td>167.4</td>
<td>2005-2017</td>
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</table>

### Chronic Disease

<table>
<thead>
<tr>
<th>Disease</th>
<th>Rate or Cases</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cancer (age-adjusted rates per 100,000)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Prostate cancer (age-adjusted rate per 100,000)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Colorectal cancer (age-adjusted rate per 100,000)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Breast cancer (invasive, female) (age-adjusted rate per 100,000)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Chronic Liver Disease</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Chronically Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate, Crude Rate per 100,000 Population (among 45+ years)(PQI-11)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Heart Failure Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Diabetic Retinopathy Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Stroke Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Hypertension Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-07)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Heart Failure Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-08)</td>
<td>123.9</td>
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<tr>
<td>Chronic Lower Respiratory Disease</td>
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<td>2005-2017</td>
</tr>
<tr>
<td>All Other Chronic Disease</td>
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<td>2005-2017</td>
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### Inpatient hospitalizations (crude rate per 100,000 Population (among 18+ years) and 45+ years)(PQI-16)

<table>
<thead>
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<th>Disease</th>
<th>Rate or Cases</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Diabetic Retinopathy</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Stroke</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Asthma in Younger Adults Admissions Rate, Crude Rate per 100,000 Population (among 20-44 years)(PQI-15)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Acute Myocardial Infarction (AMI) Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-11)</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Emergency Department Visits Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-12)</td>
<td>123.9</td>
<td>2005-2017</td>
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<tr>
<td>Major cardiovascular disease</td>
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### Death Rates

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<th>Rate or Cases</th>
<th>Notes</th>
</tr>
</thead>
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<tr>
<td>Parkinson’s deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Heart Failure Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Diabetic Retinopathy Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Stroke Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
<tr>
<td>Hypertension Deaths, 2015</td>
<td>123.9</td>
<td>2005-2017</td>
</tr>
</tbody>
</table>
## Cancer Mortality

### Key

- **Statistically higher than statewide rate**
- **Statistically lower than statewide rate**

† = Data suppressed due to small numbers

### Source

Massachusetts Vital Statistics, 2015

### Table: Cancer Mortality (Age-adjusted per 100,000), 2015

<table>
<thead>
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<th>Cancer Type</th>
<th>MA</th>
<th>Essex County</th>
<th>Middlesex County</th>
<th>Arlington</th>
<th>Bedford</th>
<th>Billerica</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lowell</th>
<th>Lynnfield</th>
<th>Peabody</th>
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</thead>
<tbody>
<tr>
<td>All Types (invasive)</td>
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<td>140.8</td>
<td>160.1</td>
<td>153</td>
<td>168.1</td>
<td>182.8</td>
<td>101.9</td>
<td>174.7</td>
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<td>Bladder</td>
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<td>5.3</td>
<td>4</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
</tr>
<tr>
<td>Bone</td>
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<td>0.4</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>†</td>
<td>0</td>
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<tr>
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<td>†</td>
<td>†</td>
<td>0</td>
<td>†</td>
<td>0</td>
<td>6.4</td>
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<td>Breast (female)</td>
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<td>0</td>
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<td>9.1</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>10.3</td>
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<tr>
<td>Esophageal</td>
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<td>4.5</td>
<td>4.3</td>
<td>†</td>
<td>0</td>
<td>11.2</td>
<td>†</td>
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<tr>
<td>Kaposi's Sarcoma</td>
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<td>0</td>
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</tr>
<tr>
<td>Kidney</td>
<td>3.5</td>
<td>2.9</td>
<td>4.1</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>0</td>
<td>†</td>
<td>0</td>
<td>†</td>
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</tr>
<tr>
<td>Larynx</td>
<td>0.8</td>
<td>1</td>
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<td>0</td>
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<td>0</td>
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</tr>
<tr>
<td>Leukemia</td>
<td>5.7</td>
<td>6.1</td>
<td>5.9</td>
<td>13.5</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>11.1</td>
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<tr>
<td>Liver</td>
<td>6.0</td>
<td>5.7</td>
<td>6</td>
<td>†</td>
<td>†</td>
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<td>15.7</td>
<td>†</td>
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<td>17.3</td>
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<tr>
<td>Lung</td>
<td>39.0</td>
<td>37.3</td>
<td>35.2</td>
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<td>41.5</td>
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<tr>
<td>Lymphoma (Hodgkin)</td>
<td>0.2</td>
<td>†</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Lymphoma (Non-Hodgkin)</td>
<td>5.2</td>
<td>4.9</td>
<td>4.9</td>
<td>†</td>
<td>0</td>
<td>12.2</td>
<td>†</td>
<td>8.9</td>
<td>†</td>
<td>†</td>
<td>3.6</td>
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<tr>
<td>Melanoma of Skin</td>
<td>2.3</td>
<td>2.5</td>
<td>1.9</td>
<td>†</td>
<td>0</td>
<td>†</td>
<td>0</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>0</td>
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<tr>
<td>Multiple Myeloma</td>
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<td>2.9</td>
<td>3.1</td>
<td>†</td>
<td>0</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>2.4</td>
<td>1.9</td>
<td>3.2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>0†</td>
</tr>
<tr>
<td>Ovary</td>
<td>3.9</td>
<td>6.7</td>
<td>6.6</td>
<td>†</td>
<td>0</td>
<td>0</td>
<td>0†</td>
<td>†</td>
<td>†</td>
<td>0</td>
<td>15.4</td>
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<tr>
<td>Pancreatic</td>
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<td>11.8</td>
<td>10.6</td>
<td>12.7</td>
<td>†</td>
<td>†</td>
<td>0</td>
<td>24.4</td>
<td>15.4</td>
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<td>Prostate</td>
<td>7</td>
<td>19.6</td>
<td>14.8</td>
<td>36.9</td>
<td>†</td>
<td>†</td>
<td>7†</td>
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<td>9</td>
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<td>24.3</td>
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<td>Soft Tissue</td>
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<td>1.7</td>
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<td>0†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>0†</td>
</tr>
<tr>
<td>Stomach</td>
<td>3.2</td>
<td>3.2</td>
<td>3.5</td>
<td>†</td>
<td>†</td>
<td>0</td>
<td>15.1</td>
<td>0</td>
<td>5†</td>
<td>0†</td>
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<td>Testis</td>
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<tr>
<td>Thyroid</td>
<td>0.5</td>
<td>†</td>
<td>0.4</td>
<td>†</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Uterine</td>
<td>2.7</td>
<td>3.2</td>
<td>3.9</td>
<td>†</td>
<td>0</td>
<td>0</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
</tr>
</tbody>
</table>
## Massachusetts Healthy Aging Community Profile

**Key**
- Statistically higher than statewide rate
- Statistically lower than statewide rate

### Population Characteristics

<table>
<thead>
<tr>
<th>Source</th>
<th>Population 65 years or older</th>
<th>Population 65-74 years (% of total population)</th>
<th>Population 75-84 years (% of total population)</th>
<th>Population 85 years or older (% of total population)</th>
<th>% of 65+ population living alone</th>
<th>% of only English speakers 65 years or older</th>
<th>% Language other than English over 65 years or older</th>
<th>% of Spanish speakers at home 65 years or older</th>
<th>% of 60+ with self-reported fair or poor health status</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>Essex County</td>
<td>Middlesex County</td>
<td>Arlington</td>
<td>Bedford</td>
<td>Billerica</td>
<td>Burlington</td>
<td>Lexington</td>
<td>Lowell</td>
<td>Lynnfield</td>
</tr>
<tr>
<td>Total population 65 years or older</td>
<td>1049751</td>
<td>123082</td>
<td>228113</td>
<td>7807</td>
<td>2518</td>
<td>6130</td>
<td>5081</td>
<td>6236</td>
<td>11690</td>
</tr>
<tr>
<td>65 years or older (% of total population)</td>
<td>15.5</td>
<td>13.9</td>
<td>14.4</td>
<td>16.4</td>
<td>18.3</td>
<td>14.8</td>
<td>19.5</td>
<td>18.7</td>
<td>10.5</td>
</tr>
<tr>
<td>Population 65-74 years (% of total population)</td>
<td>8.7</td>
<td>8.6</td>
<td>8.4</td>
<td>8.3</td>
<td>8.4</td>
<td>8.1</td>
<td>9.8</td>
<td>7.7</td>
<td>6</td>
</tr>
<tr>
<td>Population 75-84 years (% of total population)</td>
<td>4.3</td>
<td>4.3</td>
<td>4.1</td>
<td>4.1</td>
<td>4.0</td>
<td>3.5</td>
<td>3.9</td>
<td>3.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Population 85 years or older (% of total population)</td>
<td>2.3</td>
<td>2.5</td>
<td>2.1</td>
<td>3</td>
<td>4</td>
<td>1.6</td>
<td>2.7</td>
<td>3.7</td>
<td>1.6</td>
</tr>
<tr>
<td>% of 65+ population living alone</td>
<td>29.9</td>
<td>29.3</td>
<td>28.5</td>
<td>33.1</td>
<td>21.8</td>
<td>16.5</td>
<td>22.1</td>
<td>23.0</td>
<td>34.5</td>
</tr>
<tr>
<td>% of only English speakers 65 years or older</td>
<td>17.7</td>
<td>29</td>
<td>16.9</td>
<td>18.4</td>
<td>21.1</td>
<td>16.2</td>
<td>21.8</td>
<td>23</td>
<td>12.7</td>
</tr>
<tr>
<td>% Language other than English over 65 years or older</td>
<td>11.9</td>
<td>10.8</td>
<td>11.1</td>
<td>14.7</td>
<td>12.7</td>
<td>11.9</td>
<td>17</td>
<td>12.3</td>
<td>9.6</td>
</tr>
<tr>
<td>% of Spanish speakers at home 65 years or older</td>
<td>7</td>
<td>7.1</td>
<td>6.5</td>
<td>3.4</td>
<td>7.4</td>
<td>10.3</td>
<td>12.6</td>
<td>9.7</td>
<td>8.4</td>
</tr>
</tbody>
</table>

### Wellness & Prevention

<table>
<thead>
<tr>
<th>Source</th>
<th>% 60+ injured in a fall within last 12 months</th>
<th>% 60+ with depression</th>
<th>% 60+ with anxiety disorders</th>
<th>% 60+ with substance use disorders (drug use +/-or alcohol abuse)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>10.6</td>
<td>31.5</td>
<td>25.4</td>
<td>4.6</td>
</tr>
<tr>
<td>65+</td>
<td>17.6</td>
<td>32.8</td>
<td>25.7</td>
<td>5.1</td>
</tr>
<tr>
<td>% 60+ with self-reported fair or poor health status</td>
<td>18.0</td>
<td>31.0</td>
<td>24.5</td>
<td>5.6</td>
</tr>
<tr>
<td>% 60+ with physical exam/check-up in past year</td>
<td>89.3</td>
<td>90.8</td>
<td>29.0</td>
<td>6.3</td>
</tr>
<tr>
<td>% 60+ consumed five or more fruits and vegetables a day</td>
<td>21.5</td>
<td>23.6</td>
<td>19.3</td>
<td>21.4</td>
</tr>
<tr>
<td>% with any physical activity in the last month</td>
<td>73.3</td>
<td>77.8</td>
<td>69.8</td>
<td>69.8</td>
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</tbody>
</table>

### Behavioral Health

<table>
<thead>
<tr>
<th>Source</th>
<th>% 60+ with 31+ days poor mental health last month</th>
<th>% 60+ with depression</th>
<th>% 60+ with anxiety disorders</th>
<th>% 60+ with substance use disorders (drug use +/-or alcohol abuse)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>7.0</td>
<td>31.5</td>
<td>25.4</td>
<td>4.6</td>
</tr>
<tr>
<td>65+</td>
<td>6.5</td>
<td>32.8</td>
<td>25.7</td>
<td>5.1</td>
</tr>
<tr>
<td>% 60+ with self-reported as obese</td>
<td>23.1</td>
<td>31.0</td>
<td>24.5</td>
<td>5.6</td>
</tr>
<tr>
<td>% 60+ diagnosed as obese</td>
<td>19.0</td>
<td>30.1</td>
<td>21.4</td>
<td>5.7</td>
</tr>
<tr>
<td>% with any physical activity in the last month</td>
<td>73.3</td>
<td>77.8</td>
<td>69.8</td>
<td>69.8</td>
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</table>

### Chronic Disease

<table>
<thead>
<tr>
<th>Source</th>
<th>% 65+ with Alzheimer’s disease or related dementia</th>
<th>% 65+ with clinical diagnosis of deafness or hearing impairment</th>
<th>% 65+ with clinical diagnosis of blindness or visual impairment</th>
<th>% 65+ with clinical diagnosis of mobility impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>13.6</td>
<td>15.1</td>
<td>13.5</td>
<td>13.5</td>
</tr>
<tr>
<td>65+</td>
<td>12.8</td>
<td>15.1</td>
<td>13.5</td>
<td>13.5</td>
</tr>
<tr>
<td>% 65+ with self-reported as obese</td>
<td>20.7</td>
<td>21.6</td>
<td>19.5</td>
<td>23.3</td>
</tr>
<tr>
<td>% 60+ with self-reported as obese</td>
<td>23.1</td>
<td>24.4</td>
<td>22.1</td>
<td>26.6</td>
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</table>

### Living with Disability

<table>
<thead>
<tr>
<th>Source</th>
<th>% 65+ with clinical diagnosis of deafness or hearing impairment</th>
<th>% 65+ with clinical diagnosis of blindness or visual impairment</th>
<th>% 65+ with clinical diagnosis of mobility impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>16.1</td>
<td>16.0</td>
<td>10.0</td>
</tr>
<tr>
<td>65+</td>
<td>16.9</td>
<td>16.0</td>
<td>11.7</td>
</tr>
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### Access to Care

<table>
<thead>
<tr>
<th>Source</th>
<th>% Medicare managed care enrollees</th>
<th>% dualy eligible for Medicare and Medicaid</th>
<th>% 60+ with a regular doctor</th>
<th>% 60+ who did not see doctor when needed due to cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>23.1</td>
<td>9.2</td>
<td>27.1</td>
<td>3.4</td>
</tr>
<tr>
<td>65+</td>
<td>25.6</td>
<td>9.0</td>
<td>22.3</td>
<td>3.4</td>
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</tbody>
</table>

### Community Variables & Civic Engagement

<table>
<thead>
<tr>
<th>Source</th>
<th>% of grandparents raising grandchildren</th>
<th>% of assisted living sites</th>
<th># of medical transportation services for older people</th>
<th># of nonmedical transportation services for older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>0.8</td>
<td>238</td>
<td>268</td>
<td>252</td>
</tr>
<tr>
<td>% of assisted living sites</td>
<td>238</td>
<td>208</td>
<td>208</td>
<td>208</td>
</tr>
<tr>
<td>Total of all crashes involving adult age 60+ in town</td>
<td>123251</td>
<td>628</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>% of assisted living sites</td>
<td>208</td>
<td>208</td>
<td>208</td>
<td>208</td>
</tr>
<tr>
<td># of medical transportation services for older people</td>
<td>208</td>
<td>208</td>
<td>208</td>
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</table>
### Youth Risk Behavior Surveys - Middle School

#### YRBS Question

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never or rarely wore a helmet when riding a bicycle (among those who rode a bicycle)</td>
<td>15.6</td>
<td>35.4</td>
<td>11.1</td>
<td>43.6</td>
<td></td>
</tr>
<tr>
<td>Never or rarely wore a helmet when rollerblading or riding a skateboard (among those who rollerbladed or rode a skateboard)</td>
<td>34.9</td>
<td>8.6</td>
<td>9.6</td>
<td>11.4</td>
<td>15.3</td>
</tr>
<tr>
<td>Carried a weapon (such as, a gun, knife, or club)</td>
<td>14.3</td>
<td>9.4</td>
<td>14.3</td>
<td>N/A</td>
<td>19.0</td>
</tr>
<tr>
<td>Were in a physical fight</td>
<td>31.8</td>
<td>5.9</td>
<td>28.2</td>
<td>15.3</td>
<td>28.6</td>
</tr>
<tr>
<td>Were electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media)</td>
<td>30.2</td>
<td>12.7</td>
<td>33.1</td>
<td>15.0</td>
<td>15.1</td>
</tr>
<tr>
<td>Were bullied on school property</td>
<td>14.4</td>
<td>20.1</td>
<td>17.9</td>
<td>29.9</td>
<td>29.1</td>
</tr>
<tr>
<td>Which of the following do you find causes the most negative stress for you? (One response selected)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Busy schedule (school, activities, sports, etc.)</td>
<td>20.9</td>
<td>27.2</td>
<td>N/A</td>
<td>27.6</td>
<td></td>
</tr>
<tr>
<td>Parent/family demands/expectations about academics, grades, etc.</td>
<td>13.5</td>
<td>14.5</td>
<td>N/A</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Difficulty getting enough sleep</td>
<td>6.5</td>
<td>7.4</td>
<td>N/A</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>Extracurricular activity demands or pressures</td>
<td>2.5</td>
<td>3.4</td>
<td>N/A</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>School demands/expectations—such as assignments, homework, etc.</td>
<td>32.7</td>
<td>30.9</td>
<td>N/A</td>
<td>34.3</td>
<td></td>
</tr>
<tr>
<td>Social pressures from friends, peers, etc.</td>
<td>3.8</td>
<td>2.4</td>
<td>N/A</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Other family or personal issues which cause emotional stress for you</td>
<td>11.0</td>
<td>7.1</td>
<td>N/A</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>Worrying about the future such as college, career, etc.</td>
<td>9.1</td>
<td>7.1</td>
<td>N/A</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>Which of the following do you find most stressful about school? (One response selected)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School related factors that cause the most stress; Having to study things you do not understand</td>
<td>15.2</td>
<td>21.1</td>
<td>N/A</td>
<td>14.1</td>
<td></td>
</tr>
<tr>
<td>Teachers expecting too much from you</td>
<td>14.3</td>
<td>19.2</td>
<td>N/A</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>Keeping up with schoolwork</td>
<td>22.0</td>
<td>19.0</td>
<td>N/A</td>
<td>24.1</td>
<td></td>
</tr>
<tr>
<td>Having to concentrate too long during the school day</td>
<td>8.2</td>
<td>8.4</td>
<td>N/A</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>Having to study things you are not interested in</td>
<td>13.8</td>
<td>7.0</td>
<td>N/A</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>Pressure of study</td>
<td>6.2</td>
<td>5.0</td>
<td>N/A</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Getting up early in the morning to go to school</td>
<td>15.2</td>
<td>13.0</td>
<td>N/A</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>Going to school</td>
<td>5.1</td>
<td>7.4</td>
<td>N/A</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Mental health and suicidality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad/hopeless 2+ weeks in past 12 months</td>
<td>15.0</td>
<td>10.6</td>
<td>12.1</td>
<td>15.4</td>
<td>7.9</td>
</tr>
<tr>
<td>Seriously thought about attempting suicide</td>
<td>8.6</td>
<td>5.9</td>
<td>6.5</td>
<td>9.1</td>
<td>6.1</td>
</tr>
<tr>
<td>Made a plan about how they would attempt suicide</td>
<td>2.4</td>
<td>1.2</td>
<td>2.0</td>
<td>2.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever tried cigarette smoking (even one or two puffs)</td>
<td>1.9</td>
<td>3.1</td>
<td>1.5</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Tried cigarette smoking before age 10 years (for the first time, even one or two puffs)</td>
<td>.5</td>
<td>.5</td>
<td>N/A</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Currently smoked cigarettes (on at least 1 day during the 30 days before the survey)</td>
<td>.7</td>
<td>.7</td>
<td>.3</td>
<td>.7</td>
<td></td>
</tr>
<tr>
<td>Currently smoked cigarettes frequently (on 20 or more days during the 30 days before the survey)</td>
<td>.3</td>
<td>.3</td>
<td>.2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Currently smoked more than 5 cigarettes per day (more than 5 cigarettes per day on the days they smoked, during the past 30 days before the survey)</td>
<td>.2</td>
<td>.2</td>
<td>.2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)</td>
<td>.7</td>
<td>.7</td>
<td>.0</td>
<td>.0</td>
<td></td>
</tr>
<tr>
<td>Currently used smokeless tobacco (chewing tobacco, snuff, dip, snus, or dissolvable tobacco products on at least 1 day during the 30 days before the survey)</td>
<td>1.3</td>
<td>1.3</td>
<td>.8</td>
<td>.7</td>
<td>.4</td>
</tr>
<tr>
<td>Used electronic vapor products (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)</td>
<td>7.4</td>
<td>11.0</td>
<td>8.4</td>
<td>1.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least 1 day during the 30 days before the survey)</td>
<td>3.5</td>
<td>7.1</td>
<td>3.9</td>
<td>.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Ever drank alcohol (other than a few sips)</td>
<td>12.8</td>
<td>12.5</td>
<td>10.6</td>
<td>31.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Drank alcohol before age 11 years (for the first time other than a few sips)</td>
<td>5.2</td>
<td>4.0</td>
<td>6.1</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Currently drank alcohol (at least one drink of alcohol during the 30 days before the survey)</td>
<td>1.8</td>
<td>4.2</td>
<td>1.5</td>
<td>3.5</td>
<td>.7</td>
</tr>
<tr>
<td>Ever used marijuana</td>
<td>2.9</td>
<td>1.5</td>
<td>2.0</td>
<td>.6</td>
<td>1.5</td>
</tr>
</tbody>
</table>
## Used marijuana in the past 30 days

<table>
<thead>
<tr>
<th></th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.0</td>
<td>.6</td>
<td>.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Tried marijuana before age 10 years (for the first time)

<table>
<thead>
<tr>
<th></th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.5</td>
<td>.3</td>
<td>.1</td>
<td>.0</td>
<td></td>
</tr>
</tbody>
</table>

## Ever taken prescription pain medicine without a doctor’s prescription or differently than how a doctor said to use it (counting drugs such as codeine, Vicodin, OxyCotin, Hydrocodone, and Percocet)

<table>
<thead>
<tr>
<th></th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.6</td>
<td>1.1</td>
<td>2.7</td>
<td>4.0</td>
<td>1.5</td>
</tr>
</tbody>
</table>

## Ever used cocaine (any form of cocaine, such as powder, crack, or freebase)

<table>
<thead>
<tr>
<th></th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.6</td>
<td>.0</td>
<td>.5</td>
<td>.1</td>
<td>.0</td>
</tr>
</tbody>
</table>

## Ever sniffed glue, breathed the contents of spray cans, or inhaled paints or sprays to get high

<table>
<thead>
<tr>
<th></th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.2</td>
<td>.9</td>
<td>2.7</td>
<td>1.6</td>
<td>2.6</td>
</tr>
</tbody>
</table>

### Sexual Behavior

**Arlington**

**Bedford**

**Burlington**

**Lexington**

**Lynnfield**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had sexual intercourse</td>
<td>2.3</td>
<td>1.7</td>
<td>.9</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Had sexual intercourse before age 10 years (for the first time)</td>
<td>.7</td>
<td>.3</td>
<td>.1</td>
<td>.0</td>
<td></td>
</tr>
<tr>
<td>Had sexual intercourse with four or more persons (during their life)</td>
<td>.8</td>
<td>.5</td>
<td>.1</td>
<td>.0</td>
<td></td>
</tr>
<tr>
<td>Did not use a condom (during last sexual intercourse, among students who have had sexual intercourse)</td>
<td>50.0</td>
<td>37.5</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physical Activity and Nutrition

**Arlington**

**Bedford**

**Burlington**

**Lexington**

**Lynnfield**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Arlington</th>
<th>Bedford</th>
<th>Burlington</th>
<th>Lexington</th>
<th>Lynnfield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Described themselves as slightly or very overweight</td>
<td>20.5</td>
<td>20.7</td>
<td>25.5</td>
<td>19.1</td>
<td>24.6</td>
</tr>
<tr>
<td>Were not trying to lose weight</td>
<td>71.0</td>
<td>69.6</td>
<td>60.8</td>
<td>68.4</td>
<td>65.2</td>
</tr>
<tr>
<td>Did not eat breakfast at all during the week (during the 7 days before the survey)</td>
<td>5.5</td>
<td>8.6</td>
<td>3.6</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Did not eat breakfast on at least one day during the week during the 7 days before the survey</td>
<td>46.3</td>
<td>49.3</td>
<td>36.6</td>
<td>49.1</td>
<td></td>
</tr>
<tr>
<td>Were not physically active at least 60 minutes per day on at least one day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)</td>
<td>3.5</td>
<td>3.9</td>
<td>N/A</td>
<td>.4</td>
<td></td>
</tr>
<tr>
<td>Were not physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)</td>
<td>34.7</td>
<td>41.3</td>
<td>N/A</td>
<td>19.5</td>
<td></td>
</tr>
<tr>
<td>Watched TV for 3 or more hours per day (on an average school day)</td>
<td>11.3</td>
<td>15.2</td>
<td>6.8</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)</td>
<td>29.3</td>
<td>40.0</td>
<td>7.0</td>
<td>32.1</td>
<td></td>
</tr>
<tr>
<td>Did not attend physical education classes on 1 or more days (in an average week when they were in school)</td>
<td>2.9</td>
<td>N/A</td>
<td>.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not play on at least 1 sports team (during the past 12 months, counting teams run by school or community groups)</td>
<td>23.7</td>
<td>22.3</td>
<td>22.6</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td>Had a concussion from playing a sport or being physically active (one or more times during the 12 months before the survey)</td>
<td>11.6</td>
<td>12.5</td>
<td>N/A</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>Are currently taking medicine or receiving treatment for behavioral health, mental health condition, or emotional problem (from a doctor or other health professional)</td>
<td>13.0</td>
<td>9.6</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Risky Behavior and Threats to Safety

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>During the past 30 days, did you ever sleep away from your parent or guardians because you were kicked out, ran away, or were abandoned?</td>
<td>2.3</td>
<td>2</td>
<td>2</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nearly or never wore a seat belt (when riding in a car driven by someone else)</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, have you ridden in a car or other vehicle driven by someone who had been drinking alcohol?</td>
<td>14.4</td>
<td>12.2</td>
<td>7.9</td>
<td>12.1</td>
<td>11.7</td>
<td>14.6</td>
</tr>
<tr>
<td>During the past 30 days, drove when you had been drinking alcohol (in a car or other vehicle, one or more times, among students who had driven a car or other vehicle)</td>
<td>5.7</td>
<td>4.7</td>
<td>0.5</td>
<td>3.3</td>
<td>5.8</td>
<td>2.3</td>
</tr>
<tr>
<td>During the past 30 days, have you ridden in a car driven by someone who had been using marijuana?</td>
<td>9.3</td>
<td>9.3</td>
<td>17.6</td>
<td>15.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, have you at least checked your cell phone, text, or e-mail while driving a car or other vehicle?</td>
<td>35.6</td>
<td>31.2</td>
<td>46.4</td>
<td>28.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you at least one day carried a gun? DO NOT count the days when you carried a gun only for hunting or for a sport, such as target shooting.</td>
<td>2.7</td>
<td>1.1</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, have you at least on one day carried a gun, knife, or club?</td>
<td>11.1</td>
<td>8</td>
<td>9.7</td>
<td>5.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, have you at least on one day carried a weapon such as a gun, knife, or club on school property?</td>
<td>2.7</td>
<td>0.9</td>
<td>1.7</td>
<td>1.1</td>
<td></td>
<td>0.6</td>
</tr>
<tr>
<td>During the past 30 days, have you at least on one day not go to school because you felt you would be unsafe at school or on your way to or from school?</td>
<td>4.5</td>
<td>3.3</td>
<td>4.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you at least one day had someone threaten or injure you with a weapon such as a gun, knife, or club on school property?</td>
<td>4.8</td>
<td>2.9</td>
<td>5.2</td>
<td>2.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you at least once been in a physical fight?</td>
<td>17.8</td>
<td>11.1</td>
<td>18.2</td>
<td>15.7</td>
<td>16.1</td>
<td>11.5</td>
</tr>
<tr>
<td>During the past 12 months, have you at least once been in a physical fight on school property?</td>
<td>3.2</td>
<td>4.6</td>
<td>4.7</td>
<td>3.6</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you ever been a member of a gang?</td>
<td>5.1</td>
<td></td>
<td></td>
<td></td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Have you ever been physically forced to have sexual intercourse when you did not want to?</td>
<td>6.8</td>
<td>5.2</td>
<td>1.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you anyone force you to do sexual things that you did not want to do? Count such things as kissing, touching, or being physically forced to have sexual intercourse.</td>
<td>10.4</td>
<td>5.6</td>
<td></td>
<td></td>
<td></td>
<td>5.6</td>
</tr>
<tr>
<td>During the past 12 months, have you someone you were dating or going out with force you to do sexual things that you did not want to do? Count such things as kissing, touching, or being physically forced to have sexual intercourse.</td>
<td>5.8</td>
<td>3.7</td>
<td>3.4</td>
<td>5.3</td>
<td></td>
<td>4.2</td>
</tr>
<tr>
<td>During the past 12 months, have you someone you were dating or going out with physically hurt you on purpose? Count such things as being hit, slammed into something, or injured with an object or weapon.</td>
<td>5.6</td>
<td>1.8</td>
<td>1.7</td>
<td>1.8</td>
<td></td>
<td>1.6</td>
</tr>
<tr>
<td>During the past 12 months, have you ever been bullied on school property?</td>
<td>14.6</td>
<td>12.8</td>
<td>4.6</td>
<td>14.3</td>
<td>12.1</td>
<td>7.3</td>
</tr>
<tr>
<td>During the past 12 months, have you ever been electronically bullied? Count being bullied through texting, Instagram, Twitter, Facebook, or other social media apps.</td>
<td>13.6</td>
<td>10.5</td>
<td>15.5</td>
<td>13</td>
<td>10.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Has someone posted something about you on social media that made you feel upset or uncomfortable? Social media apps include Instagram, Twitter, Facebook, etc.</td>
<td>31.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you done something to purposely hurt yourself without wanting to die, such as cutting or burning yourself on purpose?</td>
<td>15.3</td>
<td>16.5</td>
<td>12.8</td>
<td>12.5</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?</td>
<td>27.4</td>
<td>25.7</td>
<td>27.8</td>
<td>27.6</td>
<td>27.1</td>
<td>16.2</td>
</tr>
<tr>
<td>During the past 12 months, did you ever seriously consider attempting suicide?</td>
<td>12.4</td>
<td>11</td>
<td>12</td>
<td>17.2</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, did you make a plan about how you would attempt suicide?</td>
<td>10.9</td>
<td>8.3</td>
<td>12.9</td>
<td>8.7</td>
<td>10.5</td>
<td>7.6</td>
</tr>
<tr>
<td>During the past 12 months, did you actually attempt suicide?</td>
<td>5.4</td>
<td>2.3</td>
<td>3.4</td>
<td>3.2</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?</td>
<td>1.9</td>
<td>0.9</td>
<td>0.5</td>
<td>0.5</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Have you ever tried cigarette smoking, even one or two puffs?</td>
<td>19.6</td>
<td>11.6</td>
<td>16.5</td>
<td>8</td>
<td>8.5</td>
<td>7.5</td>
</tr>
<tr>
<td>First tried cigarette smoking before age 13 years (even one or two puffs)</td>
<td>5.7</td>
<td>1.9</td>
<td>1.9</td>
<td></td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>During the past 30 days, did you smoke part or all of a cigarette?</td>
<td>2</td>
<td>2.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, do you smoke more than 10 cigarettes?</td>
<td>7</td>
<td>0.7</td>
<td>0.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, on at least one day did you smoke cigarettes?</td>
<td>6.4</td>
<td>4.6</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, on at least one day did you smoke cigars, cigarillos, or little cigars?</td>
<td>6.7</td>
<td></td>
<td></td>
<td></td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Have you ever used an electronic vapor product?</td>
<td>41.1</td>
<td>37.7</td>
<td>34.2</td>
<td>40.4</td>
<td>29.6</td>
<td></td>
</tr>
<tr>
<td>During the past 30 days, on at least one day did you use an electronic vapor product?</td>
<td>20.1</td>
<td>22.6</td>
<td>27.9</td>
<td>24.3</td>
<td>6.6</td>
<td>22.3</td>
</tr>
<tr>
<td>------------------------------------</td>
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<td>----------------------</td>
<td>-------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Were ever told by a doctor or nurse that they had asthma</td>
<td>20.3</td>
<td>21.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never saw a dentist (for a check-up, exam, teeth cleaning, or other dental work)</td>
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<tr>
<td>Takes medicine or receiving treatment from a doctor or other health professional for any type of behavioral health, mental health condition or emotional problem</td>
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<tr>
<td>Did not get 8 or more hours of sleep (on an average school night)</td>
<td>80.2</td>
<td>72.2</td>
<td>76.9</td>
<td>78.3</td>
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<tr>
<td>Has at least one teacher or other adult in your school that you can talk to if you have a problem</td>
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<tr>
<td>Can talk with at least one parent or other adult family members about things that are important to them</td>
<td>82.9</td>
<td>81.4</td>
<td>81</td>
<td>87.1</td>
<td></td>
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<tr>
<td>Are either of your parents or other adults in your family serving on active duty in the military?</td>
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</tr>
</tbody>
</table>
Appendix C:
Resource Inventory
Disclaimer:
The listings within this guide are designed as informational and are not to be interpreted as recommendations or endorsements.
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State and Regional Resources

Access to Care
Mass 211 Dial 2-1-1 or Toll Free (877) 211-6277 www.mass211.org
Medicare & Medicaid Services (800) 633-4227 www.medicare.gov
Mass Health (800) 841-2900 www.mass.gov/eohhs/gov/departments/masshealth
Health Connector Customer Service Call Center 1-877-MA-ENROLL (1-877-623-6765)
https://www.mahealthconnector.org/

Disabilities and Special Needs
Mass Commission for the Blind (800) 392-6450 www.mass.gov/mcb
Mass Commission for the Deaf (800) 882-1155 www.mass.gov/mcdhh
Mass Rehabilitation Commission (For people with disabilities) (781) 324-7160
www.mass.gov/mrc

Housing and Homelessness
Mass. Coalition for Homeless: (781) 595-7570

Mental Health and Substance Abuse
National Suicide Prevention Lifeline (800) 273-8255
SAMHSA’s National Helpline – 1-800-662-HELP (4357) Statewide ESP Toll-Free
Number 1-877-382-1609

Senior Services
1-800-AGE-INFO (800-243-4636) www.800ageinfo.com
Executive Office of Elder Affairs (617) 727-7750 www.mass.gov/elders

Veteran Services
Crisis Hotline (800) 273-8255 (Press 1)
Arlington
The mission of the Arlington Boys & Girls Club is to inspire and enable all young people, especially those from challenging circumstances, to realize their full potential as productive responsible and caring citizens.

Arlington Family Connection
PO Box 150
Arlington, MA 02476
www.arlingtonfamilyconnection.org

Arlington Family Connection supports families with children under age 6. AFC provides community resources such as parenting information, seminars, workshops, drop-in playtime, social groups, support group and community assistance programs.

Arlington Youth Counseling Center
670R Mass Avenue -Whittemore Robbins House
Arlington, MA 02476
781.316.3255

The Arlington Youth Counseling Center (AYCC) is a licensed, community-based mental health counseling center serving Arlington youth (ages 3-21) and their families. AYCC provides a variety of high quality, innovative, and therapeutic outpatient and school-based mental health services including individual, group, and family counseling, psychiatric evaluation and medication management.

AYCC also provides case management services to residents with basic resource needs (housing, food, fuel assistance, health insurance coverage etc.), and offers support groups to identified at-risk populations, including survivors of domestic violence, substance-involved youth, and youth on the autism spectrum.

Department of Children and Families
30 Mystic Street
Arlington, MA 02474
781.641.8500
https://www.mass.gov/locations/dcf-arlington-area-office

DCF provides support services to children and their families to prevent neglect and abuse. DCF offers a 24 hour hot line for child abuse and neglect.
Mass Mothers of Twins
PO Box 750031
Arlington, MA 02475
781.989.3222
www.mmba-mom.org
MMOTA-Founding Chapter’s objective is to provide support to mothers of twins, triplets and higher-order multiple births (MOTs). Toward that objective, meetings and other activities are held for the purpose of sharing information and advice pertaining to raising multiple-birth children.

Thom Mystic Valley Early Intervention
10P Gill Street
Woburn, MA 01801
781.932.2888
www.thomchild.org
Thom Mystic Valley is committed to providing high quality, comprehensive, and family-centered early intervention services to infants, toddlers, their families, and others in the community who care for them. Nurses, social workers, occupational and physical therapists, speech-language pathologists, mental health counselors, educators, and other specialists are passionate about supporting families and young children.

Disabilities and Special Needs

Arlington Disability Commission
27 Maple Street
Arlington, MA 02476
781.316-3431
The Disability Commission provides information, referral, guidance, and technical assistance to insure that people with physical, sensory, cognitive, and other disabilities have equal access to Town facilities, services, and programs.

The Edinburg Center
205 Burlington Road
Bedford, MA 01730
781.862.3600
http://www.edinburgcenter.org
The Center’s mission is distinguished by our longstanding belief that all individuals have the potential to learn, the capacity for change and the right to live a meaningful life in the community of his or her choice. Our mission is to provide an array of innovative services which promote personal growth and independence, foster hope and enhance the quality of life of people with mental health conditions, co-occurring substance use conditions and/or developmental disabilities or brain injuries.

The Center maintains a specific commitment to providing services to persons whose complex and challenging needs have typically been barriers to successful community living.

Riverside Family Support Center
300 West Cummings Park, Suite 354
Woburn, MA 01801
781.801.5247
http://riversidefamilysupport.org
Our Family Support Center offers a wide array of supports in the home and in the community for adults and children with disabilities living with their families. These services may include respite, recreational activities, provision of adaptive equipment, skill training, and intensive staff support when necessary. The Center is available to any family that has a member living in the home who is eligible for services through DDS and resides in the Central Middlesex area. Their service area includes: Arlington, Bedford, Burlington, Lexington, Wilmington, Winchester, and Woburn. However we welcome any individual who wants to participate in our clubs, classes or events.

Domestic Violence

REACH Beyond Domestic Violence
PO Box 540024
Waltham, MA 02454
781.891.0724
Hotline: 800.899.4000
https://reachma.org
REACH is a non-profit organization providing safety and support to survivors of abuse while engaging communities to promote healthy relationships and prevent domestic violence.
Food Assistance

Arlington Food Pantry
117 Broadway
Arlington, MA 02474
339.707.6758
https://arlingtonfoodpantry.org

The Arlington Food Pantry is dedicated to eliminating food insecurity by providing nutritious and culturally appropriate food in a respectful and compassionate manner to any Arlington resident in need.

Arlington EATS
c/o Arlington Food Pantry
58 Medford St
Arlington, MA 02474
http://www.arlington-eats.org

Arlington EATS maintains a clear goal: ensuring that the over 500 local students who receive free and reduced price lunch (FRL) when school is in session still have access to healthy meals when school is not in session. Arlington EATS helps our students Eat All Through Summer and the school year!

Supplemental Nutritional Assistance Program (SNAP)
https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

Housing and Homelessness

Arlington Housing Authority
4 Winslow Street
Arlington, MA 02474
781.646.3400
www.arlingtonhousing.org

The Arlington Housing Authority provides subsidized housing for elderly, low income, and disabled persons and their families.

Housing Corporation of Arlington
252 Massachusetts Ave
Arlington, MA 02476
781.859.5294
https://housingcorparlington.org

The Housing Cooperation of Arlington provides income eligible families with affordable housing, provides financial assistance to eligible families at risk of facing homelessness.

Mental Health and Substance Abuse

Eliot Community Human Services
Corporate Office
125 Hartwell Avenue
Lexington, MA 0242
781.861.0890
Emergency Psychiatric Services (800) 988-1111
http://www.eliotchs.org

Eliot Community Human Services is a private, non-profit human services organization providing services for people of all ages throughout the Commonwealth of Massachusetts. The continuum of services includes diagnostic evaluation, twenty-four hour emergency services, and crisis stabilization, outpatient and court mandated substance abuse services, individual and group outpatient counseling, early intervention, specialized psychological testing, day, residential, social and vocational programs for individuals with mental illness and developmental disabilities, outreach and support services for the homeless, batterer intervention, and consultation.

Psychological Care Associates
22 Mill Street, Suite 004 & 308
Arlington, MA 02476
781.646.0500
https://psycare.info

Psychological Care Associates provides consultations in ADD/ADHD; re-evaluation of psychiatric medication, parenting concerns/questions, addictions, sleep disturbance, school risk assessment.
Psychotherapy & Specialty Services always begin with a thoughtful evaluation and goal setting. Therapy is individual, couples, family or group, and includes CBT, DBT, Dynamic or Interpersonal approaches.

Right Turn
440 Arsenal Street
Watertown, MA 02472
781.646.3800
http://right-turn.net
Right Turn is an innovative program for men and women that provides Intensive Outpatient Treatment, 4-6 month Extended Care Housing Program for men, Medication Assisted Treatment and Intervention, in a uniquely creative environment. The hallmark of Right Turn’s approach is a unique combination of evidence-based treatment and creativity using art, music and writing. We use the arts to help individuals define themselves. We understand that there is no single road to recovery and our services help individuals and families find their own road to recovery.

Arlington Youth Health & Safety Coalition (AYHSC)
27 Maple Street
Arlington, MA 02476
781.316.3179
http://arlingtonma.gov/ayhsc
AYHSC is a community coalition with representatives from public (police, schools, local government) and private (churches, businesses, youth-serving organizations) agencies, as well as parents and youth. Using a public health approach to prevention and intervention, AYHSC focuses on positive community change through education, environmental initiatives, policy development, and improving youth access to treatment.

Senior Service

Arlington Council on Aging
Senior Center
27 Maple St.
Arlington, MA 02476
781.316.3400
www.arlingtonma.gov/coa
The mission of the Council on Aging (COA) is to provide advocacy and support services to help Arlington elders live dignified and independent lives. The Council’s primary responsibilities are to design, promote, and implement services to address the identified needs of the community’s elder population and to coordinate existing services in the community.

CMK Home Care LLC
Arlington, MA
781.266.8985
http://cmkhomecare.net
CMK Home Care is a fully insured, non-medical Home Care company based in Arlington, MA. We provide exceptional care to elders in their place of residence through our Elder Service program and to Family Caregivers through our Respite Care Management and Respite Connect programs.

Our Mission is to bring a holistic approach to caregiving for your entire family. Whether you are the sole caregiver, sharing the care with siblings/others or caring from afar, we understand the stress and sacrifice that can be involved in caring for an aging loved one. We serve at the pleasure of our clients through Compassionate, Reliable and Ethical care, with No Minimum Hours and Prior Aide Introductions. Let our GrandSolutions help you.

Minuteman Senior Services
26 Crosby Drive
Bedford, MA 01730
781.272-7177
888.222.6171 Toll Free
1-800-439-2370 TTY
https://www.minutemansenior.org
Minuteman Senior Services has been helping older and disabled adults age with independence and dignity in the setting of their choice which is most often their own homes and communities. We have been supporting caregivers, local and long distance, who want to do the right thing for their loved ones and need help and advice as they balance the competing demands of family, work and self. We offer over 20 programs and services and are continually improving and expanding to serve you and your family in new and better ways.

Brightview Senior Living
One Symmes Road
Arlington, MA 02474
781.262.3366
https://www.brightviewseniorliving.com/find-a-community/brightview-arlington
The whole community is your home. We have 93 apartments to choose from, in a variety of sizes and styles, in Assisted Living, Memory Care, and Enhanced Care, allowing residents who may need a higher level of care to live in a home-like setting instead of a nursing home.
Brightview Arlington provides assisted living, dementia care, and enhanced care in Arlington, MA and the surrounding areas of Lexington, Cambridge, Winchester, Medford, North Waltham, Belmont, Watertown, and Malden.

Sunrise of Arlington
1395 Massachusetts Avenue
Arlington, MA 02476
781.643.2100
Sunrise of Arlington offers a variety of senior living options including assisted living, memory care and short-term stays, along with coordination of hospice care available through our trusted partners, including Lahey Hospital and Medical Center and Winchester Hospital. Regardless of the level of care required, all of our residents—and their families—benefit from the full quality and depth of the Sunrise Signature Experience, which truly allows residents to age in place, on their own terms.

Support Groups

Alanon/Alateen
Meetings are held at Calvary Methodist Church, 1st floor parlor. For accessible entrance use Linwood St door. Meetings are held Thursday mornings at 10 am.
300 Massachusetts Ave
Arlington, MA 04676
Meetings are held at St. John's Episcopal Church; enter from Lombard Rd. Meetings are held Saturday at 12:00 pm.
74 Pleasant Street
Arlington, MA 04676

The Children's Room
1210 Massachusetts Avenue
Arlington, MA 04676
781.641.4741
www.childrensroom.org
The Children’s Room offers hope and healing to children and teens ages 3½ to 18 who have experienced the death of a parent or sibling. We also provide opportunities for parents and caregivers to meet with each other and talk about their own experiences parenting a grieving child, and to give and receive support around their own grief.

The Sanborn Foundation
P.O. Box 417
Arlington, MA 02476-0052
617.391.3092
http://www.sanbornfoundation.org
The mission of the Foundation is to create access to cancer care for residents of Arlington Massachusetts. This is accomplished through grants awarded by the Foundation. Grants are intended to benefit Arlington, Massachusetts residents who have cancer.
Sanborn Foundation funds may be used as follows:

Sexual Health

Boston IVF
450 Bedford Street
Suite 1000
Lexington, MA 02421
800.858.4832
https://www.bostonivf.com
Boston IVF are dedicated to helping couples bring home healthy babies. Boston IVF provides comprehensive diagnosis, evaluation, consultation, and treatments for infertility and fertility preservation.
• To support service, educational and other projects undertaken by practitioners or institutions to improve cancer care
• To help Arlington residents with cancer meet immediate short-term needs related to the disease and its treatment
• Fund research on the prevention, treatment, or cure of cancer.

Lahey Hospital and Medical Center — Support Groups
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org

Lahey Hospital and Medical Center offer free support groups to provide emotional support, coping skills and resource access to patients and families dealing with a variety of diseases. Free groups at Lahey Hospital and Medical Center offer specific support for: Breast Cancer Group, Look Good, Feel Better (Women receiving radiation or chemotherapy), Lymphoma & Leukemia Support Group, Transplant Support Group(s), Urological & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Winchester Hospital—Support Groups
41 Highland Avenue
Winchester, MA 01890
781.729.9000
http://www.winchesterhospital.org

Winchester Hospital offers a variety of free support groups to help our patients and families. Learn more about our support groups for people considering weight loss surgery, parents who have lost a baby, breastfeeding mothers, people with diabetes, caregivers, and people with cancer.

Transportation Services

The Ride (MBTA)
https://www.mbta.com/accessibility/the-ride

The Ride is operated by the Massachusetts Bay Transportation Authority (MBTA) in compliance with the federal Americans with Disabilities Act (ADA).

The Ride is a paratransit service that provides door-to-door, shared-ride transportation to eligible people who cannot use fixed-route transit (bus, subway, trolley) all or some of the time because of a physical, cognitive or mental disability. Accessible vehicles are used to serve persons with disabilities, including those who use wheelchairs and scooters. THE RIDE operates 365 days a year generally from 5 am – 1 am in 58 cities and towns.

Veterans Services

Veterans’ Services Officer
730 Massachusetts Ave.
Arlington, MA 02476
781.316.3166
https://www.arlingtonma.gov/departments/health-human-services/veterans-services

The objective of the Arlington's Veterans' Services Officer is to provide assistance, support, and services to veterans and their dependents to access every local, state and federal V.A. benefit to which they are entitled.
Bedford
Access to Health Care

Lahey Hospital & Medical Center, Burlington
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org

Our Burlington location serves more than 3,000 patients per day through our 335-inpatient hospital beds, our ambulatory care center, 24-hour emergency department and American College of Surgeons verified Level I trauma center. You have access to a variety of specialists dedicated to compassionate care and service in one hospital.

Financial Counseling Assistance at Lahey Hospital & Medical Center, Burlington
781.744.8815
Lahey Hospital & Medical Center, Burlington provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

SHINE (Serving Health Information Needs of Everyone)
Bedford Council on Aging
12 Mudge Way
Bedford, MA 01730
781.275.6825
Counselors from Minuteman Senior Services will be available: Tuesdays & Wednesdays. Please call to make an appointment.

Bedford Board of Health
12 Mudge Way
Bedford, MA 01730
781.275.6507
https://www.bedfordma.gov/bedford-board-of-health
We are dedicated to serve all Bedford residents, particularly the under served, and to promote healthy people, healthy families, and a healthy environment through compassionate care, education, and prevention. The Board will create needed regulations, set policy, hold hearings, and consider variances. Our concern is helping neighbors lead healthy lives in Bedford.

Disabilities and Special Needs

Lowell Association for the Blind
169 Merrimack St, 2nd floor
Lowell MA, 01852
978.454.5704
http://www.lowellassociationfortheblind.org
Lowell Association for the Blind (LAB) is a non-profit, community based organization dedicated to working with the blind and visually impaired. LAB’s mission is to support, educate, and nurture the blind and visually impaired residents of the Greater Merrimack Valley by helping them enrich their lives and gain independence.

Riverside Family Support Center
300 West Cummings Park, Suite 354
Woburn, MA 01801
781.801.5247
http://riversidefamilysupport.org
Our Family Support Center offers a wide array of supports in the home and in the community for adults and children with disabilities living with their families. These services may include respite, recreational activities, provision of adaptive equipment, skill training, and intensive staff support when necessary. The Center is available to any family that has a member living in the home who is eligible for services through DDS and resides in the Central Middlesex area. Their service area includes: Arlington, Bedford, Burlington, Lexington, Wilmington, Winchester, and Woburn. However we welcome any individual who wants to participate in our clubs, classes or events.

The Edinburg Center
205 Burlington Road
Bedford, MA 01730
781.862.3600
http://www.edinburgcenter.org

Bedford Youth and Family Services
Town Center, 12 Mudge Way
Bedford, MA 01730
781.275.7727
https://www.bedfordma.gov/youth-family
Bedford Youth and Family Services offers counseling for children, adolescents, adults, and families, adult and youth information and referral, community education, substance abuse education, screening and diversion.
The Center’s mission is distinguished by our longstanding belief that all individuals have the potential to learn, the capacity for change and the right to live a meaningful life in the community of his or her choice. Our mission is to provide an array of innovative services which promote personal growth and independence, foster hope and enhance the quality of life of people with mental health conditions, co-occurring substance use conditions and/or developmental disabilities or brain injuries.

The Center maintains a specific commitment to providing services to persons whose complex and challenging needs have typically been barriers to successful community living.

Domestic Violence

REACH Beyond Domestic Violence
PO Box 540024
Waltham, MA 02454
781.891-0724
Hotline: 800.899.4000
https://reachma.org
REACH is a non-profit organization providing safety and support to survivors of abuse while engaging communities to promote healthy relationships and prevent domestic violence.

Food Assistance

Bedford Community Table/Pantry
Bedford Town Center
12 Mudge Way
Bedford, MA 01730
781.275-7355
http://www.bedfordfoodpantry.org
The Bedford Community Table/Pantry is staffed solely by volunteers, and funded by donations from individuals, corporations and other organizations. Each Thursday, volunteers prepare a complimentary community dinner for all at the Bedford Town Center on Mudge Way, and pack and hand out bags of groceries to area residents who need assistance. The pantry and the community dinner do not operate between Christmas and New Year’s, Thanksgiving, other holidays and Bedford Public Schools snow days. We offer community dinners only during the school year.

Supplemental Nutritional Assistance Program (SNAP)
https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap
SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

Housing and Homelessness

Bedford Housing Authority
1 Ashby Place
Bedford, MA 01730
781.275-2428
https://www.bedfordma.gov/bedford-housing-authority
The Authority shall provide affordable, subsidized rental housing for people of low income. Other responsibilities include the administration of various rental assistance programs.

Mental Health and Substance Abuse

Eliot Community Human Services
Corporate Office
125 Hartwell Avenue
Lexington, MA 0242
781.861.0890
Emergency Psychiatric Services (800) 988-1111
http://www.eliotchs.org
Eliot Community Human Services is a private, non-profit human services organization providing services for people of all ages throughout the Commonwealth of Massachusetts. The continuum of services includes diagnostic evaluation, twenty-four hour emergency services, and crisis stabilization, outpatient and court mandated substance abuse services, individual, group and family outpatient counseling, early intervention, specialized psychological testing, day, residential, social and vocational programs for individuals with mental illness and developmental disabilities, outreach and support services for the homeless, batterer intervention, and consultation.
Bedford Prevention Services
12 Mudge Way
Bedford, MA 01730
781.275.7727
https://www.bedfordma.gov/youth-family/pages/prevention-services
Prevention Services is a Town funded program of Youth & Family Services working in close collaboration with the School Department and the Bedford Police Department.

The focus of prevention services is on tobacco, alcohol, and drug awareness education for the children, youth and adults in Bedford. Educational resources are available for any Bedford resident.

Some of the services provided by the Prevention Services Coordinator include oversight of the biannual Youth Risk Behavior Survey, implementation of drug and alcohol education program for eligible youth, coordination of Substance Abuse Awareness month, and coordination of the Safe Homes program.

Elm Brook Place
4 A Street, 1st floor
Burlington, MA 01813
781.202.3478
http://www.elmbrookplace.org
Elm Brook Place serves Men and women age 18 or older with a history of mental illness who live within the communities of: Acton, Arlington, Bedford, Boxborough, Burlington, Carlisle, Concord, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester and Woburn. Elm Brook Place is committed to providing a welcoming, empowering community environment that promotes hope, recovery and independence for individuals with psychiatric disabilities. Central to this are opportunities for meaningful work, meaningful relationships, employment, education, affordable housing, health and wellness and entitlement assistance.

Senior Services
Bedford Council on Aging
12 Mudge Way
Bedford, MA 01730
781.275.6825
https://www.bedfordma.gov/council-on-aging
The mission of the Bedford Council on Aging is to promote the health and well being and to enhance the quality of life of residents aged 60 and over, their families and caregivers in an age-friendly Bedford. The Council on Aging offers educational and informational programs including exercise, fitness, social and health and wellness programs and services.

Minuteman Senior Services
26 Crosby Drive
Bedford, MA 01730
781.272-7177
888.222.6171 Toll Free
1-800-439-2370 TTY
https://www.minutemansenior.org
Minuteman Senior Services has been helping older and disabled adults age with independence and dignity in the setting of their choice which is most often their own homes and communities. We have been supporting caregivers, local and long distance, who want to do the right thing for their loved ones and need help and advice as they balance the competing demands of family, work and self.

We offer over 20 programs and services and are continually improving and expanding to serve you and your family in new and better ways.

Support Groups
Alanon/Alateen
75 Great Road
Bedford, MA 01730
Meetings are held at First Parish on the Common, side door, 2nd floor. Meetings occur on Tuesday evenings at 7:30 pm.

NAMI Family Support Group
The Edinburg Center, 205 Burlington Road
781.761.5287
Meetings are held the First and Third Tuesdays from 6:30pm—8:30pm
NAMI Family Support Group is a peer-led support group for family members, caregivers and loved ones of individuals living with mental illness. Groups generally meet on a monthly basis but may meet weekly. The hallmark of a NAMI support group is leveraging the collective knowledge and experience of the other participants.

Meets may occur monthly or weekly for 90-minute sessions free of charge. They are designed for loved ones (18 and over) of individuals living with mental illness. Group meetings are facilitated by a trained team of family members of individuals living with mental illness. All meetings are confidential and will not recommend or endorse any medications or other medical therapies for your family member.
Lahey Hospital and Medical Center –
Support Groups
41 Mall Road
Burlington, MA 01805
781.744-5100
www.lahey.org

Lahey Hospital and Medical Center offer free support groups to provide emotional support, coping skills and resource access to patients and families dealing with a variety of diseases.

Free groups at Lahey Hospital and Medical Center offer specific support for: Breast Cancer Group, Look Good, Feel Better (Women receiving radiation or chemotherapy), Lymphoma & Leukemia Support Group, Transplant Support Group(s), Urologic & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Transportation Services

Bedford Local Transit
Town Center Building, 12 Mudge Way
Bedford, MA 01730
781.275-2255
https://www.bedfordma.gov/council-on-aging/pages/bedford-local-transit

The Bedford Local Transit (BLT) serves as the Town of Bedford’s public transportation service. The BLT offers scheduled fixed runs to shopping malls and other stops in Bedford, Billerica, and Burlington, and also on-demand door-to-door service within Bedford. Anyone may ride the BLT. The BLT uses a wheelchair accessible van. The fare for adult riders (ages 18-64) is $2.00 each way in-town and $4.00 each way out of town. For Youth (under 18), Seniors and Medicare card holders the fare is $1.00 each way in-town and $2.00 each way out of town.

Veterans Services

Edith Nourse Rogers Memorial Veterans Hospital/Veterans Administration Hospital
200 Springs Road
Bedford, MA 01730
781.687-2000

Bedford VA is a long-term care facility specializing in geriatric and psychiatric care. Comprehensive health services include mental health, Primary care, psychiatry, Women's health services, dentistry, geriatrics and ambulatory care.

Veterans Center for Addiction Treatment
200 Springs Road
Bedford, MA 01730
781.687.2275

VCAT is a Chemical Dependency Rehabilitation Program with components addressing various stages of recovery. It is a treatment center that focuses on mental health and substance abuse services by providing substance abuse treatment, detoxification, and buprenorphine services. The programs offered are designed for persons with mental and substance abuse disorders, persons with HIV/AIDS, men, women, and seniors/older adults.

Mental Health Intensive Case Management Program (MHICM) - The MHICM is a program serving veterans with psychiatric disabilities who sometimes find it difficult to stay in the community. The veterans served sometimes also struggle with alcohol or drug problems. The mission of the program is to provide state of the art, community-based care and to empower people to live at their greatest potential in the community. Home visits and other treatments are provided by a multidisciplinary team.

Compensated Work Therapy (CWT) - Bedford VA has one of the largest CWT programs within VA. The program addresses the vocational needs of veterans through assessment, counseling and on-the-job training, while helping veterans plan for rehabilitation and recovery.

Veterans’ Services Officer
12 Mudge Way
Bedford, MA 01730
781.275-1328
https://www.bedfordma.gov/veterans-services

The Mission Statement is to support the veterans residing in our district by identifying veterans and their families in need of service and providing information and access to the services for which they are eligible under the law.
Billerica
Access to Health Care

Lahey Hospital & Medical Center, Burlington
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org

Our Burlington location serves more than 3,000 patients per day through our 335-inpatient hospital beds, our ambulatory care center, 24-hour emergency department and American College of Surgeons verified Level I trauma center. You have access to a variety of specialists dedicated to compassionate care and service in one hospital.

Financial Counseling Assistance at Lahey Hospital & Medical Center, Burlington
781.744.8815

Lahey Hospital & Medical Center, Burlington provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

SHINE (Serving Health Information Needs of Everyone)
Billerica Council on Aging
25 Concord Road
Billerica, MA 01821

The SHINE Program (Serving the Health Insurance Needs of Everyone) is a state health insurance assistance program that provides free information, insurance counseling and assistance to Massachusetts residents who have Medicare. SHINE Appointments are available twice a monthly on Thursdays. Call at 978-671-0916, ext 2010 for an appointment.

Billerica Board of Health
365 Boston Road Room G03
Billerica, MA 01821
978.671.0931
https://www.town.billerica.ma.us/169/Board-of-Health

The Board of Health is mandated through federal, state and local law to protect and promote the health and safety of the community.

Big Brother Big Sister of Greater Lowell
155 Merrimack Street
Lowell, MA 01852
978.459.0551
http://www.commteam.org/how-we-help/community-volunteering/big-brothers-big-sisters-of-greater-lowell

Big Brothers Big Sisters of Greater Lowell matches youth, ages 7-15 with caring, adult mentors to serve as another trusted adult and role model in the child’s life. Our vision is that all children achieve success in life. We strive to accomplish this by providing children facing adversity with strong, enduring, and professionally supported 1-to-1 relationships that change their lives for the better, forever. Big Brothers Big Sisters of Greater Lowell has two site-based programs at the Stoklosa Middle School in Lowell, MA, and the Dutile Elementary School in Billerica, MA.

Brigid’s Crossing – Merrimack Valley
Catholic Charities
221 Pawtucket Blvd
Lowell, MA 01854
978.454.0081
https://www.ccab.org/location-merrimack

Brigid’s Crossing serves young mothers and helps them to learn the value of responsibility and independence while helping them to achieve their goals. All of our shelters are staffed by trained men and women who help guide each resident through their path to self-sufficiency and independent living. Most residents are referred through the DHCD Emergency Shelter program.

Community Teamwork Inc.
Administration
155 Merrimack Street
Lowell, Ma 01852
978.459.0551
Resource Center
17 Kirk St.
Lowell, MA 01852
978.459.0551
http://www.commteam.org

Child and Family Services: 978.454.5100

Energy and Community Resources: 978.459.6161

Housing and Homelessness Center: 978.459.0551

Community Teamwork Inc. offers an extensive range of services and programs that assist with family and children, finances, education and job training, food and nutrition, and housing and utilities.
Our mission at TFI is to use culturally-sensitive, trauma-informed therapeutic model to deliver treatment that uniquely meets the needs of each individual, each family that we serve, in an effort to enable them manage and where possible overcome their mental health challenges and live fully. We have an experienced, dedicated, culturally diverse team of clinicians who speak English, Spanish, Portuguese, Korean, Amharic, among other languages.

Grandparents as Parents – Merrimack Valley Catholic Charities
70 Lawrence Street
Lowell, MA 01852
978.452.1421
https://www.ccab.org

The Grandparents as Parents (GAP) program reaches out to those raising a second family, often their grandchildren, during a time when they were expecting to experience retirement. There is a confidential help line with access to information and referrals, group support, and informational workshops and seminars.

The Parent Aide Program – Merrimack Valley Catholic Charities
70 Lawrence Street
Lowell, MA 01852
978.452.1421
https://www.ccab.org

Catholic Charities Parent Aide Program provides home visits from a parenting mentor to families involved with the Department of Children & Families. The program provides support to parents through the development of nurturing relationships geared to improve parental self-esteem and insure a safe home environment for their children.

Women, Infants, and Children (WIC)
45 Kirk St
Lowell, MA 01852
978.454 6397
https://www.mass.gov/women-infants-children-wic-nutrition-program

WIC stands for Women, Infants, and Children and is also called the Special Supplemental Nutrition Program. WIC is a federal program designed to provide food to low-income pregnant, postpartum and breastfeeding women, infants and children until the age of five. The program provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals for health care. WIC has proven effective in preventing and improving nutrition related health problems within its population.

Thom Anne Sullivan Center
126 Phoenix Ave
Lowell, MA 01852
978.453.8331
http://www.thomchild.org/locations/lowell-anne-sullivan-center/

Thom Anne Sullivan Center is committed to providing high quality, comprehensive, and family-centered early intervention services to infants, toddlers, their families, and others in the community who care for them. Our nurses, social workers, occupational and physical therapists, speech-language pathologists, mental health counselors, educators, and other specialists are passionate about supporting families and young children.

YMCA of Greater Lowell
35 YMCA Drive
Lowell, MA 01852
978.454.7825
http://greaterlowellymca.org

YMCAs offer a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities. They also offer child care opportunities and after-school programs.

Billerica Boys & Girls Club
19 Campbell Road
Billerica, MA 01821
978.667.2193
https://www.billericabgc.com

The Boys & Girls Club of Greater Billerica was established to provide our youth with a place to gather constructively both afterschool and in the summer.

Every day Boys & Girls Clubs inspire their members. Whether encouraging young people to complete their homework, play sports or recreational activities, enter an art competition or have a healthy snack, Club staff know the important role they play in creating the wholesome environment kids need. Club programs and services promote and enhance the development of boys and girls by instilling a sense of competence, usefulness, belonging and influence.
Disabilities and Special Needs

Lowell Association for the Blind
169 Merrimack St, 2nd floor
Lowell MA, 01852
978.454.5704
http://www.lowellassociationfortheblind.org

Lowell Association for the Blind (LAB) is a non-profit, community based organization dedicated to working with the blind and visually impaired. LAB’s mission is to support, educate, and nurture the blind and visually impaired residents of the Greater Merrimack Valley by helping them enrich their lives and gain independence.

Tutoring and Beyond
10 Greenmeadow Drive
Billerica, MA 01862
978.663.7841

Tutoring and Beyond provides educational services to children and adults. Areas of focus include: mental health, Autism Spectrum Disorder, Complex Health Care Needs, Neurological Conditions, Sensory Disabilities, Intellectual Disabilities, Traumatic Brain Injuries, general education, and ADD/ADHD.

Domestic Violence

REACH Beyond Domestic Violence
PO Box 540024
Waltham, MA 02454
781.891.0724
Hotline: 800.899.4000
https://reachma.org

REACH is a non-profit organization providing safety and support to survivors of abuse while engaging communities to promote healthy relationships and prevent domestic violence.

Food Assistance

Billerica Food Pantry
70 Concord Road
Billerica, MA 01821

Supplemental Nutritional Assistance Program (SNAP)

https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

Housing and Homelessness

Billerica Housing Authority
16 River Street
Billerica, MA 01821
978.667.2175

The Billerica Housing Authority was established in 1963 by the Commonwealth of Massachusetts to provide safe, decent and affordable housing opportunities in the town of Billerica and remains committed to this mission. BHA currently administers state and federal housing programs totaling 270 units and is constantly seeking ways to increase housing opportunities.

Mental Health and Substance Abuse

Eliot Community Human Services
Corporate Office
125 Hartwell Avenue
Lexington, MA 0242
781.861.0890
Emergency Psychiatric Services (800) 988-1111
http://www.eliotchs.org

The Billerica Community Pantry, Inc. is a charitable organization that was formed by the Billerica Interfaith Association in response to a need in the Billerica community. Due to current space limitations, the Billerica Community Pantry will operate a “just in time” pantry. Food will come in one day and be given out the next. Distribution will be at 70 Concord Road from 2—6 pm on Tuesdays.
Arbour Health System – Counseling Services Programs

10 Bridge Street
Lowell, MA 01852
978.453.5736
https://arbourhealth.com/

AHS/CSP clinicians work directly with clients, their families, and treatment teams to provide therapy and individual treatment plans that reflect consistent goals and coordination of care.

The Lowell facility provides individual, couple, family, and group counseling starting at age 5 as well as psychiatric services. Counselors provide support through the coordination of services and referrals to meet the needs/goals of the patient. Areas of specialized support include: Child and Adolescent Therapy, ADD/ADHD support, School-based Services, Women’s Issues, Multicultural Issues, Dual Diagnosis, Psychopharmacology, and PDD/Asperger’s. Groups available include; Coping Skills, Spanish Speaking women’s and men’s groups, Boys Group, Anxiety Reduction, Social Skills, and Parenting. Languages spoken include Greek, Khmer, Russian, and Spanish.

Habit OPCO

650 Suffolk Street
Lowell, MA 01852
978.452.5155

Habit OPCO is a treatment center that focuses on substance abuse by providing substance abuse treatment, detoxification, methadone maintenance, methadone detoxification, and buprenorphine services. The programs offered are specifically designed for pregnant/postpartum women.

Lowell Emergency Psychiatric Care & Mobile Crisis Team

391 Varnum Avenue
Lowell, MA 01854
978.455.3397
800.830.5177
http://www.nebhealth.org

The Community Crisis Stabilization (CCS) Program is a six-bed program for adults (18+) who have MassHealth, Medicare, or who are uninsured. The typical length of stay is 3-5 days. The team provides emergency psychiatric assessments and supportive services in a variety of settings, including homes, schools, outpatient clinics and hospitals. The team also provides ongoing crisis counseling services until the client can be connected to ongoing providers. Open 7 days/week. Mobile Crisis Intervention (MassHealth children and adolescents under 21 years old) The 24/7 Mobile Crisis Team works with youth and their families with serious emotional disturbances, plus up to seven days of ongoing crisis counseling, support and stabilization.

Greater Lowell Health Alliance

295 Varnum Ave.
Lowell, MA 01854
978.934.8368
https://www.greaterlowellhealthalliance.org

The Greater Lowell Health Alliance brings together healthcare providers, business leaders, educators, and civic and community leaders with a common goal to improve the overall health of our communities.

Senior Services

Billerica Council on Aging

25 Concord Road
Billerica, MA 01821
978.671.0916
https://www.town.billerica.ma.us/136/Council-on-Aging

The Billerica Council on Aging is the primary resource for aging services in the town.
Benchmark Senior Living at Billerica Crossings
20 Charnstaffe Lane
Billerica, MA 01821
978.451.7070

Benchmark Senior Living at Billerica Crossings in Billerica, MA is an assisted living community choice for older adults who value their independence but need assistance with daily life activities. If you or your loved one needs help with medication management, bathing, dressing, or transportation

Benchmark Senior Living at Billerica Crossings is also a memory care community designed to fit the needs of residents with Alzheimer’s, memory loss, or other forms of dementia. The Mind & Memory approach celebrates the spirit and supports the capabilities of your loved one through individualized and group activities that encourage creativity and self-expression.

Brightview Senior Living
199 Concord Road
Billerica, MA 01821
978.874.3212
https://www.brightviewseniorliving.com/find-a-community/brightview-concord-river

Brightview Concord River in Billerica, Massachusetts specializes in creating a fulfilling life for our Assisted Living and Memory Care residents. Whether you need help with mobility, managing medications, or memory care, we can work with you and your family to develop a personalized plan that will enrich your life and help you live it to the fullest.

Minuteman Senior Services
26 Crosby Drive
Bedford, MA 01730
781.272-7177
888.222.6171 Toll Free
1-800-439-2370 TTY
https://www.minutemansenior.org

Minuteman Senior Services has been helping older and disabled adults age with independence and dignity in the setting of their choice which is most often their own homes and communities. We have been supporting caregivers, local and long distance, who want to do the right thing for their loved ones and need help and advice as they balance the competing demands of family, work and self. We offer over 20 programs and services and are continually improving and expanding to serve you and your family in new and better ways.

Minuteman Senior Services has been helping older and disabled adults age with independence and dignity in the setting of their choice which is most often their own homes and communities. We have been supporting caregivers, local and long distance, who want to do the right thing for their loved ones and need help and advice as they balance the competing demands of family, work and self. We offer over 20 programs and services and are continually improving and expanding to serve you and your family in new and better ways.

Sexual Health

Billerica Medical Health Center
221 Boston Road, Suite 4
North Billerica, MA 01862
978.670.1300
http://billericamedical.com

Billerica Medical Health Center offers a wide range of in-house services, procedures and tests. At BMHC, we expanded our clinical offerings to meet the changing needs of a growing patient population and distinguished this practice as a leading primary care provider in the Merrimack Valley. We believe that the best way to practice medicine is to combine state-of-the-art knowledge of issues affecting health care with personalized and innovative treatments.

Lowell Community Health Center
OB/Family Planning
161 Jackson Street,
Lowell, MA 01852
978.446.0236
http://www.lchealth.org

Lowell Community Health Center offers full services of Prenatal/Postpartum and GYN care. We have Health Educators to educate patients and the community on reproductive health and wellness as well as assist patients with finding health services. They also provide quality, affordable and confidential reproductive health care services for both male and female adults and adolescents. Teens receive confidential services, and parental consent is not needed.

Additional Services Include: Birth control information and services, Childbirth education, Referrals to support services, such as WIC, Gynecological/cervical cancer screenings and gynecological surgeries, HIV counseling and testing, Testing and treatment of STDs (sexually transmitted diseases), Testing and treatment of urinary tract infections, abnormal pap smears and breast exams.
Support Groups

Alanon/Alateen
Meetings are held at St. Ann’s Episcopal Parish Hall on
Monday evenings at 7:30 pm.
14 Treble Cove Rd.
North Billerica, MA 01862

Narcotics Anonymous
Meetings are held at St. Mary’s Church on Thursday evenings
at 7 pm.
796 Boston Road, Basement
Billerica, MA 01821

Lahey Hospital and Medical Center –
Support Groups
Lahey Hospital and Medical Center
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org
Lahey Hospital and Medical Center offer free support groups
to provide emotional support, coping skills and resource
assess to patients and families dealing with a variety of
diseases.
Free groups at Lahey Hospital and Medical Center offer
specific support for: Breast Cancer Group, Head and Neck
Cancer Support Group, Look Good, Feel Better (Women
receiving radiation or chemotherapy), Lymphoma &
Leukemia Support Group, Gynecologic Cancer Group,
Transplant Support Group(s), Urological & Prostate Cancer
Support Group, and a Quit Smoking for Life Group.

Transportation Services

MBTA Commuter Rail Service
Lowell Line stops in Lowell, North Billerica, Wilmington,
Woburn, Winchester, and Medford.

Billerica Council on Aging
25 Concord Road
Billerica, MA 01821
978.671.0916, ext 2003
https://www.town.billerica.ma.us/136/Council-
on-Aging
The Billerica Council on Aging is the primary resource
for aging services in the town. They have numerous
transportation options available.

Veterans Services

Billerica Veterans Services Center
365 Boston Road, #201
Billerica, MA 01821
978.671.0968
https://www.town.billerica.ma.us/166/Veterans-Services
The objective of the is Billerica Veterans Services Center to provide
assistance, support, and services to veterans and their dependents to
access every local, state and federal V.A. benefit to which they are
entitled.
Burlington
Access to Health Care

Lahey Hospital & Medical Center, Burlington
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org

Our Burlington location serves more than 3,000 patients per day through our 335-inpatient hospital beds, our ambulatory care center, 24-hour emergency department and American College of Surgeons verified Level I trauma center. You have access to a variety of specialists dedicated to compassionate care and service in one hospital.

Financial Counseling Assistance at Lahey Hospital & Medical Center, Burlington
781.744.8815

Lahey Hospital & Medical Center, Burlington provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

SHINE (Serving Health Information Needs of Everyone)

Burlington Council on Aging
61 Center Street
Burlington, MA 01803
781.270.1950

SHINE counselors are available on Tuesday and Wednesday afternoons by appointment.

Burlington Youth and Family Services
33 Center Street, 2nd Floor
Burlington, MA 01803
781.270.1961
http://www.burlington.org/residents/community_life_center/index.php

Burlington Youth and Family Services (BYFS) has as its goal and mandate to provide a range of services designed to improve the quality of life for Burlington families with children, adolescents and young adults. In addition, BYFS, as one of the Town agencies that handles human services problems, endeavors to collect and provide information useful to all townpeople about available local and area nonprofit and social service resources.

Burlington Board of Health
61 Center Street
Burlington, MA 01803
781.270.1955

The mission of the Burlington Board of Health is to protect, promote, and prepare for all public health issues or potential crises that occur within the community. The Board of Health enforces state-mandated and local public health regulations, conducts inspections as mandated, issues town permits, investigates community-based complaints or concerns, and supports the goals of public health by providing education and community programs.

Child, Parent and Family Support

Thom Mystic Valley Early Intervention
10 J. Gill Street
Woburn, MA 01801
781.932.2888
www.thomchild.org

Thom Mystic Valley is committed to providing high quality, comprehensive, and family-centered early intervention services to infants, toddlers, their families, and others in the community who care for them. Nurses, social workers, occupational and physical therapists, speech-language pathologists, mental health counselors, educators, and other specialists are passionate about supporting families and young children.

Thom Mystic Valley Early Intervention is a program for children ages birth to three years who are delayed in their development. Services include evaluations, speech therapy, physical therapy, occupational therapy, developmental play therapy, family support.

Disabilities and Special Needs

Communitas Burlington
Day Hab and Career Services
2 Ray Avenue
Burlington, MA 01803
781.365.1350
https://communitasma.org
Communitas has three Day Programs located in Wakefield, Burlington and Beverly. Each Program offers a wide spectrum of service models geared towards individuals with Developmental & Intellectual disabilities. Each of these three programs support participants by using a person centered approach in its day to day operations and works in creative ways to teach skills that are both meaningful to everyday living and promotes independence.

Kindle Behavior Consultants
7 Cypress Drive
Burlington, MA 01803
781.328.0951
http://www.kindlebehavior.com
Kindle Behavior Consultants offers quality behavioral services to children with Autism Spectrum Disorders (ASD) and other related disabilities. We offer 1:1 ABA therapy, social skills groups, individual assessments, parent training, school consultation, family assistance, workshops, IEP (Individualized Education Plan) development and more.

Riverside Family Support Center
300 West Cummings Park, Suite 354
Woburn, MA 01801
781.801.5247
http://riversidefamilysupport.org
Our Family Support Center offers a wide array of supports in the home and in the community for adults and children with disabilities living with their families. These services may include respite, recreational activities, provision of adaptive equipment, skill training, and intensive staff support when necessary. The Center is available to any family that has a member living in the home who is eligible for services through DDS and resides in the Central Middlesex area. Their service area includes: Arlington, Bedford, Burlington, Lexington, Wilmington, Winchester, and Woburn. However we welcome any individual who wants to participate in our clubs, classes or events.

REACH is a non-profit organization providing safety and support to survivors of abuse while engaging communities to promote healthy relationships and prevent domestic violence.

Saheli
11 Bedford Street
Burlington, MA 01803
1.866.4SAHELI - (1.866.472.4354)
https://saheliboston.org
Saheli, a community-based organization with the mission to empower South Asian women and their families to live safe and healthy lives. Saheli is uniquely focused on the needs of South Asians (from Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka). Saheli staff and volunteers speak several South Asian languages, including Hindi, Urdu, Bengali, Gujarati, Punjabi and others.

We offer survivors of domestic violence a variety of free services. We support people of many religions, ethnicity, age, gender or sexual orientation. Our popular community programs serve immigrants and families from all over the world and include financial aid to manage a domestic violence incident, funds to develop workplace skills, free computer and financial literacy classes, free counseling from two licensed counselors and social workers. This is a small community and we understand the need for privacy and confidentiality.

Food Assistance
Burlington Food Pantry
10 St. Marks Road
Burlington, MA 01803
781.270.6625
https://peoplehelpingpeopleinc.org
The Burlington Food Pantry is located on the grounds of St. Mark’s Episcopal Church in Burlington and offers food assistance to the residents of Burlington.

Supplemental Nutritional Assistance Program (SNAP)
https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap
SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

Housing and Homelessness

Burlington Housing Authority
15 Birchcrest St
Burlington, MA 01803
781.272.7786
http://www.burlington.org/residents/housing_authority.php

The Housing Authority is authorized to manage the construction, financing, maintenance, and rental policies of low-cost housing for low-income families and the elderly.

Mental Health and Substance Abuse

Eliot Community Human Services
Corporate Office
125 Hartwell Avenue
Lexington, MA 0242
781.861.0890
Emergency Psychiatric Services (800) 988-1111
http://www.eliotchs.org/

Eliot Community Human Services is a private, non-profit human services organization providing services for people of all ages throughout the Commonwealth of Massachusetts. The continuum of services includes diagnostic evaluation, twenty-four hour emergency services, and crisis stabilization, outpatient and court mandated substance abuse services, individual, group and family outpatient counseling, early intervention, specialized psychological testing, day, residential, social and vocational programs for individuals with mental illness and developmental disabilities, outreach and support services for the homeless, batterer intervention, and consultation.

Elm Brook Place
4 A Street, 1st floor
Burlington, MA 01813
781.202.3478
http://www.elmbrookplace.org

Elm Brook Place serves Men and women age 18 or older with a history of mental illness who live within the communities of: Acton, Arlington, Bedford, Boxborough, Burlington, Carlisle, Concord, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester and Woburn. Elm Brook Place is committed to providing a welcoming, empowering community environment that promotes hope, recovery and independence for individuals with psychiatric disabilities. Central to this are opportunities for meaningful work, meaningful relationships, employment, education, affordable housing, health and wellness and entitlement assistance.

Senior Services

Burlington Council on Aging
61 Center Street
Burlington, MA 01803
781.270.1950
http://www.burlington.org/residents/council_on_aging/index.php

In addition to daily opportunities for social interaction, the senior center offers exercise classes, billiards, cards, board games, low-cost lunch, educational lectures, social outings to community and cultural events, social service information and assistance, financial assistance, transportation services, and health and wellness programs.

Sunrise of Burlington
24 Mall Road
Burlington, MA 01803
781.229.8100
https://www.sunriseseniorliving.com

Sunshine of Burlington is located across the street from Lahey Clinic of Burlington and offers a beautiful senior living community. Like all Sunrise communities, this home is specifically designed for seniors and their unique needs, featuring wheelchair-accessible suites and common rooms, showers modified to fit all different assistance devices and hallways with assistance handrails. The walls in our suites are specially painted to help vision-impaired residents see appliances and other amenities with more clarity. Sunrise of Burlington offers a diverse and professional team with years of experience.
Burlington Public Transit Line B is a local bus service that will take anyone where they need to go in Burlington. There are two buses that each accommodate twenty passengers, with standing room for five passengers and accessibility for two wheelchairs. Burlington Public Transit connects with the MBA, LRTA, Lexpress and Bedford Transit. The buses do not run on Saturdays, Sundays or holidays.

Veterans Services

Veterans Services

Burlington Office of Veterans Services
61 Center Street, Room 203
Burlington, MA
781.270.1959
http://www.burlington.org/community_development/veterans_services.php

The Burlington Office of Veterans Services provides assistance and/or guidelines for local veterans regarding VA medical, employment possibilities, rehabilitation through various programs, including the State and Federal Outreach Centers. We welcome veterans and families of veterans seeking veterans’ benefits, counseling or advice on many issues. This office also coordinates Memorial Day and Veterans Day events.
Lexington
Access to Health Care

Lahey Hospital & Medical Center, Burlington
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org

Our Burlington location serves more than 3,000 patients per day through our 335-inpatient hospital beds, our ambulatory care center, 24-hour emergency department and American College of Surgeons verified Level I trauma center. You have access to a variety of specialists dedicated to compassionate care and service in one hospital.

Financial Counseling Assistance at Lahey Hospital & Medical Center, Burlington
781.744.8815

Lahey Hospital & Medical Center, Burlington provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

SHINE (Serving Health Information Needs of Everyone)
Community Center
39 Marrett Road
Lexington MA 02421
781.698.4840

The SHINE Program provides free health insurance information, counseling, and assistance to Massachusetts residents with Medicare and their caregivers and is administered by the Massachusetts Executive Office of Elder Affairs in partnership with Minuteman Senior Services and is partially funded by Centers of Medicare and Medicaid Services. Call 781-698-4840 to make an appointment.

Lexington Public Health Dept
1625 Massachusetts Ave
Lexington 02420
781.698.4533
https://www.lexingtonma.gov/public-health

Under the direction of the Lexington Board of Health, the mission of the Lexington Office of Public Health is to prevent disease and promote wellness in order to protect and improve the health and quality of life of its residents, visitors and work force.

Child, Parent and Family Support

Thom Mystic Valley Early Intervention
10P Gill Street
Woburn, MA 01801
781.932.2888
www.thomchild.org

Thom Mystic Valley is committed to providing high quality, comprehensive, and family-centered early intervention services to infants, toddlers, their families, and others in the community who care for them. Nurses, social workers, occupational and physical therapists, speech-language pathologists, mental health counselors, educators, and other specialists are passionate about supporting families and young children.

Disabilities and Special Needs

The Edinburg Center
205 Burlington Road
Bedford, MA 01730
781.862.3600
http://www.edinburgcenter.org

The Center’s mission is distinguished by our longstanding belief that all individuals have the potential to learn, the capacity for change and the right to live a meaningful life in the community of his or her choice. Our mission is to provide an array of innovative services which promote personal growth and independence, foster hope and enhance the quality of life of people with mental health conditions, co-occurring substance use conditions and/or developmental disabilities or brain injuries. The Center maintains a specific commitment to providing services to persons whose complex and challenging needs have typically been barriers to successful community living.

Riverside Family Support Center
300 West Cummings Park, Suite 354
Woburn, MA 01801
781.801.5247
http://riversidefamilysupport.org

Our Family Support Center offers a wide array of supports in the home and in the community for adults and children with disabilities living with their families. These services may include respite,
recreational activities, provision of adaptive equipment, skill training, and intensive staff support when necessary. The Center is available to any family that has a member living in the home who is eligible for services through DDS and resides in the Central Middlesex area. Their service area includes: Arlington, Bedford, Burlington, Lexington, Wilmington, Winchester, and Woburn. However we welcome any individual who wants to participate in our clubs, classes or events.

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**Domestic Violence**

**REACH Beyond Domestic Violence**  
PO Box 540024  
Waltham, MA 02454  
781.891.0724  
Hotline: 800.899.4000  
https://reachma.org  

REACH is a non-profit organization providing safety and support to survivors of abuse while engaging communities to promote healthy relationships and prevent domestic violence.

**Saheli**  
11 Bedford Street  
Burlington, MA 01803  
1.866.4SAHELI -(1.866.472.4354)  
https://saheliboston.org  

Saheli, a community-based organization with the mission to empower South Asian women and their families to live safe and healthy lives. Saheli is uniquely focused on the needs of South Asians (from Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka). Saheli staff and volunteers speak several South Asian languages, including Hindi, Urdu, Bengali, Gujarati, Punjabi and others.

We offer survivors of domestic violence a variety of free services. We support people of many religions, ethnicity, age, gender or sexual orientation. Our popular community programs serve immigrants and families from all over the world and include financial aid to manage a domestic violence incident, funds to develop workplace skills, free computer and financial literacy classes, free counseling from two licensed counselors and social workers. This is a small community and we understand the need for privacy and confidentiality.

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**Food Assistance**

**Lexington Interfaith Food Pantry**  
Church of Our Redeemer  
6 Meriam Street  
Lexington, MA 02420  
781.861.5060  
https://lexingtonfoodpantry.wordpress.com  

Anyone desiring to receive food assistance must present a letter of need from a social worker, stating that there is a need for food assistance and the number of adults and children in the family.

Currently new clients are being accepted from Lexington and two bordering communities, Lincoln and Winchester, which do not have their own pantries. Lexington residents may shop weekly, while residents of other towns may shop only one Saturday per month.

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**Supplemental Nutritional Assistance Program (SNAP)**  
https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap  

SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

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**Housing and Homelessness**

**Lexington Housing Authority**  
One Countryside Village  
Lexington, MA 02420  
781.861.0900  
http://www.lexingtonhousing.org  

The Lexington Housing Authority provides housing assistance to low income residents through the management of programs such as Low Rent Public Housing and the Housing Choice Voucher Program – Section 8. These programs are income based and the eligibility guidelines are set by HUD.
Activities for citizens 60 years of age and older and those with disabilities, can be found at the new Community Center at 39 Marrett Road. Activities at the Senior Center are supported by the Council on Aging Board, appointed by the Town Manager, and the Friends of the Council on Aging, a group who raises funds and provides other support to the organization. A list of activities can be found in our newsletter, published every other month and mailed to all residents 65 and older.

**Minuteman Senior Services**

- 26 Crosby Drive  
  Bedford, MA 01730  
  781.272-7177  
  888.222.6171 Toll Free  
  1-800-439-2370 TTY  
  [https://www.minutemansenior.org](https://www.minutemansenior.org)

Minuteman Senior Services has been helping older and disabled adults age with independence and dignity in the setting of their choice which is most often their own homes and communities. We have been supporting caregivers, local and long distance, who want to do the right thing for their loved ones and need help and advice as they balance the competing demands of family, work and self. We offer over 20 programs and services and are continually improving and expanding to serve you and your family in new and better ways.

**LYFS (Lexington Youth and Family Services)**

- First Parish Church (private entrance on right side of church)  
  7 Harrington Road  
  Lexington, MA 02421  
  781-862-0330  
  [https://www.lyfsinc.org](https://www.lyfsinc.org)

LYFS (Lexington Youth and Family Services) mission is to “strengthen the safety net” for Lexington teens and their families by providing walk-in, accessible crisis counseling services for Lexington teens who are suicidal or self-destructive. LYFS began as a drop in crisis counseling center in Lexington Center in the First Parish Church on the Battle Green. LYFS is open from 1-6 pm on Wednesdays and Fridays. If you don’t have an appointment, please use our drop-in hours, which are from 2:30 - 4:00 pm on Wednesdays and Fridays. We are a resource for Lexington teens who are struggling, feeling stressed, anxious, depressed or just need a place to talk and get support.

**Sexual Health**

**Boston IVF**

- 450 Bedford Street  
  Suite 1000  
  Lexington, MA 02421  
  800.858.4832  
  [https://www.bostonivf.com](https://www.bostonivf.com)
Support Groups

Alanon/Alateen
Meetings are held at St. Brigid’s Parish Center, 1997 Massachusetts Ave, Room 21 on Wednesday mornings at 10:00 AM.
2001 Massachusetts Ave
Lexington, MA 02421

Lahey Hospital and Medical Center – Support Groups
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org
Lahey Hospital and Medical Center offer free support groups to provide emotional support, coping skills and resource assessment to patients and families dealing with a variety of diseases.

Free groups at Lahey Hospital and Medical Center offer specific support for: Breast Cancer Group, Look Good, Feel Better (Women receiving radiation or chemotherapy), Lymphoma & Leukemia Support Group, Transplant Support Group(s), Urological & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Winchester Hospital—Support Groups
41 Highland Avenue
Winchester, MA 01890
781.729.9000
http://www.winchesterhospital.org
Winchester Hospital offers a variety of free support groups to help our patients and families. Learn more about our support groups for people considering weight loss surgery, parents who have lost a baby, breastfeeding mothers, people with diabetes, caregivers, and people with cancer.

NAMI Family Support Group
The Edinburg Center
205 Burlington Road
Bedford, MA 01730

Transportation Services

Lexpress
Community Center
39 Marrett Road
Lexington, MA 024201
781.861.1210
transportation@lexingtonma.gov
Lexpress runs Monday through Friday from 6:35 am – 6:30 pm during the school year, and from 7:00 am – 6:30 pm during July and August. The Town of Lexington Transportation Services Division oversees Lexpress operations. The Division is part of the Human Services Department.

Veterans Services

Veterans’ Services Officer
Community Center
39 Marrett Road
Lexington, MA 02421
781.698.4848
https://www.lexingtonma.gov/veterans-services
The objective of the Veterans’ Services Officer to provide assistance, support, and services to veterans and their dependents to access every local, state and federal V.A. benefit to which they are entitled.
Lowell
Access to Health Care

Lahey Hospital & Medical Center, Burlington
41 Mall Road
Burlington, MA 01805
781.744.5100
www.lahey.org

Our Burlington location serves more than 3,000 patients per day through our 335-inpatient hospital beds, our ambulatory care center, 24-hour emergency department and American College of Surgeons verified Level I trauma center. You have access to a variety of specialists dedicated to compassionate care and service in one hospital.

Financial Counseling Assistance at Lahey Hospital & Medical Center, Burlington
781.744.8815
Lahey Hospital & Medical Center, Burlington provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

Lowell Community Health Center
161 Jackson Street
Lowell, MA 01852
978.937.9700
http://www.lchealth.org
Lowell Community Health Center provides access to high quality, affordable health care to children and adults of all ages – regardless of their ability to pay. The Health Center has many specialty services in addition to comprehensive primary health care. Health Center patients may choose a primary care physician, nurse practitioner or certified nurse midwife from our team of more than 40 board certified medical providers. Behavioral health services are integrated into the care provided at the Health Center. Patients are able to schedule visits with certified mental health professionals working at the Health Center. Employees speak 28 different languages, and at least 40 staff are trained medical interpreters.

SHINE (Serving Health Information Needs of Everyone) Program
Lowell Senior Center
276 Broadway Street
Lowell, MA 01854
978.674.4131

SHINE councilor is available Mondays from 8:30-10:30 AM

Lowell Health Department
341 Pine Street
Lowell, MA 01852
978.674.4010
http://www.lowellma.gov/275/Health
Our mission is to preserve, maintain and advance the City’s public health standards. The Health Department strives to promote and protect the health and wellness of the people within Lowell: residents, workers and visitors.

Child, Parent and Family Support

Big Brother Big Sister of Greater Lowell
155 Merrimack Street
Lowell, MA 01852
978.459.0551
http://www.commteam.org/how-we-help/community-volunteering/big-brothers-big-sisters-of-greater-lowell

Big Brothers Big Sisters of Greater Lowell matches youth, ages 7-15 with caring, adult mentors to serve as another trusted adult and role model in the child’s life. Our vision is that all children achieve success in life. We strive to accomplish this by providing children facing adversity with strong, enduring, and professionally supported 1-to-1 relationships that change their lives for the better, forever. Big Brothers Big Sisters of Greater Lowell has two site-based programs at the Stoklosa Middle School in Lowell, MA, and the Dutile Elementary School in Billerica, MA.

Brigid’s Crossing – Merrimack Valley Catholic Charities
221 Pawtucket Blvd
Lowell, MA 01854
978.454.0081
https://www.ccab.org/location-merrimack
Brigid’s Crossing serves young mothers and helps them to learn the value of responsibility and independence while helping them to achieve their goals. All of our shelters are staffed by trained men and women who help guide each resident through their path to self-sufficiency and independent living. Most residents are referred through the DHCD Emergency Shelter program.
Community Teamwork Inc.

Administration
155 Merrimack Street
Lowell, MA 01852
978.459.0551

Resource Center
17 Kirk St.
Lowell, MA 01852
978.459.0551

http://www.commteam.org

Child and Family Services: 978.454.5100

Energy and Community Resources: 978.459.6161

Housing and Homelessness Center: 978.459.0551

Community Teamwork Inc. offers an extensive range of services and programs that assist with family and children, finances, education and job training, food and nutrition, and housing and utilities.

Trauma & Family Integration (TFI), LLC

144 Merrimack Street, Ste 302
Lowell, MA 01852
978.677.7823

https://www.tfilowell.com

Our mission at TFI is to use culturally-sensitive, trauma-informed therapeutic model to deliver treatment that uniquely meets the needs of each individual, each family that we serve, in an effort to enable them manage and where possible overcome their mental health challenges and live fully. We have an experienced, dedicated, culturally diverse team of clinicians who speak English, Spanish, Portuguese, Korean, Amharic, among other languages.

Grandparents as Parents – Merrimack Valley Catholic Charities

70 Lawrence Street
Lowell, MA 01852
978.452.1421

https://www.ccab.org

The Grandparents as Parents (GAP) program reaches out to those raising a second family, often their grandchildren, during a time when they were expecting to experience retirement. There is a confidential help line with access to information and referrals, group support, and informational workshops and seminars.

Massachusetts Society for the Prevention of Cruelty to Children is a private, non-profit society dedicated to leadership in protecting and promoting the rights and well-being of children and families. Services are provided both in the home and through community-based locations across the state of Massachusetts.

The Parent Aide Program – Merrimack Valley Catholic Charities

70 Lawrence Street
Lowell, MA 01852
978.452.1421

https://www.ccab.org

Catholic Charities Parent Aide Program provides home visits from a parenting mentor to families involved with the Department of Children & Families. The program provides support to parents through the development of nurturing relationships geared to improve parental self-esteem and insure a safe home environment for their children.

United Teen Equality Center, Inc.

35 Warren St
Lowell, MA 01852
978.441.9949

https://utecinc.org

UTEC's mission and promise is to ignite and nurture the ambition of our most disconnected young people to trade violence and poverty for social and economic success. We are now serve older youth, ages 17-25.

Women, Infants, and Children (WIC)

45 Kirk St
Lowell, MA 01852
978.454.6397

https://www.mass.gov/women-infants-children-wic-nutrition-program

WIC stands for Women, Infants, and Children and is also called the Special Supplemental Nutrition Program. WIC is a federal program designed to provide food to low-income pregnant, postpartum and breastfeeding women, infants and children until the age of five. The program provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals for health care. WIC has proven effective in preventing and improving nutrition related health problems within its population.

Thom Anne Sullivan Center

126 Phoenix Ave
Lowell, MA 01852
978.453.8331

http://www.thomchild.org/locations/lowell-anne-sullivan-center/
The mission of Alternative House is to facilitate the creation of a society in which violence against women will no longer exist. As a means to this end, we offer shelter, support, options, counseling, and legal advocacy for all battered women (and their children) who seek our help.

**Milly’s Place**
360 Pawtucket Street  
Lowell, MA 01854  
978.458.8853

Milly’s Place has the capacity to shelter 6 families until permanent housing is found. Clients should be referred by the DTA and meet DTA criteria. Milly’s Place offers advocacy, counseling services, and referrals. Spanish is spoken by the staff.

**Food Assistance**

**Basic Needs Program – Merrimack Valley**
Catholic Charities  
70 Lawrence Street  
Lowell, MA 01852  
978.452.1421  
https://www.ccab.org

The Basic Needs Program is designed to meet immediate needs by helping people with emergency food, referrals for housing search information, counseling, and holiday assistance when available.

**Community Servings**
18 Marbury Terrace  
Boston, MA 02130  
617.522.7777  
https://www.servings.org

Community Servings provides home-delivered meals and nutrition services to individuals and families living with critical and chronic illnesses. Our made-from-scratch meals are medically tailored – meaning they’re customized to meet the nutritional and medical needs of our clients who are fighting illnesses like HIV/AIDS, diabetes, cancer, kidney disease, and many others. We offer 15 medical diets, with up to three combinations per client. We deliver to 21 cities and towns in Massachusetts. We provide meals for the client and family members including a caregiver (parent/spouse), and children under the age of 18.
Housing and Homelessness

House of Hope
812 Merrimack Street
Lowell, MA 01854
978.458.2870
http://houseofhopelowell.org
Houses of Hope operates as a temporary shelter, providing advocacy and care for homeless families. Services include emergency food and clothing. HOH offers on-site behavioral and physical health support and referrals. Employment internship positions are available on-site for adult residents who have little prior success with employment.

Lowell Housing Authority
350 Moody Street
Lowell, MA 01854
978.364.5311
https://www.lhma.org
The Lowell Housing Authority team, working in partnership with other housing providers, local government, nonprofit organizations, provide quality housing and a variety of social service programs that assist residents in achieving their highest level of self-sufficiency.

Lowell Transitional Living Center
205-209 Middlesex Street
Lowell, MA 01852
978.458.9888
http://ltlc.org
Lowell Transitional Living Center (LTLC) provides the most vulnerable adults in our community with shelter, showers, laundry, and food. Case Managers specialize in housing, financial assistance, and health and wellness. They are here to empower guests and become partners in the journey from homelessness to housing.

Case Managers promote overall stability, emphasizing physical and behavioral health and nutrition. When needed, our case managers work with those in need of drug/alcohol rehabilitation through relationships with local rehabilitation programs, as well as proving transportation.

Merrimack House Family Shelter
423 Pawtucket Street
Lowell, MA, 01854
978.459.0551 x223
Provided through Community Teamwork, Inc., CTI Merrimack House offers a temporary, safe, and supportive environment for homeless families. Through the use of advocacy and education, families are assisted in becoming increasingly self-sufficient. The program offers educational, financial, legal, parenting and housing resources.
Mental Health and Substance Abuse

Lahey Health Behavioral Services – Lowell
Emergency Psychiatric Care & Mobile Crisis Team

391 Varnum Avenue
Lowell, MA 01854
978.455.3397
800.830.5177
http://www.nebhealth.org

The Community Crisis Stabilization (CCS) Program is a six-bed program for adults (18+) who have MassHealth, Medicare, or who are uninsured. The typical length of stay is 3-5 days. The team provides emergency psychiatric assessments and supportive services in a variety of settings, including homes, schools, outpatient clinics and hospitals. The team also provides ongoing crisis counseling services until the client can be connected to ongoing providers. Open 7 days/week.

Mobile Crisis Intervention (MassHealth children and adolescents under 21 years old) The 24/7 Mobile Crisis Team works with youth and their families with serious emotional disturbances, plus up to seven days of ongoing crisis counseling, support and stabilization.

Eliot Community Human Services

Corporate Office
125 Hartwell Avenue
Lexington, MA 0242
781.861.0890
Emergency Psychiatric Services (800) 988-1111
http://www.eliotchs.org/

Eliot Community Human Services is a private, non-profit human services organization providing services for people of all ages throughout the Commonwealth of Massachusetts. The continuum of services includes diagnostic evaluation, twenty-four hour emergency services, and crisis stabilization, outpatient and court mandated substance abuse services, individual, group and family outpatient counseling, early intervention, specialized psychological testing, day, residential, social and vocational programs for individuals with mental illness and developmental disabilities, outreach and support services for the homeless, batterer intervention, and consultation.

Arbour Health System – Counseling Services Programs

10 Bridge Street
Lowell, MA 01852
978.453.5736
https://arbourhealth.com/

AHS/CSP clinicians work directly with clients, their families, and treatment teams to provide therapy and individual treatment plans that reflect consistent goals and coordination of care.

The Lowell facility provides individual, couple, family, and group counseling starting at age 5 as well as psychiatric services. Counselors provide support through the coordination of services and referrals to meet the needs/goals of the patient. Areas of specialized support include: Child and Adolescent Therapy, ADD/ADHD support, School-based Services, Women's Issues, Multicultural Issues, Dual Diagnosis, Psychopharmacology, and PDD/Asperger’s. Groups available include; Coping Skills, Spanish Speaking women’s and men’s groups, Boys Group, Anxiety Reduction, Social Skills, and Parenting. Languages spoken include Greek, Khmer, Russian, and Spanish.

Habit OPCO

22 Olde Canal Dr
Lowell, MA 01851
978.452.5155

Habit OPCO is a comprehensive treatment program providing quality medicated-assisted treatment to individuals in the Greater Lowell area seeking interventions for addictive disorders with a primary focus on opioid abuse and dependence. The primary goals of the program are to assist individuals we serve to improve their quality of life and increase public safety within our community.

Greater Lowell Health Alliance

295 Varnum Ave.
Lowell, MA 01854
978.934.8368
https://www.greaterlowellhealthalliance.org

The Greater Lowell Health Alliance brings together healthcare providers, business leaders, educators, and civic and community leaders with a common goal to improve the overall health of our communities.

Lowell House Inc. – Outpatient Substance Abuse Services

555 Merrimack Street
Lowell, MA 01854
978.459.8656
http://lowellhouseinc.org

Lowell House, Inc. (LHI) offers a variety of support, advocacy, community outreach and prevention programs. Our programs cover a broad range of inpatient and outpatient treatment and living options that support recovery across a lifetime.
Elder Services of the Merrimack Valley, Inc. is a private non-profit agency serving elders and disabled adults who reside in Northeast Massachusetts. Our mission is to support an individual's desire to make their own decisions, secure their independence, and remain living in the community safely.

Elder Services Care Managers and Nurses work with thousands of elders and family members each day to make sure they have the right services, living arrangements, and access to good health care and benefits. We contract with over 70 different care providers to ensure services delivered meet a variety of individual needs.

Lowell Senior Center
276 Broadway Street
Lowell, MA 01854
978.674.4131
http://www.lowellma.gov/373/Senior-Center

The City of Lowell Senior Center is brought to you by the City’s Council On Aging and is focused on delivering a variety of services such as nutrition, health, recreation, transportation, referral information, and low-income programs to the elderly in Lowell. The Senior Center is a multi-purpose center that plays a major role in Healthy Aging & assisting seniors with aging in place and remaining independent in their community.

CareOne at Lowell
19 Varnum Street
Lowell, MA 01850
978.454.5644
http://ma.care-one.com

CareOne at Lowell, is dedicated to providing the most sophisticated Medical and Neuro-Rehabilitative Care in the industry. Our unique program focuses on the treatment of individuals with traumatic brain injuries, Huntington’s Disease and other neurological disorders. By cultivating a structured and supportive environment, we help our residents acquire functional living skills they need to rebuild their lives.

Using principles and techniques of behavioral analysis, cognitive behavioral therapy and neuropsychological rehabilitation, our staff creates experiences that maximize positive change. Most importantly, a primary goal is to restore each individual to his or her optimal level of functionality and independence.

Lowell Community Health Center
161 Jackson Street,
Lowell, MA 01852
978.446.0236
http://www.lchealth.org

Lowell Community Health Center offers full services of Prenatal/Postpartum and GYN care. We have Health Educators to educate patients and the community on reproductive health and wellness as well as assist patients with finding health services. They also provide quality, affordable and confidential reproductive health care services for both male and female adults and adolescents. Teens receive confidential services, and parental consent is not needed. Additional Services Include: Birth control information and services Childbirth education, Referrals to support services, such as WIC, Gynecological/cervical cancer screenings and gynecological surgeries, HIV counseling and testing, Testing and treatment of STDs (sexually transmitted diseases), Testing and treatment of urinary tract infections, abnormal pap smears and breast exams.

Alanon/Alateen
Meetings are held at Saints Medical Center, Bartlett St at Hospital Drive, 1st Floor Conference Room. Meetings occur on Sunday evenings at 6:30 pm.
Saints Medical Center
1 Hospital Drive
Lowell, MA 01852

Meetings are held at Christ Church United on Saturdays at 9:30 am.
1 Bartlett St
Lowell, MA 01852
The Lowell Regional Transit Authority (LRTA)

Transportation Services

The Lowell Regional Transit Authority (LRTA)

115 Thorndike Street
Lowell, MA 01852
http://lrta.com

The LRTA can be reached at:
Road Runner Office
978.459.0152, 113 Thorndike Street

Main Admin Office
978.459.0164, 115 Thorndike Street

Parking 978.459.0164 x 206
Email: Parking@lrta.com

The LRTA provides fixed route bus services and paratransit services to the city and 14 surrounding communities. These connect at the Gallagher Intermodal Center to the Lowell Line of the MBTA commuter rail system, which connects Lowell to Boston. The terminal is also served by several intercity bus lines including Greyhound and Peter Pan.

The LRTA offers commuter parking at the Gallagher Intermodal Center and at the North Billerica Train Station.

The LRTA Road Runner offers a curb to curb Paratransit service available to residents within the LRTA service area and who are 60 years of age or more. All of the Road Runner services are shared ride services intended to safely and efficiently transport as many passengers at a time as possible. Reservations must be made at least two business days in advance. Please be advised that all customers must be registered with Road Runner prior to transportation arrangements being made.

Road Runner’s services can be used for many purposes including work, medical, shopping, social and recreational reasons depending on the service area.

Road Runner provides services to residents in Acton, Billerica, Carlisle, Chelmsford, Dracut, Groton, Lowell, Maynard, Pepperell, Tewksbury, Townsend, Tyngsborough, and Westford.

MBTA Commuter Rail Service

Lowell Line stops in Lowell, North Billerica, Wilmington, Woburn, Winchester, and Medford.

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The Center for Hope and Healing, Inc.
21 George Street, Suite 400
Lowell, MA 01852
978.452.7721
https://www.chhinc.org

The Center for Hope and Healing has been working to support survivors and create communities free from sexual violence. CHH currently offers two adult support groups that meet bi-weekly. One is a Spanish speaking support group & the other is an English speaking support group. Both groups are 18+, all-gender, and drop-in, which means participants do not have to sign up ahead of time.

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Lowell House Inc. – Outpatient Substance Abuse Services

555 Merrimack Street
Lowell, MA 01854
978.459.8656
http://lowellhouseinc.org

Lowell House, Inc. (LHI) offers a variety of support, advocacy, community outreach and prevention programs. Our programs cover a broad range of inpatient and outpatient treatment and living options that support recovery across a lifetime.

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Massachusetts Alliance of Portuguese Speakers (MAPS) – Domestic Violence & Sexual Assault Services Program

11 Mill Street
Lowell, MA 01852
978.970.1250
https://www.maps-inc.org

Our program works with victims of Domestic Violence and Sexual Assault, helping them along the road to recovery and providing them with the information and tools to go from victim to survivor.

Our caseworkers offer crisis intervention, safety planning, information, guided referrals, medical and legal advocacy, supportive listening and related services around domestic violence and sexual assault. MAPS also conducts outreach and education in the community.

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Narcotics Anonymous

Meetings are held at Pawtucket Congregational Church on Wednesday evenings at 7:30 pm.

15 Mammoth Rd
Lowell, MA 01854
Veterans Services

Lowell Veterans Center
10 George Street, Gateway Center
Lowell, MA 01852
978.453.1151

Veterans’ Services Officer
City Hall
Lowell, MA 01852
978.674.4066

The Veteran’s Center offers readjustment counseling to assist veterans transitioning back to civilian life after they have served in a combat zone. They offer bereavement counseling for family members who lost someone in combat.

Sexual abuse counseling is available to those who experienced it while serving. Group, family, and individual counseling is also available. They also offer resources for individuals who are experiencing issues with substance abuse, depression, PTSD, employment resources, and need help accessing veteran benefits.

MassHire Lowell Career Center
107 Merrimack Street
Lowell, MA 01852
978.458.2503
https://masshirelowellcc.com

The MassHire Lowell Career Center is part of the Massachusetts One-Stop Career Center System serving the communities of Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewskbury, Tyngsborough and Westford. The Lowell Career Center operates under the direction of the City of Lowell and is chartered by the MassHire Greater Lowell Workforce Board. Through this model, local employment and training services have been consolidated to build a strong workforce development system.
Lynnfield
Access to Health Care

Lahey Medical Center – Peabody
One Essex Center Drive
Peabody, MA 01960
978.538.4000
www.lahey.org

Lahey Medical Center, Peabody includes a 24-hour emergency department and a 10-bed hospital. We combine advanced technology, research and medical education to provide the best care possible. You benefit from specialty resources at our medical centers and top-quality primary care services at community-based practices throughout northeastern Massachusetts.

Lahey Health Urgent Care
1350 Market St
Lynnfield, MA 01940
781.213.4050
https://www.laheyhealth.org/what-we-offer/urgent-care/

Daily, year-round care for all your urgent care needs, from sprains to flu, to lab testing and imaging, trust Lahey Health Urgent Care for affordable, easy to access, quality health care. Avoid a costly visit to an emergency room (and a long wait) for all your non-emergent and non-life threatening illnesses and injuries.

Lahey Health Hub
1350 Market St
Lynnfield, MA 01940
781.213.4040
https://www.lahey.org/location/lahey-health-hub/

Lahey Health Hub offers primary, specialty, and urgent care services for you and everyone in your family. Located next to MarketStreet Lynnfield’s retail destination, find expert care close to home, when and where you need it. Lahey Health Hub provided high-quality, patient-centered care all under one roof, from physicals, to lab tests, imaging, and specialty and urgent care. Make Lahey Health Hub your one-stop healthcare destination.

Financial Counseling Assistance at Lahey Medical Center, Peabody
978.538.4101

Lahey Medical Center, Peabody provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

Lynnfield Board of Health
55 Summer St
Lynnfield, MA 01940
781.334.9480
https://www.town.lynnfield.ma.us/board-health
The mission of the Lynnfield Board of Health is to prevent illness, promote wellness, and protect the environment as ascribed in our logo. In these endeavors, the Board of Health will make reasonable policies and regulations to protect and promote the public health and well being of our citizens.

Child, Parent and Family Support

YMCA of Metro North / Torigian Family YMCA
259 Lynnfield Street
Peabody, MA 01960
978.977.9622
http://www.ymcametronorth.org

YMCA’s offer a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities. They also offer child care opportunities and after-school programs.

Disabilities and Special Needs

North Shore Community Action Programs
119 Rear Foster Street
Building 13
Peabody, MA 01960
978.531.0767
https://www.nscap.org

NSCAP is a private, non-profit organization that provides a wide range of social services that enable low-income families and individuals to obtain the skills and knowledge they need to become economically self-sufficient, civically engaged, and to live in dignity and decency.

NSCAP programs and services cover five key areas: Education and Training, Economic Stabilization, Housing and Homelessness Prevention, Energy Services, and Home Care.

Communitas
30 Audubon Rd
Wakefield, MA 01880
781.587.2440
https://communitasma.org
Domestic Violence

REACH Beyond Domestic Violence
PO Box 540024
Waltham, MA 02454
781.891.0724
Hotline: 800.899.4000
https://reachma.org

REACH is a non-profit organization providing safety and support to survivors of abuse while engaging communities to promote healthy relationships and prevent domestic violence.

Food Assistance

SALVATION ARMY - Lynn Emergency Food
1 Franklin Street
Lynn, MA 01902
781-598-0673
http://www.salvationarmyma.org/lynn

Food Pantry is open Mondays, Wednesdays and Fridays, 9:00 – 11:30 am. Must be resident of either Lynn, Lynnfield, Nahant, Saugus, and Swampscott. Photo ID and proof of residency required. Clients welcome to visit once every 30 days. In addition, there is a weekly Grocery Store Surplus Food Distribution on Tuesdays and Thursdays at 12:00 p.m. All welcome.

Haven from Hunger
71 Wallis Street
Peabody, MA 01960
978.531.1530
https://www.citizensinn.org/haven-from-hunger

Haven from Hunger distributes emergency food to families throughout Peabody, Salem and Lynnfield. Eligibility restrictions for food pantry: proof of residence in Salem, Peabody, or Lynnfield and low income. There are no eligibility restrictions for the soup kitchen.

Food Pantry Hours: M,Tu,Th,F 10:30-2:30
Soup Kitchen: M,Tu,Th,F Dinner served at 5.

Supplemental Nutritional Assistance Program (SNAP)
https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

Housing and Homelessness

Lynnfield Housing Authority
600 Ross Drive
Lynnfield MA 01940
http://lynnfieldhousing.org

The Lynnfield Housing Authority (LHA) has a simple mission – to provide qualified families with safe, decent and affordable housing of the highest quality consistent with available funding. The uncertain economic times we are experiencing have made the way the mission is carried out more critical than ever. We have ensured that we rein in administrative spending to maximize the funding available to improve properties we own. The authority will continue to explore new development opportunities in a wider range of neighborhoods and expand our partnerships with others who share our vision.

Mission of Deeds
6 Chapin Avenue
Reading, MA 01867
781.944.9797
http://www.missionofdeeds.org

Mission of Deeds provides basic home essentials to those in need. Determined to improve the quality of life for these families, Mission of Deeds serves as a place where people can not only receive new beds and donated household essentials free of charge, but also be treated with kindness, respect, and compassion.

Communitas provides individualized support for people of all abilities. We offer family-centered services and resources – as well as employment and volunteering opportunities – for more than 1,000 families from Lynn, Lynnfield, Medford, North Reading, Reading, Stoneham, Wakefield and surrounding communities. Our mission is to meet individual needs – whatever they are and however they change – while inspiring dreams. We advocate passionately while compassionately delivering services and programs that expand opportunities, empower people, support independence and enrich lives.
Mental Health and Substance Abuse

Eliot Community Human Services

Corporate Office
125 Hartwell Avenue
Lexington, MA 0242
781.861.0890
Emergency Psychiatric Services (800) 988-1111
http://www.eliotchs.org/

Eliot Community Human Services is a private, non-profit human services organization providing services for people of all ages throughout the Commonwealth of Massachusetts. The continuum of services includes diagnostic evaluation, twenty-four hour emergency services, and crisis stabilization, outpatient and court mandated substance abuse services, individual, group and family outpatient counseling, early intervention, specialized psychological testing, day, residential, social and vocational programs for individuals with mental illness and developmental disabilities, outreach and support services for the homeless, batterer intervention, and consultation.

Riverside Outpatient Center
6 Kimball Lane,
Suite 310
Lynnfield, MA 01940
781.246.2010
www.riversidecc.org

Our caring and skilled clinicians work with individuals and families to develop treatment solutions for adults, teenagers, and children who may be experiencing a mental illness, behavioral or emotional problems, or substance use concerns. Our approach is to build on an individual’s strengths and potential through individual, group, and/or family counseling. Individuals also have access to treatment planning and consultation, medication management, as well as a large network of community services and local resources – including 24/7 emergency services.

Healthy Lynnfield
Lynnfield High School
275 Essex Street
Lynnfield, MA 01940
781.334.5820 x 1103
https://ahealthylynnfield.org

In an effort to promote a healthier and safer community, and in response to the rising misuse of opioids, The Town of Lynnfield formed The Lynnfield Substance Abuse Prevention Coalition, known as A Healthy Lynnfield (AHL).

Through coalition building, engagement of stakeholders, and implementation of proven best practices, municipal leaders in the Town of Lynnfield aim to reverse this crisis, save lives, and create a healthy, safe, and thriving community.

A Healthy Lynnfield engages town departments, residents, schools, parents, youth, the faith community, local government, businesses, civic organizations and health professionals in our work. Volunteers across the community are welcome to join in our efforts.

Senior Services

Greater Lynn Senior Services

8 Silsbee St
Lynn, MA 01901
781.586.8687
WWW.GLSS.NET

Greater Lynn Senior Services offers information, referral, and advocacy on a wide range of aging-related issues. They coordinate in-home services, such as homemaking, personal care, and meals on wheels to help people remain independent in their own homes.

Council On Aging

525 Salem Street
Lynnfield, MA 01940
781.598.1078
https://www.town.lynnfield.ma.us/council-aging

The Council On Aging is responsible for all senior activities. We are not a club; the center is open to anyone 60 years of age or older as well as those over 50 years with a disability at the Director’s discretion.

Sunrise of Lynnfield

55 Salem Street
Lynnfield, MA 01940
781-245-0668

Sunrise of Lynnfield, a senior living community in Lynnfield, Massachusetts, not only offers higher levels of care and support required by those with memory loss—it offers a beautiful building that our residents love to call home. Our nursing staff and experienced Designated Care Managers are available around the clock to support the needs of all who live here.

Sexual Health

Fertility Solutions

One Essex Center Drive
Peabody, MA 01960
781.326.2451
https://www.fertilitysolutionsne.com/contact-us/peabody-massachusetts

Fertility Solutions is a patient-centered practice that provides a full spectrum of infertility diagnosis and treatment. From lifestyle modifications to the latest in assisted reproductive technology, Fertility Solutions offer a decidedly different, more personal approach to fertility care.
Support Groups

Alanon/Alateen
Center Congregational Church enter from back parking lot.
Meetings occur Monday at 7:30 PM.
5 Summer St
Lynnfield, MA 01940

Lahey Medical Center – Peabody
One Essex Center Drive
Peabody, MA 01960
978.538.4000
www.lahey.org

Lahey Hospital and Medical Center offer free support groups to provide emotional support, coping skills and resource access to patients and families dealing with a variety of diseases.

Free groups at Lahey Medical Center, Peabody offer support for: Breast Cancer Group, Look Good, Feel Better (Women receiving radiation or chemotherapy), Lymphoma & Leukemia Support Group, Transplant Support Group(s), Urologic & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Lynnfield Senior Center Van
525 Salem Street
Lynnfield, MA 01940
781.598.1078
https://www.town.lynnfield.ma.us/council-aging

The Lynnfield Senior Van is available to all Lynnfield senior residents for medical appointments, pharmacy, library and shopping. We will pick up at your home and can travel to appointments within a 5-mile radius of Lynnfield, including Lynn, Wakefield, Saugus and Peabody. We cannot travel to appointments in Boston. We also offer rides to and from your home and the Senior Center. The van is used for multiple purposes; we will try to accommodate all medical requests. Please call the Center to arrange transportation at least 48 hours in advance.

Veterans Services

Veterans Services
55 Summer Street
Lynnfield, MA 01940
781.334.9440
https://www.town.lynnfield.ma.us/veterans-services

The mission of the Lynnfield Veterans’ Services Department is to advocate on behalf of all veterans, and to provide them with quality support services. The Director of Veterans Services is available to assist and guide all qualifying veterans who seek and apply for both state and Federal benefits.

Transportation Services

Greater Lynn Senior Services
8 Silsbee St
Lynn, MA 01901
781.477.4237
www.glss.net

Transportation requests for medical appointments. GLSS Medical runs Monday through Friday. Request lines are open from 8:00 a.m. to 4 p.m. GLSS requires a two business day notice. Passengers can travel to a doctor’s appointment between 8:30 a.m. and 3:30 p.m. (8:30 being the first appointment and 3:30 being the last return.) GLSS service area includes Lynn, Lynnfield, Nahant, Saugus, & Swampscott. For more information or to schedule a ride: GLSS van reservations: 781-477-4237.
Peabody
Access to Health Care

Lahey Medical Center – Peabody
One Essex Center Drive
Peabody, MA 01960
978.538.4000
www.lahey.org

Lahey Medical Center, Peabody includes a 24-hour emergency department and a 10-bed hospital. We combine advanced technology, research and medical education to provide the best care possible. You benefit from specialty resources at our medical centers and top-quality primary care services at community-based practices throughout northeastern Massachusetts.

Financial Counseling Assistance at Lahey Medical Center, Peabody
978.538.4101

Lahey Medical Center, Peabody provides financial counseling assistance to help you pay your medical bills. If you have limited insurance or no insurance coverage, you may qualify for government assistance through the MassHealth, Commonwealth Care or Health Safety Net (Free Care) programs.

Lahey Health Urgent Care
1350 Market St
Lynnfield, MA 01940
781.213.4050
https://www.laheyhealth.org/what-we-offer/urgent-care/

Daily, year-round care for all your urgent care needs, from sprains to flu, to lab testing and imaging, trust Lahey Health Urgent Care for affordable, easy to access, quality health care. Avoid a costly visit to an emergency room (and a long wait) for all your non-emergent and non-life threatening illnesses and injuries.

Lahey Health Hub
1350 Market St
Lynnfield, MA 01940
781.213.4040
https://www.lahey.org/location/lahey-health-hub/

Lahey Health Hub offers primary, specialty, and urgent care services for you and everyone in your family. Located next to MarketStreet Lynnfield’s retail destination, find expert care close to home, when and where you need it. Lahey Health Hub provided high-quality, patient-centered care all under one roof, from physicals, to lab tests, imaging, and specialty and urgent care. Make Lahey Health Hub your one-stop healthcare destination.

American Red Cross of Northeast Massachusetts
85 Lowell St.
Peabody, MA, 01960
978.922.2224
https://www.redcross.org

The Red Cross provides shelter, food, health and mental health services to help families and entire communities get back on their feet. Although the Red Cross is not a government agency, it is an essential part of the response when disaster strikes. The Red Cross works in partnership with other agencies and organizations that provide services to disaster victims.

The Red Cross also helps military members, veterans and their families prepare for, cope with, and respond to the challenges of military service. The Red Cross offers emergency communications, training, support to wounded warriors and veterans, and access to community resources.

North Shore Community Health, Inc.
Peabody Family Health Center
89 Foster Street
Peabody, MA 01960
978.532.4903
https://www.nschi.org

North Shore Community Health has 3 family practice sites that include Salem Family Health Center, Peabody Family Health Center, and Gloucester Family Health Center. These sites have medical, dental and behavioral health services and serve individuals and families of all ages. NSCHI also has two School-Based Health Centers (Salem High School Teen Health Center and Peabody Veterans War Memorial High School Teen Health Center). No one seeking care at any of our sites will ever be denied access to services due to inability to pay. We also offer translation services, outreach and enrollment services and health education.

Peabody Council on Aging SHINE Program
Peabody Council on Aging
75R Central Street
Peabody, MA 01960
978.531.2254
http://peabodycoa.org

The SHINE Program provides free health insurance information, counseling and assistance in navigating the Medicare and MassHealth systems for seniors. Three of our staff are certified SHINE counselors and can provide accurate, unbiased and up-to-date information about health care options.
Domestic Violence

Healing Abuse Working for Change
27 Congress Street
Salem, MA 01970
978.744.8552
24-hour Hotline: 1.800.547.1649
https://hawcdv.org
HAWC services include a 24-hour hotline, support groups, individual advocacy, legal advocacy, and hospital advocacy, children’s services, a shelter program, community education, and a Parent-Child Trauma Recovery Program.

Child, Parent and Family Support

North American Family Institute (NAFI)
300 Rosewood Drive, Suite 101
Danvers, MA 01923
978.538.0286
https://www.nfima.org
All NFI Massachusetts staff members are fully committed to engaging and inspiring each service recipient in a strength-based, individual and/or family focused treatment process that seeks to improve the physical, emotional and social quality of their lives. NAFI offers juvenile justice, behavioral health, adult, and community-based services.

YMCA of Metro North / Torigian

Family YMCA
259 Lynnfield Street
Peabody, MA 01960
978.977.9622
http://www.ymcametronorth.org
YMCA offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities. They also offer child care opportunities and after-school programs.

Disabilities and Special Needs

North Shore Community Action Programs
119 Rear Foster Street
Building 13
Peabody, MA 01960
978.531.0767
https://www.nscap.org
NSCAP is a private, non-profit organization that provides a wide range of social services that enable low-income families and individuals to obtain the skills and knowledge they need to become economically self-sufficient, civically engaged, and to live in dignity and decency. NSCAP programs and services cover five key areas: Education and Training, Economic Stabilization, Housing and Homelessness Prevention, Energy Services, and Home Care.

North Shore Elder Services
Elder Abuse 24-hour Hotline at
1.800.922.2275
North Shore Elder Services is an agency designated by the Commonwealth of Massachusetts to investigate reports of suspected abuse or neglect and provide services to elders in Danvers, Marblehead, Middleton, Peabody and Salem. They strive to implement the least restrictive and least intrusive measures possible to keep elders safe and respect the balance between the right of self-determination against the mandate to protect.

Food Assistance

Haven from Hunger
71 Wallis Street
Peabody, MA 01960
978.531.1530
https://www.citizensinn.org/haven-from-hunger/
Haven from Hunger distributes emergency food to families throughout Peabody, Salem and Lynnfield. Eligibility restrictions for food pantry: proof of residence in Salem, Peabody, or Lynnfield and low income. There are no eligibility restrictions for the soup kitchen.

Food Pantry Hours: M,Tu,Th,F 10:30-2:30
Soup Kitchen: M,Tu,Th,F Dinner served at 5.

Supplemental Nutritional Assistance Program (SNAP)
https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap
SNAP offers nutrition assistance to millions of eligible, low-income individuals and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

Housing and Homelessness

Citizens Inn, Inc.
81 Main Street
Peabody, MA 01960
978.531.9775
https://www.citizensinn.org
Citizens Inn, Inc., now merged with Haven from Hunger, has worked toward ending homelessness and hunger across the North Shore. Our mission calls us to support everyone with dignity and respect, as they live in our emergency shelter, Citizens Inn Between; our sober living transitional housing shelter, Citizens Inn Transition; our affordable housing units, Citizens Inn Homes; or join us for meals as part of our Citizens Inn Haven from Hunger program. Through our work, we not only provide a safe place to stay and a meal on the table, but offer tools to empower families and individuals to find permanent solutions to break the patterns of instability in their lives.

The Inn Between
25 Holten Street
Peabody, MA 01960
978.532.2372
https://www.citizensinn.org/programs-services/citizens-inn-between/

The Inn Between offers emergency housing as well as a “community room” available for homeless families who are ineligible for shelter assistance from the state.

Peabody Housing Authority
75 Central St
Peabody, MA 01960
978.531.1938
http://www.peabodyhousing.org
The mission of the Peabody Housing Authority is to provide decent, safe, and sanitary housing opportunities in the City of Peabody, thereby improving the quality of life for low income families, those with disabilities, and the elderly on fixed incomes.

Family Promise North Shore Boston
330 Rantoul Street
Beverly, MA 01915
978-922-0787
https://www.familypromisensb.org/
Family Promise North Shore Boston aims to return newly homeless families to economic self-sufficiency, while serving each family that experiences homelessness in a manner that embraces the dignity and strength of the family. We are committed to keeping families together during their time of homelessness and to helping them through the process of finding support and housing.

Mental Health and Substance Abuse

Eliot Community Human Services
Corporate Office
125 Hartwell Avenue
Lexington, MA 02424
781.861.0890 Emergency Psychiatric Services
(800) 988-1111
http://www.eliotchs.org/
Eliot Community Human Services is a private, non-profit human services organization providing services for people of all ages throughout the Commonwealth of Massachusetts.
The continuum of services includes diagnostic evaluation, twenty-four hour emergency services, and crisis stabilization, outpatient and court mandated substance abuse services, individual, group and family outpatient counseling, early intervention, specialized psychological testing, day, residential, social and vocational programs for individuals with mental illness and developmental disabilities, outreach and support services for the homeless, batterer intervention, and consultation.
Cape Ann Community Service Agency (CSA)
800 Cummings Ctr., Suite 364U
Beverly, MA 01915
978.922.0025
http://www.nebbhealth.org/services-locations/community-service-agency/

Community Service Agency (CSA) serves families and children who are enrolled members of MassHealth or eligible to be enrolled in MassHealth Standard or CommonHealth. If you are a parent or guardian of a child who has a serious mental, behavioral or emotional difficulty, we can help to get you and your family the services you need. The CSA serves residents of the following towns/cities: Beverly, Danvers, Essex, Gloucester, Hamilton, Manchester, Marblehead, Middleton, Peabody, Rockport, Salem and Wenham.

Health Care Resource Centers Peabody
172 Newbury Street
Peabody, MA 01960
978.535.9190
https://www.hcrcenters.com

HCRC Peabody is an outpatient treatment facility that provides medication-assisted treatment for those with opioid use disorder. Each patient has an individualized treatment plan along with individual and group counseling sessions.

Family Continuity
9 Centennial Drive, Ste. 202
Peabody, MA 01960
978.927.9410
http://familycontinuity.org/

Family Continuity is a private, non-profit mental health and social services agency supporting Eastern and Central Massachusetts from hub offices in Peabody, Lawrence, Whitinsville, Worcester, Plymouth, and Hyannis. Our 36 program portfolio provides a spectrum of emotional, developmental, and behavioral programs for children, adolescents, adults, couples, families and seniors. Our services encompass community and home-based services as well as outpatient clinics that provide evidence-based, best practice therapies for individuals and families. Our treatment philosophy begins with meeting an individual’s basic needs and creates a collaborative partnership between client and clinician.

The Inn Transition
42 Washington St,
Peabody, MA 01960
978. 531.9951
https://www.citizensinn.org/programs-services/citizens-inn-transition/

Citizens Inn Transition provides comprehensive case management to families in early recovery in a transitional sober housing environment. Nine sober living families and five emergency shelter families share this space, follow the same rules and expectations, and maintain a safe, supportive, sober, accepting, welcoming and recovery-oriented environment.

Healthy Peabody Collaborative
6 Allens Lane
Peabody, MA 01960
978.538.6339
http://www.healthypeabodycollaborative.org

The Healthy Peabody Collaborative (HPC) works to reduce underage substance use while creating a healthier community for all who live, work and play in Peabody.

Senior Services

Peabody Council on Aging/Peter A. Torigian Community Life Center
Peabody Council on Aging
75R Central Street
Peabody, MA 01960
978.531.2254
http://peabodycoa.org

Managed by the Peabody Council on Aging, a service agency of the City of Peabody, the Center meets the diverse interests of Peabody residents in areas such as entertainment, fitness, education, social services, daycare, and recreation.

The Peter A. Torigian Community Life Center invites your participation. To learn more about the latest programs, events and volunteer opportunities or to receive our monthly publication “Tips & Topics” call the Center at 978.531-2254.

Harriett and Ralph Kaplan Estates, Peabody
240 Lynnfield Street
Peabody, MA 01960
978. 532.4411
https://chelseajewish.org/assisted-living/harriett-and-ralph-kaplan-estates-peabody/

Harriett and Ralph Kaplan Estates offers 98 spacious studio and one-bedroom apartments with private baths, walk-in closets, kitchenette, microwave and individual heat control. Three meals a day prepared by a trained culinary chef and served in a private dining room. Residence also features fireplace lounge, living room, coffee shop, beauty salon, library, fitness center, beautifully landscaped grounds and outdoor gardens. Weekly housekeeping and linen service, daily assistance with such activities as dressing, bathing and dietary plans.
Alliance Health at Rosewood

22 Johnson Street
Peabody, MA 01960
978.535.8700
http://www.alliancehhs.org/Skilled-Nursing-Home-Rehab-Peabody

Alliance Health at Rosewood is a 135-bed, non-profit Medicare-certified skilled nursing facility. Our clinicians provide a wide range of medical and rehabilitative services, including post-acute care, short-term and long-term care, post-hospitalization rehabilitation, respite care, and hospice care. Focused on a holistic approach, we work directly with each resident and their family members to provide individualized quality care.

Brooksby Village

100 Brooksby Village Drive
Peabody, MA 01960
1.800.523.9704
https://www.ericksonliving.com/brooksby-village

Brooksby Village is a continuing care retirement community. Brooksby Village features spacious maintenance-free apartment homes, all with easy access to a host of popular amenities and services like a pool, restaurants, and a convenient on-site medical center. There are over 100 clubs and activities to keep your mind, body, and spirit thriving—plus a full continuum of on-site care if your health needs ever change.

Freedom Home Care

39 Cross Street, Suite 303
Peabody, MA 01960
978.531.6122
http://www.freedomhomecarema.com

Freedom Home Care was established to address the growing demand for high quality private pay home care services on Boston's North Shore. They are affiliated with Multicultural Home Care.

CareOne at Peabody

199 Andover Street
Peabody, MA 01960
978.531.0772
http://ma.care-one.com

CareOne at Peabody provides the loyal and dedicated staff required to successfully provide high acuity, post-hospital clinical care. Combined with rehabilitation services, up to 7 days a week, the patient-centered experience we offer will maximize your potential both medically and functionally. Whether you’re in need of short term rehabilitation, medical management or long term care, the clinical care team at CareOne at Peabody will make your experience a motivating and inspiring one.

Pilgrim Rehabilitation and Skilled Nursing Center

96 Forest Street
Peabody, MA 01960
978.532.0303
https://pilgrimrehab.org

At Pilgrim, we are providing area families with top-quality skilled nursing care for short-term rehabilitation and long-term care. We focus on maximizing patient recovery, comfort and independence for the highest possible quality of life. From post-surgery and post-hospital rehabilitation to long-term care for a chronic illness, our highly skilled care teams provide compassionate attention and specialized care every step of the way.

Sunrise at Gardner Park

73 Margin Street
Peabody, MA 01960
978.532.3200

Sunrise at Gardner Park offers assisted living, memory care, short-term stays and coordination of hospice care.

Sexual Health

Fertility Solutions

One Essex Center Drive
Peabody, MA 01960
781.326.2451
https://www.fertilitysolutionsne.com/contact-us/peabody-massachusetts

Fertility Solutions is a patient-centered practice that provides a full spectrum of infertility diagnosis and treatment. From lifestyle modifications to the latest in assisted reproductive technology, Fertility Solutions offer a decidedly different, more personal approach to fertility care.

Support Groups

Alanon/Alateen

Knights Of Columbus Hall, 96 Main St., Downtown Near City Library - 2nd Floor Room On Right - 1st Wed Step & Tradition. Meetings occur Wednesday at 7:30 pm.
96 Main Street
Peabody, MA 01960
The Red Cross provides shelter, food, health and mental health services to help families and entire communities get back on their feet. Although the Red Cross is not a government agency, it is an essential part of the response when disaster strikes. The Red Cross works in partnership with other agencies and organizations that provide services to disaster victims.

The Red Cross also helps military members, veterans and their families prepare for, cope with, and respond to the challenges of military service. The Red Cross offers emergency communications, training, support to wounded warriors and veterans, and access to community resources.

Lahey Health offers free support groups to provide emotional support, coping skills and resource access to patients and families dealing with a variety of diseases.

Free groups at Lahey Medical Center, Peabody offer support for: Breast Cancer Group, Look Good, Feel Better (Women receiving radiation or chemotherapy), Lymphoma & Leukemia Support Group, Transplant Support Group(s), Urologic & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Veterans Services

American Red Cross of Northeast Massachusetts
85 Lowell St.
Peabody, MA, 01960
978.922.2224
https://www.redcross.org

The Red Cross provides shelter, food, health and mental health services to help families and entire communities get back on their feet. Although the Red Cross is not a government agency, it is an essential part of the response when disaster strikes. The Red Cross works in partnership with other agencies and organizations that provide services to disaster victims.

The Red Cross also helps military members, veterans and their families prepare for, cope with, and respond to the challenges of military service. The Red Cross offers emergency communications, training, support to wounded warriors and veterans, and access to community resources.

North Shore Veterans Counseling Services, Inc
45 Broadway Street
Beverly, MA 01915
978.921.4851
http://www.northshoreveterans.com

The Agency believes in "SERVING THOSE WHO SERVED US". Any individual who can show documented military service, or a family member, or a significant other of that veteran is eligible to seek assistance from the agency. We address the needs of the individual with confidentiality. The North Shore Veterans Counseling Services, Inc. though based in Beverly, serves veterans, combat and non-combat alike, and their families, at no fee, North of Boston.

Transportation Services

Peabody Council on Aging
978.531.2254
Transportation offers door-to-door rides to Peabody residents upon request, for medical appointments, shopping, or trips to the Center. Wheelchair vans are also available. All reservations may be made up to two months in advance. BUT MUST BE MADE at least a full week before your appointment. We strive to accommodate every request. Due to our high volume of riders book your ride as early as possible. Ride donation of $1.00 each way is greatly appreciated.

MBTA Bus 465 - Salem Depot - Liberty Tree Mall via Peabody & Danvers

Alcoholics Anonymous
Meetings are held at St. Adelaide’s Parish on Thursday evenings, 7:30-8:30 pm.
712 Lowell Street
Peabody, MA 01960

Lahey Medical Center – Peabody
One Essex Center Drive
Peabody, MA 01960
978.538.4000
www.lahey.org

Lahey Health offers free support groups to provide emotional support, coping skills and resource access to patients and families dealing with a variety of diseases.

Free groups at Lahey Medical Center, Peabody offer support for: Breast Cancer Group, Look Good, Feel Better (Women receiving radiation or chemotherapy), Lymphoma & Leukemia Support Group, Transplant Support Group(s), Urologic & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Narcotics Anonymous
Second Congregational Church
12 Maple Street
Peabody, MA 01960
NA Meetings are located at the Second Congregational Church in Peabody, MA. Meetings are held on Thursday evenings at 7:00 pm.

Veterans’ Services Officer
City Hall
24 Lowell St.
Peabody, MA 01960
978.538.5925
http://www.peabody-ma.gov/veterans%20services.html

The mission of the City of Peabody Veterans Services Department is to assist veterans and their dependents by providing services that may include applying for benefits, both state and federal, helping in employment and under employment situations along with monetary support.
Appendix D:
Implementation Strategy
Lahey Clinic Hospital, Inc. includes both Lahey Hospital & Medical Center (LHMC) and Lahey Medical Center – Peabody (LMCP). Together, they are referred to as LHMC/LMCP throughout this report. Both hospitals are part of the Beth Israel Lahey Health system.

Between November 2018 and August 2019, LHMC/LMCP conducted a comprehensive Community Health Needs Assessment (CHNA) that included an extensive review of existing quantitative data as well as the collection of qualitative information through interviews, focus groups, community listening sessions, and a community health survey. A resource inventory was also completed to identify existing health-related assets and service gaps. This extensive array of assessment and community engagement activities allowed LHMC/LMCP to collaborate with key health system partners across the region. During the CHNA process, LHMC/LMCP also made substantial efforts to engage their own administrative and clinical staff, including senior leadership. A detailed review of the CHNA approach, data collection methods, and community engagement activities is included in LHMC/LMCP’s 2019 Community Health Needs Assessment report.

Throughout the CHNA process, LHMC/LMCP’s Community Relations staff worked with the hospital’s Community Benefits Advisory Committee (CBAC), composed of senior leadership from the hospital and community stakeholders/service providers, to:

- Vet quantitative and qualitative findings
- Prioritize community health issues and vulnerable populations
- Review existing community benefits programming
- Develop LHMC/LMCP’s 2020-2022 Implementation Strategy

IMPLEMENTATION STRATEGY PLANNING PRINCIPLES AND STATE PRIORITIES

In developing the Implementation Strategy, care was taken to ensure that LHMC/LMCP’s community health priorities were aligned with priority areas determined by the Massachusetts Department of Public Health (MDPH) and the Massachusetts Attorney General’s Office (MA AGO). In addition to the four priority areas, MDPH identified six health priorities to guide investments funded through Determination of Need processes. The MDPH and the MA AGO encourage hospitals to consider these priorities during the community benefits planning process.
Table 1: MDPH/MA AGO Priority Areas

<table>
<thead>
<tr>
<th>Community Benefits Priorities</th>
<th>Determination of Need Priority Areas</th>
</tr>
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<tbody>
<tr>
<td>Chronic disease with a focus on cancer, heart disease, and diabetes</td>
<td>Built environment</td>
</tr>
<tr>
<td>Housing stability/homelessness</td>
<td>Social environment</td>
</tr>
<tr>
<td>Mental illness and mental health</td>
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<tr>
<td>Substance use disorders</td>
<td>Violence</td>
</tr>
<tr>
<td></td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Employment</td>
</tr>
</tbody>
</table>

The following is a range of programmatic ideas and principles that are critical to community health improvement; they have been applied in the development of the Implementation Strategy.

- **Social determinants of health:** With respect to community health improvement, especially for low-income and disadvantaged populations, there is growing appreciation for the importance of addressing the underlying social determinants of health. These social determinants have been defined as “the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities.”¹ The leading social determinants of health include issues such as poverty, housing, food access, violence, racism/bigotry, and transportation. It is important that hospital implementation strategies include collaborative, cross-sector initiatives that address these issues.

- **Health education and prevention:** Primary prevention aims to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, and altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aim to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared toward helping people manage health conditions, lessen a condition’s impact, or slow a condition’s progress. Targeted efforts across the

---

continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

- **Screening and referral:** Early identification of those with chronic and complex conditions, followed by efforts to ensure that those in need of education, further assessment, counseling, and treatment, is critical to preventing and managing illness. A critical component of screening and referral efforts is taking steps to ensure that people are fully engaged in treatment, including links to a primary care provider.

- **Chronic disease management:** Learning how to manage an illness or a condition, change unhealthy behaviors, and make informed decisions about health allows individuals to lead healthier lives. Evidence-based chronic disease management or self-management education programs, implemented in community-based settings by clinical and nonclinical organizations, can help people learn skills to manage their health conditions, improve eating and sleeping habits, reduce stress, and maintain a healthy lifestyle.

- **Care coordination and services integration:** Efforts to coordinate care and integrate services across the health care continuum are critical to community health improvement. These efforts involve bringing together providers and information systems to coordinate health services, patient needs, and information. This helps better achieve the goals of treatment and care.

- **Patient navigation and access to health insurance:** One of the most significant challenges that people face in caring for themselves or their families is finding the services they need and navigating the health care system. Having health insurance that can help people pay for needed services is a critical first step. The availability of health coverage/insurance enrollment support, patient navigation, and resource inventories are important aspects of community health improvement.

- **Cross-sector collaboration and partnership:** When it comes to complex social challenges, such as community health improvement, there is a clear consensus that success will be achieved only through collective action, partnership, and collaboration across organizations and health-related sectors. No one organization or even type of organization can have a sustained impact on these types of issues on their own. Hospital implementation strategies must be collaborative and include partnerships with service providers across multiple sectors (e.g., health, public health, education, public safety).
COMMUNITY HEALTH PRIORITY AREAS

LHMC/LMCP’s CHNA and strategic planning process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the LHMC/LMCP’s CBAC and Community Relations staff identified three community health priority areas, which together embody the leading health issues and barriers to care for residents of the hospital’s service area: mental health and substance use disorder, chronic/complex conditions and risk factors, and the social determinants of health and access to care.

Community Health Needs Not Prioritized by LHMC/LMCP

It is important to note that there are community health needs that were identified by LHMC/LMCP’s assessment that were not prioritized for inclusion in the Implementation Strategy for a number of reasons:

- Feasibility of LHMC/LMCP having an impact in the short or long term
- Clinical expertise of the organization
- Limited burden on residents of the service area
- The issue is currently being addressed by community partners in a way that does not warrant additional support

For example, lack of affordable housing was identified as a community health issue, but it was deemed by the CBAC to be outside LHMC/LMCP’s primary sphere of influence. This is not to say that LHMC will not support efforts in this area; the hospital remains open and willing to work with hospitals across Beth Israel Lahey Health’s network and with other public and private partners to address this issue collaboratively.
PRIORITY POPULATIONS

LHMC/LMCP is committed to improving the health status and well-being of all residents living within its service area. However, in recognition of the considerable health disparities that exist in some communities, LHMC/LMCP focuses the bulk of its community benefits resources on improving the health status of underserved populations. The CBAC voted to prioritize low-resource individuals and families, older adults, youth/adolescents, and individuals with chronic/complex conditions.

The following is LHMC/LMCP’s Implementation Strategy. The grid below provides details on LHMC/LMCP’s goals, priority populations, objectives, activities, sample measures to track progress and outcomes, and potential partners. It is also noted that when applicable, LHMC/LMCP objectives align with state community health priorities. LHMC/LMCP looks forward to working toward these goals in collaboration with community partners in the years to come.
PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE USE DISORDER

Description: As it is throughout the Commonwealth and the nation, the burden of mental health issues and substance use disorder on individuals, families, communities, and service providers in LHMC/LMCP’s community benefits service area is overwhelming. Nearly every key informant interview, focus group, and listening session included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading issues in this domain. There were particular concerns regarding the impact of depression, anxiety, and e-cigarette/vaping on youth and social isolation among older adults. LHMC/LMCP recognizes the importance of primary prevention, so the hospital will continue to work with community partners to offer educational programs around mental health and substance misuse. The hospital will also enhance partnerships with community-based organizations to identify, screen, and refer youth with mental health and substance use issues to treatment. LHMC/LMCP will continue to partner and collaborate with community-based organizations that work with older adults to enhance access to supportive services and to services to reduce social isolation.

Resources/financial investment: LHMC/LMCP will commit direct community health program investments and in-kind resources of staff time and materials. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

<table>
<thead>
<tr>
<th>Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Populations</td>
</tr>
<tr>
<td>• Low-resource individuals and families  • Older adults  • Youth/adolescents  • Individuals with chronic/complex conditions</td>
</tr>
</tbody>
</table>
Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>State Priority Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-resource individuals and families</td>
<td>Explore opportunities for partnerships with community-based organizations</td>
<td>Provide financial resources to community-based partners to support evidence-based programs that address mental health and substance use disorder (e.g., funds to CHNAs, mini-grants)</td>
<td>• # of events/programs held</td>
<td>• CHNA 13/14</td>
<td>Mental illness and mental health</td>
</tr>
<tr>
<td>Older adults</td>
<td></td>
<td>Participate in collaboratives or task forces that address mental health and/or substance use disorder</td>
<td>• # of individuals reached</td>
<td>• CHNA 15</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Youth/adolescents</td>
<td></td>
<td></td>
<td>• # of initiatives funded</td>
<td>• Regional/local substance use disorder task forces</td>
<td></td>
</tr>
<tr>
<td>Individuals with chronic/complex conditions</td>
<td></td>
<td></td>
<td>• Financial support provided</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• # of referrals/links to treatment</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Pre-/post-activity tests to measure changes in knowledge, behaviors, intentions, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Low-resource individuals and families</td>
<td></td>
<td>Enhance partnerships with elder service providers to identify older adults at risk for mental health and substance use issues and promote access to treatment (e.g., licensed independent social workers at senior centers/Councils on Aging (COAs))</td>
<td></td>
<td>• CHNA 13/14</td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td></td>
<td></td>
<td></td>
<td>• CHNA 15</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescents</td>
<td></td>
<td></td>
<td></td>
<td>• Regional/local substance use disorder task forces</td>
<td></td>
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<tr>
<td>Individuals with chronic/complex conditions</td>
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<td></td>
<td></td>
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<tr>
<td>Low-resource individuals and families</td>
<td></td>
<td>Reduce environmental risk factors associated with mental health or substance use issues</td>
<td></td>
<td>• Senior centers/COAs</td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td></td>
<td></td>
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<tr>
<td>Youth/adolescents</td>
<td></td>
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<tr>
<td>Individuals with chronic/complex conditions</td>
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</tbody>
</table>
## Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>State Priority Area(s)</th>
</tr>
</thead>
</table>
| • Low-resource individuals and families  
• Older adults  
• Youth/adolescents  
• Individuals with chronic/complex conditions | Reduce environmental risk factors associated with mental health or substance use issues (continued) | Support initiatives that help reduce environmental risk factors associated with developing mental health issues (e.g., hoarding, social isolation) | • # of events/programs held  
• # of individuals reached  
• # of initiatives funded  
• Financial support provided  
• # of efforts and individuals reached by grantees  
• # of meetings attended  
• # of referrals/links to treatment  
• Pre-post-tests to measure changes in knowledge, behaviors, intentions, etc. | • Senior centers/COAs  
• Aging services access points | • Mental illness and mental health  
• Substance use disorder |
| Increase access to appropriate mental health and substance use disorder treatment and support services | Enhance access to integrated behavioral health services  
Provide support/referrals to individuals with mental health and/or substance use issues | | | • Primary care practices  
• Emergency department  
• Internal clinical staff | |
| Enhance the ability of local providers and community partners to understand, anticipate, and respond to health needs and social determinants of health | Provide education and support to providers and community partners to allow them to better understand and respond to emerging health needs and social determinants of health  
Support efforts to assess the overall health of the community (e.g., a Youth Risk Behavior Survey) | • Financial support provided  
• # of efforts and individuals reached | • Internal clinical staff  
• Local coalitions | • Mental illness and mental health  
• Substance use disorder |
PRIORITy AREA 2: CHRONIC/COMPLEX CONDITIONS AND RISK FACTORS

Description: LHMC/LMCP has a long history of working with community partners to create awareness of and provide education on these risk factors and their link to chronic and complex health conditions. The hospital will continue to support programs that provide opportunities for people to access low-cost, healthy food and opportunities for safe and affordable physical activity. Beyond addressing the risk factors, LHMC/LMCP is also committed to providing screening and educational opportunities, supporting individuals and caregivers throughout the service area to engage in chronic disease management programs and supportive services (e.g., integrative therapies, support groups), and providing links to care.

Resources/financial investment: LHMC/LMCP will commit direct community health program investments and in-kind resources of staff time and materials. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

| Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings |
|---|---|---|---|---|
| **Target Populations** | **Objectives** | **Activities** | **Sample Measures** | **Potential Partners** | **State Priority Area(s)** |
| • Low-resource individuals and families  
• Older adults  
• Youth/adolescents  
• Individuals with chronic/complex conditions | Increase awareness of and education about the risks and protective factors associated with chronic and complex conditions | Organize events and initiatives hosted and informed by clinical staff related to education and management of chronic/complex conditions and their risk factors (e.g., the women’s lecture series) | • # of events/programs held  
• # of individuals reached  
• # of initiatives funded  
• Financial support provided  
• # of partnerships  
• Pre-/post-activity tests to measure changes in knowledge, confidence in ability to mitigate risk factors, intention for behavioral change | • Internal clinical staff | Chronic disease |
| Support programs/activities in clinical and nonclinical settings that screen, educate, and refer patients for chronic/complex conditions and their risk factors | Implement and expand evidence-based programs and screenings (e.g., breast cancer risk assessments, skin cancer awareness and prevention, falls prevention, an osteoporosis program, Matter of Balance) | | | • Internal clinical staff  
• YMCAs |
### Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>Area(s)</th>
</tr>
</thead>
</table>
| • Low-resource individuals and families  
  • Older adults  
  • Youth/adolescents  
  • Individuals with chronic/complex conditions | Enhance access to and promote equitable care for vulnerable individuals with chronic/complex conditions | Explore partnerships with community-based organizations that work with vulnerable populations to overcome barriers to care and engage in appropriate treatment | • # of events/programs held  
  • # of individuals reached  
  • # of initiatives funded  
  • Financial support provided  
  • # of partnerships  
  • Pre-/post-activity tests to measure changes in knowledge, confidence in ability to mitigate risk factors, intention for behavioral change | • Community-based organizations | Chronic disease |

### Goal 2: Support individuals with or recovering from chronic/complex conditions and their caregivers

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>Area(s)</th>
</tr>
</thead>
</table>
| • Low-resource individuals and families  
  • Older adults  
  • Youth/adolescents  
  • Individuals with chronic/complex conditions | Increase access to supportive services to reduce stress and anxiety, reduce negative symptoms and side effects, and increase overall well-being | Partner with community-based organizations to increase opportunities for cancer survivors to engage in safe physical activities and reduce social isolation  
 Provide support and care navigation to individuals who are undergoing treatment for chronic/complex conditions and their families | • # of activities/programs  
  • Financial support provided  
  • # of individuals reached  
  • Pre-/post-activity tests to measure changes in knowledge, confidence in abilities, stress/mood, activity level, intention for behavioral change | • YMCAs  
 • Internal clinical staff | Chronic disease |
PRIORITY AREA 3: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE

**Description:** The social determinants of health are often the drivers of or the underlying factors that create or exacerbate mental health issues, substance misuse, and chronic/complex conditions. These social determinants of health, particularly poverty, also underlie many of the access-to-care issues that were prioritized in the assessment: navigating the health system (including health insurance), chronic disease management, and affording care.

LHMC/LMCP is committed to addressing social determinants and breaking down barriers to care. The hospital will continue to collaborate with community-based organizations to engage individuals in services, reduce financial burdens, increase access to appropriate primary and specialty care services, and support healthy families and communities. LHMC/LMCP is also committed to strengthening the local workforce and addressing unemployment by supporting job-training programs.

**Resources/financial investment:** LHMC/LMCP will commit direct community health program investments and in-kind resources of staff time and materials. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

<table>
<thead>
<tr>
<th>Goal 1: Address the social determinants of health and access to care</th>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>State Priority Area(s)</th>
</tr>
</thead>
</table>
| • Low-resource individuals and families  
• Older adults  
• Youth/adolescents  
• Individuals with chronic/complex conditions | Increase partnerships and collaboration with community-based organizations to address the social determinants of health | Provide community health grants to support evidence-based programs that address issues associated with the social determinants of health | • # of initiatives funded  
• Financial support provided  
• # of individuals/families reached  
• # of vouchers provided  
• # of individuals enrolled in health insurance  
• # of individuals placed at a job  
• # of individuals trained  
• Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market  
• Pre-/post-activity tests to measure physical activity, confidence, behavior change | • CHNA 13/14  
• CHNA 15 | • Built environment  
• Social environment  
• Housing  
• Education  
• Employment |
<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>State Priority Area(s)</th>
</tr>
</thead>
</table>
| • Low-resource individuals and families                 | Increase partnerships and collaboration with community-based organizations to address the social determinants of health (continued) | Participate in diverse, multisector collaborations and task forces to address social determinants of health and risk factors | • # of initiatives funded  
• Financial support provided  
• # of individuals/families reached  
• # of vouchers provided  
• # of individuals enrolled in health insurance  
• # of individuals placed at a job  
• # of individuals trained | • CHNA 13/14  
• CHNA 15 | • Built environment  
• Social environment  
• Housing  
• Education  
• Employment |
| • Older adults                                          | Increase access to affordable and safe transportation options               | Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation | • Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market  
• Pre-/post-activity tests to measure physical activity, confidence, behavior change | • Senior centers/COAs  
• Aging services access points | Built environment |
| • Youth/adolescents                                     | Educate providers and community members about hospital and/or public assistance programs that can help identify and enroll individuals in appropriate health insurance plans and/or reduce their financial burden | Provide enrollment counseling/assistance and patient navigation support services to uninsured and/or underinsured residents to enhance access to care (e.g., patient financial counselors, the Serving Health Information Needs of Everyone program) |                                                                                   | • CHNA 13/14  
• CHNA 15 | |
| • Individuals with chronic/complex conditions          | Provide community health grants to community partners to support evidence-based programs that address issues associated with access-to-care issues |                                                                                   |                                                                                   |                     |                        |
### Goal 1: Address the social determinants of health and access to care

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>State Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low-resource individuals and families</td>
<td>Work to help strengthen the local workforce</td>
<td>Collaborate with local community partners to support job-training programs that strengthen the local workforce and address underemployment</td>
<td>• # of initiatives funded&lt;br&gt;• Financial support provided&lt;br&gt;• # of individuals/families reached&lt;br&gt;• # of vouchers provided&lt;br&gt;• # of individuals enrolled in health insurance</td>
<td>• Local high schools&lt;br&gt;• Local colleges/universities</td>
<td>Employment</td>
</tr>
<tr>
<td>• Older adults</td>
<td>Increase awareness of domestic violence and promote links to services</td>
<td>Provide crisis intervention and education to staff to identify and respond to the needs of victims</td>
<td>• # of individuals placed at a job&lt;br&gt;• # of individuals trained&lt;br&gt;• Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market&lt;br&gt;• Pre-/post-activity tests to measure physical activity, confidence, behavior change</td>
<td>• LHMC Emergency Department&lt;br&gt;• LHMC Social Work&lt;br&gt;• Saheli&lt;br&gt;• Local first responders</td>
<td>Violence</td>
</tr>
<tr>
<td>• Youth/adolescents</td>
<td>Promote resilience and emergency preparedness</td>
<td>Provide free training to first responders and community partners</td>
<td></td>
<td>• LHMC Trauma Department&lt;br&gt;• Local schools&lt;br&gt;• Local public health departments</td>
<td></td>
</tr>
<tr>
<td>• Individuals with chronic/complex conditions</td>
<td>Increase access to affordable and nutritious foods</td>
<td>Support community-based programs that address food insecurity and promote access to healthy foods</td>
<td></td>
<td>• Mill City Grows&lt;br&gt;• YMCAs&lt;br&gt;• Senior centers/COAs&lt;br&gt;• Aging services access points</td>
<td>Built environment</td>
</tr>
</tbody>
</table>
## Goal 1: Address the social determinants of health and access to care

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Objectives</th>
<th>Activities</th>
<th>Sample Measures</th>
<th>Potential Partners</th>
<th>State Priority Area(s)</th>
</tr>
</thead>
</table>
| Low-resource individuals and families   | Increase access to affordable and free opportunities for physical activity| Support community-based initiatives to offer free or low-cost physical activity | • # of initiatives funded  
• Financial support provided  
• # of individuals/families reached  
• # of vouchers provided  
• # of individuals placed at a job  
• Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market  
• Pre-/post-activity tests to measure physical activity, confidence, behavior change | • YMCAs  
• Senior centers/COAs  
• Aging services access points | Built environment |
| Older adults                            |                                                                           |                                                                            |                                                                              |                                         |                        |
| Youth/adolescents                       |                                                                           |                                                                            |                                                                              |                                         |                        |
| Individuals with chronic/complex        |                                                                           |                                                                            |                                                                              |                                         |                        |
| conditions                               |                                                                           |                                                                            |                                                                              |                                         |                        |
Appendix E:

Acronyms
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>AG</td>
<td>Attorney General</td>
</tr>
<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>BH</td>
<td>Beverly Hospital</td>
</tr>
<tr>
<td>BH-AGH</td>
<td>Beverly Hospital/Addison Gilbert Hospital</td>
</tr>
<tr>
<td>BILH</td>
<td>Beth Israel Lahey Health</td>
</tr>
<tr>
<td>BILHBS</td>
<td>Beth Israel Lahey Health Behavioral Services</td>
</tr>
<tr>
<td>CBAC</td>
<td>Community Benefits Advisory Committee</td>
</tr>
<tr>
<td>CBSA</td>
<td>Community Benefits Service Area</td>
</tr>
<tr>
<td>CHIA</td>
<td>Center for Health Information and Analysis</td>
</tr>
<tr>
<td>CHNA</td>
<td>Community Health Needs Assessment</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>HMOs</td>
<td>Health Maintenance Organizations</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow, Inc.</td>
</tr>
<tr>
<td>LEP</td>
<td>Limited English Proficiency</td>
</tr>
<tr>
<td>LHMC</td>
<td>Lahey Hospital &amp; Medical Center</td>
</tr>
<tr>
<td>LMCP</td>
<td>Lahey Medical Center - Peabody</td>
</tr>
<tr>
<td>MassCHIP</td>
<td>Massachusetts Community Health Information Profile</td>
</tr>
<tr>
<td>MHAC</td>
<td>Massachusetts Healthy Aging Collaborative</td>
</tr>
<tr>
<td>MDPH</td>
<td>Massachusetts Department of Public Health</td>
</tr>
<tr>
<td>MHPC</td>
<td>Massachusetts Health Policy Commission</td>
</tr>
<tr>
<td>PAC</td>
<td>Project Advisory Committee</td>
</tr>
<tr>
<td>PHIT</td>
<td>Population Health Information Tool</td>
</tr>
<tr>
<td>PQI</td>
<td>Prevention Quality Indicator</td>
</tr>
<tr>
<td>SDOH</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>YRBS</td>
<td>Youth Risk Behavior Survey</td>
</tr>
</tbody>
</table>