Appendix A:

Data Book

		Massachusetts	Essex County	Greater Lawrence	Lawrence	Haverhill	Methuen	Andover	North Andover	Data Source
Race, Ethnicity, & Age	Total Population	6,873,003	787,038	261,683	80,022	63,783	50,518	36,098	31,262	*US Census Bureau ACS 5-year 2016-2020*
	White (non-Hispanic)	70.8%	69.5%	52.2%	14.1%	69.2%	58.2%	72.9%	81.1%	*US Census Bureau ACS 5-year 2016-2020*
	Black (non-Hispanic)	6.8%	3.2%	2.6%	1.9%	2.7%	4.0%	2.3%	2.5%	*US Census Bureau ACS 5-year 2016-2020*
	Asian (non-Hispanic)	6.7%	3.4%	4.6%	2.1%	1.3%	4.7%	15.1%	5.8%	*US Census Bureau ACS 5-year 2016-2020*
	Race White Alone	76.60%	78.20%	67.80%	47.20%	77.90%	69.30%	78.20%	85.20%	*US Census Bureau ACS 5-year 2016-2020*
	Race Black or African American Alone	7.50%	4.30%	4.10%	5.30%	3.20%	5.20%	2.30%	3.10%	*US Census Bureau ACS 5-year 2016-2020*
	Race Asian Alone	6.80%	3.40%	4.70%	2.10%	1.30%	4.70%	15.10%	5.80%	*US Census Bureau ACS 5-year 2016-2020*
	Race Native Hawaiian and Other Pacific Islander Alone	0.04%	0.02%	0.01%	0%	0.03%	0%	0%	0%	*US Census Bureau ACS 5-year 2016-2020*
	Race American Indian and Alaska Native Alone	0.20%	0.17%	0.18%	0.41%	0.05%	0.09%	0.09%	0.10%	*US Census Bureau ACS 5-year 2016-2020*
	Some Other Race Alone	4.20%	9.10%	17%	37.10%	10.40%	14.20%	0.60%	2.30%	*US Census Bureau ACS 5-year 2016-2020*
	Two or More Races	4.80%	4.70%	6.30%	7.90%	7.10%	6.50%	3.70%	3.50%	*US Census Bureau ACS 5-year 2016-2020*
	Hispanic (of any Race)	12%	21.40%	38.30%	81.10%	23.20%	30.20%	7.60%	8.10%	*US Census Bureau ACS 5-year 2016-2020*
	Under Age 5	5.20%	5.60%	6%	7.70%	5%	5.40%	5.20%	5.70%	*US Census Bureau ACS 5-year 2016-2020*
	Under Age 18	19.80%	21.30%	23.70%	26.80%	21.90%	20.80%	24.20%	23.50%	*US Census Bureau ACS 5-year 2016-2020*
	Age 18 to 64	63.60%	61.60%	62.70%	63%	63.60%	63.20%	61.50%	60.50%	*US Census Bureau ACS 5-year 2016-2020*
	Age 65 and Over	16.50%	17.10%	13.60%	10.20%	14.50%	16%	14.40%	16%	*US Census Bureau ACS 5-year 2016-2020*
	Age 85 and Over	2.40%	2.70%	2%	1.70%	2.10%	1.70%	1.70%	3.50%	*US Census Bureau ACS 5-year 2016-2020*
	Age 5 to 9	5.30%	5.50%	6.20%	7.10%	6%	5.10%	6%	6.10%	*US Census Bureau ACS 5-year 2016-2020*
	Age 10 to 14	5.70%	6.30%	7%	7.80%	6.80%	5.90%	7.20%	7.40%	*US Census Bureau ACS 5-year 2016-2020*
	Age 15 to 19	6.60%	6.50%	7.40%	7.30%	6.40%	7.50%	8.80%	7.80%	*US Census Bureau ACS 5-year 2016-2020*
	Age 20 to 24	7.10%	6.50%	7%	7.90%	6.50%	6.60%	5.40%	8.20%	*US Census Bureau ACS 5-year 2016-2020*
	Age 25 to 34	14.30%	12.40%	13.50%	17.10%	14.50%	12.20%	7%	11.70%	*US Census Bureau ACS 5-year 2016-2020*
	Age 35 to 44	12.20%	12%	13.10%	13.30%	12.50%	15.10%	13.10%	10.70%	*US Census Bureau ACS 5-year 2016-2020*
	Age 45 to 54	13.30%	13.80%	13.10%	10.90%	13.30%	13.20%	16.70%	13.50%	*US Census Bureau ACS 5-year 2016-2020*
	Age 55 to 59	7.10%	7.70%	7.10%	6.10%	8.10%	7%	8.30%	6.60%	*US Census Bureau ACS 5-year 2016-2020*
	Age 60 to 64	6.50%	6.60%	6%	4.60%	6.50%	6%	7.90%	6.30%	*US Census Bureau ACS 5-year 2016-2020*
	Age 65 to 74	9.50%	9.80%	8%	5.70%	8.70%	9.80%	8.50%	8.70%	*US Census Bureau ACS 5-year 2016-2020*
	Age 75 to 84	4.60%	4.60%	3.70%	2.80%	3.70%	4.50%	4.20%	3.80%	*US Census Bureau ACS 5-year 2016-2020*
	Age 85 and Over	2.40%	2.70%	2%	1.70%	2.10%	1.70%	1.70%	3.50%	*US Census Bureau ACS 5-year 2016-2020*
	Median Age	39.6	40.9	38.2	32.2	38.4	39.6	42.9	38.4	*US Census Bureau ACS 5-year 2016-2020*
	Child Dependency Ratio	31.10%	34.50%	38.50%	42.60%	34.40%	33%	39.30%	38.90%	*US Census Bureau ACS 5-year 2016-2020*
Language & Citizenship	Percent of People over age 5 who Speak English at Home	76.10%	73.30%	58.50%	20.10%	77.30%	62.20%	78.70%	86.60%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of People over age 5 who Speak a Language other than English at Home	23.90%	26.70%	41.50%	79.90%	22.70%	37.80%	21.30%	13.40%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of People over age 5 who speak Other Indo-European Language at Home	9.00%	5.90%	4.20%	1.70%	3.70%	4.90%	8.50%	5.20%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of People over age 5 who speak Asian-Pacific Islander Language at Home	4.40%	2.10%	2.80%	1.80%	0.90%	2.50%	8.40%	3.40%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of People over age 5 who Speak Spanish at Home	9.10%	17.70%	33.30%	75.50%	17.70%	27%	3.80%	4.30%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Households that are Language Isolated	5.80%	7%	10.90%	28.30%	3.60%	5.50%	3.70%	2.10%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of People over age 5 whose Ability to Speak English is "Less Than Very Well"	9.20%	11.20%	16.60%	38.30%	6.70%	11.50%	5.30%	4%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Population that is Foreign Born	16.90%	17.50%	23.50%	40.80%	11.60%	23.10%	17.60%	10.8%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Population that is Foreign Born (naturalized citizen)	9.10%	9.90%	13%	19.70%	6.40%	15.50%	11.10%	7.50%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Population that is Foreign Born (non-citizen)	7.70%	7.60%	10.40%	21.10%	5.10%	7.60%	6.40%	3.30%	*US Census Bureau ACS 5-year 2016-2020*
Income, Unemployment, & Poverty	Median Household Income	$84,385	$82,225	$87,690	$45,045	$69,237	$83,527	$153,315	$113,916	*US Census Bureau ACS 5-year 2016-2020*
	Unemployment Rate	5.10%	5.20%	6.90%	11%	5.10%	6.60%	3.90%	2.60%	*US Census Bureau ACS 5-year 2016-2020*
	Population Below 200% FPL	21.50%	22.70%	28.80%	48.50%	28.40%	22%	8.50%	12.80%	*US Census Bureau ACS 5-year 2016-2020*
	Population Below 100% FPL	9.80%	10.10%	12.40%	21%	12%	9.10%	3.50%	6.60%	*US Census Bureau ACS 5-year 2016-2020*
	Households Below 100% FPL	10.60%	11.20%	13.50%	25.20%	11.50%	9.40%	3.50%	8.30%	*US Census Bureau ACS 5-year 2016-2020*
	Families Below 100% FPL	6.60%	7.30%	9.30%	17.90%	9.20%	6.30%	1.80%	3.90%	*US Census Bureau ACS 5-year 2016-2020*
	White Alone People Below Poverty Level	7.90%	8.10%	9.70%	20.10%	9.60%	6.40%	3.50%	6.10%	*US Census Bureau ACS 5-year 2016-2020*
	Black or African American Alone People Below Poverty Level	17.60%	17.10%	13.30%	13.10%	23.30%	10.70%	2.40%	9.10%	*US Census Bureau ACS 5-year 2016-2020*
	Asian Alone People Below Poverty Level	11.80%	9%	4.10%	0%	6.60%	7.40%	4%	2.90%	*US Census Bureau ACS 5-year 2016-2020*
	Native Hawaiian and Other Pacific Islander Alone People Below Poverty Level	12%	30%	0%	No data	0%	No data	No data	No data	*US Census Bureau ACS 5-year 2016-2020*
	American Indian and Alaska Native Alone People Below Poverty Level	23.30%	34.20%	30.50%	37.80%	27.30%	22.20%	0%	0%	*US Census Bureau ACS 5-year 2016-2020*
	Some Other Race Alone People Below Poverty Level	22.20%	21.70%	23.70%	23.80%	26.10%	20.90%	0%	32.30%	*US Census Bureau ACS 5-year 2016-2020*
	Two or More Races People Below Poverty Level	15.50%	14.70%	15.20%	22.90%	13.90%	11%	2%	3.80%	*US Census Bureau ACS 5-year 2016-2020*
	Hispanic or Latino People Below Poverty Level	23%	20.40%	21.30%	22.90%	24%	16.10%	0.90%	18.40%	*US Census Bureau ACS 5-year 2016-2020*
	White Not Hispanic or Latino People Below Poverty Level	6.70%	6.60%	6.50%	14.50%	7.50%	4.90%	3.70%	5.90%	*US Census Bureau ACS 5-year 2016-2020*
	Households with Public Assistance Income	2.80%	3.80%	6.10%	11%	6.40%	5.40%	0.70%	1.40%	*US Census Bureau ACS 5-year 2016-2020*
	People Below Poverty Level - Age Under 18 (Children)	12.20%	13.60%	16.40%	25.20%	19.60%	12.20%	2%	7.60%	*US Census Bureau ACS 5-year 2016-2020*

Education	People Below Poverty Level - Age 65 and Over (Seniors)	8.90%	9.70%	13.20%	29.30%	7.80%	11.30%	6.20%	7.20%	*US Census Bureau ACS 5-year 2016-2020*
	Family Below Poverty Level - Female No Spouse with Children	34%	34.60%	34%	39.70%	36.30%	21.40%	9.20%	36.10%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - Less than 9th Grade	4.20%	5.50%	7.70%	18.30%	3.40%	5.80%	2%	1.50%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - 9th to 12th Grade	4.70%	4.80%	6.70%	13.30%	6.30%	4.80%	1.20%	1.30%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment- Less than High School Degree	8.90%	10.30%	14.40%	31.60%	9.70%	10.60%	3.20%	2.80%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - High School Degree	23.50%	24.50%	25.60%	31.40%	31%	29.20%	8.20%	14.20%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - Some College No Degree	15.30%	16.30%	17.70%	19.40%	20.40%	21.30%	9%	11.70%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - Associates Degree	7.70%	8.20%	7.70%	5.10%	9.50%	9.30%	5.40%	10%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - Bachelor's Degree	24.50%	24.30%	20%	8.50%	19.60%	18.20%	35.20%	33.90%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment - Graduate Degree	20%	16.40%	14.60%	4%	9.90%	11.40%	39.10%	27.40%	*US Census Bureau ACS 5-year 2016-2020*
	Educational Attainment- Bachelor's Degree or Higher	44.50%	40.70%	34.60%	12.50%	29.50%	29.60%	74.30%	61.30%	*US Census Bureau ACS 5-year 2016-2020*
Built Enviornment	Percent of Households Without Internet Access	9.30%	10.30%	12.30%	22.90%	11.60%	8.60%	2.90%	4.90%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Children with Low Access to Healthy Food	59.40%	62.20%	70%	44.80%	85.90%	68.60%	93.30%	90.10%	*USDA ERS 2019*
	Percent of Residential Buildings with Potential of Lead Paint	65.10%	68.50%	62.10%	83.90%	54%	61.20%	64%	51.60%	*Tax Assessor (ATTOM) 2021*
	Median Residential Building Age (year)	1961	1959	1971	1941	1960	1969	1970	1976	*US Census Bureau ACS 5-year 2016-2020*
	Walkability Index (higher score=more walkable)	11.6	12.2	12.4	15	12	11.4	9.3	10.4	*EPA 2019*
	Percent of Land Protected From Development	11.10%	11.80%	No data	5.20%	6.90%	2.70%	11.30%	13.10%	*EPA Smart Location Database 2019*
Housing	Percent of Occupied Housing Units that are Rented	37.50%	36.20%	42.40%	70.30%	41.80%	26.50%	19.50%	29.20%	*US Census Bureau ACS 5-year 2016-2020*
	Median Gross Rent as a Percentage of Income	29.60%	32.10%	33.50%	33.70%	32%	37%	27.10%	30%	*US Census Bureau ACS 5-year 2016-2020*
	Housing Cost Burdened Renters	46.30%	51.30%	53.10%	56.20%	51.70%	55.60%	37.80%	48.40%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Occupied Housing Units that are Owned	62.50%	63.80%	57.60%	29.70%	58.20%	73.50%	80.50%	70.80%	*US Census Bureau ACS 5-year 2016-2020*
	Median Selected Monthly Ownership Costs as a Percentage of Income	19.90%	20.90%	22.40%	24%	21.10%	20.40%	18.70%	19.20%	*US Census Bureau ACS 5-year 2016-2020*
	Housing Cost Burdened Owners	26.10%	28.30%	27%	39.60%	28.50%	24.70%	19.80%	24.80%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Households that are Families	63.20%	66.60%	69%	68.50%	63%	73.40%	75.60%	68.90%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Households that are Nonfamily Households	36.80%	33.40%	31%	31.50%	37%	26.60%	24.40%	31.10%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Occupied Housing Units that are Overcrowded	2%	2.80%	3.60%	7.30%	2.80%	2.10%	1%	1.90%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Renter Occupied Housing Units with 1.51 to 2 Occupants Per Room	1.20%	1.30%	1.50%	1.90%	0.80%	2.20%	1.50%	0%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Owner Occupied Housing Units with 1.51 to 2 Occupants Per Room	0.20%	0.30%	0.70%	3.20%	0.20%	0.50%	0.10%	0.10%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Renter Occupied Housing with 1 or more Severe Housing Problems	9%	10.50%	12.90%	23.40%	12.20%	8.90%	3.70%	6.20%	*HUD CHAS 2014-2018*
	Percent of Owner Occupied Housing with 1 or more Severe Housing Problems	6.50%	7.30%	6.30%	5.60%	5.80%	7.80%	7.90%	5.30%	*HUD CHAS 2014-2018*
	Eviction Rate	1.50%	1.80%	3%	2.30%	2.70%	6.50%	1.50%	1.60%	*Eviction Lab 2016*
Transportation	Commute Mean Travel Time (minutes)	30	30.2	27.8	23.3	27.5	27.3	32.7	32.6	*US Census Bureau ACS 5-year 2016-2020*
	Median Commute Distance (miles)	12.4	13.6	14.1	12.7	15.8	13.9	14.3	13.8	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Occupied Housing Units Without a Vehicle	12.20%	10.60%	12.10%	26%	9.90%	5%	2.70%	6%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Commuters Driving Alone	74.10%	79.70%	81%	72%	83.30%	86.80%	82.10%	86.50%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Commuters Carpooling	7.90%	9.10%	10.40%	16%	9.40%	8.80%	6.90%	5.60%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Commuters Taking Public Transit	10.40%	5.60%	3.50%	3.80%	3.70%	1.40%	5.10%	3.90%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Commuters Walking	5.20%	3.40%	2.60%	3.70%	2%	1.50%	4.10%	1.60%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Commuters Biking	0.90%	0.20%	0.10%	0.20%	0.10%	0.10%	0.10%	0%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Commuters Taking a Taxicab, Motorcycle, or Other Means	1.40%	2%	2.40%	4.30%	1.50%	1.50%	1.70%	2.30%	*US Census Bureau ACS 5-year 2016-2020*
Access to Health Care	Percent of Population that is Uninsured	2.70%	3%	4.20%	6.40%	3.90%	4%	1.30%	2.50%	*US Census Bureau ACS 5-year 2016-2020*
	Percent of Adults who had a Doctor Visit in Past Year	79.60%	81.20%	79.90%	77.40%	80.10%	80.70%	82.80%	81.90%	*CDC BRFSS PLACES 2019*
	Percent of Adults who had a Dental Visit in Past Year	72.30%	74.30%	69.90%	57.80%	71.40%	72.90%	82.90%	81.10%	*CDC BRFSS PLACES 2018*
	Primary Care Physicians per 100k People	105	81	83	114	59	74	57	95	*HRSA PCSA 2010*
	Specialist Physicians per 100k People	210	123	128	119	102	142	148	159	*HRSA PCSA 2010*
	Dentists per 100k People	78	73	81	54	62	95	133	113	*HRSA PCSA 2010*
	OB-GYNs per 100k People	15	10	10	3	18	6	9	18	*HRSA PCSA 2010*
Health & Wellness	Life Expectancy at Birth (years)	80.6	80.8	80.6	79.4	79.9	80.2	84.1	81.7	*CDC NCHS USALEEP 2010-2015*
	Poor Physical Health Among Adults	11.20%	11.40%	12.50%	15.50%	12.50%	12.10%	8.40%	9.30%	*CDC BRFSS PLACES 2019*
	Poor Mental Health Among Adults	14%	12.60%	14.40%	16.80%	15%	14.10%	10.10%	11.50%	*CDC BRFSS PLACES 2019*
	No Leisure-Time Physical Activity Among Adults	26.60%	29.80%	32.60%	43%	30.90%	30.60%	21.10%	23.50%	*CDC BRFSS PLACES 2019*
	Percent of Adults who Regularly Smoke	14.90%	13.50%	15.80%	18.50%	17.30%	16.10%	9.80%	11.80%	*CDC BRFSS PLACES 2019*
	Percent of Adults who Binge Drink	20.20%	19.60%	20%	18.60%	21%	20.40%	20.50%	21.10%	*CDC BRFSS PLACES 2019*
	Percent of Adults Getting Less Than 7 Hours Sleep	35.10%	33.80%	35.50%	38.80%	35.60%	35%	31.10%	32%	*CDC BRFSS PLACES 2018*
	Arthritis Prevalence Rate Among Adults	23.90%	24.80%	24%	21.50%	25.60%	25.90%	23.90%	24.40%	*CDC BRFSS PLACES 2019*
	Asthma Prevalence Rate Among Adults	10.20%	9%	9.50%	10%	9.90%	9.50%	8.30%	8.70%	*CDC BRFSS PLACES 2019*
	Cancer (except skin) Prevalence Rate Among Adults	7.10%	7%	6.40%	4.70%	6.80%	7.10%	7.50%	7.40%	*CDC BRFSS PLACES 2019*
	Chronic Kidney Disease Prevalence Rate Among Adults	2.50%	2.80%	2.70%	3.20%	2.60%	2.70%	2.20%	2.30%	*CDC BRFSS PLACES 2019*
	Coronary Heart Disease Prevalence Rate Among Adults	5.50%	5.80%	5.60%	5.90%	5.70%	5.90%	4.60%	4.90%	*CDC BRFSS PLACES 2019*
	Depression Prevalence Rate Among Adults	20.30%	18%	19.20%	18.90%	20.70%	19.70%	17.20%	18.30%	*CDC BRFSS PLACES 2019*
	Diabetes Prevalence Rate Among Adults	8.20%	9.20%	9.20%	11.80%	8.40%	8.60%	6.80%	6.90%	*CDC BRFSS PLACES 2019*

High Blood Pressure Prevalence Rate Among Adults	27.60%	26.80%	26%	26%	26.60%	27%	24.30%	24.70%	*CDC BRFSS PLACES 2019*
High Cholesterol Prevalence Rate Among Adults	29%	29.30%	28.20%	26.90%	28.40%	29.20%	29.30%	28.60%	*CDC BRFSS PLACES 2019*
Obesity Prevalence Rate Among Adults	26%	26.30%	27.50%	32.20%	27.30%	26.30%	21.60%	22.90%	*CDC BRFSS PLACES 2019*
Stroke Prevalence Rate Among Adults	2.80%	2.80%	2.80%	3.10%	2.90%	2.90%	2.20%	2.40%	*CDC BRFSS PLACES 2019*
Teeth Loss Prevalence Rate Among Adults Age 65 and Over	13%	11.60%	14.20%	20.70%	14%	12.90%	6.10%	7.60%	*CDC BRFSS PLACES 2018*

Appendix B:

Community Engagement Summary & Qualitative Instruments

Interviews

Interview guide

List of key interviewees

LGH/GLFHC Community Health Needs Assessment

Key Informant Interview

Please complete this section for each interview:

Date:
Name of Interviewee:
Name of Organization:
Interviewer:
Did anything unusual occur during this interview? (Interruptions, etc.)

Thank you for taking the time to speak with me today. Lawrence General Hospital and Greater Lawrence Family Health Center are conducting a community health needs assessment (explain needs assessment requirements and process if person is not familiar).

During this interview, we will ask about you and the work you do, strengths and challenges in the community, the populations that you work with, and opportunities for partnership and collaboration among community organizations.

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

Question	Direct Answer	Additional Information
Community Characteristics, Strengths, Challenges		
Tell me about yourself and the work that you do.		
How would you describe your community to somebody who is unfamiliar?		
Have you seen the community/population change over the last several years? How?		
What do you consider to be the community's (or population's) greatest strengths and assets?		
We're interested in understanding challenges related to the social determinants of health (e.g., housing, economic insecurity, transportation, food insecurity, etc.) What challenges do community members face in their day-to-day lives?		
Health Priorities and Challenges		
What do you think are the most pressing *health* concerns in the community?		
We understand that different groups of people have different health concerns.		

Thinking about your community, do you see disparities - where some groups are more impacted or face more significant barriers than others?		
Community-Based Work		
Do you currently partner with any other organizations or institutions in your work? How?		
Suggested Improvements		
When you think about the community 3 years from now, what improvements would you like to see? Think short and long term.		
In what ways do you think healthcare (e.g., hospitals, health centers) can and/or should help tackle the improvements/barriers/needs we've discussed today?		
Before we wrap up, is there anything we have NOT asked about that you'd like to share?		

Interviewees

- AgeSpan Senior Leadership
- Andover Municipal Leaders
- Jess Andors, Lawrence Community Works
- Amy Bositis, Greater Lawrence Family Health Center
- Aida Castro, Family Services of Merrimac Valley
- Pat Davison, Disabilities Advocate
- Joan Hatem Roy, AgeSpan
- Holy Family Hospital Leadership
- Ana Javier, Lawrence Methuen Community Council
- Greater Lawrence Community Action Council
- Greater Lawrence Family Health Center Senior Leadership
- Kathleen Keenan, North Andover Library
- Donna Kivlin, The Psychological Center
- Steve LaMaster, Vinfen
- Lawrence General Hospital Senior Leadership
- Lawrence Municipal Leaders
- Ana Luna, ACT Lawrence
- Harold Magoon, Lawrence Methuen Community Council
- Heather McMann, Groundwork Lawrence
- Lesly Melendez, Groundwork Lawrence
- Methuen Municipal Leaders
- Merrimack Valley YMCA Leaders
- North Andover Municipal Leaders
- Carina Pappalardo, The Psychological Center

Focus groups

Focus group guide

List of focus groups

LGH/GLFHC Focus Group Guide

Opening Script (10 Minutes)

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

We want to hear your thoughts about things that impact health in your community. The information we collect will be used by LGH and GLFHC for their community health needs assessment – this assessment is done to better understand and address health and social service needs in the community. The information gathered during this assessment is used to inform plans that outline how healthcare organizations will address the identified priorities in partnership with community organizations.

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

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

(if recording): With your permission, we would like to audio record the focus group to help ensure that we took accurate notes. No one besides the project staff would have access to these recordings, and we would destroy them after the report is written. Does everyone agree with the audio recording? *If all participants agree, you can record the Zoom. If one or more person does not agree or are hesitant, do not record the focus group.*

Does anyone have any questions before we begin?

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

   Probes:

   - Are there organizations or programs that are doing good work, or that you think should be highlights?

   In some ways, the most important part of this assessment is the action plan that is created as a result of the assessment. We want to make sure that this action builds on the communities strengths/assets and what is already being done well.

   This region does a pretty good job when it comes to health and public health. You have had to deal with a lot (gas explosions, pandemics, etc.), What are the keys to Lawrence's success?

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

   Probes

   - Think about health defined broadly. It is not just about diabetes or depression, or asthma. What are the underlying issues that are a challenge for community residents?
     - What about things like housing, food/nutrition, transportation, access to the internet, language barriers (the social determinants of health)?

   - Think about the specific health conditions. What are the leading health issues in this region - including mental health and substance use?

   - What are the leading barriers to care? What prevents people from getting the services they need? (cost, transportation, lack of insurance, language issues)

   - Are there gaps in services for community residents?
     - Health services: primary care, mental health, substance use, specialty care, dental
     - Social services: Housing, food, employment/jobs
     - Education/training: English language, job training, basic eduation

3. **What do you think the Greater Lawrence Family Health Center, Lawrence General Hospital, and other organizations should do to improve access to care and community health services in the community?**

If you had a blank check or a magic wand, what programs, services, or actions would you take to make things better when it comes to the health?

4. **Of all the things we talked about today, what do you think are the top 3 or 4 issues? What should be prioritized?**

Focus Groups

- Merrimack Valley Homelessness Meeting - April 5, 2022
- International Veterans Care Services - April 26, 2022
- My Care Family Patient Family Advisory Council - May 17, 2022
- Vinfen Clubhouse - May 2022

Listening sessions

Listening session presentation
List of listening session dates

Welcome!
Please use the Zoom chat to introduce yourself.

- Name and pronouns, if you'd like to share
- Title and organization you represent and what community you're from
- Favorite comfort food!

Agenda

- Purpose and importance of community health needs assessments
- Project activities
- Key themes and prioritization
- Discussion

The Importance of Community Health Needs Assessments

Needs Assessment	Education & Engagement	Planning & Implementation
• Characterize communities • Identify health issues, barriers to care, and service gaps • Identify disparities and inequities	• Collaborate with community • Foster dialogue • Engage key stakeholders	• Identify and align priorities • Leverage existing resources • Promote cross-sector collaboration

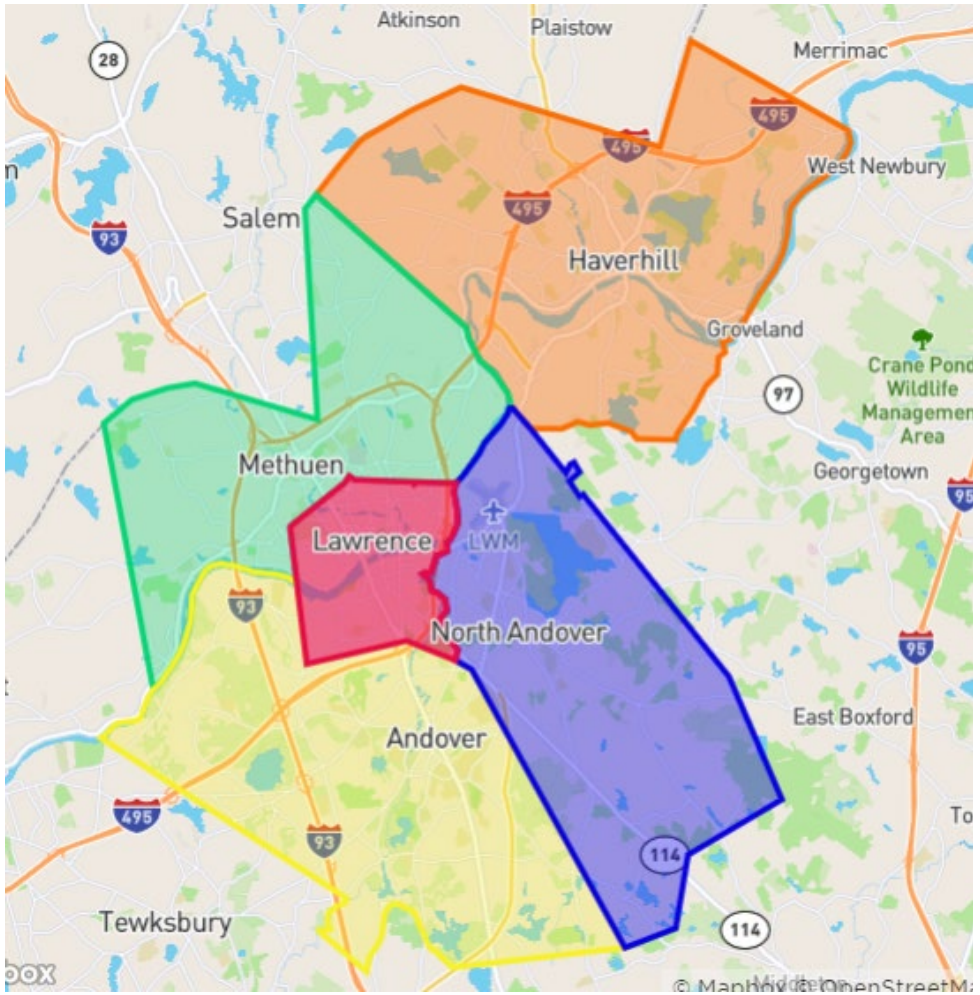
Social Determinants of Health

Project Activities

CHNA Service Area

The CHNA looks at communities in both LGH's and GLFHC's primary service areas:

Andover
Haverhill
Lawrence
Methuen
North Andover



Assessment Activities

900+

Survey respondents

20

Key Informant Interviews

4

Focus Groups

MV Homeless Coalition
Veterans
Patient Family Advisory Council
Individuals in SUD recovery

2

Listening Sessions scheduled

Quantitative Data Collection:

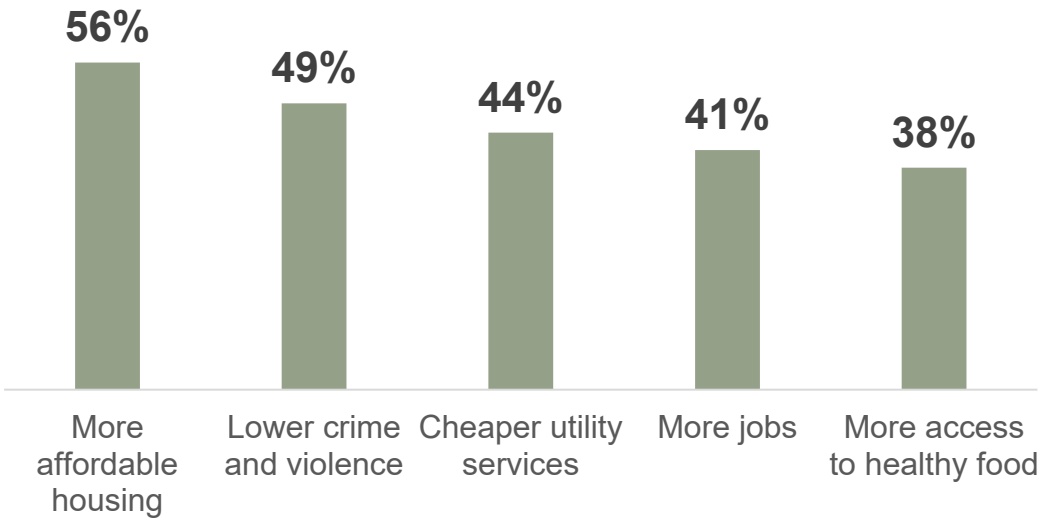
US Census Bureau
CDC
National Center for Health Statistics
Behavioral Risk Factor Surveillance Survey
Etc.

Key Themes

Social Determinants of Health

- **Housing –** need for more affordable housing
- **Economic insecurity –** need for more positions with higher pay, benefits, and upward mobility
- **Food insecurity –** exacerbated by the pandemic; need access to healthier foods
- **Childcare –** lack of affordable options; major barrier to employment
- **Crime and violence –** community violence, racism/discrimination, domestic violence
- **Educational attainment –** has significant impacts on health literacy
- **Racism and discrimination**

What things would you like to see change in your community?
(Community Health Survey)



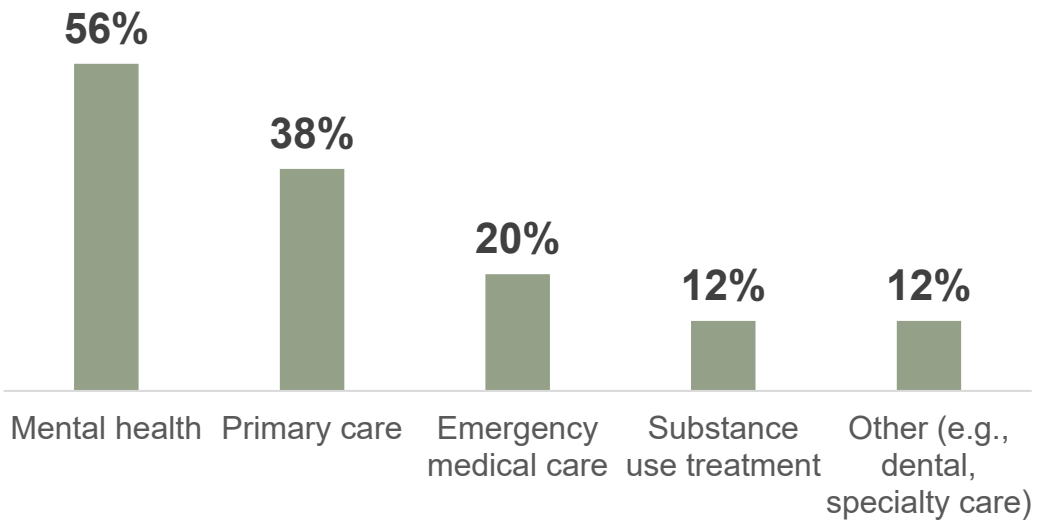
Source: US Census Bureau American Community Survey

Behavioral health

- **Youth mental health –** increase in anxiety, depression, behavioral issues, suicidal ideation
- **Depression and anxiety –** high prevalence among adults and youth
- **Trauma –** due to violence, adverse childhood experiences, poverty, etc.
- **Substance use –** particularly opioids and alcohol
- **Crisis outreach**
- **Care coordination and care transitions**

If you were not able to get healthcare in the past year, what kind of healthcare were you not able to get?

(Community Health Survey)



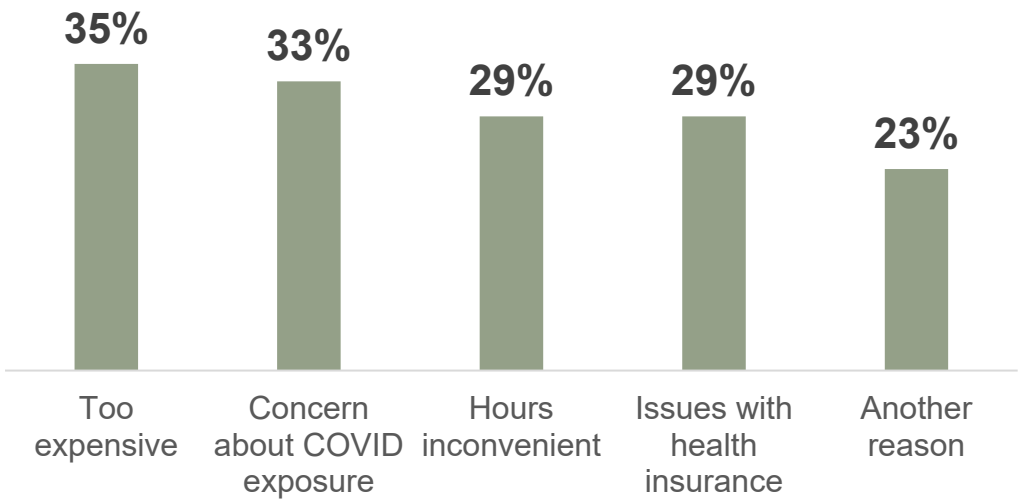
Source: COVID-19 Community Impact Survey, MA DPH

Access to care

- Cost and insurance barriers
- Inconvenient hours
- Mistrust of healthcare system/providers
- Language and cultural barriers
- Capacity of healthcare system (especially mental health) to meet the needs of community (e.g., long wait times, not taking new patients)
- Navigation of healthcare system

Why were you not able to get the primary care services you needed within the past year?

(Community Health Survey)

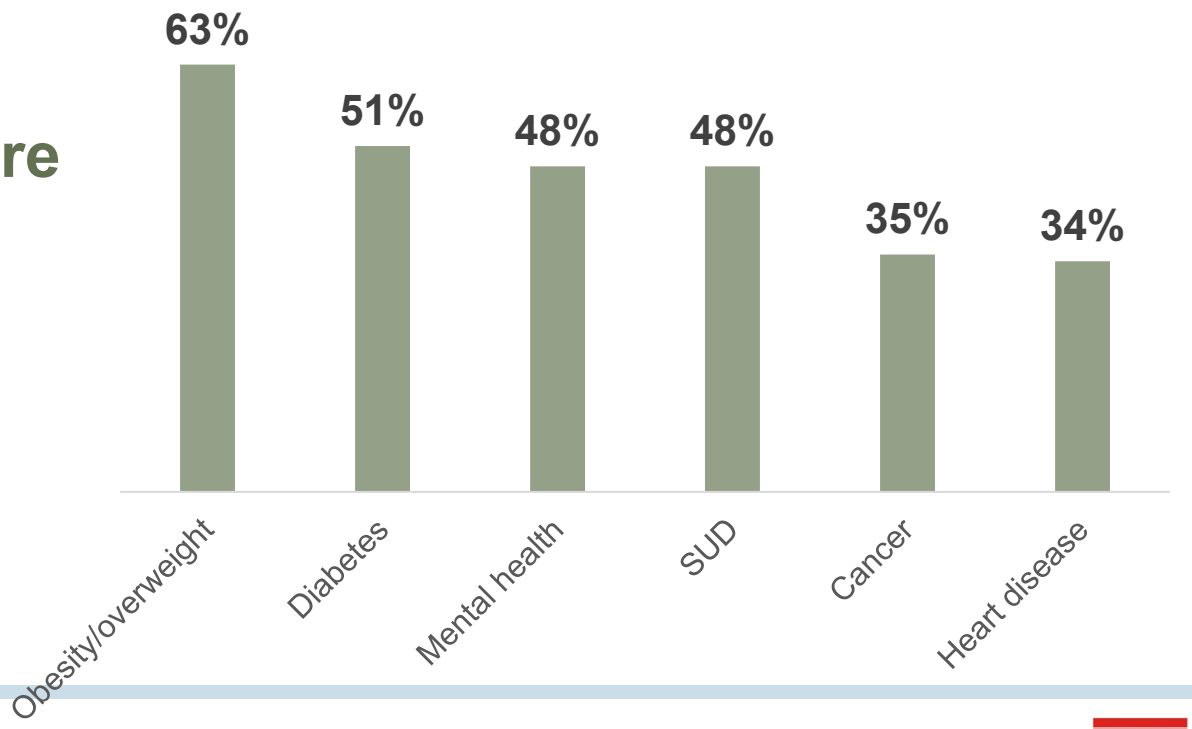


Chronic/complex conditions and risk factors

- Diabetes
- Heart disease
- Cancer
- Asthma/lung diseases
- Obesity/overweight

Significant discussion around the need for more culturally appropriate education and prevention, chronic disease management, and support

What health issues are you most concerned about in your community?
(Community Health Survey)



Discussion

- Do these results surprise you?
- Do you want to advocate to elevate any of the priorities that did not rise to the top of the poll?
- Within each priority area:
  - What are the existing strengths/assets?
  - What is most needed?

Focus Groups

- Listening Session in English - June 8, 2022
- Listening Session en Espanol - June 16, 2022
- Senior Center - July 21, 2022

Community Health Survey

Copy of survey instrument

Output of survey results

Community Health Survey for Greater Lawrence

We would like to know your thoughts on health in your community. Your community might be the place where you live, work, play, or learn.

Please enter the zip code of the community in which you spend the most time:

Zip code: _____

1) How would you describe your community?
- ☐ Very unhealthy
- ☐ Unhealthy
- ☐ Somewhat healthy
- ☐ Healthy
- ☐ Very healthy

2) How would you rate your own mental health?
- ☐ Very unhealthy
- ☐ Unhealthy
- ☐ Somewhat healthy
- ☐ Healthy
- ☐ Very healthy

3) How would you rate your own physical health?
- ☐ Very unhealthy
- ☐ Unhealthy
- ☐ Somewhat healthy
- ☐ Healthy
- ☐ Very healthy

4) What things would you like to improve in your community? Choose your top 5.
- ☐ More jobs
- ☐ More access to healthy food
- ☐ Better access to internet
- ☐ Improve public transportation system
- ☐ Better parks and recreation
- ☐ Better sidewalks and crosswalks
- ☐ Better schools with safe, welcoming, engaged staff
- ☐ Cleaner environment
- ☐ Lower crime and violence
- ☐ More affordable childcare
- ☐ More affordable housing
- ☐ Cheaper utility services (electric, gas, oil, water)
- ☐ More arts and cultural events
- ☐ More inclusion for diverse members of the community
- ☐ Stronger community leadership
- ☐ Other, please specify: _____

5) What health issues are most concerning in your community? <u>Choose your top 5.</u>

- ☐ Cancer
- ☐ Heart disease
- ☐ Stroke
- ☐ Asthma and lung diseases
- ☐ Obesity/overweight
- ☐ Maternal health
- ☐ Diabetes
- ☐ Dental problems
- ☐ Infectious and contagious diseases (flu, pneumonia, HIV, COVID, Hepatitis C, sexually transmitted diseases)
- ☐ Injuries
- ☐ Memory and neurological issues
- ☐ Mental health issues
- ☐ Substance use issues
- ☐ Violence (including domestic violence, interpersonal violence, child abuse, elder abuse)
- ☐ Other (please specify):
- ☐ _____

6) Is there a time in the last year when you needed medical care (including mental health care) but you weren't able to get it?

- ☐ Yes *(if yes, move to question 7)*
- ☐ No *(if no, move to question 13)*

7) What kind of health care were you not able to get? Check all that apply.

- ☐ Primary care (if checked, please answer question 8)
- ☐ Mental health care (if checked, please answer question 9)
- ☐ Substance use treatment/care (if checked, please answer question 10)
- ☐ Emergency medical care (if checked, please answer question 11)
- ☐ Other (please specify): _____ *(if checked, please answer question 12)*

8) Why were you not able to get <u>primary care</u>? Check all that apply.

- ☐ I wasn't sure where to find the services
- ☐ Concern about COVID exposure
- ☐ Too expensive
- ☐ Issues with health insurance
- ☐ Transportation issues
- ☐ Hours are not convenient
- ☐ Fear or distrust of health care system
- ☐ Language barriers
- ☐ Another reason not listed (please specify): _____

9) Why were you not able to get <u>mental health care</u>? Check all that apply.

- ☐ I wasn't sure where to find the services
- ☐ Concern about COVID exposure
- ☐ Too expensive
- ☐ Issues with health insurance
- ☐ Transportation issues
- ☐ Hours are not convenient
- ☐ Fear or distrust of health care system
- ☐ Language barriers
- ☐ Another reason not listed (please specify): _____

10) Why were you not able to get substance use treatment/care? Check all that apply.

- ☐ I wasn't sure where to find the services
- ☐ Concern about COVID exposure
- ☐ Too expensive
- ☐ Issues with health insurance
- ☐ Transportation issues
- ☐ Hours are not convenient
- ☐ Fear or distrust of health care system
- ☐ Language barriers
- ☐ Another reason not listed (please specify): _____

11) Why were you not able to get emergency medical care? Check all that apply.

- ☐ I wasn't sure where to find the services
- ☐ Concern about COVID exposure
- ☐ Too expensive
- ☐ Issues with health insurance
- ☐ Transportation issues
- ☐ Hours are not convenient
- ☐ Fear or distrust of health care system
- ☐ Language barriers
- ☐ Another reason not listed (please specify): _____

12) Why were you not able to get an other type of health care? Check all that apply.

- ☐ I wasn't sure where to find the services
- ☐ Concern about COVID exposure
- ☐ Too expensive
- ☐ Issues with health insurance
- ☐ Transportation issues
- ☐ Hours are not convenient
- ☐ Fear or distrust of health care system
- ☐ Language barriers
- ☐ Another reason not listed (please specify): _____

13) How often do you have to have someone help you understand instructions and information from your doctors or pharmacies?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

14) Would you be more likely to access primary care health services if they were provided in a women-only center in your community?

- ☐ Yes
- ☐ No
- ☐ Does not apply

15) Have you ever experienced racism and discrimination in your community?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

16) Have you ever witnessed racism and discrimination in your community?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

17) How often do you think racism and discrimination affects the ability of people in your community to get the health care they need?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

About You

The next questions help us to better understand how people of diverse identities and life experiences have similar or different priorities or needs. You may skip any questions that you prefer not to answer.

18) What is your age?

- ☐ Under 18 years old
- ☐ 18-24 years old
- ☐ 25-44 years old
- ☐ 45-64 years old
- ☐ 65-74 years old
- ☐ 75-84 years old
- ☐ Over 85 years old
- ☐ Prefer not to answer

19) What is your current gender identity?

- ☐ Genderqueer or gender non-conforming
- ☐ Man
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Woman
- ☐ Prefer to self-describe: _____
- ☐ Prefer not to answer

20) What is your sexual orientation?

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay or lesbian
- ☐ Straight/heterosexual
- ☐ Prefer to self-describe: _____
- ☐ Prefer not to answer

21) Which one of these groups best represents your race? You will have space to enter ethnicity in the next question. Check all that apply

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

22) Do you identify as Hispanic or Latino/a?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

23) What is your ethnicity? Check all that apply.

- ☐ African (please specify): _____
- ☐ African American
- ☐ American
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander (please specify): _____
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European (please specify): _____
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican-American, Chicano
- ☐ Middle Eastern (please specify): _____
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other ethnicity (please specify): _____
- ☐ Unknown/not specified
- ☐ Prefer not to answer

24) What is the primary language(s) spoken in your home? Check all that apply.

- ☐ Arabic
- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (including Mandarin and Cantonese)
- ☐ English
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Khmer
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other language (please specify): _____
- ☐ Prefer not to answer

25) Do you identify as a person with a disability?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

26) What is the highest level of education you completed?

- ☐ No schooling completed
- ☐ Nursery school to 8th grade
- ☐ Some high school, no diploma
- ☐ High school graduate, diploma, or a GED
- ☐ Some college credit, no degree
- ☐ Trade/technical/vocational training
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional degree or higher
- ☐ Prefer not to answer

27) Are you currently:

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

28) What was your total income last year, before taxes?

- ☐ Less than $20,000
- ☐ $20,001 to $40,000
- ☐ $40,001 to $60,000
- ☐ $60,001 to $80,000
- ☐ $80,001 to $100,000
- ☐ Over $100,000
- ☐ Prefer not to answer

29) What is your housing situation?

- ☐ I rent my home
- ☐ I own my home
- ☐ I stay with friends, family, or others who have space for me
- ☐ I am experiencing homelessness and am staying in a shelter
- ☐ I am experiencing homelessness and am living on the street
- ☐ Other (please specify): _____
- ☐ Prefer not to answer

Thank You!

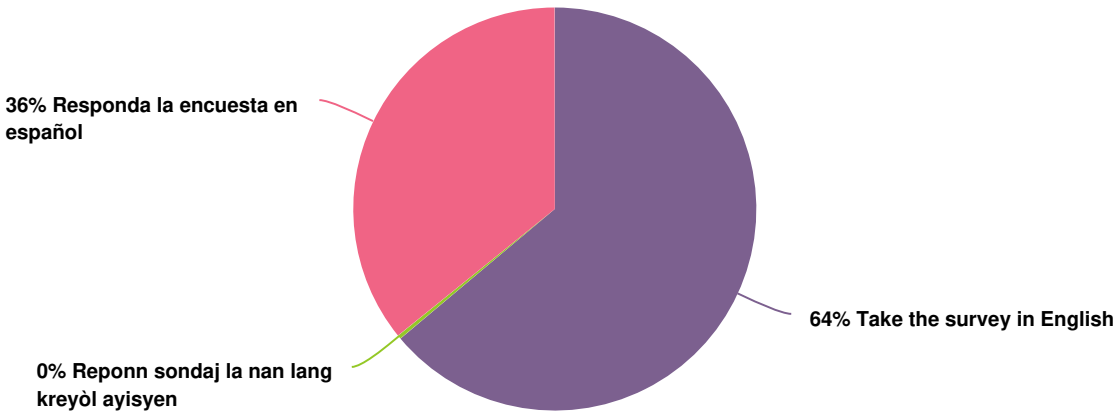
Report for Greater Lawrence Survey

Response Counts

Completion Rate:	**96.8%**		
	Complete		726
	Partial		24

Totals: 750

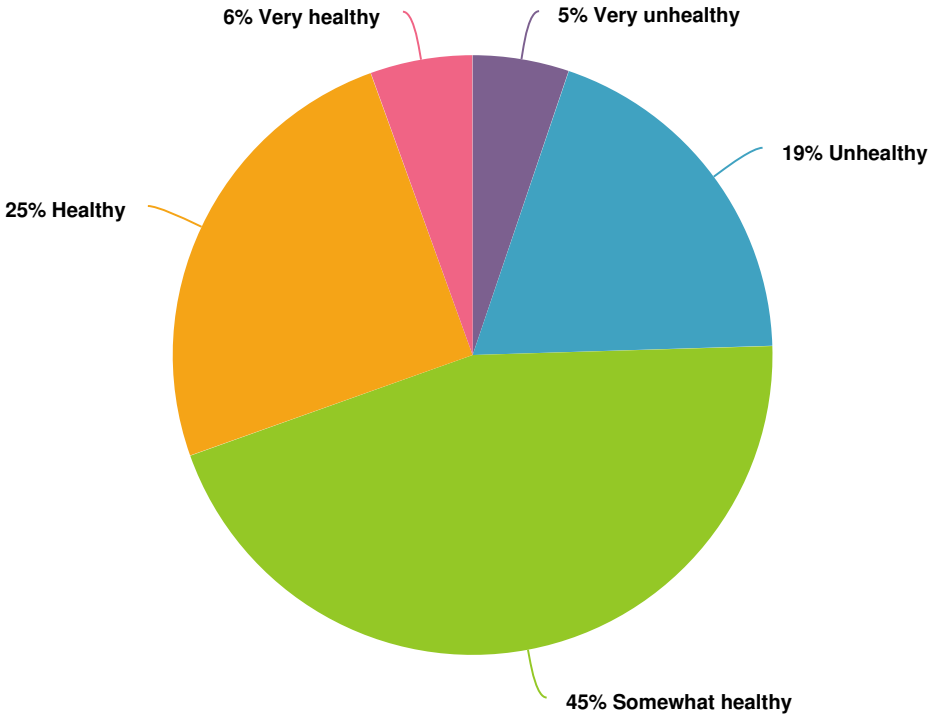
1. Select a language.



Value	Percent	Responses
Take the survey in English	63.9%	470
Reponn sondaj la nan lang kreyòl ayisyen	0.3%	2
Responda la encuesta en español	35.8%	263

Totals: 735

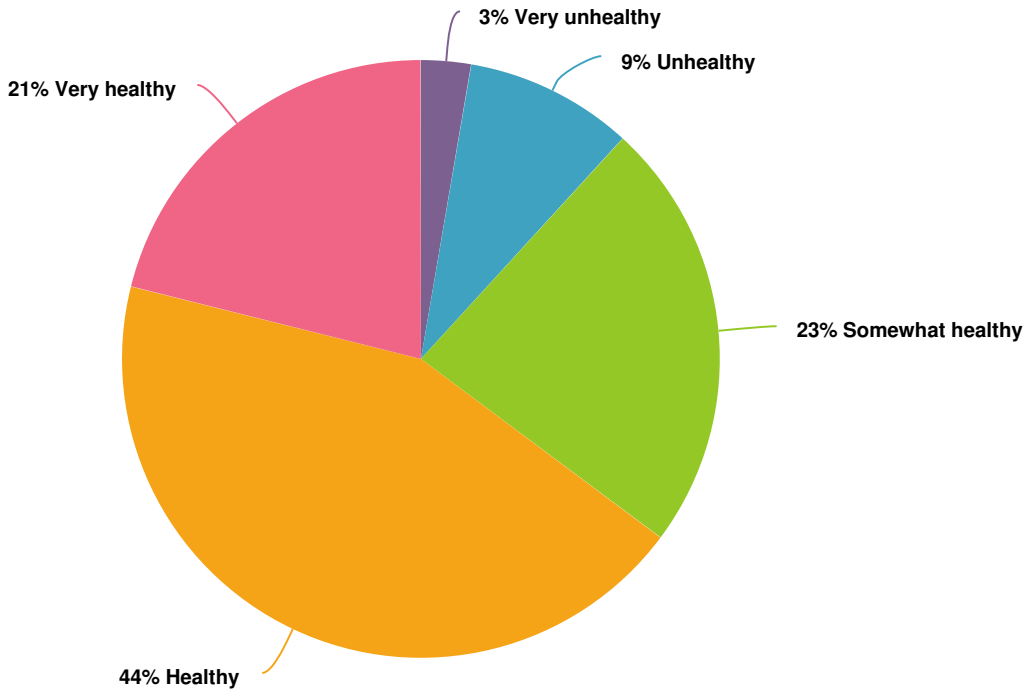
2. How would you describe your community?



Value	Percent	Responses
Very unhealthy	5.2%	39
Unhealthy	19.3%	144
Somewhat healthy	45.0%	336
Healthy	24.9%	186
Very healthy	5.5%	41

Totals: 746

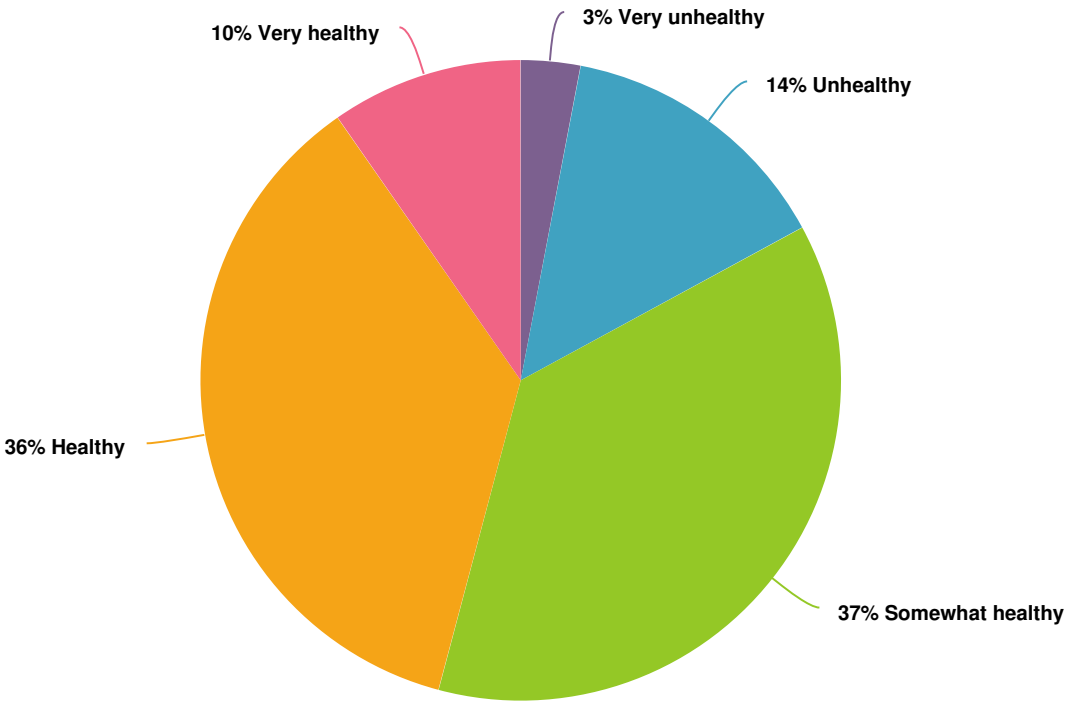
3. How would you rate your own mental health?



Value	Percent	Responses
Very unhealthy	2.7%	20
Unhealthy	9.1%	68
Somewhat healthy	23.4%	174
Healthy	43.7%	325
Very healthy	21.1%	157

Totals: 744

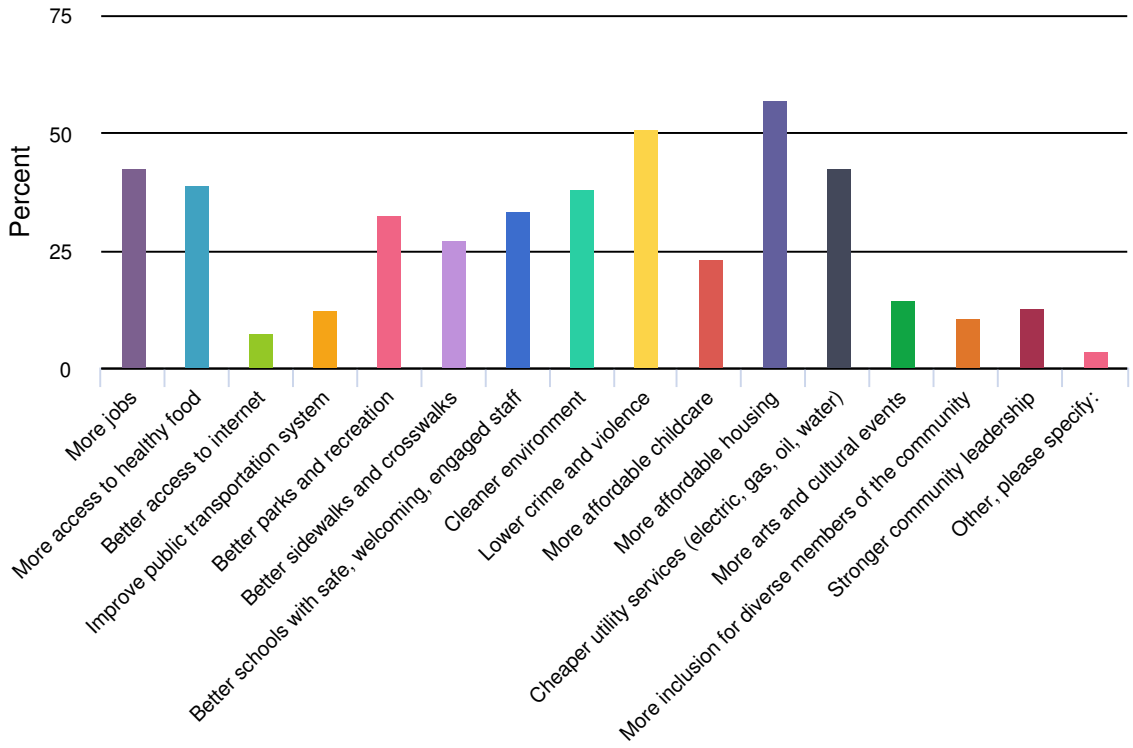
4. How would you rate your own physical health?



Value	Percent	Responses
Very unhealthy	3.0%	22
Unhealthy	14.1%	105
Somewhat healthy	37.1%	276
Healthy	36.2%	269
Very healthy	9.7%	72

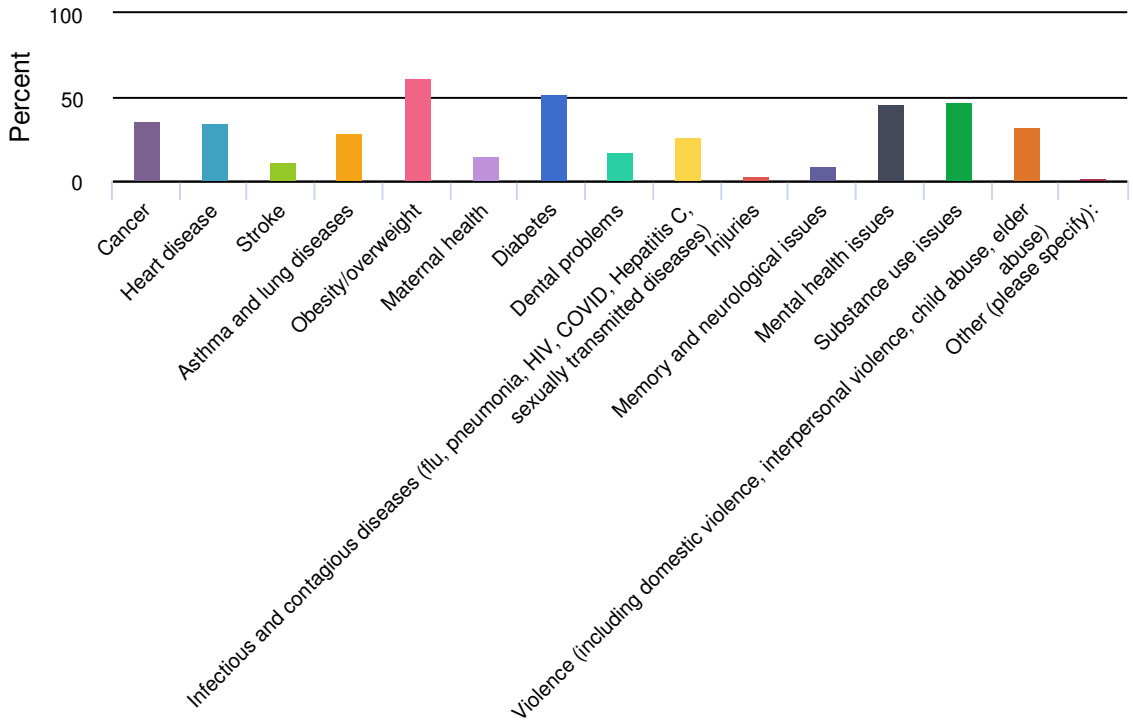
Totals: 744

5. What things would you like to improve in your community? Choose your top 5.



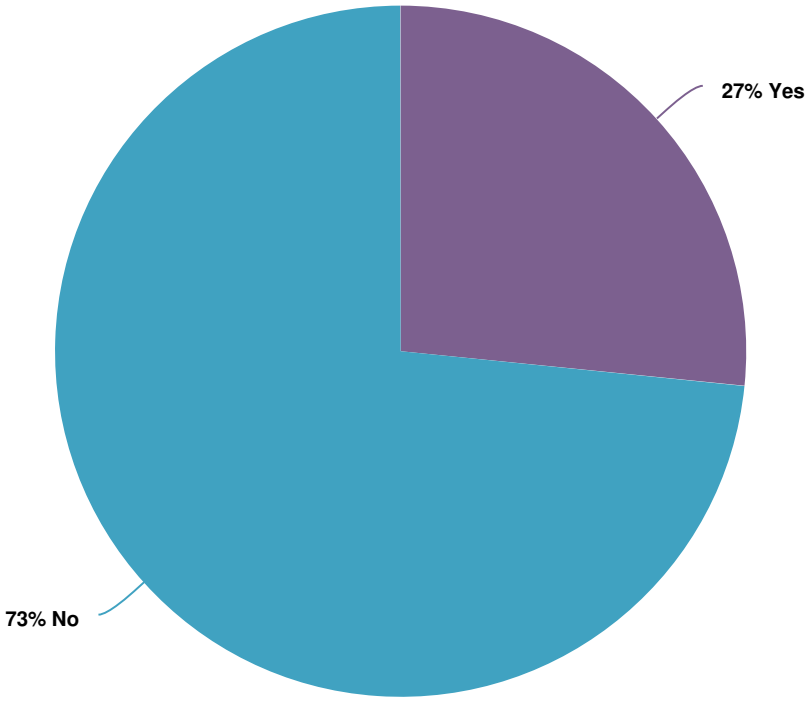
Value	Percent	Responses
More jobs	42.6%	317
More access to healthy food	38.8%	289
Better access to internet	7.4%	55
Improve public transportation system	12.5%	93
Better parks and recreation	32.9%	245
Better sidewalks and crosswalks	27.4%	204
Better schools with safe, welcoming, engaged staff	33.4%	249
Cleaner environment	38.0%	283
Lower crime and violence	51.0%	380
More affordable childcare	23.1%	172
More affordable housing	57.0%	425
Cheaper utility services (electric, gas, oil, water)	42.8%	319
More arts and cultural events	14.5%	108
More inclusion for diverse members of the community	10.6%	79
Stronger community leadership	13.0%	97
Other, please specify:	3.6%	27

6. What health issues are most concerning in your community? Choose your top 5.



Value	Percent	Responses
Cancer	35.5%	260
Heart disease	35.2%	258
Stroke	11.3%	83
Asthma and lung diseases	29.2%	214
Obesity/overweight	61.3%	449
Maternal health	15.0%	110
Diabetes	52.7%	386
Dental problems	17.2%	126
Infectious and contagious diseases (flu, pneumonia, HIV, COVID, Hepatitis C, sexually transmitted diseases)	26.9%	197
Injuries	3.6%	26
Memory and neurological issues	9.2%	67
Mental health issues	46.0%	337
Substance use issues	48.0%	351
Violence (including domestic violence, interpersonal violence, child abuse, elder abuse)	32.5%	238
Other (please specify):	2.0%	15

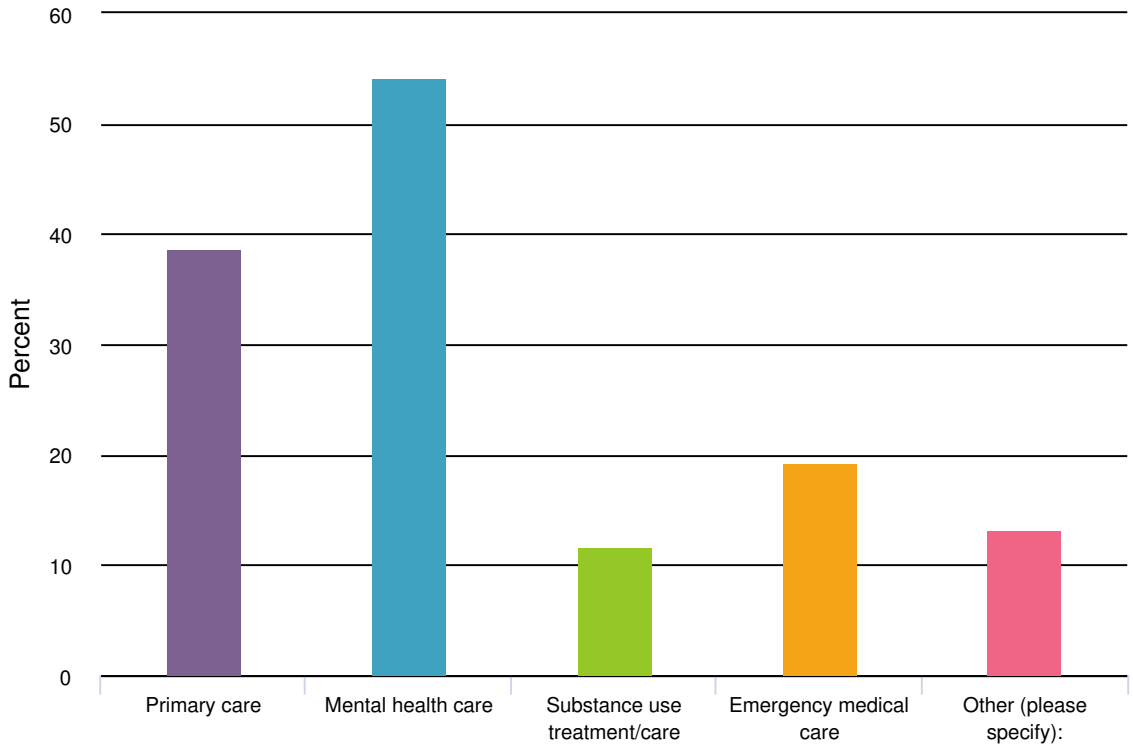
7. Is there a time in the last year when you needed medical care (including mental health care) but you weren't able to get it?



Value	Percent	Responses
Yes	26.6%	194
No	73.4%	535

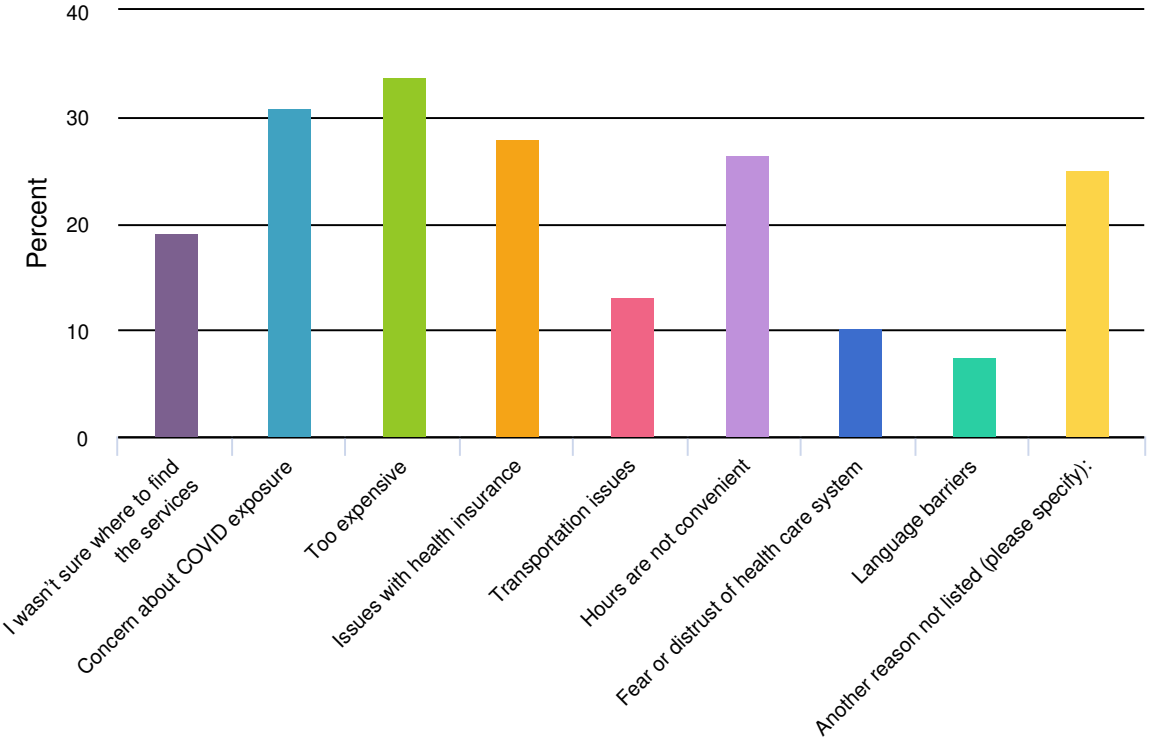
Totals: 729

8. What kind of health care were you not able to get? Check all that apply.



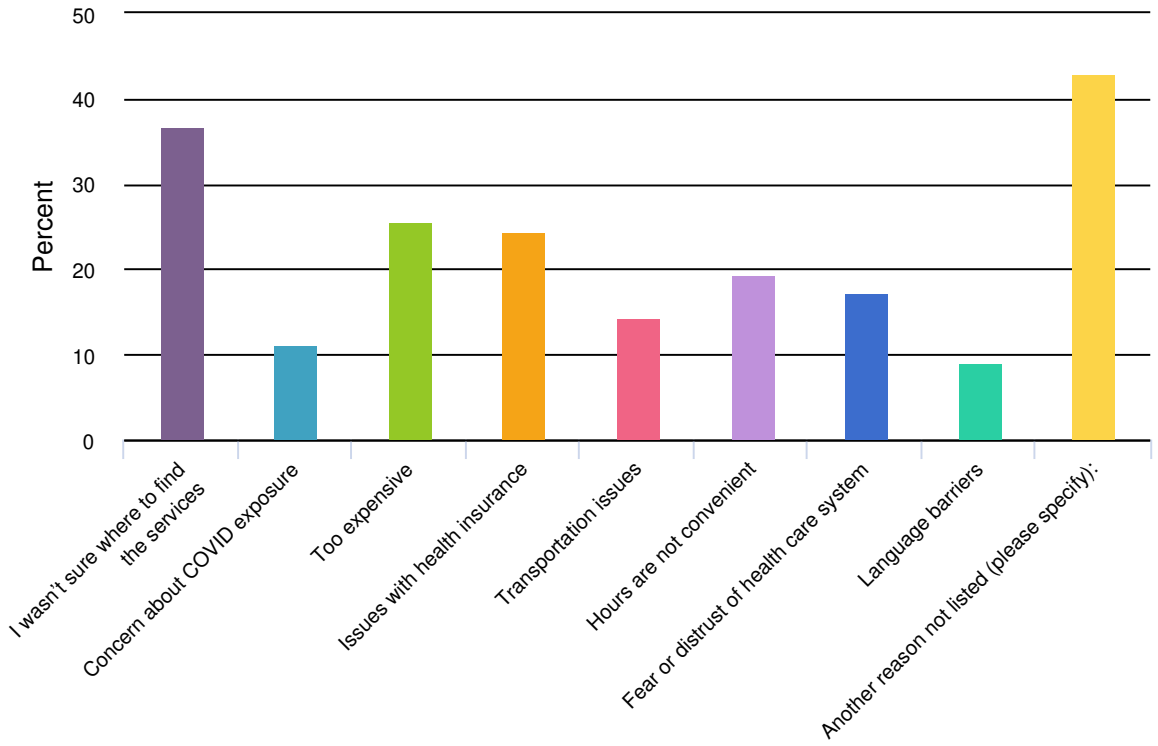
Value	Percent	Responses
Primary care	38.7%	70
Mental health care	54.1%	98
Substance use treatment/care	11.6%	21
Emergency medical care	19.3%	35
Other (please specify):	13.3%	24

9. Why were you not able to get primary care? Check all that apply.



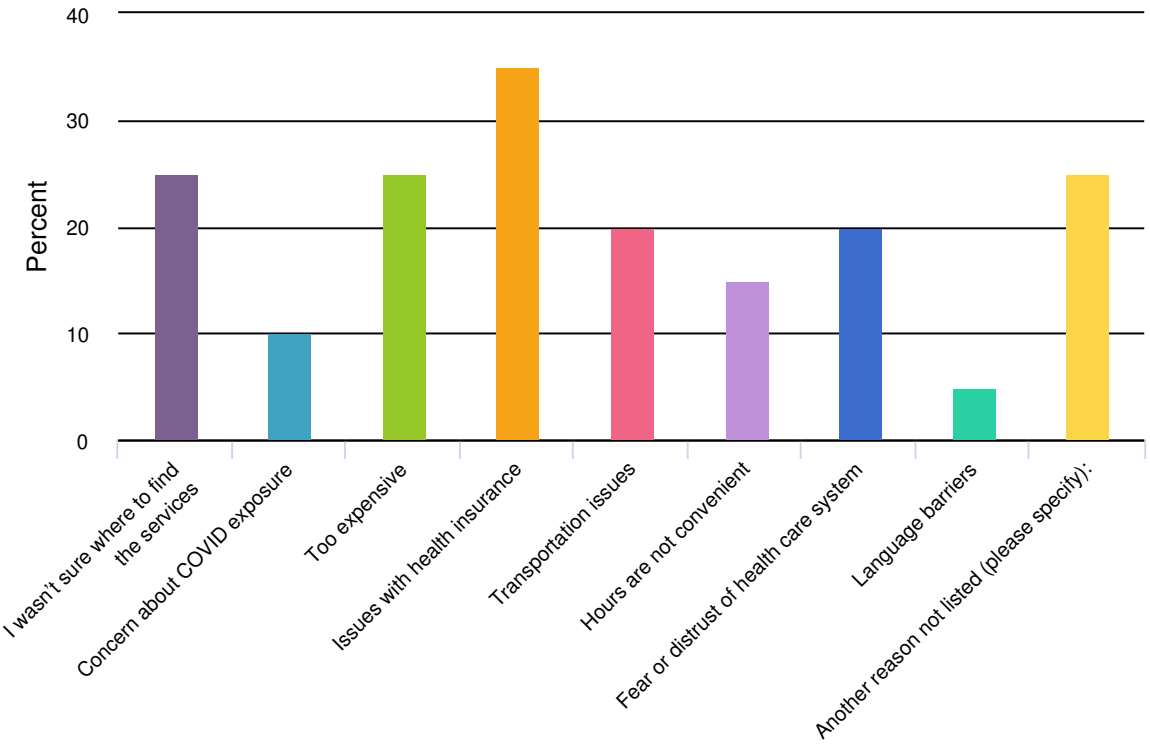
Value	Percent	Responses
I wasn't sure where to find the services	19.1%	13
Concern about COVID exposure	30.9%	21
Too expensive	33.8%	23
Issues with health insurance	27.9%	19
Transportation issues	13.2%	9
Hours are not convenient	26.5%	18
Fear or distrust of health care system	10.3%	7
Language barriers	7.4%	5
Another reason not listed (please specify):	25.0%	17

10. Why were you not able to get mental health care? Check all that apply.



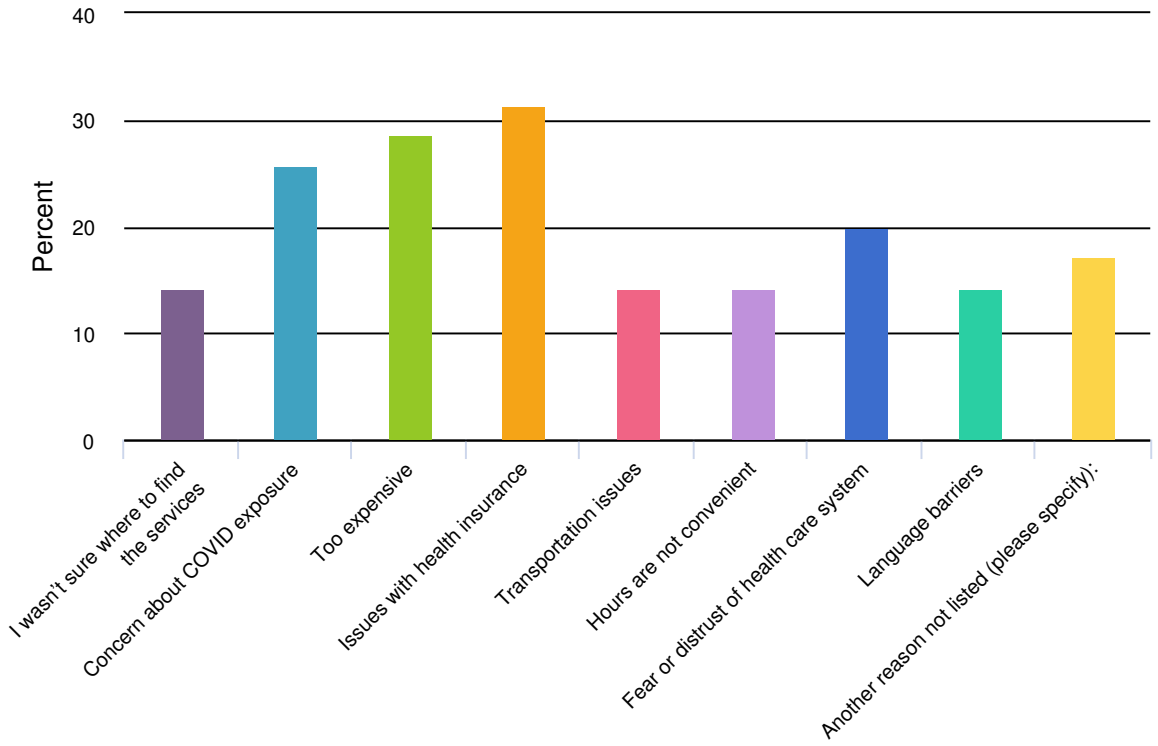
Value	Percent	Responses
I wasn't sure where to find the services	36.7%	36
Concern about COVID exposure	11.2%	11
Too expensive	25.5%	25
Issues with health insurance	24.5%	24
Transportation issues	14.3%	14
Hours are not convenient	19.4%	19
Fear or distrust of health care system	17.3%	17
Language barriers	9.2%	9
Another reason not listed (please specify):	42.9%	42

11. Why were you not able to get substance use treatment/care? Check all that apply.



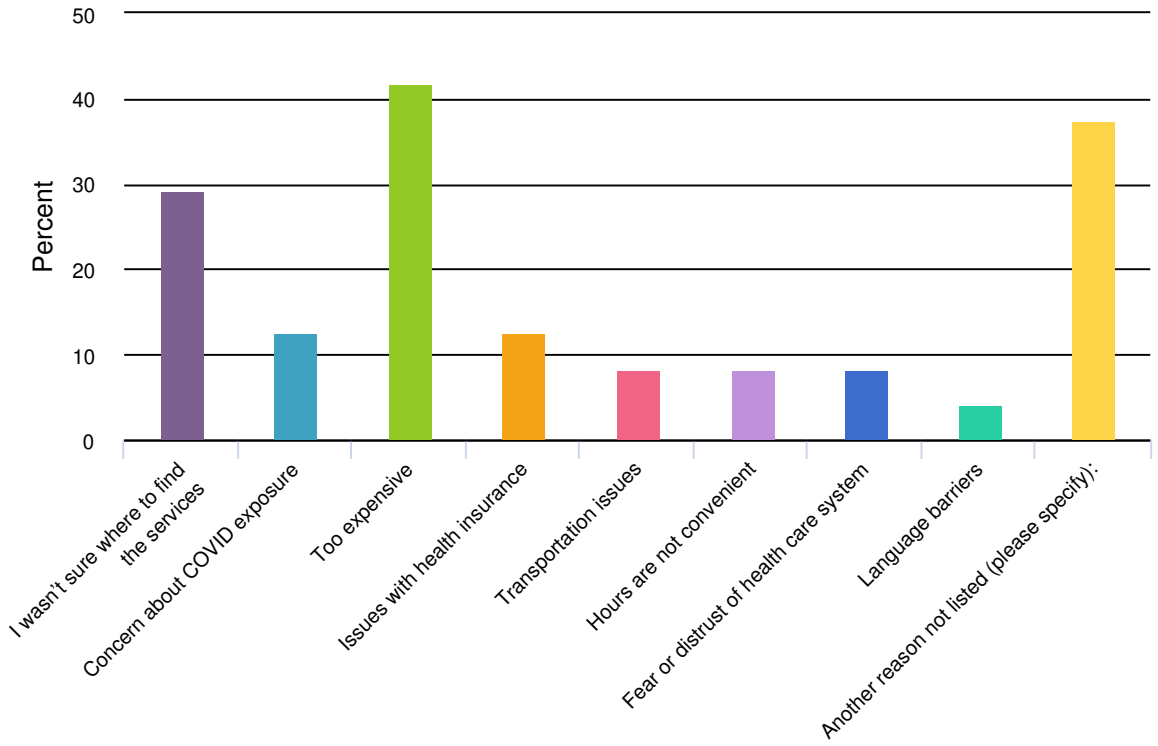
Value	Percent	Responses
I wasn't sure where to find the services	25.0%	5
Concern about COVID exposure	10.0%	2
Too expensive	25.0%	5
Issues with health insurance	35.0%	7
Transportation issues	20.0%	4
Hours are not convenient	15.0%	3
Fear or distrust of health care system	20.0%	4
Language barriers	5.0%	1
Another reason not listed (please specify):	25.0%	5

12. Why were you not able to get emergency medical care? Check all that apply.



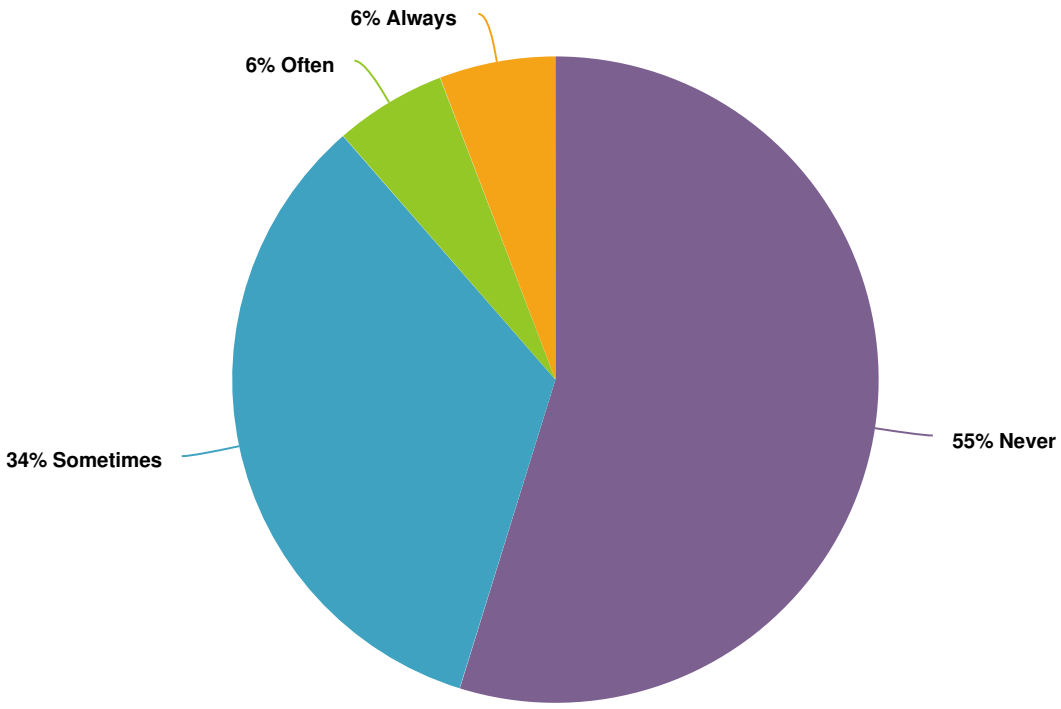
Value	Percent	Responses
I wasn't sure where to find the services	14.3%	5
Concern about COVID exposure	25.7%	9
Too expensive	28.6%	10
Issues with health insurance	31.4%	11
Transportation issues	14.3%	5
Hours are not convenient	14.3%	5
Fear or distrust of health care system	20.0%	7
Language barriers	14.3%	5
Another reason not listed (please specify):	17.1%	6

13. Why were you not able to get an other type of health care? Check all that apply.



Value	Percent	Responses
I wasn't sure where to find the services	29.2%	7
Concern about COVID exposure	12.5%	3
Too expensive	41.7%	10
Issues with health insurance	12.5%	3
Transportation issues	8.3%	2
Hours are not convenient	8.3%	2
Fear or distrust of health care system	8.3%	2
Language barriers	4.2%	1
Another reason not listed (please specify):	37.5%	9

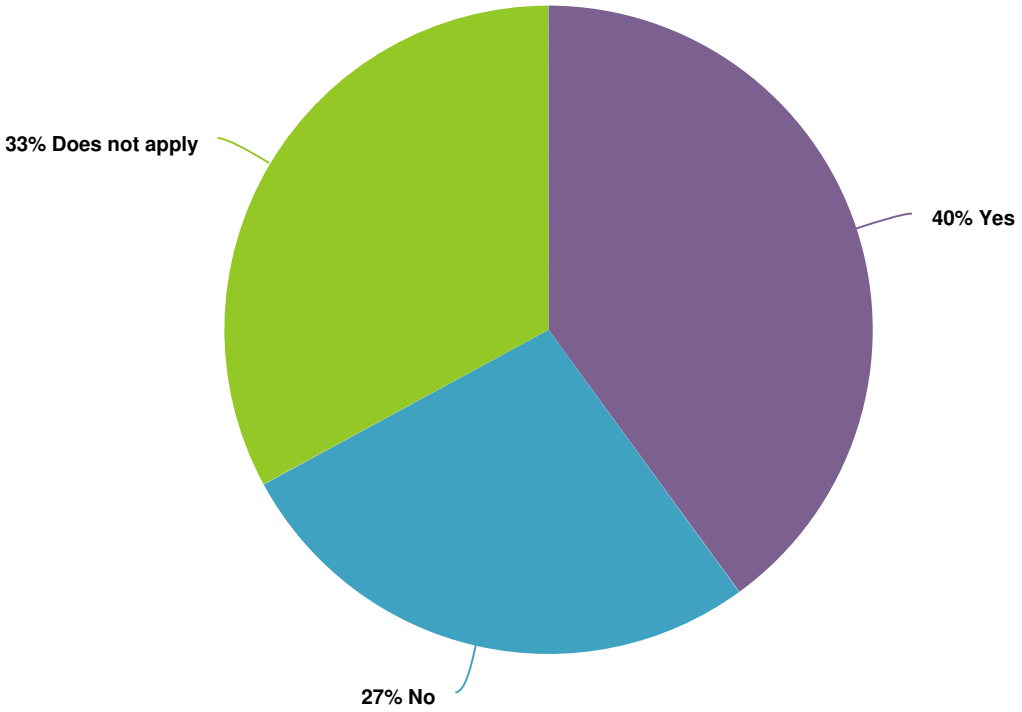
14. How often do you have to have someone help you understand instructions and information from your doctors or pharmacies?



Value	Percent	Responses
Never	54.8%	404
Sometimes	33.8%	249
Often	5.6%	41
Always	5.8%	43

Totals: 737

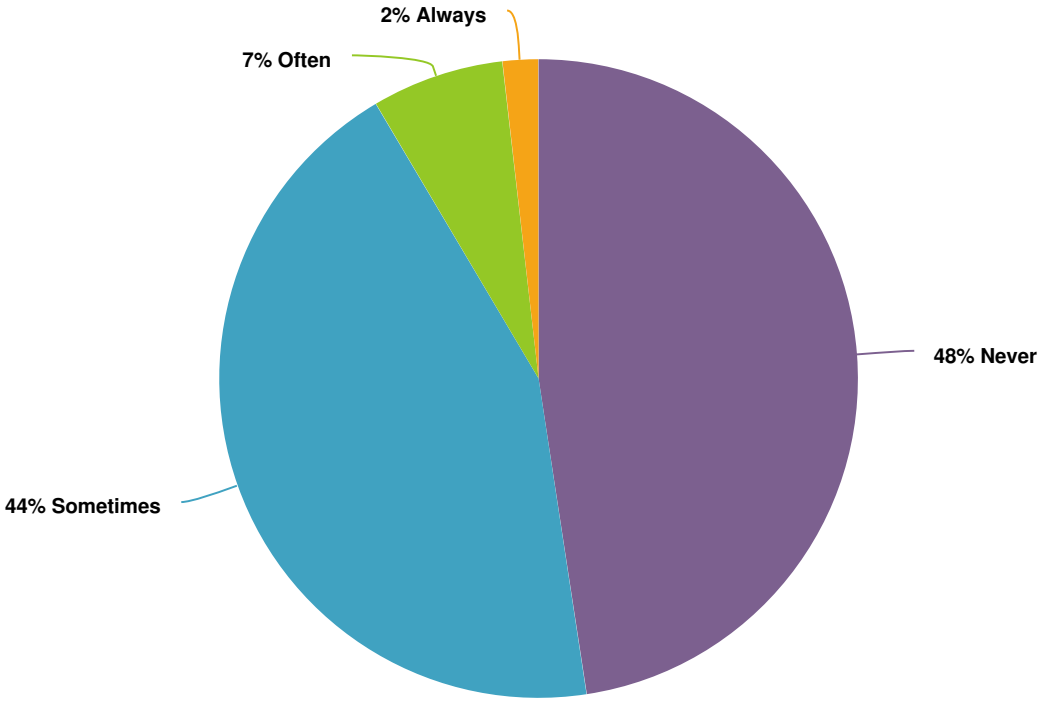
15. Would you be more likely to access primary care health services if they were provided in a women-only center in your community?



Value	Percent	Responses
Yes	40.0%	293
No	27.1%	199
Does not apply	32.9%	241

Totals: 733

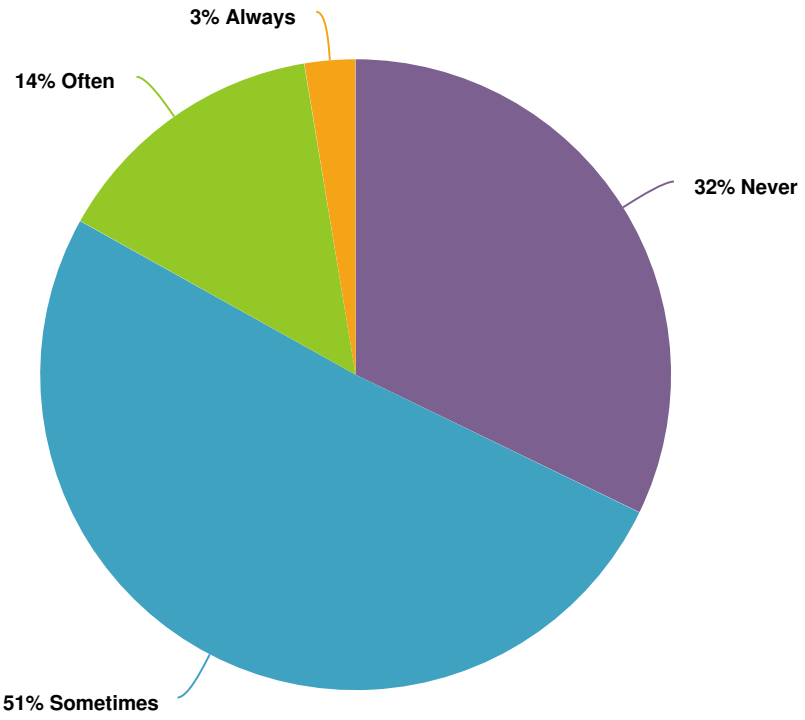
16. Have you ever experienced racism and discrimination in your community?



Value	Percent	Responses
Never	47.6%	350
Sometimes	43.9%	323
Often	6.7%	49
Always	1.8%	13

Totals: 735

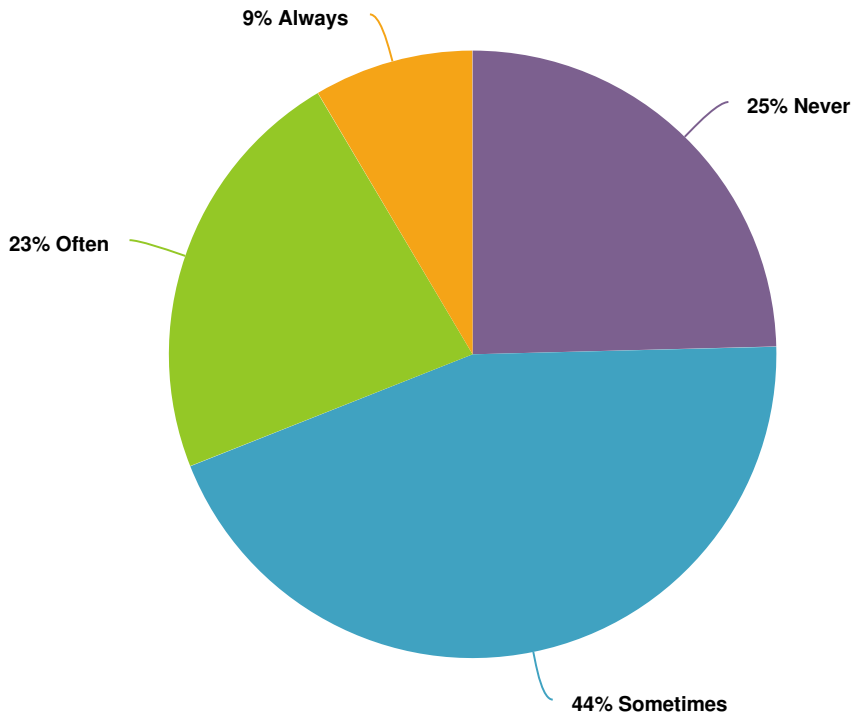
17. Have you ever witnessed racism and discrimination in your community?



Value	Percent	Responses
Never	32.2%	236
Sometimes	50.9%	373
Often	14.3%	105
Always	2.6%	19

Totals: 733

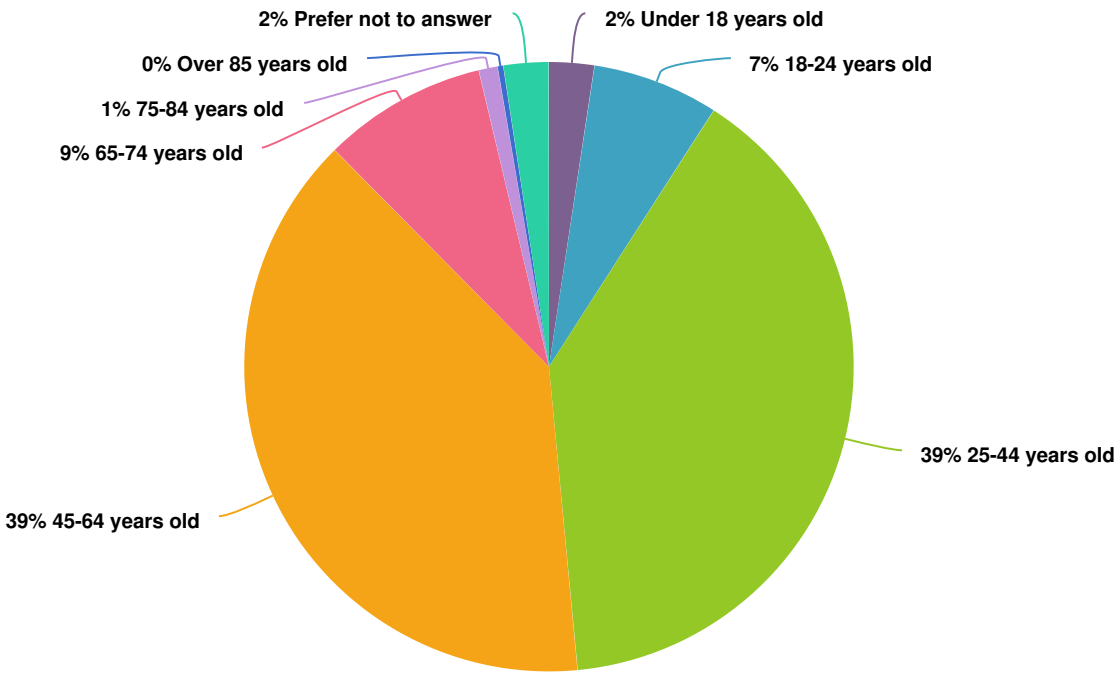
18. How often do you think racism and discrimination affects the ability of people in your community to get the health care they need?



Value	Percent	Responses
Never	24.6%	180
Sometimes	44.4%	325
Often	22.5%	165
Always	8.5%	62

Totals: 732

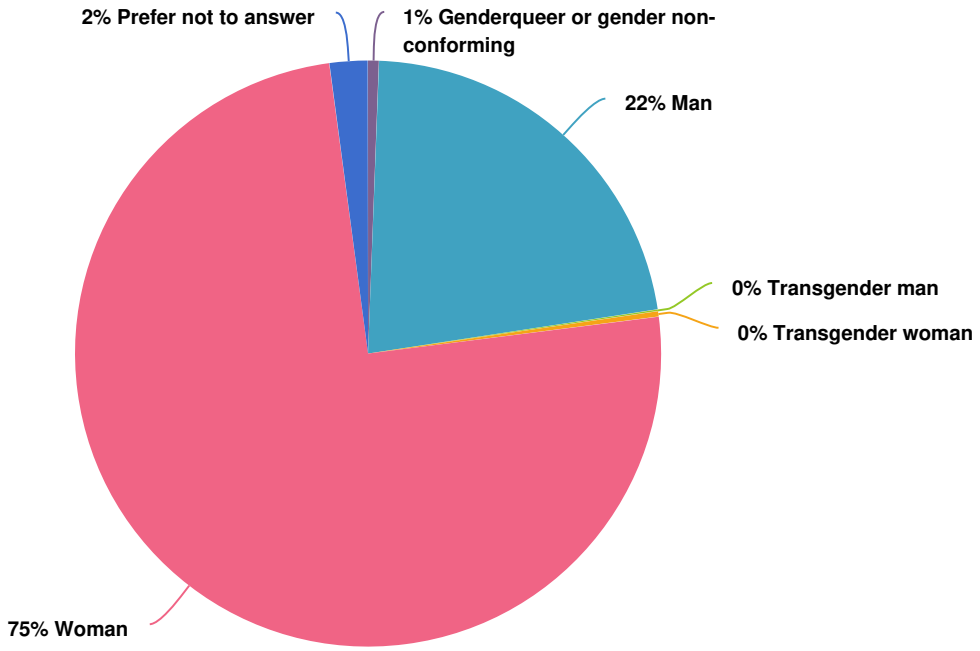
19. What is your age?



Value	Percent	Responses
Under 18 years old	2.4%	17
18-24 years old	6.7%	47
25-44 years old	39.4%	277
45-64 years old	39.1%	275
65-74 years old	8.7%	61
75-84 years old	1.0%	7
Over 85 years old	0.3%	2
Prefer not to answer	2.4%	17

Totals: 703

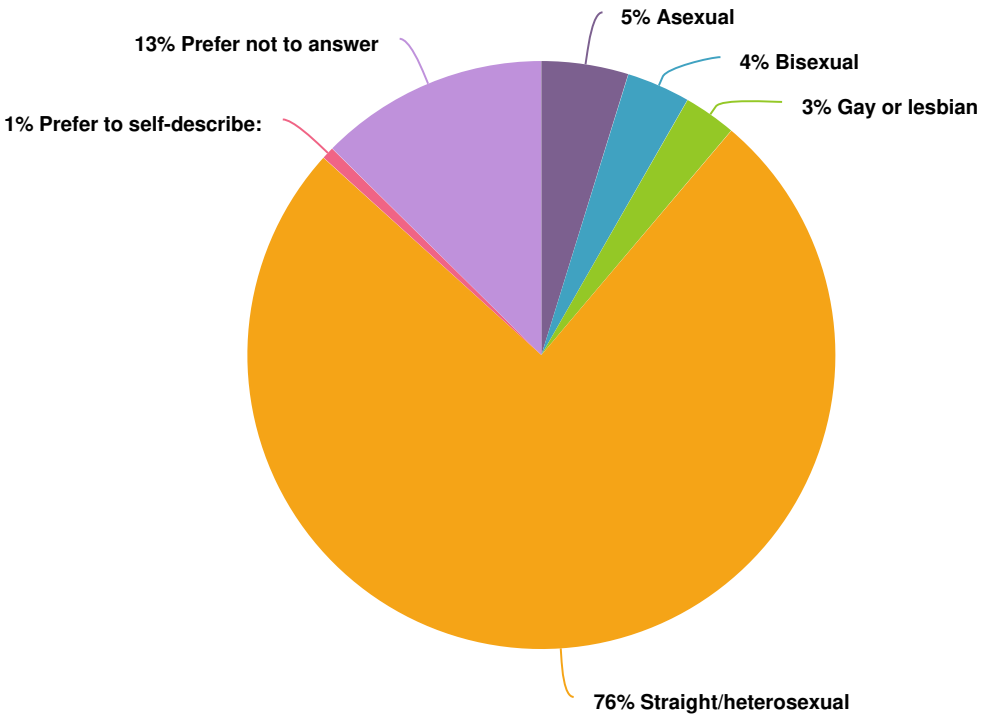
20. What is your current gender identity?



Value	Percent	Responses
Genderqueer or gender non-conforming	0.6%	4
Man	22.0%	155
Transgender man	0.1%	1
Transgender woman	0.3%	2
Woman	74.9%	527
Prefer not to answer	2.1%	15

Totals: 704

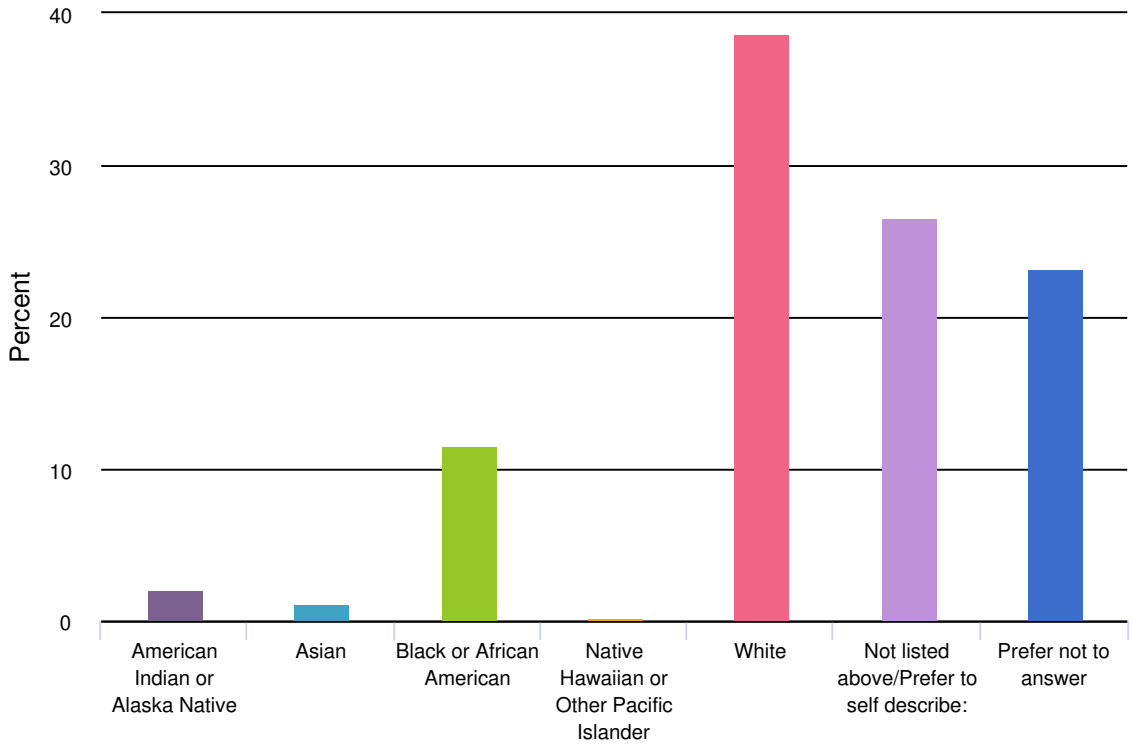
21. What is your sexual orientation?



Value	Percent	Responses
Asexual	4.8%	33
Bisexual	3.5%	24
Gay or lesbian	2.9%	20
Straight/heterosexual	75.6%	524
Prefer to self-describe:	0.7%	5
Prefer not to answer	12.6%	87

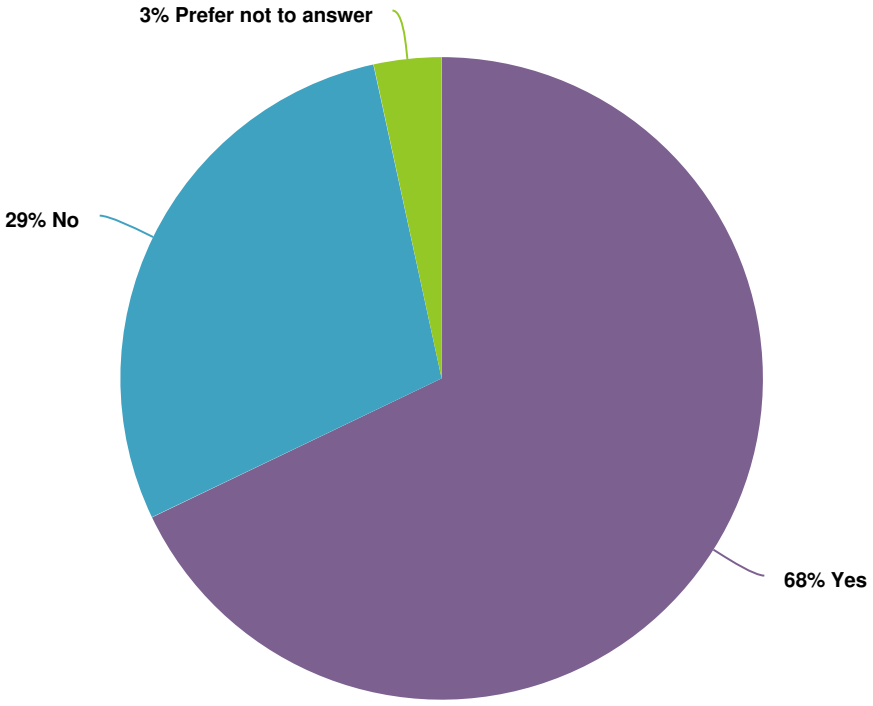
Totals: 693

22. Which one of these groups best represents your race? You will have space to enter ethnicity in the next question. Check all that apply



Value	Percent	Responses
American Indian or Alaska Native	2.0%	14
Asian	1.2%	8
Black or African American	11.5%	79
Native Hawaiian or Other Pacific Islander	0.3%	2
White	38.7%	265
Not listed above/Prefer to self describe:	26.5%	181
Prefer not to answer	23.2%	159

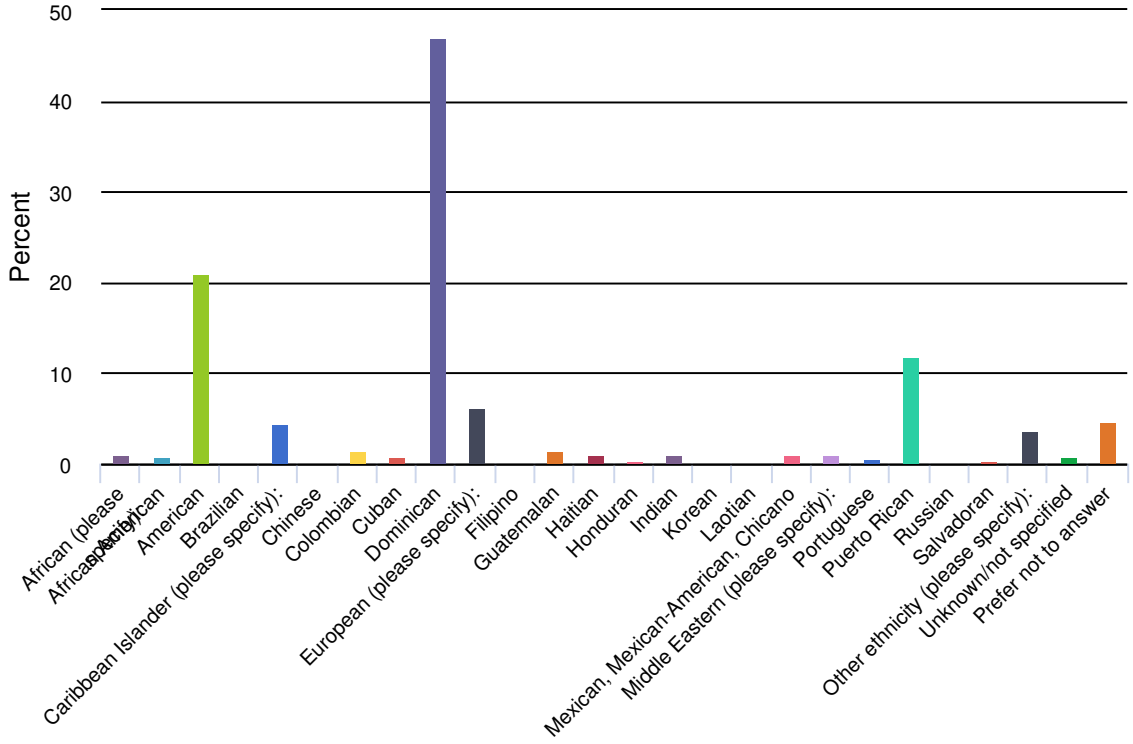
23. Do you identify as Hispanic or Latino/a?



Value	Percent	Responses
Yes	67.9%	477
No	28.7%	202
Prefer not to answer	3.4%	24

Totals: 703

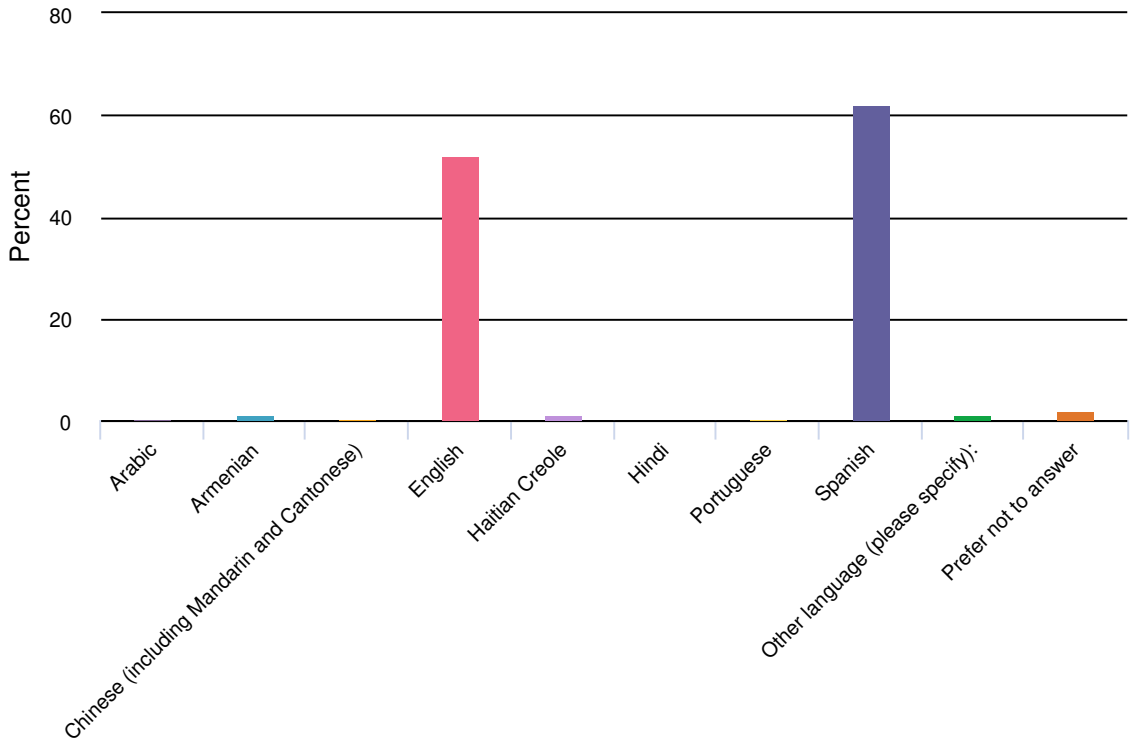
24. What is your ethnicity? Check all that apply.



Value	Percent	Responses
American	21.1%	149
Caribbean Islander (please specify):	4.5%	32
Dominican	47.0%	332
European (please specify):	6.2%	44
Puerto Rican	11.9%	84
Other ethnicity (please specify):	3.7%	26
Prefer not to answer	4.7%	33
African (please specify):	1.0%	7
African American	0.8%	6
Brazilian	0.3%	2
Chinese	0.3%	2
Colombian	1.4%	10

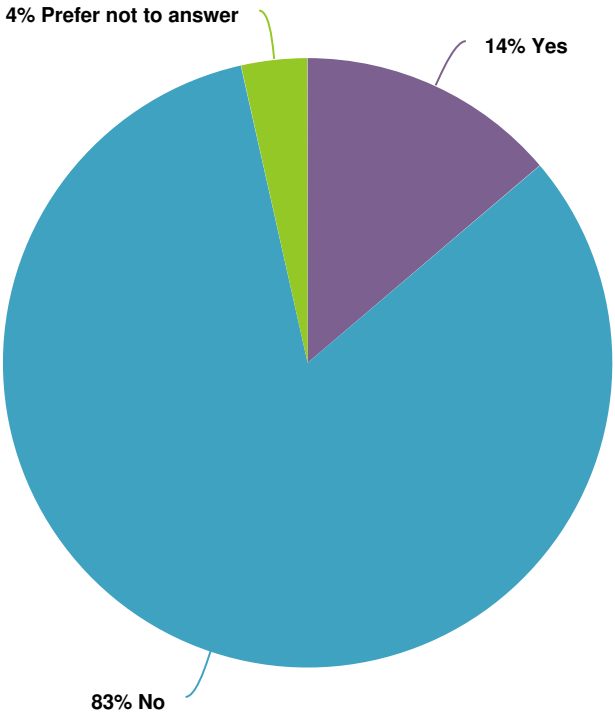
Value	Percent	Responses
Cuban	0.8%	6
Filipino	0.1%	1
Guatemalan	1.6%	11
Haitian	1.1%	8
Honduran	0.4%	3
Indian	1.0%	7
Korean	0.3%	2
Laotian	0.1%	1
Mexican, Mexican-American, Chicano	1.0%	7
Middle Eastern (please specify):	1.0%	7
Portuguese	0.7%	5
Russian	0.3%	2
Salvadoran	0.4%	3
Unknown/not specified	0.8%	6

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



Value	Percent	Responses
Arabic	0.4%	3
Armenian	1.0%	7
Chinese (including Mandarin and Cantonese)	0.3%	2
English	51.9%	368
Haitian Creole	1.1%	8
Hindi	0.1%	1
Portuguese	0.4%	3
Spanish	61.9%	439
Other language (please specify):	1.3%	9
Prefer not to answer	1.8%	13

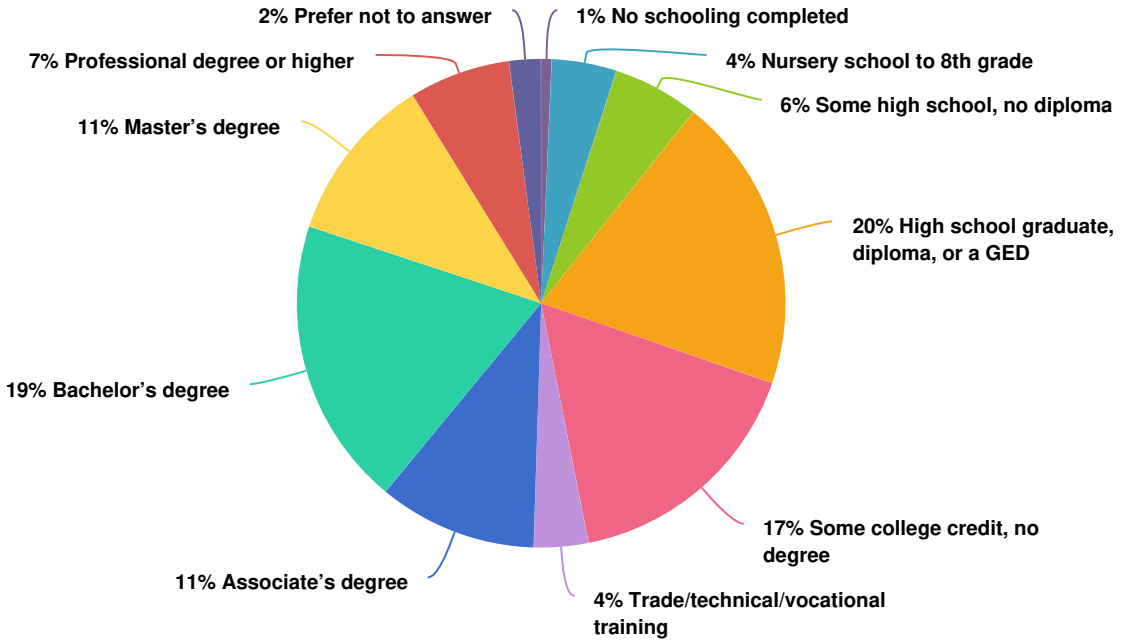
26. Do you identify as a person with a disability?



Value	Percent	Responses
Yes	13.8%	97
No	82.7%	583
Prefer not to answer	3.5%	25

Totals: 705

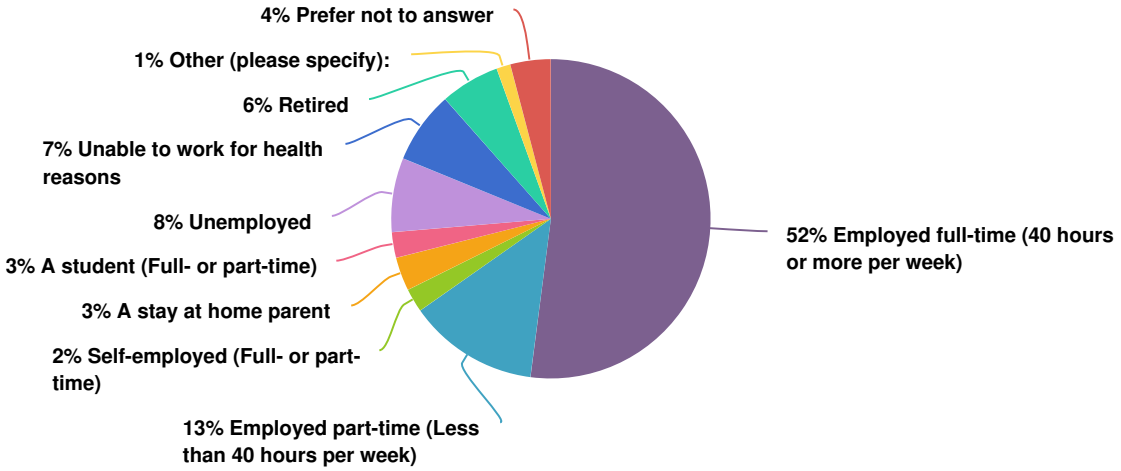
27. What is the highest level of education you completed?



Value	Percent	Responses
No schooling completed	0.7%	5
Nursery school to 8th grade	4.3%	30
Some high school, no diploma	5.7%	40
High school graduate, diploma, or a GED	19.6%	138
Some college credit, no degree	16.6%	117
Trade/technical/vocational training	3.6%	25
Associate's degree	10.5%	74
Bachelor's degree	19.1%	134
Master's degree	11.1%	78
Professional degree or higher	6.7%	47
Prefer not to answer	2.1%	15

Totals: 703

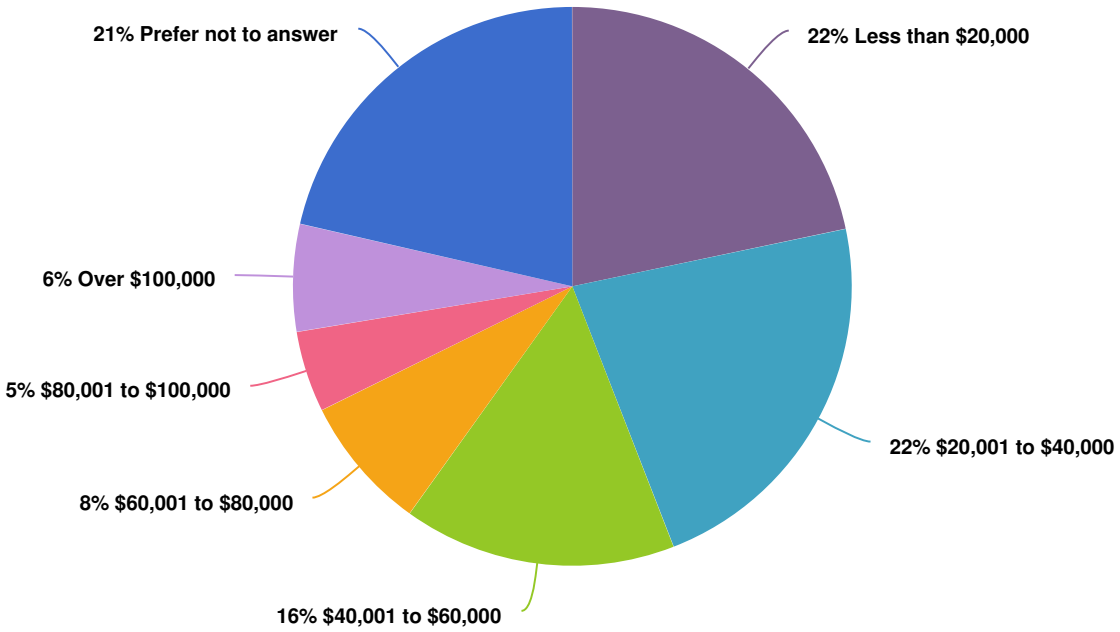
28. Are you currently:



Value	Percent	Responses
Employed full-time (40 hours or more per week)	52.0%	365
Employed part-time (Less than 40 hours per week)	13.2%	93
Self-employed (Full- or part-time)	2.4%	17
A stay at home parent	3.4%	24
A student (Full- or part-time)	2.6%	18
Unemployed	7.5%	53
Unable to work for health reasons	7.3%	51
Retired	6.0%	42
Other (please specify):	1.4%	10
Prefer not to answer	4.1%	29

Totals: 702

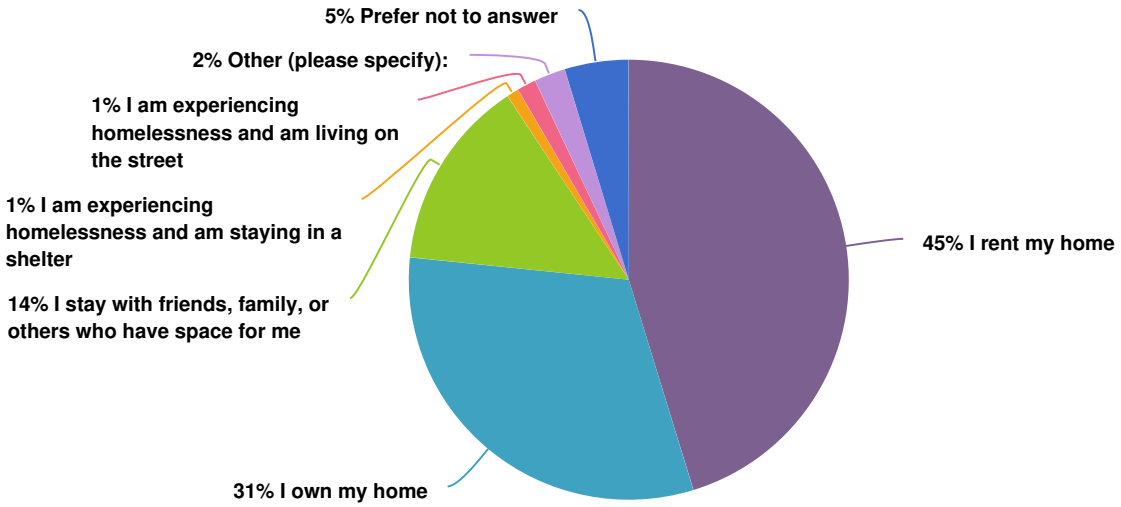
29. What was your total income last year, before taxes?



Value	Percent	Responses
Less than $20,000	21.7%	151
$20,001 to $40,000	22.4%	156
$40,001 to $60,000	15.8%	110
$60,001 to $80,000	7.8%	54
$80,001 to $100,000	4.7%	33
Over $100,000	6.2%	43
Prefer not to answer	21.4%	149

Totals: 696

30. What is your housing situation?



Value	Percent	Responses
I rent my home	45.3%	319
I own my home	31.4%	221
I stay with friends, family, or others who have space for me	14.1%	99
I am experiencing homelessness and am staying in a shelter	0.9%	6
I am experiencing homelessness and am living on the street	1.4%	10
Other (please specify):	2.3%	16
Prefer not to answer	4.7%	33

Totals: 704

Appendix C:
Resource Inventory

Greater Lawrence Community Health Needs Assessment
Resource Inventory

Adult Education

- Community Action, Inc.
- Greater Lawrence Community Action Council
- Lawrence Adult Learning Center
- Methuen Adult Learning Center

Collaboratives and Community Health Partnerships

- Lawrence Mayor's Health Task Force
- Lawrence-Methuen Community Coalition
- Methuen Cares
- Regional Food Partnership

Disability Services

- Fidelity House CRC
- Northeast Independent Living
- Disability Resource Center (Essex County)

Domestic Violence Services

- Delamano
- Jeanne Geiger Crisis Center
- YWCA Northeastern MA

Early Childhood Services

- Child Care Circuit
- Child Development and Education, Inc.
- Haverhill Head Start (Community Action, Inc.)
- Lawrence Head Start (Greater Lawrence Community Action Council)
- Methuen Head Start (Greater Lawrence Community Action Council)
- Merrimack Valley YMCA
- YWCA Northeastern MA
- Women, Infants, and Children (WIC) Programs

Education and Research

- Dana Farber Cancer Institute Center for Community-Based Research
- Esperanza Academy
- Greater Lawrence Technical School
- Merrimack College
- Northern Essex Community College

- Public school departments
- Top Notch Scholars
- Notre Dame Academy

Elder Services

- AgeSpan/Elder Services of Merrimack Valley
- The Center for Seniors, Families, and Community

Employment Services

- Merrimack College
- Merrimack Valley Career Center/MassHire
- Merrimack Valley Workforce Board/MassHire
- Merrimack Valley YMCA
- Northern Essex Community College
- Notre Dame Academy

Food Insecurity

- Bread and Roses
- Common Grounds
- Community Giving Tree
- Cor Unum Meal Center
- Greater Boston Food Bank
- Merrimack Valley Food Bank
- Lazarus House
- Neighbors in Need
- Project Bread

Healthcare

- Behavioral Health
    - Blueskies Wellness, Inc.
    - Eliot Health Services
    - Ferreras Counseling and Wellness, Inc.
    - Greater Lawrence Family Health Center
    - JRI Children's Friend and Family Services
    - Lawrence General Hospital
    - Point After Club
- Hospital services
    - Holy Family Hospital
    - Lawrence General Hospital
- Primary Care/Medical Specialty Care
    - Greater Lawrence Family Health Center
    - Holy Family Hospital
    - Community Medical Associates (Lawrence General Hospital)

- Post-Acute Services
    - Home Care Agencies
        - All Care VNA
        - Alternative Health Care
        - Amedisys
        - Better Life at Home
        - Blissful Homecare
        - Boston Home Health Aides
        - Comfort Home Care
        - Elara Caring
        - Encompass Homecare
        - Home Health VNA
        - Middlesex Healthcare Services
        - Innovive
        - Northeast Rehab Hospital Home Care
        - Partners Health Care at Home
        - Pathways
        - Whittier Home Care Agency
        - Constellations
    - Skilled Nursing Facilities
        - Academy Manor of Andover
        - Baker-Katz
        - Brentwood Rehab
        - Care One at Essex
        - Hanna Duston Healthcare
        - Hathorne Hill
        - Mary Immaculate
        - The Meadows at Edgewood
        - Nevins Nursing Rehab Center
        - Northwood
        - Penacook Place
        - Prescott House
        - Wingate at Andover
        - Wingate at Haverhill
- Emergency Services
    - Lawrence General Hospital Emergency Medical Services
    - American Red Cross Northeast Chapter

Housing Services

- Community Action, Inc.
- Daybreak Shelter
- Emergency Rental and Mortgage Assistance Program
- Emmaus Inc.
- Greater Lawrence Community Action Council

- House of Mercy
- ACT Lawrence
- Lawrence Housing Authority

Interfaith Organizations

- Merrimack Valley Project
- AMEDAL

Legal Aid

- Northeast Legal Aid

Multi-Service Agencies

- Community Action, Inc.
- Greater Lawrence Community Action Council
- Merrimack Valley YMCA
- YWCA of Northeastern Massachusetts
- Si Se Puede

Multi-Service Cultural Agencies

- International Institute of Greater Lawrence
- Massachusetts Alliance for Portuguese Speakers
- Merrimack Valley Immigration Education Center

Municipal Programs

- Elder Services Departments/Councils on Aging/Senior Centers
- Health and Human Services Departments
- Housing Departments/Housing Authorities
- Human Rights Commissions
- Offices/Commissions on Disability
- Police and Fire Departments
- Public Schools
- Parks and Recreation Departments
- Veterans Offices/Officers
- Workforce Development, Employment, and Training Departments

Philanthropy

- Essex County Community Foundation

Planning and Community Development

- Lawrence Community Works
- Merrimack Valley Regional Planning Commission
- The Lawrence Partnership

- ACT Lawrence

Recreation

- Beyond Soccer
- Boys & Girls Clubs
- Merrimack Valley YMCA
- Serving Stars
- YWCA of Northeastern Massachusetts

Resource Inventories

- We Are (Somas) Lawrence
- 2-1-1

Services for Individuals Formerly Incarcerated

- Essex County Pre-Release and Re-Entry Program
- Lawrence Community Correction Center
- UTEC

Transportation

- Merrimack Valley Regional Transportation Authority

Youth/Adolescents

- Groundwork Lawrence
- Youth Development Organization
- UTEC

Appendix D:

Evaluation of 2022 Implementation Strategy

Appendix D: Evaluation of Impact of 2020-2022 Implementation Strategy

The following document provides details on the achievements made in FY2020, FY 2021, and FY 2022 regarding Lawrence General's 2020-2022 Implementation Strategy that was developed in 2019 as part of Lawrence General's 2019 CHNA. The following document outlines by priority area the strategy, measures, and the achievements in each fiscal year. This information was compiled as part of the 2022 CHNA process and fulfills Lawrence General' 2020-2023 Implementation Strategy evaluation requirements. This information was extremely valuable as Lawrence General's Community Benefits Staff and Senior Leadership Team developed the 2023 – 2025 Implementation Strategy.

Priority Area: Chronic Disease and Related Risk Factors				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
Further development of community management strategies through alignment with: ● Development of innovative care management and wellness enhancement through My Care Family Medicaid ACO ● Ongoing efforts to improve key performance measures around chronic disease management	Develop at least one enhancement for Medicaid ACO and at least 3 interventions to address improvement for BIDCO	● Embedded ACO Care Coordinator and ED Navigator at LGH to prevent readmissions and revisits to ED among My Care Family members by addressing social needs, improving transitions of care, and referrals to Care Management. ● Launched Multi-Visit Patient (MVP) program to decrease hospital utilization and cost among My Care Family super-utilizers by addressing underlying social and behavioral drivers of utilization. ● Provided population health management support to BIDCO provider practices to ensure quality metrics related to diabetes, hypertension, and cancer screening were achieved	● Developed and launched a new clinically integrated network, Lawrence Integrated Health Provider Network (LIHPN) ● Continued providing quality-focused population health management support to provider practices transitioning from BIDCO to LIHPN ● Launched a Hospital Quality and Efficiency Program (HQEP) to engage providers in work to decrease Medicare readmission rates from 17.46% to 15.46% (2 percentage points).	● Achieved a readmission rate of 13.8% among My Care Family Medicaid ACO members in 2021 by embedding an ACO Care Coordinator and ED Navigator and convening weekly cross-continuum rounds focused on care coordination for the highest risk/highest utilizing ACO members. ● Launched a clinically integrated network (Lawrence Integrated Health Provider Network), engaging community and hospital providers in initiatives to improve disease management, preventive screening, hospital quality and efficiency. In 2021 LIHPN launched its Arcadia data analytics platform to support network provider quality performance, and providers successfully reduced 30-day

Priority Area: Chronic Disease and Related Risk Factors				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
				readmissions among targeted Medicare beneficiaries to 13.82%, surpassing the network's goal.
Ongoing program development and access to the Weight Management and Bariatric Center ● Continued physician education regarding existing support and treatment programming available through WMBC ● Enhancement and growth of social media outreach to population struggling with weight management ● Enhanced web-based educational material ● Planned growth in Weight Management and Bariatric Center	Sustain and grow the number of patients served by the Weight Management and Bariatric Center	● Patient education and support groups transitioned from in-person to virtual online sessions due to COVID-19 pandemic ● Program numbers sustained overall but planned growth limited by pandemic-related cancellations of elective surgeries	● Patient education and support groups continued to be offered virtually with option for patients to be seen by provider via telehealth ● Program numbers sustained but planned growth continued to be limited by pandemic-related cancellations of elective surgeries and staffing shortages.	● Continued physician education and support groups, and planned growth were challenging due to the COVID-19 pandemic and resulting staffing shortages. However, overall program numbers were sustained, providers were able to continue seeing patients via telehealth, and support groups were run virtually (depending on staffing). ● Developed a plan to partner with and leverage Merrimack College Health Coach program students to support and motivate bariatric patients throughout their journey to surgery.
Enhancement of Heart and Vascular care through a more aligned and expanded program providing complete assessment and comprehensive care plans. Formation of Integrated Heart and Vascular Clinic to do comprehensive circulatory assessments ● Public education around link between the two forms	Complete development of comprehensive program	Plan for Heart and Vascular program (screenings, clinic, and patient education) put on hold due to COVID-19 pandemic.		

Priority Area: Chronic Disease and Related Risk Factors				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
of the disease, value of prevention and early detection ● Physician education around benefits of early assessment, diagnosis and treatment planning				
Continue to fund and guide efforts through the Mayor's Health Task Force and other community-based program sponsorships to educate and support health lifestyle choices, access to fitness and nutrition programs, healthy youth programming, homelessness outreach, etc. ● Host free community health education series to address health issues identified in the community and to provide resources and support in low barrier, informal environment ● "Healthy on the Block" Bodega project – supporting the provision and merchandising of healthy food and fresh produce in neighborhood markets ● Groundwork Lawrence – sponsoring Community Farm Share program, Farmer's Market, and Costello Community Garden	Maintain level of community sponsorship and add at least four free public health educations events	● Maintained sponsorship of Groundwork Lawrence, YMCA, and other community partners ● Continued to provide community education on joint replacement and spinal surgeries. All community health education was focused on COVID-19 testing, prevention, and treatment. ● "Healthy on the Block" Bodega project expansion put on hold due to COVID-19 pandemic response. ● Continued financial sponsorship of The Center through DON funding, but weekly in-person fitness classes cancelled due to the COVID-19 pandemic	● Maintained sponsorship of Groundwork Lawrence, YMCA, and other community partners ● Continued to provide community education on joint replacement and spinal surgeries. All community health education focused on COVID-19 testing, prevention, treatment and vaccines. ● "Healthy on the Block" Bodega project expansion put on hold due to COVID-19 pandemic response. Joined new effort with community partners to map food system assets across Lawrence, Methuen, and Haverhill. ● Continued financial sponsorship of The Center through DON funding, but weekly in-person fitness classes remained on hold due to the COVID-19 pandemic	● Although in-person community health education events were suspended during most of 2020 and 2021 due to the COVID-19 pandemic, LGH continued to offer virtual patient education including Joint and Spine camps. ● Continued to support the "Healthy on the Block" program with DON funds previously granted to the Mayor's Health Task Force (MHTF), and in 2022 joined the Regional Food Partnership with several key partners including Groundwork Lawrence (GWL), Merrimack College, MHTF, and the Merrimack Valley Planning Commission (MVPC). ● Increased support for GWL programming aimed at increasing access to healthy food in the hospital's service area.

Priority Area: Chronic Disease and Related Risk Factors				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
● Weekly fitness classes at The Center in Lawrence – a fun, low cost, and social community fitness program to encourage physical activity among Lawrence residents				● Developed and launched a free community blood pressure screening and cardiac health education program, serving residents at the MHTF S.A.L.S.A festival, GWL Farmer's Markets, Lawrence barbershops and churches, and the North Shore Pride Festival.
Continue to run wellness programming including Weight Watchers, running club, Let's Get Healthy campaign, and expand stress reduction Mindfulness programs, etc. for the 1,800 employees of LGH, who are working in the community ● Empower employees to utilize annual $150 wellness reimbursement for gym/fitness centers and weight management programs; expand gym/fitness club discounts in Merrimack Valley and Southern NH ● Continue to host onsite Weight Watchers program; Nutritional cooking workshops; Smoking Cessation education; Yoga and Fitness/Exercise classes	Increase employee engagement activities by the number of employees served	● Employee Wellness Wagon was parked in the hospital cafeteria where employees could access free water, snacks, donated cloth masks, and inspirational quotes. ● Wellness Trays with leftover supplies from the Wellness Wagon were sent to every department, every shift. ● Virtual wellness offerings including yoga and mindfulness meditation were made available to all employees on the LGH intranet and via email. ● Employees were invited to contribute to the creation of mosaics representing values like resiliency and hope.	● Wellness Wagon/Wellness trays put on hold due to challenges related to the ongoing COVID-19 pandemic. ● Continued to offer virtual wellness programs to all LGH employees. ● Mosaics created by employees were hung in the hospital cafeteria alongside a COVID-19 tribute to all who have been impacted by the pandemic.	● Although planned employee wellness programming was largely suspended in 2020 due to the COVID-19 pandemic, LGH continued to offer virtual programming to staff including virtual mindfulness and yoga classes. ● The Wellness Wagon was similarly paused through much of the pandemic but resumed in September 2021, rounding weekly and visiting all departments to offer staff tea, water, healthy snacks, and inspirational quotes. The Wellness Wagon was visited by staff a total of 3417 times from Sept 2021 to March 2022. ● Free blood pressure and cholesterol screenings were offered to LGH employees in

Priority Area: Chronic Disease and Related Risk Factors				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
● Continue to offer Let's Get Healthy wellness challenges; weight loss and step/walking challenges and boost walking and gardening clubs ● Expand Mindfulness programming to include a multi-week Stress Management support group, Mindful Leadership workshops, weekly Thai Chi classes, and weekly Reiki and Massage therapy through the Wellness Wagon initiative ● Expand Wellness Wagon to round on employees in all inpatient and ambulatory units				October 2021, serving a total of 225 employees. ● In 2022 LGH welcomed its first Therapy Dog who rounds weekly with her handler, stopping to visit both staff and patients across the hospital.

Anticipated Impact: Our goal long term is a reduction in the prevalence of obesity, heart and vascular disability and death, lowering of TME for discreet populations like ACO members
Resources: Management and planning staff, nurses and doctors, administrative staff
Collaborations: Members of our Merrimack Health Network, Greater Lawrence Family Health Center, AllWays Health Partners, YMCA, participating community-based care partners, Merrimack College, and others.

Priority Area: Aging Population				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
Outreach/engagement with local senior centers, education programming, and mutual training of senior organization staff and hospital-based staff ● Scheduled education sessions on health issues of concern to seniors, such as mobility and joint pain, strategies for staying healthy and out of the hospital, chronic disease management, and other topics as opportunities arise ● Work with local senior life community to train providers on age-appropriate care, strategies for inpatient care of the dementia patient, etc.	Administer at least two senior educational events and one training session per year for staff	● All in-person community health education for seniors put on hold due to COVID-19 pandemic except for joint and spine classes offered to those considering or scheduled for orthopedic surgeries. ● In-person staff education events canceled or postponed due to COVID-19 pandemic	● Continued to offer joint and spine classes. ● Efforts to prevent Medicare readmissions included provider education on use of a Home Diuretic protocol to prevent readmissions among heart failure patients.	● Continued to offer joint and spine classes. ● Developed patient education on COPD and Pneumonia to prevent readmissions by improving patient knowledge of follow-up needed and disease management after discharge.
Continue to develop opportunities to support recovery after discharge through Medicare Bundled Payment Care Initiative for qualifying patients ● Identify appropriate Medicare recipients (above 65 years of age) who have CHF, GI Bleed of Cellulitis and enroll them in a 90-day care management program	Manage total cost of care for eligible patients who complete program	Enroll eligible Medicare beneficiaries with CHF or GI Bleed in a 90-day care management program to improve care coordination, decrease hospital readmissions, and help these seniors remain healthy at home	LGH exited the BPCI program on 12/31/2020 due to changes in the program made by CMS. RN Care Managers continued to follow patients who entered program in December through the end of March 2021 when all clinical episodes were completed.	Leveraged lessons learned from BPCI advanced to continue preventing readmissions among heart failure patients and begin to decrease readmissions among COPD and Pneumonia patients.

Anticipated Impact: Age sensitive care among our providers and a better-informed senior community in our region. Fewer readmissions, shorter lengths of stay in rehab facilities, fewer emergency visits, etc.
Resources: clinical staff, physicians, management and administrative support
Collaborations: Local Senior Centers, Senior Residential Communities (e.g., Methuen Village, Brightview, etc.), Mayor's Health Task Force, Home Health Foundation, etc.

Priority Area: Behavioral Health				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
Ongoing advancement of internal policies that support appropriate, effective care. ● Protocol for post-surgical pain management in patients with Substance Use Disorder	Implement Addiction Specialist role to assist in policy development and advancement	● Added two (2) Psychiatric Nurse Practitioners to medical staff to better meet the needs of patients with behavioral health issues in the hospital. ● Provided training to hospital staff on patient suicide risk and prevention, with more extensive training for Patient Safety Monitors. ● Updated alcohol and opioid withdrawal protocols as recommended by Addiction Medicine specialist.	● Addiction Medicine specialist role eliminated due to hospital financial constraints resulting from the COVID-19 pandemic ● Added Behavioral Health Care Coordinator to serve as liaison with Emergency Services Provider and serve as BH resource to hospital staff. ● Continued to update alcohol and opioid withdrawal protocols as needed	● Developed plan to add BH Technician on all shifts in the EC to maintain a safe and therapeutic environment for all BH patients in the EC ● Exploring partnership with BH facility to embed inpatient BH services at LGH
Expand program for Neonatal Abstinence Syndrome pre-natal, intrapartum, postpartum and post discharge support to mothers and babies exposed to opioids.	Expand supportive services to patients enrolled in program.	NAS grant expansion put on hold due to COVID-19 pandemic and departure of the grant Primary Investigator	● NAS grant expansion remained on hold due to COVID-19 pandemic ● Small number of families served	● NAS grant expansion remained on hold due to COVID-19 pandemic ● Small number of families served
Development of the Bridge program in our Emergency Center, to provide Medical Alternative Therapy and immediate registration in recovery program to patients presenting in the EC with Substance Use Disorder.	Number of patients served by program.	Increased the number of patients with opioid use disorder served by the Emergency Center Bridge Program by 5%.	Addiction Medicine Specialist role eliminated; Bridge Clinic staff returned to GLFHC.	Consider new partnerships and programming to better connect patients with SUD to recovery options and resources.
Include in our Master Facility Plan Phase 2 an observation unit with Mental Health observation beds to provide a more appropriate, therapeutic environment for patients with behavioral health issues.	Secure Board of Trustees approval, financing, and architectural and staffing plan.	Plan to build observation unit with Mental Health beds to provide a more appropriate, therapeutic environment for patients with behavioral health issues put on hold due to COVID-19 pandemic.	Plan to build observation unit with Mental Health beds remained on hold due to COVID-19 pandemic.	Plan to build observation unit with Mental Health beds remained on hold, LGH to explore partnership with inpatient BH facility to embed services at LGH.
Organizational participation in collaborative community-wide	Successful completion of summit program	LGH Leaders participated in collaborative community-wide	No further GLOA events planned for 2021.	No further GLOA events planned for 2022.

Greater Lawrence Opioid Alliance.		Greater Lawrence Opioid Alliance summit.		

Anticipated Impact: Reduced lengths of stay and readmissions, more appropriate care for opioid exposed patients (adults and children), more successful transitions from addition into recovery programs, more space to appropriately and comfortably monitor emergency patients with behavioral health or substance use disorders, developing community-wide response to opioid crisis
Resources: Where appropriate, grant funding and capital improvement dollars (cash, financing and charitable donations), clinical staff, physicians, management and administrative support
Collaborations: Greater Lawrence Family Health Center, Lahey Behavioral Health, other community treatment programs, support programs for mothers in recovery, law enforcement agencies, EMS, local school systems and family support agencies, etc.

Priority Area: Access to Care				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
Continue to recruit primary care providers to the region to provide needed primary care access.	Recruit and retain a total of 13 primary care physicians in owned practices distributed in our service area.	Plan to absorb primary care patient panels from 3 retiring PCPs.	Absorbed patient panels of 3 local retiring PCPs, recruited 2 new PCPs to CMA and added OBGYN and Cardiology to CMA.	Added 1 ARNP to CMA primary care practice.
Continue to provide financial support to the Greater Lawrence Family Health Center including on site Primary Care site, support of medical training through the Residency Program, and other collaborations with the health center.	Maintain current funding and support levels.	Funding and support levels maintained.		
Ongoing development of the Medicaid ACO product (My Care Family) in partnership with Greater Lawrence Family Health Center and AllWays Health Partners; learning from our members and improving access through innovative and responsive programming.	Increase number served.	My Care Family Enrollment grew to 43,779 members from FY 2020 to FY 2022.		
Enhanced management of high volume in Emergency Center ● Creation of Observation Unit (chest pain and behavioral health) to relieve pressure in our Emergency Center, providing shorter wait times for patients with emergency medical needs ● Develop "Vertical Waiting" option for ambulatory short-stay emergency patients ● Ongoing patient flow improvement efforts to	Secure Board of Trustees approval, financing, and architectural and staffing plan; reduce length of stay and inpatient EC boarding time; reduce total cost of care for emergency expense.	● Plan for observation unit put on hold due to COVID-19 pandemic ● Continued implementation of new roles, tools and processes to improve patient throughput ● ACO ED Navigator went remote during COVID-19 pandemic, provided patient education about when to use ED during telephonic communication	● Implemented Vertical Care processes in the Emergency Center ● Continued patient progression efforts. Used LIHPN HQEP program to engage providers in efforts to decrease LOS across med/surg service lines. ● Hired new ACO Emergency Center Navigator to identify social needs, connect patients back to primary care, and provide education	● Continued efforts to improve patient throughput with mixed results due to the COVID-19 pandemic and staffing challenges. ● ACO Emergency Center Navigator continued to provide patient education about appropriate options for urgent and emergent care.

move patients waiting for inpatient beds ● Education for ACO patients about appropriate options for urgent and emergent care to reduce unnecessary emergency room visits			about appropriate use urgent and emergent care	
Purchase mobile health unit (MHU) to bring access to care into the community (health screenings, education, vaccinations, etc.)	Secure funding to purchase mobile health unit	MHU purchased in partnership with city of Lawrence (see COVID-19 response below).	New MHU purchased, starting with COVID-19 vaccinations then will move to health screenings post-pandemic.	Plan for MHU to be repurposed to provide free health screenings to the community prior to the end of 2022.

Anticipated Impact: Reduced ER boarding for inpatients, increased patient satisfaction with access time for care, shorter emergency and inpatient lengths of stay.
Resources: Doctors and nurses, support staff, administration and ACO staff and community partners.
Collaborations: My Care Family ACO partners, Greater Lawrence Family Health Center, Lahey Behavioral Health

Priority Area: COVID-19 Pandemic				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
Collaborate with government and healthcare partners to provide widespread COID-19 testing	Establish COVID-19 testing site at LGH.	● Opened drive-through COVID testing site ● Partnered with city, state, health center, Partner's to increase COVID testing for community residents ● Partnered with city and health center to provide mobile COVID testing in Lawrence ● Partnered with city to purchased LGH mobile health unit to provide COVID testing and flu vaccine in Lawrence	● Partnered with state, city, and others to provide drive-through testing. ● Partnered with city of Lawrence to provide mobile COVID-19 testing at the neighborhood level in Lawrence. ● Partnered with the city and other stakeholders to establish and operate a COVID-19 vaccine site for eligible residents. ● Partnered with city and other stakeholders to deliver COVID-19 vaccine via MHU. ● Participate in cross-sector collaboration to provide evidence-based, culturally appropriate education on the COVID-19 vaccine	Continued to partner with the state to provide drive-through COVID-19 testing.
Establish nurse-staffed COVID-19 hotline and provide clinical guidance to the community on COVID-19 prevention including testing, masks, social distancing, quarantine and isolation	Establish nurse-staffed COVID-19 hotline as resource to community.	● Hotline staffed through ● Bilingual educational flyers created and distributed to community related to preventing spread of COVID-19, safe quarantine/isolation practices, how to access testing and care.	● Nurse hotline no longer needed ● Bilingual COVID-19 vaccine information campaign launched with El Mundo, cross sector partnership in Lawrence	Vaccine rates achieved.

		• Bilingual social media campaign related to COVID-19 prevention, testing, treatment		
Participate in community-wide COVID-19 response, identifying and addressing urgent needs related to food and income security, housing stability, and homelessness.	Establish LGH presence on community coalitions formed in response to COVID-19.	• Provided clinical guidance to hotels for homeless residents needed to quarantine • Participated in community COVID-19 coalitions included food security, housing stability, income security.	Continued to participate in coalitions focused on the homeless, food security, financial and housing stability.	Continued to participate in coalitions focused on the homeless, food security, financial and housing stability.

Priority Area: Diversity, Equity, and Inclusion (DEI)				
Strategy	**Measurement**	**FY 2020**	**FY 2021**	**FY2022**
Re-establish an LGH DEI Steering Committee with Executive support to assess current state, identify gaps, establish plan and goals for improvement	DEI Steering Committee with charter and goals, completed plan for improvement	● DEI Steering Committee chartered 7/16/2020, staff representation from most hospital departments. ● Seeking to engage consultant to support DEI work at LGH and with GLFHC	● Completed organizational DEI assessment and began developing implementation plan. ● Developed Health Equity dataset and dashboard sourced from the LGH EMR ● Chartered Board-level DEI Subcommittee in November 2021 to provide oversight and support for DEI/Health equity efforts.	● Completed 3-year DEI Implementation Plan with clear metrics and goals. ● Utilized Health Equity dataset and dashboard to identify disparities in patient outcomes for patients with limited English proficiency (LEP), developed plan to standardize linguistic supports to eliminate these disparities.
Establish joint LGH/GLFHC DEI Advisory Board to enhance communication and learning about DEI topics between the two organizations	Formation of DEI Advisory Board	● Advisory Board membership established, kickoff and follow up meetings held ● Advisory Board leadership established (DEI program officer and GLFHC physician)	Established charter and goals for Advisory Board, met throughout 2021	Continued to meet regularly with discussion focused on how best to improve health equity for shared LGH/GLFHC patients
Hire a DEI Program Officer to oversee DEI activities and progress	Recruit and hire DEI Program Officer	DEI Program Officer hired, in place 8/2020	DEI Program officer led comprehensive organizational DEI assessment, LGH chartered a DEI Steering Committee and Board Subcommittee	DEI program officer developed a 3-year DEI Implementation Plan with clear goals and metrics for FY 2022. All goals are on track for completion by end of FY 2022.

Appendix E:

2023-2025 Implementation Strategy

Background and the Purpose of Implementation Strategy

Lawrence General Hospital (LGH), based in Lawrence, Massachusetts, is a private, non-profit community hospital that provides patient-centered, compassionate and quality health care for the whole family to those in the Merrimack Valley and southern New Hampshire. For nearly 150 years, the dedicated doctors, nurses, and staff of the hospital have been committed to improving the health of the people and communities it serves. Its physicians and caregivers are dedicated to treating all patients, regardless of their race, ethnicity, national origin, gender, religion, age, marital status, sexual orientation, gender identity, socioeconomic status, veteran status, disability, and other characteristics that make our patients and employees unique. Every member of the Lawrence General team is committed to providing a high level of care and supporting education and research to improve the health of our local community. Lawrence General's work is rooted in a spirit of collaboration and its leadership and staff are acutely aware that the hospital cannot achieve that mission on its own. The hospital collaborates with other health care institutions, community-based organizations, residents, and our patients, ensuring that it engages the Greater Lawrence community and provides the very best care to the patients it serves.

Lawrence General is a leading member of the region's health care system and participates in a broad range of community coalitions, task forces, and committees that strive to address area needs and create opportunities for residents eager to thrive and lead healthy, productive lives. Lawrence General acknowledges its role as critical community resource while understanding the need to collaborate with area stakeholders to achieve shared goals. Lawrence General is committed to identifying, educating, preventing, and addressing issues that may hinder residents from leading healthy lives or accessing the social services they may require. The ultimate purpose of this assessment and this Implementation Strategy is to promote a common, data-driven, prioritized agenda - created through an inclusive, engaged process - and detailed roadmap, with the hope that it will encourage collaboration and collective action.

In 2021-2022, LGH and the Greater Lawrence Family Health Center conducted a Community Health Needs Assessment (CHNA) for the Greater Lawrence Region, including LGH's Community Benefits Service Area (CBSA). The assessment was conducted through an inclusive, engaged process involving community residents and the region's leading health organizations. The assessment gathered information related to five communities in the Greater Lawrence Region: Andover, Haverhill, Lawrence, Methuen, and North Andover. These communities represent where LGH draws the vast majority of it patients and is how LGH defines its CBSA. GLFHC draws the vast majority of its patients from the communities of Haverhill, Lawrence, and Methuen. LGH's CBSA does not exclude medically underserved, low-income, or minority populations and LGH 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.

A report that provides background information on the purpose and goals of the assessment as well as details on the assessment's approach, methods, key findings, and agreed upon priorities, and final outcomes can be found on LGH's and GLFHC's websites.

Prioritization, Planning, and Strategy Development

Federal and Commonwealth community benefits guidelines require nonprofit hospitals to rely on their analysis of their CHNA data to determine the community health issues and population segments on which it chooses to focus its Implementation Strategy. By analyzing assessment data, hospitals, along with its community partners, can identify the health issues that they believe are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities or are disproportionately impacted by systemic racism or other forms of discrimination due to their race, ethnicity, spoken language, religion, immigration status, disability status, age, sexual orientation, gender identity, or other personal characteristics.

Once LGH's CHNA was completed, the LGH Steering Committee and the LGH CBAC participated in a series of meetings that allowed them to review the full-breadth of quantitative and qualitative findings from the assessment, as well as to begin the planning process that culminated in the CHNA report and the LGH Implementation Strategy. During these the JSI staff applied an interactive, anonymous polling software that facilitated prioritization of the community health issues and the population segments that those involved thought should be the focus of LGH's Implementation Strategy. This prioritization process helped to ensure that LGH and its partners maximized the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

LGH and its partners are committed to promoting health, enhancing access and delivering the best care for those in their CBSA. The goals, strategies, and activities that LGH's Senior Leadership and its CBAC identified through the prioritization and planning process are articulated below. In the coming years, every effort will be made to implement these activities in close partnership with LGH's community health partners, and the community at-large. Recognizing that community benefits planning is ongoing and will change with continued community input, the LGH Implementation Strategy will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues may arise, which may require a change in the Implementation Strategy or the strategies documented within it. LGH Senior management and the Board of Trustees are committed to assessing information and updating the plan as needed.

Planning and Strategy Development Principles

The following are a range of programmatic ideas and principles, drawn from the peer reviewed literature and body of experience, which are considered critical to community health improvement. These ideas have been applied in the development of the Implementation Strategy provided below.

- **Social Determinants of Health:** The social determinants of health are "the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes." The leading social determinants of health include issues such as economic security, affordable housing, access to healthy foods, public safety, accessible transportation, and community cohesion (including racial/health equity). Though LGH has been involved in this work for several years, there is growing appreciation for the idea that these issues are at

the heart of health inequities between and within communities. It is important that the LGH Implementation Strategy continue to deepen and explore the development of 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, or altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aims to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared to helping people to manage health conditions, lessen a condition's impact, or slow its progress. Targeted efforts across the continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

- **Screening and Referral:** Early identification of those with chronic and complex conditions followed by efforts to ensure that those in need of education, further assessment, counseling, and treatment are critical to preventing illness before it takes hold or managing illness so as to lessen or slow its impacts. A critical component of screening and referral efforts is taking steps to ensure that people are fully engaged in treatment, including linkages to a primary care provider.

- **Chronic Disease Management:** Learning how to manage an illness or condition, change unhealthy behaviors, and make informed decisions about your health can help one live a healthier life. Evidence-based chronic disease management or self-management education (SME) programs, implemented in community-based setting by clinical and non-clinical organizations, can help people to learn skills to manage their health conditions, improve eating and sleeping habits, reduce stress, maintain a healthy lifestyle.

- **Care Coordination and Service 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 to help 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 across all communities is finding the services they need and navigating the health care system. Having health insurance that can help people to pay for needed services is a critical first step. The availability of 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 is best and mostly efficiently achieved through collaboration and partnership 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. Strategic plans like this one need to be collaborative and include partnerships with service providers across multiple sectors (e.g., health, public health, education, public safety, and community health)

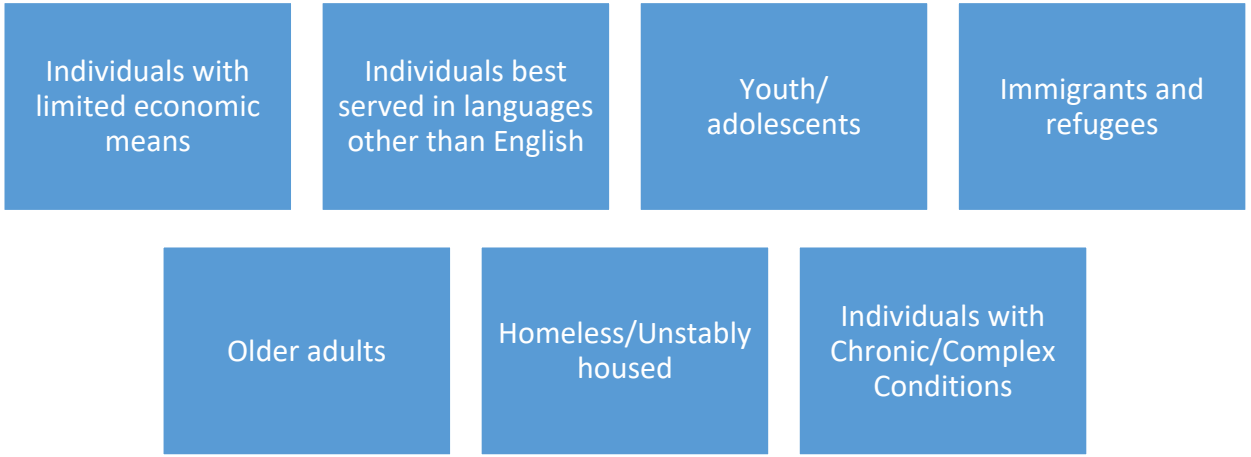
Priorities

Following is a listing of the population segments and community health issues that were prioritized by the Steering Committee, the LGH CBAC, and other stakeholders in the Community during the CHNA Process.

Community Health Needs Assessment: Priority Populations

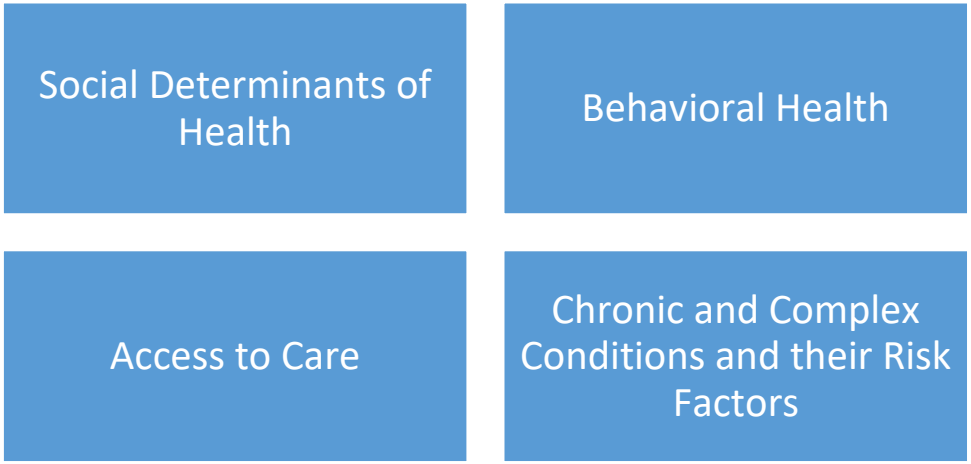
LGH is committed to improving the health status and well-being of all residents living throughout its service area. Certainly all geographic, demographic, and socioeconomic segments of the population face challenges of some kind that can hinder their ability to access care or maintain good health. However, based on the assessment's quantitative and qualitative findings there was broad agreement that LGH's Implementation Strategy should prioritize segments of the population that have more complex and intense needs, face inequities due to their race, gender identity, health status, or other personal characteristics, and/or are disproportionately impacted by social factors in ways that limit their access to care.

Following is a listing of the population segments that were prioritized by the Steering Committee, the LGH CBAC, and other stakeholders in the community during the CHNA Process.



Community Health Needs Assessment: Community Health Priorities

Following is a listing of the community health issues that were prioritized by the Steering Committee, the LGH CBAC, and other stakeholders in the Community during the CHNA Process. The priority issues identified below have been framed in a broad context to ensure that the breadth of unmet needs and community health issues can be addressed. The Implementation Strategy is the mechanism that will be applied to promote action on a specific range of activities within these broader areas of priority. The Implementation Strategy includes information on goals, strategies/objectives, and specific activities will be the focus of LGH's and its community partners' efforts, which will help to maximize impact, and leverage the breadth of resources and partnerships, across the Greater Lawrence region.



Community Health Needs Not Prioritized by LGH and GLFHC

It is important to note that there are community health needs that were identified by the Greater Lawrence Region CHNA that were not prioritized for investment or included in LGH's Implementation Strategy. Specifically, supporting education across the lifespan, strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in LGH's Implementation Strategy. While these issues are important, LGH's CBAC and GLFHC's and LGH's senior

leadership teams it was decided that these issues were outside of the organization's sphere of influence and investments in others areas[1] were both more feasible and likely to have greater impact. As a result, LGH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. GLFHC and LGH remain open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

LGH Community Benefits Resources

Over the past year, LGH 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. LGH has leveraged grants and other funds to address health disparities and health inequities and has provided uncompensated "charity care" to low-income individuals who were unable to pay for care and services at the hospital.

This year, LGH 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. LGH 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, LGH'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.

[1] The issues that were identified in the Greater Lawrence Region CHNA and are addressed in some way in the LGH Implementation Strategy are housing issues, food Insecurity, transportation, navigation of healthcare system, linguistic access/barriers, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, outreach/education/prevention, services to support long-term recovery, and opioid use.

Implementation Strategy

Behavioral Health

Goal: Build behavioral health service capacity, with an emphasis on reaching individuals best served in languages other than English, immigrants, and other groups who require culturally appropriate services.				
Core Strategies	**Priority Population Segment(s)**	**Proposed Activities**	**Sample Measures**	**Selected Key Partners**
Participate in multisector community efforts to promote collaboration between sectors and improve access to services for individuals with behavioral health needs, substance use disorder, recent opioid overdose, and/or homelessness	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents • Older adults • Homeless/unstably housed • Individuals with BH and SUD	• Participate in the LLEAPS n' Bounds program to develop and deploy a Crisis Intervention Team, centering the voices of Black, Indigenous, People of Color (BIPOC) residents, as an alternative to traditional law enforcement responses to individuals experiencing a behavioral health crisis, struggling with SUD and/or homelessness. • Continue to participate in weekly HUB meetings hosted by the Lawrence Methuen Community Coalition (LMCC), to drive cross-sector post-overdose outreach in the LGH CBSA • Continue to allocate Determination of Need (DON) funding to support the Mayor's Health Task Force (MHTF) efforts to improve behavioral health provider knowledge and coordination in the city of Lawrence.	• % of coalition meetings attended by LGH • # and type of coalition activities participated in by LGH • Contributions made to coalitions (data shared, meeting space provided, coordination of activities, etc.)	• MHTF • Lawrence Police Department • LMCC • Methuen CARES • Family Continuity • BILH Behavioral Health Services • Department of Mental Health
Expand access to services and improve the quality of care for patients in crisis	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents	• Collaborate closely with Beth Israel Lahey Health's (BILH) Commonwealth funded Community Behavioral Health Center (CBHC) and the Lawrence Police Department (PD) to expand access to community-based BH crisis intervention services	• Completed cross-sector workflows with BILH and Lawrence PD • Decrease number of Behavioral restraints used in the LGH EC by 10%	• BILH Behavioral Health Services • Greater Lawrence Family Health Center (GLFHC)

	• Older adults Homeless/unstably housed	• Add a 24/7 Behavioral Health Technician, preferably who is bilingual/bicultural (Spanish speaking/Hispanic) , in LGH's emergency department (ED) to help maintain a therapeutic environment and support BH patients awaiting disposition • Continue clinical collaboration to bridge patients from the LGH to outpatient clinics offering Medically Assisted Treatment (MAT) to individuals with SUD (e.g. GLFHC Office-based Addiction Treatment (OBAT) clinic and Column Health). • Partner with the Boston Medical Center (BMC) Healing Communities Study (HCS) to expand access to Narcan for individuals with opioid use disorder.	• # of patients with SUD bridged to treatment with Column Health or GLFHC OBAT Clinic • Develop plan to expand access to Narcan at LGH.	• BMC Healing Communities Study • Lawrence Methuen Community Coalition (LMCC)

Social Determinants of Health (SD0H)

Goal: Take action to address the underlying Social Determinants of Health (e.g., affordable housing, food security, transportation, job training/employment services, violence prevention, education) to promote economic security, improve access to health care, and support individuals and families to live healthier, happier, more fulfilling and productive lives.				
Core Strategies	**Population Segment(s)**	**Proposed Activities**	**Sample Measures**	**Selected Key Partners**
Participate in multisector Community coalitions to promote collaboration, advocate for enhanced policies/system changes that address the social determinants of health	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents	• Continue to allocate DON funding to support MHTF capacity, coordination and activities aimed at addressing SDOH in the city of Lawrence. • Participate in a Regional Food Resiliency Coalition with CBO, municipal, and academic partners across the LGH CBSA.	• LGH presence on MHTF Advisory Council • # of MHTF meetings attended/hosted	• Mayors Health Task Force • Groundwork Lawrence • Merrimack College

(e.g., housing, food insecurity, economic insecurity)	• Older adults • Homeless/unstably housed • Individuals with chronic and complex conditions	• Partner with healthcare providers, CBOs, and municipal leaders to convene a Merrimack Valley Homelessness/Housing Insecurity Coalition to support regional collaboration and problem-solving, including engagement of non-traditional partners such as banks, housing developers, landlords, and local businesses • Continue to participate in the Lawrence Partnership	• # of and type of activities supported by DON funding • Other contributions made to MHTF	• Merrimack Valley Regional Planning Commission • GLFHC • Lawrence Partnership
Implement SDoH screening/assessment, and referral activities that Identify those who are being impacted by social factors and ensure those with unmet needs are linked to and engaged with community resources	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents • Older adults • Homeless/unstably housed • Individuals with chronic and complex conditions	• Add a Resource Specialist role to LGH ED to screen all admitted patients for SDOH needs and facilitate referrals to appropriate services prior to discharge • Add a bilingual/bicultural CHW to LGH's primary care practice (Community Medical Associates) to support annual SDoH screening for all patients, referrals to appropriate services and follow-up to ensure services were received.	• Screen at least 75% of admitted patients for SDoH • Refer at least 75%of all patients with positive SDoH screens to appropriate resources • Develop sustainable workflows for patient follow-up to ensure services are received as intended	• Community Medical Associates • Unite Us • GLFHC • AllWays Health Partners
Promote job training and employment opportunities for those experiencing economic insecurity or who lack meaningful opportunities for advancement	• Individuals with limited economic means • Individuals best served in languages other than English • Immigrants and refugees	• Build external pipelines to employment at LGH in collaboration with local academic institutions and CBOs who offer job preparedness training to local residents. • Develop and implement initiatives to achieve workforce diversity goals reflective of the diversity of the LGH patient population. • Develop internal advancement pathways for LGH employees, especially those in entry-level positions.	• Build external pipeline program with at least 3 local partners • # of new LGH staff hired through pipeline program • # of LGH staff offered, placed, and completing internal advancement training	• Notre Dame Education Center • Northern Essex Community College • TopNotch Scholars • Lawrence Public Schools • Lawrence Community Works

Access to Care

Goal: Enhance access to comprehensive, equitable services by building workforce and provider capacity, supporting patient navigation, and addressing barriers to access focusing on both clinical and non-clinical social, enabling and supportive services (e.g., primary care, specialty care, housing supports, job training/employment supports, etc.)				
Core Strategies	**Priority Population Segment(s)**	**Proposed Activities**	**Sample Measures**	**Selected Key Partners**
Provide proactive, specialized, linguistically/culturally appropriate eligibility assessment and financial/health insurance counseling services that help to ensure that individuals without health insurance and/or experiencing economic insecurity have access to health insurance	• Individuals with limited economic means • Individuals best served in languages other than English • Immigrants and refugees	Continue to provide LGH patients and the public free consultations with our bilingual (Spanish/English) Certified Application Counselors to help with insurance enrollment, optimization and education on how to utilize insurance benefits to access care.	• # of individuals counseled • # of individuals assessed for eligibility • # of individuals enrolled in insurance or other programs	• LGH Enrollment Counselors
Develop initiatives that support those with more complex or intense needs to navigate the system and coordinate their care (clinical and non-clinical services) across the system	• Individuals with limited economic means • Individuals best served in languages other than English • Immigrants and refugees • Homeless and Unstably Housed	• Continue to provide expanded access to intensive case management and care navigation services for patients within LGH's Medicaid ACO. • Develop and implement care coordination strategy for high-risk patients within the LGH network's Medicare Shared Savings Program(MSSP). • Continue to offer support to the LGH provider network to ensure patients receive needed cancer screening (breast, cervical, colorectal) and disease management (diabetes, hypertension).	• Develop plan with AllWays Health Partners to ensure continuity of CM services for patients who remain in Medicaid ACO • Implement at least one strategy to prevent readmissions among MSSP patients • Achieve payer thresholds for cancer screening, diabetes and	• AllWays Health Partners • Steward Health System

			hypertension management	
Develop partnerships to enhance access and promote transportation equity with regional transportation providers and community partners	• Individuals with limited economic means • Individuals best served in languages other than English • Immigrants and refugees • Homeless and Unstably Housed	• Continue to provide Uber Health rides as needed to LGH patients who lack transportation or insurance transportation benefits. • Continue to provide Crossways chair car rides for patients who lack transportation or insurance transportation benefits and who cannot be transported by Uber or ambulance	• # of Uber Health rides provided annually • # of Crossways rides provided annually	• Uber Health • Crossways Home Care

Chronic and Complex Conditions and their Risk Factors

Goal: Develop and/or support evidence-informed programs that raise awareness, educate, and engage those in need in primary care services, and promote self-management support for those with chronic and complex conditions				
Core Strategies	**Priority Population Segment(s)**	**Proposed Activities**	**Sample Measures**	**Selected Key Partners**
Develop and support initiatives that raise awareness and educate community residents about the importance of healthy eating and active living, including efforts that help people to change unhealthy behaviors	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents • Older adults • Homeless/unstably housed • Individuals with chronic and complex conditions	• Continue allocate DoN funding to support MHTF-sponsored community events and activities that promote healthy living (e.g. annual SALSA and Ciclovia festivals). • Continue to provide funding to Groundwork Lawrence that supports year-round Farmer's Markets across the LGH CBSA to expand access to fresh, affordable, locally-grown food. • Continue to allocate DoN funding to support exercise classes for seniors at The Center in Lawrence	• # of participants at SALSA and Ciclovia events • # of people served by GWL Farmer's Markets (will confirm that I can get this info) • # of senior exercise class participants at The Center	• MHTF • Groundwork Lawrence • The Center
Increase capacity and expand access to chronic disease screening, assessment, and referral	• Individuals best served in languages other than English	• Analyze LGH PCP network claims data to identify and address health disparities (e.g. diabetes and hypertension management,	• Implement at least one strategy to address health disparities	• Groundwork Lawrence • MHTF

initiatives in clinical and non-clinical settings (e.g., hypertension, diabetes, asthma, depression, etc.)	• Immigrants and refugees • Individuals with limited economic means • Youth and adolescents • Older adults • Homeless/unstably housed • Individuals with chronic and complex conditions	cancer screening rates) and develop strategies to address identified disparities • Partner with CBOs, municipalities, businesses, churches, and others to implement a free, low-barrier Community Health Screening program, to help individuals identify health risks such as hypertension, provide health education, and connect individuals to primary care. • Develop plan to Utilize the Mobile Health Unit and expand health screening program offerings across the LGH CBSA.	identified among PCP network patients • Hold at least 12 screening events annually within the LGH service area • # of people served by free health screening program annually	• Municipal Public Health departments Senior Centers
promote appropriate infectious disease screening/testing, vaccination (Inc. vaccine hesitancy), follow-up/case finding, and treatment (e.g., COVID-19, TB, HIV, etc.) geared to both clinical service providers and consumers	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents • Older adults • Homeless/unstably housed • Individuals with chronic and complex conditions	• Continue to host the COVID-19 Task Force made up of regional healthcare providers, municipalities, and CBOs to support local access to COVID-19 testing and vaccines. • Provide education for providers on current practices in infectious disease screening, testing, vaccination, follow-up, and treatment.	• # served by drive-through COVID-19 testing site • Deliver at least one event annually to educate local providers on Infectious Disease • # of providers participating in education	• GLFHC • Pentucket Medical Associates • City of Lawrence
Increase access to evidence-informed, linguistically/culturally appropriate, self-management support programming for those with chronic medical conditions	• Individuals best served in languages other than English • Immigrants and refugees • Individuals with limited economic means • Youth and adolescents • Older adults • Homeless/unstably housed Individuals with chronic and complex conditions	• Increase PCP knowledge of the LGH Weight Management program which offers treatment options for healthy weight loss • Continue to offer free, virtual education sessions to the public in English and Spanish • Continue to provide additional care navigation services for Medicare beneficiaries with heart failure and COPD to prevent 30-day readmissions.	• # of educational offerings to PCPs/# of PCPs educated • # of people who attended educational sessions • # of people with HF or COPD receiving care navigation services	• GLFHC • LIHPN Provider Practices