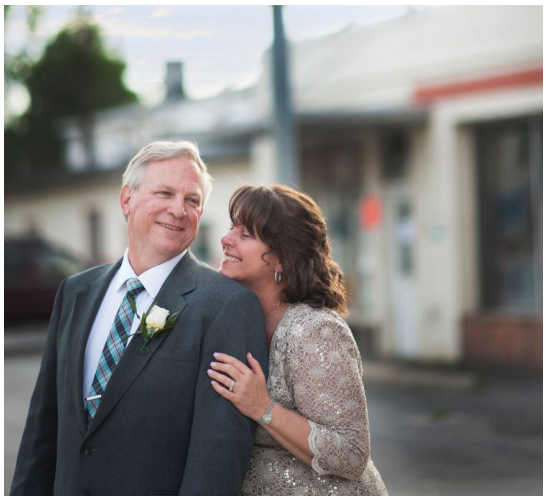
COMMUNITY HEALTH NEEDS ASSESSMENT

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

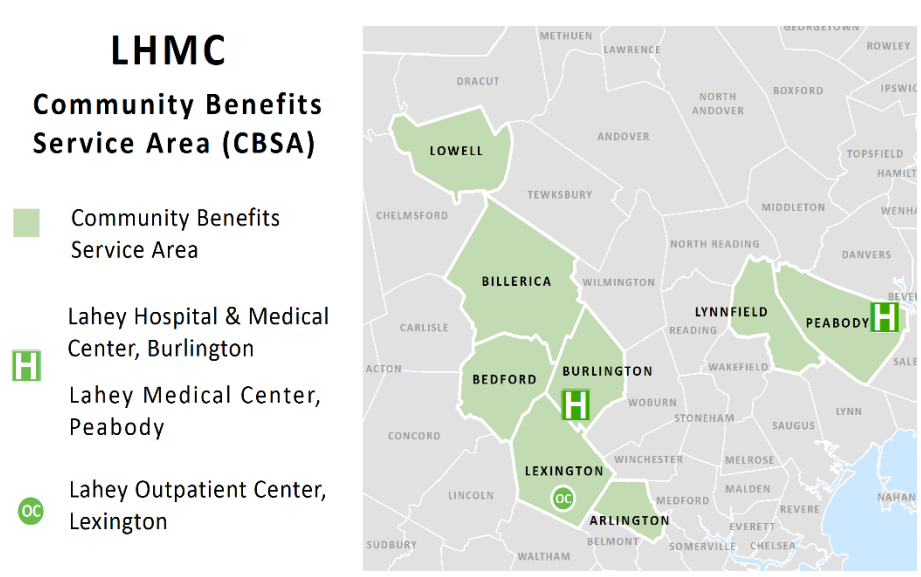
Lahey Clinic Hospital, Inc. includes both Lahey Hospital & Medical Center (LHMC) and Lahey Medical Center – Peabody. Together, they are referred to as LHMC/LMCP throughout this report. Both hospitals are part of the Beth Israel Lahey Health (BILH) system.

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

LHMC/LMCP Community Benefits Service Area



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 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

Phase 1 – Preliminary Assessment and Engagement	Phase 2 – Targeted Engagement	Phase 3 – Strategic Planning and Reporting
Identify health needs	**Engage key stakeholders**	**Develop Community Health Needs Assessment and Implementation Strategy**
• Collection and analysis of quantitative data to characterize community characteristics, health needs, and barriers to care. • Qualitative data collection through key informant interviews with hospital leaders, local service providers, town leaders, and community stakeholders. • Evaluation of the hospital's current portfolio of community benefits activities. • Synthesis of findings from quantitative and qualitative research to identify themes and areas of consensus.	• Focus groups with target populations and service providers. • Community forums with community residents and service providers. • 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.	• 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. • Creation of a Resource Inventory to catalog local organizations, service providers, and community assets that have the potential to address identified needs. • Literature review of evidence-based strategies and identification of successful strategies being conducted by community-based organizations to respond to identified health priorities. • Development of a final CHNA report and Implementation Strategy.
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

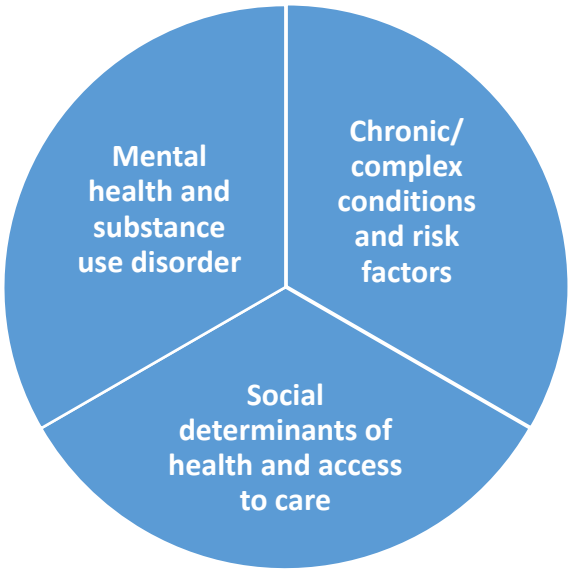
socioeconomic status (fresh foods being expensive, and gyms and health centers unaffordable). Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

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.

2020-2022 LHMC/LMCP Community Health Priorities



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.

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

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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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Noreen Gavin, Community Relations Coordinator, Community Relations, Beth Israel Lahey Health
Marylou Hardy, Regional Manager, Community Relations, Winchester Hospital
Wendy Hawkins, Project Manager/Senior Planning Analyst, Market Analytics and Intelligence, Beth Israel Lahey Health
Robert Murray, Manager, Market Analytics and Intelligence, Lahey Health
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Grace Numerosi, Regional Manager, Community Relations, Beverly Hospital-Addison Gilbert Hospital
Michelle Snyder, Regional Manager, Community Relations, Lahey Hospital & Medical Center

Lahey Hospital & Medical Center Community Benefits Advisory Committee 2019
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Eric Conti, Superintendent, Burlington Public Schools; President, Middlesex League
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Christine Healey, Director, Community Relations, Beth Israel Lahey Health
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Bruce MacDonald, Executive Director, Metro North YMCA
Linda McGoldrick, Lahey Hospital & Medical Center Board of Trustees
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Beth Israel Lahey Health – North: Project Advisory Committee 2019
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Sharon Cameron, Public Health Director, City of Peabody
Karin Carroll, Public Health Director, City of Gloucester
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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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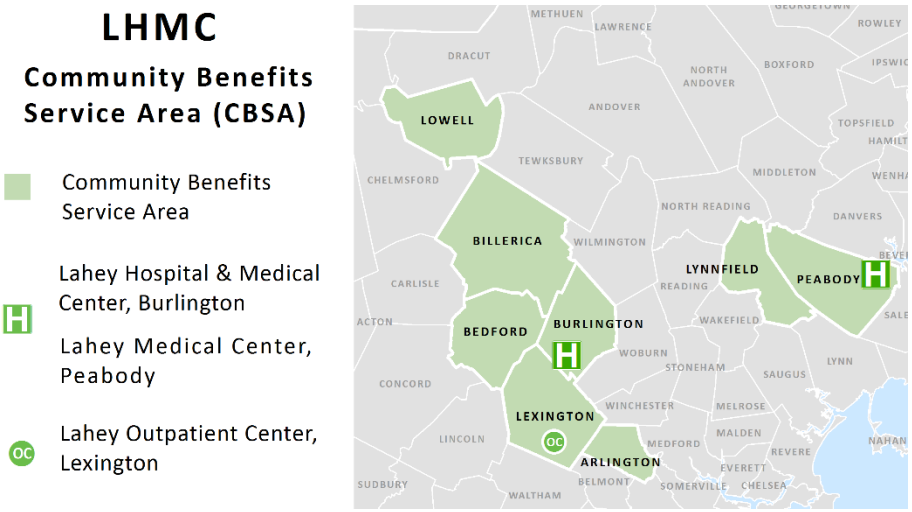
Figure 1: LHMC/LMCP Community Benefits Service Area



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

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:

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

LHMC/LMCP CBAC	
Meeting Date	**Agenda**
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
PAC	
Meeting Date	**Agenda**
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.

Table 2: Assessment phases

Phase 1 – Preliminary Assessment and Engagement	Phase 2 – Targeted Engagement	Phase 3 – Strategic Planning and Reporting
Identify health needs	**Engage key stakeholders**	**Develop CHNA and Implementation Strategy**
• Collection and analysis of quantitative data to characterize community characteristics, health needs, and barriers to care. • Qualitative data collection through key informant interviews with hospital leaders, local service providers, town leaders, and community stakeholders. • Evaluation of hospital's current portfolio of community benefits activities. • Synthesis of findings from quantitative and qualitative research to identify themes and areas of consensus.	• Focus groups with target populations and service providers. • Community forums with community residents and service providers. • 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.	• Meetings with the CBAC and PAC to present CHNA findings, prioritize community health issues, identify vulnerable populations, and discuss potential responses. • Creation of a Resource Inventory to catalog local organizations, service providers, and community assets that have the potential to address identified needs. • Literature review of evidence-based strategies and identification of successful strategies being conducted by community-based organizations to respond to identified health priorities. • Development of a final CHNA report and Implementation Strategy.
Steering Committee meetings to plan and manage project activities.		

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:

- U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017)
- 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, Registry of Vital Records and Statistics (2015)
- 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

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

*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.

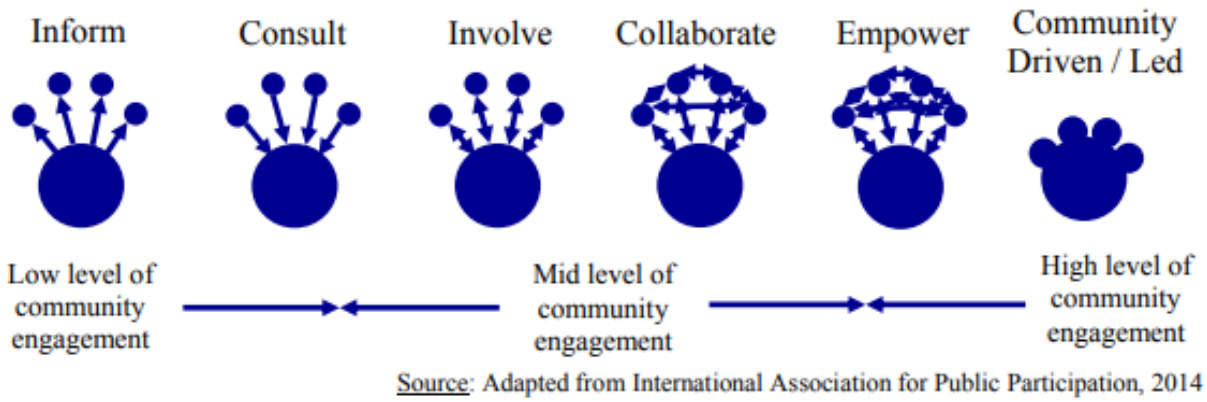
Additionally, quantitative data was not stratified by age, race/ethnicity, income, or other characteristics, which limited the ability to identify health disparities in an objective way. Qualitative activities allowed for exploration of these issues, but the lack of objective quantitative data constrained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



Source: Adapted from International Association for Public Participation, 2014

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.

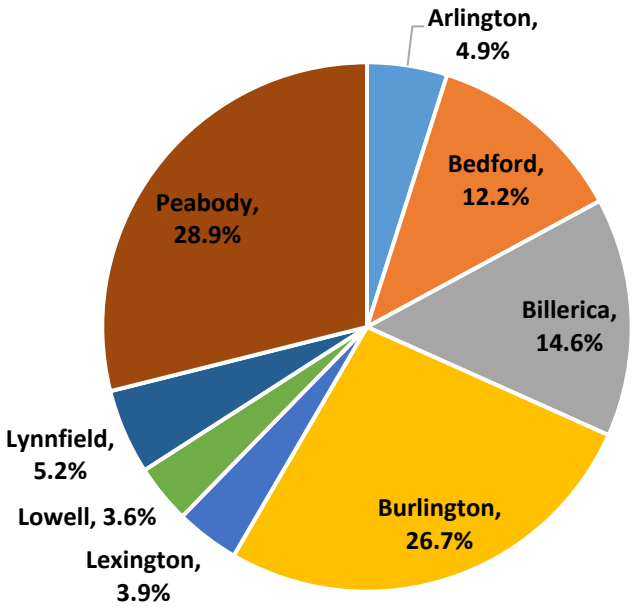
Community listening sessions (two) – LHMC/LMCP partnered with the two CHNAs in its service area to co-host the listening sessions. One session was held in collaboration with CHNA 15 and Emerson Hospital in Bedford and one in collaboration with CHNA 13/14 in Peabody. CHNA 15 and 13/14 included representatives 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.

Figure 3: Community Health Survey results, responses by municipality



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

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

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 5: Sample of 2017-2019 community benefits programs and outcomes

Health Priority Area	Program	Program Highlights	Outcomes
Wellness, prevention, and chronic disease management	Free breast cancer risk assessments	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.	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.
Elder health	Serving Health Information Needs of Everyone (SHINE) program	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.	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.
Behavioral health (mental health and substance use)	Medication disposal box	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.	In FY18, LHMC collected and disposed of 471 pounds of medications.

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.

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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 6: Population and age distribution (2013-2017)

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

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.

[2] "CDC Health Disparities & Inequalities Report (CHDIR)." CDC, 10 Sept. 2015, https://www.cdc.gov/minorityhealth/chdireport.html

[3] "Hispanic/Latino Profile." U.S. Department of Health and Human Services: Office of Minority Health, n.d., https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64

[4] "Why Are Asians at Higher Risk?" Asian Diabetes Prevention Initiative, n.d., https://asiandiabetesprevention.org/what-is-diabetes/why-are-asians-higher-risk

- 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)

	White alone (%)	Black or African American alone (%)	Asian alone (%)	Hispanic or Latino of any race (%)	Foreign-born (%)
Massachusetts	78.9	7.4	6.3	11.2	16.2
Essex County	80.6	4.0	3.4	19.6	16.2
Middlesex County	77.9	5.2	11.2	7.7	20.5
Arlington	81.7	1.9	11.5	4.3	18.6
Bedford	79.1	3.3	14.6	4.0	16.2
Billerica	86.6	3.4	6.2	4.3	11.0
Burlington	76.2	5.1	16.0	2.0	21.7
Lexington	68.3	0.8	27.3	2.1	25.9
Lowell	60.8	7.3	21.0	20.3	26.7
Lynnfield	92.6	0.6	5.0	2.8	8.5
Peabody	87.7	3.4	1.4	9.3	15.7

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 biggest barrier for non-English speakers is lack of information. People don't know what programs are available to them." – *Key informant*

- 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

[5] Denboba, DL, et al. "Reducing health disparities through cultural competence." *Journal of Health Education,* vol. 21, no. 1, 1998, S47-S53

(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)

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

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.[6] 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.[7]

Education

Higher education is associated with improved health outcomes and social development at the individual and community levels.[8] Compared with individuals with more education, people with less education are more likely to experience health issues, such as obesity, substance use, and injury.[9] 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.[10] 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%).

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6 "Social Determinants of Health: Know What Affects Health," CDC, 29 Jan. 2018, https://www.cdc.gov/socialdeterminants/
7 Chetty, Raj, et al. "The Association Between Income and Life Expectancy in the United States, 2001-2014." *Journal of the American Medical Association,* vol. 315, no. 16, 2016, p.1750-1766
8 Zimmerman, Emily B., Woolf, Steven H., and Haley, Amber. "Population Health: Behavioral and Social Science Insights – Understanding the Relationship Between Education and Health," *Institute of Medicine*, June 2014, https://nam.edu/wp-content/uploads/2015/06/BPH-UnderstandingTheRelationship1.pdf
9 "Adolescent and School Health: Health Disparities," CDC, 17 Aug. 2018, https://www.cdc.gov/healthyyouth/disparities/index.htm
10 Zimmerman, Population Health

Table 9: Educational attainment (2013-2017)

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

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%).

Table 10: Characteristics of public school students (2017, 2018-2019)

	Dropout rate (%) 2017	First language not English (%), 2018-2019	English language learners (%), 2018-19	Students with disabilities* (%), 2018-19	Economically disadvantaged students** (%), 2018-19
Massachusetts	4.9	21.9	10.5	18.1	31.2
Essex County	N/A	N/A	N/A	N/A	N/A
Middlesex County	N/A	N/A	N/A	N/A	N/A
Arlington	1.0	12.0	4.3	15.5	7.5
Bedford	0.5	18.2	6.6	16.6	8.7
Billerica	6.5	8.5	1.5	17.0	15.6
Burlington	0.4	18.3	4.2	13.7	11.4
Lexington	0.2	30.8	8.8	14.1	5.4
Lowell	6.5	28.6	23.7	17.3	53.8
Lynnfield	0.0	7.4	2.1	17.7	7.2
Peabody	6.5	14.0	8.9	19.7	30.3

Source: Massachusetts Department of Elementary and Secondary Education School and District Profiles
Source: MA Department of Elementary and Secondary Education, 2018-2019
*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

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.

Among those who responded to the Community Health Survey, 46% identified "low-income populations" as a segment with the greatest health needs.

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%).

- 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)

	Unemployment rate (%)	Median household income ($)	Below 200% poverty (%)
Massachusetts	6.0	74,167	23.7
Essex County	6.0	73,533	24.2
Middlesex County	4.8	92,878	17.9
Arlington	3.6	103,594	11.9
Bedford	4.8	125,208	10.4
Billerica	4.9	99,453	11.4
Burlington	4.9	99,254	10.4
Lexington	4.9	162,083	8.2
Lowell	8.4	48,581	41.6
Lynnfield	7.2	117,706	5.5
Peabody	5.3	65,085	22.9

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.[11] 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.[12]

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

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.[13] Many key informants and focus group/forum participants expressed concern over the limited options for affordable housing throughout the service

[11] Krieger, James and Higgins, Donna L. "Housing and Health: Time Again for Public Health Action," *American Journal of Public Health,* vol. 92, no. 5, 2002, 758-768

[12] Kottke, Thomas, Abariotes, Andriana, and Spoonheim, Joel B. "Access to Affordable Housing Promotes Health and Well-Being and Reduces Hospital Visits," *The Permanente Journal,* vol. 22, 2018, 17-79

[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).

> "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*

Table 12: Housing (2013-2017)

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

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.

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.

30% of Community Health Survey respondents identified transportation issues as barriers that prevent people from being able to live a healthy life.

- 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)

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

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

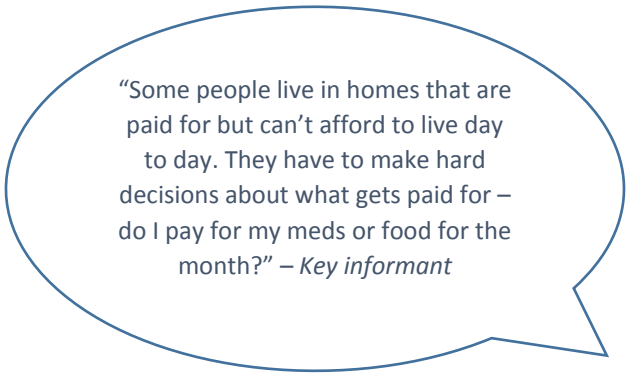
Shading represents statistical significance compared with the commonwealth overall. Figures highlighted in orange are statistically higher compared with the commonwealth overall, while figures highlighted in blue are significantly lower.

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.[14] 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.[15] 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).[16]

- 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.

[14] Elsheikh, E. and Barhoum, N. "Structural Racialization and Food Insecurity in the United States: A Report to the U.N. Human Rights Committee on the International Covenant on Civil and Political Rights," 2013, https://haasinstitute.berkeley.edu/sites/default/files/Structural%20Racialization%20%20%26%20Food%20Insecurity%20in%20the%20US-%28Final%29.pdf

[15] "Access to Healthy Food and Why It Matters: A Review of the Research," *The Food Trust*, n.d., http://thefoodtrust.org/uploads/media_items/executive-summary-access-to-healthy-food-and-why-it-matters.original.pdf

[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

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

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)

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

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.[17] 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*

[17] "Health Insurance and Access to Care," *National Center for Health Statistics*, Feb. 2017, https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf

- 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)

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

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.

46% of Community Health Survey respondents identified physical inactivity, nutrition, and/or obesity as health issues people struggle with the most.

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)

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

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.[18] 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:

[18] "Adults Need More Physical Activity," CDC, 23 March 2019, https://www.cdc.gov/physicalactivity/inactivity-among-adults-50plus/index.html

- 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

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

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.[19] 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)

	All causes mortality rate	Premature mortality rate (< 75)
Massachusetts	684.5	279.6
Essex County	691.9	284.4
Middlesex County	616.5	227.7
Arlington	614.6	233.3
Bedford	663.0	265.8
Billerica	903.4	315.4
Burlington	821.5	272.9
Lexington	425.6	146.5
Lowell	917.9	479.1
Lynnfield	607.7	209.5
Peabody	731.3	295.8

Source: MDPH Registry of Vital Records and Statistics, 2015

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.[20] Over half of American adults have at least one chronic condition, while 40% have two or more.[21] 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.

[20] "Chronic Diseases in America," CDC, 15 April 2019, https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

[21] "Chronic Diseases in America," CDC

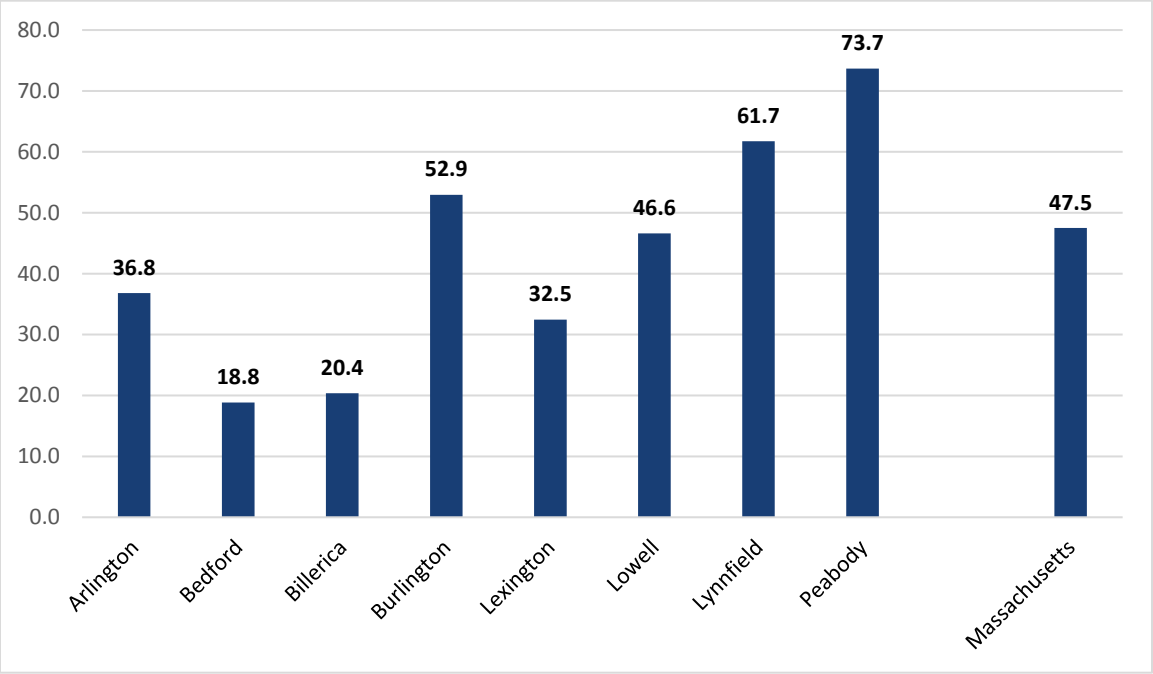
Cardiovascular and Cerebrovascular Diseases

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.

46% of Community Health Survey respondents identified cardiovascular conditions (e.g., hypertension, heart disease, stroke) as health issues people struggle with the most.

- 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.

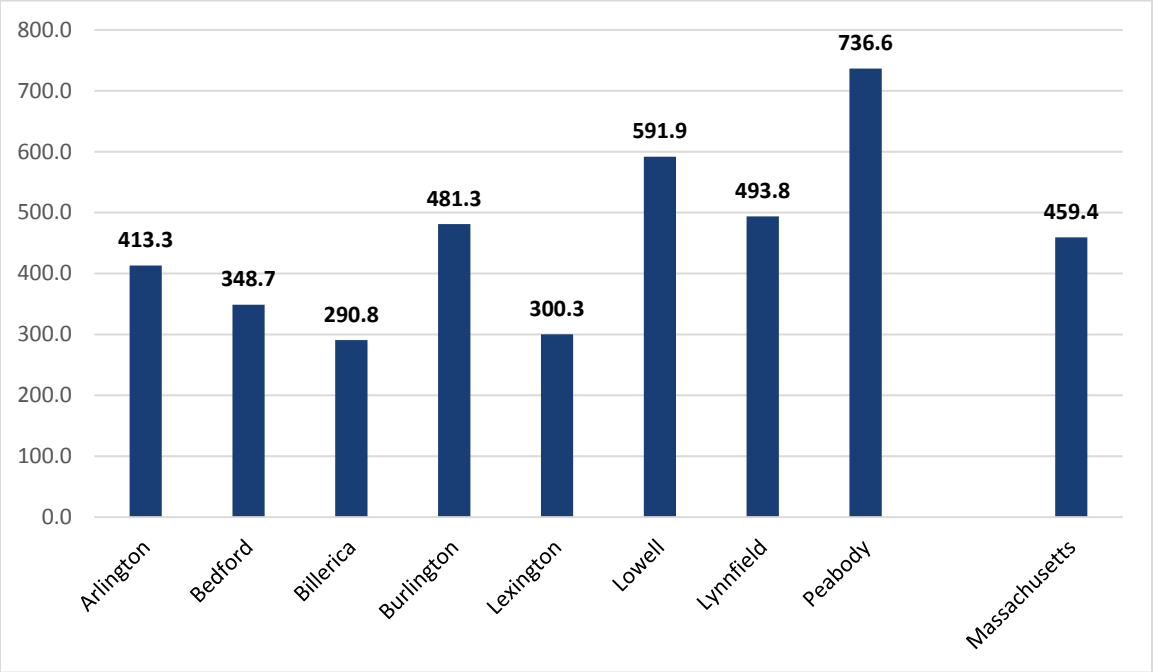
Figure 4: Hypertension PQI rates per 100,000 population (2017)



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

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

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

	Cancer inpatient hospitalizations (all types)	Cancer mortality (all types)*	Breast cancer mortality (female)*	Lung cancer mortality*	Prostate cancer mortality*
Massachusetts	456.3	152.8	9.8	39.0	7.0
Essex County	N/A	146.4	16.9	37.3	19.6
Middlesex County	N/A	140.8	16.2	35.2	14.8
Arlington	478.4	160.1	19.8	28.7	36.9
Bedford	395.8	153.0	50.3	38.7	‡
Billerica	331.5	168.1	23.2	43.7	‡
Burlington	413.9	182.8	‡	57.0	‡
Lexington	486.9	101.9	0.0	9.7	0.0
Lowell	357.7	174.7	14.8	41.5	‡
Lynnfield	524.7	121.3	‡	35.3	0.0
Peabody	610.0	158.8	21.1	43.1	24.3

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.

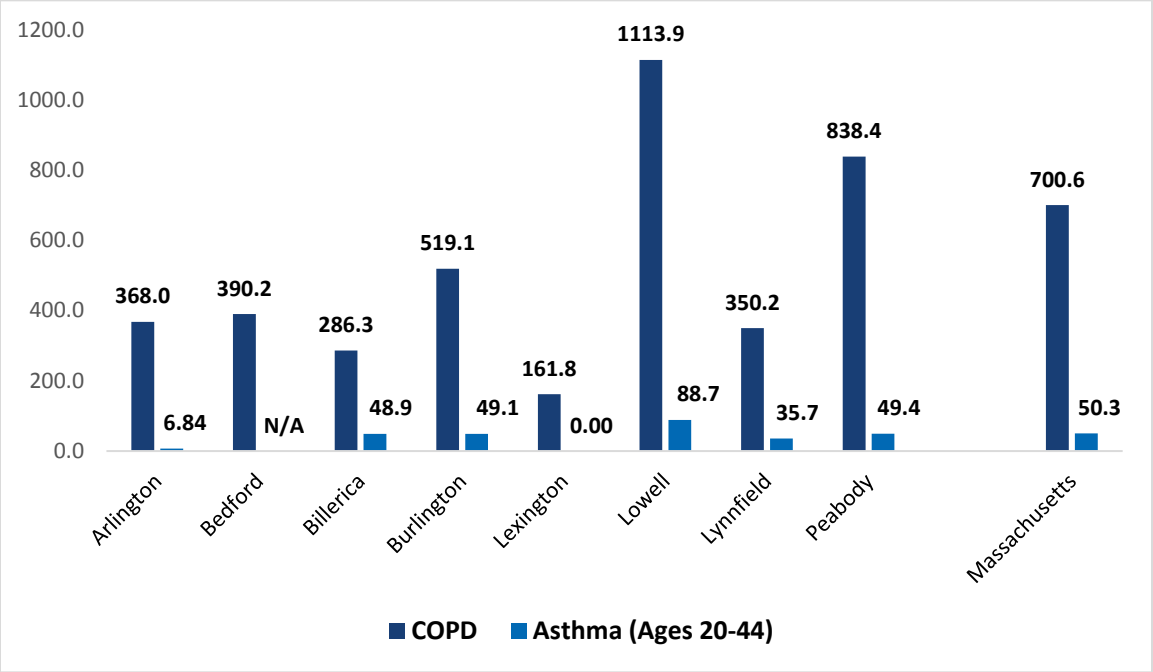
Respiratory Diseases

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).

[22] "Respiratory Diseases," Office of Disease Prevention and Health Promotion, n.d., https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases

Figure 6: COPD (ages 45+) and asthma among younger adults (20-44) PQI rates, per 100,000 (2017)



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

- 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

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

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

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

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, 2015

‡ Data suppressed because of small numbers.

[23] "Hispanic Health: Preventing Type 2 Diabetes," CDC, 18 Sept. 2017, https://www.cdc.gov/features/hispanichealth/index.html

[24] "Management of Common Comorbidities of Diabetes." American Association of Clinical Endocrinologists, n.d., http://outpatient.aace.com/type-2-diabetes/management-of-common-comorbidities-of-diabetes

[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

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.

46% of Community Health Survey respondents identified mental health as a health issue that people struggle with. Survey respondents also identified outpatient mental health service as the hardest health service for people to access.

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)

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

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.

Figure 7: Youth mental health, from YRBS data

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

Source: Youth Risk Behavior Surveys, multiple years

*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?"

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.

Community Health Survey respondents identified inpatient substance use services as the second hardest health service for community residents to access.

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.

- 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

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

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

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

Source: YRBS

*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

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.

Community Health Survey respondents were asked to identify the segments of the population with the greatest health needs – older adults (65+) was the most common response (65%).

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)

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

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)

	Rate per 1,000
Massachusetts	4.3
Essex County	4.8
Middlesex County	3.1
Arlington	‡
Bedford	‡
Billerica	‡
Burlington	‡
Lexington	0.0
Lowell	6.4
Lynnfield	0.0
Peabody	‡

Source: MDPH Registry of Vital Records and Statistics, 2015

‡ 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.

[26] "Maternal, Infant, and Child Health." HealthyPeople 2020, n.d., https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

Table 29: Infectious disease

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

Source: MDPH Bureau of Infectious Disease and Laboratory Services, 2017

*Source: MDPH Registry of Vital Records and Statistics, 2015

**Source: Massachusetts Healthy Aging Collaborative, 2018

‡ 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

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

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.

Figure 9: LHMC/LMCP priority areas, 2020-2022

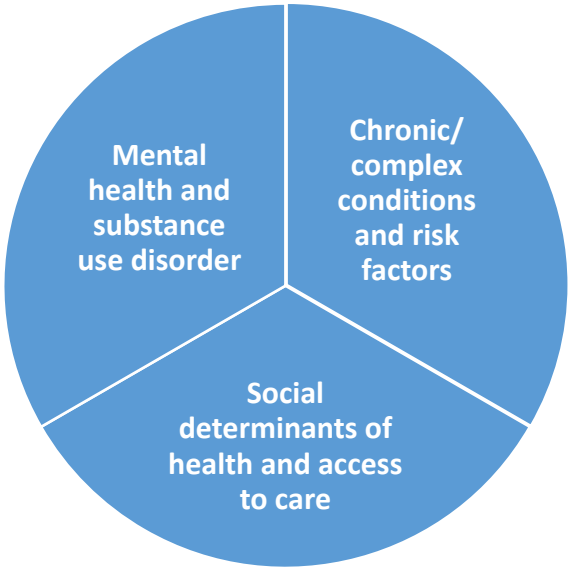


Table 31 includes a comparison of priority issues that were chosen from the 2016 and 2019 community health needs assessments.

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

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

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

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

Appendix A:

Detailed Community Engagement Approach

APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

Key Informant Interviews

BILH-Northern Region (formerly Lahey Health) Internal Interviewees		
Name	**Title/Affiliation**	**Sectors(s) Represented/ Population Served**
Richard Nesto, MD	Chief Medical Officer, Beth Israel Lahey Health	Health System Leadership
Deborah Costello	Chief Operating Officer, Home Health and Hospice, Lahey Health at Home	Home Health
Hilary Jacobs	President, Beth Israel Lahey Health Behavioral Health Services	Behavioral Health
Leslie Sebba, MD	President and Chief Medical Officer, Lahey Clinical Performance Network	Health System Leadership
Theresa Giove	Executive Director, Urgent Care	Health System Leadership; Clinical Care
Linda Wller-Newcomb	Vice President, Lahey Health Cancer Institute	Health System Leadership; Chronic/Complex Conditions
Richard Iseke	Chief Quality Officer, Lahey Health System	Health System Leadership
Pauline Lodge	Senior Vice President, Business Dev/Marketing & Communications	Health System Leadership
Wayne Saltsman, MD	Chief Medical Officer, Lahey Health Continuing Care	Health System Leadership
LHMC Internal Key Informant Interviewees		
David Longworth, MD	Interim Chair, Beth Israel Lahey Health Primary Care Network Chief Executive Officer, Lahey Hospital & Medical Center	Hospital leadership
Stathos Antoniades	Chief Operating Officer, Lahey Hospital & Medical Center	Hospital leadership
Andrew Villanueva, MD	Chief of Quality and Safety, Lahey Hospital & Medical Center	Hospital leadership
Patrick Aquino, MD	Psychiatry, Lahey Hospital & Medical Center	Hospital leadership; Behavioral health
Michelle McCool Heatley	Assistant Chief Nursing Officer, Lahey Hospital & Medical Center	Hospital leadership; Clinical services
Lars Reinhold, MD	Interim Chief of Primary Care, Lahey Hospital & Medical Center	Hospital leadership; Primary care
Sandi Mackey	Trauma Service Nurse Director, Lahey Hospital & Medical Center	Hospital leadership; Clinical services
Brenda Joseph and committee members	Cancer Committee, Lahey Hospital & Medical Center	Hospital-based; Chronic/complex conditions
Ursala Tice and council members	Diversity Council, Lahey Hospital & Medical Center	Hospital-based; Diversity
Jane Edmonds	Board of Directors, Lahey Hospital & Medical Center Vice President for Programming & Community Outreach Babson, College	Hospital leadership; Higher education

APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

External Key Informant Interviewees		
Kelly Magee-Wright	Executive Director, Minuteman Senior Services	Older adult health/healthy aging
Alison Cservenchi	Director, Bedford Council on Aging	Older adult health/healthy aging
Heidi Porter	Director, Bedford Board of Health	Municipal leadership; Health
Kathy Fox David Neylon	Health Agent, Public Health, Town of Lexington	Municipal leadership; Public health
Melissa Interess	Acting Director, Human Services Department, Town of Lexington	Municipal leadership; Human services
Amy Pessia	Executive Director, Merrimack Valley Food Bank	Food insecurity
Peg Sallade	Director, A Healthy Lynnfield Coalition	Substance abuse prevention
John Feudo	Executive Director, Burbank YMCA	Healthy communities; Children and families
Bill Petryszyn	Executive Director, North Suburban YMCA	Healthy communities; Children and families
Kevin Cyr	Director of Teaching and Learning, Lynnfield Public Schools	Education; Youth and adolescents

Municipal Leadership	
Burlington Town Leaders	Paul Sagarino, Town Administrator Marge McDonald, Director, Council on Aging Christine Shruhan, Executive Director, Burlington Youth & Family Services Steve Yetman, Fire Chief Michael Kent, Chief of Police Ed Weiner, Chairperson, Burlington Board of Health Susan Lumenello, Director, Burlington Board of Health
Billerica Town Leaders	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
Peabody Town Leaders	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
Arlington Town Leaders	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 Subtance Use Prevenention Director Karen Koresky

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?

APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

Focus Groups

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

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?*

APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

- **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

Name of group	Population/Sectors Represented	Date	Location	Number of attendees (approximate)
Community session - Bedford	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.)	March 7, 2019	Minuteman Senior Services, Bedford	25
Community session - Peabody	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.)	May 2, 2019	Peabody Senior Center	12

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 it's 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?

APPENDIX A: DETAILED COMMUNITY ENGAGEMENT SUMMARY

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
Elected officials
Community Teamwork
Lynnfield Rotary
Wicked Local Lexington

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

__ Transportation issues

__ Cannot find or afford healthy foods

__ No or limited health insurance

__ No or limited education

__ Poverty, low wages, no jobs

__ Other (please specify)

__ Unsafe streets (bad roads or sidewalks)

__ Physical inactivity or sedentary lifestyle

__ Social isolation, lack of support, loneliness

__ Long commute to/from work or school

__ Discrimination, racism, distrust

__ Crime or violence

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

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

Key

Statistically higher than statewide rate

Statistically lower than statewide rate

	MA	*Essex County*	*Middlesex County*	*Arlington*	*Bedford*	*Billerica*	*Burlington*	*Lexington*	*Lowell*	*Lynnfield*	*Peabody*	*Source*
Demographics												
Population	6789319	775860	1582857	44992	14105	42791	26103	33339	110964	12732	52610	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Age												
Under 5 years	5.3	5.6	5.5	7	5.7	5.3	5.3	4.7	6.9	4.8	5.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
5 to 9 years	5.5	5.8	5.5	6.3	7.5	5.3	5.5	6.9	6.3	6.4	3.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
10 to 14 years	5.9	6.4	5.7	4.7	7.5	5.1	6.1	9.2	6	8.1	4.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
15 to 19 years	6.8	6.7	6.5	4.8	6	6.8	5.5	7.2	7.5	7.2	5.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
20 to 24 years	7.2	6.6	6.9	3.4	3.3	5.8	5.4	3.3	9.5	4.7	6.7	US Census Bureau, 2013-2017 ACS 5-Year Estimates
25 to 34 years	13.9	12.1	15.2	14.1	8.9	14.7	13.7	6.1	16.6	6.6	13	US Census Bureau, 2013-2017 ACS 5-Year Estimates
35 to 44 years	12.3	12	13.2	15	13.9	12.9	12.2	12.5	12.6	10.7	11.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
45 to 54 years	14.3	14.9	14.4	15.8	17	16.6	15.2	18.5	13	17.2	13.2	US Census Bureau, 2013-2017 ACS 5-Year Estimates
55 to 59 years	7.1	7.5	6.9	6.3	7.8	6.6	6.1	6.9	6.1	7.7	7.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
60 to 64 years	6.2	6.4	5.8	6.2	4.1	6.1	5.7	5.9	5.1	6	7.3	US Census Bureau, 2013-2017 ACS 5-Year Estimates
65 to 74 years	8.7	8.9	8	8.4	6.8	9.2	10.3	9.7	6	10	9.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
75 to 84 years	4.5	4.5	4.3	4.9	7.5	4	6.5	5.3	2.9	6.8	6.2	US Census Bureau, 2013-2017 ACS 5-Year Estimates
85 years and over	2.3	2.5	2.1	3	4	1.6	2.7	3.7	1.6	3.8	4.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Median age (years)	39.4	40.8	38.5	41.4	43.3	40.5	42.2	45.0	33.3	46.0	44.3	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Age under 18 (%)	20.4	21.8	20.3	21.5	24.8	19.6	20.4	26.1	22.7	23.7	17.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Age over 65 (%)	15.5	15.9	14.4	16.4	18.3	14.8	19.5	18.7	10.5	20.6	20.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Race / Ethnicity / Culture												
White alone (%)	78.9	80.6	77.9	81.7	79.1	86.6	76.2	68.3	60.8	92.6	89.7	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Black or African American alone (%)	7.4	4.0	5.2	1.9	3.3	3.4	5.1	0.8	7.3	0.6	3.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Asian alone (%)	6.3	3.4	11.2	11.5	14.6	6.2	16.0	27.3	21.0	5.0	1.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Native Hawaiian and Other Pacific Islander (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	US Census Bureau, 2013-2017 ACS 5-Year Estimates
American Indian and Alaska Native (%)	0.2	0.2	0.2	0.3	0.2	0.0	0.1	0.1	0.5	0.0	0.2	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Some Other Race (%)	4.1	8.9	2.6	1.0	0.6	2.0	0.3	0.6	7.7	0.9	2.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Two or More Races (%)	3.1	2.7	2.9	3.7	2.2	1.8	2.3	3.0	2.6	0.9	2.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Hispanic or Latino of Any Race (%)	11.2	19.6	7.7	4.3	4.0	4.3	2.0	2.1	20.3	2.8	9.3	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Foreign Born (%)	16.2	16.2	20.5	18.6	16.2	11.0	21.7	25.9	26.7	8.5	15.7	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Language Spoken at Home by Population 5 Years and Older												
Language other than English	23.1	25.6	26	20.6	19.9	13.5	25.1	31.1	43.8	12.2	21.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
speak English less than "very well" (%)	9.1	10.5	9.3	5.6	5	4.3	7.9	7.2	20.9	3.1	8.2	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Speak Spanish at home (%)	8.8	16.5	5.9	2.7	1.8	3.3	2	2	15.3	2.2	6.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
speak English less than "very well" (%)	3.6	7.2	2.1	0.3	0.5	0.7	0.8	0.4	6.7	0.1	2.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Other Indo-European languages (%)	8.8	5.7	11.3	10	8.6	7.1	11.9	10.5	10.4	6.2	13.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
speak English less than "very well" (%)	3.1	1.9	3.7	2.7	1.1	2.2	3.1	1.2	4.5	1.2	5.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Asian and Pacific Islander Languages (%)	4.2	2.3	7	6.8	9.5	2.1	6.8	16.6	15.1	3.3	0.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
speak English less than "very well" (%)	2	1	2.9	2.3	3.3	1.2	3.1	5.3	8.4	1.3	0.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Household												
Total households	2585715	291659	593784	18632	5240	14474	9572	11755	38965	4529	21467	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Family households (families) (%)	63.7	66.9	64.9	61.7	71.8	78.6	73.2	78.7	62.6	77.9	62	US Census Bureau, 2013-2017 ACS 5-Year Estimates
With own children of the householder under 18 years (%)	27.1	29	28.9	29.5	37.5	31.6	31.2	41.6	29.1	32.1	21.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
In married couple family (%)	47.2	48.7	51.6	51.6	63.1	61	61.6	71.3	34.7	70.4	46.7	US Census Bureau, 2013-2017 ACS 5-Year Estimates
In married couple family - With own children of the householder under 18 years (%)	18.9	19.5	22.9	25.3	32.4	26.2	26.5	38	14.4	29	15.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Male householder, no wife present, family(%)	4.2	4.6	3.6	2.1	2.1	6	2.4	1.4	7.5	2.6	4.3	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Male householder, no wife present, family - With own children of the householder under 18 years(%)	1.7	2.1	1.3	0.8	1.3	2.2	0.6	0.5	3.2	0.7	1.3	US Census Bureau, 2013-2017 ACS 5-Year Estimates

DEMOGRAPHICS

Key

Statistically higher than statewide rate

Statistically lower than statewide rate

	MA	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Lexington	Lowell	Lynnfield	Peabody	Source
Demographics												
Female householder, no husband present, family(%)	12.3	13.6	9.7	7.9	6.6	11.6	9.2	6	20.4	4.8	11.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Female householder, no husband present, family - With own children of the householder under 18 years(%)	6.5	7.4	4.7	3.4	3.8	3.2	4.2	3	11.5	2.5	4.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Nonfamily households(%)	36.3	33.1	35.1	38.3	28.2	21.4	26.8	21.3	37.4	22.1	38	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Average family size	3.13	3.19	3.14	3.03	3.12	3.22	3.23	3.21	3.36	3.27	3.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Income/Poverty												
Unemployment Rate among Civilian Labor Force (%)	6	6	4.8	3.6	4.8	4.9	4.9	4.9	8.4	7.2	5.3	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Median household income (dollars)	$ 74,167	$ 73,533	$ 92,878	$ 103,594	$ 125,208	$ 99,453	$ 99,254	$ 162,083	$ 48,581	$ 117,706	$ 65,085	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below federal poverty line - all residents (%)	11.1	10.9	8.2	5.2	2.5	4.3	4	3.6	22.4	1.8	9.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below federal poverty line - families (%)	7.8	8.1	5.5	3.2	1.5	2.5	2.9	2.7	17.9	1.4	7.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below federal poverty line - under 18 years (%)	14.6	15.4	9.3	3.8	1	5.4	4.3	2.6	30.5	2.5	18	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below federal poverty line - age 65+ (%)	9	9.6	7.5	10.2	5.1	3.4	4.4	3.8	16.7	2.4	7.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below 200% of poverty level	23.7	24.2	17.9	11.9	10.4	11.4	10.4	8.2	41.6	5.5	22.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below 300% of poverty level	36.4	37.7	28.2	18.4	17.3	25.0	19.3	12.0	57.3	13.7	36.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below 400% of poverty level	48.6	49.7	39.2	26.8	28.2	37.2	30.0	18.0	70.3	26.2	53.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Below federal poverty line - female head of household, no husband present (%)	24.4	24.1	19.6	4.9	11.9	4.2	8.6	19.4	30.8	19	19.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
With cash public assistance income (%)	2.8	3.5	1.8	1.8	1.2	1.7	1.5	1.8	4.6	0.9	3.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
With Food Stamp/SNAP benefits in the past 12 months (%)	12.3	14.1	7.7	4.6	3.9	4.3	4.1	3.5	24.1	1.8	12.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
SNAP Gap (%)	48			64	64	69	67	73	42	72	55	Food Bank of Western MA 2018
Health Insurance												
Without insurance (%)	3	3.3	2.8	1.1	0.7	2.5	2.1	1	5.3	0.4	2.7	US Census Bureau, 2013-2017 ACS 5-Year Estimates
With public insurance (%)	35.5	38.4	28.4	23.8	27.7	27.8	30.3	22.3	47.7	26.8	41.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
With private insurance (%)	74.2	71.6	80.4	88	87.2	82.1	85.1	90.1	56.1	88.1	73.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Transportation												
Takes car, truck, van (alone) to work (%)	70.7	74.2	68.1	81.6	81.0	60.5	80.5	86.9	82.5	71.8	75.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Takes car, truck, van (carpool) to work (%)	7.5	8.5	6.9	7.0	7.9	6.0	7.5	5.0	8.0	6.3	9.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Takes public transportation (excluding cab) to work(%)	10.2	5.9	12.1	3.5	3.6	20.4	2.8	3.5	3.2	8.5	3.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Mean commute time (minutes)	29.3	29.8	30.3	32.3		29.2	29.2	31.6	25.8		26.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Worked outside county of residence(%)	30.8	32.3	30.4	29.9	18.6	19.1	21.2	25.7	16.5	53.2	32.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Housing												
Vacant housing units (%)	9.7	6.3	5.2	5	2	3.3	5.4	3.9	6.1	5.5	4.7	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Owner-occupied (%)	62.4	63.8	62.6	60.9	74	80.9	70.2	80.8	42.2	87.9	64.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Avg household size of owner occupied	2.69	2.74	2.76	2.66	2.79	3.03	2.97	2.97	2.94	3.01	2.61	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Monthly owner costs exceed 30% of household income (%)	31.5	33	29.2	26.1	33.5	29.7	31	29.7	35.1	33.9	37	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Renter-occupied (%)	37.6	36.2	37.4	39.1	26	19.1	29.8	19.2	57.8	12.1	35.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Avg household size of renter occupied	2.26	2.4	2.2	2.0	2.1	2.2	2.1	2.1	2.6	1.4	2.1	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Gross rent exceeds 30% of household income (%)	50.1	53	46	37.7	53	43.4	40.7	38.2	57.7	74.6	58.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Median Household Income for Section 8 Participant, 2017				$14,794	$16,596		$18,083	$14,088				Metro Housing Boston, October 2018
Educational Attainment (Population 25 Years and Older)												
High school degree or higher (%)	90.3	89.4	92.8	97	97.6	92.6	95.2	97.9	79.8	96.4	89.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Bachelor's degree or higher (%)	42.1	38.8	54.1	70	70.1	33.7	53.6	81.6	22.6	53.1	30.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
School Enrollment												
Graduation rate(%), 2017	88.3			95.4	96.7	85.2	95.5	98.5	82.4	97.4	86.4	Massachusetts Department of Elementary and Secondary Education School and District Profiles
Drop out rate(%), 2017	4.9			1	0.5	6.5	0.4	0.2	6.5	0	6.5	Massachusetts Department of Elementary and Secondary Education School and District Profiles
First language not English, 2018-19	21.9			12	18.2	8.5	18.3	30.8	28.6	7.4	14	Massachusetts Department of Elementary and Secondary Education School and District Profiles
English language learners(%), 2018-19	10.5			4.3	6.6	1.5	4.2	8.8	23.7	2.1	8.9	Massachusetts Department of Elementary and Secondary Education School and District Profiles
Students with Disabilities(%), 2018-19	18.1			15.5	16.6	17	13.7	14.1	17.3	17.7	19.7	Massachusetts Department of Elementary and Secondary Education School and District Profiles

DEMOGRAPHICS

	MA	*Essex County*	*Middlesex County*	*Arlington*	*Bedford*	*Billerica*	*Burlington*	*Lexington*	*Lowell*	*Lynnfield*	*Peabody*	*Source*
Demographics												
High Needs, 2018-19	47.6			25.9	31	30.1	27.8	29.7	72.4	25	48.2	Massachusetts Department of Elementary and Secondary Education School and District Profiles
Economically disadvantaged(%), 2018-19	31.2			7.5	8.7	15.6	11.4	5.4	53.8	7.2	30.3	Massachusetts Department of Elementary and Secondary Education School and District Profiles
Total Expenditures per Pupil, 2017	$ 15,911.38			$ 14,222.82	$ 17,852.10	$ 15,899.20	$ 20,605.99	$ 18,288.83	$ 14,354.00	$ 15,205.89	$ 14,581.68	Massachusetts Department of Elementary and Secondary Education School and District Profiles
Crime												
Violent crime rate (per 100,000)	353.1			83.6	61.6	92.7	198.7		289.3	53.7	290.2	FBI Uniform Crime Reports 2017
Murder/non-negligent manslaughter	2.6			0.0	0.0	2.3	0.0		0.9	0.0	3.8	FBI Uniform Crime Reports 2017
Forcible rape	30.4			15.4	6.8	11.6	26.2		11.7	0.0	22.8	FBI Uniform Crime Reports 2017
Robbery	70.1			15.4	27.4	18.5	18.7		129.4	15.3	32.2	FBI Uniform Crime Reports 2017
Aggravated assault	250.1			52.8	27.4	60.3	153.7		147.4	38.3	231.4	FBI Uniform Crime Reports 2017
Property crime rate (per 100,000)	1398.1			565.5	403.9	565.8	1818.0		1974.9	797.4	1183.6	FBI Uniform Crime Reports 2017
Burglary	247.1			176.0	61.6	120.6	97.5		425.9	38.3	157.4	FBI Uniform Crime Reports 2017
Larceny-theft	1040.9			356.4	321.8	410.4	1675.5		1231.0	713.1	940.8	FBI Uniform Crime Reports 2017
Motor vehicle theft	110.0			33.0	20.5	34.8	45.0		318.1	46.0	85.4	FBI Uniform Crime Reports 2017
Arson	5.6			0.0	0.0	4.6	3.7		9.0	0.0	0.0	FBI Uniform Crime Reports 2017

DEMOGRAPHICS

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

MOE = Margin of Error

	MASSACHUSETTS			ESSEX COUNTY			MIDDLESEX COUNTY			ARLINGTON			BEDFORD			BILLERICA			BURLINGTON			LEXINGTON			LOWELL			LYNNFIELD			PEABODY		
			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop			% of Total Pop		
	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+	Est.	MOE	5+
Population 5 years and over	6,426,464	235		732,066	65		1,495,498	38		41,849	352		13,305	213		40,517	314		24,723	300		31,761	229		103,302	621		12,125	172		49,584	433	
Speak only English at home	4,940,967	10294	76.88	544,778	2972	74.42	1,106,909	4930	74.02	33,247	838	79.45	10,659	476	80.11	35,033	704	86.46	18,523	841	74.92	21,894	733	68.93	58,033	1994	56.18	10,645	519	87.79	38,703	1206	78.06
SPANISH or SPANISH CREOLE	564401	3666	8.78	120,772	1519	16.50	88,210	1614	5.90	1146	331	2.74	244	173	1.83	1,327	436	3.28	500	275	2.02	640	202	2.02	15,845	1114	15.34	269	183	2.22	3,197	637	6.45
Speak English less than "very well"	231354	3814	3.60	53064	1757	7.25	31,478	1666	2.10	109	67	0.26	71	97	0.53	297	154	0.73	188	110	0.76	115	83	0.36	6,949	1027	6.73	15	24	0.12	1,180	308	2.38
FRENCH (Incl. Haitian, Cajun)	132329	4043	2.06	8641	916	1.18	32,936	1836	2.20	891	347	2.13	154	137	1.16	381	242	0.94	236	150	0.95	286	124	0.90	1,354	304	1.31	112	74	0.92	554	298	1.12
Speak English less than "very well"	44747	2433	0.70	2059	373	0.28	10216	968	0.68	364	237	0.87	0	19	0.00	100	99	0.25	89	101	0.36	36	44	0.11	396	179	0.38	23	24	0.19	65	59	0.13
GERMAN or WEST GERMANIC	19924	1092	0.31	1992	387	0.27	6,207	574	0.42	171	121	0.41	60	60	0.45	109	74	0.27	39	43	0.16	145	79	0.46	125	80	0.12	45	39	0.37	117	82	0.24
Speak English less than "very well"	1928	325	0.03	271	119	0.04	549	157	0.04	22	28	0.05	0	19	0.00	11	16	0.03	16	25	0.06	43	49	0.14	0	29	0.00	13	19	0.11	43	50	0.09
RUSSIAN, POLISH, OTHER SLAVIC LANGUAGES	68622	2476	1.07	5884	777	0.80	19501	1347	1.30	950	384	2.27	240	208	1.80	384	235	0.95	283	190	1.14	580	240	1.83	349	194	0.34	26	28	0.21	274	179	0.55
Speak English less than "very well"	24843	1475	0.39	2728	431	0.37	5473	625	0.37	154	98	0.37	15	23	0.11	92	72	0.23	67	71	0.27	47	40	0.15	112	110	0.11	0	19	0.00	213	152	0.43
OTHER INDO-EUROPEAN LANGUAGES	342002	6921	5.32	25321	1912	3.46	110749	3831	7.41	2162	357	5.17	685	299	5.15	1997	485	4.93	2376	580	9.61	2337	441	7.36	8931	1110	8.65	563	365	4.64	5930	827	11.96
Speak English less than "very well"	124738	3762	1.94	8599	939	1.17	39346	2095	2.63	600	177	1.43	136	98	1.02	692	366	1.71	585	226	2.37	248	106	0.78	4183	651	4.05	110	95	0.91	2472	468	4.99
KOREAN	16205	1117	0.25	1074	305	0.15	7287	841	0.49	412	270	0.98	0	19	0.00	80	110	0.20	121	108	0.49	813	249	2.56	62	45	0.06	38	65	0.31	9	14	0.02
Speak English less than "very well"	6657	703	0.10	648	212	0.09	3010	468	0.20	86	62	0.21	0	19	0.00	43	58	0.11	47	56	0.19	425	181	1.34	18	24	0.02	0	19	0.00	0	29	0.00
CHINESE (Incl. Mandarin, Cantonese)	129412	3282	2.01	4625	645	0.63	50676	2171	3.39	1244	324	2.97	828	290	6.22	360	193	0.89	627	279	2.54	3320	552	10.45	856	377	0.83	295	225	2.43	49	59	0.10
Speak English less than "very well"	65004	2159	1.01	1838	292	0.25	21368	1356	1.43	612	213	1.46	304	129	2.28	304	181	0.75	379	202	1.53	897	198	2.82	496	256	0.48	145	127	1.20	14	23	0.03
VIETNAMESE	40633	2373	0.63	3198	710	0.44	7571	1104	0.51	89	67	0.21	108	105	0.81	88	92	0.22	79	100	0.32	57	72	0.18	1702	492	1.65	1	2	0.01	0	29	0.00
Speak English less than "very well"	25302	1535	0.39	1842	429	0.25	4532	828	0.30	22	32	0.05	35	55	0.26	24	28	0.06	0	23	0.00	51	71	0.16	1225	395	1.19	1	2	0.01	0	29	0.00
TAGALOG (Incl. Filipino)	8099	1054	0.13	1087	681	0.15	2258	459	0.15	227	226	0.54	0	19	0.00	51	67	0.13	78	125	0.32	29	34	0.09	110	90	0.11	0	19	0.00	17	27	0.03
Speak English less than "very well"	2050	491	0.03	368	346	0.05	616	279	0.04	0	26	0.00	0	19	0.00	51	67	0.13	78	125	0.32	9	15	0.03	32	28	0.03	0	19	0.00	0	29	0.00
OTHER ASIAN AND PACIFIC ISLAND LANGUAGES	73329	2937	1.14	6894	773	0.94	36300	2104	2.43	891	333	2.13	327	209	2.46	263	143	0.65	786	374	3.18	1067	261	3.36	12856	1084	12.45	71	77	0.59	315	289	0.64
Speak English less than "very well"	27609	1545	0.43	2868	449	0.39	13671	1044	0.91	256	154	0.61	99	70	0.74	63	52	0.16	253	185	1.02	293	142	0.92	6923	788	6.70	10	17	0.08	45	70	0.09
ARABIC	33313	2482	0.52	3324	783	0.45	8543	1099	0.57	160	110	0.38	0	19	0.00	76	69	0.19	431	245	1.74	92	65	0.29	568	327	0.55	60	85	0.49	71	81	0.14
Speak English less than "very well"	13085	1451	0.20	1212	317	0.17	3412	642	0.23	77	72	0.18	0	19	0.00	13	22	0.03	120	99	0.49	33	42	0.10	293	199	0.28	60	85	0.49	28	33	0.06
OTHER AND UNSPECIFIED LANGUAGES	57228	3205	0.89	4476	726	0.61	18351	1816	1.23	259	196	0.62	0	19	0.00	368	263	0.91	644	377	2.60	501	285	1.58	2511	671	2.43	0	19	0.00	348	387	0.70
Speak English less than "very well"	15631	1442	0.24	1130	338	0.15	4792	873	0.32	53	70	0.13	0	19	0.00	50	54	0.12	120	104	0.49	76	64	0.24	994	396	0.96	0	19	0.00	0	29	0.00

DEMOGRAPHICS

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

MOE = Margin of Error

MASSACHUSETTS	Estimate	MOE	%
Total Pop	6,789,319		
Irish	1,403,567	11,116	20.67
Italian	871,822	8,323	12.84
English	647,855	6,278	9.54
French (except Basque)	437,190	5,490	6.44
German	400,519	4,838	5.90

ARLINGTON	Estimate	MOE	%
Total Pop	44992	53	
Irish	9511	652	21.14
Italian	6166	675	13.70
English	5112	590	11.36
German	3961	565	8.80
Polish	1768	339	3.93

BEDFORD	Estimate	MOE	%
Total Pop	14105	24	
Irish	2437	416	17.28
Italian	2158	424	15.30
English	1578	321	11.19
German	1189	277	8.43
American	683	312	4.84

BILLERICA	Estimate	MOE	%
Total Pop	42791	63	
Irish	12384	1000	28.94
Italian	9868	771	23.06
English	4288	645	10.02
French (except Basque)	3078	598	7.19
French Canadian	2527	552	5.91

BURLINGTON	Estimate	MOE	%
Total Pop	26103	26	
Irish	6171	799	23.64
Italian	4581	642	17.55
English	2190	430	8.39
German	1246	308	4.77
French (except Basque)	1142	315	4.37

LEXINGTON	Estimate	MOE	%
Total Pop	33339	40	
Irish	3782	450	11.34
English	3422	459	10.26
Italian	2939	378	8.82
German	2595	356	7.78
Russian	1476	354	4.43

LYNNFIELD	Estimate	MOE	%
Total Pop	12732	23	
Italian	3873	573	30.419416
Irish	3480	463	27.332705
English	939	223	7.3751178
German	879	414	6.9038643
American	681	308	5.3487276

PEABODY	Estimate	MOE	%
Total Pop	52610	52	
Irish	12471	1096	23.704619
Italian	11507	1154	21.872268
English	4374	588	8.3140087
French (except Basque)	3434	655	6.5272762
Portuguese	2771	509	5.2670595

LOWELL	Estimate	MOE	%
Total Pop	110964	77	
Irish	17275	1269	15.568112
French (except Basque)	6868	751	6.1893948
Italian	6379	865	5.7487113
Portuguese	5183	880	4.6708843
English	4717	563	4.2509282

CLINICAL INDICATORS

Key

Statistically higher than statewide rate

Statistically lower than statewide rate

N/A = Not available

‡ = Data suppressed due to small numbers

	MA	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Lexington	Lowell	Lynnfield	Peabody	Source
All-Cause; Injuries; Assaults (Age-adjusted per 100,000)												
All cause												
Deaths, 2015	684.5	691.9	616.5	614.6	663	903.4	821.5	425.6	917.9	607.7	731.3	MDPH Registry of Vital Records and Statistics
Premature mortality for <75 yr population, 2015	279.6	284.4	227.7	233.3	265.8	315.4	272.9	146.5	479.1	209.5	295.8	MDPH Registry of Vital Records and Statistics
Injuries and Poisonings												
Deaths, 2015	58	62	47.7	45.7	‡	65.9	43	37	99.9	‡	48.6	MDPH Registry of Vital Records and Statistics
Motor Vehicle Related												
Deaths, 2015	5.4	4.1	3.4	‡	0	‡	‡	0	6.2	‡	‡	MDPH Registry of Vital Records and Statistics
Assault												
Deaths, 2015	2	2.2	0.6	0	0	‡	0	0	‡	0	‡	MDPH Registry of Vital Records and Statistics
Behavioral Health												
Admissions to BSAS Contracted/Licensed Programs FY17												
Number of people served	81006	10462	12726	218	0-100	399	111	0-100	2044	0-100	839	MA Bureau of Substance Abuse Services (BSAS)
Number of admissions	109001	11334	13454	206	0-100	527	115	0-100	2900	0-100	754	MA Bureau of Substance Abuse Services (BSAS)
% Male	67.8	66	68.3	54.4	57.8	70.2	70.4	50.9	68.6	73.9	74	MA Bureau of Substance Abuse Services (BSAS)
% Black of African American	7.3	3.4	4.4	4.4	N/A	1.3	0	N/A	3.8	0	2.4	MA Bureau of Substance Abuse Services (BSAS)
% Multi-Racial	6.3	3.9	4.1	N/A	0	3.4	0	0	7.1	0	1.6	MA Bureau of Substance Abuse Services (BSAS)
% Other	9.4	10.2	7.7	4.4	0	1.5	N/A	N/A	15.8	0	5.9	MA Bureau of Substance Abuse Services (BSAS)
% White	77.1	82.5	83.8	89.7	96.7	93.7	98.3	94.2	73.2	100	90.1	MA Bureau of Substance Abuse Services (BSAS)
% Hispanic	14	14.6	11	7.8	9.4	3.6	N/A	N/A	24	N/A	7.2	MA Bureau of Substance Abuse Services (BSAS)
% No Education/Less Than High School Education	25.5	23.8	23.6	26.4	N/A	22.1	15.1	20	37.7	32.3	17.9	MA Bureau of Substance Abuse Services (BSAS)
% College Degree or Higher	7.4	8.5	9.1	11.7	10	5.4	N/A	22.2	3	15.4	10.8	MA Bureau of Substance Abuse Services (BSAS)
% Less Than 18	1.3	1.5	2.1	8.7	0	1.1	0	N/A	1.1	N/A	N/A	MA Bureau of Substance Abuse Services (BSAS)
% 18 to 25	14.7	15.9	16.6	20.9	N/A	26	13	17	14.4	33.3	19	MA Bureau of Substance Abuse Services (BSAS)
% 26 to 30	21.7	22.2	21.9	23.8	46.9	19	28.7	45.3	20.1	21.7	23.5	MA Bureau of Substance Abuse Services (BSAS)
% 31 to 40	30.9	31.9	29.9	23.3	23.4	22.8	33.9	17	32.1	23.2	32.1	MA Bureau of Substance Abuse Services (BSAS)
% 41 to 50	17.6	15.8	16.7	11.2	9.4	19.7	12.2	N/A	20.2	8.7	15.9	MA Bureau of Substance Abuse Services (BSAS)
% 51 and older	13.9	12.6	12.8	12.1	12.5	11.4	12.2	N/A	12.1	N/A	9	MA Bureau of Substance Abuse Services (BSAS)
% Employed at Enrollment	44.9	46.1	47	53.4	41.4	46.2	43.3	50	40.2	47.8	47.2	MA Bureau of Substance Abuse Services (BSAS)
% Homeless at Enrollment	30.1	26.2	27.9	27.3	19.6	20.5	28	0	37.7	0	20.2	MA Bureau of Substance Abuse Services (BSAS)
% At Risk of Homelessness	38.1	32.4	35	32	31.1	24.4	34.3	17.3	44.8	25	25.4	MA Bureau of Substance Abuse Services (BSAS)
% Past Year Needle Use	47.6	43	45.3	49	62.7	43.1	47.6	46.2	51.7	50	42.9	MA Bureau of Substance Abuse Services (BSAS)
% Prior Mental Health Treatment	46.2	44.6	44.1	52.5	35.6	42.3	36.2	51.9	40.8	40.9	42.3	MA Bureau of Substance Abuse Services (BSAS)
Primary Substance of Use 2017												
Total Admissions	98948	10545	12528	202	0-100	494	494	0-100	2659	0-100	730	MA Bureau of Substance Abuse Services (BSAS)
% Alcohol	32.8	34.2	35.8	34.2	25.4	34.8	34.8	26.9	31.3	31.8	2809	MA Bureau of Substance Abuse Services (BSAS)
% Crack/Cocaine	4.1	3.5	3	3.5	N/A	2.4	2.4	N/A	3.6	N/A	4.1	MA Bureau of Substance Abuse Services (BSAS)
% Heroin	52.8	49.5	49.9	44.6	57.6	53	53	48.1	56.4	47	53.3	MA Bureau of Substance Abuse Services (BSAS)
% Marijuana	3.4	4.6	3.9	6.4	N/A	3.2	3.2	N/A	3.2	9.1	4	MA Bureau of Substance Abuse Services (BSAS)
% Other	0.3	0.4	0.4	N/A	N/A	N/A	N/A	N/A	0.4	N/A	N/A	MA Bureau of Substance Abuse Services (BSAS)
% Other Opioids	4.6	5.6	4.9	3.5	N/A	4.7	4.7	N/A	3.8	N/A	6.4	MA Bureau of Substance Abuse Services (BSAS)
% Other sedatives/hypnotics	1.5	1.7	1.7	5	N/A	1.2	1.2	N/A	1.2	N/A	2.3	MA Bureau of Substance Abuse Services (BSAS)
% Other stimulants	0.5	0.4	0.5	N/A	N/A	N/A	N/A	N/A	*	N/A	N/A	MA Bureau of Substance Abuse Services (BSAS)
Mental Disorders (age adjusted per 100,000)												
Inpatient hospitalizations (crude rate per 100,000)	5957.6	N/A	N/A	4520.6	4570.7	4053.2	5174	3347.4	6436.4	4784	7605	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	62.9	80.9	60.1	58	57.8	72.9	64.3	37.1	77.9	55.9	104.2	MDPH Registry of Vital Records and Statistics
Suicide Deaths, 2015	9	7.9	8.4	12.3	--1	--1	--1	13.5	8	0	--1	MDPH Registry of Vital Records and Statistics
Opioids (age adjusted per 100,000)												
Fatal opioid overdoses (count, by residence), 2017	1966	N/A	N/A	3	3	14	8	0	53	2	23	Massachusetts Registry of Vital Records and Statistics, MDPH, May 2019
Fatal opioid overdoses (count, by residence), 2018	1976	N/A	N/A	3	3	13	3	3	64	5	13	Massachusetts Registry of Vital Records and Statistics, MDPH, May 2019
Fatal opioid overdoses (count, by occurrence), 2017	2042	N/A	N/A	1	2	8	16	0	59	3	12	Massachusetts Registry of Vital Records and Statistics, MDPH, May 2019
Fatal opioid overdoses (count, by occurrence), 2018	2045	N/A	N/A	2	1	8	19	1	72	2	9	Massachusetts Registry of Vital Records and Statistics, MDPH, May 2019
Opioid-Related EMS Incidents (count, by occurrence), 2017	22294	N/A	N/A	67	23	97	58	16	1138	11	163	Office of Emergency Medical Services, Bureau of Health Care Safety and Quality, MDPH
Opioid-Related EMS Incidents (count, by occurrence), 2018	20948	N/A	N/A	33	21	79	46	8	1229	17	173	Office of Emergency Medical Services, Bureau of Health Care Safety and Quality, MDPH
Inpatient hospitalizations (crude rate per 100,000)	781.3	N/A	N/A	376.5	377	514.6	356.2	211	906.5	390.9	734.3	Center for Health Information and Analysis Hospital Discharge Data 2017
Fatal Overdoses, 2015	24.6	30.3	19.4	15.6	‡	27.4	‡	‡	54.6	‡	20.2	MDPH Registry of Vital Records and Statistics
Chronic Disease (age-adjusted rates per 100,000)												
Diabetes												
Diabetes Short-Term Complications Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-01)	69.9	N/A	N/A	19.8	9.4	32.0	130.0	16.2	104.9	20.6	41.4	Center for Health Information and Analysis Hospital Discharge Data 2017
Diabetes Long-Term Complications Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-03)	93.0	N/A	N/A	53.8	75.4	55.2	101.1	40.6	139.8	61.7	124.3	Center for Health Information and Analysis Hospital Discharge Data 2017
Uncontrolled Diabetes Admissions Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-14)	44.7	N/A	N/A	14.2	9.4	32.0	33.7	16.2	79.2	20.6	43.7	Center for Health Information and Analysis Hospital Discharge Data 2017
Prevention Quality Diabetes Composite, Crude Rate per 100,000 Population (among 18+ years)(PQI-93)	200.3	N/A	N/A	84.9	84.8	104.7	235.8	85.2	315.8	92.6	207.2	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	16.8	15.1	15.5	12.8	‡	30.2	16.3	9.6	26.9	‡	10	MDPH Registry of Vital Records and Statistics

Key

Statistically higher than statewide rate

Statistically lower than statewide rate

N/A = Not available

‡ = Data suppressed due to small numbers

	MA	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Lexington	Lowell	Lynnfield	Peabody	Source
Chronic disease (rates per 100,000) - continued												
Hypertension Admission Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-07)	47.5	N/A	N/A	36.8	18.8	20.4	52.9	32.5	46.6	61.7	73.7	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	6.9	5.5	6.8	‡	‡	‡	‡	‡	14.9	0	5.7	MDPH Registry of Vital Records and Statistics
Major cardiovascular disease												
Inpatient hospitalizations (crude rate per 100,000) (among 18+ years)	1771.2	N/A	N/A	1392.7	1545.6	1206.6	1785.6	1302.4	1841	1749	2520.4	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	180.8	180.6	159.7	139.7	144.7	258.8	206.1	103.8	223.4	131.5	178.8	MDPH Registry of Vital Records and Statistics
Heart Disease												
Deaths, 2015	138.7	141	121.6	104.4	94.1	193.1	162.3	82.8	159.1	121.9	144	MDPH Registry of Vital Records and Statistics
Coronary Heart Disease												
Deaths, 2015	82.3	83.3	74.6	53	60.3	125.7	89	46	104.9	66.1	78.3	MDPH Registry of Vital Records and Statistics
Heart Failure												
Heart Failure Admissions Rate, Crude Rate per 100,000 Population (among 18+ years)(PQI-08)	459.4	N/A	N/A	413.3	348.7	290.8	481.3	300.3	591.9	493.8	736.6	Center for Health Information and Analysis Hospital Discharge Data 2017
Cerebrovascular												
Deaths, 2015	28.4	29	25.3	18.9	24	31.2	21.5	10.7	32.7	‡	24.1	MDPH Registry of Vital Records and Statistics
Chronic lower respiratory diseases												
Inpatient hospitalizations (crude rate per 100,000)	428.3	N/A	N/A	220.8	254.5	186.1	336.9	113.6	580.3	267.5	547.8	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	33	33.8	27.6	24.8	29.3	60.6	49.4	13.1	50.1	33.4	39.2	MDPH Registry of Vital Records and Statistics
Bacterial Pneumonia Admission Rate, per 100,000 Population (among 18+ years)(PQI-11)	201.3			141.5	160.2	168.6	182.9	117.7	321.6	226.3	303.8	
Asthma												
Asthma in Younger Adults Admissions Rate, Crude Rate per 100,000 Population (among 20-44 years)(PQI-15)	50.3	N/A	N/A	6.8	N/A	48.9	49.1	0.0	88.7	35.7	49.4	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	1	‡	1	0	‡	0	‡	0	‡	0	0	MDPH Registry of Vital Records and Statistics
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions Rate, Crude Rate per 100,000 Population (among 45+ years)(PQI-05)	700.6	N/A	N/A	368.0	390.2	286.3	519.1	161.8	1113.9	350.2	838.4	Center for Health Information and Analysis Hospital Discharge Data 2017
Chronic Liver Disease												
Deaths, 2015	8.1	8.2	6.6	‡	0	15.8	‡	0	18.9	‡	8.5	MDPH Registry of Vital Records and Statistics
Cancer (age-adjusted rates per 100,000)												
All-cause												
Inpatient hospitalizations (crude rate per 100,000)	456.3	N/A	N/A	478.4	395.8	331.5	413.9	486.9	357.7	524.7	610	Center for Health Information and Analysis Hospital Discharge Data 2017
Deaths, 2015	152.8	146.4	140.8	160.1	153	168.1	182.8	101.9	174.7	121.3	158.8	MDPH Registry of Vital Records and Statistics
Breast (invasive, female)												
Deaths, 2015	9.8	16.9	16.2	19.8	50.3	23.2	‡	0	14.8	‡	21.1	MDPH Registry of Vital Records and Statistics
Colorectal												
Deaths, 2015	12	10	11.8	9.1	‡	‡	‡	10.3	18.2	‡	6.9	MDPH Registry of Vital Records and Statistics
Lung												
Deaths, 2015	39	37.3	35.2	28.7	38.7	43.7	57	9.7	41.5	35.3	43.1	MDPH Registry of Vital Records and Statistics
Prostate												
Deaths, 2015	7	19.6	14.8	36.9	‡	‡	‡	0	‡	0	24.3	MDPH Registry of Vital Records and Statistics
Maternal and Child Health												
Infant Mortality, 2015 (rate per 1,000)	4.3	4.8	3.1	‡	‡	‡	‡	0	6.4	0	‡	MDPH Registry of Vital Records and Statistics
Infectious Disease												
Chlamydia cases (lab confirmed), 2017	29203	5162	3330	83	26	128	42	34	757	32	130	MDPH Bureau of Infectious Disease and Laboratory Services
Gonorrhea cases (lab confirmed), 2017	7307	1069	580	20	<5	18	10	6	144	<5	48	MDPH Bureau of Infectious Disease and Laboratory Services
Syphillis cases (probable and confirmed), 2017	1091	234	86	5	0	<5	<5	<5	20	0	8	MDPH Bureau of Infectious Disease and Laboratory Services
Hepatitis A cases (confirmed), 2017	53	16	5	0	0	0	0	0	0	0	3	MDPH Bureau of Infectious Disease and Laboratory Services
Chronic Hepatitis B (confirmed and probable), 2017	2023	472	140	15	<5	8	<5	13	91	<5	9	MDPH Bureau of Infectious Disease and Laboratory Services
Hepatitis C cases (confirmed and probable), 2017	7765	1239	710	24	8	103	12	11	213	7	49	MDPH Bureau of Infectious Disease and Laboratory Services
Pneumonia/Influenza												
Confirmed Influenza cases, 2017	24278	5117	2447	112	54	165	160	102	838	38	201	MDPH Bureau of Infectious Disease and Laboratory Services
Deaths, 2015	17.1	18.7	13.7	20.2	20	35.9	31.6	‡	24.1	‡	14.6	MDPH Registry of Vital Records and Statistics
HIV/AIDS (age-adjusted rate per 100,000)												
Incidence, 2017	1870	379	216	<5	<5	6	7	0	84	<5	<5	MDPH Bureau of Infectious Disease and Laboratory Services
Deaths, 2015	1.1	1.5	0.6	0	0	0	0	0	‡	0	0	MDPH Registry of Vital Records and Statistics
Infectious and Parasitic Disease (age-adjusted rate per 100,000)												
Deaths, 2015	18.9	18.1	15.8	11.7	‡	23.2	‡	8.9	32	35.7	24	MDPH Registry of Vital Records and Statistics
Urinary Tract Infection Admissions Rate, per 100,000 Population (among 18+ years)(PQI-12)	165.4	N/A	N/A	169.8	84.8	75.6	154.0	109.6	193.4	308.6	287.7	Center for Health Information and Analysis Hospital Discharge Data 2017
Elder Health (age-adjusted rate per 100,000)												
Alzheimers deaths, 2015	20.2	14.5	22.8	21.2	38.2	72.3	38.5	12.9	50.8	31.9	13.9	MDPH Registry of Vital Records and Statistics
Parkinson's deaths, 2015	7.7	6.3	7.9	‡	‡	‡	20.1	‡	7.4	‡	11.1	MDPH Registry of Vital Records and Statistics

Cancer Mortality

Key

Statistically higher than statewide rate

Statistically lower than statewide rate

‡ = Data suppressed due to small numbers

Source: Massachusetts Vital Statistics, 2015

	MA	*Essex County*	*Middlesex County*	*Arlington*	*Bedford*	*Billerica*	*Burlington*	*Lexington*	*Lowell*	*Lynnfield*	*Peabody*
Cancer Mortality (Age-adjusted per 100,000), 2015											
All Types (invasive)	152.8	146.4	140.8	160.1	153	168.1	182.8	101.9	174.7	121.3	158.8
Bladder	4.7	5.3	4	‡	‡	‡	‡	‡	‡	0	6.5
Bone	0.3	‡	0.4	0	0	0	0	‡	0	0	0
Brain/Central Nervous System	4.7	4.7	4.2	‡	‡	‡	0	‡	6.4	‡	6.3
Breast (female)	9.8	16.9	16.2	19.8	50.3	23.2	‡	0	14.8	‡	21.1
Cervical	0.6	‡	1	0	0	0	0	0	‡	0	‡
Colorectal	12.0	10	11.8	9.1	‡	‡	‡	10.3	18.2	‡	6.9
Esophageal	4.9	4.5	4.3	‡	0	11.2	‡	0	6.6	0	6.5
Kaposi's Sarcoma	0.0	0	0	0	0	0	0	0	0	0	0
Kidney	3.5	2.9	4.1	‡	‡	‡	‡	0	‡	0	‡
Larynx	0.8	1	0.6	0	0	‡	0	0	0	0	‡
Leukemia	5.7	6.1	5.9	13.5	‡	‡	‡	‡	11.1	‡	6.4
Liver	6.0	5.7	6	‡	‡	15.7	‡	0	17.3	0	‡
Lung	39.0	37.3	35.2	28.7	38.7	43.7	57	9.7	41.5	35.3	43.1
Lymphoma (Hodgkin)	0.2	‡	‡	0	0	0	0	0	0	0	0
Lymphoma (Non-Hodgkin)	5.2	4.9	4.9	‡	0	12.2	‡	8.9	‡	‡	3.6
Melanoma of Skin	2.3	2.5	1.9	‡	0	‡	0	‡	‡	0	‡
Multiple Myeloma	3.1	2.9	3.1	‡	0	‡	‡	‡	‡	‡	‡
Oral Cavity	2.4	1.9	3.2	0	0	‡	‡	‡	‡	0	‡
Ovary	3.9	6.7	6.6	‡	0	0	0	‡	‡	0	15.4
Pancreatic	11.3	11.8	10.6	12.7	‡	0	24.4	15.4	10.4	0	8
Prostate	7	19.6	14.8	36.9	‡	‡	‡	0	‡	0	24.3
Soft Tissue	1.5	1.2	1.7	‡	0	0	0	‡	‡	0	‡
Stomach	3.2	3.2	3.5	‡	‡	0	15.1	0	5	‡	‡
Testis	0.1	0	0	0	0	0	0	0	0	0	0
Thyroid	0.5	‡	0.4	‡	0	0	0	0	0	0	0
Uterine	2.7	3.2	3.9	‡	0	0	‡	‡	‡	‡	‡

Massachusetts Healthy Aging Community Profile

Key

Statistically higher than statewide rate

Statistically lower than statewide rate

	MA	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Lexington	Lowell	Lynnfield	Peabody	Source
POPULATION CHARACTERISTICS												
Total population 65 years or older	1049751	123692	228153	7367	2585	6319	5085	6236	11690	2628	10988	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Population 65 years or older (% of total population)	15.5	15.9	14.4	16.4	18.3	14.8	19.5	18.7	10.5	20.6	20.9	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Population 65-74 years (% of total population)	8.7	8.9	8	8.4	6.8	9.2	10.3	9.7	6	10	9.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Population 75-84 years (% of total population)	4.5	4.5	4.3	4.9	7.5	4	6.5	5.3	2.9	6.8	6.2	US Census Bureau, 2013-2017 ACS 5-Year Estimates
Population 85 years or older (% of total population)	2.3	2.5	2.1	3	4	1.6	2.7	3.7	1.6	3.8	4.8	US Census Bureau, 2013-2017 ACS 5-Year Estimates
% of 65+ population living alone	29.9	29.3	28.5	33.1	21.8	16.5	22.1	23.0	34.5	24.3	34.5	US Census Bureau, 2013-2017 ACS 5-Year Estimates
% of only English speakers 65 years or older	17.7	19	16.7	18.4	21.1	16.2	21.8	23	12.7	22.8	23.6	US Census Bureau, 2013-2017 ACS 5-Year Estimates
% Language other than English over 65 years or older	11.9	10.8	11.1	14.7	12.7	11.9	17	12.3	9.6	13.8	17	US Census Bureau, 2013-2017 ACS 5-Year Estimates
% of Spanish at home speakers 65 years or older	7	7.1	6.5	3.4	7.4	10.3	12.6	9.7	8.4	5.2	6.4	US Census Bureau, 2013-2017 ACS 5-Year Estimates
WELLNESS & PREVENTION												
% 60+ injured in a fall within last 12 months	10.6			17.6	9.4	9.5	9.5	9.4	10.4	11.7	14.0	2018 Massachusetts Healthy Aging Community Profile
% 65+ had hip fracture	3.7			4.0	4.2	2.9	3.2	4.7	3.9	3.4	4.3	2018 Massachusetts Healthy Aging Community Profile
%60+ with self-reported fair or poor health status	18.0			16.2	13.5	15.5	15.5	13.5	22.8	16.0	19.6	2018 Massachusetts Healthy Aging Community Profile
% 60+ with physical exam/check-up in past year	89.3			90.8	87.8	88.8	88.8	87.8	92.2	86.7	90.8	2018 Massachusetts Healthy Aging Community Profile
% 60+ consumed five or more fruits and vegetables a day	21.5			22.4	27.6	19.3	19.3	27.6	19.1	21.3	22.7	2018 Massachusetts Healthy Aging Community Profile
% with any physical activity in the last month	73.3			77.8	88.4	69.8	69.8	88.4	62.3	68.6	64.6	2018 Massachusetts Healthy Aging Community Profile
BEHAVIORAL HEALTH												
% 60+ with 15+ days poor mental health last month	7.0			6.5	5.6	4.0	4.0	5.6	7.6	4.4	9.4	2018 Massachusetts Healthy Aging Community Profile
% 65+ with depression	31.5			32.8	32.2	29.0	29.5	30.6	35.4	28.3	34.3	2018 Massachusetts Healthy Aging Community Profile
% 65+ with anxiety disorders	25.4			25.7	24.6	23.4	24.3	21.9	28.3	24.7	29.2	2018 Massachusetts Healthy Aging Community Profile
% 65+ with substance use disorders (drug use +/or alcohol abuse)	6.6			5.1	5.8	6.1	5.7	4.9	8.2	4.4	6.6	2018 Massachusetts Healthy Aging Community Profile
CHRONIC DISEASE												
% 65+ with Alzheimer's disease or related dementias	13.6			12.8	13.4	11.9	13.5	15.1	16.4	12.0	14.9	2018 Massachusetts Healthy Aging Community Profile
% 65+ with osteoporosis	20.7			22.9	20.7	18.8	21.6	24.9	19.5	23.3	25.2	2018 Massachusetts Healthy Aging Community Profile
% 60+ self reported as obese	23.1			15.3	16.2	30.1	30.1	16.2	27.9	21.2	24.5	2018 Massachusetts Healthy Aging Community Profile
% 65+ diagnosed as obese	19.0			16.5	15.4	21.8	19.9	12.0	21.8	18.6	23.6	2018 Massachusetts Healthy Aging Community Profile
LIVING WITH DISABILITY												
% 65+ with clinical diagnosis of deafness or hearing impairment	16.1			16.9	18.1	13.0	16.0	19.0	12.7	16.7	17.9	2018 Massachusetts Healthy Aging Community Profile
% 65+ with clinical diagnosis of blindness or visual impairment	1.5			1.6	1.3	1.6	2.0	1.5	1.6	1.3	1.8	2018 Massachusetts Healthy Aging Community Profile
% 65+ with clinical diagnosis of mobility impairments	3.9			3.8	3.7	3.3	3.7	4.0	5.4	3.4	4.3	2018 Massachusetts Healthy Aging Community Profile
ACCESS TO CARE												
% Medicare managed care enrollees	23.1			25.8	23.6	28.9	28.9	19.7	34.1	17.0	22.4	2018 Massachusetts Healthy Aging Community Profile
% dually eligible for Medicare and Medicaid	16.7			9.2	5.6	9.1	7.0	9.3	35.6	6.4	12.4	2018 Massachusetts Healthy Aging Community Profile
% 60+ with a regular doctor	96.4			97.5	98.3	96.3	96.3	98.3	97.6	95.3	95.5	2018 Massachusetts Healthy Aging Community Profile
% 60+ who did not see doctor when needed due to cost	4.1			1.0	2.3	4.4	4.4	2.3	4.6	3.7	7.0	2018 Massachusetts Healthy Aging Community Profile
# of nursing homes within 5 miles	399			17	2	3	4	6	12	3	15	2018 Massachusetts Healthy Aging Community Profile
# of home health agencies	299			43	26	41	31	32	80	22	53	2018 Massachusetts Healthy Aging Community Profile
# of adult day health centers	131			1	0	0	1	0	7	0	2	2018 Massachusetts Healthy Aging Community Profile
COMMUNITY VARIABLES & CIVIC ENGAGEMENT												
% of grandparents raising grandchildren	0.8			0.4	0.0	1.1	1.2	0.3	1.4	0.8	0.6	2018 Massachusetts Healthy Aging Community Profile
# of assisted living sites	238			2	0	2	3	1	0	1	2	2018 Massachusetts Healthy Aging Community Profile
Total of all crashes involving adult age 60+/town	132351			628	340	576	762	714	1952	269	1558	2018 Massachusetts Healthy Aging Community Profile
# of medical transportation services for older people	268			11	15	9	31	11	6	4	9	2018 Massachusetts Healthy Aging Community Profile
# of nonmedical transportation services for older people	252			25	35	34	71	29	29	2	16	2018 Massachusetts Healthy Aging Community Profile

YRBS Question	Arlington (2018)	Bedford (2017-2018)	Burlington (2018)	Lexington (2017)	Lynnfield (2017)
Never or rarely wore a helmet when riding a bicycle (among those who rode a bicycle)	15.6		35.4	11.1	43.6
Never or rarely wore a helmet when rollerblading or riding a skateboard (among those who rollerbladed or rode a skateboard)	34.9			20.5	71.6
Never or rarely wore a seatbelt when riding in a car	1.5		1.3	1.6	1.8
Rode in a car driven by someone who had been drinking alcohol	13.4	8.6	9.6	11.4	15.3
Carried a weapon (such as, a gun, knife, or club)	14.3	9.4	14.3	N/A	19.0
Were in a physical fight	31.8	5.9	28.2	15.3	28.6
Were electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media)	30.2	12.7	33.1	15.0	15.1
Were bullied on school property	14.4	20.1	17.9	29.9	29.1
Which of the following do you find causes the most negative stress for you? (One response selected)	**Arlington**	**Bedford**	**Burlington**	**Lexington**	**Lynnfield**
Busy schedule (school, activities, sports, etc.)	20.9		27.2	N/A	27.6
Parent/family demands/expectations about academics, grades, etc.	13.5		14.5	N/A	11.3
Difficulty getting enough sleep	6.5		7.4	N/A	4.6
Extracurricular activity demands or pressures	2.5		3.4	N/A	2.1
School demands/expectations—such as assignments, homework, etc.	32.7		30.9	N/A	34.3
Social pressures from friends, peers, etc.	3.8		2.4	N/A	3.3
Other family or personal issues which cause emotional stress for you	11.0		7.1	N/A	6.7
Worrying about the future such as college, career, etc.	9.1		7.1	N/A	10.0
Which of the following do you find most stressful about school? (One response selected)	**Arlington**	**Bedford**	**Burlington**	**Lexington**	**Lynnfield**
School related factors that cause the most stress; Having to study things you do not understand	15.2		21.1	N/A	14.1
Teachers expecting too much from you	14.3		19.2	N/A	14.9
Keeping up with schoolwork	22.0		19.0	N/A	24.1
Having to concentrate too long during the school day	8.2		8.4	N/A	7.5
Having to study things you are not interested in	13.8		7.0	N/A	11.2
Pressure of study	6.2		5.0	N/A	5.4
Getting up early in the morning to go to school	15.2		13.0	N/A	18.7
Going to school	5.1		7.4	N/A	4.1
Mental health and suicidality	**Arlington**	**Bedford**	**Burlington**	**Lexington**	**Lynnfield**
Felt sad/hopeless 2+ weeks in past 12 months		**15**			
Seriously thought about attempting suicide	15.0	10.6	12.1	15.4	7.9
Made a plan about how they would attempt suicide	8.6	5.9	6.5	9.1	6.1
Attempted suicide	2.4	1.2	2.0	2.6	2.5
Substance Use	**Arlington**	**Bedford**	**Burlington**	**Lexington**	**Lynnfield**
Ever tried cigarette smoking (even one or two puffs)	1.9	3.1	1.5	1.2	1.4
Tried cigarette smoking before age 10 years (for the first time, even one or two puffs)			.5	N/A	.0
Currently smoked cigarettes (on at least 1 day during the 30 days before the survey)		.7	.5	.3	.7
Currently smoked cigarettes frequently (on 20 or more days during the 30 days before the survey)	.3		.3	.2	.0
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)			.2	.2	.0
Currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)		.7		.7	.0
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)		1.3	.8	.7	.4
Used electronic vapor products (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	7.4	11.0	8.4	1.8	3.2
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)	3.5	7.1	3.9	.6	1.8
Ever drank alcohol (other than a few sips)	12.8	12.5	10.6	31.8	9.7
Drank alcohol before age 11 years (for the first time other than a few sips)	5.2		4.0	6.1	1.1
Currently drank alcohol (at least one drink of alcohol during the 30 days before the survey)	1.8	4.2	1.5	3.5	.7
Ever used marijuana	2.9	1.5	2.0	.6	1.5

Used marijuana in the past 30 days			1.0	.6	.4
Tried marijuana before age 10 years (for the first time)	.5		.3	.1	.0
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)	3.6	1.1	2.7	.4	1.5
Ever used cocaine (any form of cocaine, such as powder, crack, or freebase)	.6	.0	.5	.1	.0
Ever sniffed glue, breathed the contents of spray cans, or inhaled paints or sprays to get high	4.2	.9	2.7	1.6	2.6
Sexual Behavior	**Arlington**	**Bedford**	**Burlington**	**Lexington**	**Lynnfield**
Had sexual intercourse	2.3		1.7	.9	1.9
Had sexual intercourse before age 10 years (for the first time)	.7		.3	.1	.0
Had sexual intercourse with four or more persons (during their life)	.8		.5	.1	.0
Did not use a condom (during last sexual intercourse, among students who have had sexual intercourse)	50.0		37.5	.2	.0
Physical Activity and Nutrition	**Arlington**	**Bedford**	**Burlington**	**Lexington**	**Lynnfield**
Described themselves as slightly or very overweight	20.5	20.7	25.5	19.1	24.6
Were not trying to lose weight	71.0	69.6	60.8	68.4	65.2
Did not eat breakfast at all during the week (during the 7 days before the survey)	5.5		8.6	3.6	3.7
Did not eat breakfast on at least one day during the week (during the 7 days before the survey)	46.8		49.3	36.6	49.1
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)	3.5		3.9	N/A	.4
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)	34.7		41.3	N/A	19.5
Watched TV for 3 or more hours per day (on an average school day)	11.3		15.2	6.8	12.2
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)	29.3		40.0	7.0	32.1
Did not attend physical education classes on 1 or more days (in an average week when they were in school)	2.9			N/A	.4
Did not play on at least 1 sports team (during the past 12 months, counting teams run by school or community groups)	23.7		22.3	22.6	9.5
Had a concussion from playing a sport or being physically active (one or more times during the 12 months before the survey)	11.6		12.5	N/A	14.6
Are currently taking medicine or receiving treatment for behavioral health, mental health condition, or emotional problem (from a doctor or other health professional)	13.0		9.6	N/A	

Risky Behavior and Threats to Safety	MA (2017)	Arlington (2018)	Bedford (2017-2018)	Burlington (2018)	Lexington (2017)	Lynnfield(2017)
During the past 30 days, did you ever sleep away from your parents or guardians because you were kicked out, ran away, or were abandoned?		2.3		2		1.4
Rarely or never wore a seat belt (when riding in a car driven by someone else)		4		4		
During the past 30 days, have you ridden in a car or other vehicle driven by someone who had been drinking alcohol?	14.4	12.2	7.9	12.1	11.7	14.5
During the past 30 days, drove when they had been drinking alcohol (in a car or other vehicle, one or more times, among students who had driven a car or other vehicle)	5.7	4.7	0.5	3.3	5.8	2.3
Have you ever ridden in a car driven by someone who had been using marijuana?		9.3	17.6	15.3		
During the past 30 days, have you at least checked your cell phone, text, or e-mail while driving a car or other vehicle?	35.6	31.2		46.4	28.5	
During the past 12 months, have you at least on 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.	2.7	1.1				0.5
During the past 30 days, have you at least on one day carried a gun, knife, or club?	11.1	6	9.7	5.9		4.3
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?	2.7	0.9	1.7	1.1		0.5
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?	4.5	3.3		4.4		1.9
During the past 12 months, have you at least one one day had someone threaten or injur you with a weapon such as a gun, knife, or club on school property?	4.8	2.9		5.2		2.1
During the past 12 months, have you at least once been in a physical fight?	17.8	11.1	18.2	15.7	16.1	11.5
During the past 12 months, have you at least once been in a physical fight on school property?		3.2	4.6	4.7	3.6	2.9
During the past 12 months, have you ever been a member of a gang?		5.1				1.8
Relationship and Sexual Violence	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield(2017)**
Have you ever been physically forced to have sexual intercourse when you did not want to?	6.8			5.2		1.6
During the past 12 months, have you had 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.	10.4	5.6				5.6
During the past 12 months, have you had 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.	5.8	3.7	3.4	5.3		4.2
During the past 12 months, have you had 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.	5.6	1.8	1.7	1.8		1.6
Bullying	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield(2017)**
During the past 12 months, have you ever been bullied on school property?	14.6	12.8	4.6	14.9	12.1	7.4
During the past 12 months, have you ever been electronically bullied? Count being bullied through texting, Instagram, Twitter, Facebook, or other social media apps.	13.6	10.5	15.5	13	10.3	8.3
Has someone posted something about you on social media that made you feel upset or uncomfortable? Social media apps include Instagram, Twitter, Facebook, etc.	.	31.8				
Self-Harm and Suicidality	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield(2017)**
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?		15.3	16.5	12.6	12.5	6.7
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?	27.4	25.7	27.8	27.6	27.1	16.2
During the past 12 months, did you ever seriously consider attempting suicide?	12.4	11	15	12	17.2	7.6
During the past 12 months, did you make a plan about how you would attempt suicide?	10.9	8.3	12.9	8.7	10.4	6
During the past 12 months, did you actually attempt suicide?	5.4	2.3	3.4	3.2	4	2.1
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?	1.9	0.9		0.5		0.3
Substance Use	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield (2017)**
Have you ever tried cigarette smoking, even one or two puffs?	19.6	11.6	16.5	8	8.5	7.5
First tried cigarette smoking before age 13 years (even one or two puffs)	5.7			1.8		1.5
During the past 30 days, did you smoke part or all of a cigarette?				2	2.6	
During the past 30 days, did you smoke more than 10 cigarettes?		0.7		0.4		
During the past 30 days, on at least one day did you smoke cigarettes?	6.4		4.5	1.9		2.8
During the past 30 days, on at least one day did you smoke cigars, cigarillos, or little cigars?	6.7		3.4			3.7
During the past 30 days, did you at least on one day use chewing tobacco, snuff, dip, snus, or dissolvable tobacco products? Examples of these products are as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, Copenhagen, Camel Snus, Marlboro Snus, General Snus, Ariva, Stonewall, or Camel Orbs. DO NOT count any electronic vapor products.	4.8		0.8	2.5		1.9
Have you ever used an electronic vapor product?	41.1	37.7	34.2	40.4		29.6
During the past 30 days, on at least one day did you use an electronic vapor product?	20.1	22.6	27.9	24.3	6.6	22.3

During the past 12 months, did not try to quit using all tobacco products, including cigarettes, cigars, smokeless tobacco, shisha or hookah tobacco, and electronic vapor products		53.4		37.2		
During your life, have you ever had at least one drink of alcohol?	56.2	58	49.2	52.6	65.4	45.1
Had their first drink of alcohol before age 13 years (other than a few sips)		9		6.9		5.7
During the past 30 days, did you drink one or more drinks of an alcoholic beverage?	31.4	24.5	29.1	20.5	25.5	16.6
Had at least one drink of alcohol on school property (at least one day during the past 30 days)		1.6		1.8		1
During the past 30 days, did you on at least one day have 4 or more drinks of alcohol in a row (if you are female) or 5 or more drinks of alcohol in a row (if you are male)?	15.9	11.6	15	12.5	10.7	8.2
Reported 10 or more as the largest number of drinks they had in a row (within a couple of hours, during the 30 days before the survey)		2		2.6		
During your life, have you ever used marijuana?	37.9	35	30	32	18.4	22.1
Tried marijuana for the first time before age 13 years (also called grass, pot, or weed)	4.4	4.4		6.8		1.5
During the past 30 days, have you used marijuana?	24.1	21.5	18.6	20.5	11.5	11.6
During the past 30 days, did you on at least one day use marijuana on school property?		6.4		6.2		1.5
During your life, ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, Oxycontin, Hydrocodone, and Percocet, one or more times during their life)		3.8	4	5.2	3	
During the past 30 days, have you used prescription drugs not prescribed to you?		3.7	1.2	4.2		3.3
Ever took steroids without a doctor's prescription (pills or shots, one or more times during their life)		1.4	0.3	2.3		
During your life, have you used any form of cocaine, including powder, crack, or freebase?	4.1	2	1.4	3.2		1
During your life, have you used heroin? It is also called smack, junk, or China White.	1.4	1.1	0	1.9	1.3	0.2
During your life, have you used methamphetamines? It is also called speed, crystal, crank, or ice.	1.7	1.1	0.3	2.3		0.5
During your life, have you used ecstasy? It is also called MDMA.	2.8	1.6	0.5	2		0.7
During your life, have you used synthetic marijuana? It is also called K2, Spice, fake weed, King Kong, Yucatan Fire, Skunk, or Moon Rocks.	5	2.7		4.1		1.3
During your life, have you taken over-the-counter medication, including cough syrup, to get high?		2.7		3.7	3.4	2.8
During your life, have you used other illegal drugs?		1		1.6		
During your life, have you used a needle to inject any illegal drug into your body?		1.7		2		
During the past 30 days, did you sniff glue, breathe the contents of aerosol spray cans, or inhale any paints or sprays to get high?	20.1	17.2	0.8	13.8		0.7
Sexual Behavior	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield(2017)**
Had sexual intercourse for the first time before age 13 years	2.4	1.3		1.4		0.5
Had sexual intercourse with four or more persons during their life	6.7	4.2		5.5		1.4
Were currently sexually active (had sexual intercourse with at least one person, during the 3 months before the survey)	25	13.8		19.6		16.4
Did you drink alcohol or use drugs before you had sexual intercourse the last time?	18.2	19.9	14.7	19.8	26.5	17.9
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	42.2	37.1	60.6	37	67.9	26.8
Did not use any method to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)	9.6	8.7		6.6		5.4
Had been pregnant or gotten someone pregnant (at least once)		1.8	0.9	1.7		1.4
Have you ever sent or received sexual messages or nude or semi-nude pictures or videos electronically?		36.7		40	60.5	28.3
Were never tested for human immunodeficiency virus (HIV) (not counting tests done if they donated blood)	89.5	75.5		73.8		94.7
Have been tested for other sexually transmitted diseases (STDs) such as genital herpes, chlamydia, syphilis, or genital warts (ever in their life)		9.7		8.4		6.7
Had been taught about AIDS or HIV infection in school		75.6		73.3		46.2
Had been taught in school about birth control methods		77.3		71.6		12.8
Had been taught in school about how to use condoms		51.7		47.8		7.5
Talked with their parents or other adults in their family about sexuality or ways to prevent HIV infection, other sexually transmitted diseases (STDs), or pregnancy (at least once)		46		33.5		41.7
Have an adult in their school who can help find sexual health services (HIV, STD and pregnancy testing, access to birth control) or support around their sexuality		41.5		36		17.5
Felt comfortable asking an adult at school if they needed help finding sexual health services		25.7		21.9		12.6
Physical Activity and Nutrition	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield(2017)**
Described themselves as slightly or very overweight	28.1	24.4	24.1	27.8	N/A	25

Were not trying to lose weight	56.2	59.1	59.7	55		61.4
Did not eat fruit or drink 100% fruit juices (such as orange juice, apple juice, or grape juice, not counting punch, Kool-Aid, sports drinks, or other fruit-flavored drinks, during the 7 days before the survey)	5.8	3.5		5.1		4.7
Did not eat fruit in past 7 days		5.4		9.4		
Did not eat vegetables (green salad, potatoes (not counting French fries, fried potatoes, or potato chips), carrots, or other vegetables, during the 7 days before the survey)	6.9	2.8				3.5
Drank a can, bottle, or glass of soda or pop one or more times per day (such as Coke, Pepsi, or Sprite, not counting diet soda or diet pop, during the 7 days before the survey)	10.5	44.7		55.2		59.8
Did not eat breakfast on all 7 days (during the 7 days before the survey)	63.7	50		58.8		79.4
Were not physically active for a total of at least 60 minutes per 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)	15.1	11.7		14		3.3
Played video or computer games or used a computer for 3 or more hours per day (Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work, on an average school day)	47.9	40		46.1		38.1
Did not go to physical education (PE) classes on 1 or more days (in an average week when they were in school)	40.5	35.7				26.9
Did not play on at least one sports team (counting any teams run by their school or community groups, during the 12 months before the survey)		30.1		30.7		
Had a concussion from playing a sport or being physically active one or more times (during the 12 months before the survey)		8.7		10.8		10.9
Has long-term disabilities (long-term means 6 moths or more)		9.1				14.5
Has physical disabilities or long- term health problems (Long-term means 6 month or more)		9.1				8.4
Medical Attention and Social Support	**MA (2017)**	**Arlington (2018)**	**Bedford (2017-2018)**	**Burlington (2018)**	**Lexington (2017)**	**Lynnfield(2017)**
Were ever told by a doctor or nurse that they had asthma		20.3				21.4
Never saw a dentist (for a check-up, exam, teeth cleaning, or other dental work)		1.7				
Takes medicine or receiving treatment from a doctor or other health professional for any type of behavioral health, mental health condition or emotional problem		19.7		15.3		11.3
Did not get 8 or more hours of sleep (on an average school night)	80.2	72.2		76.9		78.3
Has at least one teacher or other adult in your school that you can talk to if you have a problem		61.3	74.7	55.2		57.2
Can talk with at least one parent or other adult family members about things that are important to them		82.9	81.4	81		87.1
Are either of your parents or other adults in your family serving on active duty in the military?		5				4.4

Appendix C:

Resource Inventory

2019 Community Resource Guide
Lahey Hospital and Medical Center

Disclaimer:

The listings within this guide are designed as informational and are not to be interpreted as recommendations or endorsements.

Beth Israel Lahey Health
Lahey Hospital & Medical Center

Table of Contents

Community Directory

Areas of Care

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

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)

Arlington Council on Aging
27 Maple St. Senior Center
Arlington, MA 02476

Call 781.316.3400 for an appointment.

Arlington Health Dept

27 Maple St.
Arlington, MA 02476
781.316.3170
https://www.arlingtonma.gov/departments/health-human-services/health-department

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

Child, Parent and Family Support

Arlington Boys & Girls Club

60 Pond Lane
Arlington, MA 02474
781.648.1617
www.abgclub.org

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
https://www.arlingtonma.gov/departments/health-human-services/arlington-youth-counseling-center-aycc

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.mmota-founding.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
https://www.arlingtonma.gov/town-governance/all-boards-and-committees/disability-commission

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, 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.

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 Case 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
https://www.sunriseseniorliving.com/communities/sunrise-of-arlington/overview.aspx

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.

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.

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:

- 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 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, 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.

Child, Parent and Family Support

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.

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

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 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, 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.

Geriatric Research, Education and Clinical Center (GRECC) - The Geriatric Research, Education, and Clinical Centers (GRECCs) are United States Department of Veterans Affairs (VA) centers of excellence focused on aging. They were established by Congress in 1975 in order to improve the health and health care of older Veterans. They have three main missions: (1) to build new knowledge through research; (2) to improve health care through the development of new clinical programs; and (3) to ensure that "VA" staff are educated about aging-related issues.

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.

Peer Services - Strong recovery requires not only eliminating destructive behaviors, but adding meaningful activity in its place. Finding our way to feeling connected to the community can be a challenging aspect to recovery. Knowledge of social supports is essential. Any Veteran can build a "wellness plan". CRCT Peers connect Veterans through coffee socials and community resources to network and to facilitate community reintegration. Meetings are Thursdays 7:30 - 9:00am at the Bedford VA Canteen.

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.

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.

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
978.663.8433
https://www.town.billerica.ma.us/767/Billerica-Food-Pantry

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.

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

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

650 Suffolk Street
Lowell, MA 01854
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 suppportive 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
https://www.benchmarkseniorliving.com/senior-living/ma/billerica/benchmark-senior-living-at-billerica-crossings

Benchmark Senior Living at 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' 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 townspeople about available local and area nonprofit and social service resources.

Burlington Board of Health

61 Center Street
Burlington, MA 01803
781.270.1955
http://www.burlington.org/departments/board_of_health/index.php

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.

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.

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.

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.

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.

Support Groups

Alanon/Alateen

Meetings are held at the North Congregational Church Enter up walkway to left side of building. Meetings occur on Tuesday evenings at 7:30 pm.

896 Main St,
Woburn, MA, 01801

Meetings are also held at Saint Brigid's Parish Center at 10:00 am on Wednesday mornings.

1997 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 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), Urologic & Prostate Cancer Support Group, and a Quit Smoking for Life Group.

Narcotics Anonymous

344 Cambridge Street
Burlington, MA 01803

Meetings are held at the Church of Christ on Sundays at 7:30 pm and Tuesdays at 7:00 pm.

Transportation Services

Burlington Public Transit B-Line

25 Center Street
Burlington, MA 01803
781.270.1965
http://www.burlington.org/residents/burlington_public_transit.php

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

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.

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.

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.

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

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.

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.

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

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.

Senior Services

Lexington Senior Center

Community Center
39 Marrett Road
Lexington MA 02421
781.698.4840
https://www.lexingtonma.gov/human-services/senior-services

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

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.

CareOne at Lexington

178 Lowell Street
Lexington, MA 02420
781.778.3600
http://ma.care-one.com

CareOne at Lexington is a newly renovated, premier skilled nursing facility serving patients in need of short term rehabilitation and medical management programs. With 4 Board Certified Geriatricians leading our expert nursing and rehabilitation teams, the clinical outcomes our patients achieve are outstanding. Short term rehabilitation goals are defined and include improving the quality of life for our patients recovering from surgery or acute illnesses.

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.

Support Groups

Alanon/Alateen

Meetings are held at St. Brigid's Parish Center, 1997 Massachusetts Ave, Room 21 on Wednesday mornings at 10:00AM.

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 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, 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

Meetings: 1st & 3rd Tuesdays 6:30–8:30 pm
Contact: Janet at 781.761.5287
jhodges@edinburgcenter.org

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. 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.

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

151 Warren Street
Lowell, MA 01852
978.937.3087
https://www.mspcc.org

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/

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.

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.

Domestic Violence

Alternative House

11 Kearney Square
Lowell, MA 01851
978.454.1436
Toll Free Hotline: 888.291.6228
https://www.alternative-house.org

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.

Lowell Food Pantry

70 Lawrence Street
Lowell, MA 01852
978.452.1421
https://www.ccab.org

Lowell Food Pantry assists Residents of Lowell, Dracut, Chelmsford, Billerica, Westford, Dunstable, Pepperell, and Tyngsboro.

Merrimack Valley Food Pantry

735 Broadway Street
Lowell, MA 01854
978.454.7272
https://mvfb.org

The Merrimack Valley Food Pantry is a community-supported non-profit organization that provides nutritious food and personal care items to emergency feeding programs serving the low-income, homeless and hungry. They are one of four food banks in Massachusetts that serves food pantries, shelters and meal programs that in turn, serve individuals and families.

Women, Infants, and Children (WIC)

45 Kirk Street
Lowell, MA 01852
978.454.6397

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.

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

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 suppportive 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 incerease 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.

Senior Services

Elder Services of the Merrimack Valley, Inc

280 Merrimack St, Suite 400
Lawrence, MA 01843
978.683.7747
https://www.esmv.org

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.

Sexual Health

Lowell Community Health Center

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 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 ar Christ Church United on Saturdays at 9:30 am.

1 Bartlett St
Lowell, MA 01852

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 a 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.

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.

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.

Narcotics Anonymous

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

15 Mammoth Rd
Lowell, MA 01854

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 Gallager 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 service 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.

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

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.

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

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.

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.

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. Iindividuals 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
https://www.sunriseseniorliving.com/communities/sunrise-of-lynnfield/overview.aspx

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 assess 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.

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 though 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.

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.

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.

Peabody Dept of Health

24 Lowell Street
Peabody, MA. 01960
978-538-5926
http://www.peabody-ma.gov/health.html

The Peabody Department of Health and Human Services promotes the health and well-being of residents of (and visitors to) Peabody through the provision of school health services, public immunization clinics, communicable disease follow-up, health education, and the permitting and inspection of facilities such as food establishments, swimming pools, tanning salons, and housing.

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

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.

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.

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.

North Shore Elder Services

Elder Abuse 24-hour Hotline at
1.800.922.2275

Reportable Conditions are:

- Physical, Emotional/Mental or Sexual Abuse
- Financial Exploitation
- Caretaker Neglect
- Self-neglect
- Financial exploitation

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 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

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 0242
781.861.0890Emergency 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.nebhealth.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 residents 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
https://www.sunriseseniorliving.com/communities/sunrise-at-gardner-park/overview.aspx

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

Meetings are held in the basement of St. John's Rectory near City Hall on Saturdays at 1 pm.

17 Chestnut Street
Peabody, MA 01960

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 assess 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.

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

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.

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.

Beth Israel Lahey Health
Lahey Hospital & Medical Center

Appendix D:

Implementation Strategy

Lahey Clinic Hospital, Inc.
Implementation Strategy 2020-2022

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

Community Benefits Priorities	Determination of Need Priority Areas
Chronic disease with a focus on cancer, heart disease, and diabetes	Built environment
Housing stability/homelessness	Social environment
Mental illness and mental health	Housing
Substance use disorders	Violence
	Education
	Employment

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

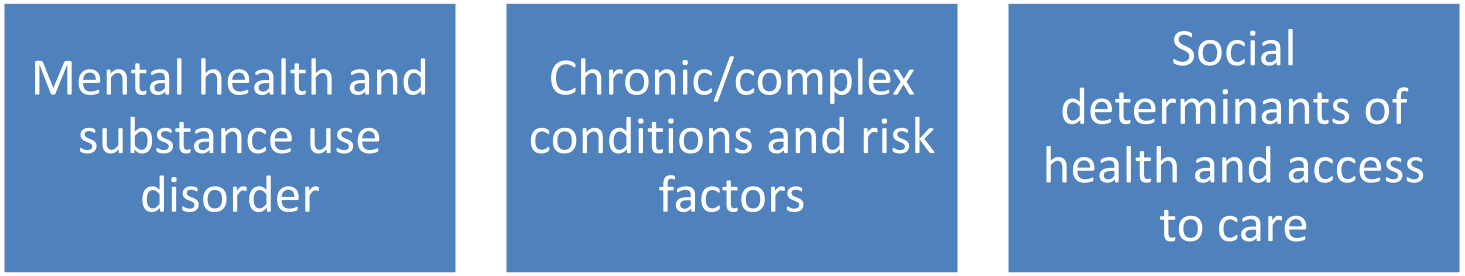
[1] O. Solar and A. Irwin, World Health Organization, "A Conceptual Framework for Action on the Social Determinants of Health," Social Determinants of Health Discussion Paper 2 (Policy and Practice), 2010, available at https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

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

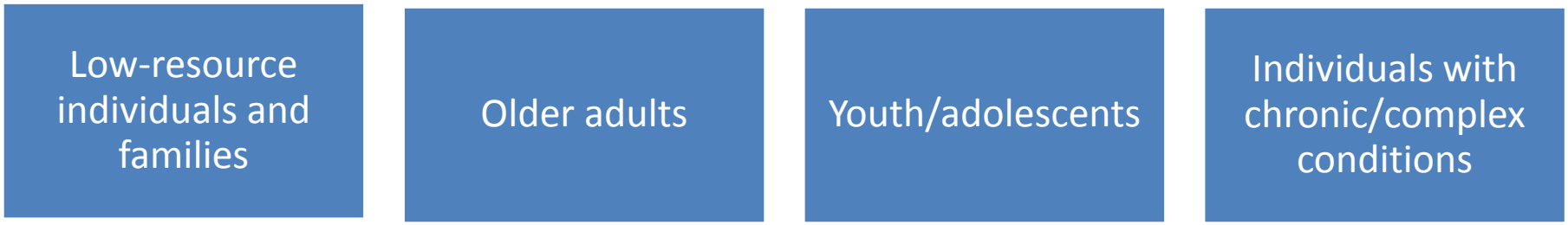
It is important to note that there are community health needs that were identified by LHMC/LMCP's assessment that were not prioritized for inclusion in the Implementation Strategy for a number of reasons:

- 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.

Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder					
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	Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners	Support community-based health education events to raise awareness of and provide education about risk/protective factors and services available within the community (e.g., education series on vaping)	• # 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-activity tests to measure changes in knowledge, behaviors, intentions, etc.	• Local school districts	• Mental illness and mental health • Substance use disorder

Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder					
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	Explore opportunities for partnerships with community-based organizations to identify, screen, assess, and refer those with mental health and substance use disorder to treatment	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)	• # 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-activity tests to measure changes in knowledge, behaviors, intentions, etc.	• CHNA 13/14 • CHNA 15 • Regional/local substance use disorder task forces	• Mental illness and mental health • Substance use disorder
		Participate in collaboratives or task forces that address mental health and/or substance use disorder		• CHNA 13/14 • CHNA 15 Regional/local substance use disorder task forces	
		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)		• Senior centers/COAs	
	Reduce environmental risk factors associated with mental health or substance use issues	Organize drug takeback opportunities at the hospital and with community-based partners (e.g., a medical disposal program)		• Local law enforcement agencies • Internal clinical staff	

Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder					
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	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		• Primary care practices	
		Provide support/referrals to individuals with mental health and/or substance use issues		• 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	• Financial support provided • # of efforts and individuals reached	• Internal clinical staff • Local coalitions	• Mental illness and mental health • Substance use disorder
		Support efforts to assess the overall health of the community (e.g., a Youth Risk Behavior Survey)		• Local school districts • Youth-serving organizations	

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.

<table>
<tr><th colspan="6">Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings</th></tr>
<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>
<tr><td rowspan="2">• Low-resource individuals and families
• Older adults
• Youth/adolescents
• Individuals with chronic/complex conditions</td><td>Increase awareness of and education about the risks and protective factors associated with chronic and complex conditions</td><td>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)</td><td rowspan="2">• # 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</td><td>• Internal clinical staff</td><td rowspan="2">Chronic disease</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><td>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)</td><td>• Internal clinical staff
• YMCAs</td></tr>
</table>

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	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					
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 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.

Goal 1: Address the social determinants of health and access to care					
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 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

Goal 1: Address the social determinants of health and access to care					
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 partnerships and collaboration with community-based organizations to address the social determinants of health (continued)	Participate in diverse, multisector collaboratives 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 • 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
	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		• Senior centers/COAs • Aging services access points	Built environment
	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)		• Senior centers/COAs • Aging services access points	
		Provide community health grants to community partners to support evidence-based programs that address issues associated with access-to-care issues		• CHNA 13/14 • CHNA 15	

Goal 1: Address the social determinants of health and access to care					
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	Work to help strengthen the local workforce	Collaborate with local community partners to support job-training programs that strengthen the local workforce and address underemployment	• # 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	• Local high schools • Local colleges/universities	Employment
	Increase awareness of domestic violence and promote links to services	Provide crisis intervention and education to staff to identify and respond to the needs of victims		• LHMC Emergency Department • LHMC Social Work • Saheli • Local first responders	Violence
		Promote partnership with local first responders and community organizations that are addressing domestic violence			
	Promote resilience and emergency preparedness	Provide free training to first responders and community partners		• LHMC Trauma Department • Local schools • Local public health departments	
	Increase access to affordable and nutritious foods	Support community-based programs that address food insecurity and promote access to healthy foods		• Mill City Grows	Built environment
		Support community-based organizations that provide counseling and coaching on obesity and exercise		• YMCAs • Senior centers/COAs • Aging services access points	

Goal 1: Address the social determinants of health and access to care					
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 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

Appendix E:

Acronyms

ACA	Affordable Care Act
AG	Attorney General
AHRQ	Agency for Healthcare Research and Quality
BH	Beverly Hospital
BH-AGH	Beverly Hospital/Addison Gilbert Hospital
BILH	Beth Israel Lahey Health
BILHBS	Beth Israel Lahey Health Behavioral Services
CBAC	Community Benefits Advisory Committee
CBSA	Community Benefits Service Area
CHIA	Center for Health Information and Analysis
CHNA	Community Health Needs Assessment
EMS	Emergency Medical Services
HMOs	Health Maintenance Organizations
JSI	John Snow, Inc.
LEP	Limited English Proficiency
LHMC	Lahey Hospital & Medical Center
LMCP	Lahey Medical Center - Peabody
MassCHIP	Massachusetts Community Health Information Profile
MHAC	Massachusetts Healthy Aging Collaborative
MDPH	Massachusetts Department of Public Health
MHPC	Massachusetts Health Policy Commission
PAC	Project Advisory Committee
PHIT	Population Health Information Tool
PQI	Prevention Quality Indicator
SDOH	Social Determinants of Healthl
YRBS	Youth Risk Behavior Survey