MASS GENERAL BRIGHAM INCORPORATED
DON APPLICATION #21012113-AS

ATTACHMENTS

AMBULATORY SURGERY/SUBSTANTIAL CAPITAL EXPENDITURE/DON-REQUIRED EQUIPMENT
MASS GENERAL BRIGHAM INTEGRATED CARE, INC.

MASS GENERAL BRIGHAM AMSURG, INC.
JANUARY 21, 2021

BY

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TABLE OF CONTENTS

Attachments

Attachment 1

2. PROJECT DESCRIPTION

The Applicant

Mass General Brigham Incorporated, a Massachusetts not-for-profit corporation with its principal office located at 800 Boylston Street, Suite 1150, Boston, Massachusetts 02199 (the "Applicant"), is the parent organization of a charitable, integrated health care system (referred to herein as "Mass General Brigham") that currently comprises two tertiary and seven community acute care hospitals, hospitals specializing in inpatient and outpatient services in behavioral health, rehabilitation medicine and ophthalmology and otolaryngology, a home health agency, a nursing home and a physician network with approximately 7,500 employed and affiliated primary care and specialty care physicians. Mass General Brigham also operates a non-profit managed care organization and a for-profit insurance company that collectively provide health insurance and administrative services products to the MassHealth Program (Medicaid), ConnectorCare and commercial populations. Mass General Brigham maintains the largest non-university-based, non-profit, private medical research enterprise in the United States; its hospitals are principal teaching affiliates of the medical and dental schools of Harvard University; and it operates a graduate level program for health sciences.

In order to fulfill its four-part mission of patient care, research, education and community service, the Applicant has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics, population health, ambulatory care and insurance risk management. Implementation of this strategy relies on a series of synergistic priorities that include:

i. improving health outcomes across the full continuum of care with an emphasis on the development by Mass General Brigham's academic medical centers of multidisciplinary centers of excellence for tertiary and quaternary care;

ii. enhancing the patient experience, particularly for primary care and behavioral health care, by developing community-based health care settings that improve access and ease of navigation for patients;

iii. reducing the total cost of health care by developing delivery models that focus on value while simultaneously improving outcomes; and

iv. investing in research and innovations that meaningfully improve the diagnosis and treatment of all forms of human illness.

The Proposed Project

The Applicant is filing an Application for a Determination of Need (the "Application") with the Massachusetts Department of Public Health (the "Department") for the (i) construction and development of three ambulatory care centers to be located at 1400 West Park Drive, Westborough, MA 01581 (the "Westborough Site"); 100 Brigham Way, Westwood, MA 02090 (the "Westwood Site"); and 2 Hill Street, Woburn, MA 01801 (the "Woburn Site") (each such Site being sometimes referred to herein individually as a "Project Site" and collectively as the "Project Sites"); (ii)

construction and development of a licensed clinic, as described below, at each of the Project Sites; and (iii) acquisition and implementation of magnetic resonance imaging ("MRI") and computed tomography ("CT") units at each of the Project Sites (collectively, the "Proposed Project").

The following clinical services (collectively, the "Clinical Services") will be available at each of the Project Sites:

i. surgical services appropriate to the ambulatory setting (collectively, the "Ambulatory Surgery Services") that are expected to include general surgery, orthopedics, otolaryngology, ophthalmology services, and such other ambulatory surgical services as may be needed based on ongoing assessments of evolving patient needs in the communities served by each Project Site;

ii. physician services (collectively, the "Physician Services") consisting of primary care, behavioral health, and specialty care services that are expected to include endocrinology, neurology, cardiology, gastroenterology, dermatology, pain management, and such other specialty care physician services as may be needed based on ongoing assessments of evolving patient needs in the communities served by each Project Site; and

iii. diagnostic imaging services (collectively, the "Imaging Services") that are expected to include X-ray, ultrasound, ECHO, stress testing, mammography, CT and MRI services.

The Applicant will execute the Proposed Project through the following two, newly-organized not-for-profit affiliates that have been organized and are existing under M.G.L. c. 180:

i. Mass General Brigham Integrated Care, Inc. ("IC") which will apply for a clinic license to provide the Physician Services at the Westborough Site and the Woburn Site and the Imaging Services at each of the Project Sites.[1]

ii. Mass General Brigham AmSurg, Inc. ("AmSurg") which will apply for its own, distinct clinic license to provide the Ambulatory Surgery Services at each Project Site as a freestanding ambulatory surgery center. [2]

The Proposed Project will benefit the Applicant's patients as well as the overall health care system of The Commonwealth in multiple ways. First, the Applicant selected the location of each Project Site so that the primary service area of the Project Site would correlate with the locations where a significant percentage of its patients reside. (See Section F1.a.i below.) In addition, each of the Project Sites is located near major transportation routes, and each will offer ample free parking

[1] Certain Mass General Brigham physician practices currently provide physician services in an existing medical office building at the Westwood Site. These practices will continue to provide such physician services after the Applicant develops a second, adjacent building at the Westwood Site as part of the Proposed Project.

[2] To be certified as a Medicare ambulatory surgery center, the center must be operated by a legal entity that is not certified to participate in the Medicare program under any other provider category. See 42 CFR 416.2.

and other amenities. As a result, the accessibility and convenience for patients of each Project Site should result in a highly desirable overall patient experience.

Second, the Project Sites will be designed to utilize industry-defined best practices for efficient and effective delivery of the Clinical Services. For example, co-locating the Physician Services, Imaging Services and Ambulatory Surgery Services at each Project Site will foster greater care coordination, improve the overall quality of the Clinical Services and promote better health outcomes for the Applicant's patients. In particular, the Applicant's investment in expanding primary care and behavioral health care services at each of the Project Sites will improve access to and integration of these services into the full suite of Clinical Services offered at each of the Project Sites. Moreover, the Applicant retained IDEO, a leading experience design company, to engage with groups of the Applicant's patients who reside in the communities around each Project Site in order to transform the care experience for patients and ensure the highest levels of patient satisfaction at the Project Sites.

Third, the Applicant will collaborate with clinical leadership at Mass General Brigham's academic medical centers to review quality of care outcomes at the Project Sites and to design and implement such quality and process improvement initiatives as are necessary to ensure that the Clinical Services are of the highest quality.

Finally, since each Project Site will operate as a lower-cost, freestanding (non-hospital-based) facility, the Proposed Project will meaningfully contribute to the Applicant's (and The Commonwealth's) goals of containing the rate of growth of total medical expenditures ("TME").

In summary, the Proposed Project, which is part of an approximately $400 million investment by the Applicant in new ambulatory health care facilities in eastern Massachusetts and southern New Hampshire, is one of the integral components of Mass General Brigham's above-described system-wide strategy. By co-locating comprehensive Physician Services, Imaging Services and Ambulatory Surgery Services in these three convenient, community-based, lower cost and high quality Project Sites, the Applicant will make substantial progress in achieving its strategic priorities of improving patient access and outcomes while also lowering the total cost of health care for its patients and other residents of The Commonwealth.

As the information in this Application will demonstrate, the Proposed Project meets the factors of review for Determination of Need approval.

Factor 1: Applicant Patient Panel Need, Public Health Values and Operational Objectives

F1.a.i **Patient Panel:**

Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant's existing Patient Panel and payer mix.

A. The Applicant's Patient Panel

Mass General Brigham[3] serves a large and diverse patient panel, as demonstrated by the utilization data for the 36-month period covering Fiscal Year 2017 ("FY17") through Fiscal Year 2019 ("FY19") and the preliminary data available for Fiscal Year 2020 ("FY20").[4] Attachment 1 illustrates the demographic diversity of Mass General Brigham's patient panel in table form. The number of patients utilizing Mass General Brigham's services has increased since FY17, with 1,408,587 unique patients in FY17; 1,504,625 unique patients in FY18; and 1,528,359 unique patients in FY19.[5] Preliminary data for FY20 indicates that Mass General Brigham had 634,989 unique patients. Mass General Brigham's patient mix consists of approximately 42.2% males and 57.8% females based on FY19 data, with gender unknown for less than 0.01% of the patient panel. The Massachusetts Center for Health Information and Analysis ("CHIA") reports that Mass General Brigham's patient panel represents 19% of all discharges in The Commonwealth.[6]

[3] Utilization of patient care services at the following Mass General Brigham provider organizations was used to determine the Applicant's patient panel: Brigham and Women's Hospital, Brigham and Women's Faulkner Hospital, The General Hospital Corporation d/b/a Massachusetts General Hospital, Newton-Wellesley Hospital, North Shore Medical Center, Cooley Dickinson Hospital, Martha's Vineyard Hospital, McLean Hospital, Nantucket Cottage Hospital (post-Epic data only), Massachusetts Eye and Ear Infirmary (post-Epic data for specific locations only), Spaulding Rehabilitation Hospital (excluding data for certain programs), Brigham and Women's Physicians Organization, Massachusetts General Physicians Organization, Newton-Wellesley Medical Group, North Shore Physicians Group, Cooley Dickinson PHO (post-Epic data only) and Mass General Brigham Community Physicians (excluding pre-Epic non-risk patients).

[4] The Applicant's fiscal year is from October 1 – September 30. Annual comparisons are calculated using data for FY17-FY19. The FY20 data was pulled as of January 7, 2020, and is, therefore, subject to change for purposes of annual comparisons.

[5] The methodology for aggregating Mass General Brigham's patient panel data has evolved into an automated process utilizing internal data resources. Initially, in 2017, when Mass General Brigham began developing its patient panel information for Determination of Need applications, such as the Change of Ownership for Massachusetts Eye and Ear Infirmary and the Substantial Capital Expansion for Brigham and Women's Hospital, staff manually aggregated the necessary data. However, since these submissions, Mass General Brigham staff have developed a new automated process that allows for the collection and amalgamation of system-wide data. This refined methodology allows staff to continuously monitor and improve the way that data are aggregated. Accordingly, between June 2018 and December 2019, staff further refined the data collection processes leading to an increase of no more than 1% in overall patient counts for the system. Staff will continue to refresh and refine the process for aggregating data across the system, leading to more exact patient panel data.

[6] Massachusetts Center for Health Information Analysis, Fiscal Year 2017: Partners HealthCare System, https://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2017-annual-report/system-profiles/Partners-HealthCare.pdf (last visited Jan. 5, 2021).

Age demographics for the past three Fiscal Years show that the majority of Mass General Brigham's patient panel is between the ages of 18-64 (61.0-62.1%). Patients that are 65 and older also make up a significant portion of the total patient panel (26.2-28.5%). Only 10.5-11.7% of Mass General Brigham patients are between 0-17 years of age.

Mass General Brigham's patient panel reflects a mix of races. Data based on patient self-reporting demonstrates that in FY19, 73.4% of the total patient panel identified as White; 5.6% identified as African American or Black; 4.4% identified as Asian; 1.3% identified as Hispanic/Latino; 0.1% identified as American Indian or Alaska Native; and 0.1% identified as Native Hawaiian or Other Pacific Islander. Since patients were grouped into these categories based on how they self-identified,[7] there is a portion of the patient panel (15.2% in FY19) that either chose not to report their race or identified as a race that did not align with the above categories.

Mass General Brigham provides care to patients from a broad range of geographies, including all 50 states. While Mass General Brigham's patients reside mainly in eastern Massachusetts, there is a sizeable portion of its patient panel that resides outside of Massachusetts (11.0%, or 167,835 patients, in FY19). By applying the Department's Health Service Area ("HSA") categories to FY19 data, 44.6% of Mass General Brigham's patients reside in HSA 4 (682,126 patients); 16.0% reside in HSA 6 (244,000 patients); 11.4% reside in HSA 5 (174,459 patients); 6.7% reside in HSA 3 (101,785 patients); 6.6% reside in HSA 1 (100,146 patients); and 3.4% reside in HSA 2 (52,353 patients). The remaining 0.4% of Mass General Brigham's patients (5,655 patients) either reside in MA but outside of HSAs 1-6 or their origin is unknown.

The COVID-19 pandemic challenged health care systems to address hospital capacity to care for critically ill COVID-19 patients while continuing to provide outpatient services at both hospital and community-based settings and to utilize enhanced precautions to address patient and provider safety. Consistent with the Department's Memorandum dated March 15, 2020, the Applicant's hospitals and ambulatory surgical centers postponed or canceled any nonessential, elective invasive procedures, and its providers deferred many outpatient encounters, including routine physicals and diagnostic tests, such as MRI and CT, when clinically appropriate to do so. These measures resulted in a significant, but temporary, decline in utilization of clinical services at all Mass General Brigham provider organizations that is inconsistent with the utilization patterns described above. While the Applicant cannot predict the time frame during which the utilization of its clinical services will return to pre-COVID-19 levels, the Applicant is confident that utilization will normalize as The Commonwealth emerges from this extraordinary period.[8] Moreover, COVID-19 has not lessened the need for clinical services - patients still require health care for acute, urgent and chronic issues. Indeed, the COVID-19 pandemic has underscored the importance of a coordinated care model that decentralizes outpatient care out of large hospital-

[7] With the exception of the category "Hispanic/Latino," the race categories shown above are based on the 1997 Office of Management and Budget standards on race and ethnicity. Patients were grouped into these categories based on their responses as follows – White: "White"; African American or Black: "African American", "Black", "Black or African American"; American Indian or Alaska Native: "American Indian", "American Indian or Alaska Native"; Asian: "Asian"; Native Hawaiian or Other Pacific Islander: "Native Hawaiian or Other Pacific Islander", "Native Hawaiian/Other Pacific Islander", "Pacific Islander"; Hispanic/Latino: "Hispanic", "Hispanic or Latino"," Latino"; Other/Unknown: All other responses.

[8] The government's response to the pandemic continues to impact the Applicant's facilities. See, e.g., Order of the Commissioner of Public Health Regarding Scheduling and Performance of Elective Invasive Procedures, issued December 7, 2020. https://www.mass.gov/info-details/covid-19-state-of-emergency#health-care-delivery.

based settings and instead utilizes multiple access points in community settings, such as the Project Sites. Therefore, the Applicant believes that it is appropriate to use the historic utilization data (FY17 through FY19 and preliminary FY20) shown above to define its patient panel and to demonstrate the need for the Proposed Project, disregarding the anomalous utilization decline attributable to the measures taken in response to the COVID-19 pandemic.

B. The Patient Panel for the Project; Demographics and Payer Mix

As newly-formed organizations, neither IC nor AmSurg have their own existing patient panels. Therefore, the Applicant has determined that the most appropriate patient panel for the Proposed Project (the "Patient Panel") will be all of those individuals in the Applicant's patient panel (as described in paragraph A. above) who reside in the respective primary service areas of the Project Sites. For purposes of defining the Patient Panel, the primary service area of a Project Site is defined as those zip codes that are approximately within a 20-minute drive time of such Project Site.[9]

The Patient Panel has steadily increased since FY17, with 215,548 unique patients in FY17, 219,423 unique patients in FY18 and 227,371 unique patients in FY19. Preliminary data indicates that for the first three months of FY20 there were 96,861 unique patients in the Patient Panel.[10] In FY17, 49% of the Patient Panel had a Mass General Brigham primary care provider; this percentage increased to 52% in FY19. Approximately 41% of the Patient Panel identified as male and 59% identified as female. Current age demographics show that the majority (63%) of the Patient Panel is between 18-64 years of age. Patients 65 and older also make up a significant portion (26%) of the Patient Panel. Only 11% are between 0-17 years of age. Preliminary data for FY20[11] indicates an increase to 30% in the over 65 age cohort.

Data based on self-reporting demonstrates that in FY19, 77% of the Patient Panel identified as White; 5% identified as African American or Black; 6% identified as Asian; 1% identified as Hispanic/Latino; and 0.1% identified as Native Hawaiian or Other Pacific Islander. As noted above, since patients were grouped into these categories based on how they self-identified, there is a portion of the Patient Panel (11% in FY19) that chose either not to report their race or identified as a race that did not align with the aforementioned categories.

Information pertaining to the portion of the Patient Panel associated with each Project Site is set forth below. The demographic information for the Patient Panel, sorted by each Project Site, is set forth on Attachment 3, and the payer mix for the Patient Panel, sorted by each Project Site, is set forth on Attachment 4.

Westborough Site

The demographics of the portion of the Patient Panel associated with the Westborough Site is consistent with those of the Patient Panel as a whole. This portion of the Patient Panel has steadily increased since FY17, with 41,254 unique patients in FY17, 42,251 unique patients in FY18 and 42,666 unique patients in FY19 and, based on preliminary data, 16,208 unique patients for the first

[9] Attachment 2 sets forth the zip codes comprising the primary service area of each Project Site.
[10] Supra note 4.
[11] Supra note 4.

three months of FY20.[12] In FY17, 51% of the patients in the Patient Panel for the Westborough Site had a Mass General Brigham primary care provider and 48% of these patients were in a risk contract; these percentages grew to 53% and 55%, respectively, in FY19.[13]

Woburn Site

The demographics of the portion of the Patient Panel associated with the Woburn Site is consistent with those of the Patient Panel as a whole. This portion of the Patient Panel has steadily increased since FY17, with 97,072 unique patients in FY17, 98,587 unique patients in FY18 and 103,846 unique patients in FY19 and, based on preliminary data, 44,465 unique patients for the first three months of FY20.[14] In FY17, 45% of the patients in the Patient Panel for the Woburn Site had a Mass General Brigham primary care provider and 53% of these patients were in a risk contract; these percentages grew to 48% and 57%, respectively, in FY19.

Westwood Site

The demographics of the portion of the Patient Panel associated with the Westwood Site is consistent with those of the Patient Panel as a whole. This portion of the Patient Panel has steadily increased since FY17, with 77,222 unique patients in FY17, 78,585 unique patients in FY18 and 80,859 unique patients in FY19 and, based on preliminary data, 36,188 unique patients for the first three months of FY20.[15] In FY17, 53% of the patients in the Patient Panel for the Westwood Site had a Mass General Brigham primary care provider and 56% of these patients were in a risk contract; these percentages grew to 55% and 60%, respectively, in FY19.

[12] Supra note 4.
[13] The number of patients in risk contracts is slightly understated throughout this Application. This is because the Patient Panel includes employees of the Applicant's self-insured AllWays Health Partners product. However, due to confidentiality requirements, the Applicant is not able to determine which patients within the Patient Panel are both insured through AllWays Health Partners and are employees of the Applicant's health system. Therefore, these patients are included in the non-risk contract numbers.
[14] Supra note 4.
[15] Supra note 4.

F1.a.ii **Need by Patient Panel:**

Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.

A. Methodology for Determining Need for Clinical Services

The Proposed Project is designed to meet the current and projected future needs of the Patient Panel for the Clinical Services. As indicated below, historical volume trends indicate high utilization rates for each of the Clinical Services by the Patient Panel. In addition, industry projections forecast that the need for the Clinical Services will increase in the future, particularly as the 65+ patient population increases and requires diagnosis and treatment of age-related conditions. Through the Proposed Project, the Applicant seeks to meet the needs of the Patient Panel for Clinical Services in lower cost and more conveniently located community settings. The Applicant also believes that expanding access to the Clinical Services and co-locating the Clinical Services at each Project Site will encourage the Patient Panel to obtain a substantial amount of their healthcare services at the Project Sites.

For the purposes of this Application, however, the Applicant has elected to use a conservative projection of the volume of Clinical Services that will be provided to the Patient Panel at the Project Sites. First, the Applicant has assumed that by the end of a 3-year ramp-up period only seventy percent (70%) of the Patient Panel will choose to access Clinical Services at the Project Sites (the "Projected Utilization Rate"). The Projected Utilization Rate was derived by assuming that (i) one hundred percent (100%) of the members of the Patient Panel who have a Mass General Brigham primary care provider and (ii) fifty percent (50%) of the other members of the Patient Panel who have received specialty care or ambulatory surgery services from a Mass General Brigham provider will transfer their care to the Project Sites. Second, the Applicant has elected to determine the projected need for Clinical Services at the Project Sites based on the Patient Panel's FY19 utilization of such Clinical Services despite the fact that the Applicant projects that future utilization of Clinical Services at the Project Sites will increase over the FY19 utilization levels due to such factors as the increasing need for Clinical Services of an aging population (see paragraph E. below) and the attractiveness of having expanded access to Clinical Services co-located in convenient, community settings (see paragraph F. below).

B. Patient Panel Demand for Ambulatory Surgery Services

There are no independent community hospitals within the primary service area of any of the Project Sites.[16]

Ambulatory surgery has increased substantially in the United States over the last several decades as improvements in the administration of anesthesia and analgesics and the development and expansion of minimally invasive or non-invasive procedures have allowed ambulatory surgery to become more feasible.[17] Advances in medical devices and pharmaceuticals have also contributed to reduced recovery times, further facilitating migration of surgical procedures from inpatient to outpatient care and making it possible for patients who previously spent days in the hospital recovering from a surgical procedure to instead be discharged the same day as their surgery.[18] CMS and commercial health plans have recognized the benefits of ambulatory surgery and have expanded the scope of procedures for which they will reimburse for surgical procedures performed at an ambulatory surgery center.[19] The provision of less-invasive surgical services in an outpatient facility has also allowed for improved quality outcomes and a better surgical experience for patients, making ambulatory surgery an attractive alternative for certain patients in need of surgical services.

Given these benefits of ambulatory surgery, the Applicant believes that through the development of the Project Sites it will be able to offer the Patient Panel a more convenient and lower cost alternative for lower acuity and less invasive surgical procedures.

In order to ascertain the projected volume of Ambulatory Surgery Services and corresponding need for operating room ("OR") capacity at each Project Site, the Applicant determined that in FY19 the Patient Panel underwent 20,615 surgical procedures at one of the Applicant's existing facilities that could have been performed at a Project Site. Breaking this FY19 total down by Project Site, there were 4,369 of such surgical procedures for the Westborough Patient Panel members, 7,264 for the Westwood Patient Panel members, and 8,982 for the Woburn Patient Panel members. By applying the 70% Projected Utilization Rate to these FY19 totals, the Applicant projects that after a 3-year ramp-up period the Project Sites will have the following annual volumes of Ambulatory Surgery Services procedures associated with their respective Patient Panels: 3,201 procedures for the Westborough Site; 5,387 for the Westwood Site; and 5,937 for the Woburn Site. Assuming that each OR at a Project Site has a capacity of 1,000 procedures per year, the Applicant projects

[16] Health Policy Commission, Bulletin on Independent Community Hospitals for Determination of Need Applicants, HPC-2020-01, Issued: 02/20/2020, available at: https://www.mass.gov/doc/bulletin-hpc-2020-01-independent-community-hospitals/download

[17] *Outpatient Surgeries Show Dramatic Increase*, 10 HEALTH CAPITAL TOPICS 1 (2010), available at https://www.healthcapital.com/hcc/newsletter/05_10/Outpatient.pdf; Margaret J. Hall et al., *Ambulatory Surgery Data From Hospitals* and *Ambulatory Surgery Centers*: United States, 2010, 102 NAT'L HEALTH STATISTICS REPORTS 1 (2017), available at https://www.cdc.gov/nchs/data/nhsr/nhsr102.pdf; John Bian & Michael A. Morrisey, Free-Standing Ambulatory Surgery Centers and Hospital Surgery Volume, 44 INQUIRY 200 (2007), available at http://journals.sagepub.com/doi/pdf/10.5034/inquiryjrnl_44.2.200.

[18] Munnich EL, Parente ST. Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up. Health Aff (Millwood). 2014;33:764–769. doi:10.1377/hlthaff.2013.1281; Hall et al., *supra* note 17.

[19] Munnich & Parente, supra note 18.

that each Project Site will need a minimum of four (4) ORs to accommodate this projected volume of Ambulatory Surgery Services.[20]

C. Patient Panel Demand for the Physician Services at the Woburn and Westborough Sites[21]

Currently the members of the Patient Panel associated with the Woburn and Westborough Sites obtain primary and specialty care and behavioral health physician services at facilities of the Applicant outside of their respective communities. Under the Proposed Project, the Applicant (through IC) will provide primary care and behavioral health Physician Services at both the Westborough and Woburn Sites, and will also provide such specialty care Physician Services as are needed at each of those Project Sites based on ongoing assessments of evolving patient needs in the communities served by the Westborough and Woburn Sites. By providing the Physician Services at the Westborough and Woburn Sites, the Applicant will increase access to primary and specialty care and behavioral health Physician Services in convenient, community-based settings not only for the applicable members of the Patient Panel but also for other individuals who live in the primary service areas of the Westborough and Woburn Sites.

In order to ascertain the need for Physician Services at the Westborough and Woburn Sites, the Applicant first determined that in FY19 there were 55,385 visits for Physician Services by Westborough Patient Panel members and 174,063 such visits by Woburn Patient Panel members. By applying the 70% Projected Utilization Rate to these FY19 totals, the Applicant projects that after a 3-year ramp-up period the Patient Panel will utilize the Westborough Site for 42,267 Physician Services visits annually and the Woburn Site for 138,594 Physician Services visits annually.

D. Patient Panel Demand for MRI and CT Imaging Services[22]

The use of diagnostic imaging in the United States, including MRI and CT imaging, has increased significantly over the last two decades.[23] Several factors have contributed to this increase including

[20] The 1,000 procedures per OR per year amount is based on the assumptions that (i) the ambulatory surgery centers at the Project Sites will operate 9 hours per day, 5 days per week for 48 weeks annually; (ii) each surgical procedure will take an average of 95 minutes to complete (including both surgical case time and OR turnover time); and (iii) the ambulatory surgery centers will operate at 70% efficiency (i.e., an average 70% of the available procedure times will be utilized).

[21] See note 1 supra regarding physician services at the Westwood Site.

[22] While the Project Sites will provide an array of Imaging Services, including x-ray, ultrasound, ECHO, mammography, CT and MRI, this section of the Application will focus solely on the projected need for CT and MRI services at the Project Sites.

[23] Rebecca Smith-Bindman et al., *Rising Use Of Diagnostic Medical Imaging In A Large Integrated Health System*, 27 HEALTH AFFAIRS 1491 (2008), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765780/pdf/nihms-137739.pdf (last visited Jan. 5, 2021); Rebecca Smith-Bindman et al., *Use of Diagnostic Imaging Studies and Associated Radiation Exposure For Patients Enrolled in Large Integrated Healthcare Systems*, 1996-2010, 307 JAMA2400 (2012), *available* at https://jamanetwork.com/journals/jama/fullarticle/1182858 (last visited Jan. 5, 2021); Robert J. McDonald et al., *The Effects of Changes in Utilization and Technological Advancements of Cross-Sectional Imaging on Radiologist Workload*, 22 ACADEMIC RADIOLOGY 1191 (2015); Michael Walter, *Feeling overworked? Rise in CT, MRI images adds to radiologist workload*, RADIOLOGY BUSINESS (Jul. 31, 2015), https://www.radiologybusiness.com/topics/quality/feeling-overworked-rise-ct-mri-images-adds-radiologist-workload (last visited Jul. 17, 2019); *Increases in Imaging Procedures, Chronic Diseases Spur Growth of Medical Imaging Informatics Market*, IMAGING TECHNOLOGY NEWS (Oct. 28, 2016),

advancements in technology, expansion of clinical applications and patient-and physician-generated demand.[24] The development and improvement in these advanced diagnostic imaging technologies is widely credited with leading to improved patient outcomes – through earlier and more accurate diagnoses of disease using noninvasive techniques – as well as improved patient care processes.[25]

The Applicant has been no exception to this upward trend. Over the FY17 through FY19 period the number of CT and MRI scans received by members of the Patient Panel at one of the Applicant's facilities has grown from 26,453 CT and 17,731 MRI scans in FY17 to 27,926 CT and 19,777 MRI scans in FY18 and to 31,535 CT and 20,298 MRI scans in FY19.

Breaking the FY19 totals down by Project Site yields the following:

Project Site	FY19 CT Scans	FY19 MRI Scans
Westborough	5,174	4,006
Westwood	13,270	8,298
Woburn	13,091	7,994

This increased demand for CT and MRI services has impacted the Applicant's existing MRI and CT units across all of its locations, resulting in capacity constraints and extended wait times. For example, at one of the Applicant's downtown locations, the average wait time for an MRI scan is 39 days and for a CT scan is 23 days, and patients seeking outpatient MRI and CT services at one of the Applicant's community hospitals must wait, on average, 20 days for an MRI scan and 15 days for a CT scan.[26]

It is the Applicant's goal to provide real-time and/or same-day CT and MRI services appointment availability at the Project Sites so that the members of the Patient Panel will not have to make an additional trip to a Project Site or elsewhere for CT and MRI services. Studies show that shorter wait times for outpatient CT and MRI services are associated with greater patient satisfaction.[27] By adding CT and MRI units at the Project Sites, the Applicant will also be better able to accommodate demands for urgent CT and MRI scans at its other facilities. Additionally, the projected utilization supports multiple CT and MRI units at the Westwood Site and the Woburn Site, which will also

https://www.itnonline.com/content/increases-imaging-procedures-chronic-diseases-spur-growth-medical-imaging-informatics-market (last visited Jan. 5, 2021).

[24] Rising Use Of Diagnostic Medical Imaging In A Large Integrated Health System, supra note 23. Use of Diagnostic Imaging Studies and Associated Radiation Exposure For Patients Enrolled in Large Integrated Healthcare Systems, 1996–2010, supra note 23; McDonald et al., supra note 23; Walter et al., supra note 23; Increases in Imaging Procedures, Chronic Diseases Spur Growth of Medical Imaging Informatics Market, supra note 23.

[25] Rising Use Of Diagnostic Medical Imaging In A Large Integrated Health System, supra note 23. Use of Diagnostic Imaging Studies and Associated Radiation Exposure For Patients Enrolled in Large Integrated Healthcare Systems, 1996–2010, supra note 23; McDonald et al., supra note 23; Walter et al., supra note 23; Increases in Imaging Procedures, Chronic Diseases Spur Growth of Medical Imaging Informatics Market, supra note 23.

[26] Wait times were calculated by determining the average number of days between an order for a MRI or CT scan and the scan itself. In calculating the wait times, the Applicant looked at all of its currently available MRI and CT units.

[27] Holbrook A, Glenn, Jr. H, Mahmood R, et. al. Shorter Perceived Outpatient MRI Waiting Times Associated with Higher Patient Satisfaction, J Am Coll Radiol 2016;13:505-509.

facilitate immediate access for urgent cases and create capacity to address MRI and CT unit equipment malfunction issues, eliminate cancelling and rescheduling patients and reduce delays associated with urgent scans.

In order to ascertain the projected need for additional CT and MRI units at the Project Sites, the Applicant applied the 70% Projected Utilization Rate to the FY19 totals of CT scans and MRI scans received by the members of the Patient Panel associated with each of the Project Sites shown above, and the result is the following projected annual number of CT and MRI scans at each Project Site after a 3-year ramp-up period:

Project Site	Projected CT Scans	Projected MRI Scans
Westborough	3,963	3,054
Westwood	10,598	6,963
Woburn	9,701	5,944

Assuming that the units to be located at the Project Sites have an annual capacity of approximately 4,900 CT scans and 3,275 MRI scans,[28] the Applicant projects a need for one 1.5T MRI unit, one 3T MRI unit and two 128-slice CT units at each of the Westwood Site and the Woburn Site and one 1.5T MRI unit and one 128-slice CT unit at the Westborough Site.[29] The cumulative total of MRI and CT units for the Proposed Project is three 1.5T MRI units, two 3T MRI units, and five 128-slice CT units.

E. Need for the Clinical Services for an Aging Patient Population

The Proposed Project also will allow the Applicant to address the needs of an aging Patient Panel for improved access to the Clinical Services. As noted above, 30% of the Patient Panel is 65 years old or older. According to the University of Massachusetts Donahue Institute's ("UMDI") *Long-Term Population Projections for Massachusetts Regions and Municipalities*, the statewide population is projected to grow a total of 11.8% from 2010 through 2035.[30] An analysis of UMDI's projections shows that the growth of the Commonwealth's population is segmented by age sector and that within the next 20 years the bulk of the state's population growth will cluster around residents that are age 50 and older.[31] Moreover, between 2015 and 2035, the Commonwealth's

[28] The annual CT and MRI unit capacities are based on the assumptions that (i) the units at the Project Sites will operate 10 hours per day, 6 days per week for 48 weeks annually; (ii) each CT scan and MRI scan will take an average of 30 minutes and 45 minutes, respectively, to complete; and (iii) the CT and MRI units will operate at 85% efficiency (i.e., an average of 85% of the available scanning times will be utilized).

[29] The Westborough Site will be constructed, with necessary shielding, to accommodate an additional 1.5T MRI unit and 128-slice CT unit to accommodate future CT and MRI demand at the Westborough Site. The Applicant will obtain all required Department approvals prior to implementing additional CT or MRI units at the Westborough Site.

[30] University of Massachusetts Donahue Institute, Long-term Population Projections for Massachusetts Regions and Municipalities 11 (Mar. 2015), available at http://pep.donahue-institute.org/downloads/2015/new/UMDI_LongTermPopulationProjectionsReport_2015%2004%20_29.pdf. The Massachusetts Secretary of the Commonwealth contracted with the University of Massachusetts Donahue Institute (UMDI) to produce population projections by age and sex for all 351 municipalities. Id. at 7. Within the past five years, Massachusetts has been experiencing an increase in the population growth rate per year due to high immigration and low domestic outflow, which is expected to slow down in 2030. *Id*. at 12.

[31] *Massachusetts Population Projections – EXCEL Age/Sex Details*, UNIVERSITY OF MASSACHUSETTS DONAHUE INSTITUTE (2015), http://pep.donahue-institute.org/downloads/2015/Age_Sex_Details_UMDI_V2015.xls. This data has been extracted for counties where current Mass General Brigham's hospitals and affiliates are located. *Id.*

65+ population is expected to increase at a higher rate compared to all other age cohorts.[32] By 2035, the 65+ age cohort will represent approximately a quarter of the Massachusetts population.[33] The general trend of growth appears consistent across the counties where the Applicant's affiliates (including IC and AmSurg) are or will be located. The demand for the Clinical Services by this aging population is expected to increase as well.

Over the last 20 years, the number of older people undergoing surgical procedures has increased faster than the rate of population aging.[34] Approximately, 53% of all surgical procedures are performed on the 65+ age cohort. This is likely to be related to changes in anesthetic and surgical techniques, patient expectations and increasing evidence of improved morbidity and mortality following surgery even in the oldest cohorts.[35] Consequently, recent projections estimate that approximately half of the population over the age of 65 will require surgery at least once in their lifetime.[36] As noted above, all of the Ambulatory Surgery Services procedures received by the Patient Panel over the last three fiscal years were performed at one of the Applicant's facilities, and a significant portion of the Patient Panel is the 65+ age cohort. Through the creation of the Project Sites, these Ambulatory Surgery Services can be shifted to the outpatient community ambulatory surgery setting. The projected increase in the 65+ population in tandem with the volume of older adults seeking lower-acuity surgical services necessitates the need for additional options for the Applicant's patients to obtain outpatient surgical care. Accordingly, through the Proposed Project the Applicant seeks to expand access to lower-acuity and less-invasive surgical capacity in the community for this aging population through the addition of four ORs at each of the Project Sites.

Literature on patterns of CT and MRI use indicate that imaging rates tend to be higher among older adults.[37] According to a study published in 2013, average MRI and CT utilization rates were approximately 24, 72, 159, and 240 per 1,000 persons for ages <18, 18-44, 45-54 and 65+ years, respectively.[38] The high MRI and CT utilization rates among older adults are likely related to the modalities' capabilities in the diagnosis and treatment of age-related conditions. Specifically, MRI and CT have proven effectiveness in the fields of oncology, cardiology, neurology and orthopedics, among others.[39] The capability of MRI and CT in these fields is particularly important

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[32] UNIVERSITY OF MASSACHUSETTS DONAHUE INSTITUTE, *supra* note 31, at 14. The report uses the cohorts as defined by the U.S. Census Bureau 2010 Census Summary, which are 0-19, 20-39, 40-64, and 65+. *Id.* Figure 2.5 in the report demonstrates that where the 65+ cohort increases from 2015 to 2035, all other cohorts are predicted to decrease. *Id.*

[33] *Id.*

[34] Judith S. L. Partridge et al., Frailty in the older surgical patient: a review, 41 AGE AND AGEING 142 (2012), available at https://academic.oup.com/ageing/article/41/2/142/47699.

[35] Id.

[36] Relin Yang et al., *Unique Aspects of the Elderly Surgical Population: An Anesthesiologist's Perspective*, 2 GERIATRIC ORTHOPAEDIC SURGERY & REHABILITATION 56 (2011), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3597305/.

[37] Rising Use Of Diagnostic Medical Imaging In A Large Integrated Health System, supra note 23; Kathleen Lang et al., National trends in advanced outpatient diagnostic imaging utilization: an analysis of the medical expenditure panel survey, 2000-2009, 13 BMC MED. IMAGING 40 (2013), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4222739/.

[38] Lang et al., *supra* note 37.

[39] Lawrence N. Tanenbaum, *3T MRI in clinical practice*, 34 APPLIED RADIOLOGY 8 (2005), *available at* https://appliedradiology.com/articles/3t-mri-in-clinical-practice; *Magnetic Resonance Imaging (MRI)*, RADIOLOGYINFO.ORG, available at https://www.radiologyinfo.org/en/submenu.cfm?pg=mri (last visited Jan. 5,

for older adults as research studies and their findings demonstrate that the prevalence of cancer increases with age, and that age is also a leading risk factor for cardiovascular disease and certain neurological and musculoskeletal disorders.[40]

F. The Value of Co-Locating Clinical Services in a Community Setting

Though the Applicant currently has a number of outpatient surgery centers, MRI and CT units and physician offices located in the greater Boston area, these other Applicant locations are not located in the primary service area of the Project Sites. The Proposed Project will provide members of the Patient Panel with the convenience of receiving all of the Clinical Services in an integrated care setting closer to home, thereby increasing patients' access to the Clinical Services. Siting the Clinical Services at each Project Site rather than expanding capacity at one of the Applicant's existing facilities will provide the Patient Panel with increased access to an alternative, lower-cost, comprehensive, community-based care within the Patient Panel's communities. The Proposed Project will also break down barriers to obtaining necessary care (e.g., lack of providers of Clinical Services in the community, driving to Boston, expensive parking, etc.), and offer the opportunity for a greater number of Mass General Brigham patients to receive care close to home, including primary and behavioral health care. The benefits of co-locating the Clinical Services at the Project Sites are further discussed in Sections F1.b.i and F1.b.ii below. Moreover, the co-location of Clinical Services at each Project Site will afford patients the opportunity to receive a continuum of integrated surgical, imaging, primary and specialty care and behavioral health services in one convenient community-based location.

2021) [hereinafter *MRI*]; Carlo Liguori et al., *Emerging clinical applications of computed tomography*, 8 MED. DEVICES 265 (2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467659/; *Computed Tomography*, RADIOLOGYINFO.ORG, https://www.radiologyinfo.org/en/submenu.cfm?pg=ctscan (last visited Jan. 5, 2021); *Applications and Clinical Benefits of CT Imaging*, IMAGINIS, available at http://www.imaginis.com/ct-scan/applications-and-clinical-benefits-of-ct-imaging (last visited Jan. 5, 2021).

[40] WORLD HEALTH ORGANIZATION, WORLD REPORT ON AGEING AND HEALTH (2015), *available at* http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf; Nathan A. Berger et al., *Cancer in the Elderly*, 117 TRANSACTIONS OF THE AMERICAN CLINICAL AND CLIMATOLOGICAL ASSOCIATION 147 (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1500929/pdf/tacca117000147.pdf; *Coronary Heart Disease: Risk Factors*, NATIONAL HEART, LUNG & BLOOD INSTITUTE, https://www.nhlbi.nih.gov/health/health-topics/topics/cad/atrisk (last visited Jan. 5, 2021); *Atherosclerosis: Risk Factors*, NATIONAL HEART, LUNG & BLOOD INSTITUTE, https://www.nhlbi.nih.gov/health-topics/atherosclerosis (last visited Jan. 5, 2021); MARTA KOWALSKA ET AL., *Chapter 5: Aging and Neurological Diseases, in* SENESCENCE: PHYSIOLOGY OR PATHOLOGY (Jolanta Dorszewska & Wojciech Kozubski eds., 2017), *available at* https://www.intechopen.com/books/senescence-physiology-or-pathology/aging-and-neurological-diseases; Ramon Gheno et al., *Musculoskeletal Disorders in the Elderly*, 2 J. CLINICAL IMAGING SCI. 1 (2012), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424705/.

F1.a.iii **<u>Competition</u>:**

Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.

The Proposed Project will not have an adverse impact on competition in the Massachusetts health care market based on price, TME, provider costs or other recognized measures of health care spending as evidenced by the information below.

By co-locating the Clinical Services at each Project Site, the Applicant can take advantage of certain efficiencies of co-located services. For its ambulatory care strategy, the Applicant has determined that it is more cost effective to co-locate the Clinical Services at the Project Sites, and not expand capacity elsewhere within the Applicant's system. Consequently, the Proposed Project competes on the basis of provider cost.

Due to Medicare requirements with respect to reimbursement of outpatient services, the Applicant will not receive outpatient hospital rates for the provision of any of the Clinical Services at the Project Sites. Consequently, by shifting patients to an equally high-quality, but more cost-efficient setting for the Ambulatory Surgery Services, the Proposed Project will have a positive effect on the overall Massachusetts healthcare market by lowering the cost of Clinical Services for the Patient Panel.

By providing Ambulatory Surgery Services at each Project Site, the Applicant's hospitals will be able to maximize efficiency and quality outcomes for patients. For example, on average, the Medicare program and its beneficiaries share in more than $2.3 billion in savings each year when patients receive certain preventive and surgical procedures at freestanding ambulatory surgery centers instead of other outpatient surgical facilities.[41] Since ambulatory surgery centers focus on performing specific services and do so more efficiently, Medicare reimburses ambulatory surgery centers as a percentage of the amount paid to hospital outpatient departments ("HOPDs").[42]

In 2003, Medicare procedures performed in ambulatory care centers cost 83% of the amount paid to HOPDs for the same services. As of August 2016, procedures performed in an ambulatory care center cost Medicare just 53% of the amount paid to HOPDs.[43] The Applicant estimates that it will be 25% less costly to receive the Ambulatory Surgery Services at a Project Site, as compared to one of the Applicant's community hospitals.[44]

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[41] *THE ASC COST DIFFERENTIA*L, AMBULATORY SURGERY CENTER ASS'N, HTTP://WWW.ASCASSOCIATION.ORG/ADVANCINGSURGICALCARE/REDUCINGHEALTHCARECOSTS/PAYMENTDISPARITIESBETWEENASCSANDHOPDS (LAST UPDATED AUG. 2016) (stating that for the year 2016, Medicare pays hospitals $1,745 for performing an outpatient cataract surgery while paying ASCs only $976 for performing the same surgery. Beneficiary savings are also significant with a typical cataract surgery costing a beneficiary $349 in the HOPD setting and $195 in an ASC). *Id*.

[42] Id.

[43] *Id*.

[44] The savings are calculated based on the average rates from the Applicant's top three payers.

A 2014 *Health Affairs* article also discusses the key reimbursement differences between inpatient, HOPD and ambulatory surgery center settings.[45] Using data on procedure length, researchers found that ambulatory surgery centers provide a lower-cost alternative to hospitals as venues for outpatient surgeries due to operating efficiencies that lead to reductions in cost.[46] On average, procedures performed in ambulatory surgery centers take 31.8 fewer minutes than those performed in hospitals—a 25% difference relative to the mean procedure time.[47] Consequently, in a comparison of an ambulatory surgery center and a HOPD that have the same number of staff and of operating and recovery rooms, the ambulatory surgery center can perform more procedures per day than the hospital.[48] Researchers estimated the cost savings for an outpatient procedure performed in an ambulatory surgery center using the noted time differences in procedures and estimates of the cost of operating room time.[49] Estimated charges for this time are $29–$80 per minute, not including fees for the surgeon and anesthesia provider.[50] This calculation suggests that even excluding physician payments and time savings outside of the operating room, ambulatory surgery centers could generate savings of $363–$1,000 per outpatient case.[51] These results support the claim that ambulatory surgery centers provide outpatient surgery at lower costs than hospitals.[52]

TME is based on price and utilization; by moving existing patients to a more cost-effective setting, the Proposed Project seeks to lower the cost for Ambulatory Surgery Services, while enabling the Applicant to more effectively manage utilization and resources across its system. Thus, the Proposed Project will have a positive impact on TME as these patients will no longer need to be seen in higher cost settings, such as academic medical centers. For Ambulatory Surgery Services, the Applicant estimates that $7,900,000 will be saved for every 1,000 patients treated at a Project Site versus one of the Applicant's other facilities. Based on the aforementioned data and examples, shifting patients to a lower-cost setting for appropriate lower-acuity and less-invasive surgeries will have a positive impact on the Massachusetts healthcare market through the creation of operating efficiencies that lead to cost reductions in overall care and, ultimately, TME. These efficiencies and savings are created without sacrificing quality or patient experience.

As discussed in Section F1.a.ii, the Applicant's facilities have seen an increase in demand for CT and MRI services each year over past three years. Notwithstanding the Applicant's efforts to meet increased demand, including operating with extended hours and adding additional MRI and CT units throughout its system, the Applicant's existing CT and MRI units are at or near capacity. The Applicant expects the demand for CT and MRI services at the Project Sites to increase in the coming years in connection with both an expansion in the population seeking the Clinical Services (both overall population increase and an increase in the elderly population) and planned implementation of the Physician Services and Ambulatory Surgery Services at each Project Site. The Applicant projects that for CT and MRI services, approximately $1,750,000 will be saved for

[45] Munnich & Parente, *supra* note 18.
[46] *Id*.
[47] Id.
[48] Id.
[49] Id.
[50] *Id*.
[51] Id.
[52] Id.

every 1,000 patients of the Applicant that are seen at a Project Site versus one of the Applicant's other facilities.

As noted throughout this Application, the Proposed Project is part of the Applicant's ambulatory care strategy to meet the health care needs of its Patient Panel, in this case the residents of Westborough, Westwood, Woburn, and the surrounding communities of each, at a convenient community-based patient-focused location. The overall effort will help to address primary, specialty care and behavioral health care access challenges and shortages. By providing Physician Services, including increased primary care capacity at the Project Sites, and coordinating these services with specialty clinical services, embedded behavioral health services, Ambulatory Surgery Services and CT and MRI services, the Applicant can more efficiently and effectively meet the health care needs of many of the Applicant's patient panel living within the primary service area of each Project Site. This will eliminate or limit the need for those residents to travel far outside their community for many of the Applicant's services, and as discussed in Section F1.b.ii(A), the Project Sites will offer care to patients in person and digitally to ensure patients get the right care at the right time in the most accessible and cost-effective manner.

F1.b.i **Public Health Value /Evidence-Based:**

Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

A. Applicant's Proposed Establishment of the Project Sites

The Proposed Project is supported by Patient Panel need, including, as detailed in Section F1.a.ii, an increased prevalence of conditions that require Ambulatory Surgery Services and MRI and CT scans, as well as evidence-based research. Each Project Site will provide the full complement of Clinical Services.[53]

The Ambulatory Surgery Services consist of surgical services that do not require an overnight stay in a hospital or visit to an emergency department and are limited in scope and will be performed in an OR at one of the Project Sites. To accommodate growth in lower-acuity surgical demand within the Applicant's patient panel and increase its offering of accessible, lower-cost community-based surgical care, the Applicant proposes to expand its OR capability through the provision of the Ambulatory Surgery Services at the Project Sites.

The Proposed Project will also include the Physician Services and the CT and MRI units, described in Section F1.a.ii above.

B. Research Supporting the Proposed Project

Summarized below is evidence-based analysis supporting the provision of the Clinical Services in an outpatient setting. As an overview, this analysis focuses on quality of care, efficiency, dependability and convenience. Cost-savings are also associated with providing the Clinical Services in outpatient facilities; however, these arguments are addressed above. Finally, the operating costs of providing the Clinical Services at the Project Sites is lower than providing these services at one of the Applicant's hospitals.

High-Quality Ambulatory Surgery Services

Ambulatory care – i.e. personal health care consultation, treatment, surgery, or other health care services provided by health care professionals in outpatient settings – is quickly emerging as one of the fastest growing segments of the U.S. health care market[54] An important reason for the expansion of ambulatory care lies in the fact that compared with the traditional hospital care settings, ambulatory care settings – including medical offices and clinics, diagnostic imaging

[53] Certain Mass General Brigham physician practices currently provide physician services in an existing medical office building at the Westwood Site. These practices will continue to provide such physician services after the Applicant develops a second, adjacent building at the Westwood Site as part of the Proposed Project.

[54] Bernard J. Healey & Tina Marie Evans, *Chapter 5: Ambulatory Care Services, in* Introduction to Health Care Services: Foundations and Challenges (Jossey-Bass 1st ed. 2014); Harry A. Sultz & Kristina M. Young, *Chapter 4: Ambulatory Care, in* Health Care USA (Jones and Bartlett Publishers 6th ed. 2009); *Helping you choose: Quality ambulatory care*, The Joint Commission, https://www.jointcommission.org/assets/1/6/HYC_ahc.pdf (last visited Jan. 5, 2021); *Ambulatory Care*, Agency for Healthcare Research & Quality, https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/ambulatory-care/index.html (last updated Feb. 2018).

centers, ambulatory surgery centers, and hospital outpatient departments – provide similar quality services.[55] While some ambulatory care settings are general practice, others have evolved to meet the needs of patients with specialized medical requirements.[56] Due to advances in technology that have made it more possible to use CT and MRI services to perform diagnostic and interventional tests and procedures in the outpatient setting, many health care facilities have expanded to offer a range of services such as diagnostic imaging.[57] Moreover, the Applicant will assure that providers have the opportunity to advance knowledge and care in their specialty areas, so that their patients will benefit from having excellent community access to highly trained professionals who have researched and developed innovative ways to diagnose and care for the patients' conditions.[58]

It is recognized and established that, compared with hospital settings, outpatient surgical facilities provide similar or higher quality services, as well as excellent access to physicians who are skilled in particular areas of need.[59] Moreover, the outpatient surgical setting enhances patient care by allowing: (i) physicians to focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources, and the attention of management; and (ii) physicians to intensify quality control processes, since outpatient settings are focused on a smaller space and a small number of ORs.[60] The Ambulatory Surgery Services that will be provided at each of the Project Sites will adhere to the same quality standards and will utilize the same technologies and advanced surgical tools as those available at the Applicant's main hospital campus locations, and will be staffed by highly specialized, focused, and trained physicians and staff.

Efficiencies Associated with Outpatient Surgery Setting

In addition to providing high-quality care, outpatient facilities also operate at high efficiency.[61] Outpatient surgical departments, by design, focus on a limited scope of surgical procedures that are lower-acuity and do not require an overnight stay.[62] At the Project Sites, the focus will be on

[55] HEALEY & EVANS, *supra* note 54; SULTZ & YOUNG, *supra* note 54; *Helping you choose: Quality ambulatory care*, *supra* note 54; *Ambulatory Care*, *supra* note 54.
[56] HEALEY & EVANS, *supra* note 54.
[57] HEALEY & EVANS, supra note 54.
[58] HEALEY & EVANS, *supra* note 54.
[59] POSITION STATEMENT: AMBULATORY SURGICAL CENTERS (Am. Ass'n of Orthopaedic Surgeons 2010), *available at* https://www.aaos.org/uploadedFiles/1161%20Ambulatory%20Surgical%20Centers.pdf; Munnich & Parente, *supra* note 18; BERNARD J. HEALEY & TINA MARIE EVANS, *Chapter 5: Ambulatory Care Services, in* INTRODUCTION TO HEALTH CARE SERVICES: FOUNDATIONS AND CHALLENGES 110-14 (Jossey-Bass 1st ed. 2014); HARRY A. SULTZ & KRISTINA M. YOUNG, *Chapter 4: Ambulatory Care, in* HEALTH CARE USA 122-24 (Jones and Bartlett Publishers 6th ed. 2009).
[60] AMBULATORY SURGERY CENTERS: A POSITIVE TREND IN HEALTH CARE (Ambulatory Surgery Center Ass'n), *available at* http://www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/apositivetrendinhealthcare.
[61] Position Statement: Ambulatory Surgical Centers, *supra* note 59.
[62] Mona Al-Amin & Michael Housman, *Ambulatory surgery center and general hospital competition: entry decisions and strategic choices*, 37 HEALTH CARE MANAGEMENT REVIEW 223 (2012); POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note; Dennis C. Crawford et al., *Clinical and Cost Implications of Inpatient Versus Outpatient Orthopedic Surgeries: A Systematic Review of the Published Literature*, 7 ORTHOPEDIC REVIEW 116 (2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4703913/pdf/or-2015-4-6177.pdf.

lower-acuity orthopedic, general surgery, otolaryngology, and ophthalmology procedures that are clinically appropriate for an outpatient delivery setting.

This focused approach is characterized by greater uniformity in cases referred and, thus, less variation in the types of procedures performed.[63] With less variety, surgical schedules are more predictable and the outpatient facility is better able to predict the resources it needs to maintain and lower costs for operation.[64] For instance, the ORs are often designed for specific types of procedures, and equipment and supplies that are best suited to these procedures are set up by the same clinical staff who often work together on a daily basis, which makes surgery much easier to schedule and perform.[65] Moreover, repeated delivery of a comparatively limited range of surgeries by specially trained and highly skilled experts allows for honing of techniques and provision of increased levels of high-quality care in less time.[66] Overall, this relatively narrow focus promotes increased efficiencies among care providers, maximizes the value of necessary staff resources and medical supplies, and leads to improved operational efficiency and economies of scale, which in turn translates into increased productivity, faster OR and procedure room turnover, and more patients receiving quality care with shorter wait times.[67]

Dedicated Operating Rooms & Reduced Delays for Ambulatory Surgery Services

Another advantage of the provision of surgery in the outpatient setting is that it allows physicians and patients to avoid delays inherent in an acute care hospital OR setting. In a hospital setting, scheduled outpatient procedures are always at risk of being delayed or moved due to emergency surgeries and procedures that take longer than expected, which adversely impacts patients and providers.[68] An outpatient surgical setting, on the other hand, can generally stay within a set schedule since the procedures are less complex, more routine, and are not likely to be delayed.[69] Thus, while the Ambulatory Surgery Services provided at a Project Site will be identical to those same services accessed through a hospital on an outpatient basis, patients will benefit from ORs dedicated solely to the Ambulatory Surgery Services and will experience greater scheduling efficiencies.[70]

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[63] David Cook et al., *From 'Solution Shop' Model to 'Focused Factor' In Hospital Surgery: Increasing Care Value and Predictability*, 33 HEALTH AFFAIRS 746 (2014), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1266; POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59.

[64] Cook et al., *supra* note 63; POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59.

[65] POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59.

[66] Cook et al., *supra* note 63; POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59; Munnich & Parente, *supra* note 18; AMBULATORY SURGERY CENTERS: A POSITIVE TREND IN HEALTH CARE, *supra* note 60.

[67] POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59; Cook et al., *supra* note 63.

[68] POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59; *The Benefits of Outpatient Surgical Centers*, THE CTRS. FOR ADVANCED ORTHOPAEDICS (Jun. 15, 2017), https://www.cfaortho.com/media/news/2017/06/the-benefits-of-outpatient-surgical-centers; Crawford et al., *supra* note 62; HEALEY & EVANS, *supra* note 54; SULTZ & YOUNG, *supra* note 54.

[69] POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59; *The Benefits of Outpatient Surgical Centers*, *supra* note 68; Crawford et al., *supra* note 62.

[70] POSITION STATEMENT: AMBULATORY SURGICAL CENTERS, *supra* note 59; *The Benefits of Outpatient Surgical Centers*, *supra* note 68; Crawford et al., *supra* note 62.

Convenience for Patients and Families of Patients Receiving the Clinical Services

The Project Sites will provide enhanced convenience for patients and their families.[71] Two factors frequently lacking on hospital campuses, and the large medical building complexes associated with them, are convenient location and easily accessible facilities and services.[72] This is of particular concern in large urban settings, such as Boston, where inner-city congestion, an aging and at times unreliable public transportation system, traffic, and limited and costly parking play a role in reducing accessibility.[73] Ambulatory and clinic facilities, such as the Project Sites, are preferred by patients and families as they are more accessible and offer an opportunity to bypass the hassles of dealing with a large, complex hospital campus.[74] Generally, and as will be the case at the Project Sites, patients enter the easily navigable facility directly from available free parking, which eliminates the need for the ill, injured, or elderly patient to walk through a maze of hallways to reach the correct hospital department.[75] Moreover, patients and their families benefit from the accessibility of these services within the community; each Project Site is conveniently located and brings accessible, world-class care to communities west and north of Boston.[76]

To help engage patients and plan for the design, functionality, and patient experience at the Project Sites, the Applicant engaged IDEO, an organization focused on human-centered design. With IDEO, the Applicant has focused the design and development of the Project Sites on reimagining the patient care experience, before, during and after a member of the Patient Panel receives the Clinical Services at a Project Site. The design of the Project Sites not only seeks to improve the patient experience, but seeks to increase physician, staff, care providers, and others' satisfaction when engaging with the Project Sites.

As part of the design of the Project Sites, the Applicant, IDEO, and the architects view community engagement, activation, and involvement as a core component of the care experience. This includes building engagement and connection with the Patient Panel, both on-site at a Project Site and off-site, by integrating partnered services from each community into the Project Sites and into the lives of the Patient Panel. For example, the Applicant anticipates that the Project Sites will provide a dedicated community gathering space to highlight health-related local businesses and host community-centered events aimed at having a positive effect on the health of the community. Such space may be used to host farmers markets and other opportunities to increase connections between individuals and healthy activities.

High Quality CT and MRI Services

The CT and MRI services that the Applicant proposes to provide at the Project Sites will be identical to those a patient can access at one of the Applicant's main hospital campus locations and will adhere to strict quality standards. Specifically, the Project Sites will follow a robust Clinical

[71] HEALEY & EVANS, *supra* note 54; SULTZ & YOUNG, *supra* note 54; Munnich & Parente, *supra* note 18.
[72] HEALEY & EVANS, *supra* note 54; SULTZ & YOUNG, *supra* note 54.
[73] HEALEY & EVANS, *supra* note 54; SULTZ & YOUNG, *supra* note 54. *See also INRIX: Congestion Costs Each American 97 hours, $1,348 A Year, available at* http://inrix.com/press-releases/scorecard-2018-us/ (reporting that Boston has the nation's worst rush hour traffic and highest cost of congestion per driver).
[74] HEALEY & EVANS, *supra* note 54; SULTZ & YOUNG, *supra* note 54.
[75] HEALEY & EVANS, *supra* note 54.
[76] SULTZ & YOUNG, *supra* note 54; *Mass General Waltham Maps & Directions*.

Quality Assurance Program. This Program, which is currently in place at the Applicant's existing clinic locations, will utilize input from the Applicant and the Applicant's hospitals and departments of imaging in order to develop efficient and effective procedures to ensure patients receive high-quality, patient-focused CT and MRI services and related diagnostic and support care. The Project Sites will also utilize the Clinical Quality Assurance Program to provide necessary oversight to its CT and MRI services, including supervising clinical service provision and conducting any necessary quality reviews, and all staff members will be informed of quality assurance protocols and procedures as well as acceptable practice standards. Combined with the fact that the CT and MRI services will have the same advanced technologies as the Applicant's main hospital campus locations, as well as highly specialized, focused, and trained physicians and staff, these quality assurance mechanisms ensure that the CT and MRI services Patient Panel will receive excellent CT and MRI services at the Project Sites.

MRI as an Imaging Modality

MRI is a well-established, non-invasive imaging system that uses a magnetic field combined with pulses of radio waves to produce detailed images of organs, tissues, and structures within the human body.[77] MRI has the major benefit of imaging the human body without the need for ionizing radiation.[78] Today, MRI is not only capable of performing anatomic imaging, but also allows for dynamic functional assessment of pathology that is integral to assessing treatment effects. Research into the various uses and benefits of MRI is extensive, with studies focusing on specific diseases, as well as parts of the body that may benefit from this imaging modality. Some of the most prevalent conditions for which patients seek MRI services involve the brain, spine, breast, prostate, heart and musculoskeletal system, among other parts of the body.[79] MRI, and specifically 3T MRI, is the preferred imaging modality for the prostate and breast.[80] In addition, MRI can

[77] Magnetic Resonance Imaging (MR/). NAT'L INST. OF BIOMEDICAL IMAGING & BIOENGINEERING, https://www.nibib.nih.gov/science-education/science-topics/magnetic-resonance-imaging-mri (last visited Jan. 5, 2021).

[78] Id.

[79] Gail Dean Deyle, *The role of MRI in musculoskeletal practice:* a *clinical perspective,* 19 J. MANUAL & MANIPULATIVE THERAPY 152 (2011), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3143009/ (last visited Jan. 5, 2021); Maravi et al., *Role of MRI in Orthopaedics,* 21 ORTHOPAEDIC J. M.P. CHAPTER 74 (2015); Apostolos H. Karantanas, *What's new in the use of MRI in the orthopaedic trauma patient?,* 45 lNT'L J. CARE INJURED 923 (2014), *available at* https://www.ncbi.nlm.nih.gov/pubmed/24502985 (last visited Jan. 5, 2021); *Tests for Bone Cancer,* AM. CANCER Soc'y, https://www.cancer.org/cancer/bone-cancer/detection-diagnosis-staging/how-diagnosed.html (last updated Feb. 5, 2018); *Tests for Osteosarcoma,* AM. CANCER Soc'y https://www.cancer.org/cancer/osteosarcoma/detection-diagnosis-staging/how-diagnosed.html (last updated Jan. 30, 2018); Duarte Nascimento et al, *The role of magnetic resonance imaging in the evaluation of bone tumours and tumour-like lesions,* 5 INSIGHTS IMAGING 419 (2014), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4141345/ (last visited Jan. 5, 2021); *Magnetic Resonance Imaging (MRI) – Head,* RADIOLOGYINFO.ORG, https://www.radiologyinfo.org/en/info.cfm?pg=headmr (last updated Feb. 5, 2019); M. Symms et al., *A review of structural magnetic resonance neuroimaging*, 75 J. NEUROLOGY, NEUROSURGERY & PSYCHIATRY 1235 (2004), *available at* http://jnnp.bmj.com/content/jnnp/75/9/1235.full.pdf; *What is fMRI?,* UC SAN DIEGO CTR. FOR FUNCTIONAL MRI, http://fmri.ucsd.edu/Research/whatisfmri.html (last visited Jan. 5, 2021); Marc C. Mabray et al., *Modern Brain Tumor Imaging,* 3 BRAIN TUMOR RESEARCH & TREATMENT 8 (2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4426283/.

[80] Jurgen J. Futterer & Jelle O. Barentsz, *3T MRI of prostate cancer*, APPLIED RADIOLOGY (Feb. 12, 2009), https://www.appliedradiology.com/articles/3t-mri-of-prostate-cancer; Reni S. Butler et al., *3.0 Tesla vs 1.5 Tesla breast magnetic resonance imaging in newly diagnosed breast cancer patients*, 5 WORLD J. RADIOLOGY 285 (2013), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3758496.

decrease the need for more invasive procedures, including, in some prostate cancer cases, the need to biopsy.[81] In the breast, multiple studies have shown that MRI is the most sensitive means of assessing the extent of malignancy in women diagnosed with breast cancer.[82] These studies suggest that 3T MRI is more accurate for pre-operative assessment of breast cancer extent, and therefore, that 3T MRI can be a valuable guide to surgical planning and a valuable tool in improving treatment outcomes.[83]

Finally, MRI is valuable in the diagnosis and management of a variety of conditions affecting the cardiovascular system.[84] Cardiac MRIs allow for gold standard level imaging of cardiac structure, and are designed to provide accurate assessments of morphology, volumes and flow quantification, myocardial perfusion, and tissue characterization.[85] While MRI of the cardiovascular system can be used for all age cohorts, it is particularly important for older adults with age-related cardiovascular conditions.[86]

3T MRI

Over the last four decades, technical and engineering advances have yielded MRI systems with higher field strengths, and today most clinical MRIs operate at field strengths of 1.5T or 3T.[87] Clinical application of higher magnetic field strengths, such as 3T, has several advantages. Most notably, increased magnetic field strength is associated with better diagnostic image quality (i.e. higher resolution images, better contrast between different tissues, and increased ability to image smaller structures with improved resolution), which is beneficial when diagnosing neurologic, oncological, and musculoskeletal, and cardiovascular conditions affecting these areas of the

[81] Mehralivand S, Shih J, Rais-Bahrami S, et al. A Magnetic Resonance Imaging-Based Prediction Model for Prostate Biopsy Risk Stratification. *JAMA. Oncol.* 2018;4(5):678-685.
[82] Butler et al., supra note 80; Habib Rahbar et al., Accuracy of 3T versus 1.5T breast MRI for pre-operative assessment of extent of disease in newly diagnosed DCIS, 84 EUROPEAN J. RADIOLOGY 611 (2015), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4348176/.
[83] Rahbar et al., *supra* note 82.
[84] Constantin B. Marcu et al., *Clinical applications of cardiovascular magnetic resonance imaging*, 175 CMAJ 911 (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586078/.
[85] *Id.*; F. Alfayoumi, *Evolving clinical application of cardiac MRI*, 8 REVIEWS IN CARDIOVASCULAR MED. 135 (2007), *available at* https://www.ncbi.nlm.nih.gov/pubmed/17938613; Wen-Yih Isaac Tseng et al., *Introduction to Cardiovascular Magnetic Resonance: Technical Principles and Clinical Applications*, 32 ACTA CARDIOLOGICA SINICA 129 (2016), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816912/; Matthias G. Friedrich, *The Future of Cardiovascular Magnetic Resonance Imaging*, 38 EUROPEAN HEART J. 1698 (2017), *available at* https://academic.oup.com/eurheartj/article/38/22/1698/3861988.
[86] Marcu et al., *supra* note 84; Tseng et al., *supra* note 85; W.P. Bandettini & A.E. Arai, *Advances in clinical applications of cardiovascular magnetic resonance imaging*, 94 HEART 1485 (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582334/; Justin D. Anderson & Christopher M. Kramer, *MRI of Atherosclerosis: Diagnosis and Monitoring Therapy*, 5 EXPERT REVIEW OF CARDIOVASCULAR THERAPY 69 (2007), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3938864/.
[87] Beth W. Orenstein, *4T, 7T, 8T, and Beyond — High-Field MR Research Seeks a Closer Look Inside the Human Body*, 10 RADIOLOGY TODAY 16 (2009), *available at* http://www.radiologytoday.net/archive/050409p16.shtml.

body.[88] As compared to 1.5T MRIs, 3T MRIs allow for faster scan times, which provides convenience for both physicians and patients and increases availability of the resource.[89]

1.5T MRI

As technology has continued to improve, scan times for 1.5T MRI units continue to improve. The 1.5T MRI unit the Applicant proposes to acquire allows for simultaneous multi-slice scanning. This scanning method can reduce musculoskeletal exam time by up to 46%.[90] Reduced scan times improve patient experience while increasing the daily throughput of patients on a single unit, thereby maximizing capacity without the need to add additional units. Additionally, for patients with medical devices or implants, a 1.5T unit is a safer alternative to a 3T unit.

Based on these factors, in planning the Proposed Project, the Applicant has determined that providing both 1.5T MRI unit and 3T MRI unit systems at the Woburn and Westwood Sites, and a 1.5T MRI unit system at the Westborough Site will meet the Patient Panel's clinical needs.

CT as an Imaging Modality

The Applicant has determined that the 128-slice CT unit it plans to acquire is the appropriate unit for the needs of the Patient Panel. This 128-slice CT unit provides high quality scans and delivers lower doses of radiation than older CT units. The Applicant has determined that a costlier higher slice unit is not required to meet the clinical needs of the Patient Panel.

CT is a well-established, non-invasive imaging system that has been available for clinical use for several decades and has gained widespread acceptance in several fields of medicine.[91] Generally speaking, CT is a diagnostic imaging test that combines the use of sophisticated x-ray technology and computer processing to provide detailed anatomical and structural information.[92] Since its introduction into clinical use in the United States in the 1970s, CT has made enormous technical and engineering advances that have led to improvements in image quality, speed, and dose reduction, and have increased the clinical utilization of the technology.[93]

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[88] Tanenbaum, supra note 39; Why the 3 Tesla MRI is the Best Scanner for Diagnostic Imaging, Radiology Affiliates Imaging (Sep. 12, 2016), available at https://4rai.com/blog/why-the-3-tesla-mri-is-the-best-scanner-for-diagnostic-imaging.

[89] Tanenbaum, *supra* note 39; *Why the 3 Tesla MRI is the Best Scanner for Diagnostic Imaging*, *supra* note 88.

[90] Siemens Healthineers, *Simultaneous Multi-Slice Accelerate Advanced Neuro Applications for Clinical Routine*, available at https://www.siemens-healthineers.com/magnetic-resonance-imaging/options-and-upgrades/clinical-applications/simultaneous-multi-slice (last visited Jan. 5, 2021).

[91] Liguori et al; *Computed Tomography*; *Computed Tomography in Clinical Use*, 12 J. INT'L COMMISSION ON RADIATION UNITS & MEASUREMENTS 25 (2012).

[92] Liguori et al; *Computed Tomography*; *Computed Tomography (CT)*, U.S. FOOD & DRUG ADMINISTRATION, https://www.fda.gov/radiation-emittingproducts/radiationemittingproductsandprocedures/medicalimaging/medicalx-rays/ucm115317.htm (last updated Mar. 6, 2018); *Computed Tomography (CT or CAT) Scan of the Brain*, JOHNS HOPKINS MEDICINE, https://www.hopkinsmedicine.org/healthlibrary/test_procedures/neurological/computed_tomography_ct_or_cat_scan_of_the_brain_92,P07650 (last visited Jan. 5, 2021).

[93] Norbert J. Pelc, Sc.D., *Recent and Future Directions in CT Imaging*, Ann Biomed Eng. (feb. 2014), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3958932/ (last visited Jan. 5, 2021); International Society for Computed Tomography, *Half a Century in CT: How Computed Tomography Has Evolved*, Oct. 7, 2016, available at

Serving the Primary Care Needs of an Expanding Patient Panel

The entire Commonwealth has a shortage of primary care providers.[94] As noted in Section F1.a.i, approximately 52% of the Patient Panel has a primary care provider affiliated with the Applicant. The establishment of the Project Sites, and the provision of the Clinical Services will result in increased access to primary care, behavioral health care, and other clinical providers and specialists practicing within the Patient Panel's community.

Value of Co-Located Clinical Services

The evidence-based literature details the benefits of co-locating the Clinical Services. Generally speaking, a variety of benefits of co-location are identified in the literature, including but are not limited to, improved access for patients, more patient/family satisfaction, greater opportunities for providers to collaborate and improve their skills and service to patients, improved referrals (appropriate, timely, and with higher completion rates), increased efficiency, and improved health outcomes.[95] Locating CT and MRI units at each Project Site will assist a variety of providers in providing timely and accurate diagnoses of patients with a variety of health conditions, including cardiovascular, oncology, orthopedics, urology, and women's health. The availability of CT and MRI services at the Project Sites will also effectively meet the Patient Panel's need for any pre- and post-surgery imaging services as those patients would have convenient community access to CT and MRI services at a Project Site. In addition, availability of CT and MRI services at the point of care can provide immediate information to clinicians, eliminate the need for costly follow-up visits, allow for an earlier commencement or adjustment of treatment, and thereby improve health outcomes.

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https://www.isct.org/computed-tomography-blog/2017/2/10/half-a-century-in-ct-how-computed-tomography-has-evolved (last visited Jan. 5, 2021).

[94] *See* Robert Wood Johnson Foundation, *County Health Rankings & Road Maps*, available at https://www.countyhealthrankings.org/app/massachusetts/2019/measure/factors/4/map (showing The Commonwealth having a primary care to resident ratio of 960:1, Worcester County having a primary care to resident ratio of 1,000:1 and Middlesex County having a ratio of 760:1 compared to a ratio of 960:1 for Massachusetts as a whole) (last visited Jan. 5, 2021).

[95] SUSANNA GINSBURG, ISSUE BRIEF: COLOCATING HEALTH SERVICES: A WAY TO IMPROVE COORDINATION OF CHILDREN'S HEALTH CARE? (The Commonwealth Fund 2008), *available at* https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2008_jul_colocating_health_services__a_way_to_improve_coordination_of_childrens_health_care_ginsburg_colocation_issue_brief_pdf.pdf (last visited Jan. 5, 2021); Dennis L. Kodner & Corinne Kay Kyriacou, *Fully integrated care for frail elderly: two American models*, 1 INT'L J. INTEGRATED CARE (2000), *available at* https://ijic.ubiquitypress.com/articles/10.5334/ijic.11/ (last visited Jan. 5, 2021).

F1.b.ii **Public Health Value/Outcome-Oriented:**

Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

A. Improving Health Outcomes and Quality of Life

The Applicant anticipates that the Proposed Project will provide patients with improved access to high-quality Clinical Services in their local community, which in turn will improve health outcomes and quality of life. Research indicates that delayed access to quality health care negatively affects patient satisfaction as well as health outcomes due to delays in diagnosis and treatment.[96] Given that quality of life is a multidimensional concept that includes aspects of physical health, delayed access to care also results in decreased quality of life.[97] By co-locating the Clinical Services at each Project Site, the Applicant hopes and expects to provide its patients with access to a continuous quality health care experience, reduced wait times, improved patient satisfaction, and better health outcomes. These benefits will be experienced by both patients receiving the majority of their health care at a Project Site and those receiving hospital or specialty care at the Applicant's Boston hospitals who will have access to related Clinical Services at a lower cost setting closer to home.

Additionally, as more fully discussed in Section F.1.b.i, shifting patients to an ambulatory care setting allows for high-quality lower-cost health care. As a proxy for quality, researchers have found that the "highest-risk Medicare patients were less likely than other high-risk Medicare patients to visit an emergency department or be admitted to a hospital following an outpatient surgery when they were treated in an ambulatory surgery center, even among similar patients undergoing the same procedure who were treated by the same physician in an ambulatory surgery center and a hospital. These results indicate that ambulatory surgery centers provide high-quality care, even for the most vulnerable patients."[98] Furthermore, by co-locating the Clinical Services, and offering expanded hours based on patient need and demand, the Project Sites will offer the Patient Panel a one-stop shop for health care within the Patient Panel's community.

Care Models and Quality Systems

The Applicant will ensure the Project Sites follow care models similar to and consistent with other Applicant facilities, and that high quality patient outcomes are achieved through the utilization of strategies that improve the quality and efficiency of the patient experience. These care models are rooted in collaboration, and include patient-centered medical homes, care integration, and other care initiatives specifically designed by Mass General Brigham clinicians. As outlined below, the Applicant offers a number of programs in which the Project Sites will participate to ensure quality care for patients receiving the Clinical Services.

[96] Julia C. Prentice et al., *Delayed Access to Health Care and Mortality*, Health Serv. Res. (Apr. 2007), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955366/ (last visited Jan. 5, 2021).
[97] Id.
[98] Munnich & Parente, *supra* note 18.

First, the Applicant will ensure each Project Site participates in Mass General Brigham's Patient Reported Outcome Measures ("PROMs") platform. PROMs are a way to assess the metrics of most importance to patients, such as symptom management and functional status. Tracking these outcomes allows providers to take better care of patients by reviewing individual scores to prepare for certain aspects of a procedure. Furthermore, these questionnaires allow quality improvement staff to group together specific patients based on symptoms or procedures to understand which patients will benefit the most from certain treatments. Mass General Brigham is a national leader in the collection of PROMs and has developed an innovative technology-enabled platform that facilitates the collection of this information on a large scale across its system. As an initial step in the surgical consultation process, PROMs are collected to aid surgeons in determining the best course of treatment and the effects surgery will have on a patient. This information is then used in various ways to provide decision support for a surgeon. For example, for spine surgery, this data, as well as other clinical information, is incorporated into a surgical decision platform (Provider Order Entry), which helps the surgeon and patient assess the appropriateness of surgery.

Second, the Project Sites will offer the Shared-Decision Making Program. Through this Program, patients considering surgery at a Project Site have the opportunity to review video-based decision aids prescribed by their primary care provider. The Shared Decision-Making Program is a collaboration between primary care and specialists that seeks to provide patients with necessary information on a wide array of treatment options, so a patient is able to work with a surgical consultant and primary care provider to determine if surgery is the best option for care.

Third, Project Site staff will participate in the eConsult Program. Through the eConsult program primary care provider and surgeons consult (as needed) through a non-face-to-face electronic interaction that seeks to ensure patients are receiving appropriate care services, while avoiding any unnecessary higher cost consultations. Clinical decision support in the electronic health record ("EHR") and physician-level variation reporting minimize inappropriate ordering of radiology and other high-cost diagnostic tests by a primary care provider.

Finally, for each Project Site's highest risk and most complex patients, clinical staff will offer the Integrated Care Management program ("iCMP"). iCMP provides eligible patients with a care manager who develops a care plan in tandem with the patient and other members of the clinical team. The care manager works in-person and telephonically to coordinate a patient's care and ensures that patients are not readmitted to the hospital when possible. Additionally, the care manager connects patients with community-based resources that are vital for recovery. The Applicant also offers the Integrated Care Management program, Patients Linked to Urgent Supports. This program provides intensive wrap-around services (psycho-social supports) to a small number of patients. Services include acute community paramedicine, crisis stabilization units, and coordinated transportation. The Applicant intends to implement these programs to ensure all of the Project Sites' surgical patients have the highest quality care, as well as a superior care experience. Through the Proposed Project, these programs will be offered to patients at all of the Project Sites, thereby ensuring improved quality outcomes.

Increased Access to High Quality Clinical Services Locally

Furthermore, additional access will be created by the Proposed Project through the implementation of expanded access to the Clinical Services in the primary services area of each Project Site. It is

often difficult for patients, especially elderly individuals, to travel to Boston for the Clinical Services. Time spent on travel, as well as monies spent on costly parking add unnecessary stress and access barriers for patients. Accordingly, through the establishment of the Project Sites, patients will be able to receive imaging and physician services and have outpatient day-surgery close to home without the challenges associated with traveling to Boston or outside of their community to access such care. Ultimately, the ability to access the Clinical Services locally will improve the Patient Panel's health care experience and improve the Patient Panel's overall quality of life.

Access to Virtual Care and Digital Health Investment

The Applicant recently launched investment into digital health, including a focus on interactions with patients, research platforms, and coordination among facilities across the Applicant's system. These investments and resources will be integrated throughout the Project Sites and available to the care teams providing the Clinical Services to the Patient Panel. Since 2015, the Applicant has invested in a system-wide EHR to support seamless care for all patients across the Applicant's system, and to increase the interoperability of the Applicant's EHR. Through increased interoperability, the Applicant is able provide patients with greater access to their medical records and better facilitate the transfer of patient health and care information, which increases patient care coordination.

In 2019, the Applicant expanded this investment to more intentionally focus on the patient experience. As discussed throughout this Application, the Applicant utilizes numerous patient-centered tools such as the Patient Portal; shared decision-making tools; patient education videos and tip sheets; new scheduling and access tools, such as video visits and eVisits; and patient-provided data from fitness and medical devices. Primary care questionnaires at the adult and pediatric levels allow patients to answer questions about their health and wellness at home, in the portal, or in the office on tablets. Whether it be for Ambulatory Surgery Services, CT and MRI services or Physician Services, these interactions help the care team learn more about the patient and engages the patient more fully in their own care. Extensive registries and decision support for providers and patients ensure patients get the care they need at the right time and in the right place.

Increased Access to High Quality Primary Care

The Applicant has an established record of excellence in the provision of primary care, which the Applicant seeks to build upon at the Project Sites[99] through the provision of primary care as part of the Physician Services. Advanced Primary Care, described below, sustains the Applicant's accomplishment of becoming a Patient Center Medical Home Institution, where 97% of the Applicant's primary care practices were recognized by NCQA. The Applicant sustains this focus on patient, quality, technology and team with a sustainable model called Advanced Primary Care. The Applicant anticipates utilizing Advanced Primary Care to continue the Applicant's excellence in providing primary care services to patients. The elements Advanced Primary Care include: (i) expanded access, being available when patients need their care providers most. Based on patient demand, need, and once fully ramped up, the Applicant anticipates that each of the Project Sites

[99] Certain Mass General Brigham physician practices currently provide physician services in an existing medical office building at the Westwood Site. These practices will continue to provide such physician services after the Applicant develops a second, adjacent building at the Westwood Site as part of the Proposed Project.

will offer expanded hours to ensure patients are able to obtain the care they need when they need it; (ii) integrated care, seamless care, everywhere, every time; (iii) engaged patients, engaging patients directly in their care, and meeting more of their needs inside and outside the clinic, including virtual care for patients that may not need to be seen at a Project Site; (iv) safe, equitable and high-quality care, keeping patients both healthy and safe; (v) smarter spending, rebalancing resource use toward primary care; and (vi) vital workforce, understanding and optimizing our workforce's experience.

Access to High Quality After Hours Care

In addition, the expanded hours noted above will be available to patients with urgent needs that can be met outside of the hospital. At the Project Sites, the Applicant anticipates operating expanded hours for certain services based on patient demand and need. The Applicant also knows that not all care needs to take place within a health care facility. As discussed in this Application, the Applicant anticipates using technology and telehealth services to provide the right type of care, at the right time, in the right setting, and in a manner that is convenient to patients.

B. Assessing the Impact of the Proposed Project

To assess the impact of the Proposed Project, the Applicant has developed the following quality metrics and reporting schematic, as well as metric projections for quality indicators that will measure patient satisfaction, quality of care, and access.

As members of Mass General Brigham, IC and AmSurg will participate in robust performance improvement initiatives and will be integrated with and have access to Mass General Brigham's data warehouse and advanced analytics program, including the creation of quality and safety dashboards that allow for the evaluation of specific quality metrics. These dashboards are created under the guidance of quality collaboratives across Mass General Brigham. Currently, Mass General Brigham has approximately 30 quality collaboratives and leadership groups covering a range of medical and surgical specialty areas working to improve quality and safety throughout the Applicant's system. IC and AmSurg will be able to work with these groups to develop additional care improvement initiatives. To form these collaboratives, quality improvement staff from Mass General Brigham bring together groups of clinical leaders and data scientists to better define care pathways and to pilot innovations for improvement, employing a robust evaluation program as part of the pilot. This process allows for the creation of best practices and benchmarks to be shared across the system.

IC and AmSurg will also have access to Mass General Brigham's Internal Performance Framework. ("IPF"), a continuous quality improvement infrastructure that allows for better care management supported by a well-developed quality improvement infrastructure. The IPF often utilizes the above detailed quality collaboratives and also provides significant support around data analytics. As discussed in Section F1.b.ii, IC and AmSurg will participate in Mass General Brigham's Patient Reported Outcome Measures platform and will be able to use these resources to impact patient reported outcomes.

Ambulatory Surgery Services

1. **Patient Experience/Satisfaction:** Patients who are satisfied with care are more likely to seek additional treatment when necessary. The Applicant will ensure that AmSurg staff review overall ratings of care with surgical services via a benchmarked patient experience survey tool.

   Measure: Overall rating of care.

   Projections: As the Ambulatory Surgery Services associated with the Proposed Project are not currently being provided, the Applicant will establish baseline performance and projections for this measure within six months of commencement of the Ambulatory Surgery Services.

   Monitoring: Performance data will be monitored in an ongoing fashion and any site receiving lower than a top rating for Overall Rating of Care will be reviewed for improvement opportunities.

2. **Clinical Quality (Pre-Operative Time Out)**: This measure ensures pre-operative compliance with practices aimed at ensuring high quality outcomes among members of the care team and promoting communication.

   Measure: The procedure team conducts a pre-operative time out.

   Projections: A pre-operative time out will be completed 100% of the time on all surgical cases at each Project Site.

   Monitoring: Reviewed quarterly by clinical staff.

3. **Access – Wait Times:** The number of days from the date that a surgery is ordered to the scheduled surgery date. This information will be obtained via the Applicant's EHR system, EPIC.

   Measure: Time interval from when the case was initiated for scheduling in Epic to the date of surgery.

   Projections: As the Ambulatory Surgery Services associated with the Proposed Project are not currently being provided, the Applicant will establish baseline performance and projections for this measure within six months of commencement of the Ambulatory Surgery Services

   Monitoring: Reviewed quarterly by clinical staff.

CT and MRI Services

1. **Patient Satisfaction:** Patients that are satisfied with care are more likely to seek additional treatment when necessary. The Applicant will ensure that IC staff review

overall ratings of care for CT and MRI services via a benchmarked patient experience survey tool.

Measure: Overall rating of Care

Projections: As the CT and MRI services associated with the Proposed Project are not yet being provided, the Applicant will establish baseline performance and projections for this measure within six months of commencement of the CT and MRI services.

Monitoring: Performance data will be monitored in an ongoing fashion and any site receiving lower than the national average for Overall Rating of Care will be reviewed for improvement opportunities.

2. **Clinical Quality (Reporting of Critical Value Results):** The Applicant will ensure that IC adopts a Communication of Critical Results Policy, which defines the requirement and process for verifiable and timely communication of critical test results to the responsible provider. To facilitate timely reporting and communication of critical test results, radiologists will use an automated system that triggers an alert to the responsible provider once the radiologist documents a critical finding. When an alert regarding a critical test results is triggered to the responsible provider, the expectation is that there is a telephone or in person conversation between the radiologist and the responsible provider about the results. Subsequently, this communication is documented.

   Measure: Number of radiologists documenting critical value reporting on cases being interpreted.

   Projections: Baseline: 100% Year 1: 100% Year 2: 100% Year 3: 100%

   Monitoring: Audits will be conducted annually.

3. **Access (Outpatient Availability Score):** Outpatient Availability Score ("OAS") reflects outpatient imaging appointment availability by calculating the percentage of free, unscheduled (open) outpatient appointment times vs. total available outpatient appointment times. This measure is an alternative to "first available appointment" metrics, which may be inaccurate due to last-minute cancellations that suggest more availability than truly exists, and "average time from scheduling to imaging appointment" metrics, which are not just a function of availability but also reflect patient preference. To calculate the OAS measure, a "snapshot" of data is taken, showing open vs. total available slots for the next 60 days from the time the snapshot is taken. For each of the 60 days, a cumulative "percent availability" score can be calculated based on open appointments vs. all available appointments up to that point in the 60 day period. Although the OAS does not indicate when a specific time is open, it does indicate the likelihood that the patient would have a reasonable number of scheduling options to choose from. Based on literature, below 40% availability, referring physicians begin to experience difficulties because there is a lower chance that a patient will find a convenient time, compared

with when the measure is at the 60% or 80% mark. Low availability does not mean that all appointments are booked; rather, some appointments are available, but these are generally the less desirable ones that are less likely to be accepted by patients. At any given time when the snapshot is taken, this measure calculates the number of days it takes to reach 40%, 60%, and 80% appointment availability. A higher the number of days to hit given percentage thresholds reflects less access (longer delays for patients). Targets can be set for the number of days to reach selected percent availability scores.

Measure: Percentage of low (40%), medium (60%), and high (80%) appointment availability in Epic.

Projections: As the CT and MRI services for the Proposed Project are not yet being provided, the Applicant will establish baseline performance and projections for this measure within six months of commencement of the CT and MRI services.

Monitoring: This data will be reviewed quarterly by clinical staff.

Physician Services

1. **Patient Satisfaction:** Patients who are satisfied with care are more likely to seek additional treatment when necessary. The Applicant will ensure that IC staff review overall ratings of care for Physician Services via a benchmarked patient experience survey tool.

   Measure: Overall rating of care

   Projections: As the Physician Services associated with the Proposed Project are not yet being provided, the Applicant will establish baseline performance and projections for this measure within six months of commencement of the Physician Services.

   Monitoring: Performance data will be monitored in an ongoing fashion and any site receiving lower than the national average for overall rating of care will be reviewed for improvement opportunities.

2. **Access – Wait Times:** The number of days from the date that a clinic visit is ordered or requested to the scheduled date of the visit. This information will be obtained via the Applicant's EHR system, EPIC.

   Measure: Time interval from when the case was initiated for scheduling in Epic to the date of visit.

   Projections: As the Physician Services associated with the Proposed Project are not currently being provided, the Applicant will establish baseline performance and projections for this measure within six months of commencement of the Physician Services.

   Monitoring: Reviewed quarterly by clinical staff.

F1.b.iii **Public Health Value/Health Equity-Focused:**

For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's need-base, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g. culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.

In light of the recent nationwide movement to address racism and oppression, the Applicant's leadership has made a commitment to examine and work to eliminate the many impacts that racism has on the Applicant's patients and employees. Through this commitment, the Applicant has launched the ***United Against Racism*** initiative, which includes a roadmap for achieving equality within the Applicant's system and eliminating racism and oppression faced by the Applicant's patients, communities, and staff. Key elements of the ***United Against Racism*** plan focus on addressing racism through the lens of patient care, leadership and culture across the Applicant's system, and through partnerships with the communities, and organizations within the community, that Applicant serves.

A. Non-Discrimination

To ensure health equity to all populations, including those deemed underserved, the Proposed Project will not adversely affect accessibility of services for poor, medically indigent, and/or Medicaid eligible individuals. The Applicant does not discriminate based on ability to pay or payer source and this practice will continue following implementation of the Proposed Project. As further detailed throughout this narrative, the Proposed Project will increase access to the Clinical Services for all of the Applicant's patients.

B. Culturally and Linguistically Appropriate Service

In addition, the Applicant has adopted the Culturally and Linguistically Appropriate Service ("CLAS") standards set forth by the U.S. Department of Health and Human Services Office of Minority Health for all practice sites. The Applicant will ensure that effective, understandable, and respectful care will be provided at the Project Sites with an understanding of patients' cultural health beliefs and practices and preferred languages. The Applicant will ensure that the Project Sites have arrangements to offer ongoing education and training in culturally and linguistically appropriate areas for staff at all levels and across all disciplines. Language assistance services are provided by certified translators at no cost to patients with limited English proficiency at all points of clinical contact in a timely manner; additional translation services in less frequently encountered languages are available at all times through the Applicant's language assistance lines. Additionally, all patient-related materials and signage are posted in multiple languages.

With regard to language assistance, the Project Sites will offer access to interpreter and translation services via several modalities at no cost to limited-English speaking ("LEP") and hearing-impaired patients at all points of clinical contact in a timely manner. For LEP patients, access to

qualified interpreters skilled in 50+ languages via iPad Video Remote (Interpreters on Wheels) or via phone (Language Line) will be available at the Project Sites. For patients who are deaf or hard of hearing, sign language interpreter services are offered through contracted agencies, and the Mass General Brigham Bulfinch Temporary Services Department or, when in-person interpreters are not available, through the use of iPad Video Remote Units which allow for visual access to an interpreter on the iPad screen.

C. Screening and Social Determinants of Health

All of the Applicant's hospitals participate in the American Hospital Association's #123Equity Pledge Campaign, as will the Project Sites. This campaign seeks to eliminate health and health care disparities that exist for racially, ethnically and culturally diverse individuals and identifies areas for hospital and health system leaders to focus on to ensure high quality, equitable, and safe care for everyone. Specifically, the campaign requires hospital leaders to accelerate progress in the following areas: (1) Increasing the collection and use of race, ethnicity, language preference and other socio-demographic data; (2) Increasing cultural competency training; (3) Increasing diversity in leadership and governance; and (4) Improving and strengthening community partnerships. This campaign will allow staff at the Project Sites to ensure equal access to the benefits created by the Proposed Project.

Currently, each of the acute care hospitals within Mass General Brigham has a screening and referral program for the social determinants of health ("SDoH"). While variation exists among the hospitals as to the populations that are screened and the logistics for screening – at minimum, all of the 133 primary care practices of the Applicant that are participating in the MassHealth Accountable Care Organization Program ("ACO") are screening patients for SDoH needs.

All of the Applicant's hospitals and practices conducting a SDoH screen utilize a similar screening tool. It is anticipated that the Project Sites will use this tool as well. This screening tool explores eight domains of SDoH needs (housing, food insecurity, violence, etc.), and inquires if patients have issues with any of the domains and whether they would like assistance. Screenings are conducted via iPads that are linked to the Applicant's EHR. The SDoH screening tool is currently available in eight different languages including the most common languages spoken by the Applicant's patients.

The Applicant has been thoughtful about the implementation of a universal SDoH screening program, recognizing that there is a limited amount of capacity within the community-based organizations to which patients will be "linked" for services and understanding a staggered approach to implementation is best, so that available resources are not overwhelmed. The long term goal is to implement a SDoH screening program for all patients, regardless of a patient's participation in the ACO, and the Applicant anticipates being able to screen all Project Site primary care patients for SDoH.

When a patient has a positive SDoH screen, social and/or community health workers follow-up with the patient to confirm that a request for assistance has been made by the patient. Upon confirmation, the staff member may assist the patient directly or refer the patient to a community-based organization that may be able to provide specific services or support. The follow-up

provided is unique and individualized as each patient's SDoH need(s) and circumstances form the basis for the follow-up provided.

As noted above, SDoH screens are tracked in a patient's EHR, and include whether a SDoH screen was conducted, if there were positive responses indicating the patient needs assistance, and if the patient was provided with written support materials or referred to a support person. Moreover, case managers and other staff assisting patients with SDoH needs may provide notes in the EHR and Epic system as to where the patient is in the process of accessing resources to address the patient's SDoH needs. Currently, the Applicant is working to implement a data exchange system with external community-based partners that will enable the Applicant practices and providers to understand the final disposition of the patient if referred to an external organization or support.

The Applicant is also collecting data utilizing the information that is provided in Epic to better understand the SDoH needs of patients, including information on the most common SDoH needs, and if those SDoH needs vary by geography; ethnicity and race; or other demographic factors. These data points inform staff about the demand for community-based resources in specific geographies. Staff will share this relevant data with appropriate care teams and the Determination of Need – Community Health Initiative – Community Advisory Board given their oversight of the community health needs assessment processes and SDoH challenges.

D. Transportation

For patients relying on public transportation, there are a number of local and affordable options for patients to reach each Project Site. Like other facilities within the Applicant's system, the Applicant anticipates that the Project Sites will use Circulation for eligible patients. Circulation is a medical transportation on-demand ride ordering technology utilized by the Applicant that enables eligible patients and providers to order transportation to and from medical appointments.

Westborough Site

The Westborough Site is located at the intersection of I-495 and Route 9 in Westborough. This location provides convenient access to patients traveling from Route 9 and is located just off the exit from I-495.

For the aging population, senior centers throughout the Westborough Site's primary service area provide free and subsidized transportation for medical appointments. For example, the town of Westborough also provides in-town transportation services, by mini-bus, through the senior center. Mini-bus transportation is available for medical appointments and other senior center activities.

Westwood Site

The Westwood site conveniently neighbors the Route 128 Massachusetts Bay Commuter Rail stop and is located just off of I-95 in Westwood. This location provides convenient access to patients traveling from I-95 or using the commuter rail.

If a patient is unable to drive or use public transit, or has a disability that prevents MBTA and or commuter rail travel to the Westwood Site, The RIDE is available in Westwood and the surrounding areas with operating hours to the MBTA—generally from 5 AM to 1 AM daily.

Reservation for the RIDE can be made 7 days a week from 8:30-5:00 and RIDE trips can be scheduled from 1 to 7 days in advance, permitting patients to schedule transportation to and from the Westwood Site in advance of an appointment. The MBTA is also piloting its on-demand paratransit program in Westwood.

For Westwood residents over the age of 60, or disabled, the Westwood Senior Center runs shuttles for medical appointments. Reservations are on a first come first served basis, and the shuttle will pick and drop off patients at their homes. There is no cost for utilizing the shuttle, however there is a suggested donation of $2.00.

Woburn Site

The Woburn Site is located at the intersection of Montvale Avenue and Route 93 in Woburn. This location provides convenient access to patients traveling from Route 93 and is located less than three miles from I-95.

The MBTA Bus #354 route runs from Burlington to downtown Boston and currently includes a stop at the intersection of Montvale Avenue and Hill Street allowing for public transportation access just steps from the proposed site. The MBTA Anderson/Woburn Regional Transportation Center located at 100 Atlantic Avenue is 3.1 miles or approximately a nine-minute drive from the Woburn Site. The Anderson/Woburn Regional Transportation Center includes a commuter rail stop on the Lowell Line, as well as a Park and Ride Parking Lot and Logan Express parking lot and access. MBTA riders can access bus service at the MBTA Anderson/Woburn Regional Transportation Center providing patients with public transportation access for traveling to and from the commuter rail to the Woburn Site for care.

If a patient is unable to use public transit, or has a disability that prevents MBTA bus travel to the Woburn Site, The RIDE is available for the majority of towns within the Woburn primary service area (with the exception of Andover and limited service for Billerica) with similar operating hours to the MBTA—generally from 5 AM to 1 AM daily. Reservation for the RIDE can be made 7 days a week from 8:30-5:00 and RIDE trips can be scheduled from 1 to 7 days in advance, permitting patients to schedule transportation to and from the Woburn Site in advance of an appointment. The MBTA is also piloting an on-demand paratransit program with Uber, Lyft, and Curb Mobility (taxi), where RIDE customers can book subsidized rides instantly, right from their smartphones or call in for concierge service.[100]

For the aging population, senior centers and Councils on Aging throughout the Woburn Site's primary service area provide free and subsidized transportation for medical appointments. For example, the Stoneham Council on Aging as well as the Winchester Jenks Center provide free transportation for seniors to medical appointment locally and in adjacent towns. In addition, Woburn Checker Cab which operates taxi service in Woburn, Winchester, Burlington, Reading, Stoneham, and all other surrounding communities has agreements with local senior centers to provide flat rates and discounted taxi vouchers for seniors traveling in Woburn and surrounding towns.

[100] MBTA, *On-Demand Para Transit Pilot Program*, available at https://www.mbta.com/accessibility/the-ride/on-demand-pilot (last visited Jan. 5, 2021).

In addition, Mystic Valley Elder Services TRIP Metro North Program is an innovative transportation program available to older adults and adults living with disabilities in the Woburn Site communities including Medford, Melrose, North Reading, Reading, Stoneham, and Wakefield. With TRIP, participants choose a driver with whom they are comfortable – a friend or a neighbor (and in some cases, certain relatives may qualify, too) – and the TRIP participant and the driver work together to track mileage. This arrangement allows the TRIP participant to maintain independence in making the arrangements with their driver and at the end of each month, participants are sent a mileage reimbursement check to reimburse their driver for mileage.

F1.b.iv Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

Ambulatory Surgery Services

The Proposed Project will allow for the expansion of lower-cost surgical services in the community setting for patients in need of lower-acuity surgical services, for whom an ambulatory surgery center is an appropriate treatment setting. The Ambulatory Surgery Services provide an alternative point of access with equally high quality at a lower-cost. Furthermore, the Ambulatory Surgery Services provided in this setting are more convenient for patients and clinicians allowing for improved access to timely surgical care; thereby increasing quality outcomes and patient experience. The Applicant also plans to implement numerous patient amenities, including multi-disciplinary care team working together and embedded behavioral health, patient access tools, pre-registration, price transparency, online scheduling, virtual care, health navigation, and health coaching to improve patient experience and ensure high rates of patient satisfaction. For these reasons, the Applicant is seeking to provide Ambulatory Surgery Services at the Project Sites.

Physician Services and CT and MRI Services

The Proposed Project will facilitate improved health outcomes and quality of life indicators for the Patient Panel by allowing patients in need of Physician Services or CT and MRI services to receive care in an integrated community setting close to where they live. The Physician Services and CT and MRI services at the Project Sites provide the Patient Panel with a desirable alternative to traveling to Boston for coordinated, integrated care within the Applicant's system. Receiving care at a Project Site will be more convenient for many patients, resulting in improvement in access and care coordination. The Proposed Project will ensure that patients receive primary care, specialty care, and ambulatory care services at each Project Site and have access to timely co-located Clinical Services, whether centered at a Project Site or as a convenient alternative to post-acute services at an Applicant's hospital facility. Combined with the fact that the Applicant does not discriminate and offers a variety of services to address SDoH, as discussed above, and health care disparities (e.g., CLAS standards, interpreting services, and social services), the Applicant anticipates that the Proposed Project will result in improved patient care experiences and quality outcomes while assuring health equity.

F1.c Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.

The Proposed Project will increase access to community primary care services for children and adults of the Patient Panel. To ensure continuity of care, improved health outcomes and enhanced quality of life, through the Proposed Project, staff at the Project Sites will continue existing formal processes of the Applicant for linking patients with primary care providers and specialists for follow-up care, as well as case management/social work support to ensure patients have access to resources around SDoH issues. Providing patients with linkages to these necessary services prevents unnecessary hospital admissions, ensures appropriate care management and provides the patient with the resources for leading a better life. Moreover, patients at the Project Sites will benefit from the Applicant's population health management strategies, including a system of care coordination and care delivery alternatives aimed at improving patient experience and outcomes.

As discussed in Section F1.b.ii, the Applicant has a number of integrated care programs in place to ensure continuity of care and care integration. In addition to programs, such as eConsult and Shared Decision-Making, the Project Sites will ensure patient interests are fully met while addressing health care costs by providing expanded access to afterhours care either through the Project Site's or Applicant's primary care practices or the Applicant's extensive network of urgent care practices. Telehealth visits also reduce unnecessary emergency department or office visits. The Project Sites will also offer a number of alternatives to emergency department care for post-operative patients through the Mass General Brigham Mobile Observation Unit, a program that provides home-based urgent care for patients experiencing at-risk medical events believed to be treatable with enhanced home care. The Applicant's Home Hospital provides the opportunity for some patients who require an inpatient stay to be cared for at home.

All CT and MRI results for scans performed at a Project Site, and all Ambulatory Surgery Services, will be integrated into the Applicant's EHR. Studies show that integrated health information technology systems directly affect health outcomes as access to a single, integrated health record improves care coordination. This is true of the system used by the Applicant, EPIC, which not only enables imaging results and information to be available to primary care and specialty physicians across the system, but also allows patients to authorize providers outside of the Applicant to access their data, view their record, and send progress notes back for improved continuity of care via the "Care Everywhere" feature. Through Care Everywhere, when necessary, CT and MRI scans can be read by highly specialized radiologists, which reduces the diagnostic error rate and helps to ensure all patients are receiving the right care, at the right time, and in the right setting. In sum, the availability of these integrated record services ensures that patients receive the Clinical Services at a Project Site will benefit from appropriate care coordination, better outcomes, and improved quality of life.

The co-location of the Ambulatory Surgery Services, Physician Services and CT and MRI services, including primary care, specialty care, and other ancillary services allows for and fosters continuity of care, avoiding fragmentation, multiple scans and repeat visits, and other inefficiencies for patients and providers. Evidence indicates that care fragmentation is an important source of inefficiency in the US healthcare system, that health care delivery spread out across a number of

separately located providers leads to care fragmentation, and that co-location is one way to address fragmented care and promote efficiency.[101]

[101] Kurt C. Stange, *The Problem of Fragmentation and the Need for Integrative Solutions*, 7 ANNALS FAMILY MED. 100 (2009), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2653966 (last accessed Jul. 17, 2019).

F1.d Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project.

Since a broad range of input is valuable in the planning of a project, the Applicant carried out a diverse consultative process with individuals at various regulatory agencies regarding the Proposed Projects. The following individuals are some of those consulted regarding this Proposed Project:

- Lara Szent-Gyorgyi, MPA, Director, and Margo I. Michaels, MPH, Former Director, Determination of Need Program, Department of Public Health
- Determination of Need Program Analysts, Lucy Clarke and Lynn Conover
- Rebecca Rodman, Esq., Deputy General Counsel, Department of Public Health
- Ben Wood, Director, Office of Community Health Planning and Engagement, Department of Public Health
- Jennica Allen, MPH, Community Health Planning and Engagement Specialist
- Sherman Lohnes, J.D., Director, Division of Health Care Facility Licensure and Certification, Department of Public Health
- Daniel Gent, Project Engineer, Plan Review Manager, Division of Health Care Facility Licensure and Certification, Department of Public Health

The following individuals from the cities and towns of each Site were consulted regarding the Proposed Project:

Westborough Site

- Kristi Williams, Town Manager
- Ian Johnson, Chair, Select Board
- Jim Robbins, Town Planner
- James Eldridge, State Senator
- Carolyn Dykema, State Representative
- Danielle Gregoire, State Representative
- Hannah Kane, State Representative

Westwood Site

- Chris Coleman, Town Administrator
- Nancy Hyde, Chair, Board of Selectmen
- Michael Rush, State Senator
- Paul McMurtry, State Representative

Woburn Site

- Scott Galvin, Mayor
- Michael Anderson, President, City Council
- Darlene Mercer-Bruen, Alderman, Ward 5
- Cindy Friedman, State Senator
- Michael Day, State Representative
- Richard Haggerty, State Representative

F1.e.i **<u>Process for Determining Need/Evidence of Community Engagement</u>:**

For assistance in responding to this portion of the Application, Applicant is encouraged to review *Community Engagement Standards for Community Health Planning Guideline.* With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.

Based upon the need for patients to receive timely Clinical Services in the community, the Applicant developed a plan to provide such services through the establishment of AmSurg and IC In contemplation of establishing the Project Sites the Applicant, as noted above, engaged IDEO to plan and develop a new way to deliver care to patients. IDEO's work reflects feedback on the current state of the patient experience and how design approaches can address existing patient care experience challenges while identifying new opportunity areas for improvement.

The Applicant's leadership also sought to define its community broadly and engage patients, family members, local residents, and resident groups that may be impacted by the Proposed Project to obtain feedback and answer questions regarding the Proposed Project. Through IDEO and the community engagement discussed herein, the Applicant's community engagement plan incorporated a broad spectrum of individuals based on age, gender, sexual identity, race, ethnicity, disability status, socioeconomic status, and health status.

The Applicant, through IDEO, convened focus groups and held workshops to determine the needs and desires of patients in the primary service area of the Project Sites. These focus groups and workshops helped the Applicant navigate the social, business, environmental, and technological nuances of the design and planning challenges within the Project Sites. Qualitative research was conducted in small group discussions that included numerous individuals. Working with the Applicant through utilizing this research-based approach, IDEO compiled patient feedback on accessing healthcare in the community that has allowed the Applicant to better understand the needs of the Patient Panel. Based on IDEO's engagement with patients, the Applicant learned that patients (i) want to be more involved in their care, (ii) need help creating overlaps between their lives, health, and the health care they receive and need, (iii) want a greater voice and understanding of their health and their care, (iv) want relatable and understandable language when navigating unfamiliar and unknown health care procedures. (v) want a shared sense of ownership with clinicians in their care and wellbeing, and (vi) believe relationships are the foundation of health and should be at the heart of health care. With this feedback in mind, the Applicant, through the Proposed Project, seeks to reimagine how care is delivered to patients and how providers and patients interact.

As an important step in the community engagement process, the Applicant sought to engage its patients, local residents, as well as those resident groups in the communities impacted by the Proposed Project. Accordingly, representatives of the Applicant held three open community meetings at the following times and places:

1. Westborough DoubleTree Hotel, on February 27, 2020 from 9:00 to 11:00 AM:

    - John Fernandez, President, IC and Mass Eye & Ear, Lindsay A. Gainer, RN, MSN, Vice President, Operations Development, and Christine Spring, Program Director, System Behavioral & Mental Health represented the Applicant, AmSurg and IC at this meeting.
    - 82 individuals signed in at the open Westborough community meeting on the Westborough Site;

2. The Westwood Site on March 2, 2020 from 6:30 to 8:00 PM:

    - Cynthia Peterson, MBA, VP, Regional Ambulatory Operations and Business Development, Brigham and Women's Hospital, Lindsay A. Gainer, RN, MSN, Vice President, Operations Development, and Christine Spring, Program Director, System Behavioral & Mental Health represented the Applicant, AmSurg and IC at this meeting.
    - 92 individuals signed in at the open Westwood community meeting on the Westwood Site;

3. The Woburn Public Library, on March 6, 2020 from 1:00 to 2:00 PM:

    - John Fernandez, President, IC and Mass Eye & Ear, Lindsay A. Gainer, RN, MSN, Vice President, Operations Development, and Christine Spring, Program Director, System Behavioral & Mental Health represented the Applicant, AmSurg and IC at this meeting.
    - 133 individuals signed in at the Woburn open community meeting on the Woburn Site.

The date of the open community meetings and locations were widely publicized to the Patient Panel. To publicize the open community meetings to the Patient Panel, the Applicant (i) mailed 342,881 postcards to households publicizing the meeting and including email and phone numbers for follow-up questions; (ii) placed advertisements in local newspapers; (iii) reached out to local stakeholders within the primary service area of the Project Sites; and (iv) posted flyers in public spaces within the primary service areas of the Project Sites. The goal of each open community meeting was to educate community members on the Project Sites and the Applicant's overall ambulatory care strategy. A copy of the postcards and presentation materials is attached as Attachment 5.

The mailings also included an online Community Health Survey that individuals could choose to respond to. The Applicant included this survey to learn more about the needs of the patient panel and to offer additional opportunities for the community to learn and obtain information about health care access needs in the Project Sites' primary service areas. 147 individuals completed the online survey (the "Survey") which is included as Attachment 5.

At all three open community meetings, attendees were primarily interested in the different types of services that would be available at the Project Sites, including access to primary care and behavioral health services. The Applicant's representatives addressed all questions and comments

at the open community meetings, and discussing the proposed services with the attendees, many noted that they currently have to travel outside of the community to receive essential health care services. For example, the following types of questions were asked at all three open community meetings:

i. If I have a primary care provider of the Applicant in another location outside of the primary service area of a Project Site can I still receive care at a Project Site?

ii. If I have a primary care provider of the Applicant at a location outside of the primary service area of a Project Site, can I transition to a Project Site primary care provider?

iii. Will the Project Sites be able to take care of all of my health care needs at the same location or will I need to travel outside of my community for some services?

iv. Will the Project Sites accept my insurance?

v. Will the quality of care at each Project Site will be the same quality of care patients expect from the Applicant's other facilities?

These concerns and questions about accessing essential health care services are consistent with the results of the Survey, where 55% of respondents said they would be more likely to get preventative care sooner if such care was available closer to home. As noted throughout this application, the Patient Panel will be able to access the Clinical Services at the Project Sites in a number of ways. Patients will be able to schedule both in-person and telehealth appointments, to ensure patients promptly receive the right kind of care in the right type of setting.

As noted throughout this Application, the Applicant intends to offer a full suite of services at the Project Sites to enable the Patient Panel to receive health care in their community and avoid unnecessary travel and expense. If a patient needs health care services that are not offered at a Project Site, the Applicant is considering different patient navigation services to help patients find and obtain necessary health care. Any patient navigation services offered, would defer to patient choice and be agnostic to which provider or provider organization the patient is referred to. Finally, the Project Sites plan to accept insurance from a broad spectrum of local non-profit, national, and public payers and the Project Sites will accept all patients with insurance that includes the Applicant in its benefit plans.

Attendees were also interested in the different types of providers that would be staffed at the Project Sites, and whether the Applicant would be hiring additional providers to staff the Project Sites. As each Project Site ramps up services, a full spectrum of providers will be hired, including, but not limited to, primary care providers, specialty providers, nurses, mid-level providers, medical assistants, administrative staff, behavioral health employees, and social workers. Attendees were interested in when hiring will begin for staffing the Project Sites. To aid with hiring, the Applicant is considering holding job fairs in the communities surrounding each Project Site.

Finally, in Westborough, an attendee asked specifically about the availability of home health services. The attendee noted that the Applicant does not currently provide home health services in the Westborough service area. Based on this feedback and depending on future patient need and

programming, the Applicant will consider providing home health services within the primary service area of a Project Site. In addition, staff will take advantage of all of the digital health tools available within the Applicant's system to ensure patients can access care in appropriate settings. In consideration of the factors defined by the Department to be incorporated into the development of the Applicant's Community Engagement Plans such as age, gender, sexual identity, race, ethnicity, disability status, socioeconomic status, and health status, the Applicant engaged community groups and organizations that represent senior citizens, the LGBTQ community, people of color, and the poor (such as community action agencies, food pantries), identifiable disability groups, and local businesspeople through chambers of commerce with area of each Project Site. Outreach to Westborough community groups included the NAACP Worcester Branch, the Diversity and Inclusion Committee, Westborough CARES, Westborough Human Service Alliance, OUT MetroWest, Corrido 9/495 Regional Chamber, and the Diversity and Inclusion Committee. Outreach to Woburn community groups included the NAACP Mystic Valley Branch, the Westwood Commission on Disability, Woburn Pride, and OUT MetroWest. Outreach to Westwood community groups includes NAACP Framingham Branch, Westwood Commission on Disability, Westwood Food Pantry, and OUT MetroWest.

These groups were invited to the three open community meetings. In addition, the Applicant had in-person discussions wherever requested after outreach, including meetings with the Westwood Chamber of Commerce on February 19, 2020, the Woburn Senior Center on March 4, 2020, and the Westwood Senior Center on March 5, 2020. The Applicant also had meetings scheduled with the Woburn Council for Social Concern scheduled for March 17, 2020 and the Westborough Senior Center scheduled for March 24, 2020, but out of an abundance of caution, these meeting were cancelled due to COVID-19 and the need to enact appropriate social distancing policies. Presentation materials were provided to these organizations and residents were encouraged to call or email with any questions or comments regarding the Proposed Project.

The Applicant anticipates continuing community engagement and outreach to community groups within the primary service areas of the Project Sites to identify community and public health needs and services.

F1.e.ii **Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".**

In addition to the activities described in Section F1.e.ii, to ensure sound community engagement throughout the development of the Proposed Project, the Applicant took the following actions:

- Open Community Meeting at the Westborough DoubleTree Hotel, on February 27, 2020 from 9:00 to 11:00 AM
- Open Community Meeting at the Westwood Site on March 2, 2020 from 6:30 to 8:00 PM
- Open Community Meeting at the Woburn Public Library, on March 6, 2020 from 1:00 to 2:00 PM
- Westwood Chamber of Commerce on February 19, 2020
- Woburn Senior Center on March 4, 2020
- Westwood Senior Center on March 5, 2020
- Email address for questions. In addition to holding the open community meetings, in publicizing that meeting, the Applicant provided the public with an email address for questions about the meeting or the Proposed Project.

For detailed information on these activities, including agendas and presentations, see Attachment 5.

Factor 2: Health Priorities

Addresses the impact of the Proposed Project on health more broadly (that is, beyond the Patient Panel) requiring that the Applicant demonstrate that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.

F2.a. **Cost Containment:**

Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

The goals for cost containment in Massachusetts center on providing low-cost care alternatives without sacrificing high quality. In fact, The Commonwealth's independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care, the Health Policy Commission, has a stated goal of bettering health and care at a lower cost across The Commonwealth. Consequently, the Proposed Project will meaningfully contribute to Massachusetts' goals for cost containment by providing high quality Ambulatory Surgery Services for qualifying lower-acuity patients, Clinical Services in a more cost-effective setting. Accordingly, the Proposed Project will lower costs, as well as overall TME and total healthcare expenditures.

In addition, the Proposed Project seeks to align with these goals and meaningfully contribute to cost containment in Massachusetts by providing cost-effective high-quality Clinical Services and creating care efficiencies for the Applicant's patient panel. This will ultimately reduce overall provider costs, directly impacting TME. With the expansion of access to Clinical Services in a more cost-effective setting, including increased access to local primary and specialty Physician Services, the Proposed Project will compete on the basis of TME and provider costs, and contribute positively to The Commonwealth's goals of containing the rate of growth of TME and total health care expenditures.

F2.b. **Public Health Outcomes:**

Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

The offering of the Clinical Services, co-located at the Project Sites, will improve public health outcomes as patients will have access to high quality Clinical Services in the community. This convenient access to the Clinical Services will allow patients to schedule surgeries, procedures, and medical appointments in a timely manner, avoiding unnecessary travel barriers to obtaining care (driving to Boston, expensive parking, etc.) and the creation of a better patient care experience. Moreover, as discussed, studies have documented the benefits that patients receive by obtaining surgical care in the ambulatory setting – given that doctors and staff only specialize in specific types of surgery at the location – and can create efficiencies tailored to the facility and its relatively limited range of procedures and patient complexities. This experience translates to better outcomes for patients, as well as increased overall satisfaction with their care. When patients receive timely care in the appropriate setting and achieve cost savings, both the healthcare market, patients, and The Commonwealth benefit from these practices.

The Project Sites require CT and MRI capacity as demonstrated by the current volume of such services being provided by the Applicant, at other facilities, to the members of the Patient Panel residing within the primary service are of a Project Site, the anticipated growth in the Patient Panel, and the overall anticipated growth in demand for CT and MRI services throughout the Patient Panel and the general population. Providing CT and MRI services at the Project Sites will improve patient outcomes by leading to earlier diagnoses and tailored treatment plans based on the results of such imaging.

Patients will also benefit from co-located services. The co-location of primary and specialty care with the CT and MRI services at the Project Sites will permit patients in the communities surrounding each of the Project Sites to have many of their healthcare needs met, and obviate the need to travel further for the Clinical Services. Additionally, for patients who reside near a Project Site but who are seen by the Applicant's specialists in downtown Boston, enhanced and co-located Imaging Services, primary care, and specialty physician capabilities in their community, as part of a system of coordinated care, permits those patients to have pre- or post- visits closer to home, eliminating unnecessary travel, stress and expense. Co-located Clinical Services and other ancillary services at the Project Sites will provide primary care practitioners and specialists, including those located at a Project Site or one of the Applicant's hospitals, with timely clinical information needed to treat their patients. Absent the Proposed Project, patients will experience longer wait times or will need to receive Ambulatory Surgery Services, Physician Services, and/or CT and MRI services at a separate location, which may be in Boston.

In addition to the Clinical Services, the Project Sites anticipate offering physical therapy gyms, endoscopy, infusion, nutrition, virtual care and telehealth, behavioral health, pharmacist support, dietician support, social workers, athletic trainers, and health coaches. By providing improved access to timely co-located care and ancillary services in the appropriate integrated care setting, the Proposed Project will improve health outcomes for Massachusetts patients and the Massachusetts health care market overall.

F2.c. **Delivery System Transformation:**

Because the integration of social services and community-based expertise is central to goal of delivery system transformation, discuss how the needs of their Patient Panel have been assessed and linkages to social services organizations have been created and how the social determinants of health have been incorporated into care planning.

As outlined in Section F.1.b.ii, above, the Applicant has a number of programs, processes, and protocols to connect patients with social services organizations. Patients receiving Clinical Services at a Project Site will have access to clinical social workers. These clinical social workers can assess patient needs and work with patients and their families to implement appropriate interventions. As indicated in Section F1.b.iii, above, each Project Site will work with its surrounding greater community to address social determinants of health, including through health education, around topics identified as relevant to the community. Such topics may include, for example, domestic violence prevention, food insecurity, and, due to an aging Patient Panel, key concerns for seniors.

Behavioral Health

Millions of people are affected by mental illness each year. Depression and anxiety disorders cost the economy $1 trillion annually in lost productivity, while depression is the leading cause of disability worldwide each year.[102] In addition, research indicates that people with serious mental illness have an increased risk for chronic diseases like diabetes or cancer, and high-cost users of medical care with comorbid mental illness or addiction had greater historical medical morbidity and higher total medical care costs than those without.[103] Given the national shortage of services for patients with psychiatric disorders, patients are looking for care anywhere they can, yet only about half of the people in the U.S. with mental health disorders receive any treatment, and many who do get treatment receive it from a primary care provider, not a behavioral health specialist.

As a result, health care organizations have been searching for ways to provide more effective models of care for this population. Integrating behavioral health services into the primary care setting—that is, "blend[ing] care in one setting for medical conditions and related behavioral health factors that affect health and well-being"—is one increasingly popular, well-studied way to increase access to mental health services in a setting where patients are comfortable.[104] Integrated behavioral health is associated with a host of benefits, including but not limited to the following:

- Reduced net costs on patients who received a collaborative care intervention within four years (of the intervention) and, among the subset with diabetes, within three years.[105]
- Improved patient experience. Integrated care makes it simple for patients to find and access behavioral health treatments. Furthermore, patients may be more willing

[102] https://nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Impact-Ripple-Effect-FINAL.pdf.
[103] Psychosomatics, 2018 Mar-Apr; 59(2) 135-143, available at https://www.ncbi.nlm.nih.gov/pubmed/29157683.
[104] Agency for Healthcare Research and Quality, available at https://integrationacademy.ahrq.gov/about/what-integrated-behavioral-health.
[105] https://www.ajmc.com/journals/issue/2008/2008-02-vol14-n2/feb08-2835p095-100.

to accept behavioral health treatments if they do not have to deal with any stigma associated with visiting a mental health clinic.[106]

- Improved provider experience. Numerous studies have established the value of integrated behavioral health in reducing provider burnout and stress.[107] Numerous Mass General Brigham providers have expressed relief that they have the support of collaborative care teams to co-manage patients and of resource specialists to help patients locate needed referrals.
- Improved clinical outcomes.[108]

Studies such as these have led health care providers, payers and governments across the country to recognize the importance of addressing mental health in order to improve overall health—The Commonwealth of Massachusetts and Mass General Brigham included. Because of this recognition, and because of the body of evidence showing how psychotherapeutic techniques can improve many other aspects of disease management and wellness, the Applicant has committed to integrating behavioral health into the Clinical Services offered at the Project Sites. The Applicant anticipates offering embedded psychiatric outpatient services as well as behavioral health care integrated into medical management at all of the Project Sites.

- The Project Sites will have access to integrated behavioral health teams built on the nationally accepted collaborative care model and offering access to a range of population health interventions. These teams will include a care manager and a psychiatric consultant; furthermore, if the care manager is not a licensed social worker, the team will also be supported by a licensed clinical social worker. The care manager will assess the needs of referred patients, including screening for substance use disorders, and the team will decide whether the patient can be managed in primary care or should be referred to specialty care. If the former, the care manager will monitor symptoms, support medication initiation and adherence, and provide behavioral interventions to reduce symptoms; the psychiatric consultant will guide the primary care provider in starting and/or adjusting medication treatment; and the team can also refer the patient for internet-based cognitive behavior therapy. If the latter, the care manager (working with a resource specialist) will assist the patient with finding referrals and establishing treatment.
- Practices at the Project Sites either will have their own embedded collaborative care teams or will have access to the primary care-based collaborative care teams.
- Project Site providers will have access to eConsult services to help them answer questions about behavioral health/substance use disorders, whether about diagnosis, medication management, or appropriate level of care.
- The Project Sites will have access to behavioral health resource specialists who can assist with referring patients to specialty mental health services as well as other resources.

[106] https://www.ncbi.nlm.nih.gov/pubmed/26963777.
[107] https://www.ncbi.nlm.nih.gov/pubmed/26963777.
[108] https://www.ncbi.nlm.nih.gov/pubmed/23076925 Cochrane Database Syst Rev. 2012 Oct 17;10:CD006525. doi: 10.1002/14651858.CD006525.pub2.Collaborative care for depression and anxiety problems. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P.

- The Project Sites will offer outpatient psychiatric services, including medication management and psychotherapy (grounded in evidence-based treatments). IC, plans to pilot innovative models to improve the capacity of specialists to provide behavioral health treatment (e.g., care coordinators, walk-in models, brief stabilization services, team-based care) and otherwise improve patient access to services.
- The Project Sites will have access to licensed clinical social workers, who can provide case management and help connect patients to social services.
- All Project Site providers will be offered training in psychotherapy-based techniques to promote behavior change and disease self-management.

Given the shortage of access to behavioral health providers and care, the Project Sites will utilize telehealth and other digital health solutions to improve access to behavioral health support (e.g., video visits; internet-based psychotherapy; self-management apps). Access to behavioral health services through telehealth, where medically appropriate, will allow the Project Sites to offer behavioral health care patients in various circumstances, and ensure that care is provided at the right time and in the right setting. When medically appropriate, telehealth will also provide behavioral health care to patients that may not be able to get to a Project Site.[109]

Furthermore, as the Patient Panel grows, the Project Sites will have the capacity to add additional behavioral health resources depending on patient interest and need, such as the following:

- Shared medical management groups for diabetes or other chronic illnesses
- Illness coping groups (e.g., chronic pain)
- Stress reduction groups
- Skill-building groups (ex.: problem solving treatment, cognitive behavior therapy)

Based on the needs of the Patient Panel, certain Project Sites may add recovery coaches and, if there is sufficient need, office-based addiction treatment ("OBAT") nurses, with funding support from Mass General Brigham Population Health and Mass General Brigham Quality and Patient Experience. Similarly, the Project Sites may pilot the use of health coaches and outreach workers (e.g., community health workers) at certain Project Sites.

[109] Langarizadeh M., Tabatabaei M.S., Tavakol K., Naghipour M., Rostami A., Moghbeli F. *Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review* Acta Informat. Med. 2017;254:240–246 (finding that telehealth "has multiple capability and technologies for providing effective interventions to patients with various mental illnesses."); *See also* Koons, Cynthia, *The Mental-Health-Care System Isn't Ready for COVID-19 Either*, Bloomberg Businessweek, Apr. 1 2020, available at https://www.bloomberg.com/news/articles/2020-04-01/the-u-s-mental-health-care-system-isn-t-ready-for-coronavirus (stating the Coronavirus pandemic has led to a spike in therapy through telehealth).

Factor 5: Relative Merit

F5.a.i **Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.**

The Proposed Project is part of the Applicant's ambulatory care strategy to bring health care closer to where Mass General Brigham's patients live, at lower costs. The Proposed Project is part of nearly a $400 million investment in new health care offerings in eastern Massachusetts and southern New Hampshire. As the health care market continues to evolve, patients are demanding convenience and lower cost services. The Proposed Project seeks to meet those demands while developing value-based models of care for the Applicant's patients and address widespread disparities that continue to persist in health care. As discussed throughout this Application, the Applicant aims to deliver affordable primary, secondary, and behavioral health care in the community. The Applicant will also make patient-centered programs and services central to delivering better outcomes for the Patient Panel available at the Project Sites. The Proposed Project is one part of Mass General Brigham's overarching goal to reimagine the outpatient experience through research and engagement with patients, physicians and care givers.

Proposal: The Proposed Project is for the establishment of the Ambulatory Surgery Services, Physician Services, and CT and MRI services at the Project Sites.

Quality: Studies have shown that patients receiving care in ambulatory care settings - including medical offices and clinics, diagnostics imaging centers, ambulatory surgery centers, and hospital outpatient departments have high-quality outcomes, similar to patients who obtain these services in the inpatient setting. Given specialization by clinicians and their level of experience in specific fields, care is effective, timely and seamless in these ambulatory care settings. Moreover, the Applicant follows various quality assurance programs and utilizes various quality assurance mechanisms to ensure patients receive high-quality, patient-focused imaging and related diagnostic and support care.

Efficiency: Both care and operating efficiencies may be created through the shift of lower-acuity patients to a more cost-effective setting – allowing for lower costs and higher quality outcomes.
Capital Expense: There are capital expenses associated with the implementation of the Clinical Services. The total capital expenditure cost for the Proposed Project is $223,724,658.

Operating Costs: The first-year incremental operating expense of the Proposed Project is $154,510,912.

List alternative options for the Proposed Project:

Option 1

Alternative Proposal: The first alternative for the Proposed Project would be to maintain the status quo and not establish the Project Sites.

Alternative Quality: This is not a feasible solution, as demand for the services, wait times, patient experience, and convenience would not be addressed and would have a negative impact on the Patient Panel that are seeing providers at more distant locations but who will benefit from having the Clinical Services available close to home. Moreover, the benefits of co-located Clinical Services, including behavioral health would not be realized. The benefits of having co-located services are outlined in various sections throughout this Application.

Alternative Efficiency: This alternative would be inefficient because it would not create operating efficiencies that may be achieved through co-location of the Clinical Services and ancillary services that would be available at the Project Sites.

Alternative Capital Expenses: Although this alternative would allow the Applicant to forego certain construction costs and other capital expenses, including the cost of acquiring CT and MRI units, it would have an overall negative impact on access, quality of care, and patient and provider satisfaction.

Alternative Operating Costs: There would be no operating costs associated with not establishing the Project Sites. However, this alternative would exacerbate patient care fragmentation and need for patients to travel outside their community to receive the Clinical Services at one of the Applicant's other locations.

Option 2

Alternative Proposal: The second alternative for the Proposed Project would be to not provide Ambulatory Surgery Services at the Project Sites.

Alternative Quality: This is not a feasible solution, as demand for quality, services, wait times, patient experience, and convenience regarding Ambulatory Surgery Services would not be addressed. This alternative would also have a negative impact on the Patient Panel, requiring patients to see providers at more distant locations when such patients would be able to have lower-acuity surgery performed close to home. Moreover, the benefits of co-located Clinical Services, including behavioral health would not be realized. The benefits of having co-located services are outlined in various sections throughout this Application.

Alternative Efficiency: This alternative would be inefficient because it would not create operating efficiencies that may be achieved through co-location of the full complement of Clinical Services and ancillary services that would be available at the Project Sites.

Alternative Capital Expenses: Although this alternative would allow the Applicant to forego certain capital expenditures, it would have an overall negative impact on access, efficient, quality of care, and patient and provider satisfaction

Alternative Operating Costs: Although this alternative would decrease the operating costs of the Project Sites, the Applicant's patients who qualify for ambulatory care surgery would then be receiving services in a facility which has higher operating costs, i.e. a hospital. Additionally, this alternative would exacerbate patient care fragmentation and the need for patients to travel outside their community to receive the Ambulatory Surgery Services at one of Applicant's other locations.

Option 3

Alternative Proposal: The third alternative for the Proposed Project would be to not provide CT and MRI services at the Project Sites.

Alternative Quality: This is not a feasible solution, as demand for quality, services, wait times, patient experience, and convenience would not be addressed. This alternative would not alleviate wait times for MRI and CT services in the Applicant's system. This alternative would also have a negative impact on the Patient Panel, requiring patients to obtain CT and MRI services at separate and distant locations in the Applicant's system or other locations, when the Proposed Project would enable such patients to have CT and MRI services performed at a Project Site close to home.

Furthermore, the Applicant views CT and MRI services as an integral part of patient care and population health management within the Applicant's system. Therefore, even if the Applicant contracted with other area providers for CT and MRI services, scans would be performed external to the Applicant's system, without the benefit of the rigorous utilization and quality control processes for CT and MRI that are consistent across the Applicant's facilities. The CT and MRI services provided at the Project Sites will be interpreted by radiologists, including specialty radiologists, within the Applicant's system who have complete access to the patient's EHR and are able to communicate real time with their colleagues. Additionally, while area locations may have current capacity, many are part of or affiliated with other area hospitals, including those that are themselves part of health care systems spearheaded by academic medical centers. As these systems move care to locations outside of the academic medical center, volume at these locations is likely to increase, and these providers will prioritize their own patients when scheduling. Moreover, the benefits of co-located Clinical Services, including behavioral health would not be realized.

Alternative Efficiency: This alternative would be inefficient because it would not create operating efficiencies that may be achieved through co-location of the Clinical Services, including CT and MRI services and ancillary services that would be available at the Project Sites.

Alternative Capital Expenses: Although this alternative would allow the Applicant to forego certain capital expenditures, including the cost of acquiring the CT and MRI units,

it would have an overall negative impact on access, efficient, quality of care, and patient and provider satisfaction.

Alternative Operating Costs: Although this alternative would decrease the operating costs of the Project Sites, the Patient Panel would not receive CT and MRI services at the Project Sites, and may receive these services outside of Applicant's system, and potentially at a higher cost. Additionally this alternative would exacerbate patient care fragmentation and, in some cases, the need to travel outside of their community to receive the MRI and CT services at one of the Applicant's other locations.

Attachment 1
Applicant Patient Panel Demographic Information

	FY17 Count and %		FY18 Count and %		FY19 Count and %		FY20YTD[2] Count and %	
Total	1,408,587		1,504,625		1,528,359		634,989	
Gender								
Female	820,910	58.3%	874,793	58.1%	883,913	57.8%	379,809	59.8%
Male	587,404	41.7%	629,708	41.9%	644,286	42.2%	255,110	40.2%
Other/Unknown	273	0.0%	124	0.0%	160	0.0%	70	0.0%
Age								
0-17	147,325	10.5%	166,985	11.1%	179,388	11.7%	59,815	9.4%
18-64	859,511	61.0%	919,998	61.1%	948,501	62.1%	374,338	59.0%
65+	401,551	28.5%	417,605	27.8%	400,441	26.2%	200,785	31.6%
Unknown	200	0.0%	37	0.0%	29	0.0%	51	0.0%
Race								
American Indian or Alaska Native	1,656	0.1%	1,946	0.1%	2,045	0.1%	828	0.1%
Asian	58,502	4.2%	62,723	4.2%	66,601	4.4%	26,468	4.2%
Black or African American	81,341	5.8%	83,703	5.6%	85,627	5.6%	34,562	5.4%
Hispanic/Latino	22,089	1.6%	20,631	1.4%	19,630	1.3%	9,697	1.5%
Native Hawaiian or Other Pacific Islander	1,122	0.1%	1,128	0.1%	1,117	0.1%	362	0.1%
Other/Unknown	213,833	15.2%	234,921	15.6%	232,058	15.2%	77,918	12.3%
White	1,030,044	73.1%	1,099,573	73.1%	1,121,281	73.4%	485,154	76.4%
MGB PCP on Epic?								
Yes	592,167	42.0%	656,099	43.6%	690,637	45.2%	360,776	56.8%
No	816,420	58.0%	848,526	56.4%	837,722	54.8%	274,213	43.2%
Risk Contract								
BCBS	151,787	25.6%	163,675	24.9%	171,923	24.9%	N/A- eligibility based on last month of FY	
HPHC	38,158	6.4%	37,368	5.7%	36,118	5.2%		
MHACO	39,261	6.6%	67,905	10.3%	73,038	10.6%		
PACO	71,411	12.1%	82,591	12.6%	90,651	13.1%		
TAHP	18,596	3.1%	19,516	3.0%	20,399	3.0%		
None[1]	272,954	46.1%	285,044	43.4%	298,508	43.2%		

[1] AllWays Health risk data is captured in "None".

[2] FY20 is pulled as of January 7, 2020.

Attachment 2
Primary Service Areas

Westborough Project Site	Woburn Project Site	Westwood Project Site
01503	01730	02021
01519	01731	02026
01532	01801	02030
01536	01810	02032
01545	01864	02052
01568	01821	02062
01581	02420	02081
01701	02421	02132
01702	02474	02136
01721	02476	02492
01740	01876	02494
01745	01803	02090
01748	01867	
01749	01880	
01752	01887	
01757	01890	
01772	01940	
	02153	
	02155	
	02176	
	02180	

Attachment 3
Patient Panel Demographic Information

	FY17 Count and %		FY18 Count and %		FY19 Count and %		FY20YTD[1] Count and %	
Patient Panel Total	215,548		219,423		227,371		96,861	
Gender								
Female	127,577	59%	129,360	59%	133,429	59%	58,986	61%
Male/Other/Unknown	87,971	41%	90,063	41%	93,942	41%	37,875	39%
Age								
0-17	23,389	11%	25,028	11%	27,299	12%	8,832	9%
18-64	135,063	63%	138,429	63%	144,301	63%	59,132	61%
65+	57,096	26%	55,966	26%	55,771	25%	28,897	30%
Unknown	-	0%	-	0%	-	0%	-	0%
Race								
American Indian or Alaska Native	247	0%	264	0%	299	0%	114	0%
Asian	12,301	6%	13,006	6%	13,778	6%	5,585	6%
Black or African American	10,052	5%	10,146	5%	10,631	5%	4,442	5%
Hispanic/Latino	3,233	1%	3,078	1%	2,950	1%	1,501	2%
Native Hawaiian or Other Pacific Islander	130	0%	121	0%	137	0%	40	0%
Other/Unknown	21,703	10%	22,707	10%	25,158	11%	8,715	9%
White	167,882	78%	170,101	78%	174,418	77%	76,464	79%
MGB PCP on Epic?								
Yes	105,942	49%	111,605	51%	117,613	52%	61,166	63%
No	109,606	51%	107,818	49%	109,758	48%	35,695	37%
Risk Contract								
BCBS	30,026	28%	32,725	29%	33,796	29%		
HPHC	7,982	8%	7,855	7%	7,655	7%		
MHACO	3,665	3%	6,271	6%	6,888	6%	N/A- eligibility based on last month of FY	
PACO	11,450	11%	12,851	12%	15,792	13%		
TAHP	3,383	3%	3,644	3%	3,927	3%		
None[2]	49,436	47%	48,259	43%	49,555	42%		

[1] FY20 is pulled as of January 7, 2020.
[2] AllWays Health risk data is captured in "None".

Westborough Site

	FY17 Count and %		FY18 Count and %		FY19 Count and %		FY20YTD[3] Count and %	
Total	41,254		42,251		42,666		16,208	
Gender								
Female	25,061	61%	25,538	60%	25,693	60%	10,044	62%
Male/Other/Unknow[n]	16,193	39%	16,713	40%	16,973	40%	6,164	38%
Age								
0-17	3,837	9%	4,093	10%	4,504	11%	1,259	8%
18-64	25,786	63%	26,565	63%	26,855	63%	10,031	62%
65+	11,631	28%	11,593	27%	11,307	27%	4,918	30%
Unknown	-	0%	-	0%	-	0%	-	0%
Race								
American Indian or Alaska Native	53	0%	64	0%	55	0%	11	0%
Asian	2,356	6%	2,502	6%	2,542	6%	973	6%
Black or African American	1,151	3%	1,137	3%	1,187	3%	427	3%
Hispanic/Latino	196	0%	163	0%	140	0%	61	0%
Native Hawaiian or Other Pacific Islander/Other/Unknown[1]	4,034	10%	4,151	10%	4,374	10%	1,355	8%
White	33,464	81%	34,234	81%	34,368	81%	13,381	83%
MGB PCP on Epic?								
Yes	21,374	52%	22,703	54%	22,751	53%	9,872	61%
No	19,880	48%	19,548	46%	19,915	47%	6,336	39%
Risk Contract								
BCBS	6,031	28%	6,574	29%	6,642	29%		
HPHC	1,483	7%	1,452	6%	1,336	6%		
MHACO	228	1%	450	2%	489	2%	N/A- eligibility based on last month of FY	
PACO	1,723	8%	2,142	9%	3,237	14%		
TAHP	687	3%	787	3%	862	4%		
None[4]	11,222	53%	11,298	50%	10,185	45%		

[3] FY20 is pulled as of January 7, 2020.

[4] AllWays Health risk data is captured in "None".

Westwood Site

	FY17 Count and %		FY18 Count and %		FY19 Count and %		FY20YTD[5] Count and %	
Total	77,222		78,585		80,859		36,188	
Gender								
Female	46,222	60%	46,861	60%	48,235	60%	22,521	62%
Male/Other/Unknown	31,000	40%	31,724	40%	32,624	40%	13,667	38%
Age								
0-17	8,942	12%	9,507	12%	10,296	13%	2,969	8%
18-64	47,156	61%	48,405	62%	50,494	62%	22,011	61%
65+	21,124	27%	20,673	26%	20,069	25%	11,208	31%
Unknown	-	0%	-	0%	-	0%	-	0%
Race								
American Indian or Alaska Native	108	0%	99	0%	116	0%	52	0%
Asian	2,705	4%	2,933	4%	3,071	4%	1,232	3%
Black or African American	5,822	8%	5,819	7%	6,079	8%	2,656	7%
Hispanic/Latino	2,697	3%	2,595	3%	2,496	3%	1,296	4%
Native Hawaiian or Other Pacific Islander	77	0%	71	0%	82	0%	20	0%
Other/Unknown	7,044	9%	7,684	10%	8,470	10%	3,186	9%
White	58,769	76%	59,384	76%	60,545	75%	27,746	77%
PCP on Epic?								
Yes	40,768	53%	42,740	54%	44,980	56%	24,596	68%
No	36,454	47%	35,845	46%	35,879	44%	11,592	32%
Risk Contract								
BCBS	10,988	27%	11,902	28%	12,429	28%		
HPHC	3,651	9%	3,657	9%	3,659	8%		
MHACO	1,906	5%	3,079	7%	3,314	7%	N/A- eligibility based on last month of FY	
PACO	4,935	12%	5,533	13%	6,185	14%		
TAHP	1,287	3%	1,421	3%	1,519	3%		
None[6]	18,001	44%	17,148	40%	17,874	40%		

[5] FY20 is pulled as of January 7, 2020.
[6] AllWays Health risk data is captured in "None".

Woburn Site

	FY17 Count and %		FY18 Count and %		FY19 Count and %		FY20YTD[7] Count and %	
Total	97,072		98,587		103,846		44,465	
Gender								
Female	56,294	58%	56,961	58%	59,501	57%	26,421	59%
Male/Other/Unknown[1]	40,778	42%	41,626	42%	44,345	43%	18,044	41%
Age								
0-17	10,610	11%	11,428	12%	12,499	12%	4,604	10%
18-64	62,121	64%	63,459	64%	66,952	64%	27,090	61%
65+	24,341	25%	23,700	24%	24,395	23%	12,771	29%
Unknown	-	0%	-	0%	-	0%	-	0%
Race								
American Indian or Alaska Native	86	0%	101	0%	128	0%	51	0%
Asian	7,240	7%	7,571	8%	8,165	8%	3,380	8%
Black or African American	3,079	3%	3,190	3%	3,365	3%	1,359	3%
Hispanic/Latino	340	0%	320	0%	314	0%	144	0%
Native Hawaiian or Other Pacific Islander	53	0%	50	0%	55	0%	20	0%
Other/Unknown	10,625	11%	10,872	11%	12,314	12%	4,174	9%
White	75,649	78%	76,483	78%	79,505	77%	35,337	79%
PCP on Epic?								
Yes	43,800	45%	46,162	47%	49,882	48%	26,698	60%
No	53,272	55%	52,425	53%	53,964	52%	17,767	40%
Risk Contract								
BCBS	13,007	30%	14,249	31%	14,725	30%	N/A- eligibility based on last month of FY	
HPHC	2,848	7%	2,746	6%	2,660	5%		
MHACO	1,531	3%	2,742	6%	3,085	6%		
PACO	4,792	11%	5,176	11%	6,370	13%		
TAHP	1,409	3%	1,436	3%	1,546	3%		
None[8]	20,213	46%	19,813	43%	21,496	43%		

[7] FY20 is pulled as of January 7, 2020.
[8] AllWays Health risk data is captured in "None".

Attachment 4
Patient Panel Payer Mix

Westborough

Risk Contract percentages FY19 (to be considered a covered life in an Applicant risk contract in a given FY, the patient must be enrolled in the risk contract in the last month of the same FY.	**Payer Mix-List percentages FY19**
• Risk Contracts 55% • Non-Risk Contracts 45%	• AllWays Health 6% • Big 3 HMO 21% • Big 3 PPO 23% • Medicaid/Managed 5% • Medicare/Managed 28% • Other 18%

Woburn

Risk Contract percentages FY19 (to be considered a covered life in an Applicant risk contract in a given FY, the patient must be enrolled in the risk contract in the last month of the same FY.	**Payer Mix-List percentages FY19**
• Risk Contracts 57% • Non-Risk Contracts 43%	• AllWays Health 11% • Big 3 HMO 16% • Big 3 PPO 26% • Medicaid/Managed 8% • Medicare/Managed 23% • Other 16%

Westwood

Risk Contract percentages FY19 (to be considered a covered life in an Applicant risk contract in a given FY, the patient must be enrolled in the risk contract in the last month of the same FY.	**Payer Mix-List percentages FY19**
• Risk Contracts 60% • Non-Risk Contracts 40%	• AllWays Health 9% • Big 3 HMO 18% • Big 3 PPO 17% • Medicaid/Managed 12% • Medicare/Managed 23% • Other 21%

Attachment 5 - Community Engagement Materials

PARTNERS
HEALTHCARE

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U.S. Postage
PAID
Newburyport, MA
Permit No. 112

P.S. can you take our community survey by scanning this code or going to bit.ly/PartnersSurvey2020?

Monday
March 2, 2020
6:30 PM

Brigham and Women's
Health Care Center
Second Floor
100 Brigham Way, University Station
Westwood, MA 02090

Please Join Us For

Coffee & Conversation

You're invited to join our staff, patients, and neighbors for an informational presentation and discussion of our planned care center expansion in Westwood.

For questions or to RSVP please:

WestwoodInfo@partners.org

617-513-1787

bit.ly/WestwoodRSVP

PARTNERS
HEALTHCARE

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Newburyport, MA
Permit No. 112

P.S. can you take our community survey by scanning this code or going to bit.ly/PartnersSurvey2020?

Please Join Us For

Coffee & Conversation

Friday
March 6, 2020
1:00 PM

Woburn Public Library
Meeting Room
45 Pleasant St, Woburn, MA 01801

You're invited to join our staff, patients, and neighbors for an informational presentation and discussion of a planned outpatient care center in Woburn.

For questions or to RSVP please:

WoburnInfo@partners.org

617-513-1787

bit.ly/WoburnRSVP

Thursday
February 27, 2020
9:00 AM

DoubleTree by Hilton Boston
Nugget/Wellington Room
5400 Computer Drive
Westborough, MA 01581

Please Join Us For

Coffee & Conversation

You're invited to join our staff, patients, and neighbors for an informational presentation and discussion of a planned outpatient care center in Westborough.

For questions or to RSVP please:

WestboroInfo@partners.org

617-513-1787

bit.ly/WestboroRSVP

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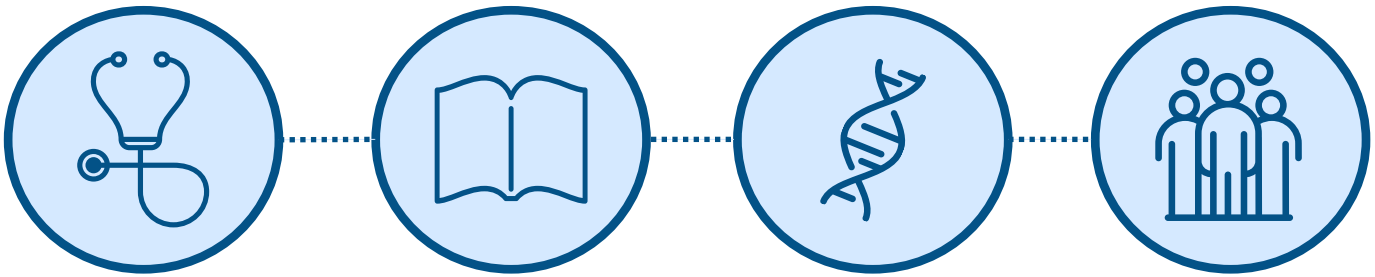
P.S. can you take our community survey by scanning this code or going to bit.ly/PartnersSurvey2020?

PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

Bringing Outpatient Services to Westborough



Goals of coming to Westborough

Partners is committed to delivering high quality, low cost outpatient care that improves the health and well-being of our patients

Our goal with our Westborough facility is to provide:

1. **Access:** Provide outstanding care to our patients by creating *convenient community sites*

2. **Cost Reduction:** Convenient community sites provide *lower-cost options* and innovative delivery models efficiently managing patient care in the Partners System

3. **Innovation**: Less complex care is provided in convenient community sites that focus on patients using *innovative digital solutions*

Westborough Facility Services

- Primary Care Adults and Children
- Behavioral Health
- General Surgery
- Pain Management Non-Anesthesia
- Ophthalmology
- Gastroenterology
- Cardiology Non-Invasive
- Orthopedic General Surgery
- Urology
- Neuroscience
- Rheumatology
- Otorhinolaryngology (Ear, Nose, Throat)

PARTNERS HEALTHCARE

Westborough Facility Location

1400 WEST PARK DR
WESTBOROUGH

Just off Rte. 9 near the 495 interchange

Many people from this area drive into Boston today for appointments at Partners sites annually.

We want to bring that care locally.

Reimagining the Patient Experience

Partners is working to *reimagine outpatient care*

We are using research to provide better care by understanding the needs of patients, physicians, and care givers needs focusing on the relationships between them to make healthcare *less complicated, less fragmented, and less costly.*

We've just started this journey. That's why we want to hear from you.

I look forward to the day my vitals are done via Amazon."

- Local Healthcare Leader

"I wish there was a place where doctors were more focused on a wellness approach, not just a pill."

- Westborough Patient

"Having every provider connected to the full picture of my health and collaborate on my treatments sounds great…isn't this how it's all supposed to work?"

- Southborough Patient

Source: Interviews conducted by IDEO

The Common Denominator

We have two of the best hospitals in the world at MGH and Brigham & Women's. But getting there is not always convenient.

> 65%
of our local patients

Find congestion and parking costs make it difficult to get care at Boston hospitals

> 70%
of our local patients

Want their health care providers in one location closer to home

> 55%
of our local patients

Would be more likely to get preventative care if it was closer to their home

Source: Community Health Survey

We Want to Learn From You….

What matters most to you as a patient?

What are your concerns?

What are your hopes?

What can be better?

Questions?

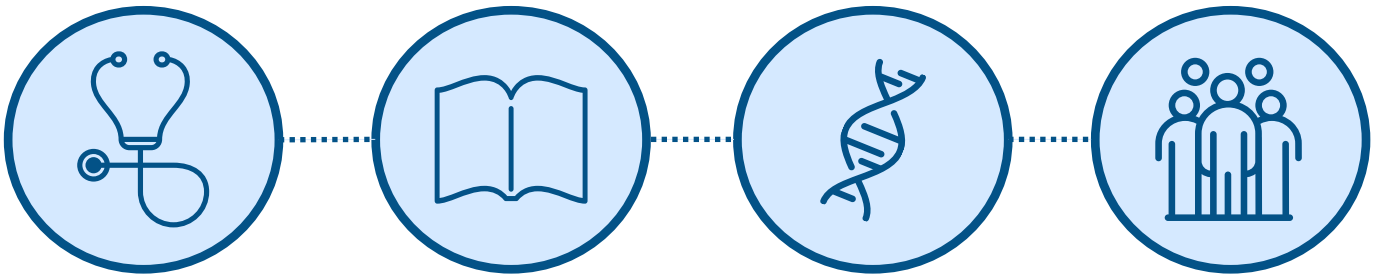
More thoughts? Take our community survey at:
bit.ly/PartnersSurvey2020

Or contact us at WestboroInfo@partners.org

PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

Bringing Outpatient Services to Woburn



Goals of coming to Woburn

Partners is committed to delivering high quality, low cost outpatient care that improves the health and well-being of our patients

Our goal with our Woburn facility is to provide:

1. **Access:** Provide outstanding care to our patients by creating *convenient community sites*

2. **Cost Reduction:** Convenient community sites provide *lower-cost options* and innovative delivery models efficiently managing patient care in the Partners System

3. **Innovation**: Less complex care is provided in convenient community sites that focus on patients using *innovative digital solutions*

Woburn Facility Services

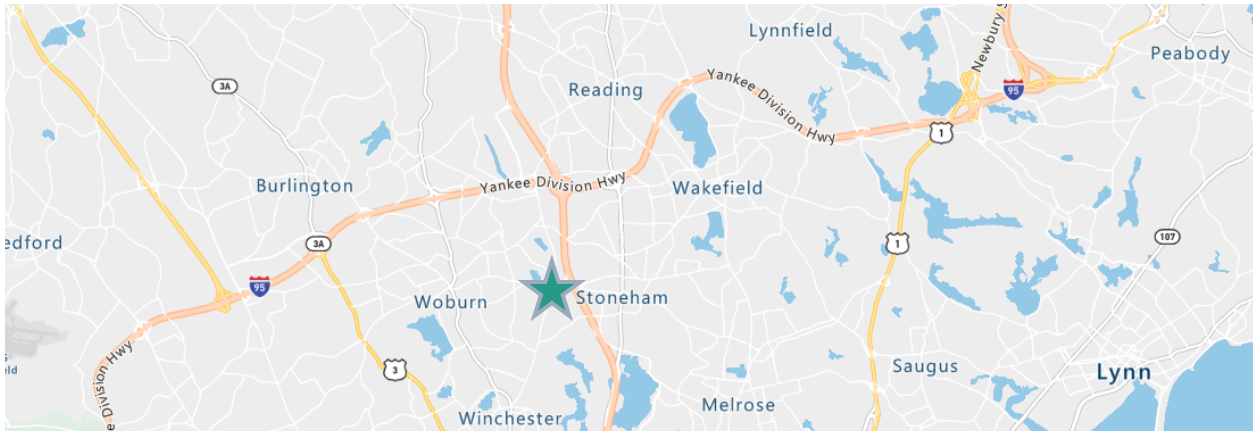
- Primary Care Adults and Children
- General Surgery
- Pain Management Non-Anesthesia
- Cardiology Non-Invasive
- Pulmonary Medicine
- Imaging (CT, MRI, X-Ray, Mammography, Bone Density, etc.)
- Behavioral Health
- Orthopedic General Surgery
- Rheumatology
- Gastroenterology
- Urology
- Same Day Surgery

PARTNERS HEALTHCARE

Woburn Site Location

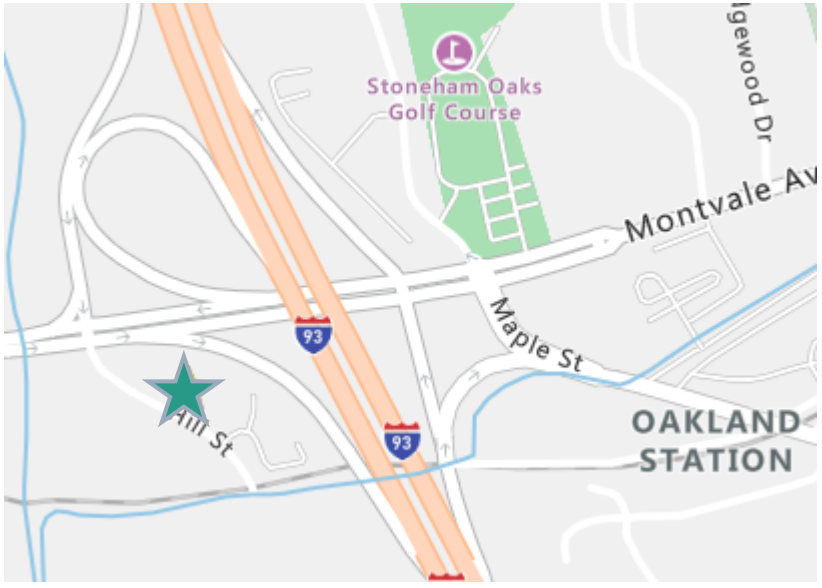
MONTVALE AVE
WOBURN

Just off Rte. 93 on Montvale Ave



Many people from this area drive into Boston today for appointments at Partners sites annually.

We want to bring that care locally.



Reimagining the Patient Experience

Partners is working to *reimagine outpatient care*

We are using research to provide better care by understanding the needs of patients, physicians, and care givers needs focusing on the relationships between them to make healthcare *less complicated, less fragmented, and less costly.*

We've just started this journey. That's why we want to hear from you.

I look forward to the day my vitals are done via Amazon."

- Local Healthcare Leader

"Medical symptoms are hard to relay when you don't know the person and only have 10 min. You miss out if you don't give people time to open up."

- Woburn Patient

"Having every provider connected to the full picture of my health and collaborate on my treatments sounds great…isn't this how it's all supposed to work?"

- Reading Patient

Source: Interviews conducted by IDEO

The Common Denominator

We have two of the best hospitals in the world at MGH and Brigham & Women's. But getting there is not always convenient.

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> 70%
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> 55%
of our local patients

Would be more likely to get preventative care if it was closer to their home

Source: Community Health Survey

We Want to Learn From You….

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What are your hopes?

What can be better?

Questions?

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Or contact us at WoburnInfo@partners.org

PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

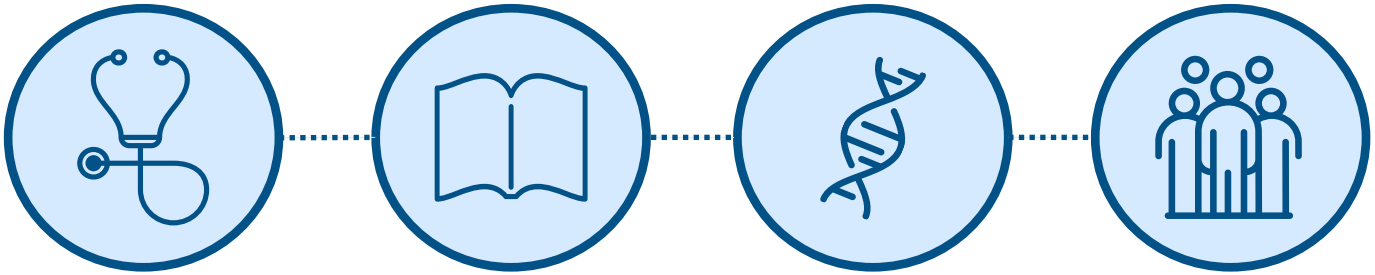
BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S
Health Care Center, Westwood

Bringing Additional Services to Westwood – An Overview

Brigham Health Care Center – Westwood

March 2, 2020

VIEW FROM NORTHWEST



Agenda

Determination of Need process – overview

Current services

Partners Ambulatory Care – investing in the community

Proposed Expansion here in Westwood

- **Construction overview**
- **Proposed services**
- **Feedback and thoughts**

Conclusion

The Common Denominator

We have two of the best hospitals in the world at MGH and Brigham & Women's. But getting there is not always convenient.

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> 70%
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Want their health care providers in one location closer to home

> 55%
of our local patients

Would be more likely to get preventative care if it was closer to their home

Source: Community Health Survey

Determination of Need Process (DoN)

- A Determination of Need (DoN) is a state regulatory process that healthcare providers must go through in order to ensure that the services being considered for expansion meet the needs of the community.

- In order to add Physician Services, Procedural Services, Ambulatory Surgery Services, and Major Imaging services (CT and MRI) to the new building here in Westwood, approval is required from the Massachusetts Department of Public Health

- Targeting Spring 2020 to submit the DoN to the Massachusetts Department of Public Health

Overview of Timelines

- Building construction is targeted to begin Fall 2020
- Patient parking garage is projected to open late Summer 2021
- We anticipate the building opening in Summer 2022

Current services here in Westwood

Since our opening in October 2018, we have added specialties such as:

First Floor (15,000 sf)	Second Floor (15,000 sf)
Phlebotomy	Dermatology
Imaging: X-Ray, Ultrasound, Mammography	Multi-Specialty Clinic: Cardiology, Gastroenterology, General Surgery, Endocrine/Diabetes Management, Neurology, Neurosurgery, Pain Management, Rheumatology, Sleep Medicine, Urology, Vascular Surgery
Orthopaedics	Primary Care
Ob-Gyn	Behavioral Health (in Primary Care)

Goals of Partners Ambulatory Care

We are committed to delivering high quality, low cost outpatient care that improves the health and well-being of our patients

Our goal in Westwood and elsewhere is to provide:

1. **Greater Access:** Provide outstanding care to patients by creating *convenient community sites*

2. **Continued Cost Reduction:** Convenient community sites provide *lower-cost options* and innovative delivery models efficiently managing patient care in the Partners System

3. **More Innovation**: Less complex care is provided in convenient community sites that focus on patients using *innovative digital solutions*

Reimagining the Patient Experience

Partners is working to *reimagine outpatient care*

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- Local Healthcare Leader

"I wish there was a place where doctors were more focused on a wellness approach, not just a pill."

- Patient

"Having every provider connected to the full picture of my health and collaborate on my treatments sounds great…isn't this how it's all supposed to work?"

- Patient

Source: Interviews conducted by IDEO

Expanding in Westwood

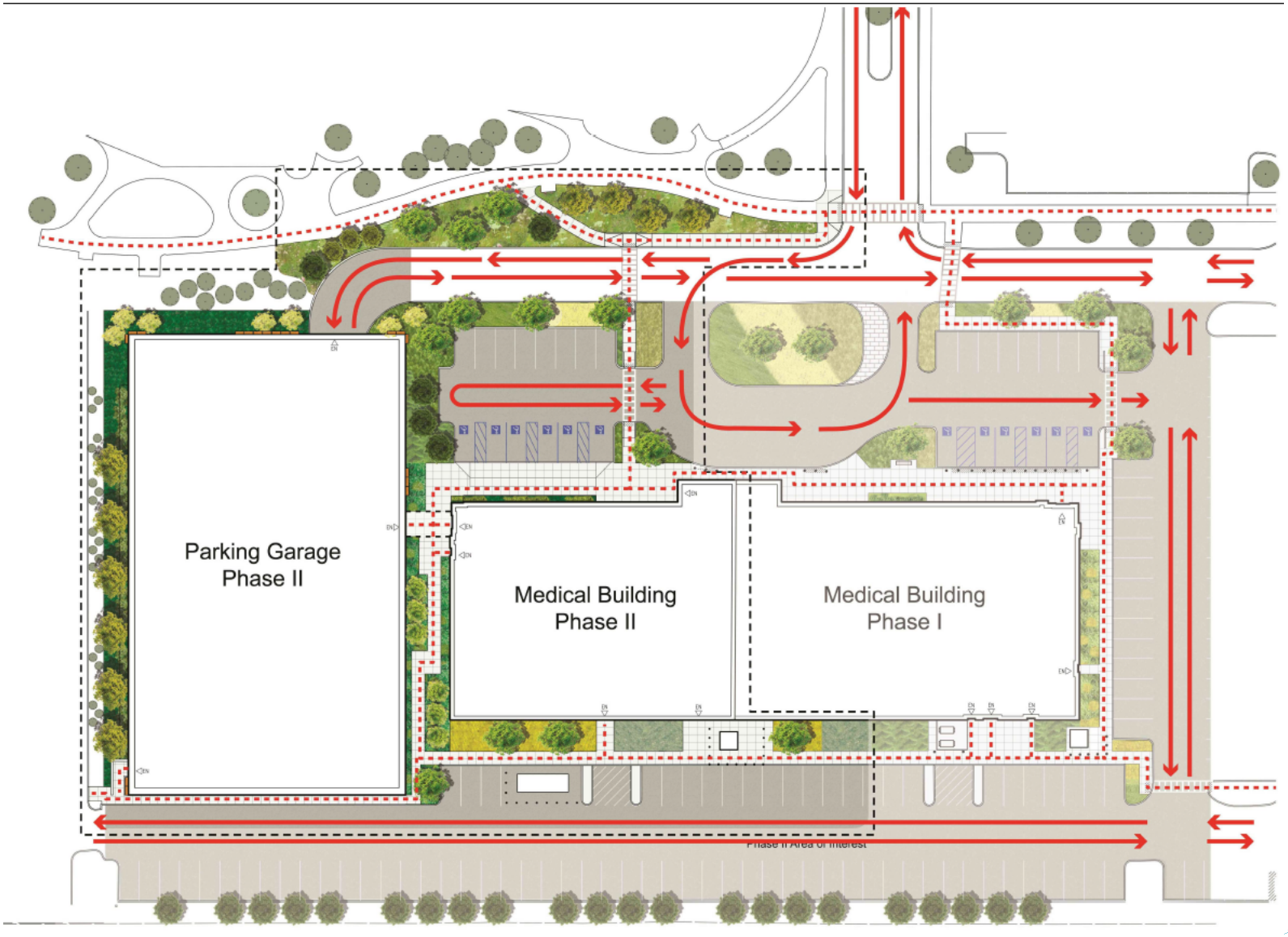
- In Westwood, the planned expansion of a second building and parking garage will:
  - Add 50,000 SF of clinical space, including additional ambulatory services and procedures as well as major imaging services
  - The new building is designed as a seamless, connected addition to Building 1
  - New parking garage for patient convenience

VIEW FROM NORTHWEST

Source: Cannon Design

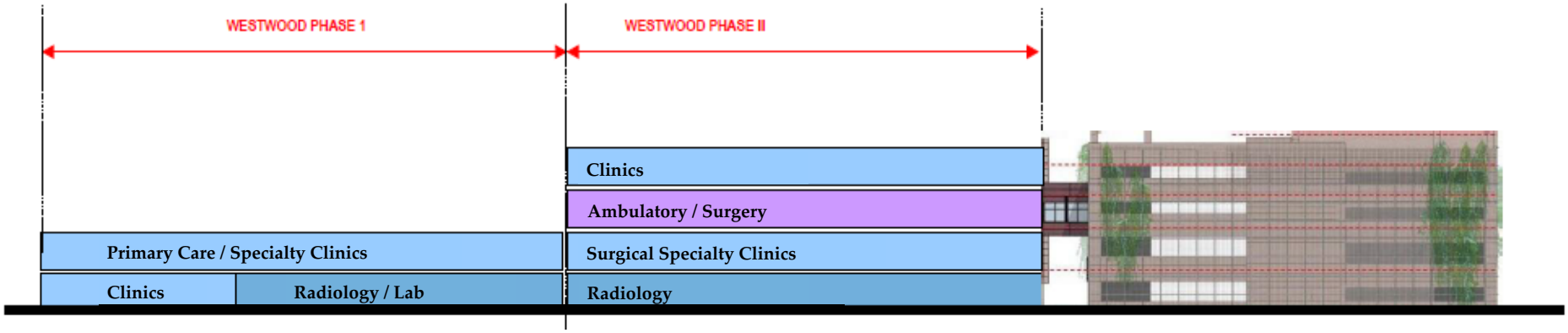
Expansion will add 50,000 SF and parking

Expansion will add 50,000 SF and parking



Expanding in Westwood

Proposed Services



This addition will enable our Westwood site to expand our services to potentially include:

- Physician services
  - Medical & surgical specialty clinics
  - Primary care
- Addition of new procedural services
  - Ambulatory surgery
  - Endoscopy
  - Microscopic controlled (Mohs) surgery
- Expansion of imaging services
  - MRI
  - CT

Expanding in Westwood

Here are examples of technology we want to provide our patients:

- As imaging technology continues to advance…
  - **Earlier diagnosis** in the disease &/or injury process (*i.e.,* multiple sclerosis, tumors, reduced cartilage)
  - **Better clarity** (*i.e.,* difference between tumor and health tissue, extent of cartilage loss)
- Medical imaging technology advancements are helping providers act quicker and more aggressively to help patients and increase the amount of positive outcomes.

Imaging Services

CT Scanners

- Model: 2 CTs
- Machines will be the Latest Technology resulting in:
  - lower radiation dose
  - Decreased scan time
  - Specialty scanning not readily available in community settings

Imaging Services

MRI Scanners

- Model: 1.5T and 3.0T strength MRI devices
- Latest Technology resulting in:
  - Decreased scan time (15-30 mins vs. traditional 40-60 mins)
  - Introduce specialty scanning in a community setting
  - Provide implanted device/hardware scanning (e.g., pacemaker)

We Want to Learn From You….

What matters most to you as a patient?

What are your concerns?

What are your hopes?

What can be better?

Are there other services you would like to see in Westwood?

More thoughts? Take our community survey at:
bit.ly/PartnersSurvey2020

Or contact us at WestwoodInfo@partners.org

Community Health Survey

* Required

1. Name *

2. Town *

3. How often do you need to visit a medical provider? *

- ◯ Once a year
- ◯ Several times a year
- ◯ Once a month
- ◯ Several times a month
- ◯ As-needed
- ◯ Other

4. Approximately how close to your home is your primary health care provider? *

- ◯ 0-5 miles
- ◯ 5-10 miles
- ◯ 10-15 miles
- ◯ 15-20 miles
- ◯ More than 20 miles away

5. Have you or anyone in your household had difficulty in getting an appointment with a health care provider when needed? *

- ◯ Yes, a great deal
- ◯ Some difficulty
- ◯ No difficulty

6. Do you feel there are adequate resources for the behavioral health needs in your community or town? *

- ◯ Yes
- ◯ No
- ◯ The community could use more resources

7. Please read the questions and choose the number that best reflects your opinion:
   1 - Strongly Disagree
   2 - Disagree
   3 - Neutral
   4 - Agreee
   5 - Strongly Agree *

	1 - Strongly Disagree	2 - Disagree	3 - Neutral	4 - Agree	5 - Strongly Agree
I have postponed seeking care to wait for an appointment that works for my schedule	◯	◯	◯	◯	◯
Traffic congestion and parking costs make it difficult to use Boston hospitals for routine medical care	◯	◯	◯	◯	◯
I would be more likely to get preventive health care, like an annual physical, if I could do it closer to home than Boston	◯	◯	◯	◯	◯
I would prefer to have my family's health care providers in one location closer to my home than Boston	◯	◯	◯	◯	◯
I have in the past used outpatient health care services in a Boston hospital that could have been provided just as easily in a clinic or medical office if there was a facility nearby	◯	◯	◯	◯	◯
In my own community or town, behavioral health services are difficult to access	◯	◯	◯	◯	◯

	1 - Strongly Disagree	2 - Disagree	3 - Neutral	4 - Agree	5 - Strongly Agree
In my own community or town, I know families who have been affected by the opioid crisis	○	○	○	○	○
In my own community or town, I know people who have had difficulty getting access to necessary health care	○	○	○	○	○
I would like the option of evening or weekend appointment at a medical center near my home	○	○	○	○	○
I believe my personal health care will be better if my local health provider is part of an integrated system, with teaching hospitals, specialty rehabilitation, eye care, and behavioral health hospitals, and a common medical record	○	○	○	○	○

Attachment 2

Massachusetts Department of Public Health
Determination of Need
Change in Service

Version: DRAFT 6-14-17

DRAFT

Application Number: 21012113-AS Original Application Date: 1/21/2021

Applicant Information

Applicant Name: Mass General Brigham Incorporated

Contact Person: Daria Niewenhous Title: Attorney

Phone: 6173484865 Ext: E-mail: DNiewenhous@mintz.com

Facility: Complete the tables below for each facility listed in the Application Form

1 Facility Name: Mass General Brigham Integrated Care, Inc. - Woburn Site CMS Number: N/A Facility type: Ambulatory Care Clinic

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
+ -										0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													

Add/Del Rows		Licensed Beds Existing	Operating Beds Existing	Change in Number of Beds (+/-) Licensed	Operating	Number of Beds After Project Completion (calculated) Licensed	Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds Current Beds	Projected	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	**List other services** if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
+ -	Physician services space (Change in Number = gross square footage of clinical space)	0	35,459	35,459	0	
+ -	Acquisition of MRI Units	0	2	2	0	
+ -	Acquisition of CT Units	0	2	2	0	

Facility: Complete the tables below for each facility listed in the Application Form

2 Facility Name: Mass General Brigham Integrated Care, Inc. - Westwood Site | CMS Number: N/A | Facility type: Ambulatory Care Clinic

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected		Actual	Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
+ -										0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			

Add/Del Rows		Licensed Beds Existing	Operating Beds Existing	Change in Number of Beds (+/-) Licensed	Operating	Number of Beds After Project Completion (calculated) Licensed	Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds Current Beds	Projected	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	**List other services** if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
+ -	Acquisition of MRI Units	0	2	2	0	
+ -	Acquisition of CT Units	0	2	2	0	

Facility: Complete the tables below for each facility listed in the Application Form

3 Facility Name: Mass General Brigham Integrated Care, Inc. - Westborough Site CMS Number: N/A Facility type: Ambulatory Care Clinic

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds Existing	Operating Beds Existing	Change in Number of Beds (+/-) Licensed	Operating	Number of Beds After Project Completion (calculated) Licensed	Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds Current Beds	Projected	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
+ -										0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below If there are changes other than those listed in table above.	

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	**List other services** if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
+ -	Acquisition of MRI Units	0	1	1	0	
+ -	Acquisition of CT Units	0	1	1	0	
+ -	Physician services space (Change in Number = gross square footage of clinical space)	0	35,459	35,459	0	

Facility: Complete the tables below for each facility listed in the Application Form

4 Facility Name: Mass General Brigham Amsurg, Inc. - Woburn Site CMS Number: N/A Facility type: Freestanding Ambulatory Surgery Center

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected		Actual	Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
+ -										0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													
	Adult									0%	0%			

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected		Actual	Projected
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	**List other services** if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
+ -	Ambulatory Surgery Center Operating Rooms	0	4	4	0	

Facility: Complete the tables below for each facility listed in the Application Form

5 Facility Name: Mass General Brigham Amsurg, Inc. - Westwood Site CMS Number: N/A Facility type: Freestanding Ambulatory Surgery Center

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
+ -										0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			

Add/Del Rows		Licensed Beds Existing	Operating Beds Existing	Change in Number of Beds (+/-) Licensed	Operating	Number of Beds After Project Completion (calculated) Licensed	Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds Current Beds	Projected	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	**List other services** if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
+ -	Ambulatory Surgery Center Operating Rooms	0	4	4	0	

Facility: Complete the tables below for each facility listed in the Application Form

6 Facility Name: Mass General Brigham Amsurg, Inc. - Westborough Site CMS Number: N/A Facility type: Freestanding Ambulatory Surgery Center

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds Existing	Operating Beds Existing	Change in Number of Beds (+/-) Licensed	Operating	Number of Beds After Project Completion (calculated) Licensed	Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds Current Beds	Projected	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
+ -										0%	0%			

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	**List other services** if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
+ -	Ambulatory Surgery Center Operating Rooms	0	4	4	0	

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Attachment 3

Massachusetts Department of Public Health
Determination of Need
Affiliated Parties

Version: DRAFT 3-15-17

DRAFT

Application Date: 1/21/2021 Application Number: 21012113-AS

Applicant Information

Applicant Name: Mass General Brigham Incorporated

Contact Person: Daria Neiwenhous Title: Attorney

Phone: 6173484685 Ext: E-mail: DNiewenhous@mintz.com

Affiliated Parties

1.9 **Affiliated Parties:**

List all officers, members of the board of directors, trustees, stockholders, partners, and other Persons who have an equity or otherwise controlling interest in the application.

Add/ Del Rows	Name (Last)	Name (First)	Mailing Address	City	State	Affiliation	Position with affiliated entity (or with Applicant)	Stock, shares, or partnership	Percent Equity (numbers only)	Convictions or violations	List other health care facilities affiliated with	Business relationship with Applicant
+ -	Finucane	Anne Marie	20 Trapelo Road	Lincoln	MA	Mass General Brigham Incorporated	Director		0%	No	CVS (MinuteClinic) in Rhode Island (Director)	Yes
+ -	Fish	John	776 Boylston Street, PH2A	Boston	MA	Mass General Brigham Incorporated	Director		0%	No		Yes
+ -	Hockfield	Susan	4 Berkeley Place	Cambridge	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Holman, III	Albert	29A Chestnut Street	Boston	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Kaplan	James	32 Cart Path Road	Weston	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Kiblanski, M.D.	Anne	800 Boylston Street, Suite 1150	Boston	MA	Mass General Brigham Incorporated	Director/Officer		0%	No		No
+ -	Kraft	Johnathan	One Patriot Place	Foxborough	MA	Mass General Brigham Incorporated	Director		0%	No	The General Hospital Corporation (Trustee)	No
+ -	Markell	Peter	73 Churchill Street	Milton	MA	Mass General Brigham Incorporated	Officer		0%	No		No
+ -	Martignetti	Carl	164 Chestnut Hill Road	Chestnut Hill	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Patrick	Diane	472 Beacon Street, Apartment 2	Boston	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Salim, M.D.	Ali	75 Francis Street, A-2-L-1	Boston	MA	Mass General Brigham Incorporated	Director		0%	No		No

Add/ Del Rows	Name (Last)	Name (First)	Mailing Address	City	State	Affiliation	Position with affiliated entity (or with Applicant)	Stock, shares, or partnership	Percent Equity (numbers only)	Convictions or violations	List other health care facilities affiliated with	Business relationship with Applicant
+ -	Reeve	Pamela	35 Swan Road	Winchester	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Schoen	Scott	51 Essex Road	Chestnut Hill	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Sperling	Scott	4 Moore Road	Wayland	MA	Mass General Brigham Incorporated	Director/Officer		0%	No		Yes
+ -	Thorndike	Alexander	215 Warren Street	Brookline	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	York	Gwill	16 Fayerweather Street	Cambridge	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Atchinson	Robert	115 Commonwealth Ave.	Boston	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Ives	David	5 Cherry Hill Street	West Newbury	MA	Mass General Brigham Incorporated	Director		0%	No		No
+ -	Ragon	Phillip	8 Follen Street	Cambridge	MA	Mass General Brigham Incorporated	Director		0%	No		Yes
+ -	Goggin	Maureen	730 Adams Street, Apartment #1	Dorchester	MA	Mass General Brigham Incorporated	Officer		0%	No		No

Document Ready for Filing

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to Determination of Need" button.

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Attachment 4

Factor 4: Financial Feasibility and Reasonableness of Expenditures and Costs - Westborough

Applicant has provided as (attachment) a certification, by an independent certified public accountant (CPA) as to the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicants existing Patient Panel.

F4.a.1: Capital Costs

For Each Functional Area document the square footage and costs for New Construction and/or Renovations.

		Present Square Footage		Square Footage Involved in Project				Resulting Square Footage		Total Cost		Cost/Square Footage	
				New Construction		Renovation							
Functional Areas	**Floor**	**Net**	**Gross**	**Net**	**Gross**	**Net**	**Gross**	**Net**	**Gross**	**New Construction**	**Renovations**	**New Construction**	**Renovations**
Clinic 1st Floor (Radiology)	1st Floor			17,988	18,596					$ 27,832,525		$ 1,497	
Clinic 2nd Floor	2nd Floor			17,471	18,492					$ 10,437,197		$ 564	
Clinic Total				**35,459**	**37,088**					$ 38,269,722			
ASC 3rd Floor	3rd Floor			18,218	19,034					$ 27,832,525		$ 1,462	
ASC Total				**18,218**	**19,034**					$ 27,832,525			
Mechanical Penthouse	Roof/Penthouse			5,414	5,926					$ 3,479,066		$ 587	
Mechanical Penthouse Total				**5,414**	**5,926**					$ 3,479,066			
Overall Total: (Calculated)				**59,091**	**62,048**					$ 69,581,312		$ 1,121	

Factor 4: Financial Feasibility and Reasonableness of Expenditures and Costs - Woburn

Applicant has provided as (attachment) a certification, by an independent certified public accountant (CPA) as to the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the

F4.a.1: Capital Costs

For Each Functional Area document the square footage and costs for New Construction and/or Renovations.

		Present Square Footage		Square Footage Involved in Project				Resulting Square Footage		Total Cost		Cost/Square Footage	
				New Construction		Renovation							
Functional Areas	**Floor**	**Net**	**Gross**	**Net**	**Gross**	**Net**	**Gross**	**Net**	**Gross**	**New Construction**	**Renovations**	**New Construction**	**Renovations**
Clinic 1st Floor (Radiology)	1st Floor			17,988	18,596					$ 31,295,545		$ 1,683	
Clinic 2nd Floor	2nd Floor			17,471	18,492					$ 10,437,197		$ 564	
Clinic Total				**35,459**	**37,088**					$ 41,732,742			
ASC 3rd Floor	3rd Floor			18,218	19,034					$ 27,832,525		$ 1,462	
ASC Total				**18,218**	**19,034**					$ 27,832,525			
Mechanical Penthouse	Roof/Penthouse			5,414	5,926					$ 3,479,066		$ 587	
Mechanical Penthouse Total				**5,414**	**5,926**					$ 3,479,066			
Overall Total: (Calculated)				**59,091**	**62,048**					$ 73,044,333		$ 1,177	

Westwood

Factor 4: Financial Feasibility and Reasonableness of Expenditures and Costs

Applicant has provided as (attachment) a certification, by an independent certified public accountant (CPA) as to the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicants existing Patient Panel.

F4.a.i. Capital Costs

For Each Functional Area document the square footage and costs for New Construction and/or Renovations.

		Present Square Footage		Square Footage Involved in Project				Resulting Square Footage		Total Cost		Cost/Square Footage	
				New Construction		Renovation							
Functional Areas	Floor	Net	Gross	Net	Gross	Net	Gross	Net	Gross	New Construction	Renovations	New Construction (Gross SF)	Renovations (Net SF)
Clinical/Radiology	1			11,738	12,723	2,844	3,100	14,582	15,823	$ 19,589,892	$ 1,447,600	$ 1,540	$ 509
Clinic Space	2			11,491	12,461			11,491	12,461	$ 9,794,946		$ 786	$ -
ASC	3			11,686	12,607			11,686	12,607	$ 22,854,874		$ 1,813	$ -
Clinical/CPD	4			11,651	12,446			11,651	12,446	$ 11,753,935		$ 944	$ -
Mechanical Room - Roof	Roof			605	688			605	688	$ 1,305,993		$ 1,898	$ -
Overall Total: (Calculated)				**47,171**	**50,925**	**2,844**	**3,100**	**50,015**	**54,025**	**$ 65,299,641**	**$ 1,447,600**	**$ 1,282**	**$ 509**

Westborough

F4.a.ii For each Category of Expenditure document New Construction and/or Renovation Costs.				
	Category of Expenditure	New Construction	Renovation	Total (Calculated)
	Land Costs			
	Land Acquisition Cost	$ 5,700,000		$ 5,700,000
	Site Survey and Soil Investigation	$ 300,000		$ 300,000
	Other Non-Depreciable Land Development	$ 300,000		$ 300,000
	Total Land Costs	$ 6,300,000		$ 6,300,000
	Construction Contract (including bonding cost)			
	Depreciable Land Development Cost	$ -		$ -
	Building Acquisition Cost	$ -		$ -
	Construction Contract (including bonding cost)	$ 41,815,000		$ 41,815,000
	Fixed Equipment Non in Contract	$ 8,630,000		$ 8,630,000
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost	$ 3,678,611		$ 3,678,611
	Pre-filing Planning and Development Costs	$ 248,639		$ 248,639
	Post-filing Planning and Development Costs	$ 150,000		$ 150,000
Add/Del Rows	Other (Moving & Storage)	$ 50,000		$ 50,000
Add/Del Rows	Other (Project Support)	$ 1,895,816		$ 1,895,816
Add/Del Rows	Other (Contingency)	$ 2,210,136		$ 2,210,136
	Net Interest Expensed During Construction*	$ -		$ -
	Major Movable Equipment	$ 10,903,110		$ 10,903,110
	Total Construction Costs	$ 69,581,312		$ 69,581,312
	Financing Costs			
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, **	$ 85,366		$ 85,366
	Bond Discount	$ -		$ -
Add/Del Rows	Other (specify)	$ -		$ -
	Total Financing Costs	$ 85,366		$ 85,366
	Estimated Total Capital Expenditure	$ 75,966,678		$ 75,966,678

Woburn

F4.a.ii For each Category of Expenditure document New Construction and/or Renovation Costs.				
	Category of Expenditure	New Construction	Renovation	Total (Calculated)
	Land Costs			
	Land Acquisition Cost	$ 5,250,000		$ 5,250,000
	Site Survey and Soil Investigation	$ 300,000		$ 300,000
	Other Non-Depreciable Land Development			$ -
	Total Land Costs	$ 5,550,000		$ 5,550,000
	Construction Contract (including bonding cost)			
	Depreciable Land Development Cost	$ -		$ -
	Building Acquisition Cost	$ -		$ -
	Construction Contract (including bonding cost)	$ 41,815,000		$ 41,815,000
	Fixed Equipment Non in Contract	$ 12,330,000		$ 12,330,000
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost	$ 3,362,611		$ 3,362,611
	Pre-filing Planning and Development Costs	$ 248,639		$ 248,639
	Post-filing Planning and Development Costs	$ 150,000		$ 150,000
Add/Del Rows	Other (Moving & Storage)	$ 50,000		$ 50,000
Add/Del Rows	Other (Project Support)	$ 1,895,816		$ 1,895,816
Add/Del Rows	Other (Contingency)	$ 2,289,156		$ 2,289,156
	Net Interest Expensed During Construction	$ -		$ -
	Major Movable Equipment	$ 10,903,110		$ 10,903,110
	Total Construction Costs	$ 73,044,332		$ 73,044,332
	Financing Costs			
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc	$ 88,419		$ 88,419
	Bond Discount	$ -		$ -
Add/Del Rows	Other (specify)	$ -		$ -
	Total Financing Costs	$ 88,419		$ 88,419
	Estimated Total Capital Expenditure	$ 78,682,751		$ 78,682,751

Westwood

F4a.ii For each Category of Expenditure document New Construction and/or Renovation Costs.				
	Category of Expenditure	New	Renovation	Total (Calculated)
	Land Costs			
	Land Acquisition Cost	$ 2,198,716		$ 2,198,716
	Site Survey and Soil Investigation	$ 51,649		$ 51,649
	Other Non-Depreciable Land Development	$ -		$ -
	Total Land Costs	**$ 2,250,366**	**$ -**	**$ 2,250,366**
	Construction Contract (including bonding cost)	$ -		$ -
	Depreciable Land Development Cost	$ -		$ -
	Building Acquisition Cost	$ -		$ -
	Construction Contract (including bonding cost)	$ 33,280,000	$ 1,137,600	$ 34,417,600
	Fixed Equipment Non in Contract	$ 12,240,000		$ 12,240,000
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost	$ 2,597,500	$ 110,000	$ 2,707,500
	Pre-filing Planning and Development Costs	$ 136,561		$ 136,561
	Post-filing Planning and Development Costs	$ 150,000		$ 150,000
Add/Del Rows	Other (Moving & Storage)	$ 125,000		$ 125,000
Add/Del Rows	Other (Project Support)	$ 1,542,000	$ 50,000	$ 1,592,000
Add/Del Rows	Other (Contingency)	$ 4,686,580	$ 150,000	$ 4,836,580
	Net Interest Expensed During Construction	$ -		$ -
	Major Movable Equipment	$ 10,542,000		$ 10,542,000
	Total Construction Costs	**$ 65,299,641**	**$ 1,447,600**	**$ 66,747,241**
	Financing Costs			$ -
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc	$ 75,994	$ 1,629	$ 77,622
	Bond Discount	$ -		$ -
Add/Del Rows	Other (specify)	$ -		$ -
				$ -
	Total Financing Costs	$ 75,994	$ 1,629	$ 77,622
	Estimated Total Capital Expenditure	**$ 67,626,000**	**$ 1,449,229**	**$ 69,075,229**

Attachment 5

Mass General Brigham Incorporated

Analysis of the Reasonableness of Assumptions Used For and Feasibility of Projected Financials of Mass General Brigham Incorporated For the Years Ending September 30, 2021 Through September 30, 2025

TABLE OF CONTENTS

BERNARD L. DONOHUE, III, CPA

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January 14, 2021

Ms. Meredith Wasko
Mass General Brigham Incorporated
399 Revolution Drive STE 645
Somerville, MA 02145

RE: Analysis of the Reasonableness of Assumptions and Projections Used to Support the Financial Feasibility and Sustainability of the Proposed Construction of Ambulatory Care Centers at the Westborough, Westwood and Woburn Sites

Dear Ms. Wasko:

I have performed an analysis of the financial projections prepared by Mass General Brigham Incorporated ("Mass General Brigham" or "the Company"; formerly Partners HealthCare System, Inc.) detailing the projected operations of Mass General Brigham including the projected operations of Mass General Brigham Integrated Care, Inc. ("IC") and Mass General Brigham AmSurg, Inc. ("AmSurg"), at three ambulatory care centers located in Westborough, Westwood and Woburn, Massachusetts (collectively, the "Project Sites"). This report details my analysis and findings with regards to the reasonableness of assumptions used in the preparation and feasibility of the projected financial information of Mass General Brigham as prepared by the management of Mass General Brigham ("Management"). This report is to be included by Mass General Brigham in its Determination of Need ("DoN") Application – Factor 4(a) and should not be distributed or relied upon for any other purpose.

I. EXECUTIVE SUMMARY

The scope of my analysis was limited to the five-year consolidated financial projections (the "Projections") prepared by Mass General Brigham as well as the actual operating results for Mass General Brigham for the fiscal years ended 2019 and 2020 ("Base Budget"), and the supporting documentation in order to render an opinion as to the reasonableness of assumptions used in the preparation and feasibility of the Projections with regards to the impact of capital projects involving and ancillary to the Project Sites.

The impact of the proposed capital projects at the three ambulatory care centers located in Westborough, Westwood and Woburn, MA, which are the subject of this DoN application, represent a relatively insignificant component of the projected operating results and financial position of Mass General Brigham. As such, I determined that the Projections are not likely to result in a scenario where there are insufficient funds available for capital and ongoing operating costs necessary to support the ongoing operations of Mass General Brigham. Therefore, it is my opinion that the Projections are financially feasible for Mass General Brigham as detailed below.

II. RELEVANT BACKGROUND INFORMATION

Refer to Factor 1 of the application for description of proposed capital projects at the Project Sites and the rationale for the expenditures.

III. SCOPE OF REPORT

The scope of this report is limited to an analysis of the Projections, Base Budget and the supporting documentation in order to render an opinion as to the reasonableness of assumptions used in the preparation and feasibility of the Projections with regards to the impact of certain capital projects involving and ancillary to the Project Sites. My analysis of the Projections and conclusions contained within this report are based upon my detailed review of all relevant information (see Section IV which references the sources of information). I have gained an understanding of Mass General Brigham, IC and AmSurg, through my review of the information provided as well as a review of Mass General Brigham website, annual reports, and the DoN application.

Reasonableness is defined within the context of this report as supportable and proper, given the underlying information. Feasibility is defined as based on the assumptions used, the plan is not likely to result in insufficient "funds available for capital and ongoing operating costs necessary to support the proposed project without negative impacts or consequences to [Mass General Brigham] existing patient panel" (per Determination of Need, Factor 4(a)).

This report is based upon historical and prospective financial information provided to me by Management. If I had audited the underlying data, matters may have come to my attention that would have resulted in my using amounts that differ from those provided. Accordingly, I do not express an opinion or any other assurances on the underlying data presented or relied upon in this report. I do not provide assurance on the achievability of the results forecasted by Mass General Brigham because events and circumstances frequently do not occur as expected, and the achievement of the forecasted results are dependent on the actions, plans, and assumptions of management. I reserve the right to update my analysis in the event that I am provided with additional information.

IV. PRIMARY SOURCES OF INFORMATION UTILIZED

In formulating my opinions and conclusions contained in this report, I reviewed documents produced by Management. The documents and information upon which I relied are identified below or are otherwise referenced in this report:

1. Five-Year Pro-Forma Statements (Projections) for the fiscal years ending 2021 through 2025, provided December 15, 2020 and updated on January 8, 2021;

2. Projected income statements for the three ambulatory care centers located in Westborough, Westwood and Woburn, including detailed assumptions for the fiscal years 2020 through 2025, revised October 30, 2020 and provided December 15, 2020;

3. DoN Projections (income statements, capital and debt service) for the fiscal years 2021 (budget) through 2030, provided December 15, 2020;

4. Multi-Year Financial Framework of Mass General Brigham Incorporated for the fiscal years ending 2021 through 2025, prepared for Mass General Brigham Finance Committee as of December 3, 2020;

5. Partners Finance Committee Ambulatory Care Update – October 2019, provided November 5, 2019;

6. Audited Financial Statements of Mass General Brigham Incorporated and Affiliates as of and for the years ended September 30, 2020 and 2019;

7. Company website – https://www.massgeneralbrigham.org;

8. Various news publications and other public information about the Company;

9. Determination of Need Application Instructions dated March 2017; and

10. Draft Determination of Need Factor 1, provided January 7, 2021.

V. REVIEW OF THE PROJECTIONS

This section of my report summarizes my review of the reasonableness of the assumptions used and feasibility of the Projections. The Projections are delineated between five categories of revenue and six general categories of operating expenses of Mass General Brigham as well as other nonoperating gains and losses for the Company. The following table presents the Key Metrics, as defined below, of Mass General Brigham which compares the results of the Projections for the fiscal years ending 2021 through 2025 to Mass General Brigham historical results for the fiscal year ended 2020.

($ in thousands)	MGB, as reported	Change in Key Metric of pro forma results compared to prior year				
	2020	2021	2022	2023	2024	2025
EBIDA ($)	584,250	500,504	137,579	17,628	20,518	77,053
EBIDA Margin (%)	4.2%	3.0%	0.3%	-0.3%	-0.3%	0.1%
Operating Margin (%)	-2.5%	3.5%	0.6%	-0.3%	-0.1%	0.3%
Total Margin (%)	1.9%	-1.3%	4.7%	0.0%	0.0%	0.4%
Total Assets ($)	25,040,363	71,241	689,081	1,187,264	1,206,497	1,226,082
Total Net Assets ($)	10,620,294	155,092	945,571	1,291,888	1,142,384	1,175,833
Unrestricted Cash Days on Hand (days)	324.5	(27.9)	(17.9)	1.7	1.1	1.7
Unrestricted Cash to Debt (%)	189.8%	-7.6%	8.5%	14.8%	9.9%	9.7%
Debt Service Coverage (ratio)	4.3	(0.7)	0.6	2.7	0.2	0.1
Debt to Capitalization (%)	44.1%	-0.8%	-3.6%	-3.5%	-2.1%	-1.9%

The Key Metrics fall into three primary categories: profitability, liquidity, and solvency. Profitability metrics, such as EBIDA, EBIDA Margin, Operating Margin, Total Margin, and Debt Service Coverage Ratio are used to assist in the evaluation of management performance in how efficiently resources are utilized. Liquidity metrics, such as Unrestricted Days Cash on Hand and Unrestricted Cash to Debt, measure the quality and adequacy of assets to meet current obligations as they come due. Solvency metrics, such as Debt to Capitalization and Total Net Assets, measure the company's ability to service debt obligations. Additionally, certain metrics can be applicable in multiple categories.

The following table shows how each of the Key Metrics are calculated.

Key Metric	Definition
EBIDA ($)	(Earnings before interest, depreciation and amortization expenses) - Income (loss) from operations + interest expense + depreciation expense + amortization expense
EBIDA Margin (%)	EBIDA expressed as a % of total operating revenues. EBIDA / total operating revenues
Operating Margin (%)	Income (loss) from operations / total operating revenues
Total Margin (%)	Excess (deficit) of revenues over expenses / total operating revenues
Total Assets ($)	Total assets of the organization
Total Net Assets ($)	Total net assets of the organization (includes unrestricted net assets and donor restricted net assets)
Unrestricted Cash Days on Hand (days)	(Cash and equivalents + investments + current portion investments limited as to use + investments limited as to use - externally limited funds) / ((Total operating expenses - depreciation & amortization) / YTD days)
Unrestricted Cash to Debt (%)	(Cash and equivalents + investments + current portion investments limited as to use + investments limited as to use - externally limited funds) / (Current portion of long-term obligations + long-term obligations)
Debt Service Coverage (ratio)	(Excess (deficit) of revenues over expenses + depreciation expense + amortization expense + interest expense) / (Principal payments + interest expense)
Debt to Capitalization (%)	(Current portion of long-term obligations + long-term obligations) / (Current portion of long-term obligations + long-term obligations + unrestricted net assets)

1. Revenues

The only revenue category on which the proposed capital projects would have an impact is net patient service revenue. Therefore, I have analyzed net patient service revenue identified by Mass General Brigham in both their historical and projected financial information. Based upon my analysis of the projected results from Fiscal Year 2021 through Fiscal Year 2025, the proposed capital projects would represent approximately .591% (about 6 tenths of 1%) of Mass General Brigham operating revenues beginning in FY 2023 to 1.414% (about 1.4%) in FY 2025. The first year in which revenue is present for the proposed capital projects is FY 2023.

It is my opinion that the revenue growth projected by Management reflects a reasonable estimation based primarily upon the Company's historical operations before taking into account the financial impact of the COVID-19 pandemic in Fiscal Year 2020.

2. Operating Expenses

I analyzed each of the categorized operating expenses for reasonableness and feasibility as it relates to the projected revenue items. I reviewed the actual operating results for Mass General Brigham for the years ended 2019 and 2020 in order to determine the impact of the proposed capital projects on the consolidated

entity and in order to determine the reasonableness of the Projections for the fiscal years 2021 through 2025. Based upon my analysis of the projected results from Fiscal Year 2021 through Fiscal Year 2025, the proposed capital projects would represent approximately .768% (about 8 tenths of 1%) of Mass General Brigham operating expenses beginning in FY 2023 to 1.396% (about 1.4%) in FY 2025.

It is my opinion that the growth in operating expenses projected by Management reflects a reasonable estimation based primarily upon the Company's historical operations before taking into account the financial impact of the COVID-19 pandemic in Fiscal Year 2020.

3. Nonoperating Gains/Expenses and Other Changes in Net Assets

The final categories of Mass General Brigham Projections are various nonoperating gains/expenses and other changes in net assets. The items in these categories relate to investment account activity (realized and unrealized), philanthropic and academic gifts, benefit plan funded status, fair value adjustments and other items. Because many of these items are unpredictable, nonrecurring, or dependent upon market fluctuations, I analyzed the nonoperating activity in aggregate. Based upon my analysis, there were no nonoperating expenses projected for the proposed capital projects. Accordingly, it is my opinion that the pro-forma nonoperating gains/expenses and other changes in net assets are reasonable.

4. Capital Expenditures and Cash Flows

I reviewed Mass General Brigham capital expenditures and cash flows in order to determine whether Mass General Brigham anticipated reinvesting sufficient funds for technological upgrades and property, plant and equipment and whether the cash flow would be able to support that reinvestment.

Based upon my discussions with Management and my review of the information provided, I considered the current and projected capital projects and loan financing obligations included within the Projections and the impact of those projected expenditures on Mass General Brigham cash flow. Based upon my analysis, it is my opinion that the pro-forma capital expenditures and resulting impact on Mass General Brigham cash flows are reasonable.

VI. FEASIBILITY

I analyzed the projected operations for Mass General Brigham and the changes in Key Metrics prepared by Management as well as the impact of the proposed capital projects at the three ambulatory care centers in Westborough, Westwood and Woburn, MA upon the Projections and Key Metrics. In performing my analysis, I considered multiple sources of information including historical and projected financial information for Mass General Brigham. It is important to note that the Projections reflect changes in accounting standards which were adopted in Fiscal Year 2020, such as changes in lease accounting and compensation – retirement benefits accounting.

Because the impact of the proposed capital projects at the three ambulatory care centers in Westborough, Westwood and Woburn, MA represents a relatively insignificant portion of the operations and financial position of Mass General Brigham, I determined that the Projections are not likely to result in insufficient funds available for capital and ongoing operating costs necessary to support the proposed projects. Based upon my review of the Projections and relevant supporting documentation, I determined the projects and continued operating surplus are reasonable and based upon feasible financial assumptions. Therefore, the proposed capital projects at the Project Sites mentioned above are financially feasible and within the financial capability of Mass General Brigham.

Respectively submitted,

Bernard L. Donohue, III, CPA

Bernard L. Donohue, III, CPA

Attachment 6

Table of Contents

Attachment A

Mass General Brigham Determination of Need
Community Health Initiative Narrative

I. Community Health Initiative Monies

The cost breakdown of the Community Health Initiative ("CHI") monies for the Proposed Project is as follows:

- Maximum Capital Expenditure: $223,724,658
- Community Health Initiative: $11,186,232.9 (5% of Maximum Capital Expenditure)
- CHI Administrative Fee to be retained by Applicant: $223,724.66 (2% of the CHI monies)
- Overall CHI Money – less the Administrative Fee: $10,962,508.2

- CHI Statewide Initiative Funding: $2,740,627.05 (25% of Overall CHI Money)
- CHI Local Funding: $8,221,881.15 (75% of Overall CHI Money)
- Evaluation Monies to be retained by Applicant: $822,188.12 (10% of CHI Local Funding)
- CHI Local Funding for Distribution: $7,399,693.03 (CHI Local Funding less Evaluation Monies)

II. Background Information

The Community Health Initiative ("CHI") process and community engagement for the proposed Determination of Need ("DoN") will be conducted by Mass General Brigham Incorporated ("Applicant" or "MGB") staff and contractors. Through this DoN, the Applicant through Mass General Brigham Integrated Care, Inc. ("IC") and Mass General Brigham AmSurg, Inc. ("AmSurg") (collectively the "Proposed Licensees") are seeking to establish three ambulatory care sites in: (1) Westwood, (2) Westborough and (3) Woburn with various services provided at each site.

Community Health Needs Assessment Process: MGB has recently completed robust community health needs assessments ("CHNAs") for each of the primary service areas associated with the proposed ambulatory care sites (see Attachments C 1-3: CHNA Reports). These CHNAs comprise information from the following sources: (1) community focus groups; (2) key informant interviews; (3) community survey responses; (4) secondary data; and (5) prioritization meetings with local residents and community groups. The prioritization of needs for each of the service areas was based on a systematic voting process that was participatory and data-informed. MGB contracted with Health Resources in Action ("HRiA"), a public health institute and leader in the fields of engagement and evaluation to carry out the needs assessments.

CHNA Methodology: The CHNA processes are based on the Association for Community Health Improvement's Community Health Assessment Toolkit. Consequently, the stages of this CHNA, included: (1) Reflect and strategize on previous assessments; (2) Identify and engage stakeholders through a clear engagement plan; (3) Define the community by developing geographic boundaries and identifying populations to participate in the processes; (4) Collect and analyze data – applying quantitative and qualitative research principles to the processes; (5) Prioritize community health issues through clearly identified criteria; (6) Document and communicate results of the CHNA to the community; (7) Plan implementation strategies by engaging in strategic partnerships; (8) Implement strategies through an

implementation committee (comprised of CAB members); and (9) Evaluate progress to determine the impact of interventions.

III. Oversight of CHI Processes

The Community Advisory Board ("CAB") provides oversight of the CHNA processes, advises on DoN community engagement activities, and selects health priorities and strategies for CHI funding. The CAB is comprised of individuals representing the constituencies outlined in the Department of Public Health's *Community Engagement Standards for Community Health Planning Guideline*. CAB members represent regional groups with some Board members and/or their organizations residing in the noted primary service areas. If the DoN is approved, the CAB will establish Ad Hoc Subcommittees comprised of representatives from the primary services areas for the proposed ambulatory care sites. These Ad Hoc Subcommittees will include representation from local stakeholders aware of the service area's needs, including staff from the local public health department(s). Members of the Ad Hoc Subcommittees will provide recommendations to the CAB regarding health priorities and strategies for each primary services area.

In general, the CAB is tasked with reviewing the DoN sub-regulatory guidelines, outlining roles and responsibilities for the group, developing a charter, and reviewing the CHNAs to determine health priorities and strategies for CHI funding. The CAB will utilize the guiding questions for racial justice reframing at each of its meetings to evaluate the group's decision making processes. This framework is critically important to ensuring fairness in the selection of health priorities and strategies, as well as the distribution of CHI funding. Post- selection of health priorities and strategies, CAB members will participate in a conflict of interest process, with those individuals without conflicts participating in an Allocation Committee to disburse CHI funding.

IV. Community Advisory Board Duties

The CAB is tasked with the following responsibilities:

- Ensuring appropriate engagement of residents and community-based organizations within the targeted communities around the CHI.
- Determining the health priorities and strategies for CHI funding based upon the needs identified in each CHNA. The CAB will ensure that all health priorities and strategies are aligned with the Department of Public Health's Health Priorities and the Executive Office of Health and Human Services' Focus Areas.
- Completing and submitting the Health Priorities and Strategies Selection Form for approval by the Department of Public Health.
- Conducting a conflict of interest disclosure process to determine which members will comprise the Allocation Committee (a Conflict of Interest Form will be developed).
- Providing oversight to an evaluator that is selected to carry out the evaluation of CHI-funded projects.
- Reporting to the Department of Public Health on the DoN – CHI.

V. Allocation Committee Duties

The Allocation Committee will be comprised of CAB members who do not have a conflict of interest, as well as experts in the chosen priority and strategy areas who are selected to participate in the process. The scope of work that the Allocation Committee will carry out includes:

- Designing and implementing formal solicitation processes (targeted and/or untargeted) for the disbursement of CHI funds for the noted health priorities and strategies. This process will include the development of a request for proposal ("RFP") and Bidders Conferences (complete with technical assistance resources).
- Developing creative, transparent, alternative strategies for disbursing DoN CHI monies.
- Engaging technical assistance resources that can support and assist applicants with their responses to the RFP.
- Disbursement of CHI funding.
- Review grantee reports on the impact of CHI funding.

VI. Timeline for CHI Activities

Upon a Notice of Determination of Need being issued by the Public Health Council, the CAB will continue meeting to facilitate the CHI Process. The timeline for CHI activities is as follows:

- Two to Three months post-approval: The CAB will begin selection of the health priorities and strategies for CHI funding.
- Three to fourth months post-approval: The CAB selects health strategies for noted health priorities and submits the Health Priorities and Strategies Selection Form to the Department of Public Health for review and approval.
- Four to five months post-approval: The CAB conducts a conflict of interest disclosure process to determine which members of the Board will move on to the Allocation Committee.
- Five to six months post-approval: The Allocation Committee is developing an RFP process and determining what (if any) other disbursement mechanisms will be used. An evaluator is selected by the Applicant to conduct evaluation work.
- Seven to eight months post-approval: The RFP for funding is released.
- Eight to nine months post-approval: Bidders conferences are held on the RFP.
- Eleven months post-approval: Responses are due for the RFP.
- Twelve to Fourteen months post-approval: Funding decisions are made, and the disbursement of funds begins.

The aforementioned process is longer than the process outlined in the DoN Guidelines for Tier 3 projects. However, given previous experience with similar RFP processes, the Applicant feels strongly that it will take seven to eight months to develop an RFP process that is transparent, fair and appropriate and that providing three to four months for applicants to respond to the RFP is critical to obtaining thoughtful, well-written and technically accurate RFP responses.

VII. Request for Additional Years of Funding

MGB is seeking additional time to carry out the disbursement of funds for the CHI. MGB is seeking to provide potential multi-year grants with CHI funding that lead to sustainable programs in the primary service areas of the proposed ambulatory care sites. To achieve sustainable programming, MGB is seeking to disburse CHI monies over a three- to five-year period to ensure the greatest impact for the largest number of individuals, as well as continued sustainability of specific projects that need additional support.

VIII. Evaluation Overview

MGB is seeking to use up to 10% of all CHI funding ($822,188.12) for evaluation. These monies will allow MGB to engage a third-party evaluator to carry out evaluation of the planning process,

as well as assess the overall impact of CHI funding. Through this evaluation, MGB is seeking to learn from each of its grantees and develop a forum for sharing best practices and understanding the feasibility of replicating interventions. The evaluation team will develop annual reports for review by the CAB and post-review, submission to the Department of Public Health.

IX. Justification for Administrative Monies

Applicants submitting a Tier 3 CHI are eligible to obtain 2% of the CHI amount for administrative costs. Consequently, MGB is requesting 2% of the CHI funding ($223,724.66) for administrative expenses to carry out the CHI work. First, administrative monies will be used to offset the development of a robust solicitation process. These monies will pay for internal resources and/or external assistance in developing the RFP, technical assistance resources that will be available to organizations that are submitting grant applications, and publication fees associated with advertising the solicitation process in local papers, as well as other operational costs, such as supplies, etc.

X. Commitment to Address the Social Determinants of Health Needs in the Proposed Service Areas

Through its CHI, MGB and the CAB are committed to supporting programs and services that address the social determinants of health (“SDoH”) needs of individuals and families in the noted primary service areas. Addressing upstream SDoH needs is critical in preventing higher healthcare utilization, such as emergency department visits, hospitalizations and readmissions, as well poor health outcomes. By conducting robust community health needs assessments and engagement processes, SDoH needs will be prioritized for the noted service areas, allowing CAB to select appropriate health priorities and strategies for CHI funding. Given the current environment, MGB and the CAB recognize that the increased incidence of COVID-19 and its potential impact on the overall well-being of individuals and families may increase the need for programs and services that address SDoH – due to potentially higher rates of unemployment, food insecurity, housing displacements and increases in domestic violence. CHI funds from the proposed project will be distributed to community-based organizations in the three proposed primary service areas to meet the critical needs of local residents, thus working to help offset the negative downstream impact of unmet SDoH needs in these communities.

Attachment B-1

Mass General Brigham

Westborough Service Area Community Health Needs Assessment

October 3, 2020

Mass General Brigham

Health Resources in Action

Advancing Public Health and Medical Research

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction
Mass General Brigham Incorporated (formerly Partners HealthCare) is a not-for-profit, integrated health care system that was formed in 1994 by an affiliation between The Brigham Medical Center, Inc. (now known as Brigham Health) and The Massachusetts General Hospital. Mass General Brigham ('System') currently operates two tertiary hospitals, six community acute care hospitals, and one acute care specialty hospital in Massachusetts; one community acute care hospital in Southern New Hampshire; one facility providing inpatient and outpatient mental health services; and three facilities providing inpatient and outpatient services in rehabilitation medicine and long-term care.

To fulfill Mass General Brigham's four-part mission of patient care, research, education and community, the organization has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics, population health, ambulatory care and insurance risk management. Developing community-based care centers that offer primary and behavioral health care, as well as specialty and surgical services also are a component of Mass General Brigham's mission.

Accordingly, the System is seeking ways to expand care options in more suburban settings, including in the Westborough service area. This potential expansion will require Mass General Brigham to fully understand the range of needs (related to health and the social determinants of health) within the Westborough service area, including the communities of: Berlin, Bolton, Grafton, Northborough, North Grafton, Shrewsbury, Upton, Westborough, Framingham, Ashland, Hopkinton, Hudson, Marlborough, Milford, and Southborough.

This community health needs assessment (CHNA or Assessment) aims to gain a greater understanding of the issues that residents within the Westborough service area face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This CHNA report provides the results from a mixed methods study aimed at identifying the most pressing social, economic, and health issues in the service area. The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the service area to inform future planning,
- Understand the current health status of residents within the service area, as well as sub-populations within their social context, and
- Engage the community to help determine community needs and social determinant of health needs.

Context
This CHNA was conducted during an unprecedented time, due to the COVID-19 novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The COVID-19 pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity also coincided with the timeline of the CHNA and impacted the content of this report, as well as data collection processes, including the design of data collection instruments and the input that was shared during focus groups, key informant interviews, and through survey responses.

Methods
The 2020 Westborough service area CHNA aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels— from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g.,

access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the Westborough service area; conducting a community priorities survey with 159 residents (in multiple languages, including: English, Spanish, Portuguese, and Chinese); facilitating 8 virtual focus groups with specific populations of interest (e.g. parents of school-age children; residents seeking essential services; residents who are immigrants; and youth); and conducting 12 key informant interviews with key stakeholders in the community. In addition, data collected for the 2019 MetroWest Community Health Assessment (CHA)—an extensive process that engaged 22 communities in the Westborough service area—were also used for this report, including data from the MetroWest Adolescent Health Surveys.

Findings

The following provides a brief overview of key findings that emerged from this assessment:

Population Characteristics

- **Demographics:** Like the Commonwealth overall, all towns in the Westborough service area experienced population growth between 2014-2018; the largest growth occurred in Hopkinton (12.5%) and Berlin (8.9%). In 2014-2018, the racial and ethnic population distributions varied widely across towns. For example, in Framingham, Marlborough, Milford, Shrewsbury and Westborough, more than one in every four residents identified as non-White. In contrast, the overwhelming majority of residents in Berlin (96%), Bolton (92%), Hudson (88%), and Northborough (84%) identified as White in 2014-2018. Quantitative data show varying levels of the foreign-born population across the service area. In 2014-2018, the foreign-born population ranged from 5.8% in Bolton to 28.4% in Framingham, compared to 16.5% in Massachusetts overall.[1]

> *"[Framingham] is a very diverse community…I see a lot of different people, hear languages of all kinds when I'm walking down the street."* – Youth focus group participant

Community Social and Economic Environment

- **Community Perceptions of Need.** Westborough Community Priorities Survey respondents were asked about a series of issues that affected them or their families currently and/or prior to the start of the coronavirus pandemic. The two most common issues reported via the survey and qualitative discussions were mental health (49.1%), followed by financial insecurity (44.4%). In regard to mental health, assessment participants described added stressors in recent months due to the pandemic, though noted that these concerns have always been present, just exacerbated by the current crisis. Concerns related to older adults and youth were frequently discussed across discussions.

[1] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

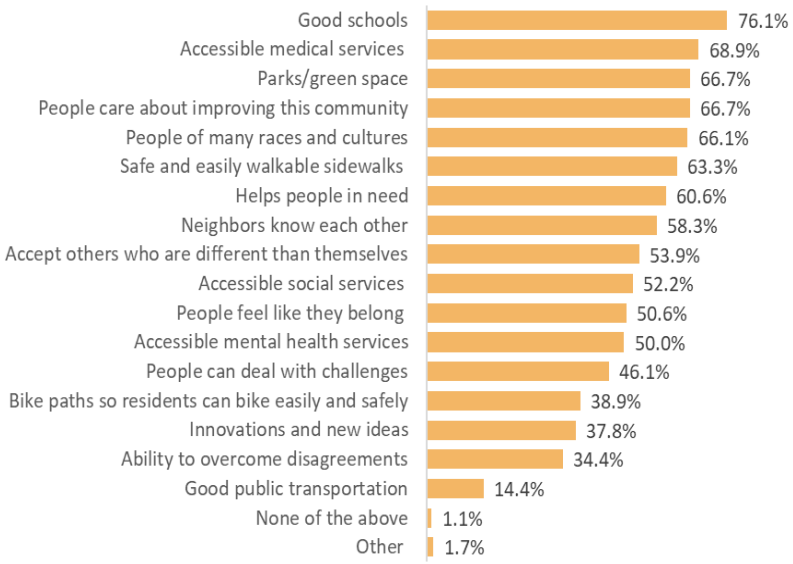
- **Community Assets.** The Westborough service area has numerous strengths according to assessment participants. Westborough Community Priorities Survey respondents cited good schools (76.1%), accessible medical services (68.9%), parks/green space (66.7%), people who care about improving the community (66.7%) and having people of many races and cultures (66.1%) as key strengths of their community.

- **Income and Financial Security.** In the Westborough service area, socioeconomic factors vary by town. For example, the median annual household income in 2014-2018 ranged from just over $79,000 in Framingham and Marlborough to $166,156 in Hopkinton. All towns in the area had median incomes above the state average.

  Nonetheless, many of the towns in this service area still have residents experiencing poverty, with incomes at or below 200% of the Federal Poverty Level (FPL), notably Framingham (23.6%), Milford (19.4%) and Marlborough (18.9%).[2] Financial insecurity was reported as a priority concern in the majority of focus groups and interviews, with participants indicating that COVID-19 has exacerbated long-standing issues of equity. According to responses from the Westborough Community Priorities Survey, one in three respondents reported that their financial situation had gotten worse since the onset of the pandemic.

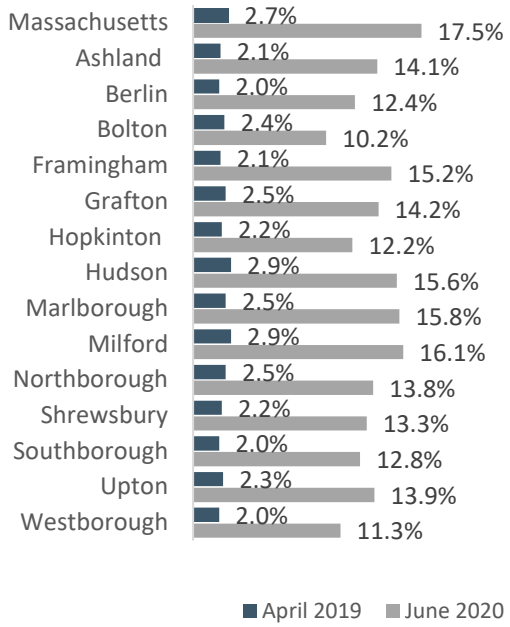
- **Employment and Workforce.** The impact of the COVID-19 pandemic and resulting economic shutdown in many sectors are reflected in unemployment data from towns in the area around Westborough with unemployment rates continuing to increase from April 2020 to June 2020 in all towns except Hudson. Economic uncertainty due to

Percent of CHNA Community Priorities Survey Respondents Reporting Strengths of Their Community, 2020 (N=180)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Percent Population 16 Years and Over Unemployed, in Massachusetts and by Town, 2019-2020



DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.
NOTE: Data are not seasonally adjusted; June 2020 data are preliminary and subject to revision.

[2] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

loss of employment was discussed in all interviews with community stakeholders as well as in focus groups with residents seeking essential services. Participants shared experiences of struggling to meet basic needs, such as housing and accessing healthy food. Lack of employment opportunities was described as especially difficult for young people, seniors, and immigrants. Multiple interviewees from social service agencies described the challenges of retaining staff due to inadequate compensation, an issue that disproportionately affects employees of color.

- **Education.** Focus group participants described the educational system as an asset of the Westborough service area, describing a highly sought-after school system. In the Westborough region, Bolton (31.4%), Hopkinton (31.8%), and Westborough (31.2%) had the largest proportions of residents age 25 and over with a graduate or professional degree in 2014-2018.[3] In terms of education and COVID-19, assessment participants discussed concerns with the re-opening of schools. Many participants noted challenges for both students and parents of coping with uncertainty about the school year.

- **Housing.** The high and rising cost of housing in the Westborough service area was a frequent theme that emerged from qualitative discussions. Participants expressed concern for seniors and "middle class" residents that are struggling to afford the cost of living. In most of the towns around Westborough, owner-occupied units are more common than in the state overall. Median monthly housing costs for owner-occupied households with a mortgage ranged from $1,966 in Milford to $3,222 in Bolton. Many of the towns around Westborough spend more than 30% of their income on housing costs; in Bolton, 68.4% of renters are considered housing insecure.[4] Given the high cost of housing and limited affordable options, residents in these areas are often forced to live in tight quarters and overcrowded conditions, making them more vulnerable to COVID-19.

- **Transportation.** Transportation was identified as one of the top day-to-day concern for many residents who participated in the assessment. Youth focus group participants, immigrants, and residents seeking essential services expressed concern about the timeliness and accessibility of public transportation, especially for essential workers and for young people. In 2014-2018, 70.2% of people in Massachusetts over age 16 commuted to work alone in a vehicle. In 2014-2018, renter-occupied households were more likely to have no vehicle available to them.[5]

> *"Public transportation is needed in a way that people can access their daily work lives"*
> – Key informant interview

- **Crime and Violence.** Assessment participants generally described the Westborough service area as a safe place to live and work. However, some interviewees were concerned that cases of domestic violence and neglect would worsen during the pandemic. Data from the MetroWest Adolescent Health Surveys show that the percent of high school and middle school students reporting violent behaviors in MetroWest has been trending down since 2012. Though physical violence seems to be declining, in 2012-2018, between one third and one quarter of MetroWest middle school students reported being victims of bullying.

- **Discrimination and Racism.** Perceptions related to discrimination and racism varied throughout qualitative discussions. Focus group participants who identified as people of color mentioned incidences of being discriminated against due to their race or nationality. The Westborough Community Priorities Survey supports these findings. More than 59% of survey respondents reported that they or their family were affected by discrimination in the past six months. Similarly, more than half of respondents indicated

[3] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
[4] Ibid.
[5] Ibid.

being affected by discrimination because of their ethnicity, ancestry, or country of origin; and 33.3% reported it was due to their gender.

Community Health Issues

- **Chronic Diseases and Related Risk Factors.** Assessment participants did not cite specific chronic diseases as pressing concerns in their communities, with the exception of a few focus group participants who discussed obesity, cardiovascular disease, and cancer. Cognitive issues, including Alzheimer's disease and dementia, also were noted as a concern for the growing senior community. Though quantitative data show that the proportion of residents who are overweight and obese in the Westborough service area often exceeds the state average of 59%. By town, the percent of adults reporting obesity or overweight ranged from 49.7% in Bolton to 64.2% in Milford.[6]

- **Mental Health.** When asked to identify health issues of greatest concern in the community, the majority of focus group participants and interviewees mentioned mental health. Stress, anxiety, depression, and isolation were the most frequently cited challenges for residents in the Westborough service area, with these individuals describing how COVID-19 has exacerbated mental health issues in the community. These issues were noted as particularly problematic for young people, seniors, those who identify as LGBTQ, and immigrants. Focus group participants who were parents also discussed the importance of digital wellness—which refers to preventative measures aimed at regulating and improving the healthy use of technology, especially in light of COVID-19.

> *"When you have underlying mental health challenges, it's only going to be that much worse by being isolated from the people you love."* – Key informant interview

- **Substance Use.** Participants expressed some concerns about substance use in the Westborough service area, though it was not a key theme discussed in most groups. This perspective on substance use differs from findings from previous assessments in the region, where substance use was ranked as the greatest health concern by community health respondents in 2016 and 2019. Specific types of substance use mentioned as concerns by participants included: alcoholism, vaping, and misuse of prescription medication. While secondary data show cigarette use decreasing among youth, vaping use has substantially increased since 2014, with 18.4% of MetroWest high school students reporting active use in 2014, versus 28.1% in 2018.[7]

- **Communicable Disease.** Interview and focus group participants shared concerns about the ongoing spread and impact of COVID-19. In general, participants reported community compliance with masks and social distancing. Though, several focus group participants did express frustration at improper use of masks and large gatherings. Most often, participants shared the challenges of stay-at-home mandates and closures brought on by the pandemic, especially for those with school-age children. COVID-19 was often discussed in terms of economic instability and increased mental health concerns. Interestingly, assessment participants also reported positive aspects from the pandemic, most notably concern towards neighbors, more time with family, and the expansion of the use of technology, including telehealth. As of August 12, 2020, there were 1,642 cases of COVID-19 per 100,000

> *"COVID has been such a perfect storm of awful things. It has exposed the real weaknesses in our community."* – Key informant interview

[6] Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.

[7] MetroWest Adolescent Health Surveys, 2014 & 2018.

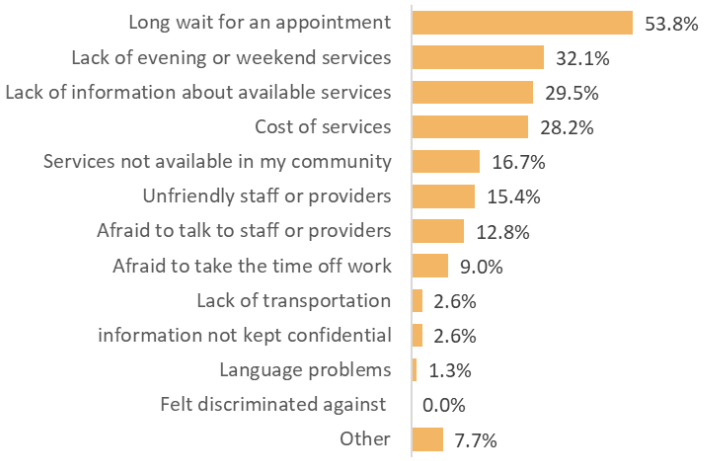
population in Massachusetts. By town, the rates of coronavirus per 100,000 population ranged from 221 in Bolton to 2,705 in Marlborough.[8]

Access to Services

- **Access to Healthcare Services.** The Westborough service area is in close proximity to healthcare resources and a high proportion of residents have health insurance. However, interview and focus group participants discussed a number of barriers to accessing health care services in the Westborough service area, including the high cost of healthcare; fear of seeking services; and challenges navigating the system. Participants also shared healthcare concerns specific to seniors, namely related to accessing specialty and geriatric services.

Overall, 45.4% of Westborough Community Priorities Survey respondents reported barriers to accessing medical, mental health, or social services in the past six months. Among respondents reporting at least one barrier, the most common barriers were long wait times for appointments (53.8%), lack of evening or weekend services (32.1%), lack of information about available services (29.5%), and cost of services (28.2%). These findings align with the top barriers identified in the 2019 MetroWest Community Health Assessment (CHA). While few Westborough Community Priorities Survey respondents had insurance issues, focus group participants commonly discussed the challenges of being underinsured and unable to pay co-pays and deductibles.

Percent of CHNA Community Priorities Survey Respondents Reporting Barriers to Accessing Medical, Mental Health or Social Services in the Past Six Months, among Respondents Reporting at Least One Barrier, 2020 (N=78)



DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.
NOTE: the question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.

- **Access to Social Services or Other Essential Services.** When asked about challenges to accessing social or other essential services, participants spoke in terms of challenges during the COVID-19 pandemic, reporting many services being curtailed at the height of the pandemic. The most frequently described challenge related to seeking essential services was access to food and childcare. Key informant interviews explained how residents have now begun prioritizing basic needs over other essentials like telephone and internet, which limits their ability to stay employed, and connected to healthcare, social services, and education. In addition, interviewees noted the need to offer more culturally sensitive services for immigrants and LGBTQ community residents. Interviewees also reported limited capacity amongst health and social services providers to serve non-English speakers.

Community Vision for the Future

- **Top Issues for Action.** Westborough Community Priorities Survey respondents were asked to consider the most important issues in their communities to take action on in the next few years. Respondents were asked to consider the importance of these issues in regard to Concern, Equity, Effectiveness, and Feasibility

[8] Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2020.

and to select the five most important issues for action. Taken together, the top five issues of concern were (1) Coronavirus/COVID-19 testing and/or the possibility of a new outbreak, (2) Mental health issues, (3) Financial insecurity/unemployment/lack of job opportunities (4) Transportation issues, and (5) Addressing systemic racism/racial injustice. These survey results align closely with key themes that arose from qualitative discussions.

Suggestions for Future Programs, Services, and Initiatives

- **Mental Health.** Increasing access to mental health services was overwhelmingly identified by focus group participants and interviewees as a top issue to address in the Westborough service area. Assessment participants envisioned a community where mental health services were readily available, culturally sensitive, and affordable. Investments would be made for more mental health supports in elementary and middle school, as well as for seniors experiencing isolation. There would be increased support and advocacy efforts to increase reimbursement rates for mental health providers. These suggestions mirror similar findings from the 2019 MetroWest Community Health Assessment.

- **Economic and Employment Opportunities.** Following mental health services, expanding economic opportunities—especially for youth and for low income workers—was suggested as a priority area for investment by many assessment participants. In terms of youth, suggestions were made to expand enrichment programs that included paid opportunities to gain relevant professional experience. Specific suggestions were made to expand the limited number of employment opportunities through programs like MassHire. In addition, it was suggested that more financial resources be invested in education and job training for low income workers and essential employees.

- **Access to Basic Needs Including Healthy Food.** Increased supports for navigating the health and social service landscape were suggested by several assessment participants – namely for those who were seeking essential services and parents. As previously discussed, accessing healthy food was a frequent concern raised by interviewees and focus group participants alike. Suggestions were made to expand food services and modernize systems that currently limit the capacity for community-based groups to address the magnitude of needs. For example, multiple key informants expressed the desire for an automated system that can be used at food pantries.

> *"Our food pantries in the area need to have delivery systems. That would begin to level the playing field. Why can't someone who is poor have food brought to their house the way I do from Wegman's or Instacart?*
> – Key informant interview

- **Transportation.** Similar to findings from the 2019 MetroWest CHA, transportation was identified as a priority concern in the Westborough service area. Assessment participants suggested exploring creative solutions to long-standing transportation issues that have been adopted in cities across the state. For example, it was suggested that investments in the built environment—better sidewalks, more bike trails, and investments in community programs, such as bicycle shares and electronic scooters be added to the community in order to mitigate issues with reliable public transportation.

- **Housing.** Access to affordable housing was among the most commonly mentioned issues in the qualitative discussions and Westborough Community Priorities Survey findings. Not only are housing options limited for low to moderate income individuals, but there are many community members who are in nontraditional homes without leases. Suggestions were made to increase legal protections for tenants who may be in these at-will tenancy agreements. Residents also expressed a desire for more affordable housing for seniors that could facilitate the growing population's ability to age in place.

- **Racial Justice.** Several participants also shared a vision related to diversity and equity, with focus group participants noting the importance of recognizing that systemic racism and structural inequities are what drive the health and economic disparities in their communities. In terms of the social determinants, assessment participants suggested prioritizing racial justice in the follow areas: 1) access to healthy and culturally appropriate food 2) economic and employment opportunities, and 3) healthy housing.

- **Improved Services for Youth and Seniors.** Lastly, programming for youth and for seniors was frequently raised during interview and focus group discussions. Many assessment participants expressed limited enrichment opportunities for young people, especially for teens aged 13-19. One participant summarized, "*It's what I call the lost ages—after the age of 11 or 12, these kids have nothing. By that age, they think teens should be working and there's no program for them. We need more youth-led programs where the intention is to speak with you and have them lead."* In terms of seniors, residents suggested more programming related to social connections and access to technology.

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data, a community survey, and discussions with community residents and stakeholders, this assessment report examines the current health status of the Westborough service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- **Overall, the Westborough service area was reported as a highly educated, high-income community, however, there are pockets of vulnerable populations across the region—particularly youth, immigrants, and older adults.** Findings from this assessment show that some residents in the Westborough service area are struggling with basic needs including access to food, shelter, and childcare. Interview participants discussed a collaborative network of community-based organizations working to alleviate some of these immediate needs, but many indicated a need for more support and coordination to address the magnitude of the situation.

- **Some residents are struggling with lack of employment and economic opportunities, especially in light of COVID-19.** During the pandemic, unemployment rates shot up across the service area, particularly Milford (16.1%), Marlborough (15.8%), Hudson (15.8%) Framingham (15.2%).[9] Young people, immigrant communities, and non-English speaking communities who are more likely to work as essential workers were identified as facing unique challenges related to social and economic factors. More resources for career transitions and job training, technology, and language classes were identified as critical to addressing these issues.

- **Housing affordability and transportation continue to be concerns in the Westborough service area.** Housing affordability was identified as a pressing concern, particularly for seniors and "*middle class*" residents. Many renters across the area, especially in towns, such as Bolton (68.4%) and Hopkinton (52.1%), are spending more than 30% of their income on housing costs.[10] Tenancy-at-will situations—or agreements between tenants and landlords, where there is no formal contract, negatively impacts already-vulnerable residents, such as undocumented immigrants and seniors. In terms of public transportation, suggestions to invest in alternate modes of transportation, such as bicycle share programs and incentives to reduce single-occupancy vehicles were shared by focus group participants.

[9] U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.

[10] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

- **As happening at the national level, conversations about racial justice and policing have been taking place in the Westborough service area.** Perceptions related to discrimination and racism varied throughout qualitative discussions. Addressing systemic racism was a theme that emerged across interviews, focus groups, and the community survey. Community leaders that were interviewed for the assessment described their commitment to addressing racial injustice and systemic oppression. Westborough Community Priorities Survey respondents ranked 'Addressing Systemic Racism/Racial Justice' as the 4th highest priority for action in the next few years.

- **Rates of obesity/overweight were higher in the majority of Westborough service area towns than the state overall.** Between 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 49.7% in Bolton to 64.2% in Milford.[11] Approximately one in every three Westborough Community Priorities Survey respondents reported overweight/obesity (34.3%) as an issue that has impacted them in the last 6 months, however, it did not rise up as a key theme from qualitative discussions.

- **Across all methods, the majority of assessment participants identified mental health as a priority health concern.** Stress, anxiety, depression, and isolation were the most frequently cited challenges among the Westborough service area, with residents describing how COVID-19 has exacerbated mental health issues in the community. Young people and seniors were identified as the populations most impacted by mental health challenges in the Westborough service area. Quantitative data from the MetroWest Adolescent Health Surveys show that the number of high school students that reported their lives have been "very stressful" has steadily increased from 28.9% in 2012 to 36% in 2018.[12]

- **Proximity of health care services was noted as a key strength of the Westborough service area by community survey respondents, but access to those services is a challenge for some residents.** Respondents to the Westborough Community Priorities Survey ranked 'accessible medical services' as the second strongest asset of the region (68.9%). However, themes that emerged from qualitative discussions highlight barriers that still persist for some residents, including being underinsured, challenges for non-English speakers, navigating services, and lack of culturally sensitive approaches to care. In addition, the Westborough service area could benefit from additional services for the growing senior population to help facilitate aging in place.

Priority Needs of the Community

Community Prioritization Meeting

Data and themes from the CHNA report were presented to service area residents and stakeholders at a virtual community prioritization meeting in September 2020. Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. The following four criteria were used to guide prioritization discussions and voting processes:

- Concern
- Equity
- Effectiveness
- Feasibility

[11] Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.

[12] MetroWest Adolescent Health Surveys, 2012 & 2018.

Meeting participants voted for up to three of the eight priorities identified from the data and based on the specific prioritization criteria. Voting identified Mental Health (71%) as the most commonly endorsed community priority, followed by Systemic Racism and Racial Injustice (57%), Financial Insecurity/Unemployment (43%), and Housing (43%).

Community Advisory Board Meeting

The goal of this meeting was for CAB members to review the CHNA findings for the service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health. To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, and Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Ultimately, the CAB identified four priorities to consider for future action:

- Mental health
- Access to services
- Systemic racism & racial injustice
- Housing

Mass General Brigham
Partners Ambulatory Care - Westborough Service Area Community Health Needs Assessment

INTRODUCTION

Mass General Brigham (formerly Partners HealthCare, 'the System') is a not-for-profit, integrated health care system that was formed in 1994 by an affiliation between The Brigham Medical Center, Inc. (now known as Brigham Health) and The Massachusetts General Hospital. Mass General Brigham currently operates two tertiary hospitals, six community acute care hospitals, and one acute care specialty hospital in Massachusetts; one community acute care hospital in Southern New Hampshire; one facility providing inpatient and outpatient mental health services; and three facilities providing inpatient and outpatient services in rehabilitation medicine and long-term care. Mass General Brigham also operates physician organizations and practices, a home health agency, nursing homes and a graduate level program for health professionals. Mass General Brigham is a non-university-based, nonprofit private medical research enterprise and its academic medical centers are principal teaching affiliates of the medical and dental schools of Harvard University. Mass General Brigham provides its services to patients primarily from the Greater Boston area and eastern Massachusetts, as well as New England and beyond. Additionally, Mass General Brigham operates a licensed, not-for-profit managed care organization that provides health insurance products to the MassHealth Program (Medicaid), ConnectorCare (a series of health insurance plans for adults who meet income and other eligibility requirements) and commercial populations.

To fulfill Mass General Brigham's four-part mission of patient care; research education; and community, the organization has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics; population health; ambulatory care; and insurance risk management. Implementation of this strategy relies on a series of synergistic priorities that include:

i. improving health outcomes across the full continuum of care with an emphasis on the development by Mass General Brigham's academic medical centers of multidisciplinary centers of excellence for tertiary and quaternary care;

ii. enhancing the patient experience, particularly for primary care and behavioral health care, by developing community-based health care settings that improve access and ease of navigation for patients;

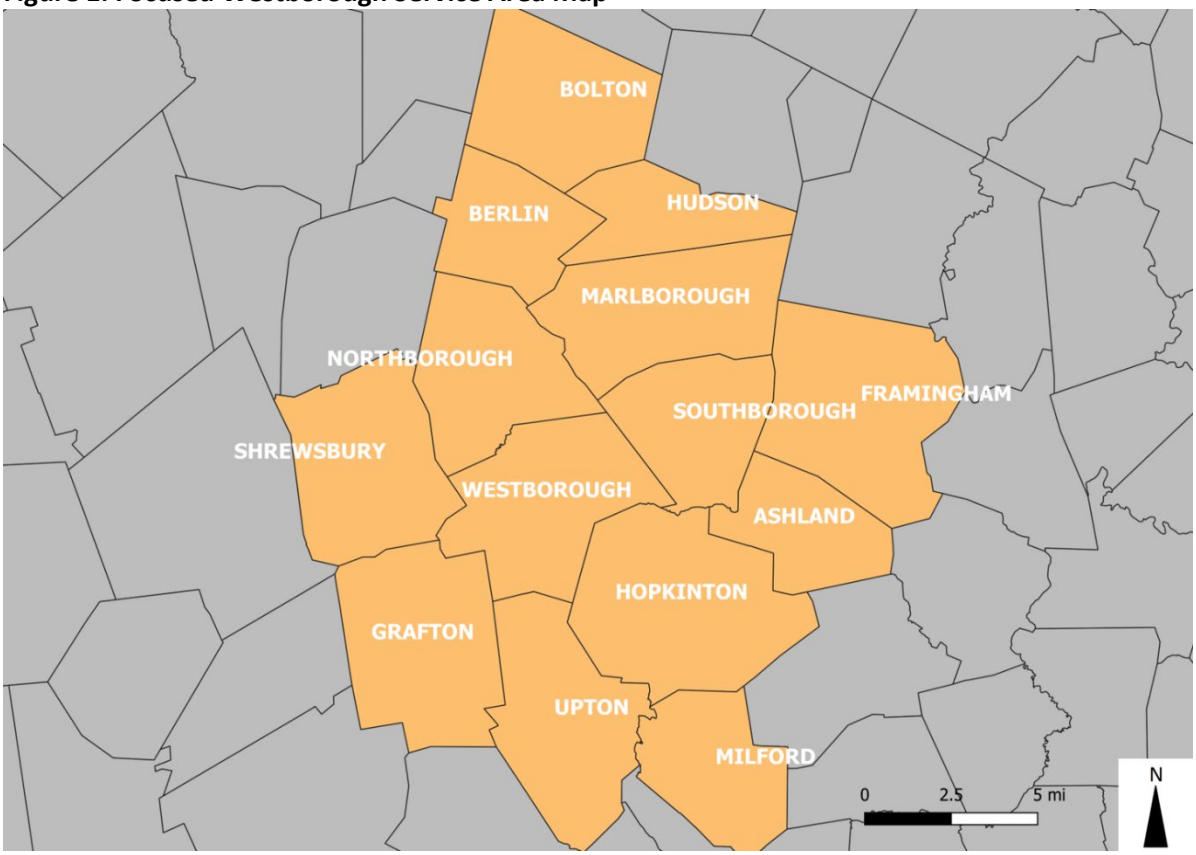
iii. reducing the total cost of health care by developing delivery models that focus on value while simultaneously improving outcomes; and

iv. investing in research and innovations that meaningfully improve the diagnosis and treatment of all forms of human illness.

Developing community-based care centers that offer primary and behavioral health care, as well as specialty and surgical services meet the second component of Mass General Brigham's mission.

Accordingly, the System is seeking ways to expand care options in more suburban settings, including in the Westborough area. This potential expansion will require Mass General Brigham to fully understand the range of needs (related to health and the social determinants of health) within the Westborough service area, including the communities of: Berlin, Bolton, Grafton, Northborough, North Grafton, Shrewsbury, Upton, Westborough, Framingham, Ashland, Hopkinton, Hudson, Marlborough, Milford, and Southborough. The Westborough service area is shown in Figure 1.

Figure 1. Focused Westborough Service Area Map



Purpose and Scope of the Community Health Needs Assessment

This community health needs assessment (CHNA or Assessment) aims to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the 2020 Westborough service area needs assessment processes, which were conducted between March-August 2020, and informed discussions about key community issues and concerns in the service area.

The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the community to inform future planning;
- Understand the current health status of the service area overall and its sub-populations within their social context; and
- Engage the community to help determine community needs and social determinant of health needs.

Priority social determinants of health areas include the social environment, built environment, employment, education, housing, and violence and trauma.

CONTEXT FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT

This CHNA was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice. This context had a significant impact on the assessment approach and content.

COVID-19 Pandemic

The novel coronavirus (COVID-19) pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process and topics, as well as concerns that participants put forth during discussions in focus groups and interviews. On February 1, 2020, the first confirmed case of COVID-19 in Massachusetts was announced, and on March 15, 2020, the Governor of Massachusetts issued an emergency order announcing emergency actions to address COVID-19 including school closures, business closures, and limitations on gatherings. Data collection planning (e.g., finalizing methodology, developing data collection instruments) occurred at the beginning of this state-wide shutdown. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (advisory bodies, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection was shifted to a virtual setting (e.g., telephone or video focus groups and an online survey), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a primary health concern for communities and also has exacerbated underlying inequities and social needs. The pandemic brought to light both the capabilities and gaps in the healthcare system, the public health infrastructure, and social service networks. In this context, an assessment of the community's strengths and needs, and in particular the social determinants of health, is both critically important and logistically challenging. Where possible, CHNA participants were asked to reflect on health and social issues beyond those directly related to COVID-19, yet the pandemic's short-term and long-term impacts remained at the forefront of many conversations. This CHNA should be considered a snapshot in time; consistent with public health best practices, the community can continue to be engaged to understand how identified issues may evolve and what new issues or concerns may emerge over time.

National Movement for Racial Justice

A wave of national protests for racial equity – sparked by the killing of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others – also coincided with the timeline of the CHNA. As part of a movement for racial justice, national attention was focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA, including the design of data collection instruments and the input that was shared during interviews and focus groups, as well as through survey responses. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in late spring 2020 in the form of protests and dialogues, locally and nationally, as context for this assessment.

METHODS

The following section details how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

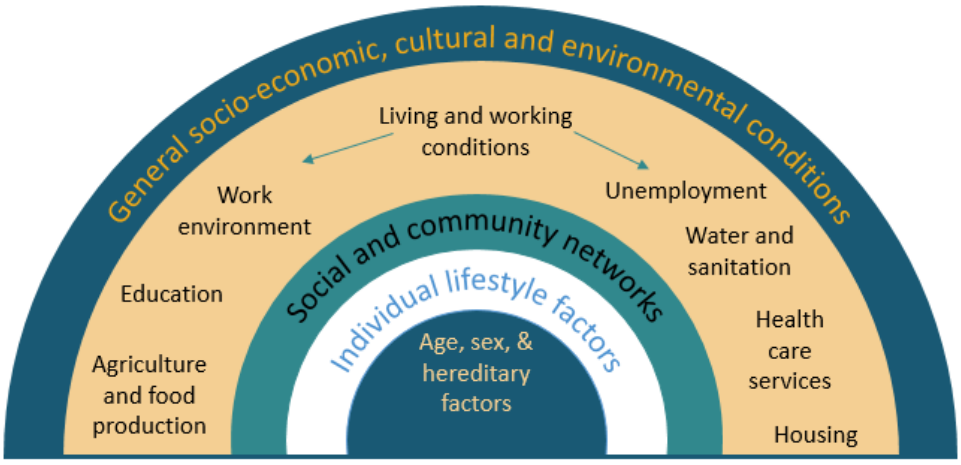
Social Determinants of Health Framework

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health.

Upstream Approaches to Health

Having a healthy population is about more than delivering quality health care to residents. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing stock, and economic policies. Figure 2 provides a visual representation of these relationships, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors, such as employment status and educational opportunities.

Figure 2. Social Determinants of Health Framework



SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. Mass General Brigham seeks to understand the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens

The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S.

In the present report, health patterns for the Westborough CHNA service area are described overall, as well as areas of need for particular population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by a regional Community Advisory Board (CAB). Mass General Brigham hired Health

Resources in Action (HRiA), a non-profit public health organization, as a consultant partner to facilitate the CHNA process, collect and analyze data, and develop the CHNA report.

Community Engagement

Community engagement is described further below under the primary data collection methods. It should be noted that, due to the COVID-19 pandemic, the community engagement for this CHNA occurred virtually. Additionally, while the CHNA aimed to engage a cross-section of individuals and to be inclusive of traditionally under-represented communities, due to the pandemic and competing priorities, community-based organizations had limited time to assist with outreach and community members had constraints on their own time for participation. Nevertheless, by engaging the community through multiple methods and in multiple languages, this CHNA aims to describe community strengths and needs during this unique time.

Community Advisory Board Engagement

As noted, a CAB provided oversight, input, and support throughout the CHNA process. The CAB was regional in focus and oversaw the work for this CHNA, as well as two other co-occurring CHNAs (taking place in the greater Woburn area and greater Westwood area). CAB members included representation from both regional groups and residents of the primary service area. The fifteen CAB members represent municipalities; the education, housing, social service, planning and transportation sectors; the private sector; community health centers; and community-based organizations. See Appendix A: Community Advisory Board Members for a full list of CAB members.

The CAB was engaged throughout the CHNA process. This engagement included meeting three times (in March to provide input on the CHNA methods and timeline; in June to hear updates on the CHNA process and to discuss virtual engagement, survey dissemination, and community outreach; and in September to discuss identified priorities) and providing regular input through email correspondence and telephonic discussions. CAB input included advising on key informant interviewees and focus group segments, identifying local data sources and communication outlets for the CHNA community health survey, and providing connections to community organizations to support data collection and outreach efforts. Additionally, the members of the CAB participated in the community prioritization meetings (see below for more information).

Secondary Data: Review of Existing Secondary Data

Secondary data are data that have already been collected for another purpose. Examining secondary data helps us to understand trends, provide a baseline, and identify differences by sub-groups. It also helps in guiding where primary data collection can dive deeper or fill in gaps.

Secondary data, including information and statistics, for this CHNA were drawn from a variety of sources, including the U.S. Census American Community Survey (ACS), the U.S. Department of Labor Bureau of Labor Statistics, the Federal Bureau of Investigation Uniform Crime Reports, the MA Department of Elementary and Secondary Education, the MA Center for Health Information and Analysis (CHIA) database, and a number of other agencies and organizations. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns or with MA overall, these are lay comparisons and *not* statistically significant differences.

It should also be noted that for most social and economic indicators, the U.S. Census American Community Survey (ACS) 5-year (2014-2018) aggregate datasets were used over the one-year datasets, since many of the towns in the service area are smaller in population size. Since the ACS uses a probability sampling technique, using the five-year aggregate dataset over the one-year data provides a larger sample size and more precision in its estimates.

In addition, data collected for the 2019 MetroWest Community Health Assessment (MetroWest CHA)—an extensive process that engaged 22 communities in the Westborough service area—were also incorporated into this report, including data from the MetroWest Adolescent Health Surveys. The MetroWest CHA's service area geography overlapped with much of the Westborough service area. The MetroWest CHA was a collaborative effort led by an advisory committee comprised of a range of organizations and partners working all across the region from September 2018 – June 2019. Similar to the Westborough service area CHNA, the MetroWest CHA aimed to identify the health-related needs and strengths of the area using a participatory approach. Methods that were used for the assessment included an online community survey that engaged nearly 800 individuals; eight focus groups with approximately 84 residents; and nine key informant interviews with key community stakeholders.

Primary Data Collection

Primary data are new data collected specifically for the purpose of the CHNA. Goals of the CHNA primary data were: 1) to determine perceptions of the strengths and needs within the service area, and identify sub-populations most affected; 2) to explore how these issues can be addressed in the future; and 3) to identify the gaps, challenges, and opportunities for addressing community needs more effectively. Primary data were collected using three different methods for this CHNA: key informant interviews, focus groups, and a community survey.

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews

A total of 12 key informant interviews were completed with 14 individuals by phone. Interviews were 45-60-minute, semi-structured discussions that engaged institutional, organizational, and community leaders, as well as front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Interviewees were asked to share their perceptions of needs both prior to and following the start of the COVID-19 pandemic. Sectors represented in these interviews included: health and human services; boards of health; nonprofit networks; youth-serving organizations; senior services; and community development. See Appendix B for the list of individuals that participated in the key informant interviews and Appendix C for a copy of the interview guide.

Focus Groups

The proposed focus group methodology for this CHNA changed during the pandemic. Rather than conducting traditional in-person focus groups of approximately eight participants each, more focus groups were conducted than originally planned, but with fewer participants in each discussion and virtually. Due to the COVID-19 pandemic, focus groups were conducted via a video conference platform or by telephone, to accommodate participants who did not have reliable internet access and/or were not familiar with video conferencing technology. Focus groups were intentionally limited in regard to the number of participants to facilitate conversation and full participation in a virtual environment, especially since the moderator could not pick up on non-verbal cues as easily.

A total of 17 community residents participated in eight virtual focus groups (telephone or video) conducted with specific populations of interest: parents of school-age children; residents seeking essential services (e.g., food assistance, housing assistance, etc.); residents who are immigrants; LGBTQ+ identifying youth; and youth who identify as residents of color. Focus groups were 60-minute, semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Focus group participants were asked to share their perceptions of needs both prior to and following the start of the COVID-19 pandemic. Please see Appendix D: Focus Group Guide for the focus group facilitator's guide.

All groups were conducted in English. Efforts were made to conduct two focus groups in Spanish, but there were challenges with recruitment and participation due to the pandemic. Several groups were recruited for and scheduled, but participants did not attend.

Throughout this report, service area residents and key stakeholders who participated in key informant interviews and focus groups are referred to as study 'participants.'

Analyses
The collected qualitative information was coded using NVivo qualitative data analysis software and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews, as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term "participants" is used to refer to key informant interview and focus group participants. Unique issues that emerged among a group of participants are specified as such. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While differences between towns and neighborhoods are noted where appropriate, analyses emphasized findings common across the Westborough service area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

Community Priorities Survey
A community priorities survey was developed and administered over six weeks from early July through mid-August 2020. The survey focused on identifying issues that had a direct impact on survey respondents, perceptions of community strengths, and important issues for community action. Given the unprecedented time, survey respondents were asked to identify current issues and concerns, as well as issues and concerns that were present around the holiday season (approximately six months ago prior to the start of the COVID-19 pandemic in the United States). The survey was administered online in four languages (English, Spanish, Portuguese, and Chinese). Please see Appendix E: Survey Instrument for the English-language version of the survey.

Extensive outreach was conducted with assistance from CAB members and organizations and through social media outreach to obtain survey responses. The survey was disseminated via email to known distribution lists of residents, as well as to individuals who attended earlier community engagement sessions for this process. Several paid Facebook ads were displayed in targeted geographic locations within the service area in all four languages to promote the survey. Additionally, several postings were run via Twitter, LinkedIn, and Facebook. Email dissemination outreach was also sent to over 50 different community-based organizations, which included local food pantries, immigrant service agencies, community centers, libraries, local news outlets, and other groups.

The final sample of the community priorities survey comprised 159 respondents who were residents of the Westborough service area. Appendix F: Additional Survey Data provides a table with the demographic composition of survey respondents. Overall, the majority of respondents were predominantly non-Hispanic White (73.9%), female (74.8%), heterosexual (93.1%), and with high socioeconomic status (Appendix F: Additional Survey Data). Throughout this report, service area residents who participated in Community Priorities Survey are referred to as survey 'respondents.'

Analyses
Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied by question. Additionally, denominators excluded respondents who selected "prefer not to answer/don't know."

For questions that allowed for multiple responses (i.e., questions that asked respondents to check all that apply), the denominator was out of the total number of respondents who selected at least one response option for the question. Stratified analyses were conducted for select questions by specific sub-groups that had large enough sample sizes (at least 30 respondents).

Data Limitations

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

With many organizations and residents focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. While extensive outreach was conducted, the overall response was not as large as expected based on previous assessment studies. Additionally, with its online administration method, the community survey used a convenience sample. Since a convenience sample is a type of non-probability sampling, there is potential selection bias in who participated or was asked to participate in the survey. Due to this potential bias, results cannot necessarily be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, focus groups and interviews were also conducted virtually, and therefore, while both video conference and telephonic options were offered, some residents who lack reliable access to the internet and/or cell phones may have experienced difficulty participating. Lastly, for the primary data collection, it should be noted that while efforts were made to engage residents through qualitative and survey data collection, given the context of the pandemic, the capacity of community organizations to assist with outreach and community members to participate was limited. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

POPULATION CHARACTERISTICS

Population Overview

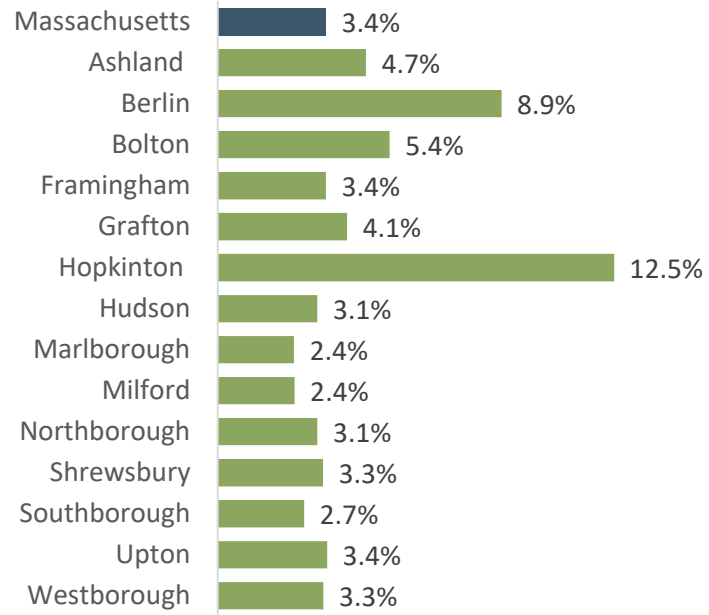
The Westborough service area is divided into towns of various sizes. By population size, the largest towns in the area are Framingham, Marlborough, and Shrewsbury (Table 1). Similar to the Commonwealth overall, all towns in this region experienced population growth between 2007-2013 and 2014-2018. The largest population growth occurred in Hopkinton (12.5%) and Berlin (8.9%) (Figure 3).

Table 1. Total Population, in Massachusetts and by Town, 2009-2013 and 2014-2018

	2009-2013	2014-2018
Massachusetts	6,605,058	6,830,193
Ashland	16,792	17,576
Berlin	2,886	3,144
Bolton	4,967	5,236
Framingham	69,288	71,649
Grafton	17,895	18,624
Hopkinton	15,271	17,178
Hudson	19,263	19,868
Marlborough	38,842	39,776
Milford	28,109	28,789
Northborough	14,529	14,985
Shrewsbury	35,849	37,037
Southborough	9,807	10,074
Upton	7,574	7,835
Westborough	18,371	18,982

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

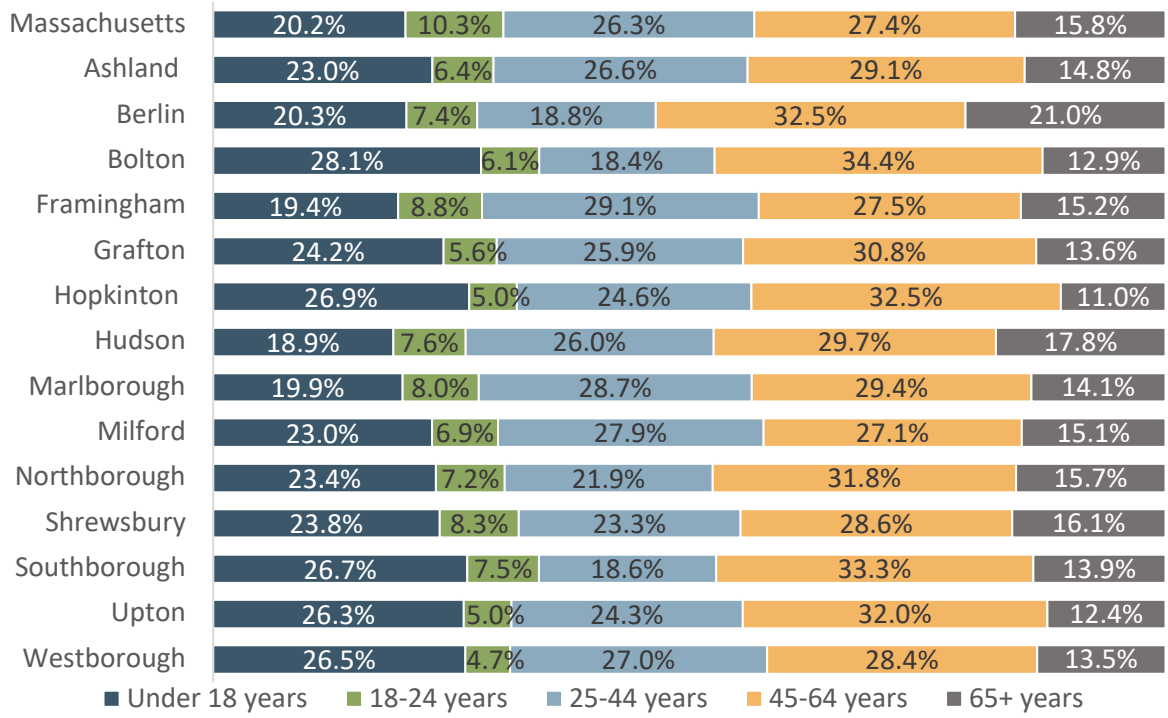
Figure 3. Percent Change in Population, in Massachusetts and by Town, 2009-2013 and 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

More than 25% of residents in Bolton, Hopkinton, Southborough, Upton, and Westborough were under the age of 18 in 2014-2018 (Figure 4). The largest populations over age 65 were in Berlin (21.0%) and Hudson (17.8%).

Figure 4. Age Distribution, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Racial, Ethnic, and Language Diversity

> *"[Framingham] is a very diverse community…I see a lot of different people, hear languages of all kinds when I'm walking down the street."* – Youth focus group participant

> "*[Hopkinton] is a predominately White town, and it's not very integrated. I would like to see us all part of the community."* – Focus group participant

Racial and Ethnic Composition

Residents engaged in the assessment described varying levels of diversity in their towns, with some describing high levels of racial and ethnic diversity, and others describing more homogenous, predominately White communities. The secondary data support these findings. In 2014-2018, the racial and ethnic population distributions varied widely across towns in the Westborough service area. For example, in Framingham, Marlborough, Milford, Shrewsbury and Westborough, more than one in every four residents identify as non-White. In contrast, for the same time period, the overwhelming majority of residents in Berlin (96%), Bolton (92%), Hudson (88%), and Northborough (84%) identified as White in. Framingham had the largest Hispanic/Latino populations (16%); Framingham and Upton had the largest non-Hispanic Black populations (6%); and Westborough and Shrewsbury had the largest non-Hispanic Asian populations (24% and 19% respectively) (Table 2).

Table 2. Racial and Ethnic Distribution, in Massachusetts and by Town, 2014-2018

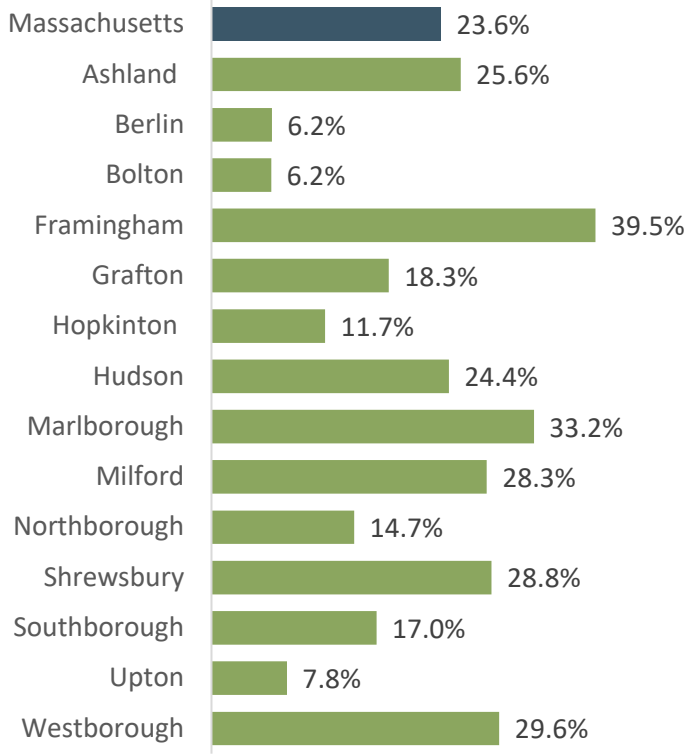
	Asian, non-Hispanic	Black, non-Hispanic	White, non-Hispanic	Other, non-Hispanic	Hispanic/ Latino
Massachusetts	6.4%	6.8%	72.2%	3.0%	11.6%
Ashland	10.3%	2.5%	78.1%	2.1%	7.1%
Berlin	1.7%	0.5%	96.4%	0.7%	0.7%
Bolton	4.3%	0.3%	92.2%	1.2%	1.9%
Framingham	8.3%	6.1%	64.8%	5.0%	15.8%
Grafton	7.8%	4.5%	77.5%	3.5%	6.7%
Hopkinton	9.7%	1.7%	83.9%	2.0%	2.6%
Hudson	2.5%	1.3%	88.0%	1.9%	6.4%
Marlborough	5.9%	3.0%	72.5%	4.7%	14.0%
Milford	2.8%	2.2%	77.0%	4.4%	13.5%
Northborough	8.0%	2.4%	83.7%	2.9%	3.1%
Shrewsbury	18.5%	3.3%	69.3%	3.5%	5.4%
Southborough	13.0%	1.5%	80.6%	1.8%	3.0%
Upton	3.1%	6.3%	81.5%	4.7%	4.4%
Westborough	23.9%	2.7%	66.2%	2.0%	5.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race and racial categories. Other includes non-Hispanic/Latino residents who identify as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races.

Language Diversity

Among Massachusetts residents over age five, 23.6% reported speaking a language other than English at home in 2014-2018 (Figure 5). Language diversity varies widely throughout the Westborough service area, as indicated in the secondary data and supported in qualitative discussions. For example, the proportion of residents who reported speaking a language other than English at home was close to 40% in Framingham, while in Berlin and Bolton, it was only 6.2%. The most commonly spoken languages other than English in the Westborough service area are other Indo-European languages (e.g., Portuguese, Italian, etc.); Spanish; and Chinese. In Framingham, Russian, Polish, or other Slavic languages account for 5% of the population who speak another language.

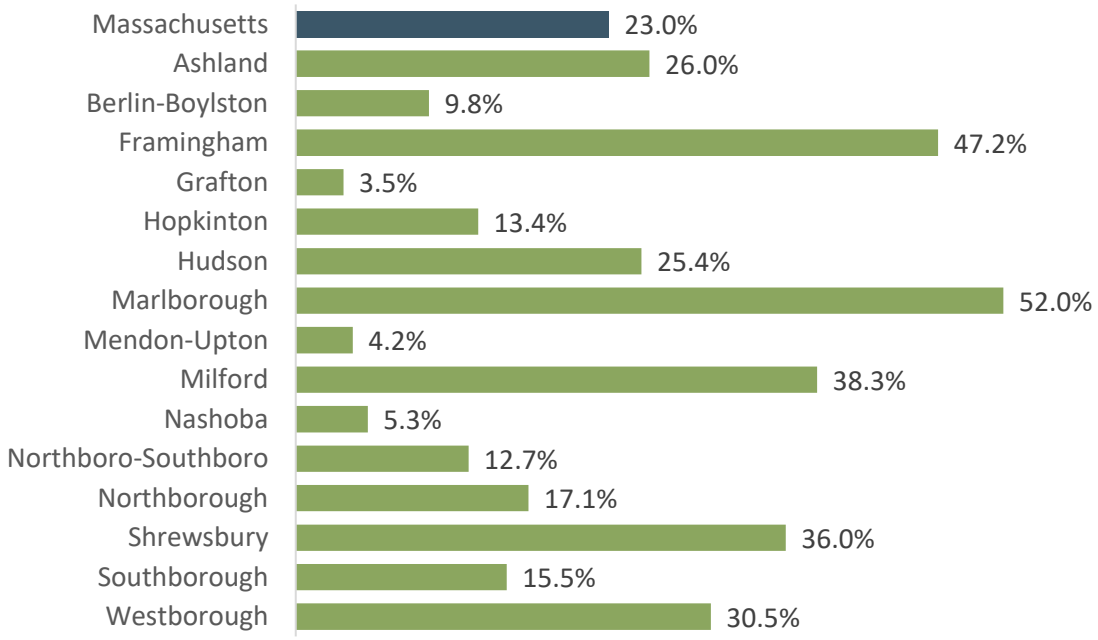
Figure 5. Percent Population 5 Years and Over Who Speak a Language Other Than English, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

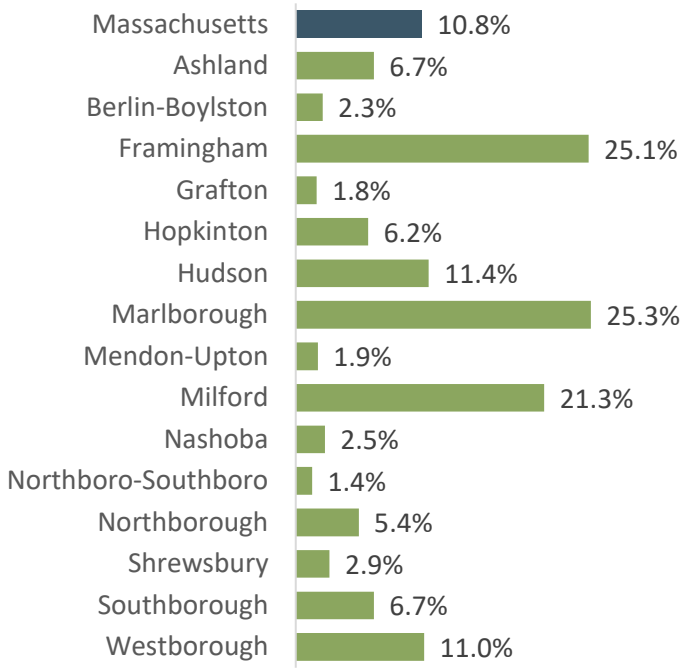
Language diversity is even more prevalent in public schools in the Westborough service area. In 2020, over half of public-school students in Marlborough did not speak English as their first language (52%). Similarly, more than one in three students in Framingham (47.2%), Milford (38.3%), and Shrewsbury (36.0%) spoke another language other than English at home (Figure 6). Focus groups with residents seeking essential services discussed increasing linguistic diversity in schools. One resident from Hudson shared, "*I've seen a larger population of first-generation immigrants in [Hudson]. I'm a teacher and we've had a lot more ELL [English language learners].*" Quantitative data support these findings. In 2014-2018, one in every four students in the Hudson public schools did not speak English as their first language (Figure 6). In Framingham and Marlborough public schools, a quarter of public-school students are enrolled as English language learners, compared to 10.8% statewide (Figure 7).

Figure 6. Percent Public School Students whose First Language is Not English, in Massachusetts and by School District, 2020



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Northboro-Southboro school district includes towns of Northborough and Southborough; Nashoba school district includes town of Bolton (in Westborough service area CHNA), as well as Lancaster and Stow (not in Westborough service area CHNA); Years represent school years (e.g., 2020 represents school year 2019-2020); First Language not English indicates the percent of enrollment whose first language is a language other than English.

Figure 7. Percent Public School Students Enrolled English Language Learner, in Massachusetts and by School District, 2020



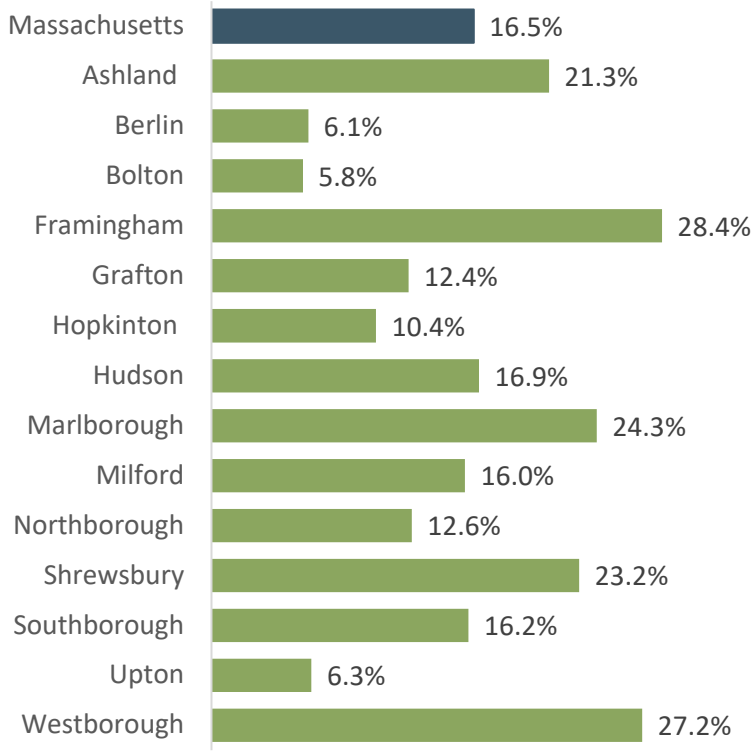
DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Northboro-Southboro school district includes towns of Northborough and Southborough; Nashoba school district includes town of Bolton (in Westborough service area CHNA), as well as Lancaster and Stow (not in Westborough service area CHNA); Years represent school years (e.g., 2020 represents school year 2019-2020); English Learners indicate the percent of students enrolled in the district who are English learners, defined as a student whose first language is a language other than English who is unable to perform ordinary classroom work in English (http://profiles.doe.mass.edu/help/data.aspx?section=students#selectedpop).

Foreign-born Population

Key informant and focus group participants described a robust immigrant community in the Westborough service area, particularly in areas such as Framingham and Marlborough. Residents from these towns most frequently reported a perceived increase in the South Asian and Hispanic/Latino communities, with one focus group participant sharing, *"There's a lot of cultures here in Marlborough and it's growing, mostly Brazilian with also a big South Asian community as well."* Another interviewee agreed and shared, *"Framingham in particular has been welcoming to immigrants since the start. There's a large Brazilian and Central American community here."* Of all the towns in the Westborough service area, Framingham and Marlborough had the largest percent of Brazilian immigrants (31.3% and 32.7%, respectively); and Westborough and Shrewsbury had the largest percent of immigrants from India. (41.9% and 37.9%, respectively).

Quantitative data show varying levels of the foreign-born population across the service area. In 2014-2018, the foreign-born population ranged from 5.8% in Bolton to 28.4% in Framingham, compared to 16.5% in Massachusetts overall (Figure 8). The towns with the lowest proportion of residents born outside the United States were Bolton (5.8%), Berlin (6.1%), and Upton (6.3%).

Figure 8. Percent Foreign Born Population, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Assessment participants described immigrants as residents with high levels of resilience and strong values. One interviewee summarized, *"The [immigrant] community is resilient. People here have faced adversity in their countries and continue to face it here. They continually find ways to adjust and cope and make a way forward and adapt to relatively strange and uncomfortable situations."*

COMMUNITY SOCIAL AND ECONOMIC ENVIRONMENT

Community Perceptions of Need

Understanding community residents' perception of priority issues is a critical step in the community health needs assessment process that facilitates insights into lived experiences, as well as facilitators and barriers to addressing concerns. The section below discusses the priorities identified by assessment participants based on the community survey, interviews, and focus groups.

Top Issues Affecting the Community

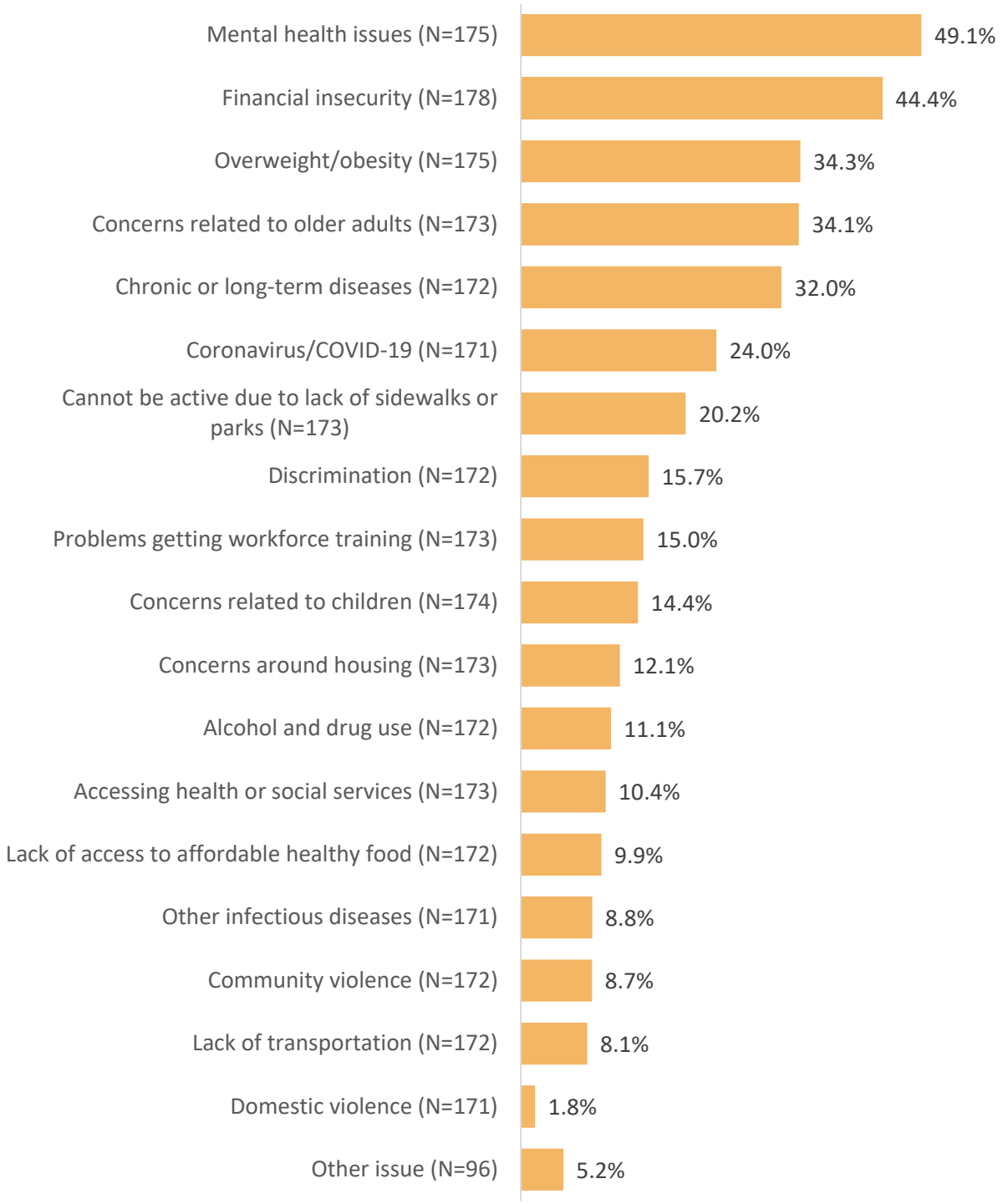
> *"For all social determinants of health…there are huge disparities that manifest into physical and mental health [issues]. Because of the underlying disparity and equity issues, things have been severely exacerbated by the pandemic."* – Key informant interview

Westborough Community Priorities Survey respondents were asked about a series of issues or problems that affected them or their families currently and/or prior to the start of the coronavirus pandemic. The two most common issues reported via the survey and qualitative discussions were mental health (49.1%), followed by financial insecurity (44.4%) (Figure 10). In regard to mental health, assessment participants described added stressors in recent months due to the pandemic; however, participants noted these concerns have always been present, and now are exacerbated by the current crisis. One interviewee summarized, *"COVID-19 has exposed the tip of the iceberg that we've [been seeing] around mental health and stressors."* Similarly, financial insecurity was a key theme across groups of residents seeking essential services, with participants sharing the challenges of maintaining well-paying jobs and meeting basic needs. Immigrants and seniors were described as especially vulnerable to financial insecurity. "*Economic uncertainty was always an issue to begin with* [pre COVID-19], *but now a lot of people have been laid off from work. They might have been working jobs that don't have emergency leave. It's not unique to the immigrant population, but they're overrepresented in this group."*

Approximately one in every three Westborough Community Priorities Survey respondents reported overweight/obesity (34.3%) as an issue that has impacted them in the last 6 months, however, it was not determined to be a key theme based on qualitative discussions. Moreover, although concerns related to older adults was listed as the fourth priority among survey respondents at 34.1%, this topic was frequently discussed across interviewees and focus group participants (Figure 9). Among respondents, 24.0% reported their family was personally affected by the coronavirus/COVID-19 and 15.7% reported being affected by some form of discrimination. Appendix F provides data on the details of responses on whether these were issues now, six months ago, or at both times. Westborough Community Priorities Survey respondents indicated that several issues such as mental health, financial insecurity, and concern for older adults are issues now but were not prior to the onset of the COVID-19 pandemic.

Interestingly, only 11.1% of Westborough Community Priorities Survey respondents identified alcohol and drug use as an issue currently affecting them. However, in the 2016 and 2019 MetroWest CHAs substance use was identified as the greatest health concern for the service area. Additionally, substance use was not identified as a key concern in focus groups, either, with the exception of focus groups with parents.

Figure 9. Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Type of Issue, 2020



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Different demographic groups in the Westborough service area indicated varying issues that affected them or their families in the past six months. For example, among respondents with a bachelor's degree or higher, the most commonly reported issues were mental health, financial insecurity, concerns about older adults, overweigh/obesity, and chronic diseases (Figure 10). Conversely, there was a lower proportion of respondents with less than a bachelor's degree who reported mental health as a priority concern, placing overweight/obesity as a higher priority; and they reported being affected by Coronavirus/COVID-19 and did not list concerns about older adults among their top five issues. By race, People of Color reported discrimination and lack of sidewalks or parks among their top five issues, which did not appear among other groups. It should be noted that racial/ethnic groups were categorized in these two groups due to small sample sizes among specific racial/ethnic groups (e.g. Black respondents, Latino respondents).

Figure 10. Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Selected Demographics, 2020

	Less than College(N=31)	College or More (N=126)	White, non-Hispanic (N=125)	People of Color (POC) (N=33)
1	Financial insecurity (54.8%)	Mental health issues (50.4%)	Mental health issues (48.0%)	Financial insecurity (51.5%)
2	Overweight/obesity (51.6%)	Financial insecurity (44.0%)	Financial insecurity (44.4%)	Discrimination (50.0%) (tied)
3	Chronic or long-term diseases (43.3%)	Concerns related to older adults (33.9%)	Concerns related to older adults (33.9%)	Mental health issues (50.0%) (tied)
4	Mental health issues (41.9%)	Overweight/obesity (29.3%)	Chronic or long-term diseases (33.3%)	Overweight/obesity (39.4%)
5	Coronavirus/COVID-19 (29.0%)	Chronic or long-term diseases (28.9%)	Overweight/obesity (32.8%)	Cannot be active due to lack of sidewalks or parks (34.4%)

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Community Assets

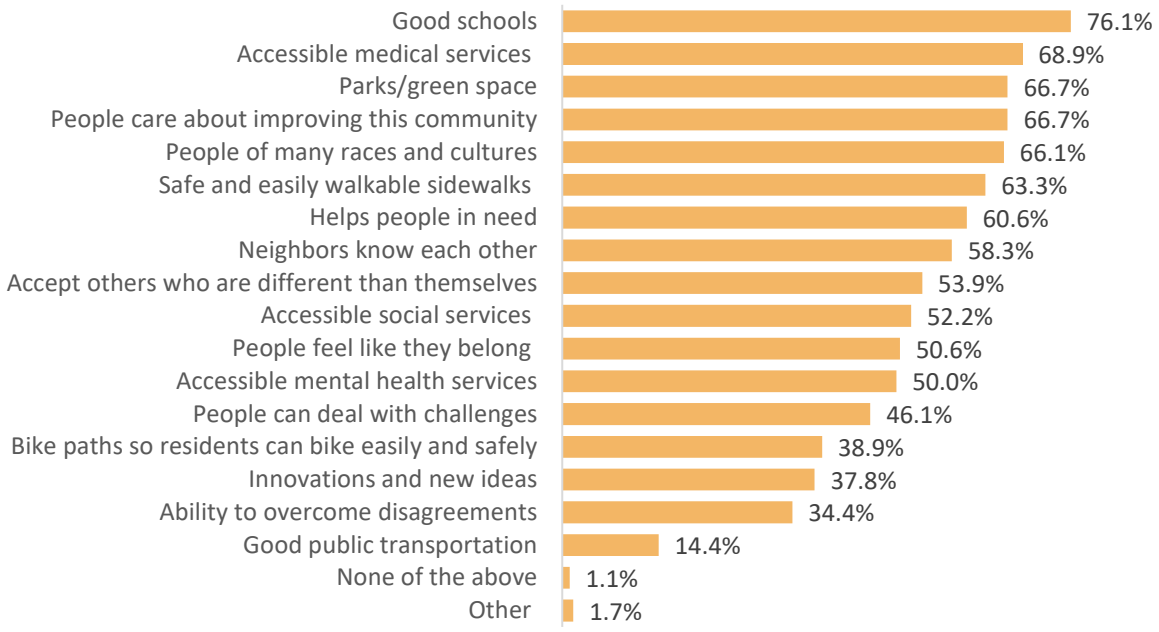
> *"There's a level of resiliency here that people have. It's the desire to keep their families together and functioning…to provide the best possible life for themselves or their families. Their commitment to their kids."* – Key informant interview

> "*Our direct neighborhood is very caring. People are always open to help each other. They'll drive your kids if you're running late. They help with the snow."* – Focus group participant

The Westborough service area has numerous strengths according to focus group and interview participants, as well as Westborough Community Priorities Survey respondents. Towns in the service area were described as generous, collaborative, and being centrally located. The most frequently cited community strength discussed in focus groups and interviews was strong educational school systems, followed by outdoor space, and substantial cultural diversity. These findings are aligned with themes identified in the 2019 MetroWest CHA. The broad access and availability of services was described as a strength of the Westborough service area. One assessment participant summarized, "*One of our strengths is that we're centrally located. We have access to medical facilities all over the place. It's a 40-minute shot to Boston; a 10-minute shot up to UMASS trauma. No matter what people need it's not too far."* Additionally, faith organizations and nonprofit organizations were identified by multiple key informants as a strength in the area, notating collaborative partnerships and nimble organizations.

Quantitative data support these findings. Respondents to the Westborough CHNA survey were asked about their perceptions of the strengths of their communities. The most common responses were good schools (76.1%), accessible medical services (68.9%), parks/green space (66.7%), people who care about improving the community (66.7%) and having people of many races and cultures (66.1%) (Figure 11). Only 1.1% of respondents reported none of the above, and 1.7% other.

Figure 11. Percent of CHNA Community Priorities Survey Respondents Reporting Strengths of Their Community, 2020 (N=180)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

The top five community strengths listed varied by demographic group, as described below in (Figure 12). Among respondents over the age of 65, for example, the top priorities included: neighbors help people in need, neighbors know each other, and people feel that they belong. People of color more commonly reported parks/and green space, people of many races and cultures, safe and easily walkable sidewalks within the top five community strengths.

Figure 12. Percent of CHNA Community Priorities Survey Respondents Reporting Strengths of Their Community, by Selected Demographics, 2020

	Under 65 Years (N=125)	65 Years or Over (N=34)	White, non-Hispanic (N=125)	People of Color (POC) (N=33)
1	Good schools (77.6%)	Good schools (88.2%)	Good schools (81.6%)	Parks/green space (75.8%)
2	Parks/green space (72.0%)	Accessible medical services (76.5%) (tied)	Accessible medical services (76.0%)	People of many races and cultures (69.7%)
3	Accessible medical services (69.6%)	Helps people in need (76.5%) (tied)	People care about improving this community (73.6%)	Good schools (66.7%)
4	People of many races and cultures (68.8%)	People care about improving this community (76.5%) (tied)	Parks/green space (69.9%)	Safe and easily walkable sidewalks (60.6%)
5	People care about improving this community (68.0%)	Neighbors know each other (73.5%) (tied)	People of many races and cultures (69.9%)	People care about improving this community (57.6%)
Tie		People feel like they belong (73.5%) (tied)		

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Income and Financial Security

> "*You realize how razor thin people's lives are. One thing runs off the rails can really send an entire family into chaos."* – Key informant interviewee

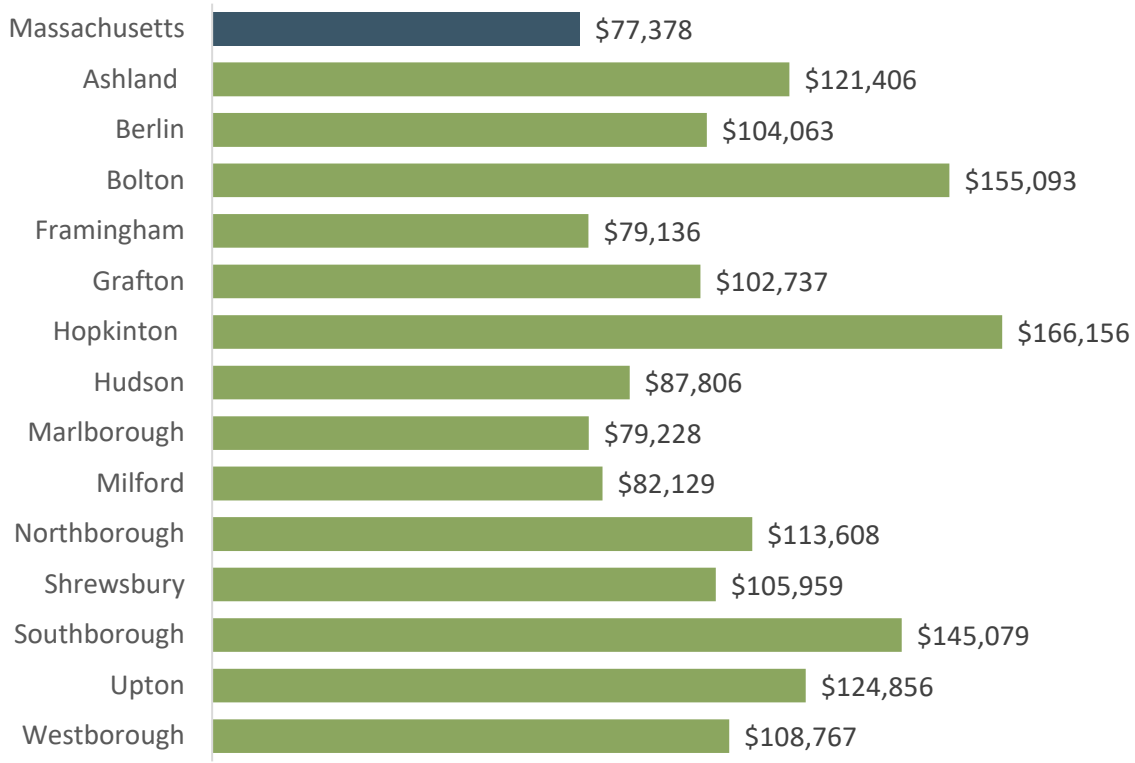
As discussed in the *Community Perceptions of Need* section, financial insecurity was reported as a priority concern in the majority of focus groups and interviews, with participants indicating that the COVID-19 pandemic has exacerbated long-standing issues of inequity. According to responses from the Westborough service area community survey, one in three respondents reported that their financial situation had gotten worse since the onset of the pandemic. Income inequality was often discussed among interview participants, one sharing, "*Like a lot of other cities, Framingham has a divide – you can pretty much see the line: across the railroad tracks – it's more impoverished…lots of immigrants. On the north side – it's Whiter, affluent, larger houses. You can clearly see the north-south divide. The disparity is huge."* Seniors were described as a population especially vulnerable to financial insecurity, with one participant sharing: "*In terms of older adults – people are living longer. But their financial planning didn't take them past 90 years old, and now they're 95. So now they don't have the funds to access the right supports at the time it's needed most."*

In the Westborough service area, socioeconomic factors vary by town. For example, the median annual household income in 2014-2018 ranged from just over $79,000 in Framingham and Marlborough to $166,156 in Hopkinton (Figure 13). All towns in the area had median incomes above the state average. Even so, many of

the towns in this area still have residents experiencing poverty, with incomes at or below 200% of the Federal Poverty Level (FPL). Given the high cost of living in the Greater Boston Area and the low federal poverty line, individuals with household incomes at even 200% of the FPL are at the extreme end of financial insecurity. The federal poverty line changes by household size, consequently in 2020, 200% FPL was the equivalent of an annual household income of $25,520 for an individual and $52,400 for a family of four. Framingham (23.6%) had the largest number of residents in poverty, followed by Milford (19.4%) and Marlborough (18.9%) (Figure 14). Similar patterns existed for families living below 200% of the FPL in 2014-2018.

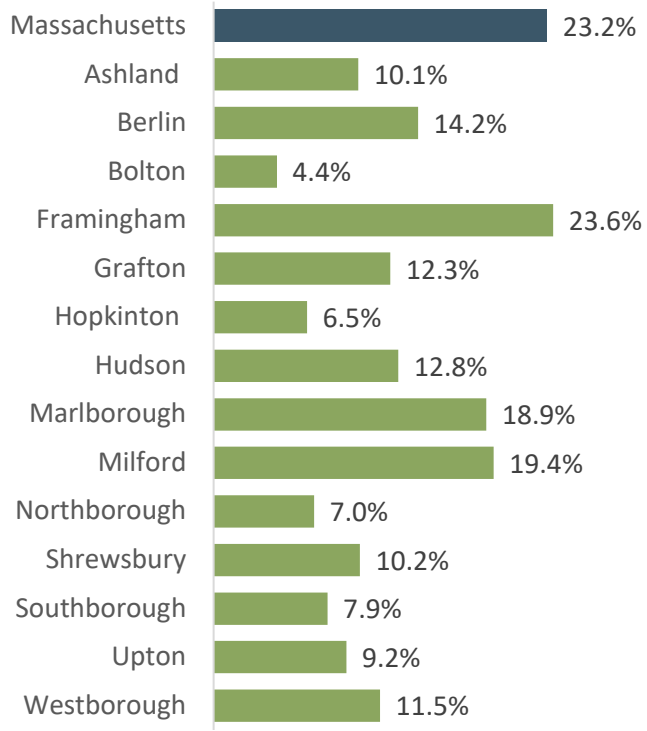
Compared to their White counterparts, there is a higher proportion of communities of color in the Westborough service area living in poverty. For example, more than half of Black residents in Bolton reported living below the poverty line in 2014-2018, despite accounting for less than 1% of the town's population. This pattern is similar in the majority of towns in the Westborough service area. The highest proportion of Asians living in poverty was in Northborough (8.3%), of non-Hispanic Blacks was in Bolton (55.6%), and of Hispanics/Latinos was in Milford (24.2%) (Table 3).

Figure 13. Median Household Income, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Figure 14. Percent Population Living Below 200% of Poverty Level, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

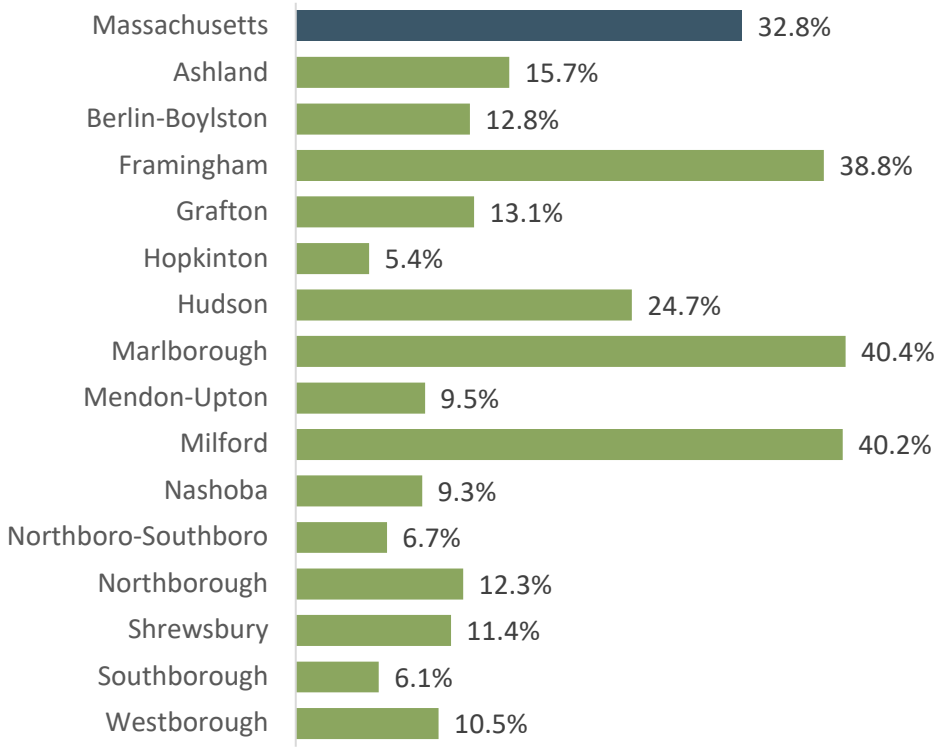
Table 3. Percent Population Living Below Poverty Level (100% FPL), by Race/Ethnicity, in Massachusetts and by Town, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	13.8%	19.7%	22.8%	7.1%	26.6%
Ashland	3.6%	19.3%	2.1%	3.3%	2.4%
Berlin	0.0%	0.0%	0.0%	4.3%	4.5%
Bolton	4.4%	55.6%	2.2%	1.1%	2.0%
Framingham	7.0%	23.5%	13.5%	7.1%	17.5%
Grafton	5.1%	7.3%	3.5%	4.4%	4.0%
Hopkinton	0.1%	3.3%	13.9%	2.1%	17.2%
Hudson	6.1%	31.2%	3.5%	5.6%	5.3%
Marlborough	6.7%	3.4%	9.8%	6.0%	8.5%
Milford	4.2%	10.9%	23.0%	5.6%	24.2%
Northborough	8.3%	1.7%	1.5%	1.6%	0.7%
Shrewsbury	5.2%	14.3%	6.9%	3.4%	7.9%
Southborough	3.1%	35.9%	7.7%	2.9%	10.7%
Upton	0.0%	0.6%	5.2%	3.6%	4.3%
Westborough	4.5%	3.9%	15.1%	3.9%	3.8%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

According to the Massachusetts Department of Elementary and Secondary Education, 32.8% of public school students in Massachusetts were economically disadvantaged during the 2019-2020 school year (Figure 15; see footer for definition). In the Westborough region, proportions varied by town, ranging from around 40% in Framingham, Marlborough, and Milford to less than 7% in Hopkinton, Northboro-Southboro, and Southborough school districts.

Figure 15. Percent Public School Students Economically Disadvantaged, in Massachusetts and by School District, 2020



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Northboro-Southboro school district includes the high school for the towns of Northborough and Southborough; Nashoba school district includes town of Bolton (in Westborough service area CHNA) as well as Lancaster and Stow (not in Westborough service area CHNA); Years represent school years (e.g., 2020 represents school year 2019-2020); Economically disadvantaged is determined based on a student's participation in one or more of the following state-administered programs: the Supplemental Nutrition Assistance Program (SNAP), the Transitional Assistance for Families with Dependent Children (TAFDC), the Department of Children and Families' (DCF) foster care program, and MassHealth (Medicaid).

Employment and Workforce

> *"A lot of youth depend on their jobs to help out with their families, and since things have been closed, we haven't been able to work."* – Youth focus group participant

> *"Many social service providers on the frontline—the majority who are people of color—are also financially unstable and have to work multiple jobs to make ends meet."* – Key Informant Interview

> *"Lost jobs are a huge problem here. It's very hard to get a job, most of the time [undocumented immigrants] can only get a job between landscaping or housecleaning because they don't ask for papers. But with the coronavirus, everything has changed."* – Key Informant Interview

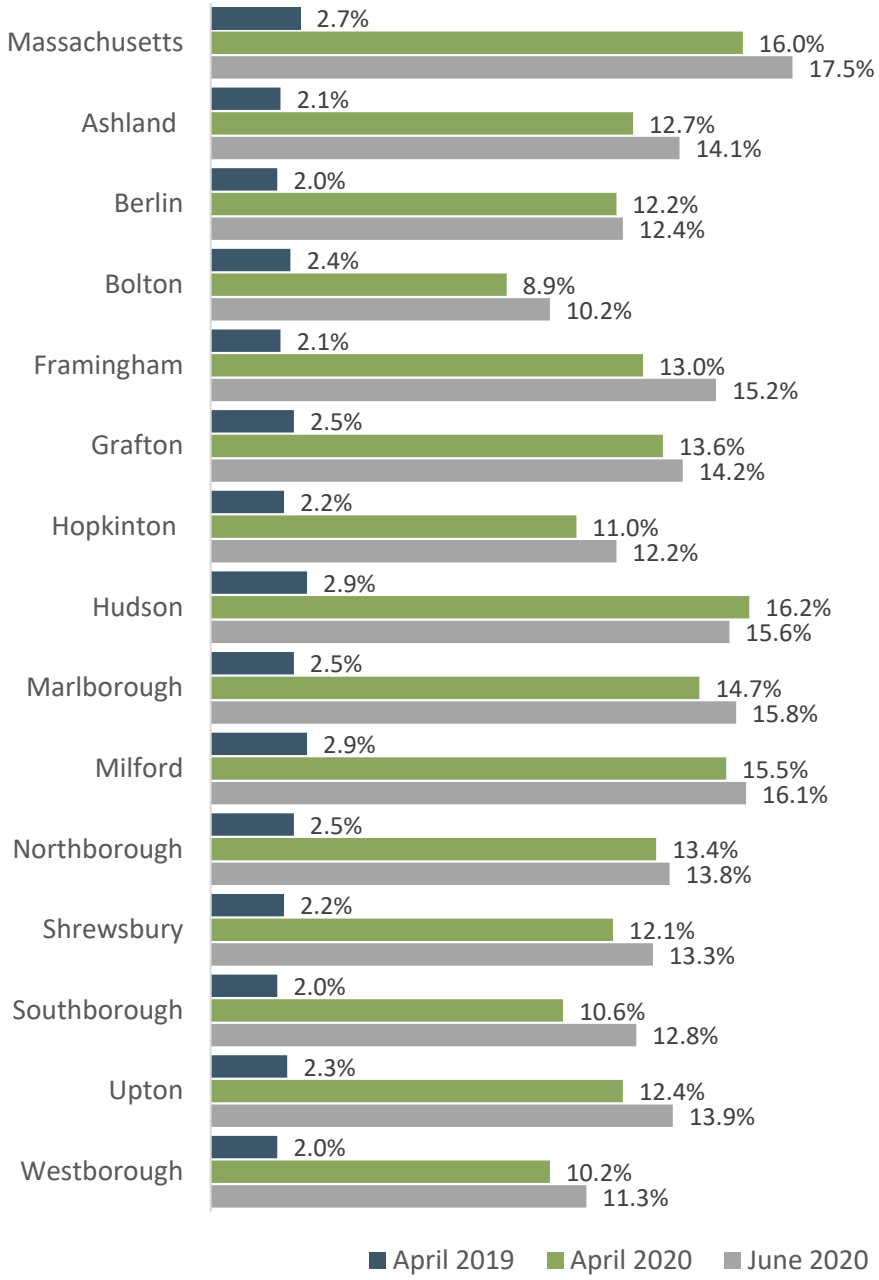
Economic uncertainty due to loss of employment was discussed in focus groups with residents seeking essential services and across all interviews. Participants shared experiences of struggling to meet basic needs, such as housing and accessing healthy food. Lack of employment opportunities was described as especially difficult for young people, seniors, and immigrants. As one youth focus group participant described, "*It's difficult because people my age [20] want to be getting jobs but the only places you can get them are in retail and that's where people are not wearing masks. So, if you want to work, you're signing up to be an essential worker."* Access to meaningful employment for young people, especially teenagers and young adults, was identified as a critical gap to address in multiple conversations.

Assessment participants also shared their perspectives on how COVID-19 has disproportionately impacted vulnerable groups, such as undocumented immigrants, sharing, "*At the beginning of COVID, we were seeing a whole underground of [undocumented] people who were housekeepers and factory workers and landscapers who did not have access to any of the stimulus money. They were not in the position to be waiting for a check."*

Multiple interviewees from social service agencies described the challenges of retaining staff, particularly employees of color, because of the inability to offer adequate compensation. Due to low pay, they are struggling to make ends meet and need to balance multiple jobs. One interviewee summarized, "*We don't have adequate funding to pay our essential workers a living wage. Most of our staff have 2-3 jobs. The staff employed at human service organizations also are economically disadvantaged—many of them are people of color—and are disproportionately affected by COVID-19 because of their race and socioeconomic status."*

The impact of the COVID-19 pandemic and resulting economic shutdown in many sectors is reflected in unemployment data from towns in the area around Westborough, between April 2019 and June 2020 (Figure 16). Unemployment rates continued to increase from April 2020 to June 2020 in all towns except Hudson. In April 2019, Massachusetts as a whole, and each city or town in the area had unemployment rates under 3%. However, during the pandemic, unemployment rates increased to 17.5% statewide in June 2020, with similar patterns in the majority of towns in the service area, particularly Milford (16.1%), Marlborough (15.8%), Hudson (15.8%) Framingham (15.2%).

Figure 16. Percent Population 16 Years and Over Unemployed, in Massachusetts and by Town, 2019-2020

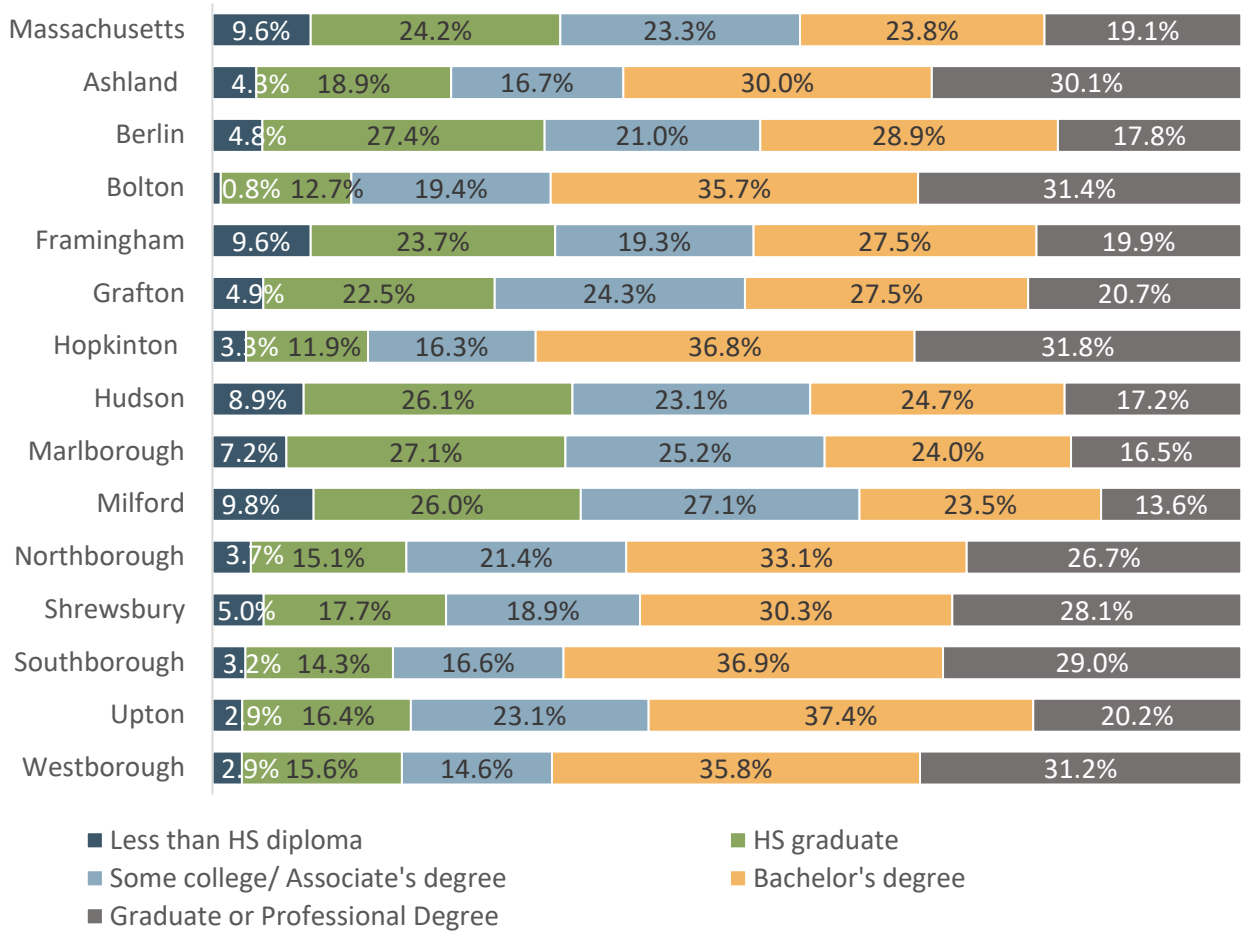


DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.
NOTE: Data are not seasonally adjusted; June 2020 data are preliminary and subject to revision.

Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. Massachusetts stands out as a state with an exceptionally high proportion of residents with college, graduate, and professional degrees (42.9% in 2014-2018; Figure 17). In the Westborough region, from 2014-2018, Bolton (31.4%), Hopkinton (31.8%), and Westborough (31.2%) had the largest number of residents age 25 and over with a graduate or professional degree. Berlin, Framingham, Hudson, Marlborough, and Milford had the largest populations with a high school diploma or less. Focus group participants who were parents, as well as those who were immigrants, described the education system as an asset of these communities. One shared, "*We have a ton of different school choices and they all offer different programs.*" Other focus group participants agreed that education was a strength of their community but perceived that the high demand was burdening the school system, sharing "*People are flocking here for the education. The schools are really good and well-ranked, but they're already bursting at the seams even though the buildings are brand new.*"

Figure 17. Educational Attainment for Population 25 Years and Over, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

While there is an increased incidence of higher educational levels in the region, it still varies by race/ethnicity. Table 4 shows the proportion of residents over the age of 25 with a bachelor's degree or higher by race and ethnicity between 2014-2018. In Bolton, 66.5% of non-Hispanic Whites had a bachelor's degree or higher, compared to 39.0% in Milford. In Northborough, 89.7% of non-Hispanic Black residents over age 25 had a bachelor's degree or higher, compared to 23.6% in Grafton.

Table 4. Percent Population 25 Years and Over with Bachelor's Degree or Higher, in Massachusetts and by Town, by Race/Ethnicity, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	60.2%	25.6%	20.8%	46.0%	18.8%
Ashland	83.8%	50.5%	53.2%	57.8%	56.5%
Berlin	72.4%	0.0%	50.0%	46.4%	41.7%
Bolton	77.6%	66.7%	100.0%	66.5%	53.5%
Framingham	68.3%	28.8%	18.3%	52.7%	20.0%
Grafton	69.7%	23.6%	21.1%	49.3%	26.1%
Hopkinton	99.3%	60.5%	44.0%	66.0%	35.1%
Hudson	61.8%	36.4%	29.1%	42.8%	18.9%
Marlborough	83.3%	50.2%	23.7%	40.5%	26.5%
Milford	79.4%	30.8%	12.1%	39.0%	11.9%
Northborough	78.4%	89.7%	48.0%	57.7%	43.9%
Shrewsbury	73.8%	65.9%	42.3%	55.4%	39.2%
Southborough	72.7%	77.6%	57.3%	65.0%	48.8%
Upton	74.3%	99.1%	42.0%	54.1%	44.3%
Westborough	87.8%	74.8%	43.1%	62.6%	21.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

In terms of education and COVID-19, assessment participants discussed concerns with the re-opening of schools. Many participants noted challenges for both students and parents coping with uncertainty about the school year. One parent shared, "*Remote learning is impossible if you have [multiple] kids. Hopkinton is going to a hybrid version of school, but there are still a lot of issues. My son's attention space is not good to just stare at a screen and try to stay focused."* Children in need of special education services and early intervention were described as especially vulnerable during this uncertain time.

Housing

> *"They should do something about housing. The elderly housing in town, a lot of it is old and run down. Those are people we should be taking care of as well."* – Focus group participant

> *"I've been trying to look into housing vouchers. I was told it's a three year wait to get into anything. I live in a town where there are three [affordable] units and the same people have been living there for 17 years and are obviously not going to leave."* – Focus group participant

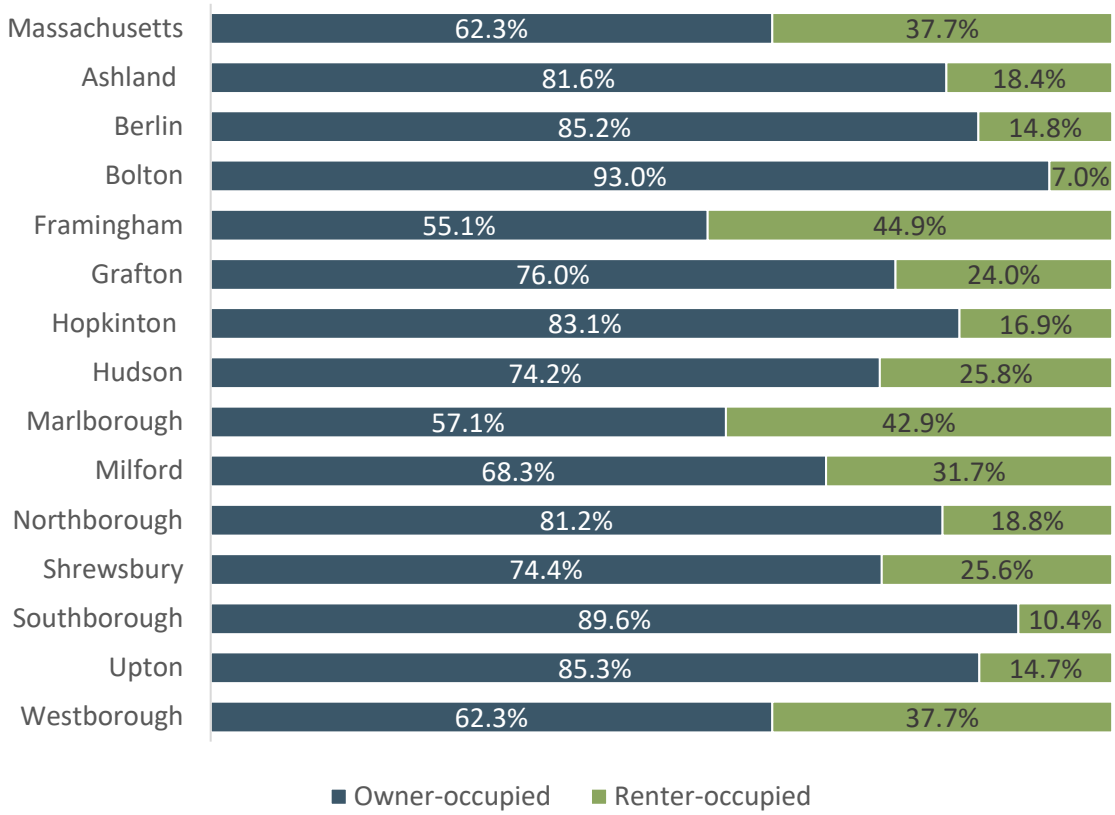
Safe and affordable housing is integral to the daily lives, health, and well-being of a community. The high and rising cost of housing in the Westborough service area was a frequent theme to emerge from qualitative discussions. Participants expressed concern for seniors and "middle class" residents that are struggling to afford the price of living in the Westborough service area. One focus group participant shared, "*There's not enough affordable housing for seniors in the MetroWest area. For an older adult who is also say—an immigrant as well—it's tough for them because there's not a lot of [affordable housing] options around. You have to maintain your home with less cash and rely on local nonprofits to help."*

Participants also noted that affordable housing in the Westborough area is limited and wait lists for subsidized housing are long. One interview participant explained, "*New apartment complexes are being developed in South Framingham, basically gentrification happening right in front of them. The cost of living there is not what they can afford. Even what's considered affordable units is not what they can pay."* Given the high cost of housing and limited affordable options, residents in these areas are often forced to live in tight quarters and overcrowded conditions, making them more vulnerable to COVID-19.

Interviewees reported that immigrants are currently at-risk of being housing insecure because of tenancy-at-will situations—or agreements between tenants and landlords where there is no formal contract specifying the length of time during which the tenancy will take place. One interview participant explained, "*[Most of our COVID- 19] cases in Framingham are in the immigrant community because they live in tight quarters. Those tenants are at will and that situation does not afford eviction protection. They pay high rates and then are being legally fleeced because they sign an agreement but they're being taken advantage of."* Another interviewee added, "*We have a fair number of people who do not live in traditional places with a lease. They're in a room in a house with a landlord who didn't give them a lease, and so they come home one day, and their locks are changed…their stuff is gone. And they're unable to have any recourse for that."*

In Massachusetts, 62.3% of housing units were owner-occupied versus 37.7% renter-occupied (Figure 18). In most of the towns around Westborough, owner-occupied units were more common than in the state overall, for example 93.0% in Bolton and 89.6% in Southborough. The exceptions were Framingham (55.1%), Marlborough (57.1%), and Westborough (62.3%).

Figure 18. Percent of Housing Units Owner- or Renter-Occupied, in Massachusetts and by Town, 2014-2018

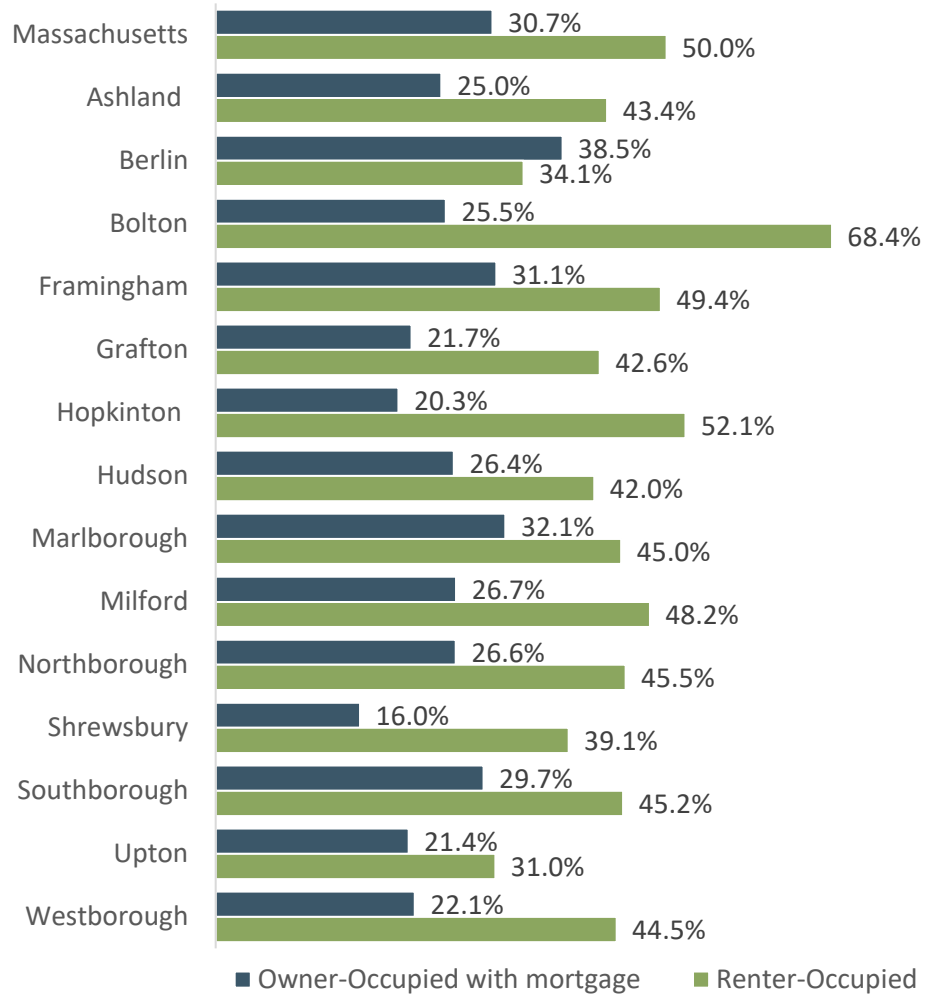


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage and 50% of all renters in Massachusetts reported spending spend more than 30% of their income on housing costs (Figure 19). Many of the towns around Westborough are similar in regard to owner-occupied units, with a range of 16.0% in Shrewsbury to 38.5% in Berlin. In Bolton, 68.4% of renters are considered housing insecure and spend more than 30% of their income on housing.

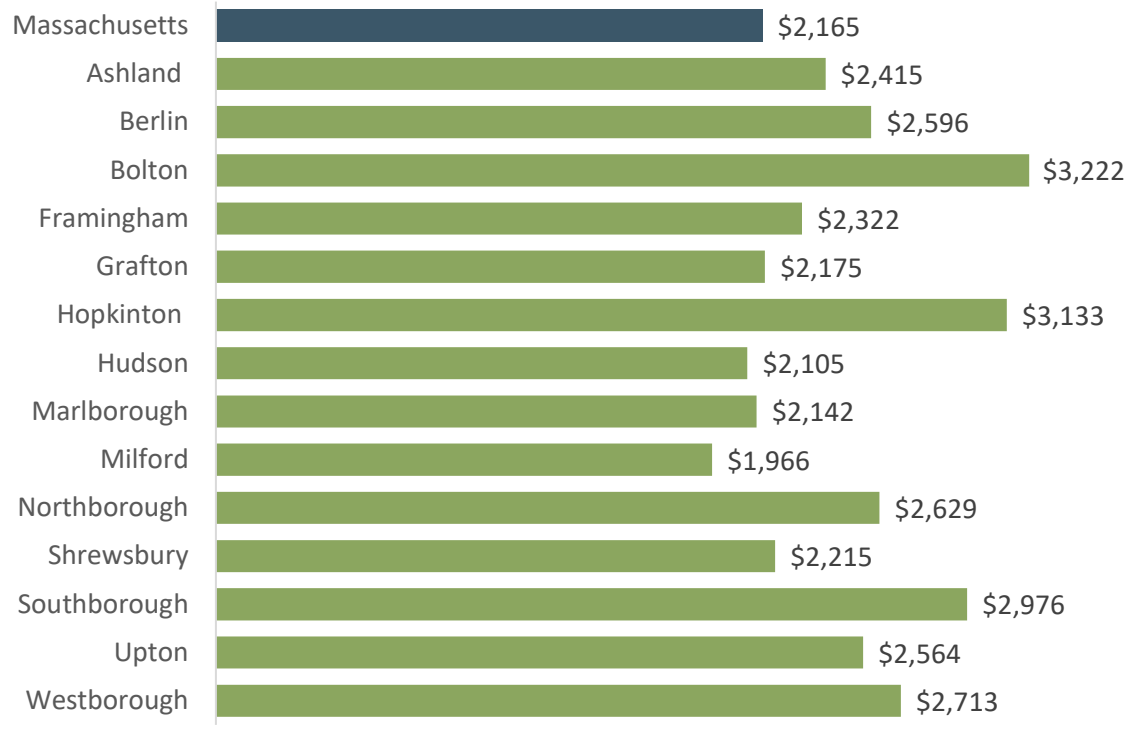
Median monthly housing costs for owner-occupied households with a mortgage ranged from $1,966 in Milford to $3,222 in Bolton (Figure 20). Median monthly housing costs for renter-occupied households in 2014-2018 ranged from $849 in Upton to $1,740 in Hopkinton (Figure 21).

Figure 19. Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, by Housing Tenure, in Massachusetts and by Town, 2014-2018



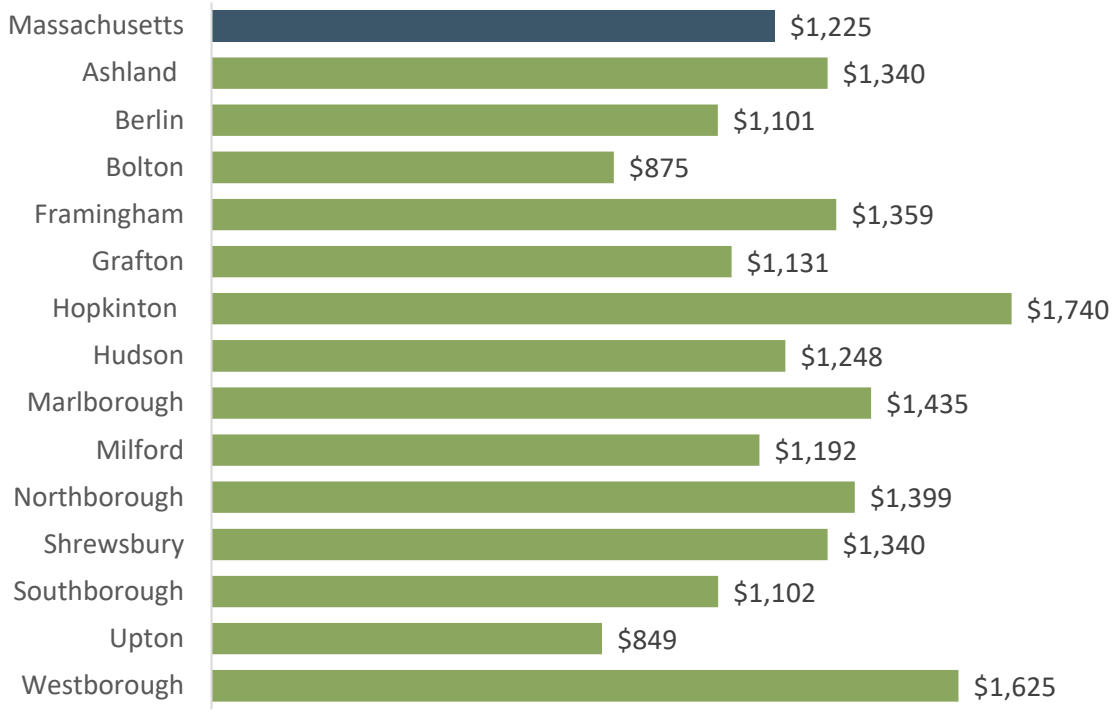
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Figure 20. Median Monthly Housing Costs for Owner-Occupied Households with a Mortgage, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Figure 21. Median Monthly Housing Costs for Renter-Occupied Households, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Transportation

> *"Public transportation is needed in a way that people can access their daily work lives"* – Key informant interview

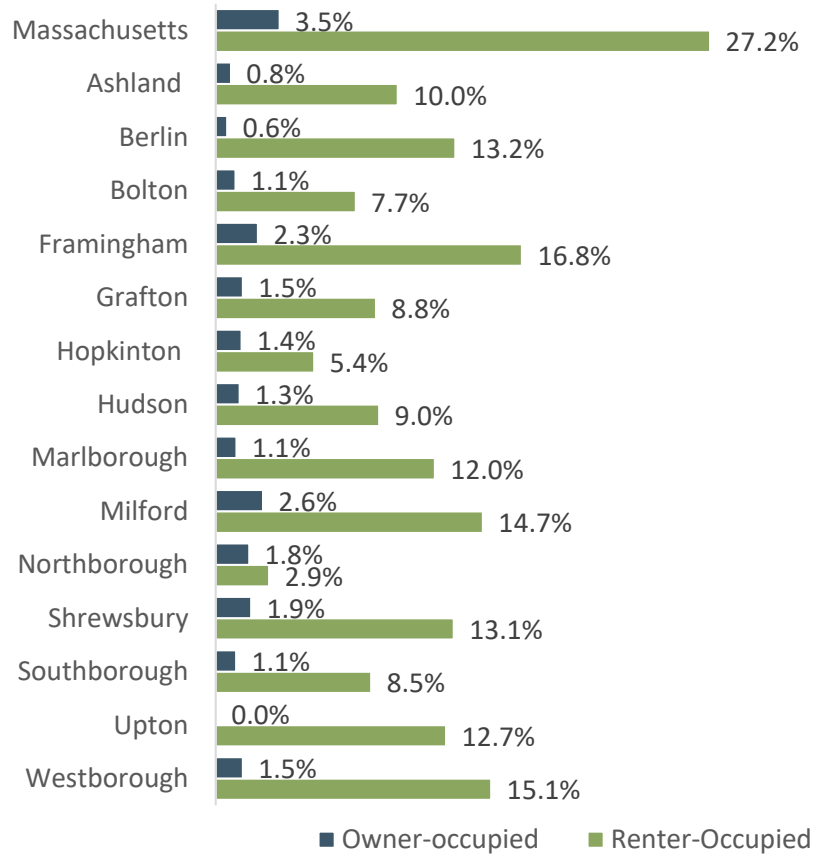
> *"People in Framingham need to revamp the busses. We need them every 15 minutes. We need stable transportation and to merge routes."* – Key informant interview

Mirroring findings from the 2019 MetroWest CHA, transportation was identified as one of the top day-to-day concerns for many residents who participated in the assessment. Youth focus group participants, immigrants, and residents seeking essential services expressed concern about the timeliness and accessibility of public transportation, especially for those who were essential workers and for young people. One youth focus group participant explained, "*If you're going someplace, you have to take [multiple] buses just to get there. There's not a lot of stops and the buses pass by once in a blue moon. When I have to get to work at the 3 but the bus only comes at 1 or 4pm, so I either have to leave 2 hours earlier or be late."* Residents suggested considering creative solutions to transportation challenges, such as investing in bicycle share programs, electronic scooters, and alternatives to single-occupancy vehicles.

According to the Census Bureau's American Community Survey, in 2014-2018, 70.2% of people in Massachusetts over age 16 commuted to work alone in a vehicle. In the Westborough service area, this figure ranges from 66.1% in Westborough to 85.3% in Berlin. Public transportation was most commonly used in Westborough. In 2014-2018 the average time spent commuting to work for residents in the Westborough service area ranged from 29.2 minutes in Hudson to 37.6 and 37.8 minutes in Hopkinton and Bolton, respectively.

In 2014-2018, renter-occupied households were more likely to have no vehicle available to them, across towns in the Westborough service area. In the towns of Westborough and Framingham, over 15% of households with renters did not have a vehicle (Figure 22). Across the region, very few owner-occupied households did not have access to a vehicle.

Figure 22. Percent Households with No Vehicles Available, by Housing Tenure, in Massachusetts and by Town, 2014-2018



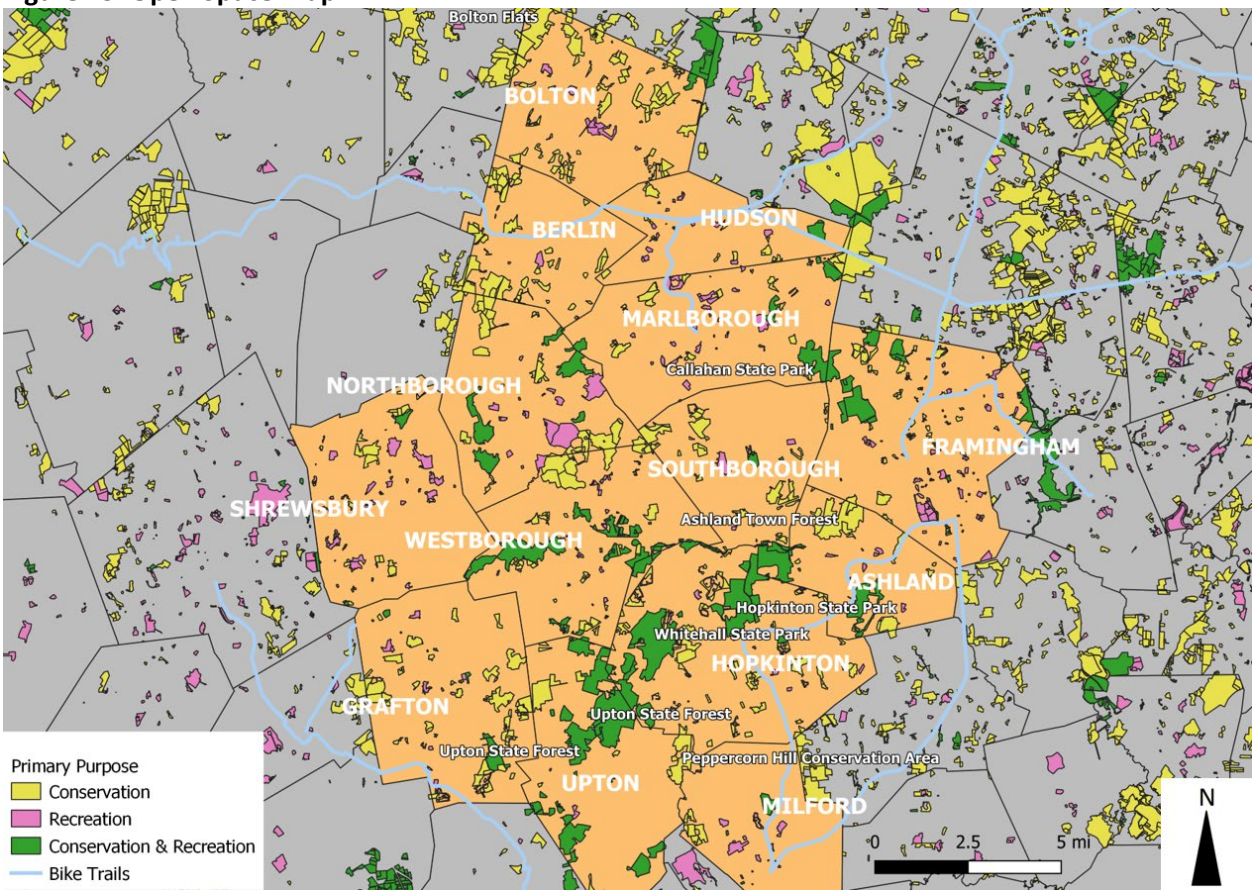
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Built Environment

> *"The atmosphere here is peaceful… it's beautiful here. It feels safe when I'm walking at night." – Focus group participant*
>
> *"Most of our communities aren't connected by sidewalks and people drive too fast so we don't let our kids ride their bikes." – Focus group participant*

Many Westborough Community Priorities Survey respondents and focus groups participants described access to green space as an asset to their community, describing ample access to parks and recreational activities. However, this perspective differed from youth focus group participants and some residents from Westborough, Northborough, and Hopkinton who reported the need for more bicycle and hiking trails. One shared, "*I wish we had bike trails. There's one in Marlborough but it's too far for me to access. There's some hiking trails but it's not safe to go biking there."* The figure below shows an open space map of the service area that identifies all of the bike trails around Westborough (Figure 23).

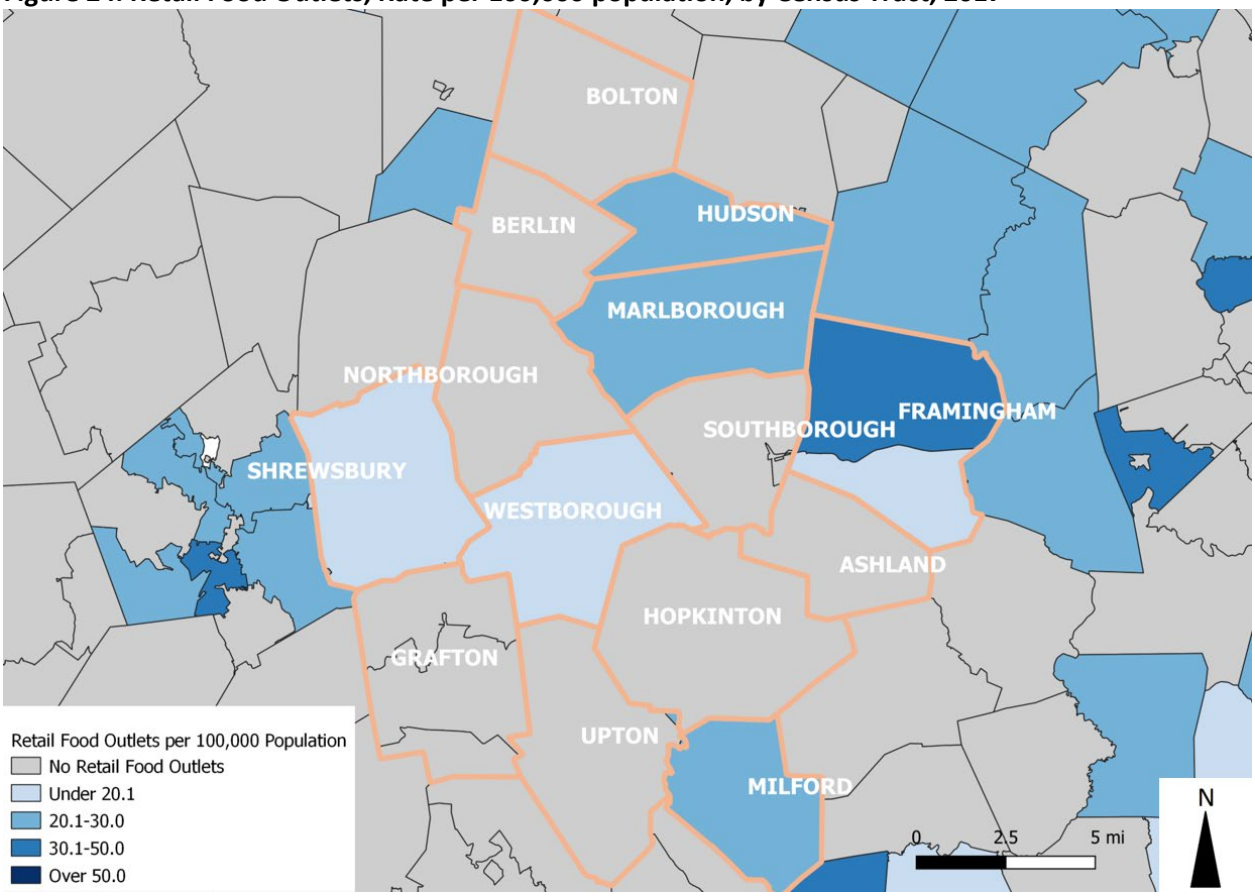
Figure 23. Open Space Map



DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Executive Office of Energy and Environmental Affairs, 2020.

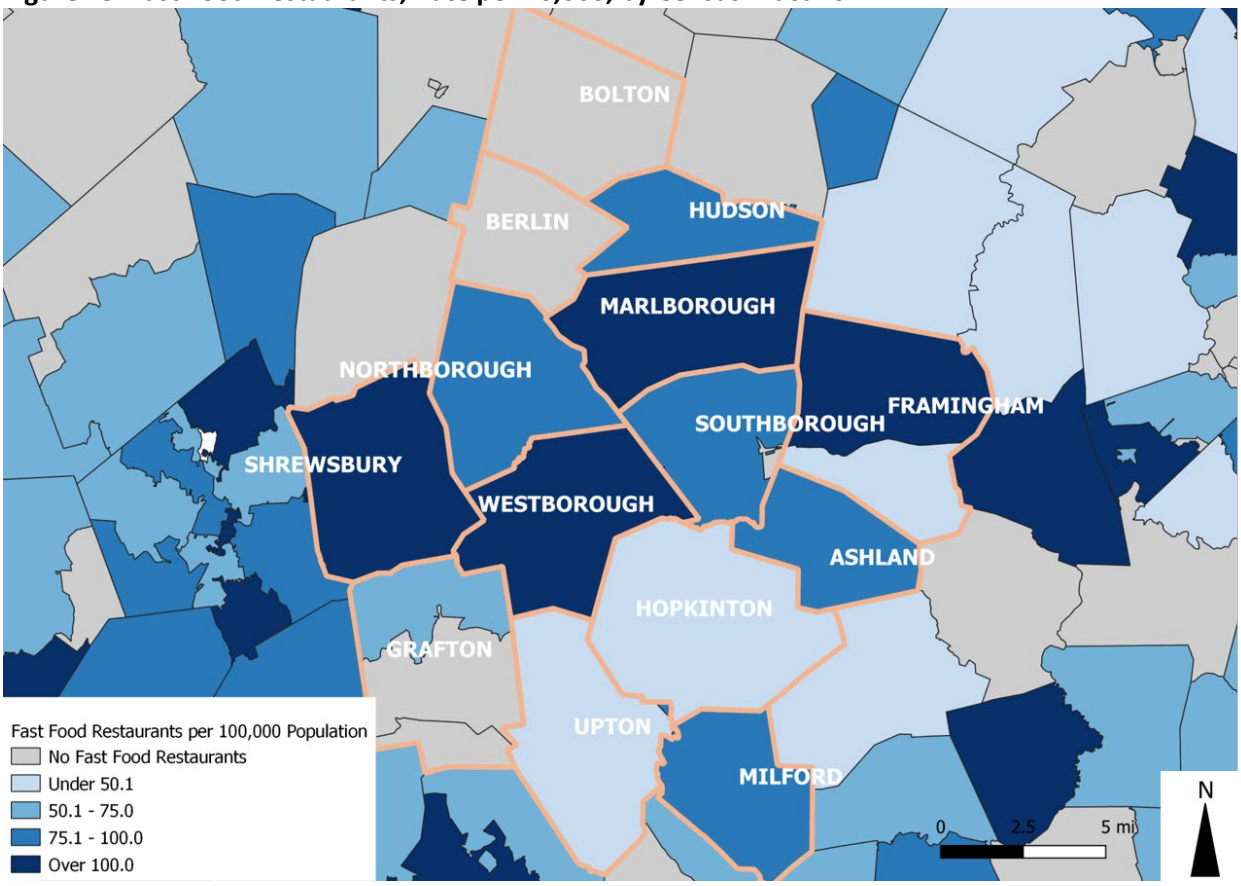
Figure 24 and Figure 25 provide maps of the density of retail food outlets and fast food restaurants throughout the service area. Several communities, Framingham and Marlborough, have the highest density of retail food outlets, which are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry, as well as the most density of retail fast food outlets.

Figure 24. Retail Food Outlets, Rate per 100,000 population, by Census Tract, 2017



DATA SOURCE: U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2017.
NOTE: Retail food outlets are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry.

Figure 25. Fast Food Restaurants, Rate per 10,000, by Census Tract 2017



DATA SOURCE: U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2017.

Crime and Violence

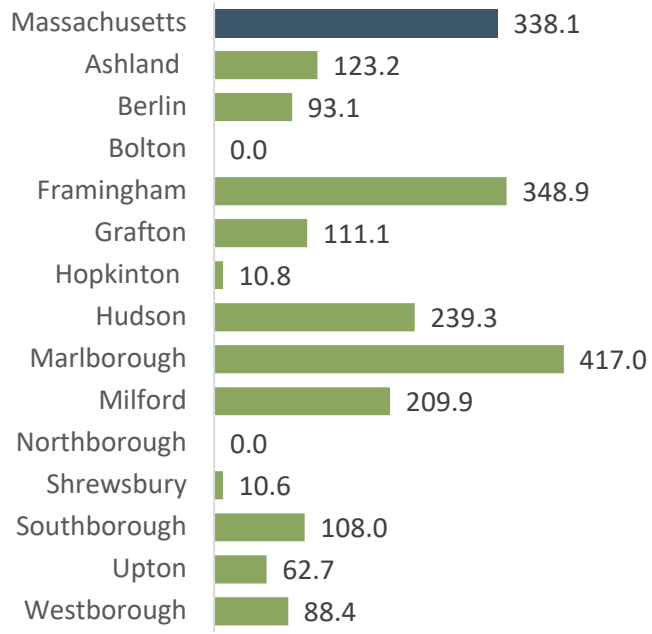
> *"In terms of physical safety, I feel safe here [in Framingham]. I've never been cat-called. When there's petty crime, everyone makes a big deal out of it." – Focus group participant*
>
> *"Public safety is a concern; [immigrant] residents don't perceive law enforcement as a protector. That, combined with the rhetoric at the federal level about immigrant issues…ICE raids…they don't see them as a friendly entity" – Focus group participant*

Assessment participants generally described the Westborough service area as a safe place to live and work. However, several key informants described concerns that cases of domestic violence and neglect would worsen during the pandemic. One shared, "*We think there's more domestic abuse. There's a lot going on now with the lack of trust with police. We're really concerned that things are happening at home and they're not calling police because they're afraid of them."* No secondary data related to domestic violence were available at the local level. However, Jane Doe Inc.—the statewide coalition against sexual and domestic violence—reports that as of December 15, 2019, there were 24 domestic violence homicide incidents, resulting in 28 domestic violence victims and 7 perpetrator suicides or death across Massachusetts (data not shown).

In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied strikingly across the towns around Westborough. Framingham (348.9) and Marlborough (417.0) both had rates higher than the state average of 338.1 incidents per 100,000 residents (Figure 26). Property crime (i.e. burglary, larceny, and auto theft) is much more common than violent crime. In 2018 in the area around Westborough, property

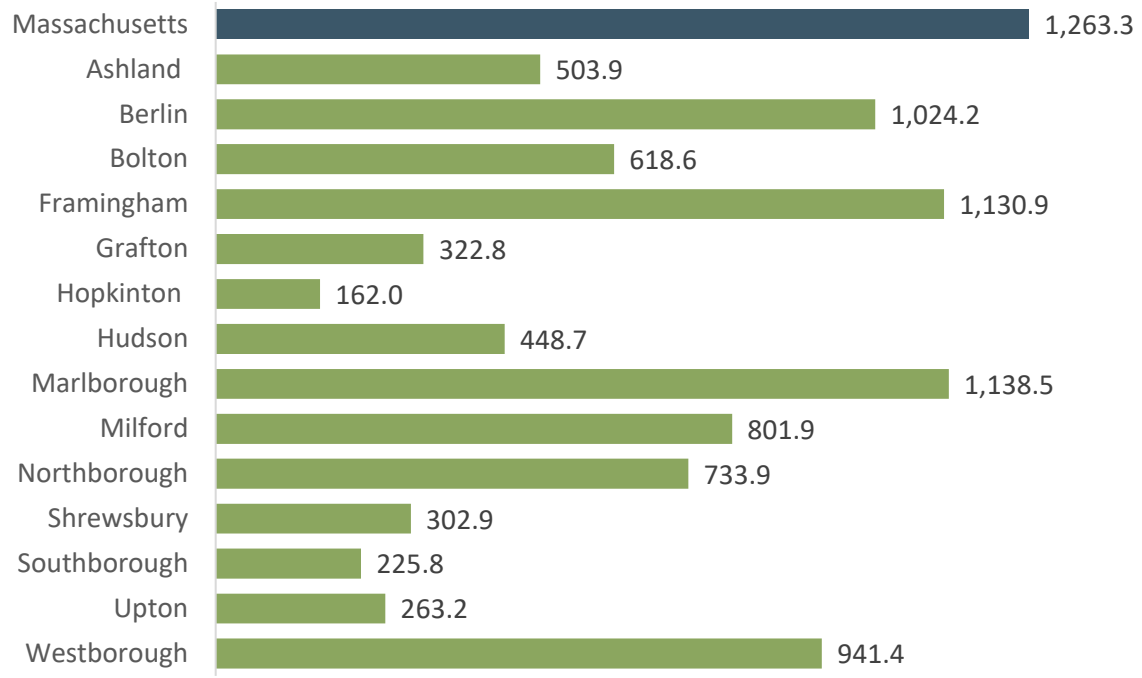
crime was most common in Marlborough (1,138.5 per 100,000 residents), Framingham (1,130.9), and Berlin (1,024.2) (Figure 27). In 2018, burglary was most common in Westborough (197.6 per 100,000 population; and larceny was most common in Marlborough (943.8).

Figure 26. Violent Crime, Rate per 100,000 Population, in Massachusetts and by Town, 2018



DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.
NOTE: Violent crime includes murder, rape, robbery, and aggravated assault.

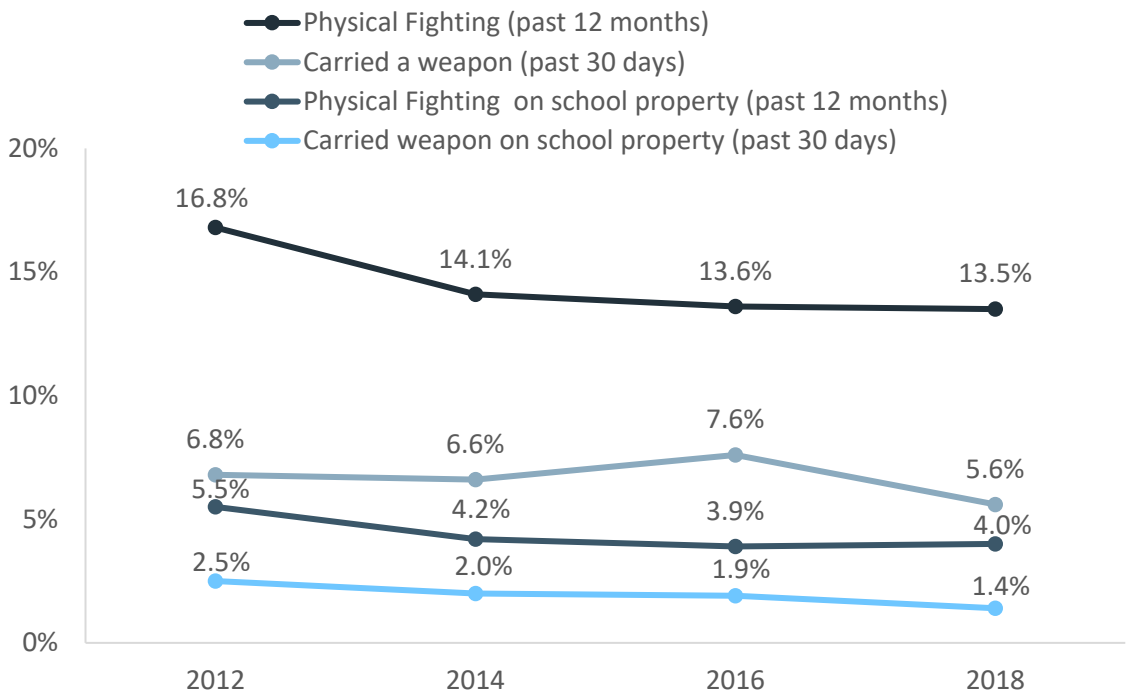
Figure 27. Property Crime, Rate per 100,000 Population, in Massachusetts, by Town, 2018



DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.
NOTE: Property crime includes commercial burglary, residential burglary, other burglary, larceny from motor vehicle, other larceny, and auto theft.

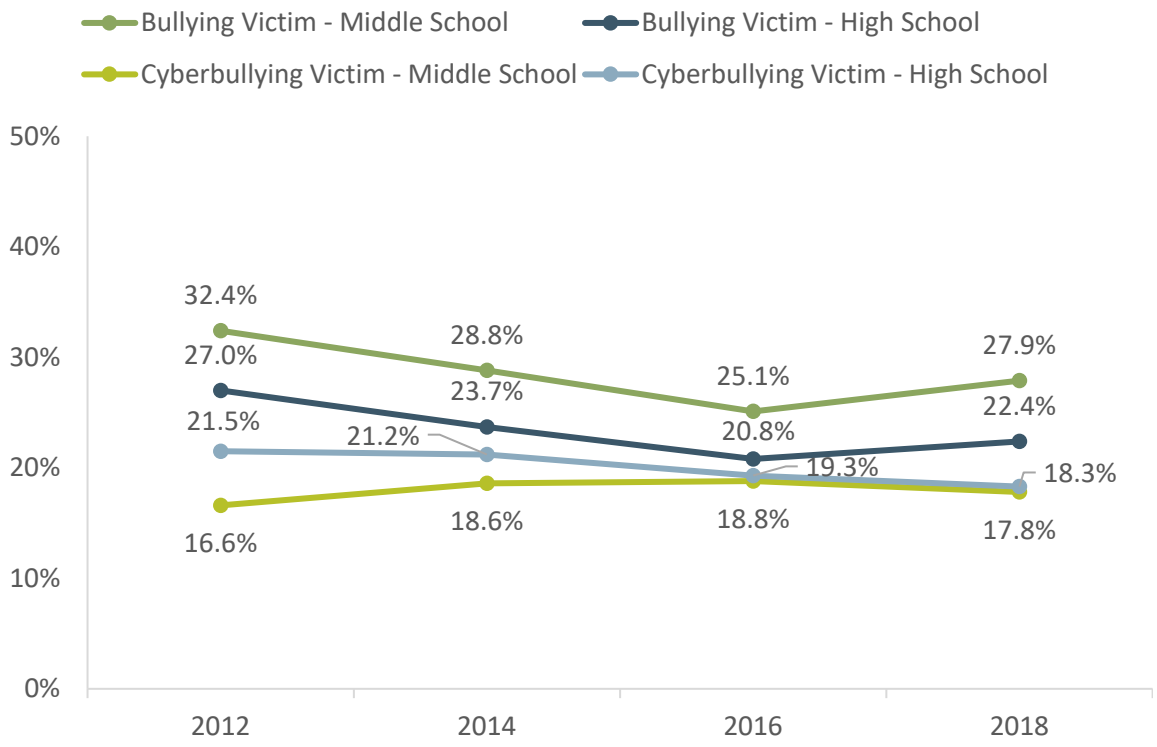
Data from the MetroWest Adolescent Health Surveys show that the percent of high school and middle school students reporting violent behaviors in the MetroWest region has been trending down since 2012 (Figure 28). Though physical violence seems to be declining, in 2012-2018, between one third and one quarter of MetroWest middle school students reported being victims of bullying (Figure 29). The prevalence of bullying was consistently lower among high school students. Prevalence of cyber-bullying was below 22% for both Middle and High School students.

Figure 28. Percent of High School and Middle School Students Reporting Violent Behaviors, MetroWest Region, 2012-2018



DATA SOURCE: MetroWest Adolescent Health Surveys, 2012, 2014, 2016 & 2018.

Figure 29. Percent of High School and Middle School Students Reporting Bullying, MetroWest Region, 2012-2018



Discrimination and Racism

> *"We need a lot of education and time to introspect and do the work. What is happening in the world with Black Lives Matter is an opportunity to do that work and being more open and accepting of everyone in our community."* – Focus group participant

> *"When I'm at the [store] at the mall with my friends—all of us people of color—we're followed. When I was there, one of my friends wanted to try something on and he was stopped and checked."* – Focus group participant

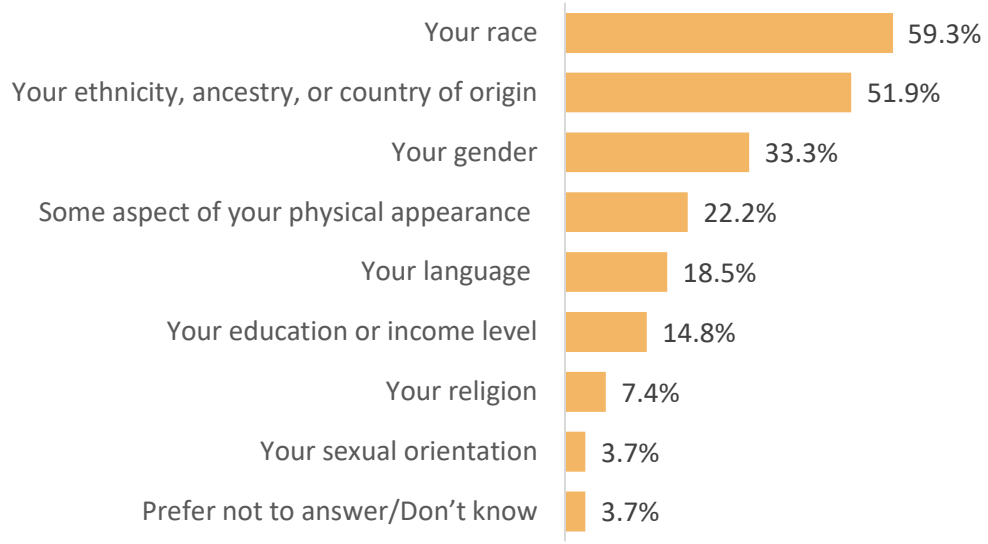
Participants reported that similar to the national dialogue—more emphasis on racial justice has been occurring in the Westborough service area. Perceptions related to discrimination and racism varied throughout qualitative discussions. Focus group participants who identified as people of color mentioned incidences of being discriminated against because of their race or nationality. For example, a young person shared, "*I don't know if it's a string of bad luck, but I see a lot of discrimination against me and my mom. We're both immigrants, and English isn't our first language. She speaks with an accent, and we speak Spanish together, and people automatically assume things about us."* Other participants validated the experience and added that residents may not identify with the terms "discrimination" and "racism." *"A lot of people don't call it discrimination and racism…they'll say they've been treated poorly. They won't outwardly say the word bias, but they'd say they're being looked at."*

The assessment survey supports these findings. Among the Westborough Community Priorities Survey respondents reporting that they themselves or their family members experienced discrimination in the past six months (15.7% of total sample), more than 59% of community survey respondents reported themselves or

their family being affected by discrimination in the past six months. Similarly, more than half of respondents indicated being affected by discrimination because of their ethnicity, ancestry, or country of origin; and 33.3% reported it was due to their gender (Figure 30).

As at the national level, conversations about racial justice and policing have been taking place in the Westborough service area. Multiple assessment participants described vigils or protests in their communities in response to the killing of Black Americans at the hands of police. A few pointed to tensions around police sentiments and the Black Lives Matter movement. Community leaders interviewed for the assessment described their commitment to addressing racial injustice and systemic racism. One shared, "*Everything we do moving forward will be focused on an anti-racism agenda. For any entity that wants to expand to our community, we'll be asking "tell us what you're thinking about anti-racism, and what is your internal and external agenda for the community."*

Figure 30: Percent of CHNA Community Priorities Survey Respondents Reporting Being Currently and/or 6 months ago Affected by Issues, among Respondents Reporting Discrimination as an Issue, 2020 (N=27)



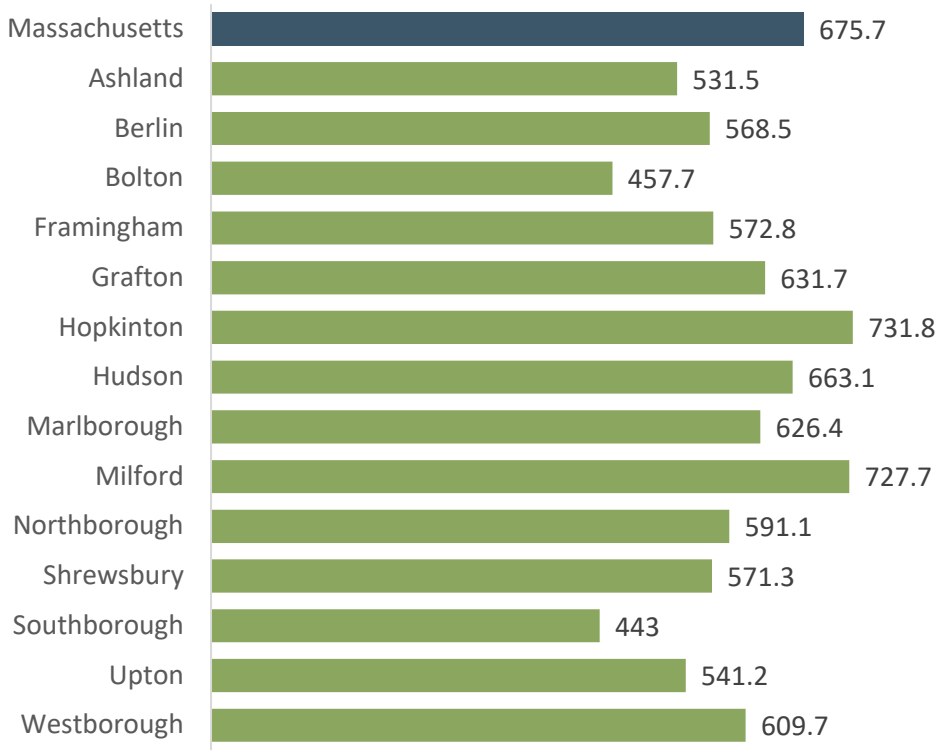
NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

COMMUNITY HEALTH ISSUES

Overall Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before age 65 years old) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted. Age-adjusted mortality rates per 100,000 residents varied between towns in the Westborough service area in 2017, from lows of 443.0 in Southborough and 457.7 in Bolton, to highs of 727.7 in Milford and 731.8 in Hopkinton (Figure 31).

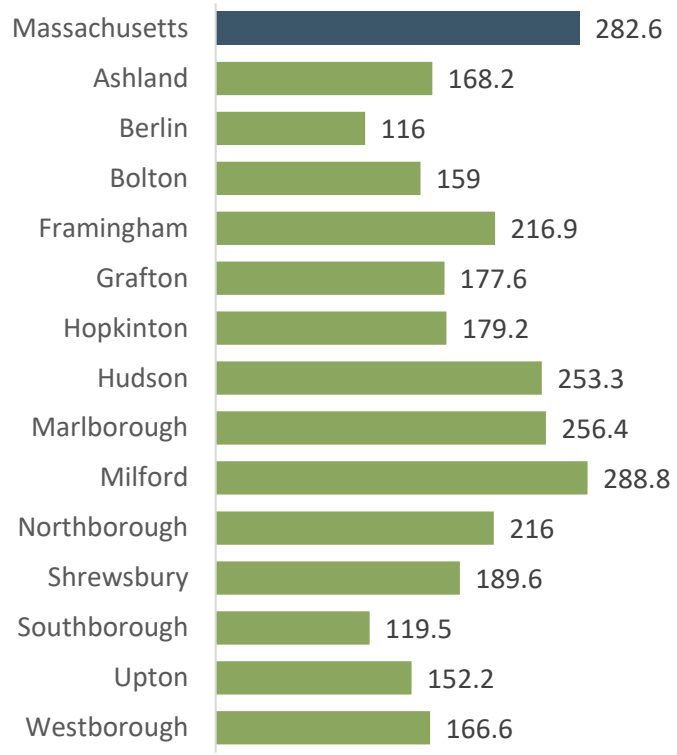
Figure 31. Overall Mortality, Age-Adjusted Rate per 100,000 Population, in Massachusetts and by Town, 2017



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

For age-adjusted premature mortality in 2017, the lowest rates were in Berlin (116.0 per 100,000), Southborough (119.5 per 100,000), and Upton (152.2 per 100,000); and the highest rates were in Milford (288.8 per 100,000), Marlborough (256.4 per 100,000), and Hudson (253.3 per 100,000), (Figure 32).

Figure 32. Premature Mortality, Age-Adjusted Rate per 100,000 Population, in Massachusetts and by Town, 2017



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

Chronic Diseases and Related Risk Factors

> *"Cardiovascular disease and underlying illnesses exacerbate the severity of COVID-19 infections. A lot of residents—especially Hispanic residents—tend to have the disease longer and have more complications.* – Key informant interviewee

> *"We started seeing an increase of Brazilian women who clean houses be diagnosed with lung cancer because of exposure to cleaning agents."* – Key informant interviewee

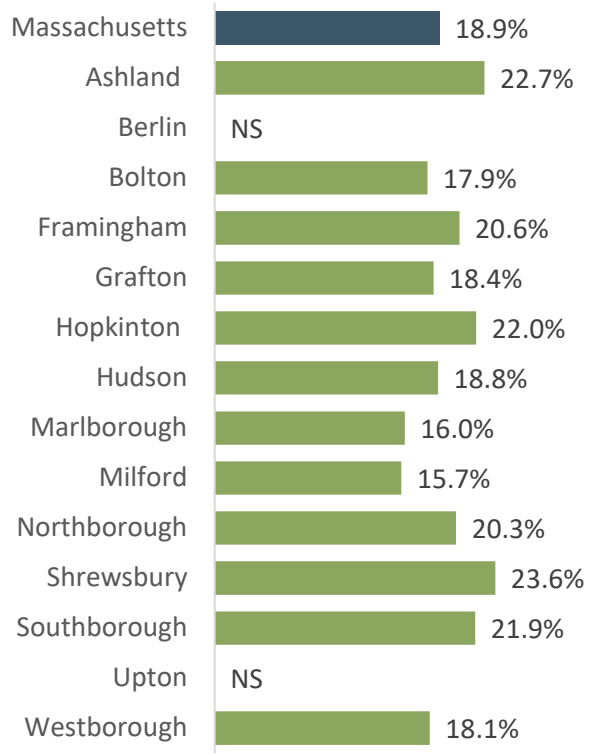
Assessment participants did not cite specific chronic diseases as pressing concerns in their communities, with the exception of a few focus group participants who discussed obesity, cardiovascular disease, and cancer. Cognitive issues including Alzheimer's disease and dementia were also noted as a concern for the growing senior community. One interviewee summarized, "*We have a growing senior community and as they age will need substantial supports. We are already seeing a lot of issues with aging like dementia and other memory loss impairments at the ages of 85 and up. Whether it's mild or huge it takes a toll on older adults."*

Overweight and Obesity

In 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 49.7% in Bolton to 64.2% in Milford (

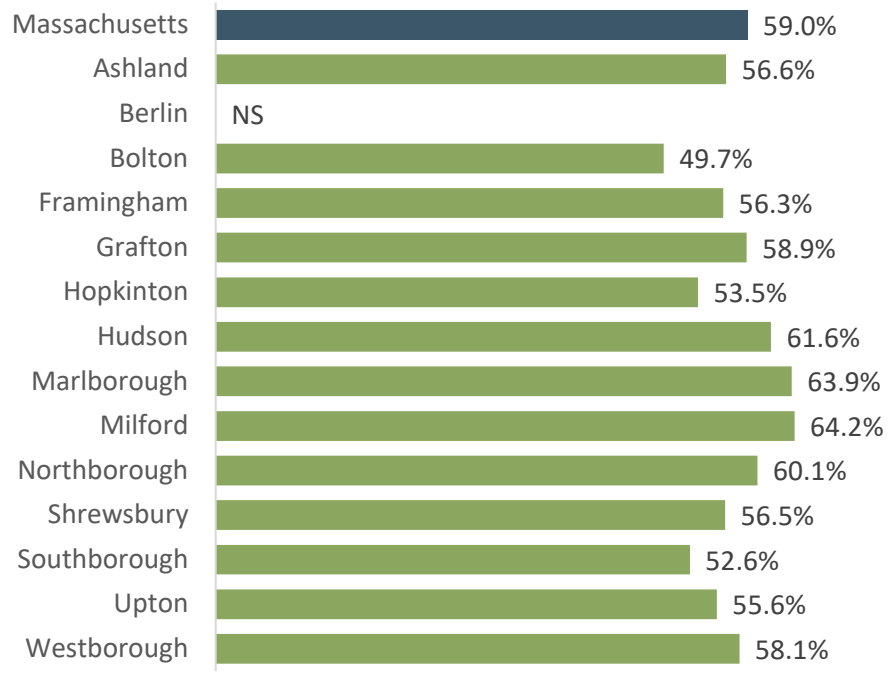
Figure 34). The percent of adults consuming five or more fruits and vegetables daily in Massachusetts was 18.9% in 2011-2015. By town, the percent of adults consuming 5 or more fruits and vegetables daily ranged from 15.7% in Milford to 23.6% in Shrewsbury (Figure 33). Overweight and obesity was mentioned by a few assessment participants who were parents, especially as it related to childhood obesity and COVID-19. One focus group participant shared, *"I worry about the kids who aren't able to play sports anymore because of COVID and the impact it will have on the kids' health and childhood obesity."*

Figure 33. Percent Adults Consuming Five or More Fruits and Vegetables Daily, in Massachusetts and by Town, 2011-2015



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2011-2015.
NOTE: Data are aggregated based on multiple years including 2011, 2013, 2015; NS = Data not shown due to insufficient sample size.

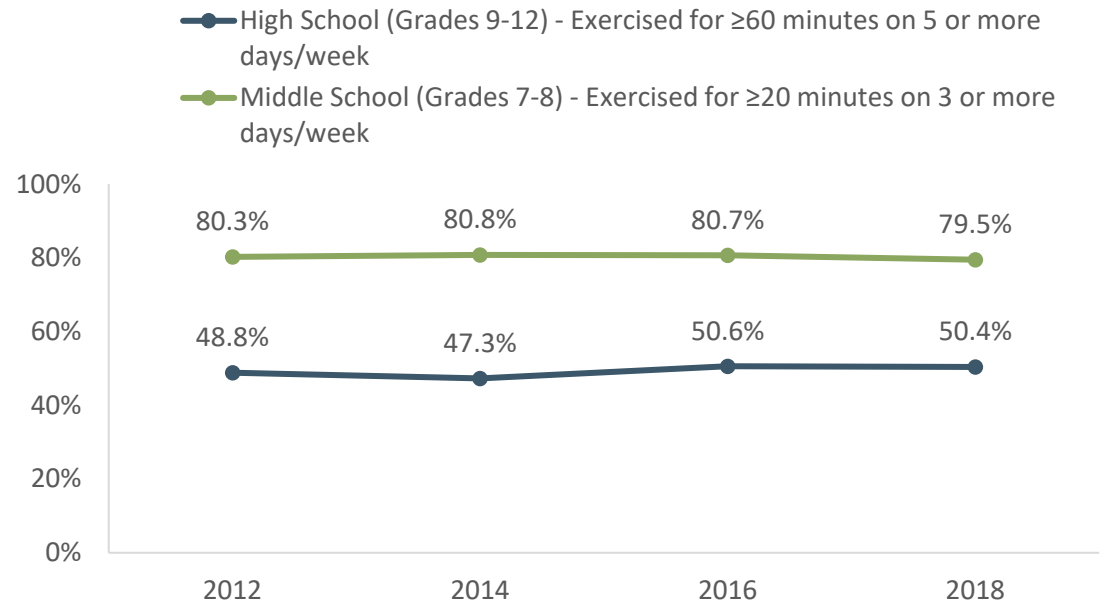
Figure 34. Percent Adults Reporting Obesity or Overweight, in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years including 2012-2014; NS = Data not shown due to insufficient sample size.

Among public school students in the MetroWest region, about 80% of middle school students were achieving at least 20 minutes of exercise on 3 or more days per week between 2012 and 2018 (Figure 35). For high school students, the physical activity target is higher (at least 60 minutes on 5 or more days per week). About half of students achieved this target between 2012 and 2018.

Figure 35. Percent of Students Reporting Physical Activity, MetroWest Region, 2012-2018

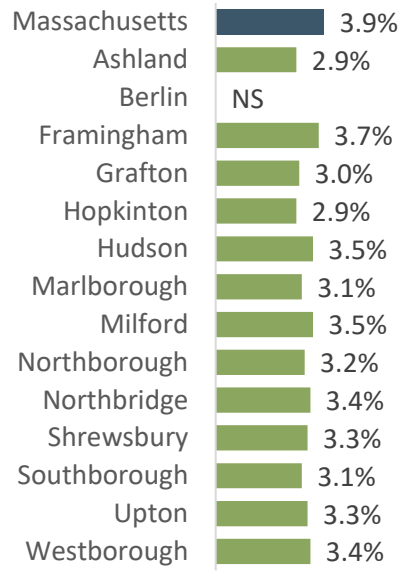


DATA SOURCE: MetroWest Adolescent Health Surveys, 2012, 2014, 2016 & 2018.

Heart Disease

While focus group and interview participants mentioned issues related to obesity and healthy eating, they did not discuss any specific chronic conditions such as heart disease, cancer, or diabetes as significant issues of concern. However, cancer and heart disease are still considered the top two leading causes of death in the Westborough service area. In 2012-2014, the percent of adults reporting angina or coronary heart disease (CHD) in Massachusetts was 3.9%. By town, the percent of adults reporting angina or CHD ranged from 2.9% in Ashland and Hopkinton to 3.7% in Framingham (Figure 36).

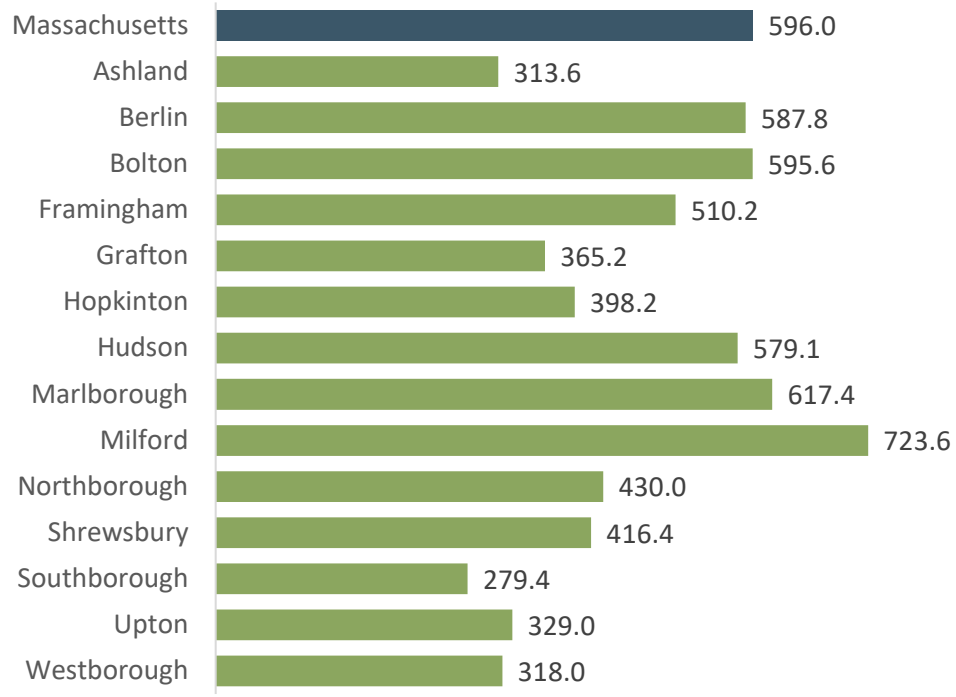
Figure 36. Percent Adults Reporting Angina or Coronary Heart Disease (CHD), in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years**;** NS = Data not shown due to insufficient sample size.

In 2014, the age-adjusted rate per 100,000 population of heart disease emergency department visits was 596.0 in Massachusetts. By town, the age-adjusted rate of heart disease emergency department visits ranged from 279.4 per 100,000 population in Southborough to 723.6 per 100,000 population in Milford (Figure 37).

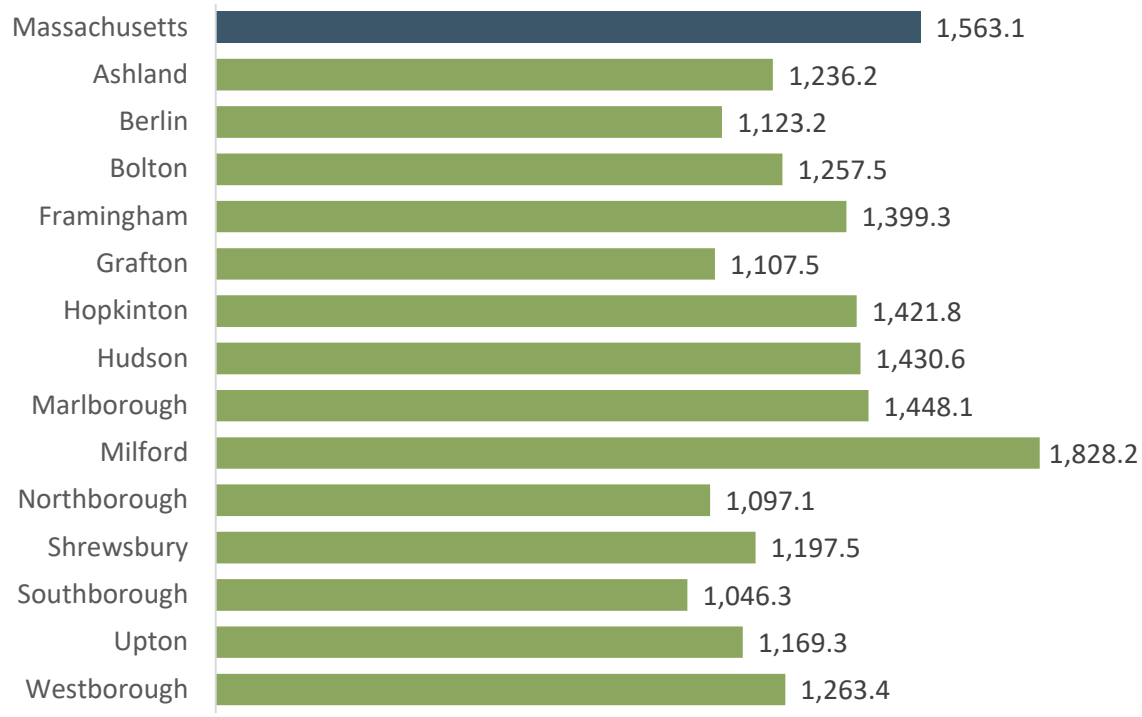
Figure 37. Heart Disease Emergency Department Visits, Age-Adjusted Rate per 100,000 Residents, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, the age-adjusted rate per 100,000 population of heart disease hospitalizations was 1,563.1 in Massachusetts. By town, the age-adjusted rate of heart disease hospitalizations ranged from 1,046.3 per 100,000 population in Southborough to 1,828.2 per 100,000 population in Milford (Figure 38).

Figure 38. Heart Disease Hospitalizations, Age-Adjusted Rate per 100,000 Residents, in Massachusetts and by Town, 2014

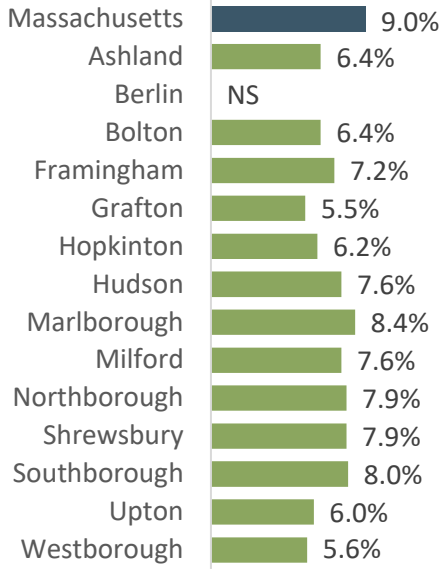


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Diabetes

In 2012-2014, the percent of adults reporting diabetes in Massachusetts was 9.0%. By town, the percent of adults reporting diabetes ranged from 5.5% in Grafton to 8.4% in Marlborough (Figure 39).

Figure 39. Percent Adults Reporting Diabetes, in Massachusetts and by Town, 2012-2014

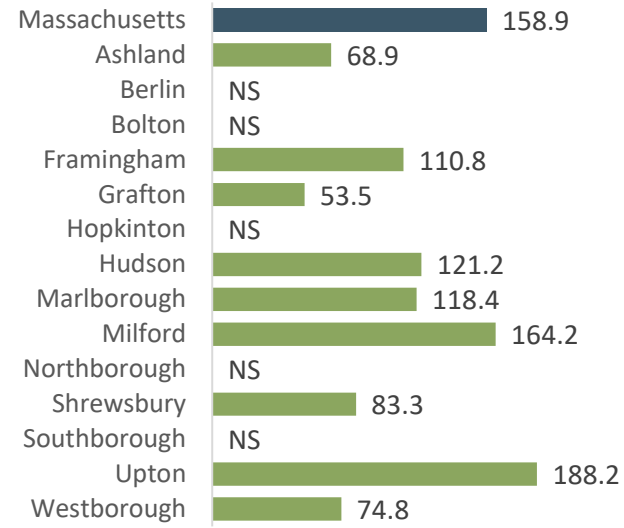


DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.

NOTE: Data are aggregated based on multiple years including 2012-2014; NS = Data not shown due to insufficient sample size.

In 2014, the age-adjusted rate of diabetes hospitalizations per 100,000 population was 158.9 in Massachusetts. By town, the age-adjusted rate of diabetes hospitalizations ranged from 53.5 per 100,000 population in Grafton to 188.2 per 100,000 population in Upton. Data for several towns are not reported due to insufficient sample size (Figure 40).

Figure 40. Diabetes Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014

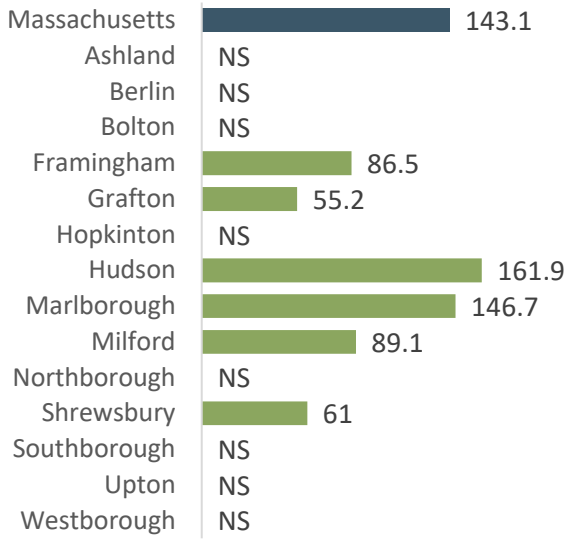


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

NOTE: NS = Data not shown due to insufficient sample size.

In 2014, the age-adjusted rate of diabetes emergency department visits per 100,000 population was 143.1 in Massachusetts. By town, the age-adjusted rate of diabetes emergency department visits ranged from 55.2 per 100,000 population in Grafton to 161.9 per 100,000 population in Hudson. Data for several towns were not reported due to insufficient sample size (Figure 41).

Figure 41. Diabetes Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.
NOTE: NS = Data not shown due to insufficient sample size.

Cancer

Cancer continues to be the leading cause of death in Massachusetts. In 2009-2013, by town, standardized incidence ratios (SIR) for breast cancer in females ranged from 88 (Milford) to 120 (Upton). These ratios indicate that the incidence of breast cancer in females was 12% lower in Milford and 20% higher in Upton than expected based on standardized rates for the state of Massachusetts (expected rate is 100). The incidence of prostate cancer in males ranged from 27% lower than expected in Ashland (SIR 73) to 20% higher than expected in Milford (SIR 120). The incidence of lung and bronchus cancer ranged from 43% lower than expected in Bolton (SIR 57) to 16% higher than expected in Billerica (SIR 116). The incidence of colorectal cancer ranged from 29% lower than expected in Upton (SIR 72) to 16% higher than expected in Grafton (SIR 116) (Table 5).

Table 5. Cancer Standardized Incidence Ratios for Leading Cancer Types, 2009-2013

	Breast Cancer (female)	Prostate (male)	Lung and Bronchus	Colorectal
Ashland	96	73	114	100
Berlin	94	81	97	87
Bolton	110	133	57	93
Framingham	97	90	97	103
Grafton	114	103	116	98
Hudson	95	108	86	132
Marlborough	90	105	88	128
Milford	88	120	105	104
Northborough	114	95	63	83
Shrewsbury	101	105	93	77
Southborough	111	106	91	90
Upton	120	78	94	72
Westborough	113	91	85	102

DATA SOURCE: Massachusetts Department of Public Health, Massachusetts Cancer Registry, 2009-2013.

In a few interviews, the concern around cancer was mentioned specifically related to poor working conditions. It was perceived that there was an increase of lung cancer in domestic workers due to the harsh chemicals in the cleaning products. One interviewee explained, "*We started seeing an increase of Brazilian women who clean houses get cancer because of exposure to cleaning agents. Cleaning agents were designed for 1-time use…they have ammonia; but if you're using it all day, there's accumulation in your lungs.*"

Behavioral Health

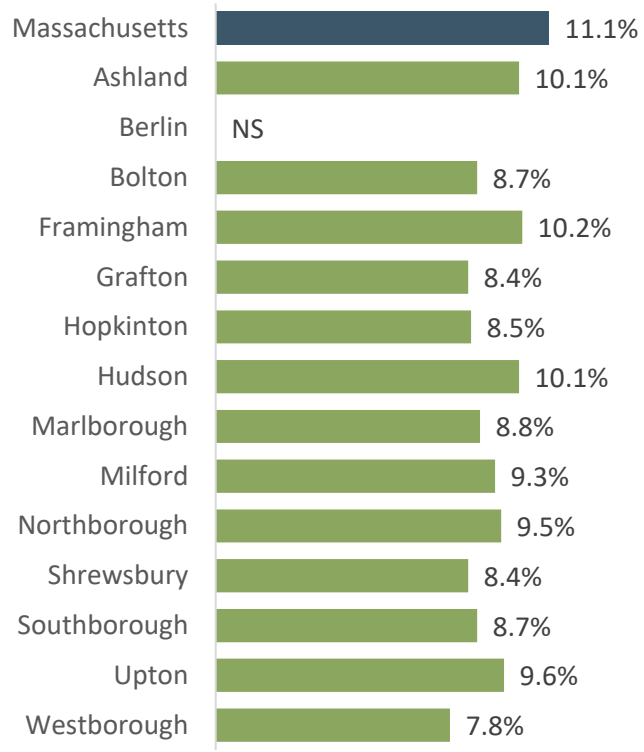
> *"Social distancing is hard – it's hard to talk to your friends. It kind of makes you crazy. Having your phone is helpful, but it's not the same." – Youth focus group participant*
>
> *"When you have underlying mental health challenge, it's only going to be that much worse by being isolated from the people you love. – Key Informant interview*

Mental Health

Similar to key findings from the 2019 MetroWest CHA, when asked to identify health issues of greatest concern in the community, the majority of focus group participants and interviewees mentioned mental health. Stress, anxiety, depression, and isolation were the most frequently cited challenges among the Westborough service area, with residents describing how COVID-19 has exacerbated mental health issues in the community. These

issues were noted as particularly problematic for young people, seniors, those who identified as LGBTQ, and immigrants. As described in the *Top Issues Affecting the Community* section, concern for mental health was the leading health issue reported by Westborough Community Priorities Survey respondents. However, between 2012-2014, the percent of adults reporting 15 or more days of poor mental health in the last month was lower in the Westborough service area than the state overall. By town, the percent of adults reporting 15 or more days of poor mental health in the last month ranged from 7.8% in Westborough to 10.2% in Framingham, compared to 11.1% in Massachusetts (Figure 42).

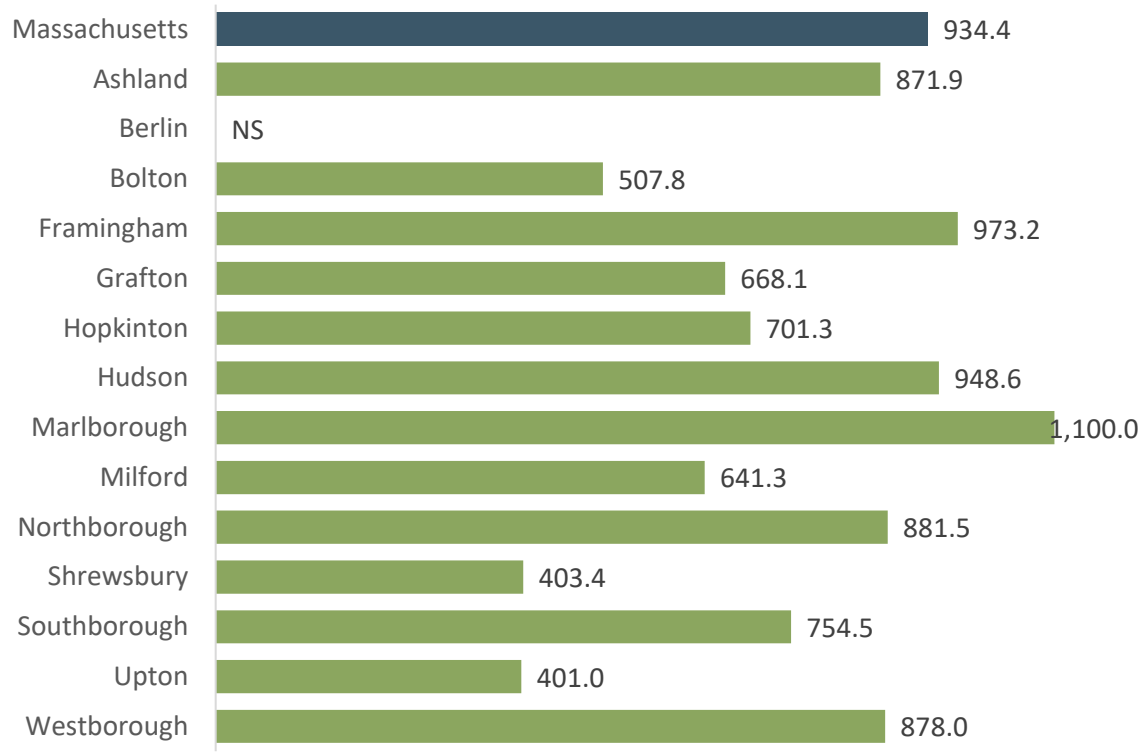
Figure 42. Percent of Adults Reporting 15 or More Days of Poor Mental Health in the Last Month, in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years; NS = Data not shown due to insufficient sample size.

Similarly, mental health hospitalizations in the area were slightly lower than the state overall, except in Marlborough. In 2014, the age-adjusted rate of mental health hospitalizations per 100,000 population was 934.4 in Massachusetts. By town, the age-adjusted rate of mental health emergency department visits ranged from 401.0 per 100,000 population in Upton to 1,100.0 per 100,000 population in Marlborough (Figure 43).

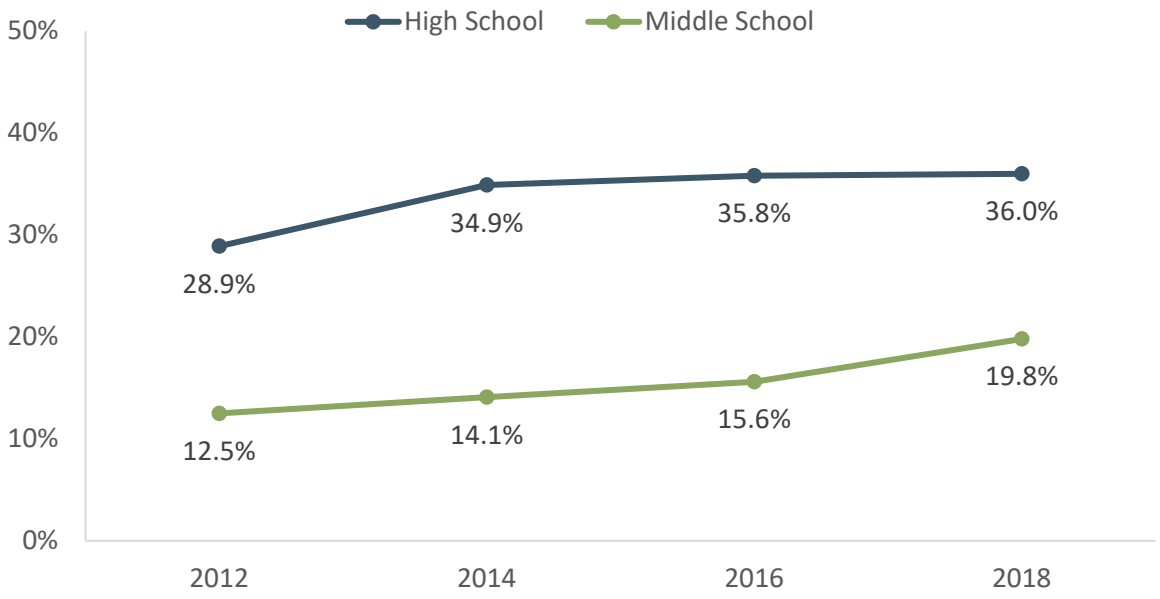
Figure 43. Mental Health Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.
NOTE: NS = Data not shown due to insufficient sample size.

In focus group and interview discussions, mental health concerns among youth were mentioned frequently. Those youth from more affluent communities described "*achievement anxiety*" among youth due to high-pressure environments. Residents from these areas described a culture of competition that negatively impacts young people. One shared "*There's this 'keeping up with the Jones' mentality in Hopkinton…an appearance to keep up with."* Another parent agreed and added, *"My high schoolers are overwhelmed- getting panic attacks about all of the events and activities. Most families I know are in a large amount of activities like sports, arts, enrichment classes, scouting. There's very little downtime for kids. So when the pandemic hit, you can imagine how drastic the shift was."* This is supported by quantitative data gathered even before the pandemic. Youth participating in the MetroWest Adolescent Health Surveys who report that their lives have been "very stressful" has steadily increased since 2012, from 28.9% to 36% in 2018 (Figure 44).

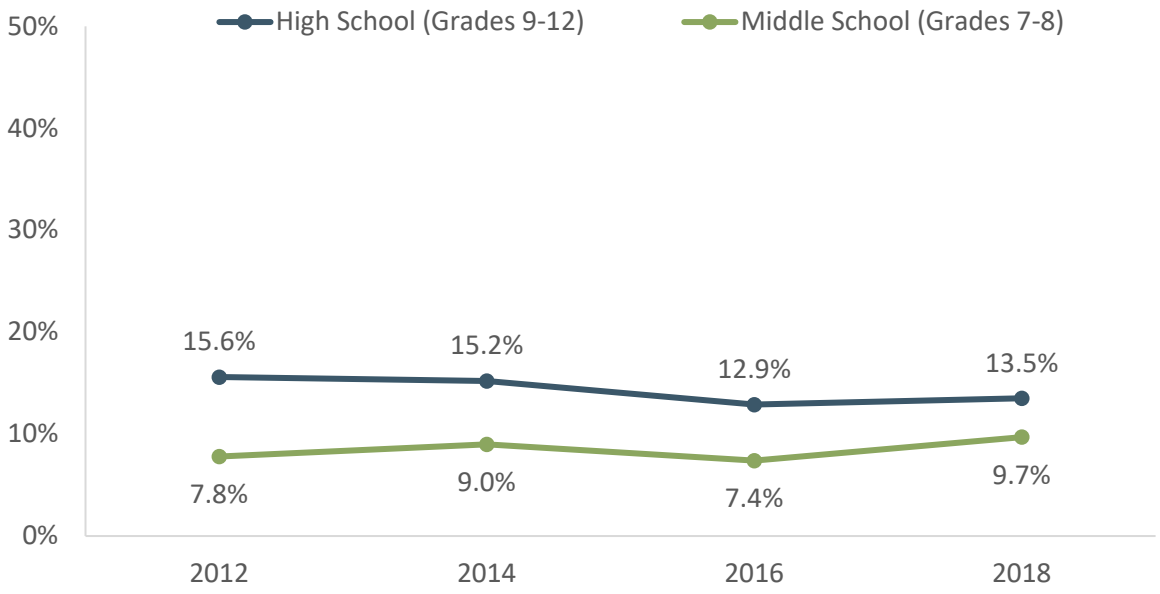
Figure 44. Percent of Students Reporting Life as "Very Stressful" in the Past 30 Days, MetroWest Region, 2012-2018



DATA SOURCE: MetroWest Adolescent Health Surveys, 2012, 2014, 2016 & 2018.

In 2012, 12.8% of middle school and 19.7% of high school students in MetroWest reported depressive symptoms in the past 30 days. In 2018, prevalence was 14.3% and 19.7%, respectively. Riskier behaviors, such as self-injury among youth, also are a concern. In 2012, 7.8% of middle school and 15.6% of high school students in MetroWest reported engaging in intentional self-injurious behaviors in the past 12 months (Figure 45). In 2018, prevalence was 9.7% and 13.5%, respectively. Statewide, self-injury was reported by 14.5% of high school students and 16.8% of middle school students in 2017. Findings from the 2018 MetroWest Adolescent Health Surveys reveal disparate mental health findings for a number of sub-groups. Specifically, the report notes that "females continue to report depressive symptoms and self-injury around twice as much as males" (in 2018, self-injury was reported by 19% of females and 8% of males). Additionally, LGBTQ youth report elevated levels of mental health problems. Compared with heterosexual cisgender youth, these youth are more than 2.5 times as likely to report depressive symptoms (41% vs. 16%) and more than three times as likely to report self-injury (35% vs. 10%), seriously considering suicide (32% vs. 10%), and attempting suicide (10% vs. 3%)." These data are validated by experiences shared by focus group participants. For example, one LGBTQ identifying youth shared, "*The suicide rate is high. I've had 9 close friends of mine commit suicide and I'm only 19 years old. They were all LGBTQ."*

Figure 45. Percent of Students Reporting Self-Injury in the Past 12 Months, MetroWest Region, 2012-2018



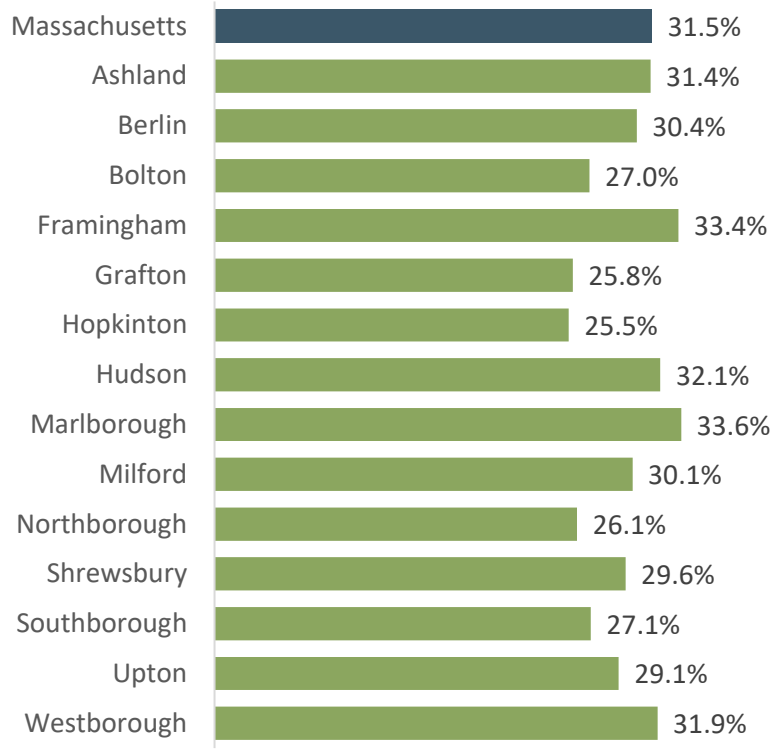
DATA SOURCE: MetroWest Adolescent Health Surveys, 2012, 2014, 2016 & 2018.

Many focus group and interview participants discussed how their concerns around youth mental health are exacerbated with the pandemic. Those with school-age children shared the challenges of remote learning and the stress that comes with the uncertainty of the coming school year. Participants shared that these challenges further increase when there is more than one child in the household. Many worried about the long-term impact of the pandemic and lack of socialization on the community's children and youth.

Focus group participants who were parents also discussed the importance of digital wellness—which refers to preventative measures aimed at regulating and improving the healthy use of technology, especially in light of COVID-19. One focus group participant shared, "*Technology and digital wellness is a major problem. Kids are getting smart phones when they are really young. They have free access to the internet, and they are getting addicted to the devices."* Another parent agreed and added, "*The digital world makes everything harder. Kids are more distracted, and they are constantly comparing themselves to others on [social media]."*

In regard to older adults, social isolation was described as a concern, especially in light of COVID-19. These findings support quantitative data presented in (Figure 46) that show that in 2018, more than one in four adults 65 years or older reported experiencing depression.

Figure 46. Percent of Adults Aged 65 years or older with Depression, in Massachusetts and by Town, 2018



DATA SOURCE: Tufts Health Plan, Massachusetts Healthy Aging Data Report, 2018.

Trauma was also discussed among interview and focus group participants in regard to mental health. Participants described caregivers as a group that have experienced high levels of trauma during the pandemic, with one sharing, "*There's a degree of trauma associated with caregivers throughout the pandemic. I can't tell you how many people we have die in residential services. For essential workers, our residential staff, ER staff, and health care providers, there's a grief associated with the number of people lost in our community.*"

Systemic issues to adequately address mental health concerns in the community were discussed by multiple key informants. Mental health workforce challenges included low reimbursement for mental health services, which makes it difficult for provider organizations to recruit and retain qualified staff. One participant summarized, "*There are funding structures in place that are not adequate, and it makes it hard for social service agencies to have ready access to highly trained clinicians. If you have a rate that is not sufficient, then you can't pay people as much as you would like, and there's always [financial] losses for the agency.*"

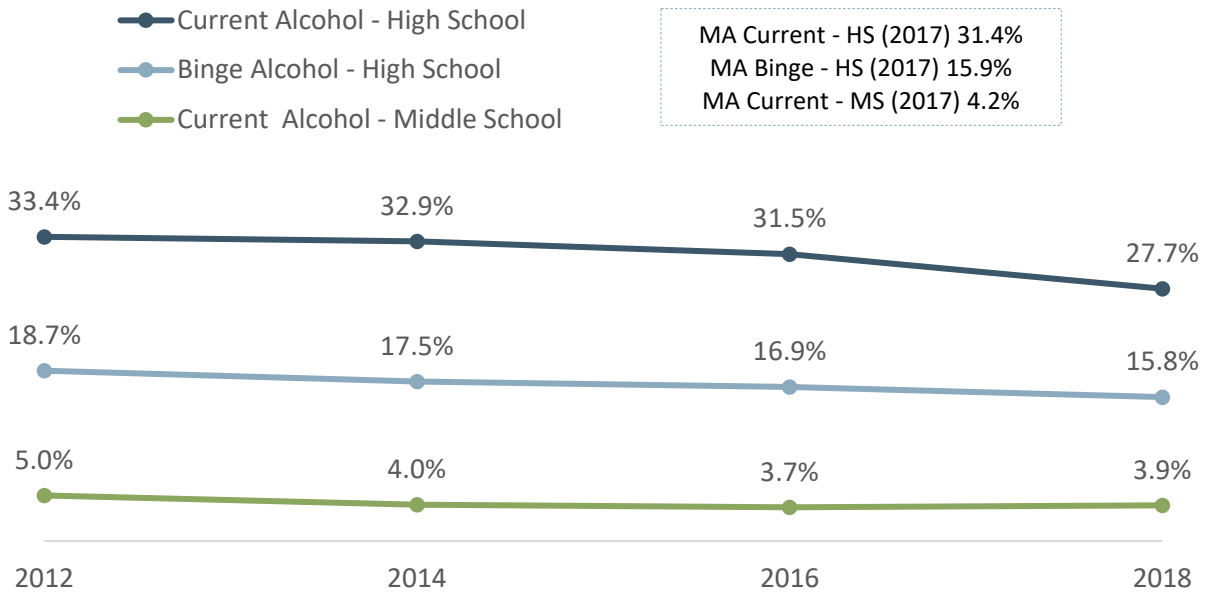
Substance Use

Participants expressed some concerns about substance use in the Westborough service area, though it was not a key theme discussed in most groups. This result differs from findings from the 2016 and 2019 MetroWest CHA, where substance use was ranked as the greatest health concern by community health respondents in 2016 and 2019. Specific types of substance use mentioned as concerns by participants included: alcoholism, vaping, and misuse of prescription medication. One focus group participant who was a parent shared, "*Alcohol is always an issue here because it's the most accessible. I think the way that parents are coping with that stress*

is alcohol. I think that it's a big problem in suburbia and I think the kids feel that." Underage drinking was also discussed as a concern, though quantitative data show that the percent of students reporting alcohol use in the MetroWest area has decreased since 2012 (Figure 48). Similar to state trends, prescription drug misuse has steadily decreased among high school students in the area from 8.8% in 2012 to 4.8% in 2018 (Figure 47).

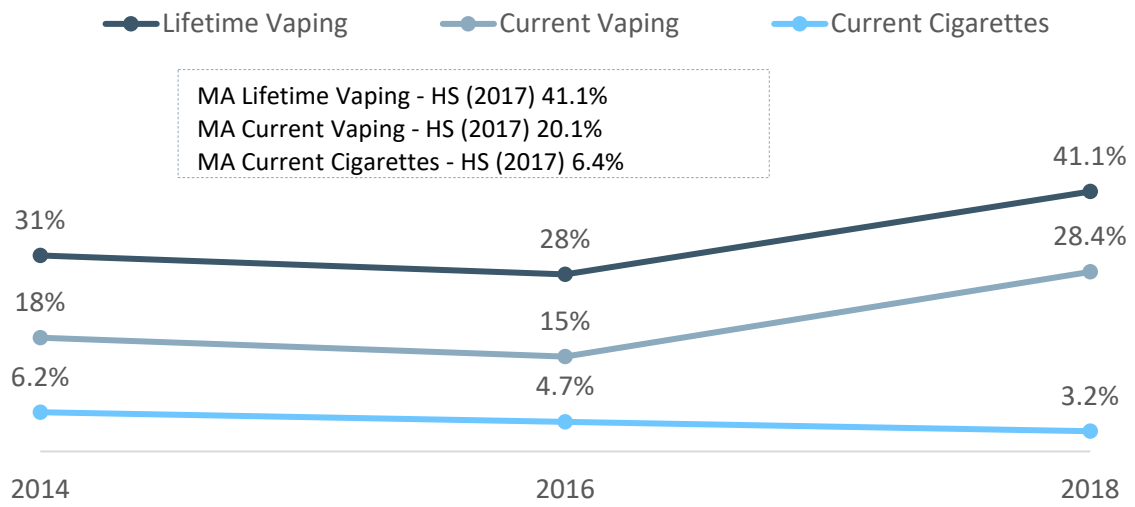
Opioids were discussed by a few assessment participants who reported that use is more prevalent in rural areas. There were perceptions that Marijuana use has been normalized and about it being a "gateway drug" for youth. In 2012, 2.4% of middle school and 21.5% of high school students reported current marijuana use, highlighting this developmental stage as a key point of marijuana initiation. Though youth focus group participants did not identify Marijuana as a concern and more frequently discussed electronic cigarettes as an issue in their communities. Quantitative data support these findings. While secondary data show cigarette use decreasing among youth, vaping use has substantially increased since 2014, with 18.4% of MetroWest high school students reporting active use in 2014, versus 28.1% in 2018 (Figure 48).

Figure 47. Percent of Students Reporting Alcohol Use, MetroWest Region, 2012-2018



DATA SOURCE: MetroWest Adolescent Health Surveys, 2012, 2014, 2016 & 2018.

Figure 48. Percent of High School Students (Grades 9-12) Reporting Vaping/Using E-Cigarettes, MetroWest Region, 2014-2018



DATA SOURCE: MetroWest Adolescent Health Surveys, 2014, 2016 & 2018.

While concern about opioids was mentioned among some assessment participants, data indicate that there have been several opioid overdose related deaths in the region in some towns. From 2014-2019, Massachusetts had around 2,000 opioid-related overdose death each year, with the fewest deaths in 2014 (1,365) and the most deaths in 2016 (2,094). By town, Framingham, Marlborough, and Hudson had the largest number of opioid overdose related deaths in the region (Table 6).

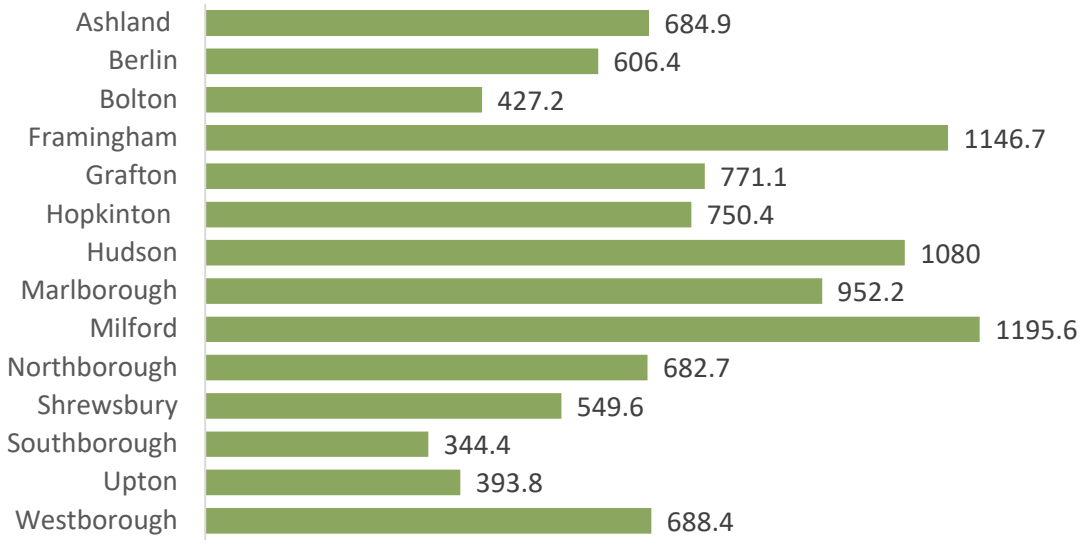
Table 6. Count of Opioid-Related Overdose Deaths, Massachusetts and by Town, 2014-2019

	2014	2015	2016	2017	2018	2019
Massachusetts	1,365	1,747	2,094	1,977	2,005	1,972
Ashland	1	4	4	4	2	3
Berlin	0	1	0	0	0	1
Bolton	0	2	1	0	1	0
Framingham	11	12	18	8	20	20
Grafton	2	2	1	0	3	6
Hopkinton	3	4	0	3	3	1
Hudson	1	6	3	4	6	7
Marlborough	9	8	4	4	14	8
Milford	4	3	12	6	6	4
Northborough	0	0	3	2	1	1
Shrewsbury	1	2	7	8	7	5
Southborough	1	0	1	0	1	2
Upton	0	0	2	1	2	2
Westborough	1	3	4	3	6	1

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Number of Opioid-Related Overdose Deaths All Intents by City/Town, 2013-2019 (updated January 2020)
NOTE: Please note that 2017-2019 death data are preliminary and subject to updates. Case reviews of deaths are evaluated and updated on an ongoing basis. A large number of death certificates have yet to be assigned final cause of death codes. The information presented in this city/town table only includes confirmed cases.

Concerns about whether there is adequate treatment available for substance use was mentioned. Figure 49 shows the rate of Bureau of Substance Addiction Services Enrollments in 2016-2017 for the region. These rates ranged from 344.4 per 100,000 population in Southborough to 1,195.6 per 100,000 population in Milford, with high substance use addiction service enrollment rates in Framingham and Hudson as well.

Figure 49. Bureau of Substance Addiction Services Enrollments, Rate per 100,000 population, by Town, 2016-2017



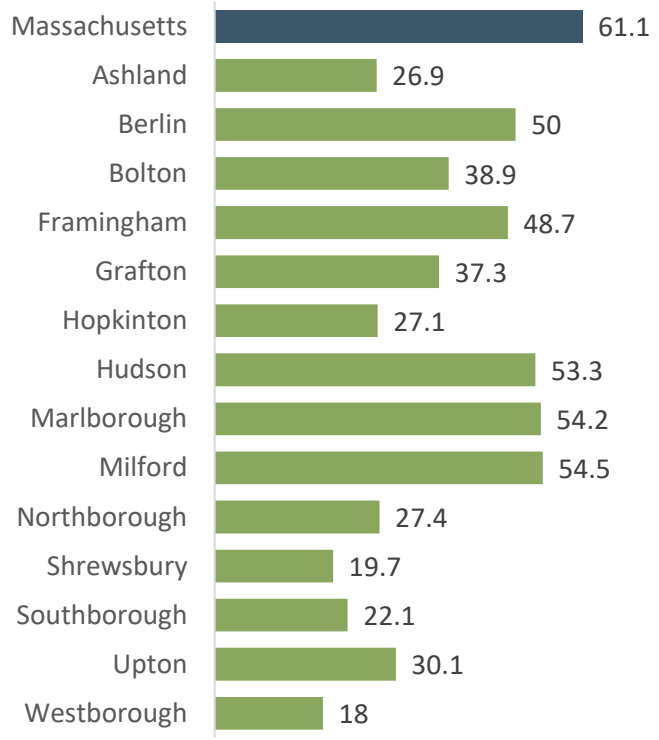
DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Addiction Services, 2016-2017.

Environmental Health

Asthma

Environmental health issues were not mentioned in the focus group or interview discussions. However, in Massachusetts, approximately 10% of adults have asthma. In 2016, Massachusetts had an age-adjusted rate of 61.1 asthma-related visits to the emergency room per 100,000 population. The rates in towns and neighborhoods ranged from 18.0 visits per 100,000 (Westborough) to 54.5 visits per 100,000 (Milford) (Figure 50).

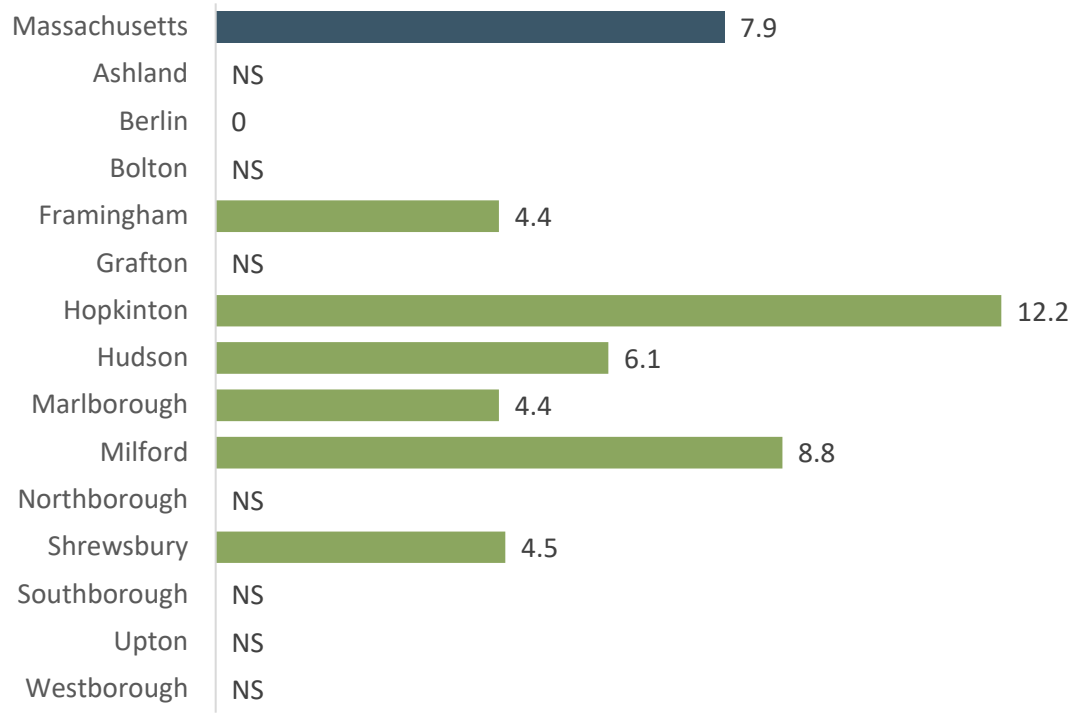
Figure 50. Asthma Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2016



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016.

In 2016, Massachusetts had an age-adjusted rate of 7.9 asthma hospitalizations per 100,000 population. The rates in towns and neighborhoods ranged from 0.0 hospitalizations per 100,000 (Berlin) to 12.2 visits per 100,000 (Hopkinton). Data from several towns are not presented due to insufficient sample size (Figure 51).

Figure 51. Asthma Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2016

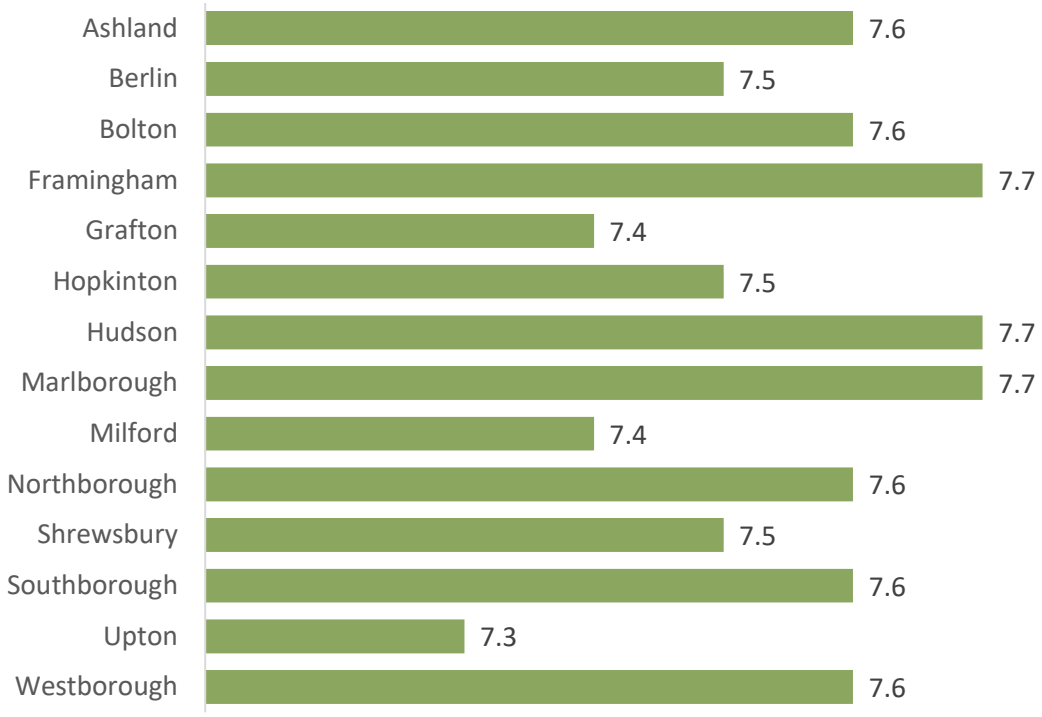


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016.
NOTE: NS = Data not shown due to insufficient sample size.

Air Quality

Fine particulate matter (PM)2.5 is an air pollutant that is a concern for people's health when there are high levels in the air. PM2.5 are tiny particles in the air that reduce visibility and cause the air to appear hazy when levels are elevated. The long-term standard (annual average) for safety is 12 micrograms/cubic meter. All towns in the area are under that threshold. In 2014, the annual average PM2.5 concentrations were around 7.6 for most towns, ranging from 7.3 micrograms/cubic meter in Upton to 7.7 micrograms/cubic meter in Framingham, Hudson, and Marlborough (Figure 52).

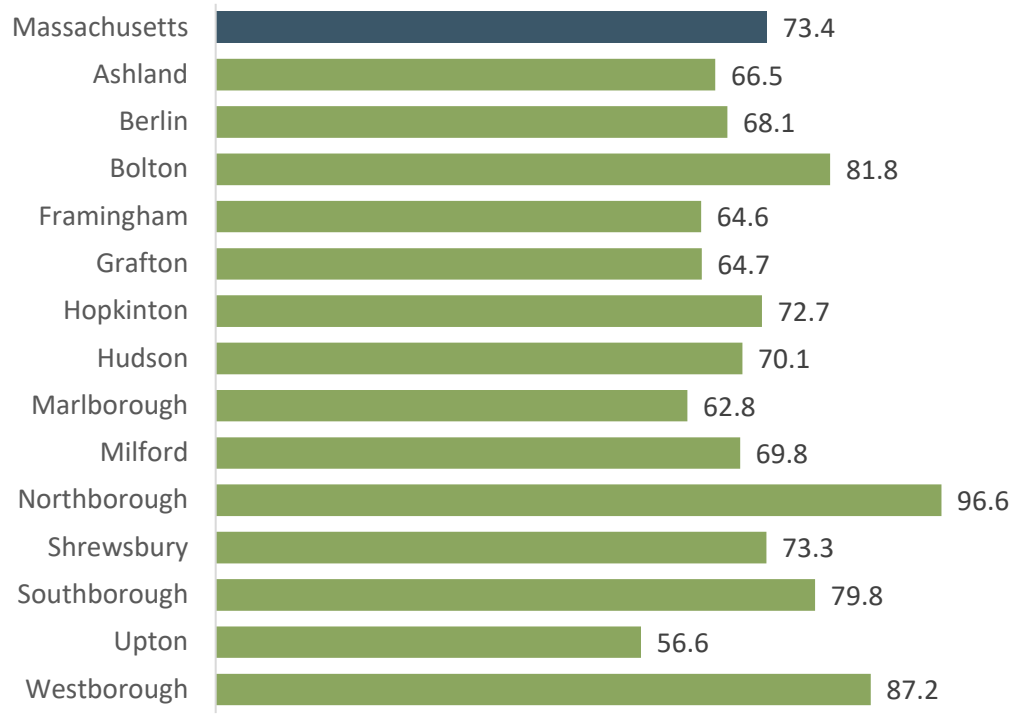
Figure 52. Air Quality Modeled Data Annual Average PM2.5 Concentrations (micrograms/cubic meter), by Towns, 2014



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Environmental Health, 2014.
NOTE: Air Quality is a localized measure, therefore statewide estimates are not available.

In 2013-2017, 73.4% of children aged 9-47 months were screened for lead poisoning in Massachusetts. By town, percentages of screened children ranged from 56.6% in Upton to 96.6% in Northborough (Figure 55).

Figure 53. Percent of Children 9-47 Months Screened for Lead Poisoning, in Massachusetts and by Town, 2013-2017



DATA: Massachusetts Department of Public Health, Bureau of Environmental Health, Childhood Lead Poisoning Prevention Program, 2013-2017.

Among participants in the MetroWest Adolescent Surveys in 2014, 6.2% reported current cigarette use, 18.0% reported current vaping (e-cigarette use), and 31.0% reported ever vaping in their lives (Figure 48). In 2018, prevalence was 3.2%, 28.4%, and 41.1%, respectively.

Infectious and Communicable Disease

> *"COVID has been such a perfect storm of awful things. It has exposed the real weaknesses in our community." – Key Informant Interview*
>
> *"People say COVID has exposed a fracture. But the leg is not fractured, the leg doesn't even exist." – Key Informant interview*

COVID-19

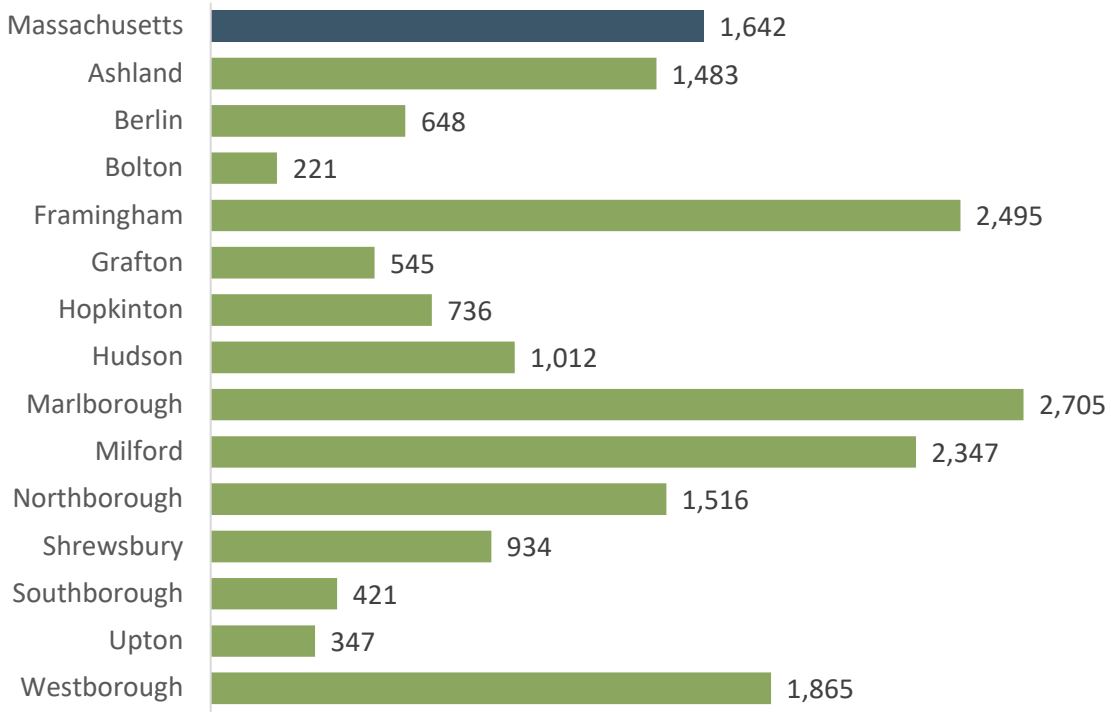
Interview and focus group participants shared concerns about the ongoing spread and impact of COVID-19. In general, participants reported community compliance with masks and social distancing. One young person shared in a focus group, *"As a community, people seem to be very conscientious about following health guidelines and doing what they can do to protect themselves and that makes me feel very safe."* Though, several focus group participants did express frustration at improper use of masks and large gatherings. One Hopkinton parent shared, "*I still see a good number of people not following social distancing. We have a state*

park in our town and the parking lot is packed full. Even on social media, I see parents posting that masks are a conspiracy. If they don't believe, it impacts everyone…basically sinking the whole ship."

Most often, participants shared the challenges of stay-at-home mandates and closures brought on by the pandemic, especially for those with school-age children. As previously mentioned, COVID-19 was often discussed in terms of economic instability and increased mental health concerns. Interestingly, assessment participants also reported positive aspects from the pandemic, most notably concern towards neighbors, more time with family, and the expansion of the use of technology, including telehealth. One focus group participant shared, *"The pandemic has made my life easier since things are online now. I can now go to events and that has opened up my access to things. My disabled friends have also highlighted that to me."*

As of August 12, 2020, there were 1,642 cases of COVID-19 per 100,000 population in Massachusetts. By town, the rates of coronavirus per 100,000 population ranged from 221 in Bolton to 2,705 in Marlborough (Figure 54).

Figure 54. Coronavirus (COVID-19) Case Rate per 100,000 Population, in Massachusetts and by Town, as of August 12, 2020

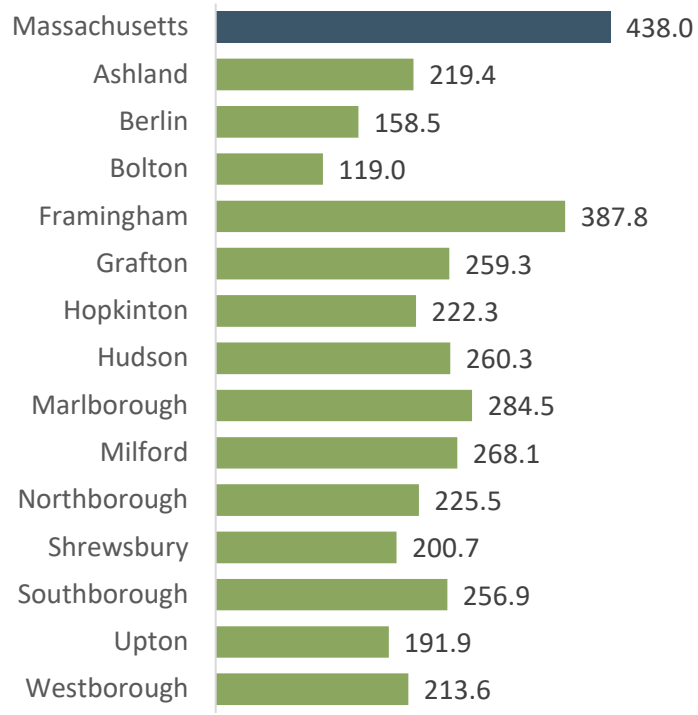


DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2020.

Sexual Health and Sexually Transmitted Diseases

Sexual health and sexually transmitted diseases were not brought up as concerns by focus group and interview participants. Rates of many of these conditions were lower in the region than Massachusetts overall. In 2018, there were 438 cases of chlamydia per 100,000 population in Massachusetts. By town, the rates of chlamydia per 100,000 population ranged from 119.0 in Bolton to 387.8 in Framingham (Figure 55).

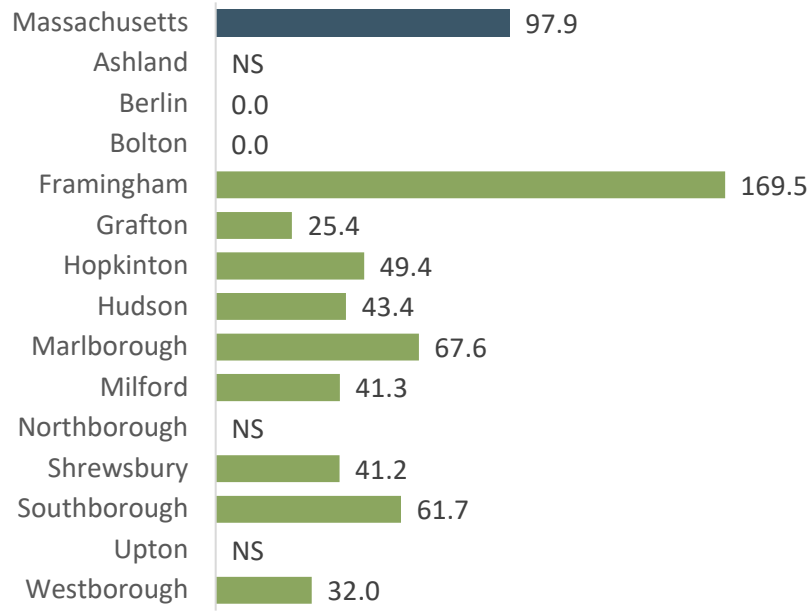
Figure 55. Chlamydia Cases, Crude Rate per 100,000 population, in Massachusetts and by Town, 2018



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2018.

In 2018, there were 97.9 cases of hepatitis C per 100,000 population in Massachusetts. By town, the rates of hepatitis C per 100,000 population ranged from 0.0 in Berlin and Bolton to 169.5 in Framingham. Data from several towns are not presented due to insufficient sample size
(Figure 56).

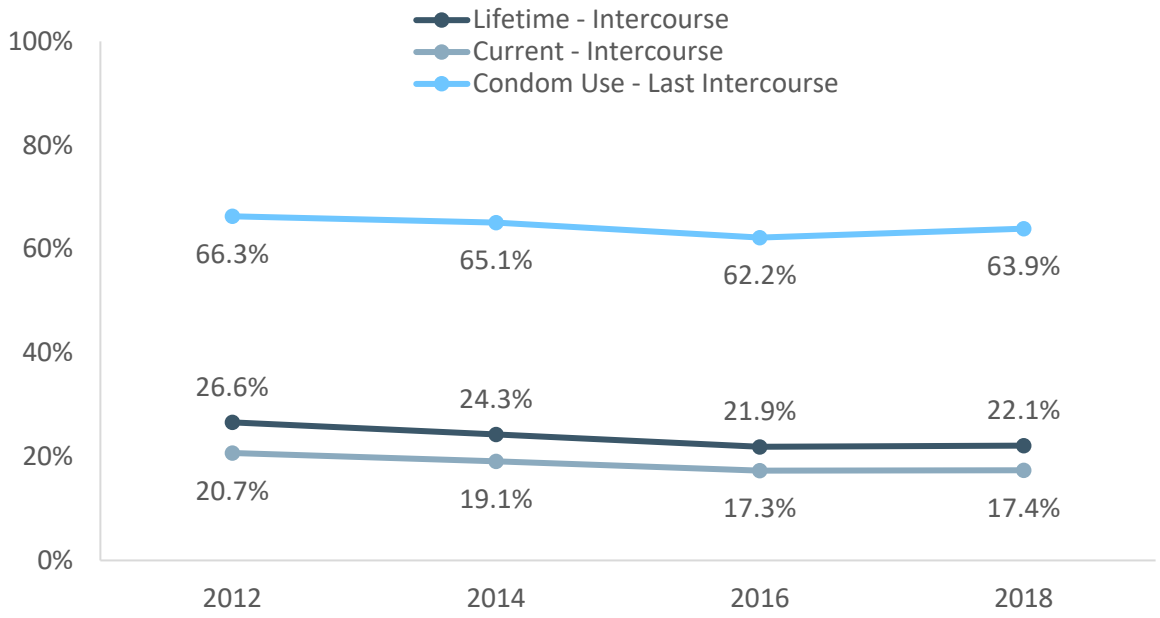
Figure 56. Hepatitis C Cases, Crude Rate per 100,000 population, in Massachusetts and by Town, 2018



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2018.
NOTE: NS = Data not shown due to insufficient sample size.

Risky sexual behaviors are still reported by many teens. Among respondents to the MetroWest Adolescent Surveys, between 22-27% reported ever engaging in sexual intercourse in the years 2012 to 2018, with slightly lower prevalence of intercourse in the past three months (Figure 57). During this time period, only 62-66% reported using condoms at last intercourse.

Figure 57. Percent of High School Students (Grades 9-12) Reporting Sexual Activity and Condom Use, MetroWest Region, 2012-2018

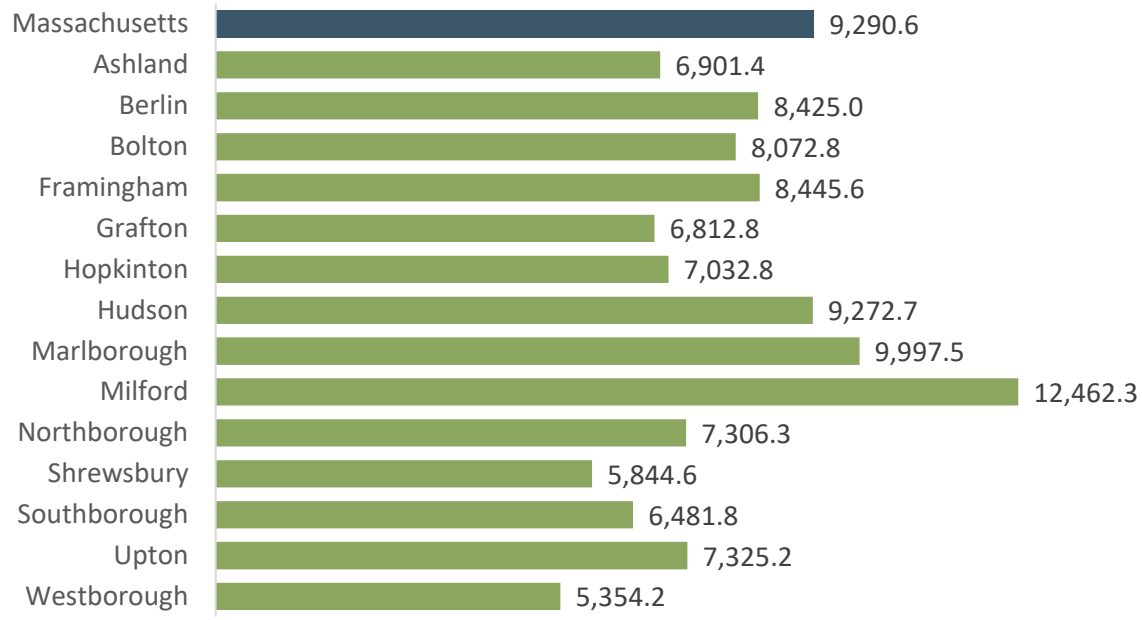


DATA SOURCE: MetroWest Adolescent Health Surveys, 2012, 2014, 2016 & 2018.

Injury

In 2014, there were 9,290.6 unintentional injury emergency department visits per 100,000 in Massachusetts. By town, unintentional injury emergency department visits ranged from 5,354.2 (Westborough) to 12,462.3 (Milford) per 100,000 population (Figure 58).

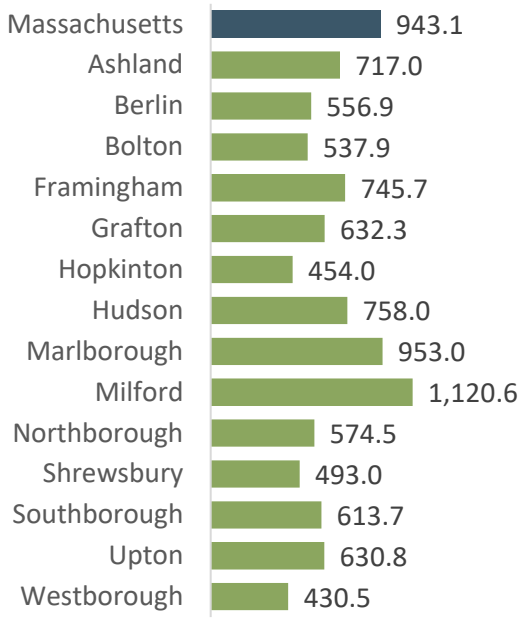
Figure 58. Unintentional Injury Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014

In 2014, there were 943.1 motor vehicle accidents where occupants were injured per 100,000 in Massachusetts. By town, accidents ranged from 430.5 per 100,000 population in Westborough to 1,120.6 per 100,000 population in Milford (Figure 59).

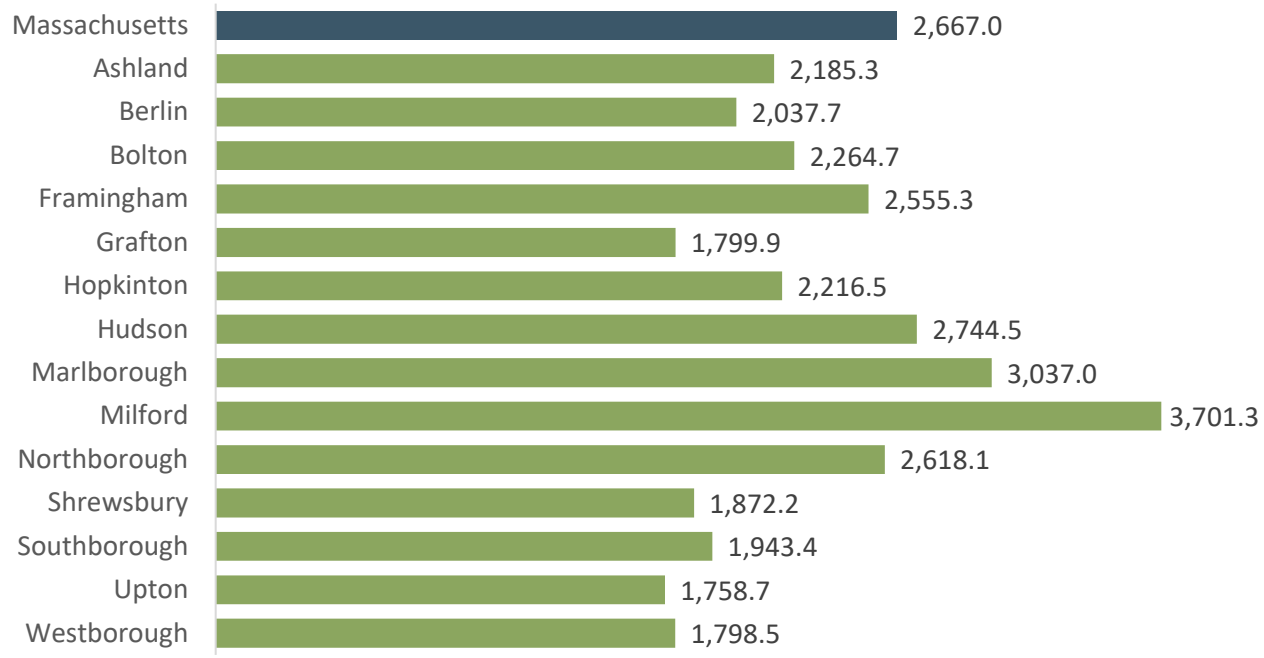
Figure 59. Motor Vehicle Accidents where Occupants are Injured, Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014

Falls are a particular concern of injury among the senior population. In 2014, the age-adjusted rate per 100,000 population of emergency department visits due to a fall was 2,667.0 in Massachusetts. By town, the age-adjusted rate per 100,000 population of fall emergency department visits ranged from 1,758.7 in Upton to 3,701.3 in Milford (Figure 60).

Figure 60. Falls Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014

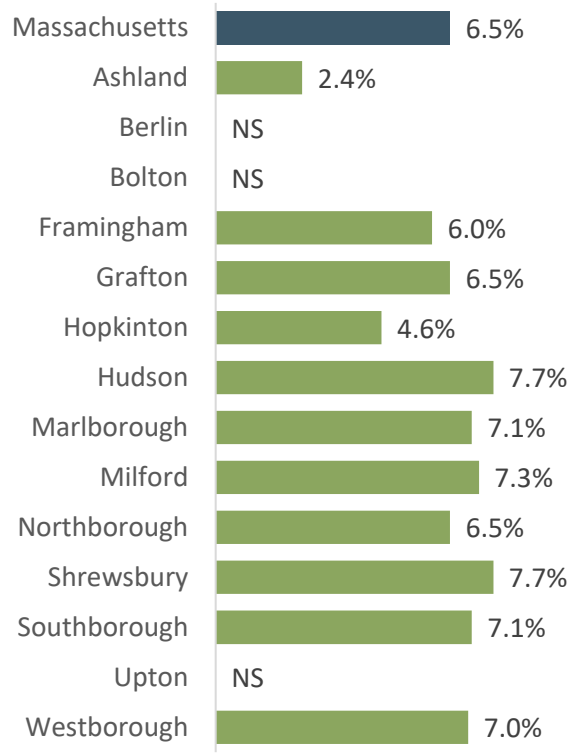


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014

Maternal and Infant Health and Early Childhood

As discussed earlier in the report, parents in focus groups and interviews described their concerns about their struggles of caring for children during the pandemic. However, issues specifically related to pregnancy and newborns were not mentioned. In looking at a key indicator, several towns in the region have slightly higher preterm birth rates than in Massachusetts overall, a potential risk factor for newborns and children. In 2015, the percent of preterm births in Massachusetts was 6.5%. By town, preterm births ranged from 2.4% in Ashland to 7.7% in Hudson and Shrewsbury (Figure 61).

Figure 61. Percent Preterm Births, in Massachusetts and by Town, 2015



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics.
NOTE: Preterm birth is defined as being born before 37 weeks of gestation; NS = Data not shown due to insufficient sample size.

ACCESS TO SERVICES

Access to Healthcare Services

Access to healthcare services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. The Westborough service area is in close proximity to healthcare resources and a high proportion of residents have health insurance. This coincides with Westborough Community Priorities Survey findings that show access to medical services was reported as the second highest asset by respondents, second only to good schools. However, barriers to accessing healthcare still exist, with some interview and focus group participants—namely those from Hudson and Marlborough—who discussed limited options for healthcare within the Westborough service area and the need to travel outside of their community to access services. This was especially true for specialty and geriatric services. Agencies that depend on volunteers to accompany seniors to specialty appointments in larger cities, such as Boston, are facing large challenges. One interviewee summarized, "*Something that's a huge need in MetroWest is the lack of specialties. Specialty care is in Boston, so if a senior has to go to an appointment and requests a navigator it can be a full day for a volunteer.*"

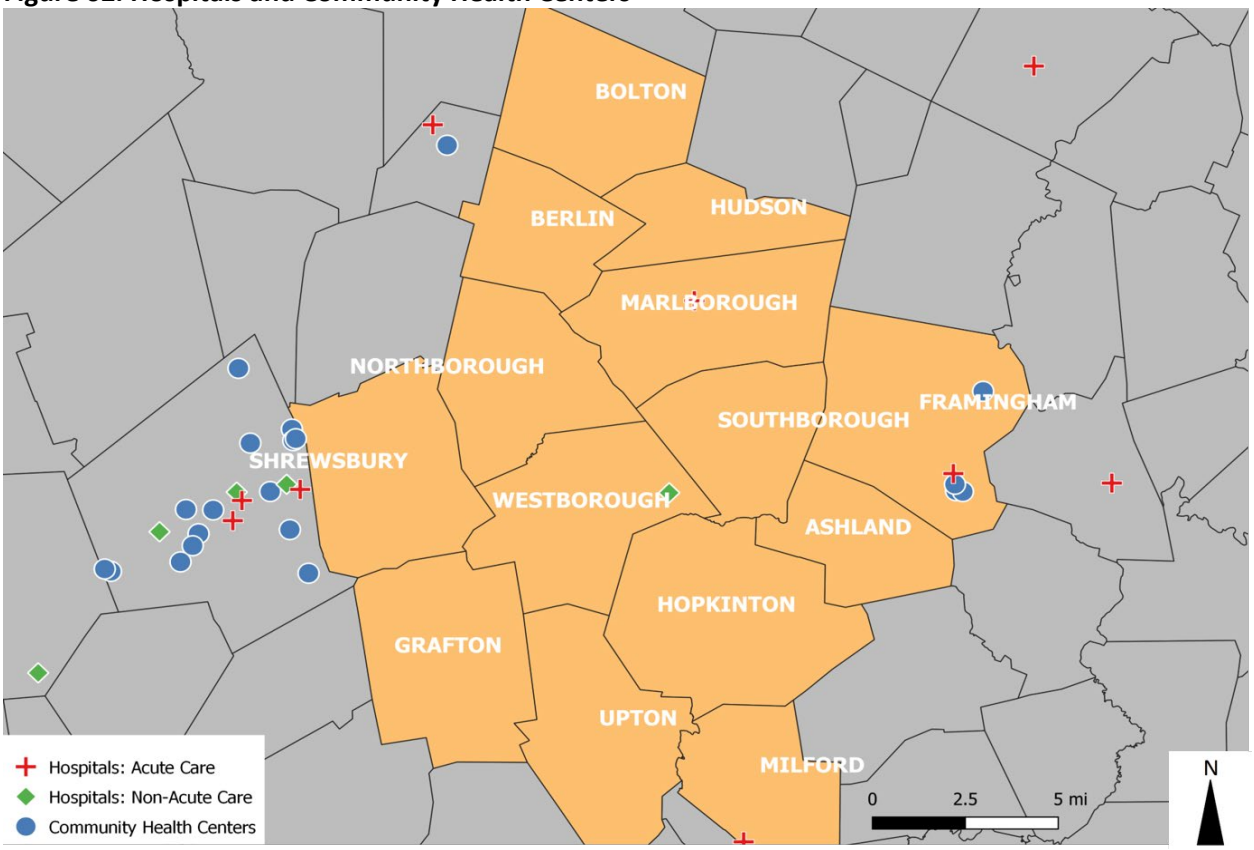
Data show that the ratio of population per healthcare provider in in Middlesex County is lower than the state overall. In 2017-2019, Massachusetts overall had one primary care provider per 970 people, whereas Middlesex County had one primary care provider for every 800 people and one for every 1,010 people in Worcester County (Table 7). Figure 62 shows a visual representation of hospitals and community health centers across the service area.

Table 7. Ratio of Population per Health Care Provider, in Massachusetts and by County, 2017-2019

	Primary Care Physicians (2017)	Dentists (2018)	Mental Health Provider (2019)
Massachusetts	970	970	160
Middlesex County	800	1,020	170
Worcester County	1,010	1,350	200

DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, 2017-2018; Centers for Medicare & Medicaid Services, National Provider Information Registry, as reported by County Health Rankings, 2019.

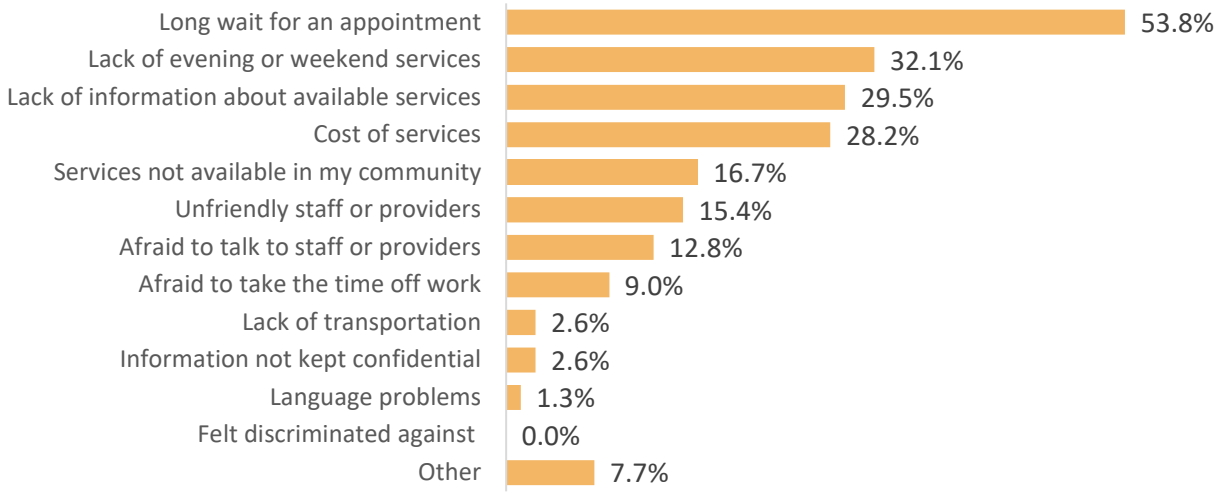
Figure 62. Hospitals and Community Health Centers



DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Department of Mental Health (DMH) & Massachusetts Department of Public Health: Bureau of Environmental Health GIS Program League of Community Health Centers, Office of Medical Services, Center for Health Information and Analysis, 2019.

Overall**,** 45.4% of Westborough Community Priorities Survey respondents reported experiencing at least one barrier to accessing medical, mental health, or social services in the past six months. Among respondents reporting at least one barrier, the most common barriers were long waits for appointments (53.8%), lack of evening or weekend services (32.1%), lack of information about available services (29.5%), and cost of services (28.2%) (Figure 63). These findings align with the top barriers identified in the 2019 MetroWest CHA.

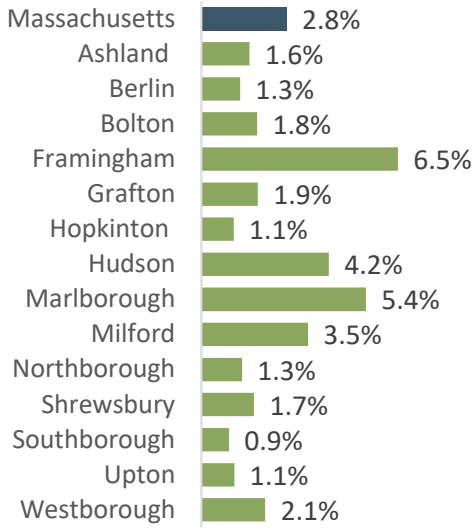
Figure 63. Percent of CHNA Community Priorities Survey Respondents Reporting Barriers to Accessing Medical, Mental Health or Social Services in the Past Six Months, among Respondents Reporting at Least One Barrier (N=78)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

While few Westborough Community Priorities Survey respondents had insurance issues, Census data indicate that health insurance coverage is still an issue for some residents, although this varies by town. The percent of the population with no health insurance ranges from 0.9% in Southborough to 6.5% in Framingham (Figure 64). Focus group participants who were seeking essential services most commonly discussed the challenges of being underinsured and being unable to pay co-pays and deductibles, or not being able to find a provider who accepts public insurance. This is especially true for residents on MassHealth. One interviewee explained, *"We have a local community health center at capacity, and we don't have another entity that is part of the MassHealth ACO. For people on MassHealth, there is no other option but to travel away from the area to seek care or don't have direct primary care access."*

Figure 64. Percent Population with No Health Insurance, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Access to Social Services or Other Essential Services

> *"We have to crack the issue of getting quality food to the people who need it."* – Key informant interviewee

When asked about challenges to accessing social or other essential services, participants spoke in terms of challenges during the COVID-19 pandemic, reporting many services being curtailed at the height of the pandemic. The most frequently described challenge related to seeking essential services was access to food and childcare. One interviewee summarized, "*After the pandemic, residents became worried about food. Our agency didn't do that before, but now we've had to create an emergency food bank. We've been working on food access since April and have made thousands of food bags for residents since then."*

Key informant interviewees explained how residents have now started prioritizing basic needs over other essentials needs, e.g. telephone and internet, which limits their ability to stay employed, and connected to healthcare, social services, and education. One interviewee shared "*What we've begun to see over the last two weeks is that there is no phone in the household. People have used their resources for food and shelter and these other things are secondary in terms of what they're dealing with. The phone becomes the obstacle with really being able to communicate with families."*

In addition, interviewees noted the need to offer more culturally sensitive services. For example, in regard to food access, one interviewee shared, "*We have a large immigrant population and there's a misalignment with the food that's delivered to them. Providing culturally appropriate food has been a challenge and we don't have it. We get caught between the mindset of 'any kind of food is good because it's food' versus giving out a product that actually makes sense."* Key informant interviews also discussed limited resources at community-based organizations and social service agencies for linguistic services. One summarized, "*There isn't anyone on staff for the Spanish and Portuguese speaking families to let them know about social distancing, about masks, and a lot of our materials are in English. There's just a lack of funding to translate."*

Childcare was another frequent theme that arose from qualitative discussions. Focus group participants in parent groups expressed a need for more affordable childcare options, especially in light of COVID-19 and for residents of lower socioeconomic status. One focus group participant summarized, *"If your kids are at home, you have to be too. How can I do my job at the same time with no childcare? It's really difficult to find affordable childcare that is readily accessible."*

COMMUNITY VISION FOR THE FUTURE

Community Perceptions for Action

> *"Mental health is the starting point to everything else. We [as a community] need to advocate for more mental health resources."* — Focus group participant

> *"We need a realistic approach to affordable housing. When you're on disability like I am—unless you have some sort of assistance—it's hard to afford. I may have to leave here."* — Focus group participant

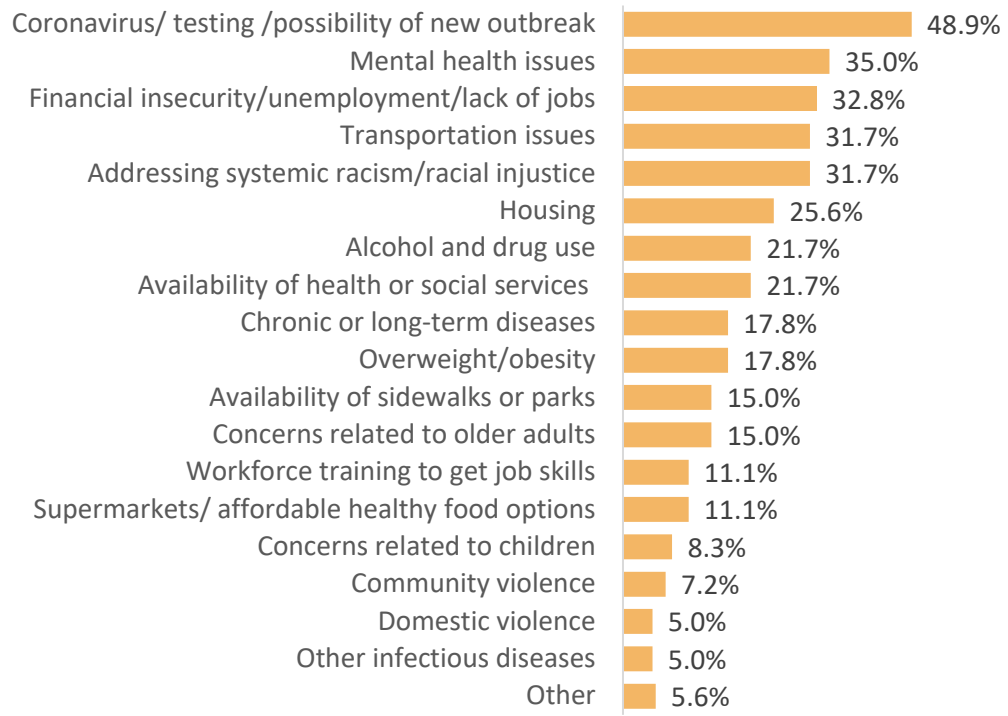
Focus group and interview participants were asked for their suggestions for addressing identified needs and their vision for the future. The following section summarizes and presents these recommendations for future consideration.

Top Issues for Action

Westborough Community Priorities Survey respondents were asked to consider the most important issues in their communities to take action on in the next few years. Respondents were asked to consider the importance of these issues in regard to Concern, Equity, Effectiveness, and Feasibility (see Appendix E for more information) and to select the five most important issues for action. Taken together, the top five issues of concern were (1) coronavirus/COVID-19 testing and/or the possibility of a new outbreak, (2) mental health issues, (3) financial insecurity/unemployment/lack of job opportunities (4) transportation issues, and (5) addressing systemic racism/racial injustice (Figure 65). Notably, although COVID-19 was the most commonly noted issue to take action on, less than half of respondents rated the virus in their top five priority areas. In separate analyses, People of Color and respondents with less than a bachelor's degree included alcohol and drug use among their top five priorities; however, it should be noted that respondents comprised small samples.

These Westborough Community Priorities Survey results align closely with key themes that arose from qualitative discussions. When asked what residents identified as their top priorities, increasing access to mental health and expanding economic and employment opportunities were the most frequently discussed. Differing from survey priorities, access to basic needs, including healthy food was a key theme in qualitative discussions. Though similar to key findings in the 2019 MetroWest CHA, housing and transportation challenges emerged across methods as top issues for action. Among most of these discussions, addressing racial injustice and systemic oppression was a cross-cutting and overarching focus discussed in the majority of these domains.

Figure 65: Percent of CHNA Community Priorities Survey Respondents Reporting Most Important Issues for Action in the Next Few Years in Their Community, 2020 (N=180)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Suggestions for Future Programs, Services, and Initiatives

Interviewees and focus group participants were asked about their vision for the next five years, including suggestions for future programs and services. Several suggestions emerged, though most frequently discussed were suggestions related to increasing access to mental health and expanding economic and employment opportunities. Following those two priorities, other suggestions emerged related to access to basic needs, transportation, housing, and racial justice.

Mental Health

Increasing access to mental health services was overwhelmingly identified by focus group participants and interviewees as a top issue to address in the Westborough service area. Assessment participants envisioned a community where mental health services were readily available, culturally sensitive, and affordable. Investments would be made in more mental health supports in elementary and middle school, as well as for seniors experiencing isolation. There would be increased support and advocacy efforts to increase reimbursement rates for mental health providers. These suggestions mirror similar findings from the 2019 MetroWest CHA.

Economic and Employment Opportunities

Following mental health services, expanding economic opportunities—especially for youth and for low income workers—was suggested as a priority area for investment by many assessment participants. In terms of youth, suggestions were made to expand enrichment programs that included paid opportunities to gain relevant professional experience. Specific suggestions were made to expand the limited number of employment opportunities through programs like MassHire. In addition, it was suggested that more financial resources be invested in education and job training for low income workers and essential employees.

Access to Basic Needs Including Healthy Food

Increased supports for navigating health and social service landscapes were suggested by several assessment participants, namely those who were seeking essential services and parents. As previously mentioned, accessing healthy food was a frequent concern raised by interviewees and focus group participants alike. Suggestions were made to expand food services and modernize systems that currently limit capacity, so community-based groups may address the magnitude of needs. For example, multiple key informants expressed the desire for an automated system that can be used at food pantries. One summarized, *"Our food pantries in the area need to have delivery systems. That would begin to level the playing field. Why can't someone who is poor or in need have food brought to their house the way I do from Wegman's or Instacart? Instead they have to wait hours in line or hours in a parking lot. How many things would that solve in the sense of a dignity standpoint, from an equity standpoint…an efficiency standpoint?"*

Transportation

Similar to findings from the 2019 MetroWest CHA, transportation was identified as a priority concern in the Westborough service area. Assessment participants suggested exploring creative solutions to long-standing transportation issues that have been adopted in cities across the state. For example, it was suggested that investments in the built environment—better sidewalks, more bike trails, and investments in community programs, such as bicycle shares and electronic scooters be added to the community in order to mitigate issues with reliable public transportation.

Housing

Access to affordable housing was among the most commonly discussed issues in qualitative discussions and Westborough Community Priorities Survey findings. Not only are housing options limited for low to moderate income individuals, but there are many community members who are in nontraditional homes without leases. Suggestions were made to increase legal protections for tenants who may be in these at-will tenancy agreements. Residents also expressed a desire for more affordable housing for seniors that could facilitate the

growing population's ability to age in place. One interviewee explained, "*There's an increased demand [for housing] as people remain in the community and age in place. It's expensive to live in MetroWest and there's not a lot of options. Seniors have to maintain their homes with less cash."* In terms of COVID-19, residents expressed concern about the lingering economic impact of the pandemic on housing affordability, foreclosures, and homelessness.

Racial Justice

Several assessment participants also shared a vision related to diversity and equity, with focus group participants noting the importance of recognizing that systemic racism and structural inequities are what drive health and economic disparities in their communities. Interviewees discussed the commitment of community-based groups in the Westborough service area to center racial justice initiatives. One explained, "*Everything we do moving forward will be focused on an anti-racism agenda. For any entity that wants to expand to our community, we'll be asking "tell us what you're thinking about anti-racism, and what is your internal and external agenda for the community."* In terms of the social determinants of health, assessment participants suggested prioritizing racial justice in the follow areas: 1) access to healthy and culturally appropriate food; 2) economic and employment opportunities; and 3) healthy housing.

Improved Services for Youth and Seniors

Lastly, programming for youth and seniors were frequently raised during interview and focus group discussions. Many assessment participants expressed limited enrichment opportunities for young people, especially for teens aged 13-19. One participant summarized, "*It's what I call the lost ages—after the age of 11 or 12 these kids have nothing. By that age, they think teens should be working and there's no program for them. We need more youth-led programs where the intention is to speak with you and have them lead."* In terms of seniors, residents suggested more programming related to social connections and access to technology.

KEY THEMES AND CONCLUSIONS

Through a review of the secondary social, economic, and epidemiological data; a community survey; and discussions with community residents and stakeholders, this assessment report examines the current health status of the Westborough service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- **Overall, the Westborough service area was reported as a highly educated, high-income community; however, there are pockets of vulnerable populations across the region—particularly youth, immigrants, and older adults.** Findings from this assessment show that some residents in the Westborough service area are struggling with basic needs including access to food, shelter, and childcare. Interview participants discussed a collaborative network of community-based organizations working to alleviate some of these immediate needs, but many indicated a need for more support and coordination to address the magnitude of the situation. Across the service area, residents in Framingham (23.6%) had the largest number of residents in poverty, followed by Milford (19.4%) and Marlborough (18.9%).

- **Some residents are struggling with lack of employment and economic opportunities, especially in light of COVID-19.** In April 2019, Massachusetts as a whole, and each city or town in the area had unemployment rates under 3%. However, during the pandemic, unemployment rates increased to 17.5% statewide in June 2020, with similar patterns in the majority of towns in the service area, particularly Milford (16.1%), Marlborough (15.8%), Hudson (15.8%), and Framingham (15.2%). Young people, immigrant communities, and non-English speaking communities who are more likely to work as essential workers were identified as facing unique challenges related to social and economic factors. More resources for career transitions and job training, technology, and language classes were identified as critical to addressing these issues.

- **Housing affordability and transportation continue to be concerns in the Westborough service area.** Consistent with findings from the 2019 MetroWest CHA, housing affordability was identified as a pressing concern, particularly for seniors and "*middle class*" residents. Many renters across the area, especially in towns, such as Bolton (68.4%) and Hopkinton (52.1%), are spending more than 30% of their income on housing costs. Tenancy-at-will situations—or agreements between tenants and landlords where there is no formal contract specifying the length of time during which the tenancy will take place – negatively impact already-vulnerable residents, such as undocumented immigrants and seniors. In terms of public transportation, participants described limited options that are often unreliable and cumbersome. Suggestions to invest in alternate modes of transportation, such as bicycle share programs and incentives to reduce single-occupancy vehicles.

- **Similar to ongoing events on the national level, conversations about racial justice and policing have been taking place in the Westborough service area.** Perceptions related to discrimination and racism varied throughout qualitative discussions. Addressing systemic racism was a theme that emerged across interviews, focus groups, and the community survey. Community leaders interviewed for the assessment described their commitment to addressing racial injustice and systemic oppression. Westborough Community Priorities Survey respondents ranked "Addressing Systemic Racism/Racial Justice" as the 4th highest priority for action in the next few years.

- **Across all data collection methods, the majority of assessment participants identified mental health as a priority health concern.** Stress, anxiety, depression, and isolation were the most frequently cited challenges among the Westborough service area, with residents describing how COVID-19 has exacerbated mental health issues in the community. Young people and seniors were identified as the populations most impacted by mental health challenges in the Westborough service area. Quantitative data from the MetroWest Adolescent Health Surveys show that the amount of high school students that reported their lives have been "Very stressful" has steadily increased from 28.9% in 2012 to 36% in 2018.

- **Rates of obesity/overweight were higher in the majority of Westborough service area towns than the state overall.** In 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 49.7% in Bolton to 64.2% in Milford. Approximately one in every three Westborough Community Priorities Survey respondents reported overweight/obesity (34.3%) as an issue that has impacted them in the last 6 months, however, it did not rise up as a key theme from qualitative discussions.

- **Proximity of health care services was noted as a key strength of the Westborough service area by community survey respondents, but access to those services is a challenge for some residents.** Westborough Community Priorities Survey respondents ranked 'accessible medical services' as the second strongest asset of the region (68.9%). However, themes that emerged from qualitative discussions highlight barriers that still persist for some participants, including being underinsured; limited linguistic access; navigating services; and lack of culturally sensitive approaches to care. In addition, the Westborough service area could benefit from additional services for the growing senior population to help facilitate aging in place.

COMMUNITY PRIORITIES FOR ACTION

Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. This section describes the process and outcomes of the Westborough-area CHNA prioritization process.

Criteria for Prioritization
When embarking on a prioritization process, using set criteria assists in providing parameters for selection. The following four criteria were used to guide prioritization discussions and voting processes with community members from the Westborough service area, as well as the Community Advisory Board who provided oversight of the CHNA.

Westborough Service Area – Prioritization Process

Assessment Study – Primary and Secondary Data Collection
- Synthesized data on social, economic, and health issues
- CHNA participants identified areas of concern and priority via key informant interviews, focus groups, and the Community Priorities Survey

Virtual Community Prioritization Meeting
- Presented study findings and voted on priorities using selected criteria

Community Advisory Board Meeting
- Regional community leaders discussed study findings and community prioritization meeting results, refined and approved priorities

Prioritization Criteria

- **Concern:** How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?
- **Equity:** Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?
- **Effectiveness:** Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?

Process Prioritization
The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection
During each step of the primary data collection phase of the CHNA, study participants were asked for input on the top priorities for action in their communities based on the prioritization criteria. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities, as well as the three highest priority issues for future action and investment (Appendices C and D). Community Priorities Survey respondents also were asked to select up to five of the most important issues for future action on in their communities (Appendix E).

Based on data gathered from key informant interviews, focus group participants, and community survey respondents, eight major priorities were identified for the Westborough service area:

- Coronavirus/COVID-19 *(specifically related to testing, transmission, disease mitigation, etc.)*
- Mental Health
- Financial Insecurity/Unemployment
- Transportation
- Systemic Racism and Racial Injustice
- Housing
- Alcohol/Substance Use
- Access to Services (e.g. healthcare, food, childcare)

Step 2: Data-Informed Voting via a Community Prioritization Meeting

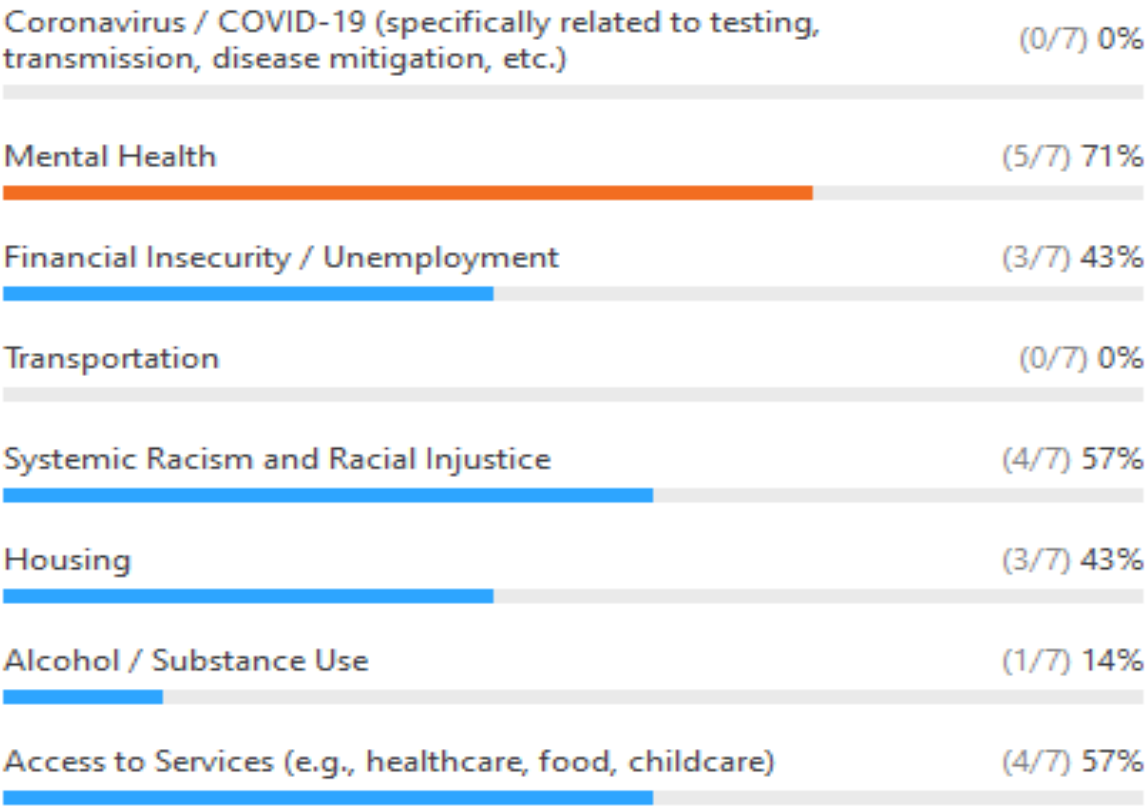
The next step of the prioritization process included presenting quantitative and qualitative data from the data collection phases to community members and stakeholders in a larger forum. On, September 3, 2020, a one-hour virtual community meeting was held for the Westborough service area, so residents and stakeholders could discuss and vote on community priorities. In order to obtain as much feedback as possible on the priorities, outreach was conducted with key informant interviewees, focus group participants, staff from organizations involved in focus group recruitment and survey administration and local Boards of Health. Various forms of outreach were employed to reach residents and stakeholders, including email and telephonic outreach, as well as social media posts.

During the remote prioritization meeting, attendees heard a brief data presentation on the key findings for the Westborough service area. Next, meeting participants were divided into small groups to discuss the data and offer their own perspectives and expertise on the various priorities. Meeting participants then shared information from their discussions with the full group.

At the end of the meeting, using the Zoom polling feature, meeting participants voted for up to three of the eight priorities identified from the data and based on the specific prioritization criteria (Concern, Equity, Effectiveness, and Feasibility). Participants were asked to identify any additional priorities that they thought were missing from the data-derived list using the Chat feature of Zoom. A total of seven community members voted during the Community Prioritization Meeting.

As seen in Figure 66, voting identified Mental Health (71%) as the most commonly endorsed community priority, followed by Systemic Racism and Racial Injustice (57%), Financial Insecurity/Unemployment (43%), and Housing (43%).

Figure 66: Westborough Prioritization Meeting, Zoom Poll Results, September 3, 2020



NOTE: Poll allowed for up to three responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Prioritization Meeting, 2020.

Step 3: Prioritization Refinement via Community Advisory Board Meeting

On September 9, 2020, the Partners Ambulatory Care – Community Advisory Board, who is charged with providing oversight of the CHNA process, met virtually to discuss the CHNA findings and community prioritization meeting output for the Westborough service area. The goal of this meeting was for CAB members to review the CHNA findings for the Westborough service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health.

In the meeting, CAB members were presented with information on community priorities that emerged from the CHNA, the community priorities survey, and the community prioritization meeting, together these prioritization steps revealed the following five priorities for the Westborough service area:

- Mental health
- Access to services
- Systemic racism & racial injustice
- Housing
- Financial insecurity

To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, and Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Much of the CAB's discussion focused on the inter-connectedness of the priorities and the difficulty in identifying a narrow area of focus given the need to address root causes of inequity in the social determinants of health. CAB members noted the importance of focusing on systemic racism and racial injustice given the demographics of the Westborough service area (the majority of residents identify as White). CAB members also discussed that a focus on housing could assist in addressing some of the other concerns related to financial insecurity, mental health, and systemic racism. Ultimately, the CAB retained four priorities to consider for future action:

- Mental health
- Access to services
- Systemic racism & racial injustice
- Housing

Financial Insecurity and Unemployment were eliminated from the list of priorities for action as these social determinants of health were determined to be embedded within other priority areas. Given the highly mutable state of current affairs, and the ability to further refine these priorities for future action, consensus among the CAB was to keep the list of priorities broader and then refine these issues at a later stage.

APPENDICES

Appendix A: Community Advisory Board Members

Name	Organization	Position
Amy Schectman	2Life Communities	President and CEO
Ann Houston	Opportunity Communities	CEO
Charles Desmond	Inversant	CEO
Charles Murphy	Montachusett Veterans Outreach Center	Executive Director
Cheryl Sbarra	Massachusetts Association of Health Boards	Senior Staff Attorney and Director of Policy and Law
Danna Mauch	Massachusetts Association for Mental Health	President and CEO
Dianne Kuzia Hills	My Brother's Table	Executive Director
Joseph D. Feaster, Jr.	Urban League of Eastern Massachusetts	Board Chairman
Laura Van Zandt	REACH (domestic violence prevention and services)	Executive Director
Mary Skelton Roberts	Barr Foundation	Co-Director of Climate
Milagros Abreu	The Latino Health Insurance Program, Inc.	Founder and Executive Director
Monica Tibbits-Nutt	128 Business Council / Fiscal Management and Control Board overseeing the MBTA	Executive Director / Vice Chair
Peter Koutoujian	Middlesex Sherriff's Office	Middlesex Sheriff

Rebecca Gallo	MetroWest Health Foundation	Senior Program Officer
Stephen J. Kerrigan	Edward M. Kennedy Community Health Center	President and CEO

Appendix B: Key Informant Interviewees

Name	Organization	Position
Alma DeManche	Executive Director	Westborough Senior Center
Andrea Salzman	Vice President for Community Services	Wayside Youth and Family
Anna Cross	Director	MetroWest Nonprofit Network
Christie Vaillancourt	Director	Hudson Board of Health
Diane Gould	CEO	Advocates
Jim Cuddy	CEO	South Middlesex Opportunity Council
Liliane Costa	Executive Director	Brazilian American Center
Lino Covarrubias	CEO	Jewish Family Services of MetroWest
Liz Garrigan-Bylery	Director	MetroWest Worker Center
Margie Rosario	Community Organizer	Community Voices Project
Sam Wong	Director	Framingham Board of Health

Appendix C: Key Informant Interview Guide

Health Resources in Action
Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
Westborough, Westwood, and Woburn Service Areas
Key Informant Interview Guide
Guide – May 19, 2020

Goals of the Key Informant Interview

- To determine perceptions of the strengths and needs of these communities, and identify sub-populations most affected
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your family are fine during these uncertain times.

- A few months ago, Partners HealthCare began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of community residents, how health needs are currently being addressed, and whether there might be opportunities to address these issues more effectively. The data from this assessment will inform the priorities for future investments into the community in the next several years on the upstream factors that affect health.

- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.

- As part of the community health assessment process, we are conducting interviews with leaders in the community and focus groups with residents to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty. The findings from these conversations will inform decisions around future investments to improve the community's health.

- Our interview will last about 30-40 minutes. After all of the data gathering is completed, we will be writing a summary report of the general themes that have emerged during the discussions. We will not include any names or identifying information. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

Could tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY OR IF COMMUNITY LEADER NOT AFFILIATED WITH ORGANIZATION]

a. [PROBE ON ORGANIZATION: What is your organization's mission/services? What communities do you work in? Who are the main clients/audiences?]

    i. Prior to the pandemic, what were some of the biggest challenges your organization faced in conducting your work in the community?
    ii. During the pandemic, what are some of the biggest challenges your organization has faced in conducting your work in the community? What new challenges do you anticipate going forward?

b. Do you currently partner with any other organizations or institutions in your work? Have there been any changes in these partnerships in light of the pandemic and its economic consequences?

III. COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (15-20 MINUTES)

How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)

c. How have you seen the community change over the last several years?

d. What do you consider to be the community's strongest <u>assets/strengths?</u>

For the following questions, please consider issues and concerns your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

e. What are some of its <u>biggest concerns/issues</u> in general? What challenges do residents face in their day-to-day lives? [PROBE ON, IF NOT YET MENTIONED: transportation; affordable housing; discrimination; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.) <u>REPEAT QUESTIONS FOR DIFFERENT ISSUES]</u>

    i. What population groups (geography, age, race/ethnicity, immigration status, gender, income/education, etc.) do you see as being most affected by these issues?

    ii. How has [ISSUE] affected their daily lives?

2. What do you think are the most pressing <u>health</u> concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICS. PROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19]

    a. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]

        i. From your experience, what are peoples' biggest challenges to addressing [THIS ISSUE]?

ii. To what extent, do you see [BARRIER] to addressing this issue among the residents you work with/your organization serves?

[PROBE ON BARRIERS BROUGHT UP/MOST APPROPRIATE FOR POPULATION GROUP: Cost or economic hardship, transportation, stigma, attitudes towards seeking services, built environment, availability/access to resources or services, knowledge of existing resources/services, social support, discrimination, insurance coverage, etc.]

3. What are current or emerging trends that could have an impact on the public health system or the community? Has anything become apparent due to the Coronavirus pandemic?

IV. *TAILORED SECTION* - SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT YET BROUGHT UP. (5-10 MINUTES)

For Interviewees Working in Housing and Transportation

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- What barriers do you see residents experiencing around accessing affordable and healthy housing? How about with transportation?
- What has been working well in the city to improve access to healthy, affordable housing? How about related to transportation? What has been challenging or not working well? Where are their opportunities for improvement or innovation?
- Are there any approaches to improving housing or transportation access that you think will have to change in light of the pandemic, social distancing, and economic impacts?

For Interviewees Working in Financial Instability, Employment, and Workforce Development

- In the wake of the pandemic and expected ongoing social distancing measures, what challenges are residents facing regarding hiring, employment, or job security?
- Thinking back to the time before the pandemic, what were the needs in this community around workforce development? What was previously needed to improve residents' employability? What training or resources were needed?
- Now that the pandemic and social distancing measures have changed so much about the economy and employment options, what are the NEW needs in this community around workforce development? What is NOW needed to improve residents' employability? What training or resources are needed to adapt to this new reality?

For Interviewees Working with Communities where Immigration and/or Discrimination is a Concern

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- What are some of the specific challenges around immigration issues or discrimination that your communities face? How has this changed since the pandemic?
- What should health care and social service providers consider when treating health and other issues in diverse populations? How can institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)

For Interviewees Working with Seniors/Older Adults

I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues the population you work with faces as a result of the pandemic? What do you anticipate will be the longer-term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected seniors in this region before the pandemic – and now?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working in the Areas of Violence, Trauma, and Safety

[For interviewees working on domestic violence:] I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues that the population you work with faces as a result of the pandemic, social distancing, and economic crisis? What do you anticipate will be the longer term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- In the wake of the pandemic, and expected ongoing social distancing measures, what challenges are community members facing regarding domestic or interpersonal violence?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working in the Areas of Substance Use or Mental Health

I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues the population you work with faces as a result of the pandemic, social distancing, and economic crisis? What do you anticipate will be the longer term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- In the wake of the pandemic, and expected ongoing social distancing measures, what challenges are community members facing regarding substance use or mental health?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

V. VISION FOR THE FUTURE (10-15 MINUTES)

4. I'd like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What's your vision?

    a. What do you see as the next steps in helping this vision become reality?

    b. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?

5. As you think about your vision, what do you think needs to be in place to support <u>sustainable</u> change?

a. How do we move forward with lasting change across organizations and systems?

b. Where do you see yourself or your organization in this?

6. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

VI. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. This is a very difficult time for everyone, and your perspective about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

Appendix D: Focus Group Guide

Health Resources in Action
Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
Westborough, Westwood, and Woburn Service Areas
General Focus Group Guide

Goals of the focus group:
- To determine perceptions of the strengths and needs of the community
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.

- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON AS A GROUP.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- A few months ago, Partners HealthCare began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these around the region with a wide range of people - community members, government officials, leaders in the faith community, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.

- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.

- We will be conducting several of these discussion groups around the area. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.

- We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the note-taking. No one but the analysts at Health

Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me turning the recorder on now?

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS (10 minutes)

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share– such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ASSETS AND CONCERNS

1. Today, we're going to be talking a lot about the community that you live in. How would you describe your community?

For the following questions, we will be discussing the strengths and concerns in your community, both prior to the coronavirus pandemic, and now. To begin with, please think back to a time before the pandemic – for example, in December during the holiday season.

2. Thinking about a few months before the coronavirus pandemic -- If someone was thinking about moving into your community, what would you have said are some of its biggest strengths about your community - or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

    a. What would you have said were the biggest problems or concerns in your community back then – a few months before the pandemic? [PROBE ON ISSUES IF NEEDED – HEALTH, ECONOMIC, SOCIAL, SAFETY, ETC.]

3. What do you think were the most pressing *health* concerns in your community back in December?

    a. How did these health issues affect your community? In what way?

    b. What specific population groups were most at-risk for these issues?

Next, please think about the same issues, now, in the midst of the pandemic, and moving forward. RIGHT NOW….

4. What do you think are the biggest strengths about your community? What are the most positive things about it? Are they different than before? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

5. What do you think are the biggest concerns in your community now? Are they different than before?

6. What do you think are the most pressing *health* concerns in your community now? How are they different?

7. Social isolation, anxiety, concerned about going out

a. How do these health issues affect your community? In what way?

    i. What are the biggest barriers or challenges that people have to seeking services for these issues?

b. What <u>specific population groups</u> are most at-risk for these issues?

IV. PERCEPTIONS OF HEALTH ISSUES, HEALTH CARE AND BARRIERS

What are the top three issues that were mentioned? It would be good to discuss issues that have arisen during the current health crisis, as well as issues that were big concerns before, that are ongoing or may return. (If needed, identify together or vote on top 3 issues.) Let's talk about some of the issues.

8. Do you agree with this list? Is there anything missing?

9. Traffic, affordable housing, accessing heath, technology – internet issues, transportation, navigating MassHealth, childcare, don't feel comfortable going out

10. What do you see as some of the biggest barriers or challenges to addressing these issues?

11. What do you think the community should do to address these issues? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

V. SPECIFIC PROBES FOR DISTINCT POPULATION GROUPS (10 minutes)

For Groups Where Housing and Transportation are a Concern

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- How much of an issue is affordable housing in your community? How has it impacted your day-to-day life?
- What barriers do residents (or you) experience around accessing affordable and healthy housing? How hard is it to find housing that is appropriate for you/your family?
- How much of an issue is accessing transportation? How has it impacted your day-to-day life?
- Are there any approaches to improving housing or transportation access that you think will have to change in light of the pandemic, social distancing, and economic impacts?

For Groups Where Financial Instability, Employment & Workforce are a Concern

- Thinking back to the time before the pandemic (for example, during the holiday season), what challenges were residents (or you) facing back then regarding hiring, employment, or job security?
    - [PROBE FOR THOSE WHERE ENGLISH ISN'T PRIMARY LANGUAGE]- How much do your language skills limit the type of job you can get?
- Now that the pandemic and social distancing measures have changed so much about the economy and employment options, what are the NEW needs in this community around employment? What is NOW needed to improve residents' employability?
- When people or families that you know are dealing with financial hardship, what are some of the issues that are most weighing on them? How do they deal with that?
- What resources or support do residents (or you) need to address financial hardship?

For Groups Where Immigration and Discrimination are Concerns

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- Have you ever felt discriminated against because of your race, ethnicity, language, or where you were born? What specifically?
    - Have you encountered this when trying to seek specific services (e.g., housing, healthcare, employment, education)?
- What are some of the specific challenges that your community faces related to immigration issues or discrimination? How has this changed since the pandemic?
- What should health care providers consider when treating health issues in diverse populations? How can health care institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)

VI. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT

12. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?

    a. What do you think needs to happen in the community to make this vision a reality?

    b. Who should be involved in this effort?

13. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive funding?

VII. CLOSING

Thank you so much for your time. This is a very difficult time for everyone, and your perspective about the communities you live in will be a great help in determining how to improve the systems that affect the health of this population.

That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

Appendix E: Survey Instrument

Updated – June 15, 2020

Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
- Community Priorities Survey

Unformatted version of the online survey

To complete the survey in Spanish, please use the drop-down menu above to select your language.
To complete the survey in Portuguese, please use the drop-down menu above to select your language.
To complete the survey in Mandarin, please use the drop-down menu above to select your language.

Being a healthy community is about more than delivering quality health care to residents. Where you live, learn, work, and play all have an enormous impact on your health.

Partners HealthCare is hoping to get a better understanding of the health of residents in your community—including all the factors that affect a community's health—and which community needs are most important to address. Please take this survey to provide feedback. It should take no more than 5-10 minutes. Filling out the survey is voluntary, and your responses are anonymous. You will not be asked your name, address, or any other information that can identify you.

This study has been underway for several months, starting before the coronavirus spread in the U.S. We recognize this is a unique time we are in. With the coronavirus crisis, understanding the community's needs and strengths has become even more important. This survey will be asking you about your concerns now, as well as several months ago.

Thank you for your time and participation. At the end of this survey is an opportunity to enter a raffle for a $200 Amazon gift card. Thank you for your feedback to improve your community's health.

1. What zip code do you live in? _____

2. We recognize this is a unique time we are in. We would like to understand what issues have **personally affected you and your family** now and 6 months ago – around the time of the holiday season. For each issue, please check if the issue was something that affected you or your family personally now and/or 6 months ago - or has not affected you or your family at either time period. You can check any that apply.

	Currently affects me or my family.	**Affected me or my family 6 months ago**	**Does not affect me or my family now nor 6 months ago.**
Financial insecurity/unemployment/lack of job opportunities	O	O	O
Problems getting workforce training to get job skills	O	O	O
Concerns around housing (such as finding affordable housing, fear of	O	O	O

eviction, overcrowding, housing quality)			
Problems getting to places because of lack of transportation	O	O	O
Cannot be active/get exercise because of lack of sidewalks or parks	O	O	O
Hard to eat well because of lack of supermarkets/lack of healthy food options I can afford	O	O	O
Fear of safety in the community/community violence (gangs, robberies. etc.)	O	O	O
Fear of safety at home/domestic violence (spouse or partner abuse, child abuse)	O	O	O
Discrimination because of my race, ethnicity, gender, language, sexual orientation, country of origin, etc.	O	O	O
Mental health issues (such as depression, anxiety, etc.)	O	O	O
Alcohol and drug (marijuana, heroin, opioids, etc.) use	O	O	O
Chronic or long-term diseases (like cancer, diabetes, heart disease, stroke, etc.)	O	O	O
Overweight/obesity	O	O	O
Coronavirus/COVID-19	O	O	O
Other infectious diseases (like pneumonia, flu, etc.)	O	O	O
Concerns related to older adults (dementia/Alzheimer's, falls, etc.)	O	O	O
Concerns related to children (premature birth, developmental delays, ADHD, etc.)	O	O	O
Problems getting the health or social services I need because they are not available in my community	O	O	O
Other: _____	O	O	O

2a - If you or your family felt discriminated against recently or in the last 6 months, what do you think are the <u>main reasons</u> for these experiences? (Please check all that apply.)

- o Your race
- o Your ethnicity, ancestry, or country of origin
- o Your language
- o Your gender
- o Your sexual orientation
- o Your religion

- Your education or income level
- Some aspect of your physical appearance (e.g., height, weight, disability, etc.)
- Prefer not to answer/Don't know

3. Either now or in the past 6 months, have any of these factors made it harder for you to get the medical, mental health, or social services (like housing, food, job training, etc.) you have needed? (Please check all that apply.)

- Services not available in my community
- Lack of information/ I don't know what services are available or where to go
- Lack of transportation
- Cost of services
- Lack of evening or weekend services
- Unfriendly staff or providers
- Felt discriminated against because of my race, ethnicity, gender, language, sexual orientation, country of origin, etc.
- Afraid to ask questions or talk to staff or providers
- Afraid if I take the time off to get services, I'll lose my job
- Long wait for an appointment
- My information is not kept confidential
- Language problems/could not communicate with staff or provider
- None of the above
- Other (Please specify) _____

4. Now we'd like to ask you about your community overall. Your community can be your town, your neighborhood, the group of people you care about, etc. What do you see as the overall strengths of your community? (Please check all that apply.)

- My community has medical services to address physical health conditions that people can access.
- My community has mental health services that people can access.
- My community has social services (e.g. food, job training, etc.) that people can access.
- My community has good schools.
- My community has good public transportation.
- My community has enough parks/green space.
- My community has sidewalks so residents can take a walk easily and safely.
- My community has bike paths so residents can bike easily and safely.
- My community helps people in need.
- Neighbors know each other in this community.
- People care about improving this community.
- People feel like they belong in this community.
- My community has people of many races and cultures.
- People can deal with challenges in this community.
- When people have disagreements, they are able to resolve their differences and determine a path forward.
- There are innovations and new ideas in this community.
- People accept others who are different than themselves in this community.
- None of the above.
- Other (Please specify) _____

5. Please think about the most important issues in your community for taking action. Consider the following when thinking about these issues:

   - **Concern:** *How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?*
   - **Equity:** *Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?*
   - **Effectiveness:** *Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?*
   - **Feasibility:** *Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?*

Given these questions, **what are the top 5 most important issues for action in your community in the next few years?** (Please check 5.)

Financial insecurity/unemployment/lack of job opportunities	O
Workforce training to get job skills	O
Housing (such as finding affordable housing, fear of eviction, overcrowding, housing quality)	O
Transportation issues	O
Availability of sidewalks or parks	O
Availability of supermarkets/healthy food options people can afford	O
Safety in the community/community violence (gangs, robberies. etc.)	O
Safety in people's homes/domestic violence (spouse or partner abuse, child abuse)	O
Addressing systemic racism/racial injustice	O
Mental health issues (such as depression, anxiety, etc.)	O
Alcohol and drug use (marijuana, heroin, opioids, etc.)	O
Chronic or long-term diseases (like cancer, diabetes, heart disease, stroke, etc.)	O
Overweight/obesity	O
Coronavirus/COVID-19 testing and/or the possibility of a new outbreak	O
Other infectious diseases (like pneumonia, flu, etc.)	O
Concerns related to older adults (dementia/Alzheimer's, falls, etc.)	O
Concerns related to children (premature birth, developmental delays, ADHD, etc.)	O
Availability of health or social services in the community	O
Other (please specify): _____	O

It is helpful to get an understanding of who is answering this survey to ensure we get a cross-section of perspectives. Please answer the following questions, which are anonymous.

6. What category best describes your age?

- Under 18 years old
- 18-29 years old
- 30-49 years old
- 50-64 years old
- 65-74 years old
- 75 years old or older

7. What is your current sex or gender identity?

- Male
- Female
- Transgender Male
- Transgender Female
- Additional Gender Category: _____

8. What is your sexual orientation?

- Straight/heterosexual
- Gay or lesbian
- Bisexual
- Prefer to self describe:_____

9. How would you describe your ethnic/racial/cultural background? (Please check all that apply.)

- African American/Black
- American Indian/Native American
- East Asian /Pacific Islander (e.g. Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, the Philippines, Samoa)
- South Asian (e.g., India, Pakistan, Bangladesh, Sri Lanka, Nepal)
- White
- Hispanic/Latino(a)
- Middle Eastern/North African
- Other (please specify) _____

10. What is the primary language(s) spoken in your home? (Please check all that apply.)

- English
- Spanish
- Portuguese/Cape Verdean Creole
- Chinese (including Mandarin and Cantonese)
- French or Haitian Creole
- Russian
- Hindi
- Arabic
- Other (Please specify) _____

11. Were you born in the United States?

    - Yes (automatic skip pattern to Q13)
    - No (automatic skip pattern to Q12)
    - Prefer not to answer (automatic skip pattern to Q13)

12. If no, how long have you lived in the United States?

    - Less than 1 year
    - 1 year to less than 3 years
    - 3 years to less than 5 years
    - 5 years to less than 10 years
    - 10 years to less than 15 years
    - 15 years to less than 20 years
    - 20 years or more
    - Prefer not to answer

13. What is the highest level of education that you have completed?

    - Primary or middle school
    - Some high school
    - High school graduate or GED
    - Some college
    - Associate or technical degree/certificate
    - College graduate
    - Graduate or professional degree

14. What is your current employment status? (Please check all that apply)

    - Employed full-time
    - Employed part-time
    - Not employed and currently looking for work
    - Student
    - Retired
    - Stay-at-home parent / significant other
    - Unable to work

15. Has your financial situation gotten worse, improved, or stayed the same since coronavirus/COVID-19?

    - Gotten worse
    - Has improved
    - Has stayed the same

16. What was your total household income before taxes during the past 12 months?

    - Less than $25,000
    - $25,000 to $34,999
    - $35,000 to $49,999
    - $50,000 to $74,999
    - $75,000 to $99,999
    - $100,000 to $149,999
    - $150,000 to $199,999
    - $200,000 or more
    - I don't know or don't want to say

This concludes our survey. Thank you for your time. We greatly appreciate your participation. Participants who complete this survey are eligible to enter a raffle for a $200 Amazon gift card. You will be automatically redirected to a form after this survey to enter the raffle. Your name and information will not be connected to the responses on your survey.

Appendix F: Additional Survey Data

Table 8. CHNA Community Priorities Survey Respondent Characteristics

	Number	%
Age		
Under 18 years old	1	0.6%
18-29 years old	8	5.0%
30-49 years old	58	36.5%
50-64 years old	58	36.5%
65-74 years old	20	12.6%
75 years old or older	14	8.8%
Sex or Gender Identity		
Male	40	25.2%
Female	119	74.8%
Sexual Orientation		
Straight/heterosexual	148	93.1%
Gay or lesbian	3	1.9%
Bisexual	4	2.5%
Prefer to self-describe	4	2.5%
Ethnic/racial/cultural background*		
African American/Black	4	2.2%
American Indian/Native American	2	1.1%
East Asian /Pacific Islander	6	3.3%
South Asian	6	3.3%
White	133	73.9%
Hispanic/Latino(a)	14	7.8%
Middle Eastern/North African	2	1.1%
Other	2	1.1%
Primary language(s) spoken at home*		
English	154	85.6%
Spanish	7	3.9%
Portuguese/Cape Verdean Creole	4	2.2%
Chinese (including Mandarin and Cantonese)	0	0.0%
French or Haitian Creole	0	0.0%
Russian	0	0.0%
Hindi	1	0.6%
Arabic	0	0.0%
Other	2	1.1%
Born in the United States		
Yes	129	82.2%
No	27	17.2%
Prefer not to answer	1	0.6%
Length of time living in the United States		

	Number	%
Less than 1 year	0	0.0%
1 year to less than 3 years	0	0.0%
3 years to less than 5 years	0	0.0%
5 years to less than 10 years	1	3.7%
10 years to less than 15 years	2	7.4%
15 years to less than 20 years	3	11.1%
20 years or more	21	77.8%
Prefer not to answer	0	0.0%
Highest level of education		
Primary or middle school	0	0.0%
Some high school	1	0.6%
High school graduate or GED	3	1.9%
Some college	15	9.6%
Associate or technical degree/certificate	12	7.6%
College graduate	63	40.1%
Graduate or professional degree	63	40.1%
Current employment status*		
Employed full-time	80	44.4%
Employed part-time	28	15.6%
Not employed and currently looking for work	12	6.7%
Student	3	1.7%
Retired	36	20.0%
Stay-at-home parent / significant other	3	1.7%
Unable to work	3	1.7%
Total household income in last 12 months		
Less than $25,000	6	3.9%
$25,000 to $34,999	8	5.2%
$35,000 to $49,999	8	5.2%
$50,000 to $74,999	10	6.5%
$75,000 to $99,999	23	14.8%
$100,000 to $149,999	37	23.9%
$150,000 to $199,999	18	11.6%
$200,000 or more	25	16.1%
I don’t know or don’t want to say	20	12.9%

NOTE: Asterisk (*) indicates the question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%; Double asterisk (**) indicates that the question includes only those who specified not being born in the United States.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Type of Issue, 2020

	Number	Affected Currently Only	Affected 6 Months Ago Only	Affect Both Currently and 6 Months Ago	Never Affected
Accessing health or social services	173	8.1%	0.6%	1.7%	89.6%
Alcohol and drug use	172	7.6%	1.7%	1.7%	89.0%
Cannot be active due to lack of sidewalks or parks	173	11.6%	5.8%	2.9%	79.8%
Chronic or long-term diseases	172	22.1%	3.5%	6.4%	68.0%
Community violence	172	8.7%	0.0%	0.0%	91.3%
Concerns around housing	173	8.7%	2.9%	0.6%	87.9%
Concerns related to children	174	8.6%	1.2%	4.6%	85.6%
Concerns related to older adults	173	22.5%	3.5%	8.1%	65.9%
Coronavirus/COVID-19	171	19.3%	4.1%	0.6%	76.0%
Discrimination	172	6.4%	3.5%	5.8%	84.3%
Domestic violence	171	0.6%	1.2%	0.0%	98.3%
Financial insecurity	178	32.6%	6.2%	5.6%	55.6%
Lack of access to affordable healthy food	172	8.1%	0.6%	1.2%	90.1%
Lack of transportation	172	5.8%	1.2%	1.2%	91.9%
Mental health issues	175	28.6%	9.1%	11.4%	50.9%
Other infectious diseases	171	2.9%	5.9%	0.0%	91.2%
Overweight/obesity	175	24.6%	1.1%	8.6%	65.7%
Problems getting workforce training	173	12.1%	2.3%	0.6%	85.0%
Other issue	96	4.2%	1.0%	0.0%	94.8%

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Attachment B-2

Mass General Brigham

Westwood Service Area Community Health Needs Assessment

October 3, 2020

Mass General Brigham

Health Resources in Action

Advancing Public Health and Medical Research

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction
Mass General Brigham (formerly Partners HealthCare) is a not-for-profit, integrated health care system that was formed in 1994 by an affiliation between The Brigham Medical Center, Inc. (now known as Brigham Health) and The Massachusetts General Hospital. Mass General Brigham ('System') currently operates two tertiary hospitals, six community acute care hospitals, and one acute care specialty hospital in Massachusetts; one community acute care hospital in Southern New Hampshire; one facility providing inpatient and outpatient mental health services; and three facilities providing inpatient and outpatient services in rehabilitation medicine and long-term care.

To fulfill Mass General Brigham's four-part mission of patient care, research, education and community, the organization has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics, population health, ambulatory care and insurance risk management. Developing community-based care centers that offer primary and behavioral health care, as well as specialty and surgical services also are a component of Mass General Brigham's mission.

Accordingly, the System is seeking ways to expand care options in more suburban settings, including in the Westwood service area. This potential expansion will require Mass General Brigham to fully understand the range of needs (related to health and the social determinants of health) within the Westwood service area, including the communities of: Canton; Dedham; Dover; Hyde Park (Boston); Medfield; Needham; Norwood; Walpole; West Roxbury (Boston); and Westwood.

This community health needs assessment ('CHNA' or 'Assessment') aims to gain a greater understanding of the issues that residents within the Westwood service area face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This CHNA report provides the results from a mixed methods study aimed at identifying the most pressing social, economic, and health issues in the service area. The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the Westwood service area to inform future planning,
- Understand the current health status of residents within the service area, as well as sub-populations within their social context, and
- Engage the community to help determine community needs and social determinant of health needs.

Context
This CHNA was conducted during an unprecedented time, due to the novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that participants raised in focus groups and key informant interviews. A wave of national protests for racial equity also coincided with the timeline of the CHNA and impacted the content of this report, as well as data collection processes, including the design of data collection instruments and the input that was shared during focus groups, key informant interviews, and through community survey responses.

Methods
The 2020 Westwood service area CHNA aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels— from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health needs of the Westwood service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the service area; conducting a community survey with 481 respondents (in multiple languages, including: English, Spanish, Portuguese, and Chinese); conducting 8 virtual focus groups with 27 participants and 10 key informant interviews with 12 individuals representing a variety of organizations, such as local non-profits including those serving youth and seniors, local health departments, and town administrators and services.

Due to COVID-19, it should be noted that while efforts were made to engage residents through virtual qualitative and survey data collection, the capacity of community organizations to assist with outreach and the capacity of community members to participate was limited. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

Findings
The following provides a brief overview of key findings that emerged from this assessment.

Population Characteristics

- **Demographics.** The area around Westwood is divided into towns of various sizes, as well as neighborhoods of the City of Boston. Over the past several years, all towns and neighborhoods in the Westwood service area have experienced population growth.[1] Notable demographic differences exist by race/ethnicity, foreign-born residents, and language in the Westwood service area. For example, within the Westwood service area, the Hyde Park neighborhood of Boston has the highest proportion of non-Hispanic Black (42.6%) and Hispanic/Latino (27.1%) residents, while Medfield has the highest proportion of non-Hispanic white (91.3%) residents. In the Westwood service area, there is variation in the population's age-distribution. Dedham (19.2%), West Roxbury (19.1%), and Westwood (18.9%) had the highest proportion of residents over 65 years old.[2]

Community Social and Economic Environment

- **Community Perceptions of Need:** The most common issues that impacted Westwood Community Priorities Survey respondents in the Westwood service area (either currently, 6 months ago, or at both timepoints) include mental health (49.8%), overweight/obesity (44.7%), and financial insecurity (43.3%). These survey findings generally align with qualitative data collected during interviews and focus groups, where some participants also identified affordable housing, transportation, the COVID-19 pandemic, and discrimination as key issues for their communities.

- **Community Assets:** Respondents to the Westwood Community Priorities Survey most commonly selected safe/walkable sidewalks (70.3%), good schools (66.3%), parks/green space (66.1%), and

[1] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
[2] Ibid.

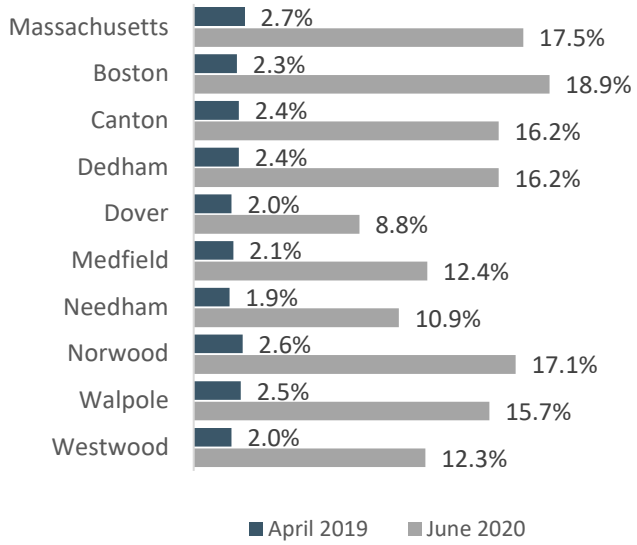
people who care about improving the community (63.2%) as assets of their communities. Interview and focus group participants also cited excellent educational opportunities, support for seniors, as well as community pride and engagement as strengths.

> *"There were people right on the edge that have been pushed over due to the pandemic."*– Focus group participant

- **Income and Financial Security:** In general, focus group and interview participants described the Westwood service area communities as affluent. However, participants noted that there are certain populations, particularly seniors and young families, that face financial insecurity especially in light of the economic impact of the COVID-19 pandemic. Within the area around Westwood, the median annual household income in 2014-2018 ranged from $64,784 in Hyde Park to $224,784 in Dover. One in three Westwood community survey respondents reported that their financial situation had gotten worse since the onset of the pandemic.

- **Employment and Workforce:** While unemployment rates in the Westwood service area have historically been low, qualitative, and quantitative data indicate that employment status has been impacted by the COVID-19 pandemic. During the pandemic, unemployment rates increased from 2.7% in the state overall in April 2019 to 17.5% statewide in June 2020. Boston, Canton, Dedham, Norwood, and Walpole all have unemployment rates over 15%. Many focus group and interview participants described job loss and/or reduction of employments hours in their communities, and noted that young people, Spanish speakers, and parents in need of childcare may be particularly vulnerable to job loss.

Percent Population 16 Years and Over Unemployed, in Massachusetts and by Town, 2019-2020



DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.
NOTE: Data are not seasonally adjusted; June 2020 data are preliminary and subject to revision.

- **Education:** While there is some variation, in general, residents of the Westwood service area have high levels of educational attainment (ranging from 10.5% of Hyde Park residents to 49.9% of Dover residents having a graduate or professional degree). Many focus group and interview participants viewed the school systems as strong assets in the Westwood service area, though many participants raised concerns about education in the context of the COVID-19 pandemic.

- **Housing:** Housing affordability was noted as a concern in most of the interviews and focus groups, where participants described high housing prices, limited affordable housing options, and ongoing development as priority issues. Many participants reported that the area is not affordable for young adults, single parents, or seniors. Quantitative data also show that many households face high housing costs: the percentage of owner-occupied households with a mortgage that spend more than 30% of their income on housing costs ranges from 23.8% in Medfield to 38.5% in Hyde Park.[3]

> *"There's very limited affordable housing for seniors. You have to be low income or super high income, that middle part is a problem."* – Key informant interviewee

> *"A lot of the industry that lower income workers work in are located on Route 1… [so] people have to walk across Route 1… because [there is] no transportation from residential areas."* – Key informant interviewee

- **Transportation:** Perceptions of transportation access differed among communities in the Westwood service area. In some communities, such as Hyde Park, participants described public transportation as an asset of the community. However, many participants outside of Boston described transportation as a major concern and noted specific challenges for low-wage workers, seniors, and students. Participants in these communities noted that public transportation is limited and, while there are some taxi voucher programs, vans, and The Ride, these transit options are still limited and/or irregular.

- **Built Environment:** Many participants described access to green and recreational space as an asset in the communities of the Westwood service area. However, overdevelopment was raised as a concern by participants who described apartments, luxury condominiums, and large houses being built in the area. Several communities, such as West Roxbury, Hyde Park, and Norwood have a high density of retail food outlets compared to other communities across the state.

- **Crime and Violence**: Crime and violence were not common concerns raised by interview and focus group participants; the Westwood area was described overall as safe. When compared to the state, rates of property crime are lower for many towns in the Westwood service area, but higher for Dedham; Hyde Park; and West Roxbury. A few interviewees expressed concern about domestic violence, particularly during the pandemic.

- **Discrimination and Racism:** Some CHNA participants shared individual experiences of discrimination based on their race, ethnicity, or language, and others noted the need to examine their privilege. Some interview and focus group participants suggested there was a critical need to form coalitions to tackle racial injustice. Among Westwood Community Priorities Survey respondents, addressing systemic racism was ranked fourth among the most important issues for future action, and 16.2% of community survey respondents reported experiencing discrimination currently and/or 6 months ago.

[3] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

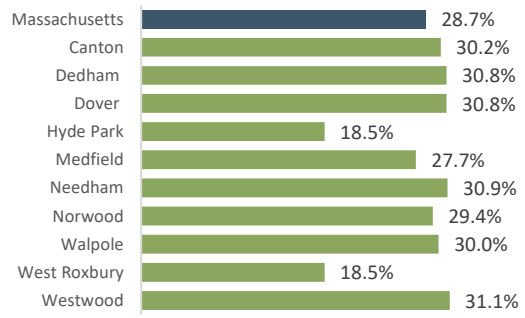
Community Health Issues

- **Overall Mortality:** Age-adjusted mortality rates per 100,000 population varied across the Westwood area in 2017, from a low of 467.4 in Westwood to highs of 670.6 in Canton and 683.2 in Norwood.[4]

- **Chronic Diseases and Related Risk Factors:** In general, rates of chronic disease in the Westwood service area are similar to the state overall. While interview and focus group participants did not cite specific chronic diseases as pressing concerns in their communities, a high proportion (44.7%) of Westwood Community Priorities Survey respondents indicated that "overweight/obesity" is an issue affecting their communities. In 2012-2014, the prevalence of overweight or obesity in Massachusetts was 59.0%; most towns in the area around Westwood had a similar prevalence, ranging from 50.2% in Westwood to highs of 64.8% in Hyde Park (2013-2017 data).

- **Mental Health:** Mental health was raised as a pressing concern in many interviews and focus groups. Participants noted that mental health conditions are present throughout the community, "*[f]rom the kids to the seniors,"* and in particular, noted high levels of anxiety among youth and isolation among seniors as key concerns. Participants shared the perception that mental health issues have become even more pressing during the COVID-19 pandemic, and again, described challenges for children and youth (specific concerns included the impact of the pandemic on development for younger children and depression for youth and young adults) and for seniors. Some participants also noted that mental health services are limited.

Percent of Adults Aged 65 years or Older with Depression, in Massachusetts, by Town and Boston Neighborhood, 2018



DATA SOURCE: Tufts Health Plan, Massachusetts Healthy Aging Data Report, 2018.

- **Alcohol/Substance Use:** Participants expressed some concerns about substance use in the Westwood service area. Specific types of substance use mentioned as concerns by participants included: alcoholism, vaping and in particular use of Juul e-cigarettes, and access to "*pills"* and "*minor drugs."* Opioid-related overdose deaths were very rare in the towns around Westwood in 2014-2019, with only Dedham in 2016 and Walpole in 2018 reporting 10 or more opioid-related overdose deaths. Some participants noted that the COVID-19 pandemic had exacerbated substance misuse.

- **Environmental Health:** Only a few interview and focus group participants shared concerns related to environmental health. While in general in 2016-2017, asthma emergency department visit rates in the Westwood service area were lower than the rate for the state (61.1 visits per 100,000 population), the rate was substantially higher for Hyde Park (122.3 per 100,000 population).[5]

[4] Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

[5] Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016; CHIA, Boston Public Health Commission, 2016-2017 Combined.

- **Infectious and Communicable Disease:** Given that the CHNA was conducted at the start of the COVID-19 pandemic, many participants shared concerns about the ongoing spread and impact of COVID-19 and about access to accurate testing. COVID-19 concerns were ranked first by Westwood Community Priorities Survey respondents among the most important issues for future action. Through mid-August 2020, the COVID-19 case rate in Massachusetts was 1,642 cases per 100,000 population. The case rate varied across the Westwood service area, with the highest case rate occurring in Hyde Park (3,302 per 100,000 population) and the lowest case rate occurring in Dover (359 per 100,000 population).[6]

- **Injury:** Interview and focus group participants did not mention injuries as a prominent issue of concern for their communities. Rates of emergency department visits, motor vehicle accidents, and hospitalizations due to falls are, in general, fairly similar among these communities when compared to the state.

- **Maternal and Infant Health:** While, as described above under, "mental health,"concerns about child development in the context of COVID-19 and social distancing were raised, in general, participants did not discuss maternal and infant health in detail during interview and focus group discussions. Maternal health data show a range of outcomes related to maternal health indicators in the area. For example, the percent of preterm births spanned from 4.1% Needham to 14.3% in Hyde Park according to the Massachusetts Department of Public Health Registry of Vital Records and Statistics.

Access to Services

- **General Access:** Overall**,** 51.1% of Westwood Community Priorities Survey respondents reported experiencing barriers to accessing medical, mental health, or social services in the past six months. Of those who had barriers, long wait times for appointments, lack of information on available services, and limited weekend and evening service options were the top barriers cited.

- **Healthcare Services:** Most participants described available local options for care, though some expressed a preference for traveling into Boston for care and others expressed a desire for more local care options. Participants described specific challenges related to accessing care, including difficulty finding providers that accept Medicaid (MassHealth) and the lack of mental health providers. Participants also stated that the COVID-19 pandemic has caused some residents to delay seeking care, and that while telehealth has expanded access for many patients, it is limited or not available for others.

> *"When I transitioned to MassHealth, I tried to find a [local] provider, but I couldn't find anything. I'm pregnant, and I have to go all the way to Boston to get services."* –Focus group participant

- **Social and Essential Services:** Interview and focus group participants described available services for seniors and, in the context of the pandemic, food pantries. Some participants described a need to improve communication about existing services, to provide additional services for seniors, and to expand access to technology including wireless internet. Across the greater Westwood area, there was variation in participants' perceptions of senior services; even in towns with robust senior services, participants noted the need for additional support for local Councils on Aging and other senior services.

[6] Massachusetts Department of Public Health, Bureau of Infectious Diseases and Laboratory Sciences, 2020; Boston Public Health Commission (BPHC), Communicable Disease Control Division, 2020.

Community Perceptions of Issues for Action

Westwood Community Priorities Survey respondents were asked to select the top five issues for future action on the survey and most frequently reported were: (1) Coronavirus/COVID-19 testing and/or the possibility of a new outbreak, (2) mental health issues, (3) housing, (4) addressing systemic racism/racial injustice, and (5) financial insecurity/unemployment/lack of job opportunities. Many of these issues align with the themes from the qualitative data collection, where transportation was also mentioned as critical concern for action.

Suggestions for Future Programs, Services, and Initiatives

Interview and focus group participants were asked to share suggestions for specific programs, services, and initiatives for action. Specifically, many residents discussed their suggestions in relation to transportation and behavioral health when asked. In terms of transportation, a few participants shared suggestions around developing local public transportation as well as "*on demand transportation for seniors to medical appointments"* through a public-provider partnership that could also provide transportation for commuters at the beginning and end of the day. When making recommendations related to behavioral health, in addition to noting a need for additional mental health services, one participant stressed the need to "*focus on the protective factors*". Lastly, some participants shared a vision for the future of their communities more broadly, which included improved access to services, equitable communities, and thriving residents.

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data, a community survey, and discussions with community residents and stakeholders, this assessment report examined the current health status of the Westwood service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- **There are many assets in the greater Westwood community, including high-quality schools, support for families and seniors, access to parks and green space, and overall cohesion and engagement among community members.** Many CHNA participants described the Westwood area as family-oriented, and identified schools as well as services for seniors, particularly Councils on Aging, as strengths. Many community survey respondents rated walkability and green space as assets. Both survey respondents and interview and focus group participants also described community pride and support, and noted that, especially during the COVID-19 pandemic, community residents engage with and care for each other.

- **While greater Westwood overall is affluent, some communities within the area face financial insecurity, especially in the context of the economic impact of the COVID-19 pandemic.** Prior to the pandemic, there was great variation in income across the area, with median annual household income ranging from about $65,000 in Hyde Park to $225,000 in Dover just a few miles away. However, income is not equally distributed across populations; additionally, assessment participants noted that the pandemic has exacerbated the financial insecurity of residents and the inequities between them. Nearly 43% of Westwood community survey respondents indicated that they or their families are impacted by financial insecurity. Unemployment rates have increased recently, likely due to the pandemic, and focus group and interview participants were concerned about this rising unemployment, particularly for Spanish speakers, service workers, young families, and seniors.

- **Housing affordability was identified as a pressing concern, particularly for young adults, single parents, and seniors.** Housing affordability was noted as a concern in most of the interviews and focus groups, where participants described high housing prices, limited affordable housing options, and ongoing development as priority issues. Quantitative data show that many owner-occupied households in the area (ranging from 23.8% in Medfield to 38.5% in Hyde Park) are cost-burdened (spending more than 30% of their income on housing costs). Given the high cost of housing and the lack of affordable housing options, participants noted that some families are living in crowded or doubled-up situations in order to afford rent. Additionally, in the context of the COVID-19 pandemic, some participants expressed concerns about an increase in homelessness as a result of rising unemployment.

- **Transportation was a concern for some communities, particularly for certain populations including low-wage workers, seniors, and students.** Perceptions of transportation access differed among communities in the greater Westwood area. In some communities, such as Hyde Park, participants described public transportation as an asset of the community. Pre-COVID data from the Census showed that 25.3% of Hyde Park residents and 17.3% and 17.1% of residents in Westwood and West Roxbury, respectively, took public transportation to work. However, many interview and focus group participants who live further outside of Boston described transportation as a major concern and noted specific challenges for low-wage workers, seniors, students, and residents that do not own a vehicle.

- **Some community members have experienced or recognized discrimination in their communities and prioritized addressing racial injustice.** Some assessment participants discussed facing discrimination themselves. Overall, 16.2% of Westwood community survey respondents reported experiencing discrimination in the past six months; among these respondents, 68.5% reported this was due to their race and nearly 49.3% reported this was due to their ethnicity or country of origin. A few focus group participants discussed being on the receiving end of anti-immigrant sentiments or hearing about discrimination in schools. Assessment participants noted that examining privilege and addressing systemic racism as a community is critical. While participants described how some conversations are happening, they also noted that there is more work to be done around taking action to address racial injustice.

- **Mental health, especially for youth and seniors and in the context of the pandemic, was a pressing concern among many community residents.** Mental health issues were the top concern that Westwood community survey respondents reported had personally affected them in the past six months, with nearly 50% of respondents noting it has affected them. Quantitative data gathered prior to the COVID-19 pandemic indicate that, across the service area, 8.7% - 10.4% of adults reported having 15 or more days in the last month during which they experienced poor mental health. Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in the community, particularly among seniors, who already tend to be socially isolated. Additionally, participants with school-age children were specifically concerned about the pandemic's effect on the development and socialization of younger children and contribution to depression among youth and young adults.

- **Substance use was also a concern, though perceptions varied by type of substance.** Substance use, particularly issues related to alcoholism, vaping and e-cigarettes, and some drugs, were noted as a concern by some focus group and interview participants. Some participants also noted that the stress of the pandemic may exacerbate substance use. However, some participants stated that

opiate and heroin use were less of a concern in the Westwood area compared to other parts of the state. In the Westwood community survey, 22.2% of respondents included alcohol and substance use as one of their top 5 community priorities for action.

- **Concerns remain about COVID-19 spread and access to testing.** Among Westwood community survey respondents, 27.3% indicated that they or their families have been directly impacted by COVID-19 in the last 6 months. Focus group and interview participants expressed concern about the accuracy and availability of COVID testing and about disease transmission due to a lack of consistent social distancing and wearing of masks. However, most of the concerns shared by assessment participants related to the COVID-19 pandemic focused on the effects it had on other aspects of residents' lives. These specific concerns included: the effect on mental health among parents, seniors, and youth; the impact on youth development; and the impact on financial insecurity and concerns about the current and cascading effects on the economy – particularly for low wage workers.

- **Many healthcare and social services are available in the area, but there is opportunity for improving access to and communication about local options.** Interview and focus group participants described available services including local healthcare options, programming for seniors and, in the context of the pandemic, food pantries. However, challenges to accessing services included difficulty finding providers that accept Medicaid (MassHealth), lack of mental health providers, limited telehealth access, and a need for additional community-wide communication about existing services.

Priority Needs of the Community

Community Prioritization Meeting

Data and themes from the CHNA report were presented to service area residents and stakeholders at a virtual community prioritization meeting in September 2020. Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. The following four criteria were used to guide prioritization discussions and voting processes:

- Concern
- Equity
- Effectiveness
- Feasibility

Meeting participants voted for up to three of the eight priorities identified from the data and based on the specific prioritization criteria. Voting identified Mental Health (45%), Housing (45%), Systemic Racism and Racial Injustice (45%), and Issues Related to Older Adults (45%) as tied for the most commonly endorsed community priorities.

Community Advisory Board Meeting

The goal of this meeting was for CAB members to review the CHNA findings for the service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health. To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern,

Equity, Effectiveness, Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Ultimately, the CAB identified five priorities to consider for future action:

- Mental health
- Housing
- Systemic racism & racial injustice
- Issues related to older adults
- Transportation

Mass General Brigham
Partners Ambulatory Care - Westwood Service Area Community Health Needs Assessment

INTRODUCTION

Mass General Brigham (formerly Partners HealthCare, 'the System') is a not-for-profit, integrated health care system that was formed in 1994 by an affiliation between The Brigham Medical Center, Inc. (now known as Brigham Health) and The Massachusetts General Hospital. Mass General Brigham currently operates two tertiary hospitals, six community acute care hospitals, and one acute care specialty hospital in Massachusetts; one community acute care hospital in Southern New Hampshire; one facility providing inpatient and outpatient mental health services; and three facilities providing inpatient and outpatient services in rehabilitation medicine and long-term care. Mass General Brigham also operates physician organizations and practices, a home health agency, nursing homes and a graduate level program for health professionals. Mass General Brigham is a non-university-based nonprofit private medical research enterprise and its academic medical centers are principal teaching affiliates of the medical and dental schools of Harvard University. Mass General Brigham provides its services to patients primarily from the Greater Boston area and eastern Massachusetts, as well as New England and beyond. Additionally, Mass General Brigham operates a licensed, not-for-profit managed care organization that provides health insurance products to the MassHealth Program (Medicaid), Connector Care (a series of health insurance plans for adults who meet income and other eligibility requirements) and commercial populations.

To fulfill Mass General Brigham's four-part mission of patient care; research; education; and community, the organization has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics, population health, ambulatory care, and insurance risk management. Implementation of this strategy relies on a series of synergistic priorities that include:

i. improving health outcomes across the full continuum of care with an emphasis on the development by Mass General Brigham's academic medical centers of multidisciplinary centers of excellence for tertiary and quaternary care;

ii. enhancing the patient experience, particularly for primary care and behavioral health care, by developing community-based health care settings that improve access and ease of navigation for patients;

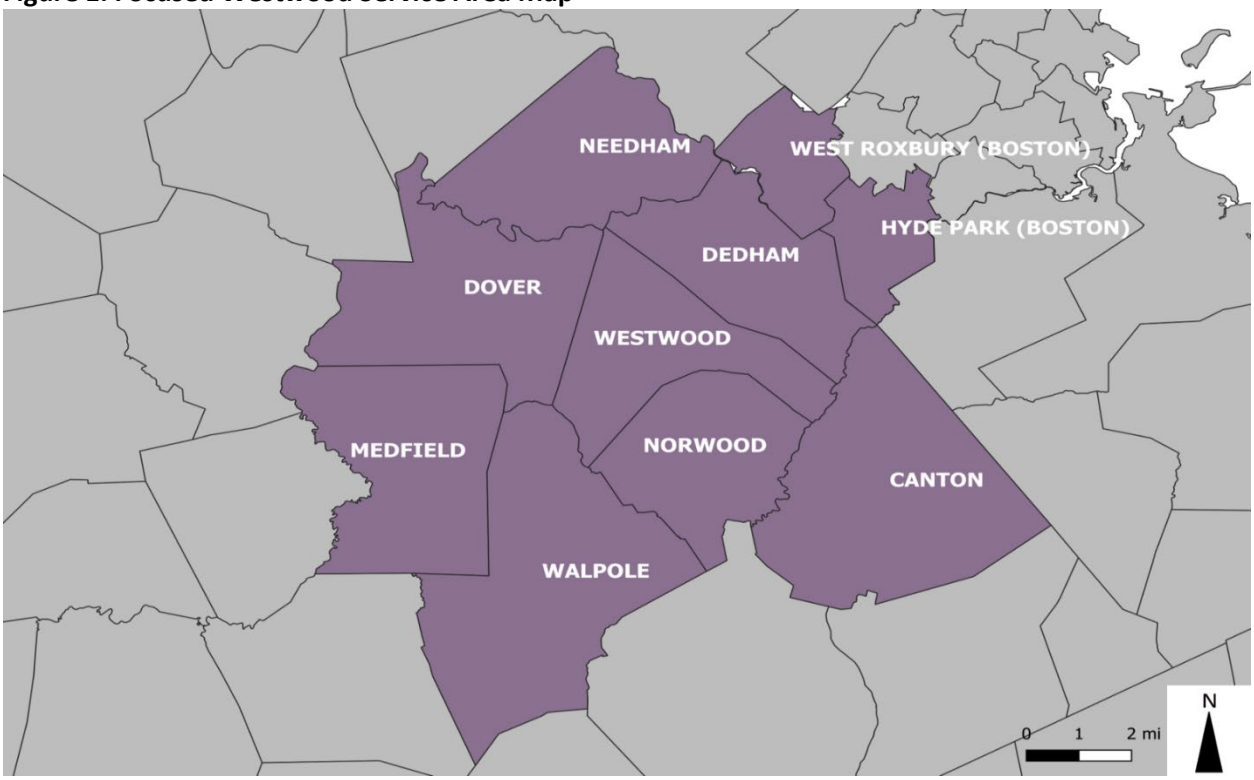
iii. reducing the total cost of health care by developing delivery models that focus on value while simultaneously improving outcomes; and

iv. investing in research and innovations that meaningfully improve the diagnosis and treatment of all forms of human illness.

Developing community-based care centers that offer primary and behavioral health care, as well as specialty and surgical services meet the second component of Mass General Brigham's mission.

Accordingly, the System is seeking ways to expand care options in more suburban settings, including in the Westwood area. This potential expansion will require Mass General Brigham to fully understand the range of needs (related to health and the social determinants of health) within the Westwood service area, including the communities of: Canton; Dedham; Dover; Hyde Park (Boston); Medfield; Needham; Norwood; Walpole; West Roxbury (Boston); and Westwood. The Westwood service area is shown in Figure 1 below.

Figure 1. Focused Westwood Service Area Map



Purpose and Scope of the Community Health Needs Assessment

This community health needs assessment (CHNA or Assessment) aims to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the various 2020 Westwood service area needs assessment processes, which were conducted between March-August 2020, and will inform discussions about key community issues and concerns in this service area.

The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the community to inform future planning;
- Understand the current health status of the service area overall and its sub-populations within their social context; and
- Engage the community to help determine community needs and social determinant of health needs process.

Priority social determinants of health areas include the social environment, built environment, employment, education, housing, and violence and trauma.

CONTEXT FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT

This CHNA was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice. This context had a significant impact on the assessment approach and content.

COVID-19 Pandemic

The novel coronavirus disease 2019 (COVID-19) pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process and topics and concerns that participants put forth during discussion in focus groups and interviews. On February 1, 2020, the first confirmed case of COVID-19 in Massachusetts was announced, and on March 15, 2020, the Governor of Massachusetts issued an emergency order announcing emergency actions to address COVID-19 including school closures, business closures, and limitations on gatherings. Data collection planning (e.g., finalizing methodology and developing data collection instruments) occurred at the beginning of this state-wide shutdown. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (advisory bodies, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection was shifted to a virtual setting (e.g., telephone or video focus groups and an online survey), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a primary health concern for communities, exacerbating underlying inequities and social needs. The pandemic brought to light both the capabilities and gaps in the healthcare system, the public health infrastructure, and social service networks. In this context, an assessment of the community's strengths and needs, and in particular the social determinants of health, is both critically important and logistically challenging. Where possible, CHNA participants were asked to reflect on health and social issues beyond those directly related to COVID-19, yet the pandemic's short-term and long-term impacts remained at the forefront of many conversations. This CHNA should be considered a snapshot in time; consistent with public health best practices, the community can continue to be engaged to understand how identified issues may evolve and what new issues or concerns may emerge over time.

National Movement for Racial Justice

A wave of national protests for racial equity – sparked by the killing of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others – also coincided with the timeline of the CHNA. As part of a movement for racial justice, national attention was focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA, including the design of data collection instruments and the input that was shared during interviews and focus groups and through Westwood Community Priorities Survey responses. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in late spring 2020 in the form of protests and dialogues, locally and nationally, as context for this assessment.

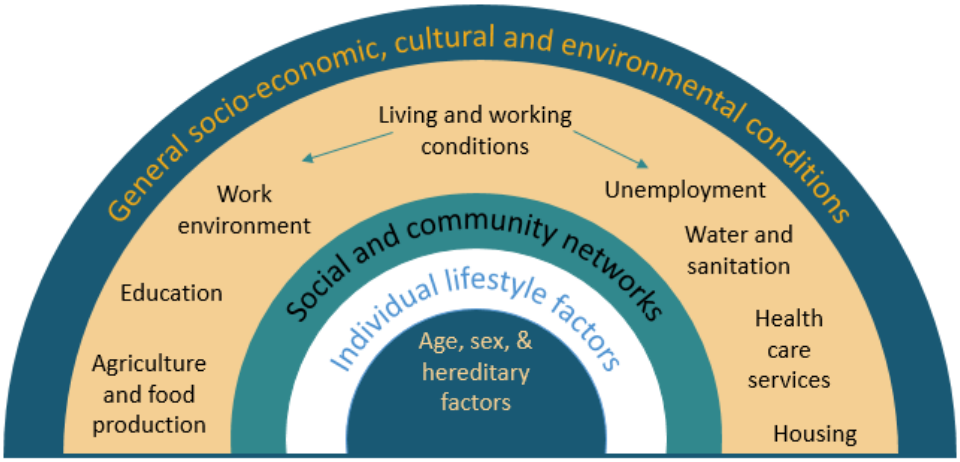
METHODS

The following section details how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

Social Determinants of Health Framework
While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health.

Upstream Approaches to Health
Having a healthy population is about more than delivering quality healthcare to residents. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing stock, and economic policies. Figure 2 provides a visual representation of these relationships, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors, such as employment status and educational opportunities.

Figure 2. Social Determinants of Health Framework



SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. Mass General Brigham seeks to understand the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths, and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens
The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory

policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S.

In the present report, health patterns for the Westwood CHNA service area are described overall, as well as areas of need for particular population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by a regional Community Advisory Board (CAB). Mass General Brigham hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant partner to facilitate the CHNA process, collect and analyze data, and develop the CHNA report.

Community Engagement

Community engagement is described further below under the primary data collection methods. It should be noted that, due to the COVID-19 pandemic, the community engagement for this CHNA occurred virtually. Additionally, while the CHNA aimed to engage a cross-section of individuals, and to be inclusive of traditionally under-represented communities, due to the pandemic and competing priorities, community-based organizations had limited time to assist with outreach and community members had constraints on their own time for participation. Nevertheless, by engaging the community through multiple methods and in multiple languages, this CHNA aims to describe community strengths and needs during this unique time.

Community Advisory Board (CAB) Engagement

A CAB provided oversight, input, and support throughout the CHNA process. The CAB was regional in focus and oversaw the work for this CHNA, as well as two other co-occurring CHNAs (in the Woburn service area and Westborough service area). CAB members included representation from both regional groups and residents of the primary service area. The fifteen CAB members represent municipalities; the education, housing, social service, planning and transportation sectors; the private sector; community health centers; and community-based organizations. See Appendix A for a full list of CAB members.

The CAB was engaged throughout the CHNA process. This engagement included meeting three times (in March to provide input on the CHNA methods and timeline; in June to be apprised on the CHNA process and to discuss virtual engagement, survey dissemination, and community outreach; and in September to finalize priorities) and providing regular input through email correspondence and telephonic discussions. CAB input included advising on key informant interviewees and focus group segments, identifying local data sources and communication outlets for the CHNA community survey, and providing connections to community organizations to support data collection and outreach efforts. Additionally, members of the CAB participated in the community prioritization meetings.

Secondary Data: Review of Existing Secondary Data

Secondary data are data that have already been collected for another purpose. Examining secondary data helps us to understand trends, provide a baseline, and identify differences by sub-groups. It also helps in guiding where primary data collection can dive deeper or fill in gaps.

Secondary data, including information and statistics, for this CHNA were drawn from a variety of sources, including the U.S. Census American Community Survey (ACS), the U.S. Department of Labor

Bureau of Labor Statistics, the Federal Bureau of Investigation Uniform Crime Reports, the MA Department of Elementary and Secondary Education, the MA Center for Health Information and Analysis (CHIA) database, and a number of other agencies and organizations. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns or with MA overall, these are lay comparisons and *not* statistically significant differences.

It should also be noted that for most social and economic indicators, the U.S. Census American Community Survey (ACS) 5-year (2014-2018) aggregate datasets were used over the one-year datasets, since many of the towns in the service area are smaller in population size. Since the ACS uses a probability sampling technique, using the five-year aggregate dataset over the one-year data provides a larger sample size and more precision in its estimates.

Additionally, because the Westwood service area includes two specific neighborhoods in Boston—West Roxbury and Hyde Park—data sources may differ for these geographies than the towns in the rest of the service area. In some instances, neighborhood-specific data are not available and data for Boston overall are provided using the same data source as the other towns. In other instances, neighborhood-specific data are available from the same data sources. In a few instances, neighborhood-level data are available, but from different data sources for these neighborhoods. In these instances, the neighborhoods are listed at the end of the graph and differentiated with gray bars to note the data source difference since results cannot be directly compared.

Primary Data Collection

Primary data are new data collected specifically for the purpose of the CHNA. Goals of the CHNA primary data were: 1) to determine perceptions of the strengths and needs of these communities, and identify sub-populations most affected; 2) to explore how these issues can be addressed in the future; and 3) to identify the gaps, challenges, and opportunities for addressing community needs more effectively. Primary data were collected using three different methods for this CHNA: key informant interviews, focus groups, and a community priorities survey.

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews

A total of 10 key informant interviews were completed with 12 individuals by phone. Interviews were 45-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders and front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Interviewees were asked to share their perceptions of needs both prior to and following the start of the COVID-19 pandemic. Sectors represented in these interviews included: local non-profits, including those serving youth and seniors; local health departments; and town administrators and services. See Appendix B for the list of key informant interviewees and Appendix C for the key informant facilitator guide.

Focus Groups

The proposed focus group methodology for this CHNA changed during the pandemic. Rather than conducting traditional in-person focus groups of approximately eight participants each, more focus groups were conducted than originally planned, but with fewer participants in each discussion and virtually. Due to the COVID-19 pandemic, focus groups were conducted via a video conference platform

or by telephone, to accommodate participants who did not have reliable internet access and/or were not familiar with video conferencing technology. Focus groups were intentionally limited in number to help facilitate conversation and full participation in a virtual environment, especially since the moderator could not pick up on non-verbal cues as easily.

A total of 27 community residents participated in eight virtual focus groups (telephone or video) conducted with specific populations of interest: seniors (ages 60+), parents of school-age children, residents seeking essential services (e.g., food assistance, housing assistance, etc.), and Spanish-speaking residents (with group discussion in Spanish). Focus groups were 60-minute semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Focus group participants were asked to share their perceptions of needs both prior to and following the start of the COVID-19 pandemic. Please see APPENDIX D: FOCUS GROUP GUIDE for the focus group facilitator's guide.

Throughout this report, service area residents and key stakeholders who participated in key informant interviews and focus groups are referred to as study 'participants.'

Analyses

The collected qualitative information was coded and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews, as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term "participants" is used to refer to key informant interview and focus group participants. Unique issues that emerged among a group of participants are specified as such. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While differences between towns and neighborhoods are noted where appropriate, analyses emphasized findings common across the Westwood service area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

Community Priorities Survey

A community priorities survey was developed and administered over six weeks from early July through mid-August 2020. The survey focused on identifying issues that had a direct impact on survey respondents, perceptions of community strengths, and important issues for community action. Given the unprecedented time, survey respondents were asked to identify current issues and concerns, as well as issues and concerns that were present around the holiday season (approximately six months ago), prior to the start of the COVID-19 pandemic in the United States. The survey was administered online in four languages (English, Spanish, Portuguese, and Chinese). Please see Appendix E for the English-language version of the survey.

Extensive outreach was conducted with assistance from CAB members and organizations and through social media to obtain survey responses. The survey was disseminated via email to known distribution lists of residents, as well as to individuals who had attended earlier community engagement sessions for this process. Two paid Facebook ads were displayed in targeted geographic locations within the service area in all 4 languages to promote the survey. Additionally, several postings were run via Twitter, LinkedIn, and Facebook. Email dissemination requests were also sent to over 50 different community-based organizations, which included local food pantries, immigrant service agencies, community centers, libraries, local news outlets, and other groups.

The final sample of the Westwood Community Priorities Survey comprised 481 respondents who were residents of the Westwood service area. Appendix F provides a table with the demographic composition of survey respondents. Overall, the majority of respondents were 50-64 years of age (40.9%), white (71.9%), female (79.1%), and primarily spoke English at home (85.2%). Throughout this report, service area residents who participated in Community Priorities Survey are referred to as survey 'respondents.'

Analyses

Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied by question. Additionally, denominators excluded respondents who selected "prefer not to answer/don't know." For questions that allowed for multiple responses (i.e., questions that asked respondents to check all that apply), the denominator was out of the total number of respondents who selected at least one response option for the question. Stratified analyses were conducted for select questions by specific sub-groups that had large enough sample sizes (at least 30 respondents).

Data Limitations

As with all data collection efforts, there are several limitations that should be acknowledged. A number of secondary data sources were drawn upon in creating this report and each has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

With many organizations and residents focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. While extensive outreach was conducted, the overall response was not as large as expected based on previous assessment studies. Additionally, with its online administration method, the community survey used a convenience sample. Because Since a convenience sample is a type of non-probability sampling, there is potential selection bias in who participated or was asked to participate in the survey. Due to this potential bias, results cannot necessarily be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, focus groups and interviews also were conducted virtually, and therefore, while both video conference and telephonic options were offered, some residents who lack reliable access to internet and/or cell phones may have experienced difficulty participating. Lastly, for primary data collection, it should be noted that while efforts were made to engage residents through qualitative and survey data collection, given the context of the pandemic, the capacity of community organizations to assist with outreach and the capacity of community members to participate was limited. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

POPULATION CHARACTERISTICS

Population Overview

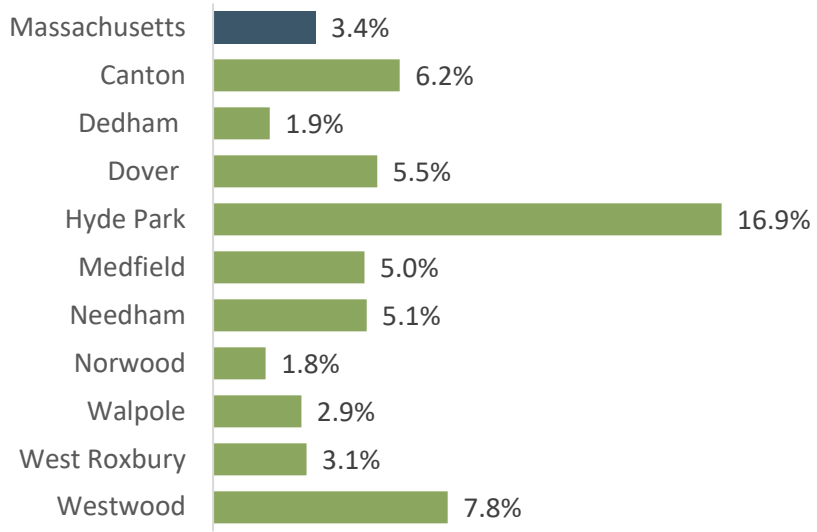
The Westwood service area is divided into towns of various sizes, as well as neighborhoods of the City of Boston. By population size, the largest towns in the service area are Needham, Norwood, and the Hyde Park and West Roxbury neighborhoods of Boston (Table 1). Like the Commonwealth overall, all towns in this region experienced population growth between 2009-2013 and 2014-2018. The largest population growth during this period occurred in Hyde Park (16.9%), Westwood (7.8%), and Canton (6.2%) (Figure 3).

Table 1. Total Population, in Massachusetts, by Town, and Boston Neighborhood, 2009-2013 and 2014-2018

	2009-2013	2014-2018
Massachusetts	6,605,058	6,830,193
Canton	21,781	23,134
Dedham	24,906	25,377
Dover	5,677	5,987
Hyde Park	29,271	34,223
Medfield	12,136	12,748
Needham	29,240	30,735
Norwood	28,698	29,201
Walpole	24,360	25,075
West Roxbury	27,628	28,487
Westwood	14,714	15,863

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

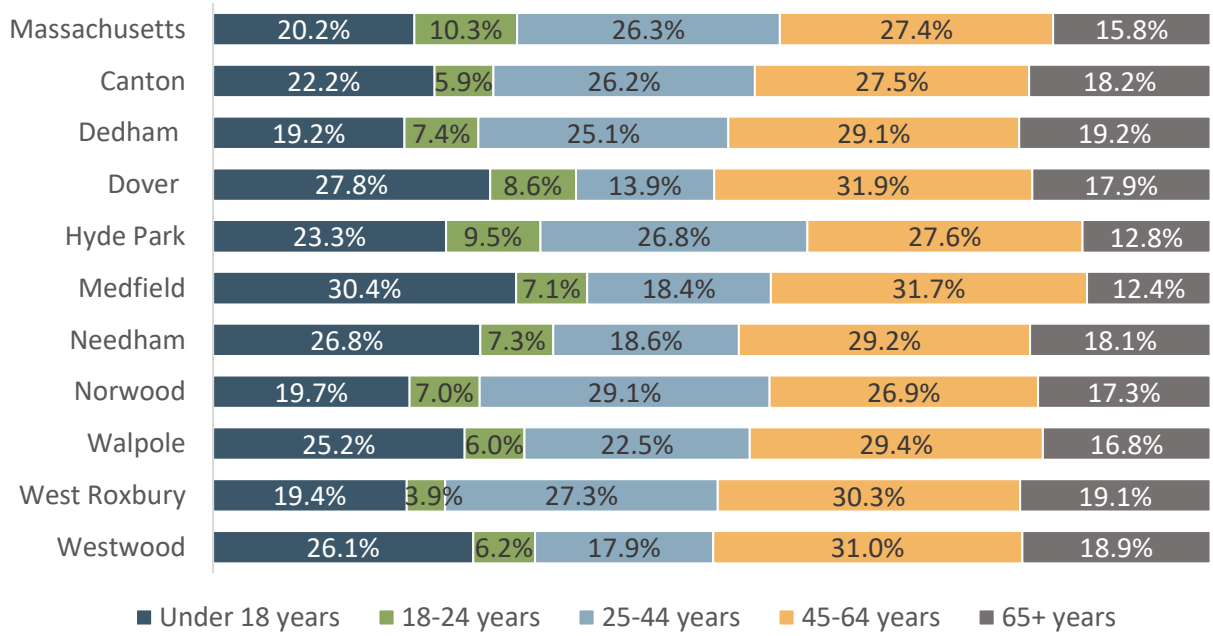
Figure 3. Percent Change in Population, in Massachusetts, by Town, and Boston Neighborhood, 2009-2013 and 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

For Massachusetts as a whole in 2014-2018, about 20% of the population was under 18 years-old, about 10% was between 18-24, just over a quarter were 25-44 years and 45-64 years-old, respectively, and over 15% was 65 or older (Figure 4). Towns in the Westwood service area varied in the age-distribution of their population in 2014-2018. For example, in Medfield, over 30% of the population was under age 18, with a lower than average population of residents between 18 and 44 years. This age distribution, and similar ones in Dover, Needham, and Westwood, suggest these towns are largely populated by families with school-aged children. In contrast, Hyde Park has a larger population of 18-44-year-olds and fewer elderly, while Dedham and West Roxbury have larger proportions of residents over 65 years-old than average.

Figure 4. Age Distribution, in Massachusetts, by Town, and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Racial, Ethnic, and Language Diversity

Notable demographic differences are also apparent by race/ethnicity, foreign-born residents, and language in the Westwood service area. The Hyde Park neighborhood of Boston stands out with a much larger population of non-Hispanic Black and Hispanic/Latino residents than other towns in this area (Table 2). Dover (9.8%), Needham (8.6%) and Westwood (8.2%) have larger Asian populations than average, and very small proportions of non-Hispanic Black residents. Besides Hyde Park, Dedham (9.2%) and West Roxbury (7.5%) have the largest Hispanic/Latino populations in the area.

Table 2. Racial and Ethnic Distribution, in Massachusetts, by Town, and Boston Neighborhood, 2014-2018

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic	Other, Non-Hispanic
Massachusetts	6.4%	6.8%	11.6%	72.2%	3.0%
Canton	7.4%	6.6%	3.9%	79.7%	2.4%
Dedham	3.0%	7.6%	9.2%	77.5%	2.7%
Dover	9.8%	1.5%	3.8%	81.9%	2.9%
Hyde Park	1.8%	42.6%	27.1%	25.4%	3.9%
Medfield	4.8%	0.9%	2.1%	91.3%	0.9%
Needham	8.6%	3.1%	3.0%	82.9%	2.3%
Norwood	6.7%	6.0%	6.9%	78.6%	1.8%
Walpole	4.2%	2.7%	5.4%	85.3%	2.3%
West Roxbury	6.9%	6.7%	7.5%	76.8%	2.1%
Westwood	8.2%	0.7%	2.3%	86.0%	2.7%

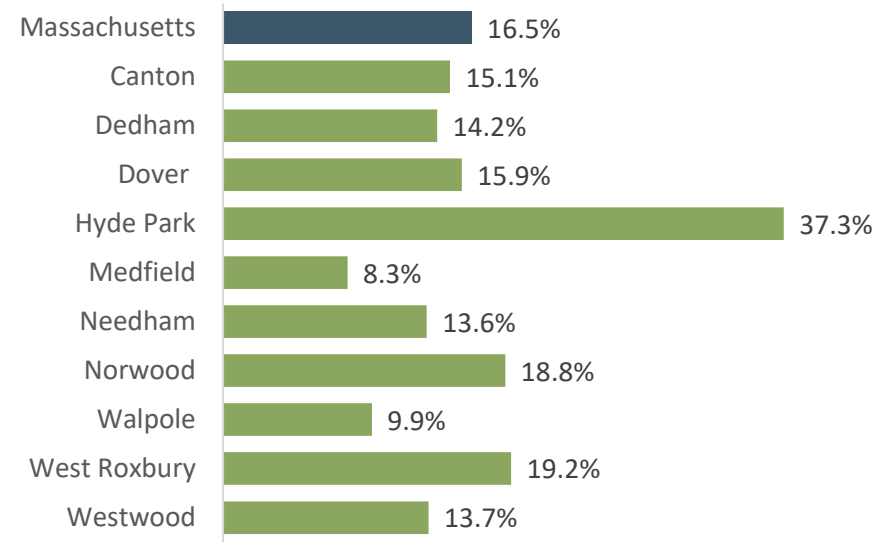
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race and racial categories. Other includes non-Hispanic/Latino residents who identify as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races.

In Massachusetts overall, 16.5% of the population was born outside of the United States in 2014-2018 (Figure 5). Of this population, the largest proportion was born in China at 9.7%, followed by the Dominican Republic (7.7%), India (6.2%), Brazil (6.1%) and Haiti (4.9%). The proportion of the population born outside the United States was only half in Medfield (8.3%) and over twice the state average in Hyde Park (37.3%).[7]

Areas with the highest proportions of the population born outside of the United States include Hyde Park (37.3%), West Roxbury (19.2%), Norwood (18.8%), Dover (15.9%), and Canton (15.1%). In Hyde Park, the largest proportion of the population born outside of the United States was born in Haiti (39.2%) *(data not shown).* In West Roxbury, Dover and Canton, the highest proportion of individuals born outside the United States were born in China (inclusive of Hong Kong and Taiwan) (19.2%, 14.2% and 13.3%, respectively). In Norwood, the highest proportion of the foreign-born population was born in India (20.0%). [8]

[7] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
[8] Ibid.

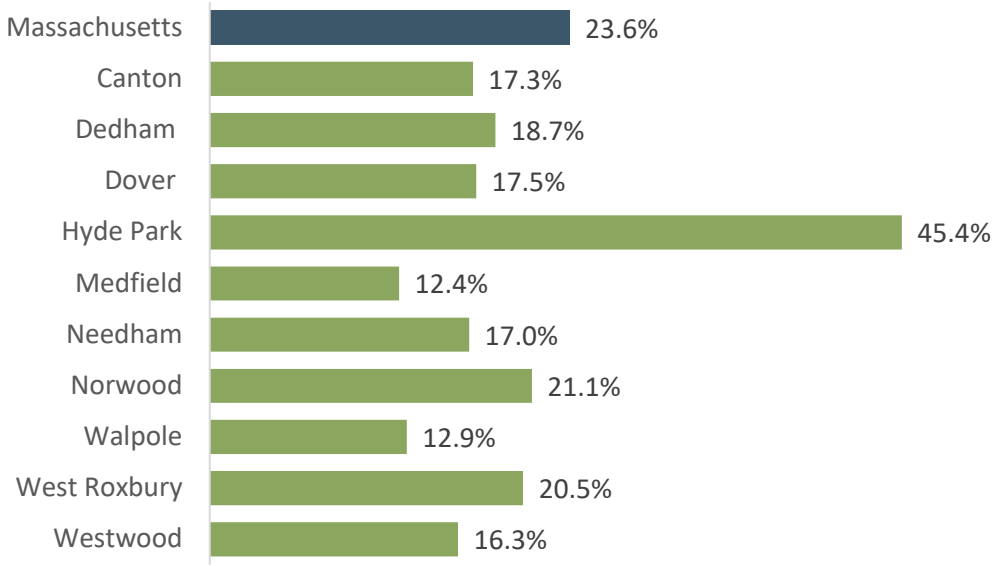
Figure 5. Percent Foreign Born Population, in Massachusetts, by Town, and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

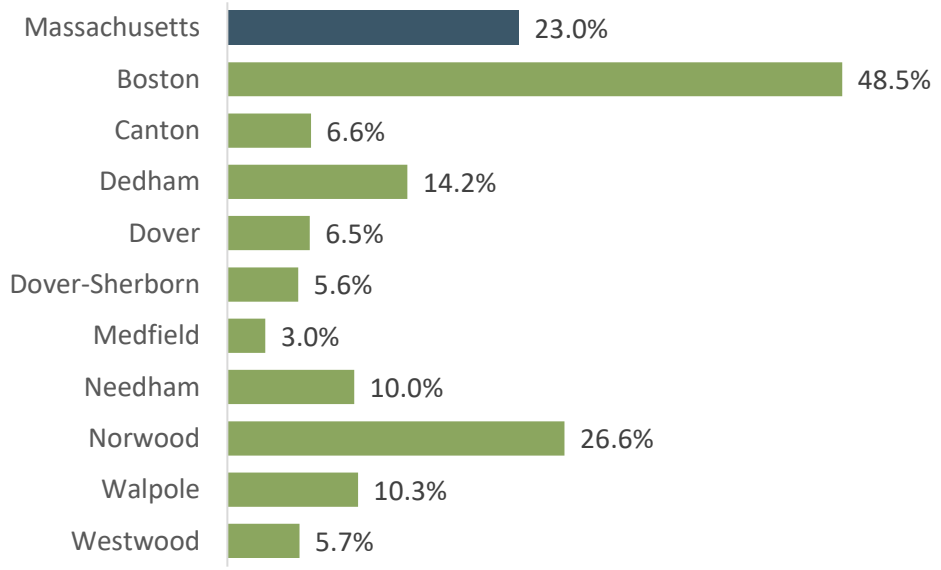
Among Massachusetts residents over age five, 23.6% reported speaking a language other than English at home in 2014-2018 (Figure 6). In Hyde Park, the number of residents that report speaking another language at home is almost twice that of the state, while under 13% do in Medfield and Walpole. The most commonly spoken languages among these residents were Spanish; the Census category of "Other Indo-European languages" (which likely is mainly comprised of Portuguese speakers); French or Haitian Creole; and Chinese. Among public school children in the region, 26.6% of those in Norwood and 14.2% of those in Dedham report that their first language is not English (Figure 7).

Figure 6. Percent Population 5 Years and Over Who Speak a Language Other Than English, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Figure 7. Percent Public School Students whose First Language is Not English, in Massachusetts and by School District, 2020



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Years represent school years (e.g., 2020 represents school year 2019-2020); First Language not English indicates the percent of enrollment whose first language is a language other than English.

COMMUNITY SOCIAL AND ECONOMIC ENVIRONMENT

Community Perceptions of Need

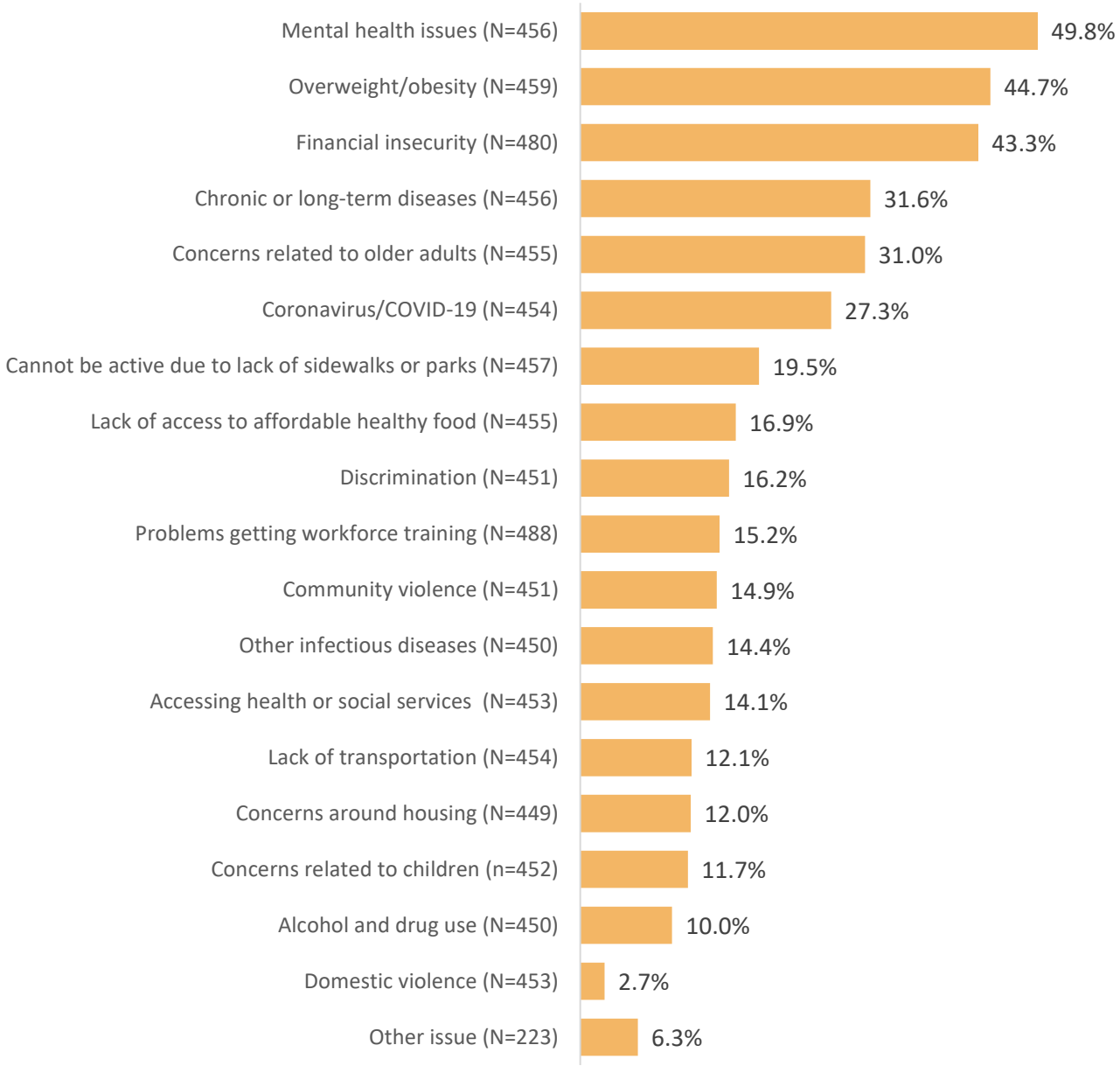
Understanding community residents' perception of priority issues is a critical step in the community health needs assessment process. This task provides insights into lived experiences, as well as facilitators and barriers to addressing concerns. The section below discusses the top issues identified by assessment participants from the Westwood Community Priorities Survey, interviews, and focus groups.

Top Issues Affecting the Community

> *"Our community is known to be fairly affluent, but there are small pockets of people that are struggling or people that have been affluent and now are struggling for whatever reason, we're definitely seeing that with the pandemic."* – Key informant interviewee

Westwood Community Priorities Survey respondents were asked about a series of issues or problems that currently and/or prior to the start of the novel coronavirus pandemic affected them or their families. The most common issues that respondents were affected by (either currently, 6 months ago, or at both timepoints) include mental health (49.8%), overweight/obesity (44.7%), and financial insecurity (43.3%) (Figure 8). Over one quarter of respondents reported their family was personally affected by the novel coronavirus/COVID-19 and 16.2% reported being affected by some form of discrimination.

Figure 8. Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Type of Issue, 2020



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

APPENDIX F: ADDITIONAL SURVEY DATA shows how the issues or problems affecting respondents or their families 6 months ago varied compared to what was affecting them currently. Respondents appeared to indicate that issues related to mental health, overweight/obesity, financial insecurity, concerns related to older adults, and COVID-19 were much more likely to affect them now, but not necessarily six months ago. These survey findings generally align with qualitative data collected during interviews and focus groups. As summarized in more detail below, many interview and focus group participants identified community needs related to mental health, financial insecurity, and the COVID-19

pandemic, and some participants also identified concerns related to discrimination and racism. Interview and focus group participants also noted that transportation and affordable housing are key issues for their communities, although only about 12% of Westwood Community Priorities Survey respondents prioritized these issues.

In the Westwood service area, there was variation among different demographic groups of Westwood Community Priorities Survey respondents around the issues that impacted them or their families over the past six months. Among non-Hispanic Black survey respondents, discrimination was the most common response (78.1%), and it was third most common among non-Black People of Color (48.7%) (Figure 9). It should be noted that racial/ethnic groups were categorized in these three groups due to small sample sizes among specific racial/ethnic groups (e.g. Latino respondents, Asian respondents).

Discrimination was not among the top five concerns that non-Hispanic Whites or their families had experienced in the past six months. Only non-Hispanic Whites reported that Coronavirus/COVID-19 was not one of the top five issues that had affected them or their families recently.

Figure 9. Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Selected Demographics, 2020

	White, Non-Hispanic (N=341)	Black, Non-Hispanic (N=33)	People of Color, Non-Black (N=42)
1	Mental health issues (49.1%)	Discrimination (78.1%)	Financial insecurity (61.9%)
2	Overweight/obesity (44.3%)	Financial insecurity (63.6%)	Mental health issues (60.0%)
3	Financial insecurity (38.7%)	Overweight/obesity (62.5%)	Discrimination (48.7%)
4	Concerns related to older adults (30.5%) (tied)	Mental health issues (54.8%)	Overweight/obesity (46.3%)
5	Chronic or long-term diseases (30.5%) (tied)	Coronavirus/COVID-19 (50.0%)	Coronavirus/COVID-19 (40.0%)

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Community Assets

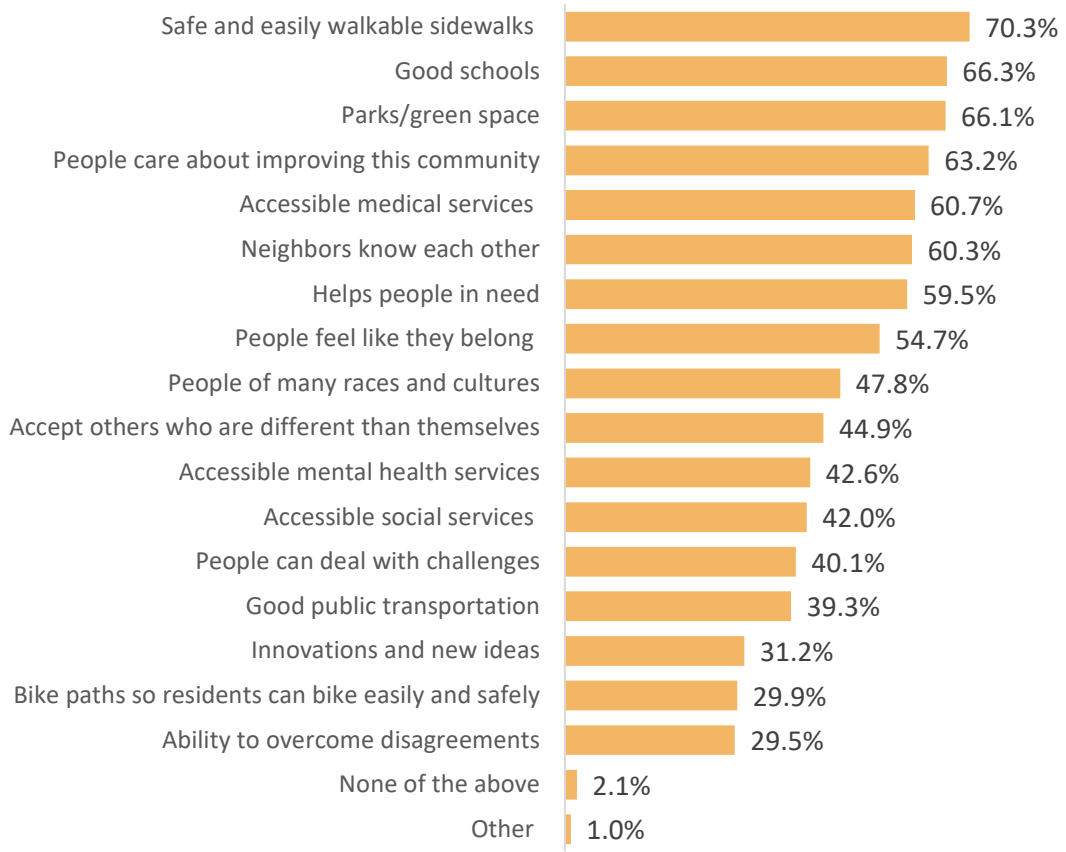
> *"Canton has a really good school system. They are not just doing well in academics; there's unity inside the schools too... The sense of community."* – Focus group participant
>
> "*Hyde Park has a huge community – we all come together when people are in need."* – Focus group participant

An understanding of community assets, including resources and services, can help identify strengths that may be leveraged or built upon to address community needs. Focus group and interview participants identified many strengths of the Westwood service area. Participants noted that many of the towns and neighborhoods in this area are *"family-oriented"* and provide excellent educational opportunities for students. Additionally, many participants described these communities as places

where "*the elderly are really cared for,"* and in particular noted strong local Councils on Aging that provide supports for seniors. Participants also described the Westwood service area as a safe and quiet area that feels like a "*small town,"* but is still close enough to commute into the City of Boston. Many residents also noted the diversity of their communities as a strength. For example, one participant described Norwood as a "*diverse town"* that is inclusive of immigrant populations, and another participant cited Norwood's diversity in regard to race and income. Lastly, many participants noted that residents take pride in their communities and care for and support each other; for example, one participant noted that in Hyde Park, "*we all come together when people are in need."* Participants also stated that the COVID-19 pandemic has highlighted this community cohesion and engagement. One interviewee elaborated on this sentiment by describing that: during the pandemic, the "*community stood up a food pantry in a matter of months… [which] speaks to the pride of the community; if [the food pantry runs] out of food they give a grocery store gift certificate to people in need, purely based on donations, no one walks away empty-handed."*

Respondents to the Westwood Community Priorities Survey also were asked about their perceptions of the strengths of their communities. The most common responses were safe/walkable sidewalks (70.3%), good schools (66.3%), parks/green space (66.1%), and people who care about improving the community (63.2%) (Figure 10). Only 2.1% of respondents reported none of the above.

Figure 10. Percent of CHNA Community Priorities Survey Respondents Reporting Strengths of Their Community, 2020 (N=481)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

The top five community strengths selected by community respondents varied by demographic group. Among most sub-groups, safe sidewalks, good schools, and parks/green space were among the top five community strengths (Figure 11). Non-Hispanic Whites included "people caring about improving their community" and "neighbors knowing each other" among the top five strengths. Non-Hispanic Blacks listed that there were "people of many races and colors" as one of the top five strengths, as well as accessibility of medical services.

Figure 11. Percent of CHNA Community Priorities Survey Respondents Reporting Strengths of Their Community, by Selected Demographics, 2020

	White, Non-Hispanic (N=341)	Black, Non-Hispanic (N=33)	People of Color, Non-Black (N=42)
1	Safe and easily walkable sidewalks (76.5%)	People of many races and cultures (75.8%)	Safe and easily walkable sidewalks (69.0%)
2	Good schools (74.5%)	Safe and easily walkable sidewalks (69.7%)	Parks/green space (59.5%)
3	Parks/green space (73.9%)	Good schools (63.6%)	Good schools (57.1%)
4	People care about improving this community (70.7%)	Accessible medical services (57.6%) (tied)	Accessible medical services (52.4%)
5	Neighbors know each other (69.8%)	Good public transportation (57.6%) (tied)	People care about improving this community (52.4%)
Tie		Parks/green space (57.6%) (tied)	

NOTE: Question in the survey allowed for up to five responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Income and Financial Security

> *"Our community has a reputation as being affluent but has pockets of hidden poverty; you find people through schools or the senior center."* – Key informant interviewee
>
> "*There were people right on the edge that have been pushed over due to the pandemic*." – Key informant interviewee

While the Westwood service area is largely affluent, some communities within the area face financial insecurity, especially in the context of the economic impact of the COVID-19 pandemic. Focus group and interview participants described the Westwood service area in general as an affluent area. However, participants noted that there are certain populations, particularly seniors and young families, that face financial insecurity even within these largely wealthy towns and neighborhoods. In particular, participants expressed concern for seniors, especially those on fixed incomes. As one focus group participant elaborated, "*Seniors – a lot of seniors – some are struggling financially. As are many of the families in town and I'm talking pre-COVID.*" Some participants who had experience accessing medical services also noted challenges navigating different types of assistance, which may have varied thresholds for qualification and misaligned incentives. For example, one focus group participant noted that "*we were told that we had to go through our 401k before getting help. It was like make yourself as*

poor as you can so we can get you through the next three days but then you will be poor again. There are so many programs that contradict other programs that you almost get punished for using them."

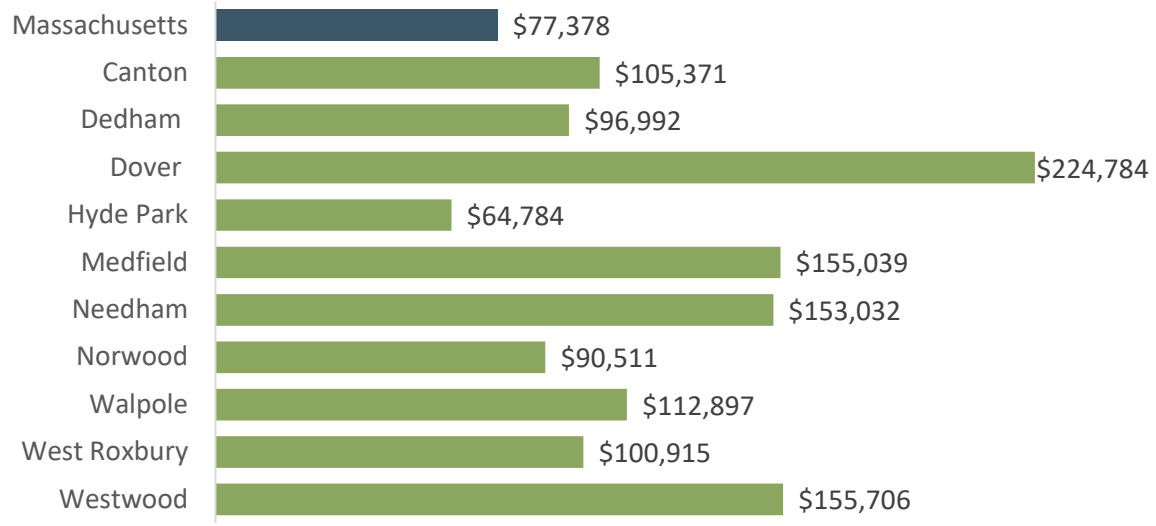
Participants were concerned about their income levels and financial security, given the impact of the pandemic to date, the cut in COVID-19 unemployment insurance relief benefits ($600/week), and the anticipated ongoing impact of the virus through at least the fall. As one focus group participant described, *"There's been pay cuts, financial difficulties that people have been facing. Financial and employment stresses are real."* As shown in Figure 12 below, a third (33.3%) of Westwood Community Priorities Survey respondents indicated that their financial situation has gotten worse since the onset of the COVID-19 pandemic.

Figure 12. Percent CHNA Survey Respondents Indicating Whether Their Financial Situation Has Gotten Worse, Has Improved, or Stayed the Same Due to Coronavirus/COVID-19 (N=418)

DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Within the Westwood service area, socioeconomic factors vary between towns. For example, the median annual household income in 2014-2018 ranged from $64,784 in Hyde Park to $224,784 just 10 miles away in Dover (Figure 13). Westwood, Medfield, and Needham also had median household incomes over $150,000. On average and as reflected in the qualitative data, this area is quite wealthy, relative to the Commonwealth as a whole.

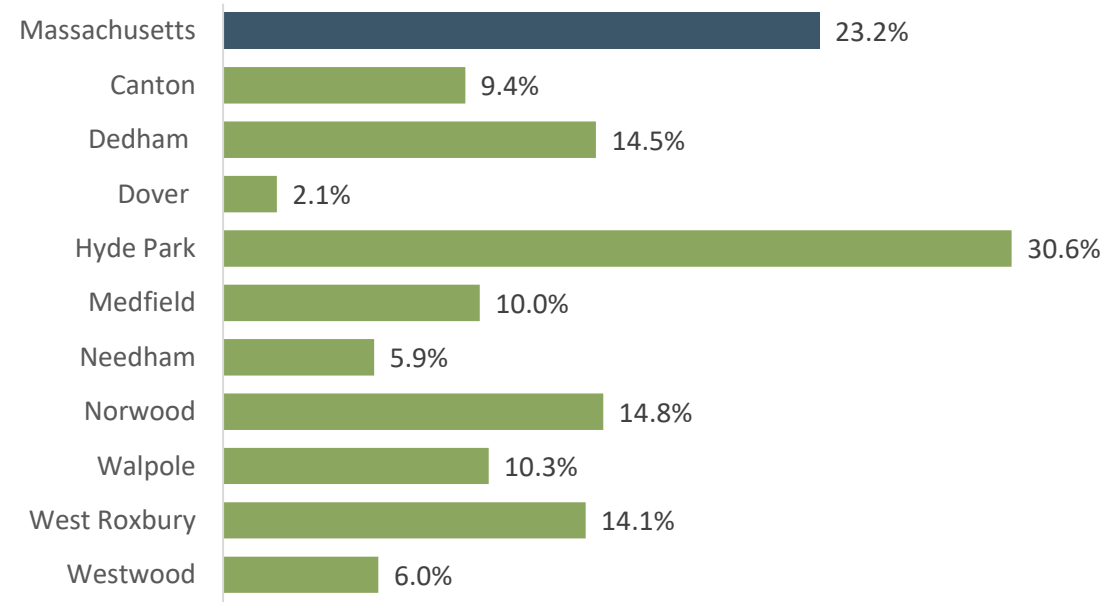
Figure 13. Median Household Income in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Nonetheless, as interview and focus group participants also described, many of the towns in this area still have residents experiencing poverty, with incomes at or below 200% of the Federal Poverty Level (FPL), Given the high cost of living in the Greater Boston Area and the low federal poverty line, individuals with household incomes at even 200% of the FPL are at the extreme end of financial insecurity. The federal poverty line changes by household size, so in 2020, 200% FPL was the equivalent of an annual household income of $25,520 for an individual and $52,400 for a family of four. Again, Hyde Park had the largest number of residents in poverty (30.6%). But Norwood (14.8%), Dedham (14.5%), and West Roxbury (14.1%) also had substantial populations (Figure 14).

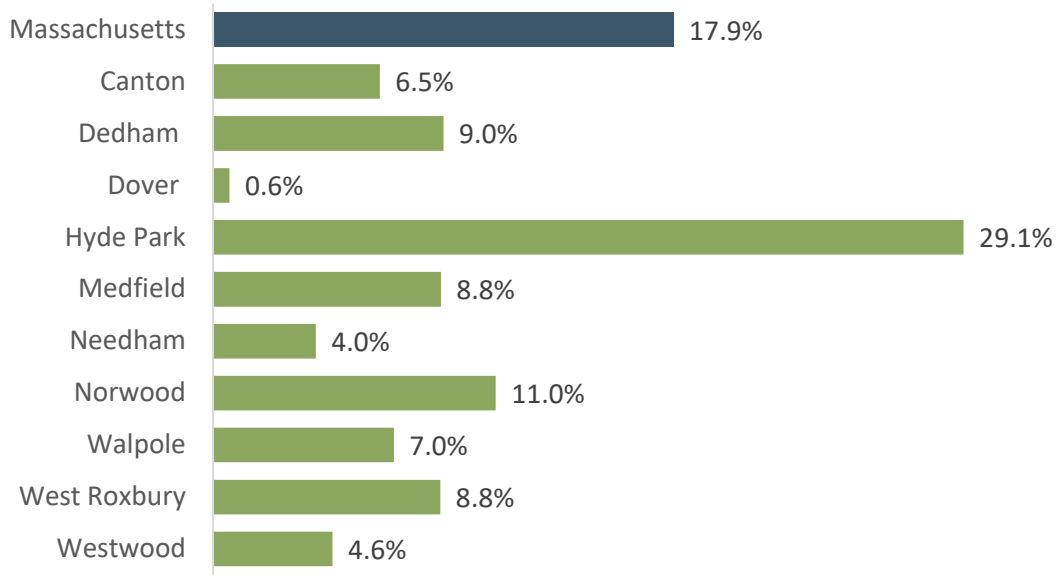
Figure 14. Percent Population Living Below 200% of Poverty Level, in Massachusetts, by Town, and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Figure 15 illustrates that much of this poverty affects children and families, not just single individuals. An almost equal number of families in Hyde Park (29.1%) were experiencing poverty in 2014-2018 when compared to the number of individual residents in poverty (30.6%; Figure 14). In other towns, the prevalence of poverty was lower among families, but still substantial in Norwood, Dedham, Medfield, and West Roxbury.

Figure 15. Percent Families Living Below 200% of Poverty Level, in Massachusetts, by Town, and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Focusing on the poorest residents living in poverty – those with incomes at or below 100% of the FPL – patterns vary substantially by race/ethnicity. For example, over 20% of Hispanic/Latino residents of Hyde Park and Norwood are experiencing extreme poverty, compared to only 5.2% of Hispanics/Latinos in Westwood and 4.3% in Dedham (Table 3). Likewise, 26.6% of Black residents in Norwood and 36.4% of those in Medfield had incomes below the FPL in 2014-2018, but only 11.5% of Black residents in Dedham.

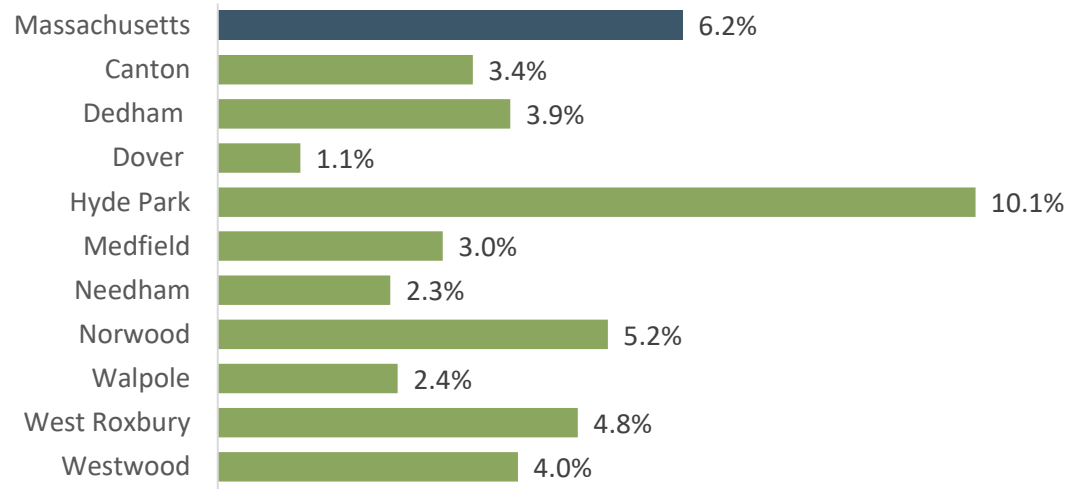
Table 3: Percent Population Living Below Poverty Level (100% FPL), by Race/Ethnicity, in Massachusetts, by Town and Boston Neighborhood, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	13.8%	19.7%	22.8%	7.1%	26.6%
Boston	29.9%	23.6%	30.8%	11.7%	31.3%
Canton	0.1%	13.6%	14.6%	4.4%	9.2%
Dedham	4.1%	11.5%	1.3%	4.2%	4.3%
Dover	0.0%	0.0%	0.0%	0.9%	6.1%
Hyde Park	18.1%	14.2%	25.9%	6.7%	23.8%
Medfield	1.8%	36.4%	0.0%	3.1%	0.0%
Needham	6.8%	14.1%	1.8%	1.8%	0.7%
Norwood	0.4%	26.6%	15.0%	6.7%	22.4%
Walpole	0.0%	14.4%	8.0%	4.2%	1.2%
West Roxbury	0.7%	3.3%	10.2%	6.4%	9.1%
Westwood	3.3%	16.5%	3.8%	2.2%	5.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

Supplemental Security Income (SSI) is provided to adults and children with disabilities and limited income and resources, as well as to people over 65 years-old with limited wealth and resources. Figure 16 shows that one in 10 households in Hyde Park receive SSI, compared to only 2.4% in Walpole, 2.3% in Needham, and 1.1% in Dover. These differences reflect both the differing age and wealth distributions of residents in the service area towns.

Figure 16. Percent Households Receiving Supplemental Security Income in Past 12 months, in Massachusetts, by Town and Boston Neighborhood, 2014-2018

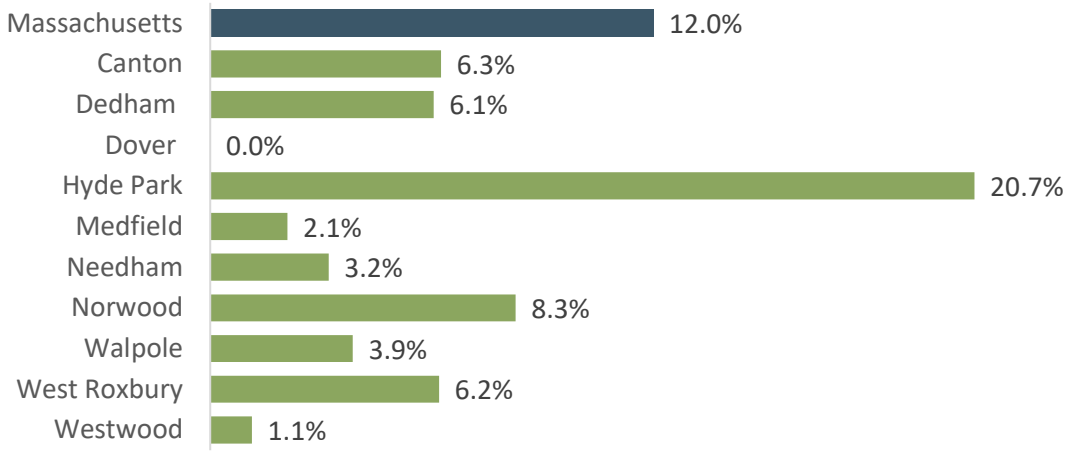


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

In particular, many interview and focus group participants expressed concern about food insecurity in the Westwood service area. Interview participants who run food pantries and home-delivered meal programs described a notable increase in use of their services during the pandemic. As one interviewee remarked when describing the increase in food insecurity due to COVID-19: "*There were people right on the edge that have been pushed over due to the pandemic*." Again, participants highlighted seniors, as well as families, who may have been relying on schools for their children's meals, as particularly vulnerable groups.

In Massachusetts overall, 12.0% of households received food stamps or Supplemental Nutrition Assistance Program (SNAP) benefits in 2014-2018 (Figure 17). This ranged from 0.0% of Dover households and 1.1% of Westwood households to 20.7% of households in the Hyde Park neighborhood of Boston.

Figure 17. Percent Households Receiving Food Stamps/SNAP Benefits, in Massachusetts, by Town and Boston Neighborhoods, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Within towns, the proportion of households receiving SNAP benefits also varied by race/ethnicity. In Massachusetts as a whole, 36.3% of Hispanic/Latino households receive food stamps, compared to only 7.9% of non-Hispanic White households, with Asian, Black, and Other race households falling in between (Table 4). Patterns of SNAP benefits by racial/ethnic group were inconsistent across area towns, likely due to the large variation in baseline racial/ethnic demographics of these towns, as previously described. For example, in Dedham, over one-quarter of Asian households received food stamps, compared to only 0.9% in Canton and 0.0% in Norwood. Not only does this highlight the persistent racial segregation in housing in this area, but also the diversity of socioeconomic statuses within such broadly defined racial groups as "Asian."

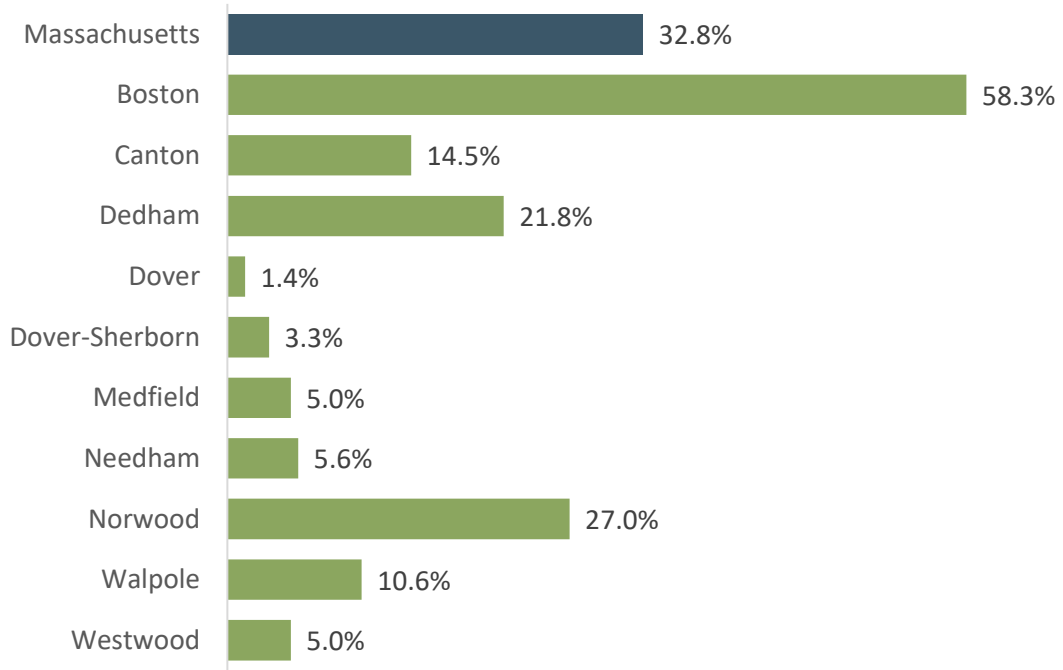
Table 4. Percent Households Receiving Food Stamps/SNAP Benefits, by Race/Ethnicity, in Massachusetts, by Town and Boston Neighborhoods, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	11.5%	27.3%	32.2%	7.9%	36.3%
Canton	0.9%	18.9%	8.4%	5.8%	0.0%
Dedham	0.0%	8.5%	6.5%	5.8%	7.5%
Dover	0.0%	0.0%	0.0%	0.0%	0.0%
Hyde Park	26.4%	20.4%	37.6%	9.1%	36.7%
Medfield	0.0%	29.4%	0.0%	2.0%	0.0%
Needham	2.1%	17.8%	0.0%	2.9%	0.0%
Norwood	0.0%	22.7%	13.0%	7.6%	25.4%
Walpole	5.3%	26.2%	0.0%	3.4%	3.7%
West Roxbury	2.6%	1.3%	20.8%	6.5%	9.7%
Westwood	0.0%	0.0%	0.0%	1.3%	0.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

According to the Massachusetts Department of Elementary and Secondary Education, 32.8% of public school students in Massachusetts were economically disadvantaged during the 2019-2020 school year (Figure 18; see citation for definition). In the Westwood service area, town disparities are again apparent. Students in Norwood (27.0%) and Dedham (21.8%) were more likely to be economically disadvantaged than their counterparts in Dover (1.4%), Dover-Sherborn (3.3%), Medfield (5.0%) and Westwood (5.0%). Nearly six in ten Boston Public School students (which includes all students, not just those in Hyde Park and West Roxbury since student data are not available by neighborhood) are considered economically disadvantaged.

Figure 18. Percent Public School Students Economically Disadvantaged, in Massachusetts and by School District, 2020



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Years represent school years (e.g., 2020 represents school year 2019-2020); Economically disadvantaged is determined based on a student's participation in one or more of the following state-administered programs: the Supplemental Nutrition Assistance Program (SNAP), the Transitional Assistance for Families with Dependent Children (TAFDC), the Department of Children and Families' (DCF) foster care program, and MassHealth (Medicaid).

Employment and Workforce

> *"The essential workers are getting paid so much less than people who work from home… It's like our lives are less important, but they give us this term 'essential'?"* – Focus group participant

> "*So many people that I know don't have a job anymore. They had to look for other jobs but there are none, especially if you don't speak English fluently."* – Focus group participant

While unemployment rates in the Westwood service area have historically been low, employment status has been impacted by the COVID-19 pandemic, as reflected in both the qualitative and quantitative

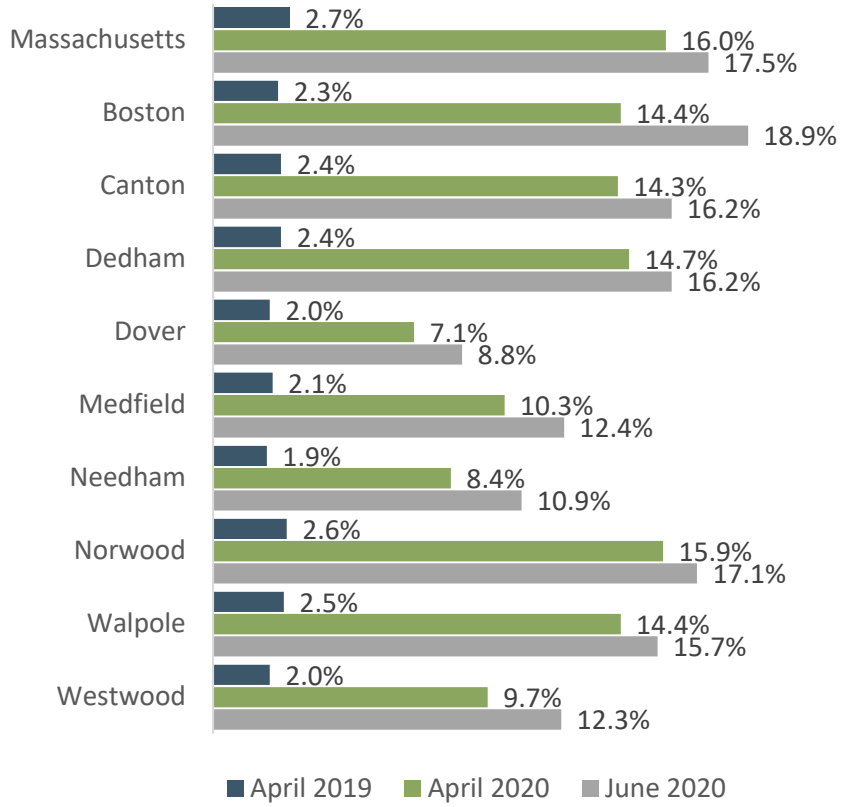
data. Many focus group and interview participants shared their perspectives on how COVID-19 has impacted employment in the Westwood service area. Participants noted that some community members have experienced job loss and others had their employment hours reduced, both of which impact financial security. As one focus group participant described, "*In my job, they cut my hours to half and that really affected me financially. No one is prepared to lose half of their wages overnight."*

Some focus group participants suggested that virtual trainings or skill-building sessions be developed for community members who have lost jobs and may even need to consider a career change. Participants also expressed concern for essential workers, naming cashiers and restaurant workers in particular, and noted that these essential workers are often paid low wages even while they are risking their lives. For example, one focus group participant stated: "*The essential workers are getting paid so much less than people who work from home… It's like our lives are less important but they give us this term 'essential'?"*

Participants also shared the perspective that certain populations, including young people, Spanish speakers, and parents in need of childcare, may be particularly vulnerable to job loss. One focus group participant described the importance of youth employment to the financial security of a household as follows: *"Lots of teenagers help their families with finances and if they don't have that help, they can sink quickly."* Participants also noted that finding employment can be particularly challenging for community members who do not speak English fluently. For example, one focus group participant stated that: "*So many people that I know don't have a job anymore. They had to look for other jobs but there are none, especially if you don't speak English fluently."* Lastly, many participants noted that when schools and daycares are closed, parents are unable to return to work in-person and also face challenges working remotely. Some participants stated that colleagues or community members have left the workforce due to a lack of childcare during the pandemic. One focus group participant described the situation as follows: "*The majority of Latinos can't work from home, and who is supposed to take care of their children? They can't decide if it's better to have school from home because they need to work."*

The impact of the coronavirus pandemic and resulting economic shutdown in many sectors are reflected in unemployment data from towns in the area around Westwood, between April 2019 and April 2020. Unemployment rates continued to increase from April 2020 to June 2020. In 2019, Massachusetts as a whole, and each city or town in the service area had unemployment rates under 3%, and in one case (Needham), under 2% (Figure 19). However, during the pandemic, unemployment rates increased significantly to 16.0% statewide in April, with similar (e.g. Norwood, 15.9%) or lower (e.g. Needham, 8.4%) rates in the Westwood service area. As with other measures, Dover, Needham, and Westwood appear to be faring better than other towns during this economic crisis.

Figure 19. Percent Population 16 Years and Over Unemployed, in Massachusetts and by Town, 2019-2020



DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.
NOTE: Data are not seasonally adjusted; June 2020 data are preliminary and subject to revision.

Education

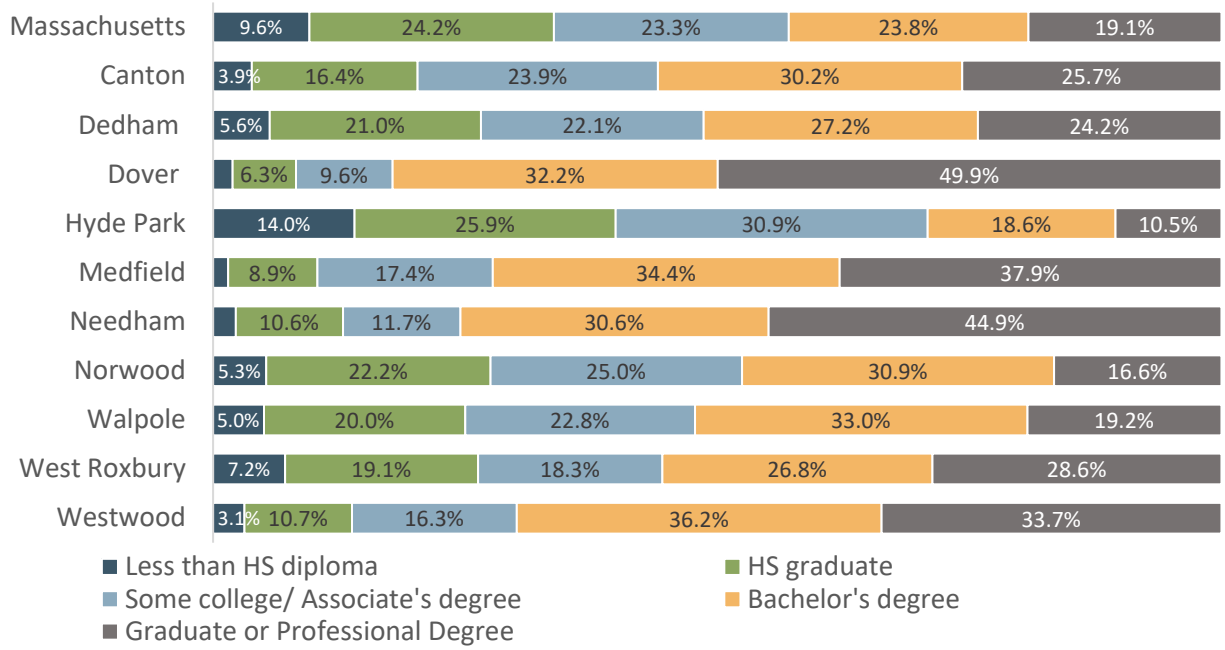
> *"School district definitely – that's why we moved here."* – Focus group participant
>
> *"[I'm] worried about the learning aspect for next school year – from a developmental and social aspect of it."* – Focus group participant

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. As described above, many focus group and interview participants viewed the school systems as strong assets in the Westwood service area. Some participants cited the area's school systems, and the opportunities they offer for students, as a reason that they moved to or remained in these communities. In addition to strong academics, some participants also noted that the school systems foster a sense of community and, in the words of one participant, "*really focus on a student as a whole person… [and want] to develop social and emotional skills."* However, some participants pointed to a lack of diversity within these communities and within the school system, and one participant noted that some families come to these communities *"for the schooling and then they leave."*

Concerns about education in the context of the COVID-19 pandemic were raised by many participants. Many participants noted the challenges for both parents and students alike coping with the uncertainty of what the school systems will look like for the 2020-2021 school year. Participants expressed concerns about the challenges of social distancing if students return to in-person education, with one noting that "*They aren't going to be wearing masks how they should".* However, participants also expressed concerns about the challenges of virtual learning and social and emotional development if students participate in online learning, with one parent noting that *"[I'm] worried about the learning aspect for next school year – from a developmental and social aspect of it.*" Participants in particular expressed concern for students who may have underlying health conditions and for students who have special needs, such as autism.

Echoing perceptions of area school systems in the Westwood service area, Massachusetts stands out as a state with an exceptionally high proportion of residents with college, graduate, and professional degrees (42.9%; Figure 20). In the Westwood service area, Dover (49.9%), Needham (44.9%), and Medfield (37.9%) had the largest proportions of residents with a graduate or professional degree in 2014-2018. In contrast, Hyde Park (25.9%), Norwood (22.2%), Dedham (21.0%), and Walpole (20.0%), had the highest proportions of residents with no more than a High School diploma among those 25 years and older.

Figure 20. Educational Attainment for Population 25 Years and Over, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Table 5 illustrates additional patterns in educational attainment across towns, by race/ethnicity. For some towns, interpretation is limited given the small number of residents by race in certain educational brackets. Other findings reveal considerable variations among different demographic groups, for example 7.4% of non-Hispanic White residents of Hyde Park over age 25 did not have a High School diploma in 2014-2018, compared with only 1.4% in Dover and 1.2% in Medfield. In Norwood, only 3.7% of Asian residents did not graduate High School, compared to 23.7% in Hyde Park. In Walpole and West Roxbury, about 30% of Hispanics/Latinos did not graduate High School, compared to only 5.2% in Canton. Again, these data illustrate the striking socioeconomic variation within broad categorizations of race/ethnicity in this region.

Table 5: Percent Population 25 Years and Over with Less than High School Diploma, in Massachusetts, by Town and Boston Neighborhood, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	14.9%	14.8%	27.4%	6.2%	30.0%
Canton	6.7%	8.1%	7.2%	3.3%	5.2%
Dedham	0.5%	5.8%	8.5%	4.9%	15.2%
Dover	7.1%	0.0%	0.0%	1.4%	0.0%
Hyde Park	23.7%	15.2%	21.5%	7.4%	20.3%
Medfield	6.1%	0.0%	0.0%	1.2%	4.2%
Needham	6.0%	1.1%	4.6%	1.9%	1.0%
Norwood	3.7%	10.6%	6.7%	4.5%	12.9%
Walpole	10.0%	3.2%	32.4%	3.6%	28.3%
West Roxbury	6.2%	7.5%	21.3%	5.6%	30.8%
Westwood	5.8%	0.0%	11.9%	2.6%	15.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

In contrast, Table 6 shows the percent population over age 25 with a bachelor's degree or higher by race/ethnicity in the Westwood service area in 2014-2018. Wide variation is again apparent, with over 90% of Asians in Dover and over 80% of Asians in Norwood and Walpole having a bachelor's degree or higher, compared to only 39.9% of those in Hyde Park and 65.9% of those in West Roxbury. In Dover 81.6% and in Needham 76.5% of non-Hispanic Whites have a bachelor's degree or higher, compared to 45.7% of Whites in Norwood and 52.2% of Whites in Walpole. In Medfield and Walpole, less than 20% of Black residents have a bachelor's degree or higher, compared to 47.3% in Needham and 56.2% in Canton.

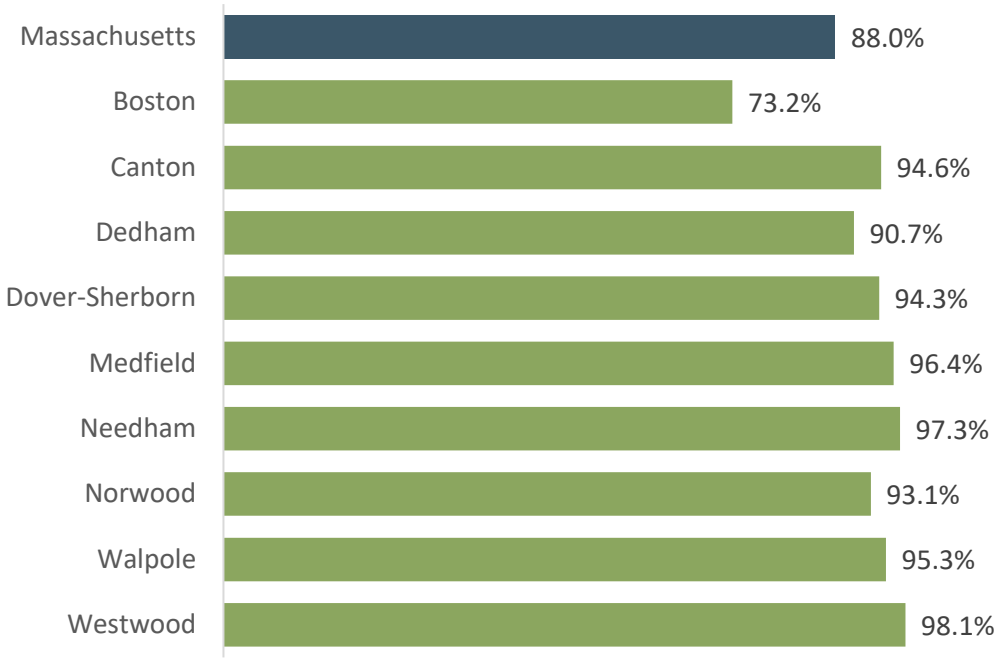
Table 6: Percent Population 25 Years and Over with Bachelor's Degree or Higher, in Massachusetts, by Town and Boston Neighborhood, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic /Latino
Massachusetts	60.2%	25.6%	20.8%	46.0%	18.8%
Canton	79.6%	56.2%	42.6%	54.2%	35.8%
Dedham	71.8%	32.9%	36.3%	54.3%	31.6%
Dover	90.3%	100.0%	100.0%	81.6%	68.4%
Hyde Park	39.9%	26.2%	19.9%	39.5%	19.2%
Medfield	74.9%	17.6%	100.0%	72.2%	77.6%
Needham	75.2%	47.3%	57.3%	76.5%	63.0%
Norwood	80.2%	36.8%	45.8%	45.7%	42.3%
Walpole	80.5%	18.5%	41.4%	52.2%	37.5%
West Roxbury	65.9%	37.4%	49.7%	57.2%	33.2%
Westwood	72.8%	100.0%	53.8%	69.8%	47.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

Among current public high school students in 2019, graduation rates were high across the region, ranging from 90.7% in Dedham to 98.1% in Westwood (Figure 21). Graduation rates were lower for Boston Public School students overall (73.2%) which is not specific to the two Boston neighborhoods in this service area (*neighborhood data unavailable*).

Figure 21. Graduation Rate among Public High School Students, in Massachusetts and by School District, 2019



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Cohort 2019 Graduation Rates, 2019.

Housing

> *"You can afford to live here, but only if two parents are working... Single parents couldn't afford to live here."* – Focus group participant
>
> *"There's very limited affordable housing for seniors. You have to be low income or super high income, that middle part is a problem."* – Key informant interview participant
>
> *"I'm sure that a lot of people are on the verge of homelessness."* – Focus group participant

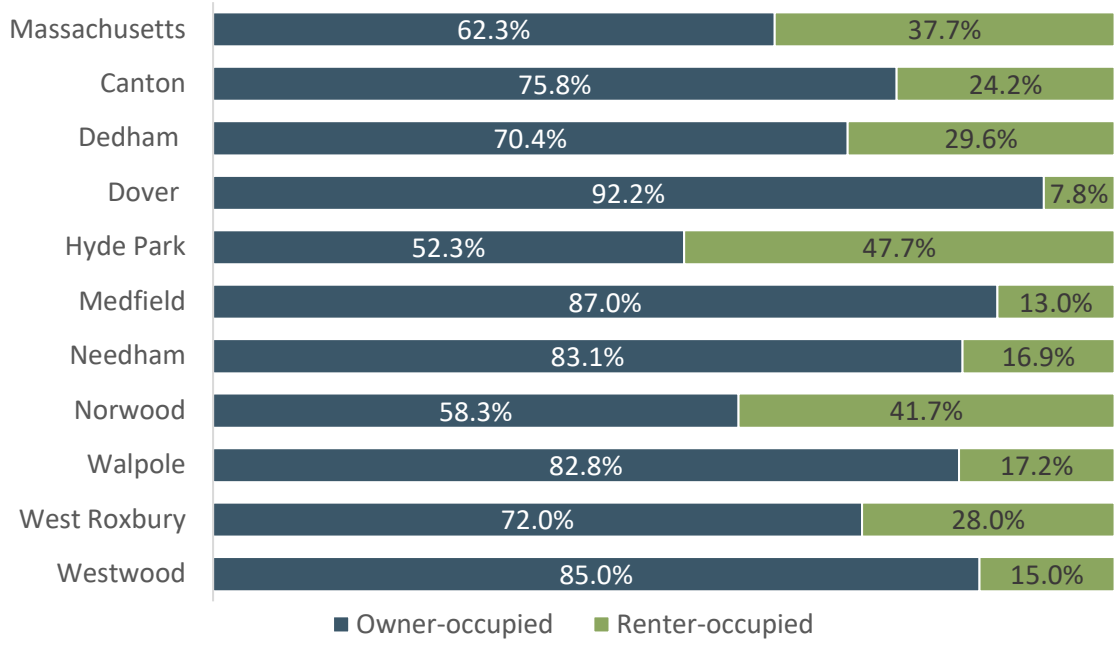
Housing affordability in the Westwood service area was raised as a concern in most of the interviews and focus groups. Many participants described an extremely high cost of housing in the Westwood service area and noted that high housing prices apply to both homeowners with mortgages and renters. Participants expressed concern for the "middle class" that "*make very good money [but] are living paycheck to paycheck because it's so expensive*" to live in these communities. Many participants stated that the area is not affordable for young adults, single parents, or seniors. For example, when describing Hyde Park, one focus group participant stated that "*Single parents couldn't afford to live here."* Participants noted that recent housing developments, such as condominiums and apartment complexes,

have made these areas even more unaffordable (see "Built Environment" below for more information on development in these areas).

Participants also stated that affordable housing in these communities is very limited, and that wait lists are very long for the affordable housing that does exist. As one participant described, "*Needham doesn't have a lot of affordable housing and the [wait] list is very long."* Given the high cost of housing and the lack of affordable housing options, participants noted that some families are living in crowded or doubled-up situations in order to afford rent. Additionally, in the context of the COVID-19 pandemic, some participants expressed concerns about an increase in homelessness as a result of rising unemployment. For example, one focus group participant stated: "*I'm sure that a lot of people are on the verge of homelessness."*

In Massachusetts, 62.3% of housing units are owner-occupied versus 37.7% renter-occupied (Figure 22). In most of the towns around Westwood, owner-occupied units are more common than in the state overall, for example 92.2% of housing units in Dover and 87.0% of housing units in Medfield are owner-occupied. The exceptions to this statistic are Hyde Park and Norwood, where 52.3% and 58.3% of housing units are owner-occupied, respectively.

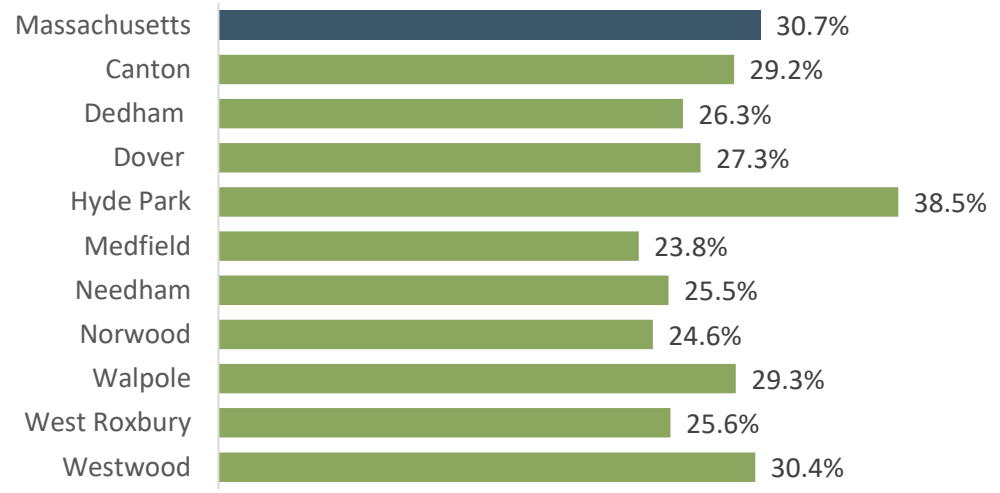
Figure 22. Percent of Housing Units Owner- or Renter-Occupied, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage spend more than 30% of their income on housing costs (Figure 23). Many of the towns around Westwood are similar, with a range of 23.8% in Medfield to 38.5% in Hyde Park.

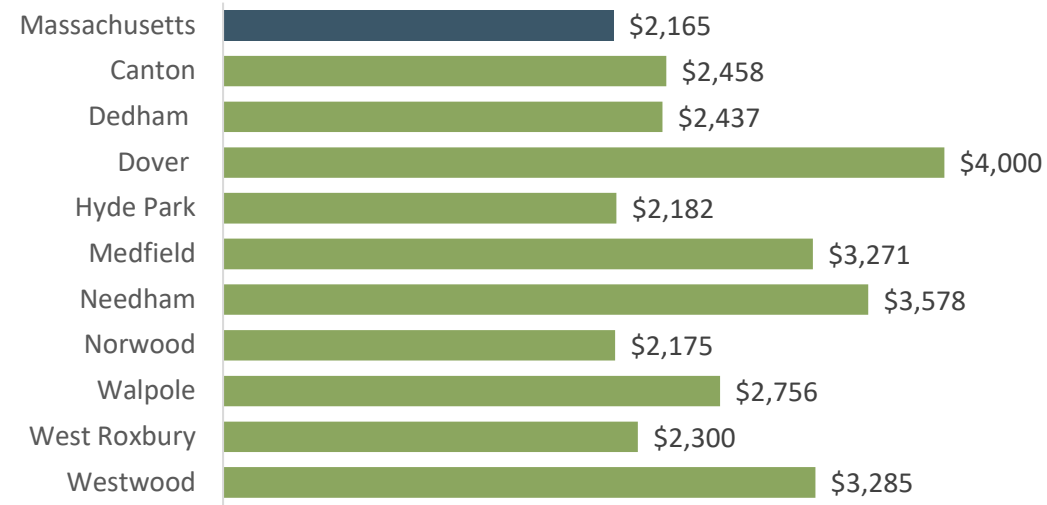
Figure 23. Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, by Owner-Occupied Household with a Mortgage, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Cost burden may not be associated with housing affordability in especially wealthy areas. For example Dover (27.3%) and Dedham (26.3%) have similar proportions of owner-occupied units spending over 30% of their income on housing, even though median housing costs are much higher in Dover ($4,000/month) than Dedham ($2,437/month) (Figure 24).

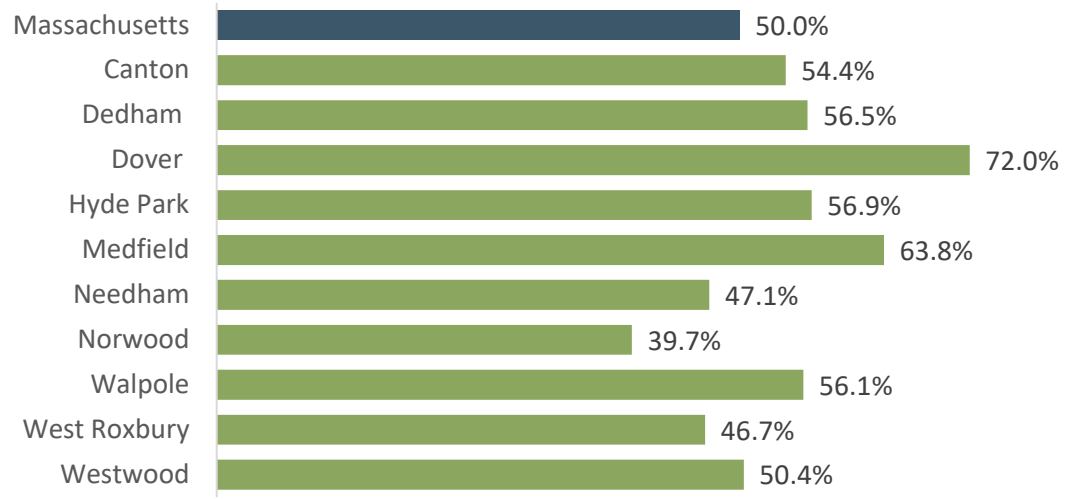
Figure 24. Median Monthly Housing Costs for Owner-Occupied Households with a Mortgage, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

In comparison, more renters tend to spend more than 30% of their income on housing costs compared to homeowners, even though their median monthly housing costs are lower. In the Westwood service area, 72.0% of rental units in Dover and 63.8% of rental units in Medfield were occupied by residents who spent over 30% of their income on housing costs (Figure 25). In Norwood, this was only 39.7%.

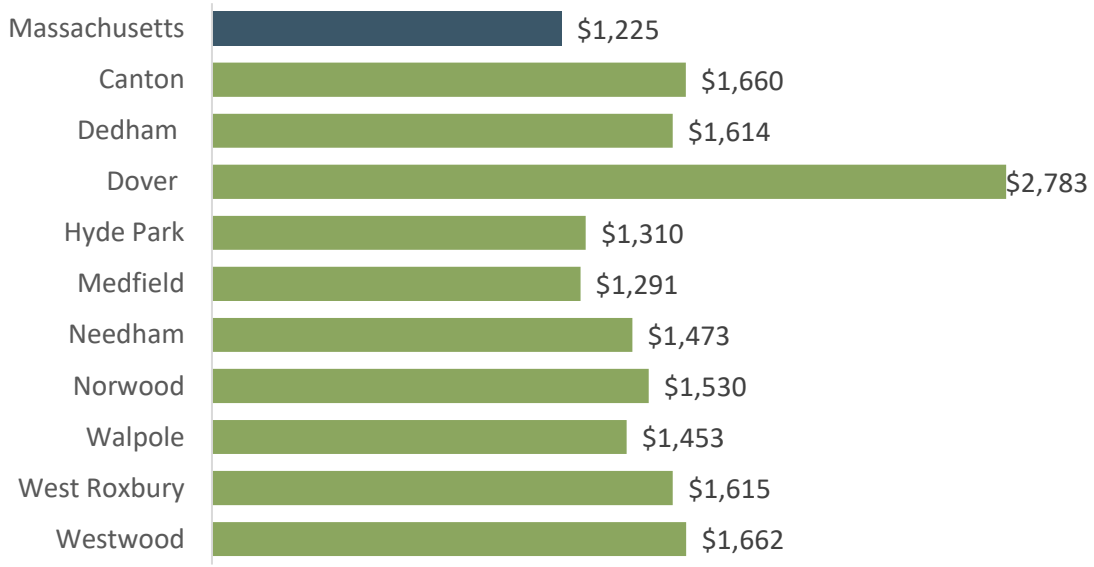
Figure 25. Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, by Renter, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Median housing costs for rental units did not vary as much across the region in 2014-2018 compared with owner-occupied costs, with a range of $1,291 in Medfield to $2,783 in Dover.

Figure 26. Median Monthly Housing Costs for Renter-Occupied Households, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

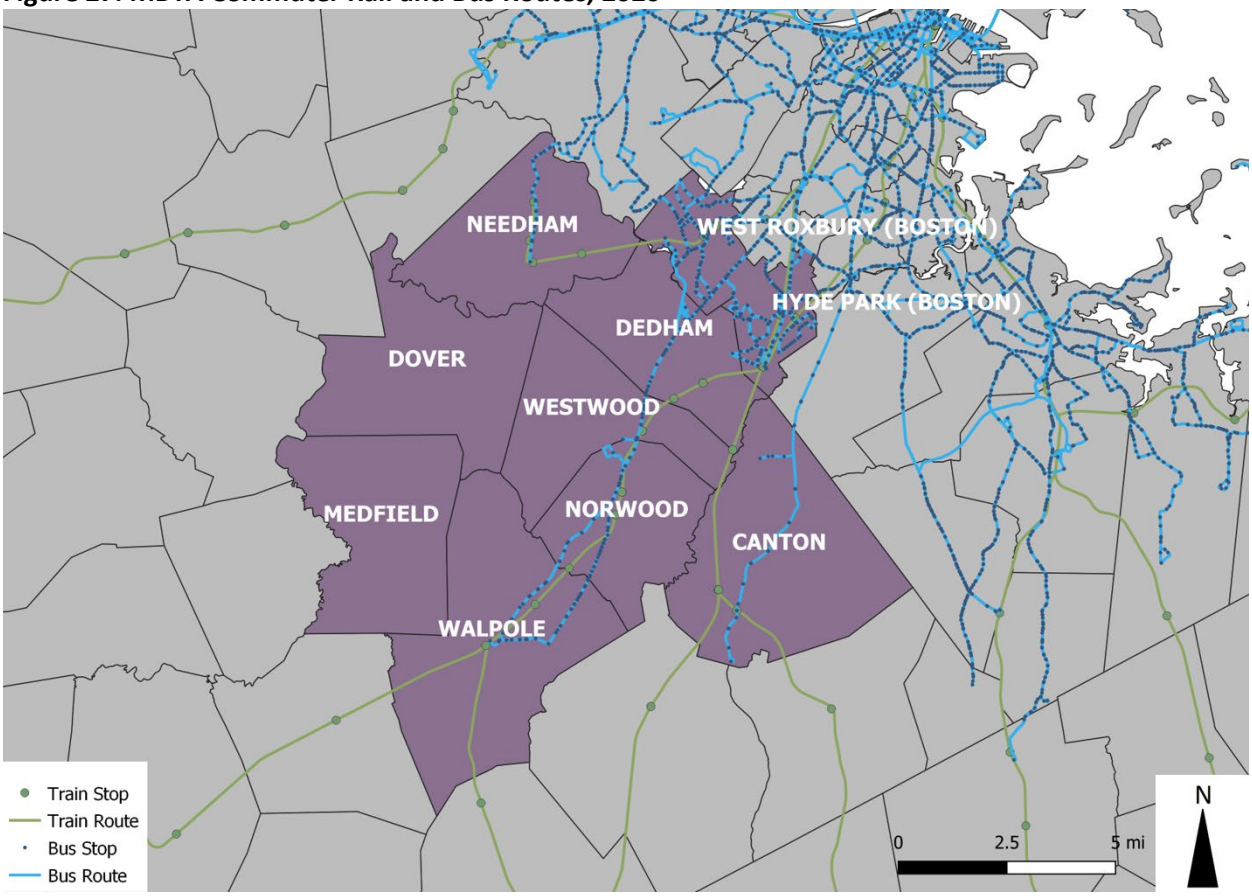
Transportation

> "*A lot of the industries that lower income workers work in are located on Route 1… [so] people have to walk across Route 1… because [there is] no transportation from residential areas."* – Key informant interviewee

> "*if you don't have a vehicle then you're not getting around Needham*." – Focus group participant

Perceptions of transportation access differed among communities in the Westwood service area. In some communities, such as Hyde Park, participants described public transportation as an asset of the community. For example, one participated stated that "*one of the things that I like the best of living in Hyde Park is that there's a lot of access to transportation, like the bus routes*." However, many participants described transportation as a major concern for towns in the Westwood service area. Participants noted that public transportation is limited and, while there are some taxi voucher programs, vans, and The Ride, these transit options are still limited and/or irregular. While many of the communities in the Westwood service area have a commuter rail or bus stop, participants were concerned about the "*first mile, last mile"* and how residents could get to these transit stops. As one participated described: "*if you don't have a vehicle then you're not getting around Needham*."

Figure 27. MBTA Commuter Rail and Bus Routes, 2020



DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Central Transportation Planning Staff (CTPS) of the Boston Region Metropolitan Planning Organization (MPO), 2020.

Participants described specific transportation concerns, as well as concerns for certain populations including low-wage workers, seniors, and students. For example, in Norwood, participants noted that "*Route 1 divides the town"* and that "*A lot of the industries that lower income workers work in are located on Route 1… [so] people have to walk across Route 1… because [there is] no transportation from residential areas."* Some participants also noted that transportation for students is needed, with one interviewee stating that the community needs *"transportation for students; that's been a hurdle."* Lastly, transportation for seniors was a common concern, with participants describing a need for additional on demand transportation to medical appointments (including in Boston), as well as transportation for seniors to do social activities.

In 2014-2018, 70.2% of people in Massachusetts over age 16 commuted to work alone in a vehicle (Table 7). In Westwood service area, this ranged from 61.2% in the Hyde Park neighborhood of Boston to 74.7% in Walpole and 74.6% in Norwood. Commuting by public transportation was most common in Hyde Park (25.3%), Westwood (17.3%), and West Roxbury (17.1%).

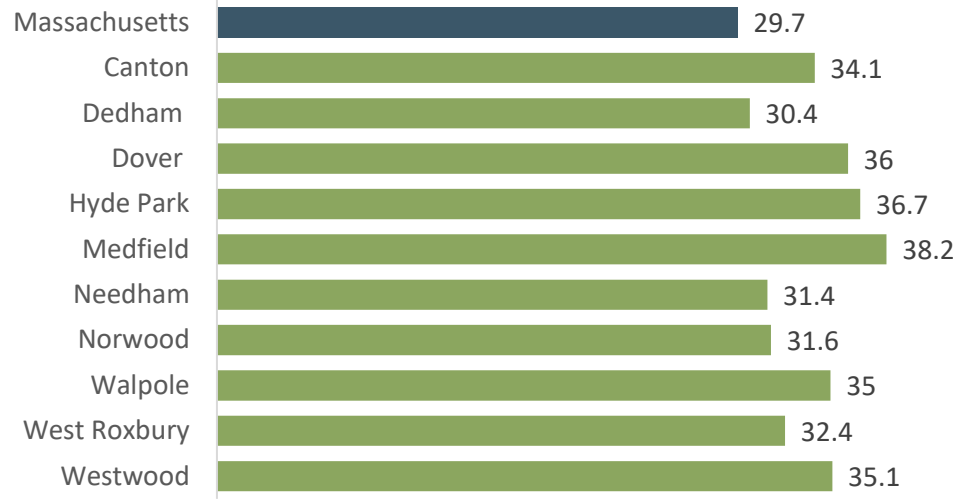
Table 7. Means of Transportation to Work for Population 16 Years and Over, in Massachusetts, by Town and Boston Neighborhood, 2014-2018

	Car, truck, or van - alone	Car, truck, or van - carpool	Public transportation	Other
Massachusetts	70.2%	7.5%	10.2%	2.1%
Norfolk County	67.9%	7.2%	14.4%	1.6%
Suffolk County	40.7%	6.7%	32.5%	3.6%
Boston	38.8%	5.9%	33.4%	3.8%
Canton	73.1%	7.2%	13.1%	0.3%
Dedham	71.6%	7.2%	11.2%	1.6%
Dover	68.4%	7.6%	9.2%	0.4%
Hyde Park	61.2%	8.3%	25.3%	0.9%
Medfield	68.3%	8.3%	9.3%	0.8%
Needham	70.4%	5.6%	11.7%	1.4%
Norwood	74.6%	7.3%	10.5%	1.2%
Walpole	74.7%	6.5%	10.7%	1.5%
West Roxbury	67.9%	6.9%	17.1%	2.0%
Westwood	66.1%	5.6%	17.3%	0.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Other includes "worked at home" category, taxicabs, motorcycle, bicycle, and other means.

All towns in the area around Westwood had a slightly longer commute time than the Massachusetts average of 29.7 minutes (Figure 28). Commute time from Medfield was the longest, at 38.2 minutes, on average, while commute time from Dedham was shortest at 30.4 minutes.

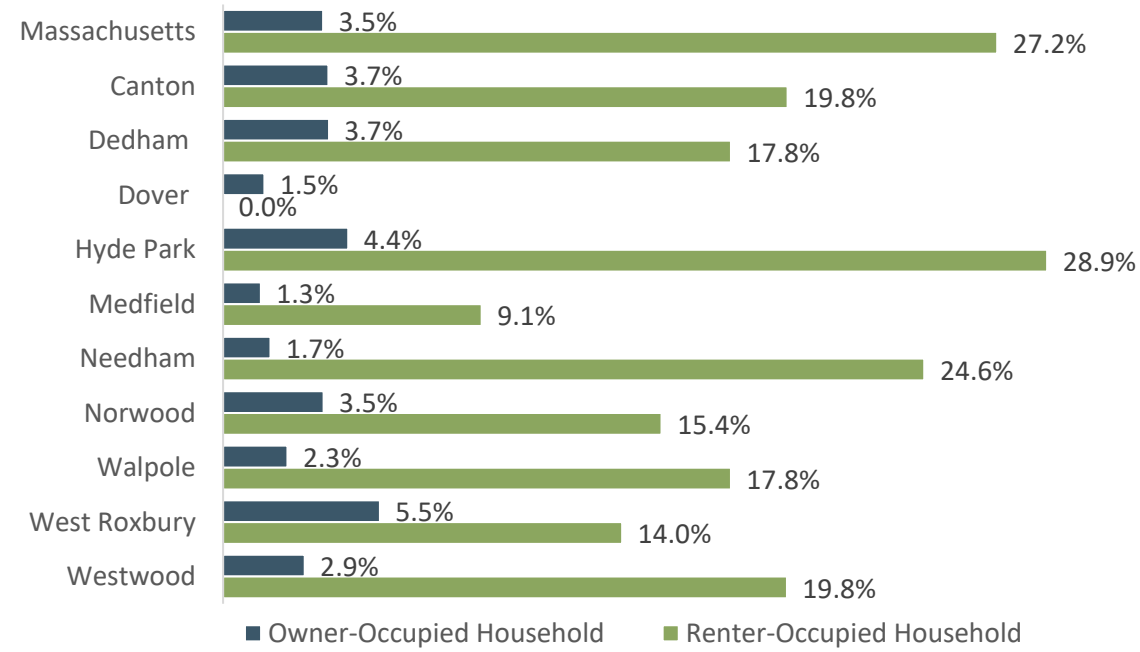
Figure 28. Mean Travel Time to Work (in Minutes), in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

In 2014-2018, renter-occupied households were more likely to have no vehicle available to them, across towns in the Westwood service area. In Hyde Park and Needham, approximately one quarter of households with renters did not have a vehicle Figure 29).

Figure 29. Percent Households with No Vehicles Available, by Housing Tenure, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Built Environment

> *"There is a fair amount of shopping and grocery stores. Whole foods, Wegmans, Target. But there are also the small mom and pop stores too."* – Focus group participant

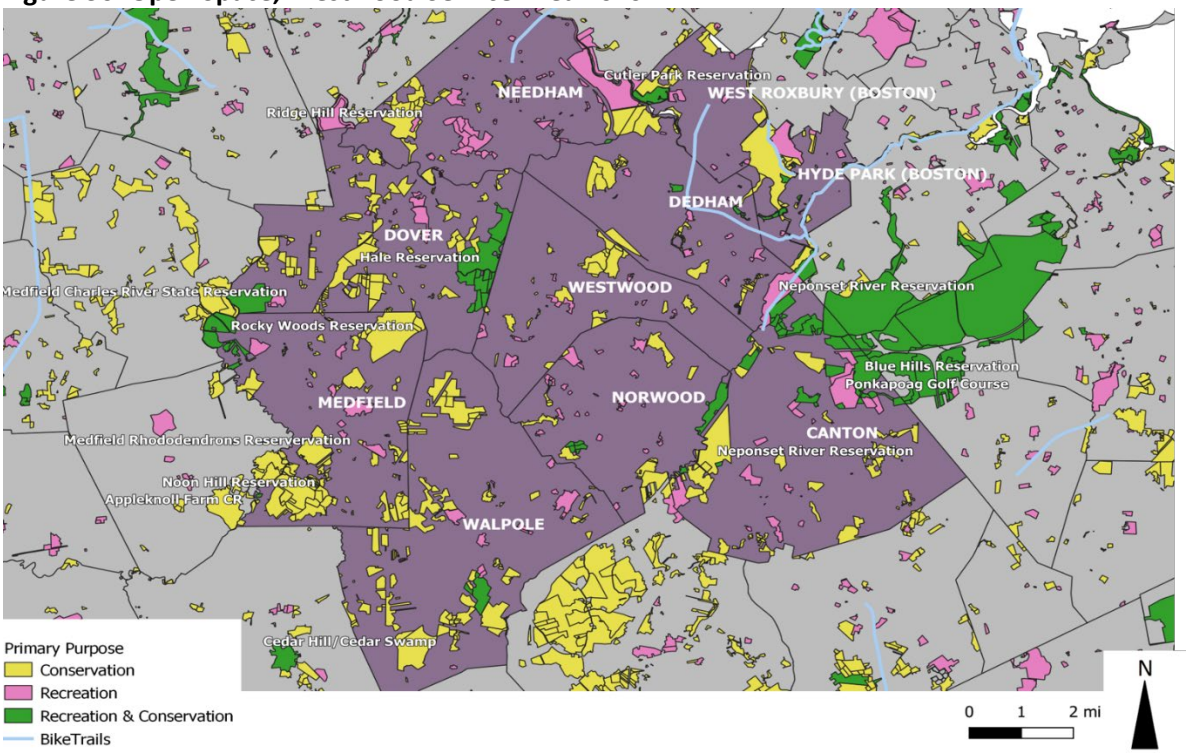
> *"Canton has a lot of green space and outdoor spaces. Places to bring kids or yourself to go hiking or biking."* – Focus group participant

> *"They're putting in all of these apartments – what will that bring? Will it overflow the school systems? Will it increase traffic?"* – Focus group participant

> *"Housing is controversial for many reasons. Structural racism, it's NIMBY [not in my backyard], it's all that."* – Key informant interviewee

Many participants described access to green and recreational space as an asset to the communities of the Westwood service area. This perspective was shared by community members who described their towns as "suburban" or "rural", as well as participants who lived in Boston neighborhoods, such as Hyde Park, "*a small town in the middle of the city."* Some participants also noted that, during the COVID-19 pandemic, they saw more residents biking and walking; other participants stated that outdoor recreation can be challenging, particularly for seniors or for residents who have trouble wearing masks. When discussing the built environment, one participant also noted that this area has "*a fair amount of shopping and grocery stores."* Figure 30 below illustrates recreational space, conservation space, and bike trails in the Westwood service area.

Figure 30. Open Space, Westwood Service Area 2020

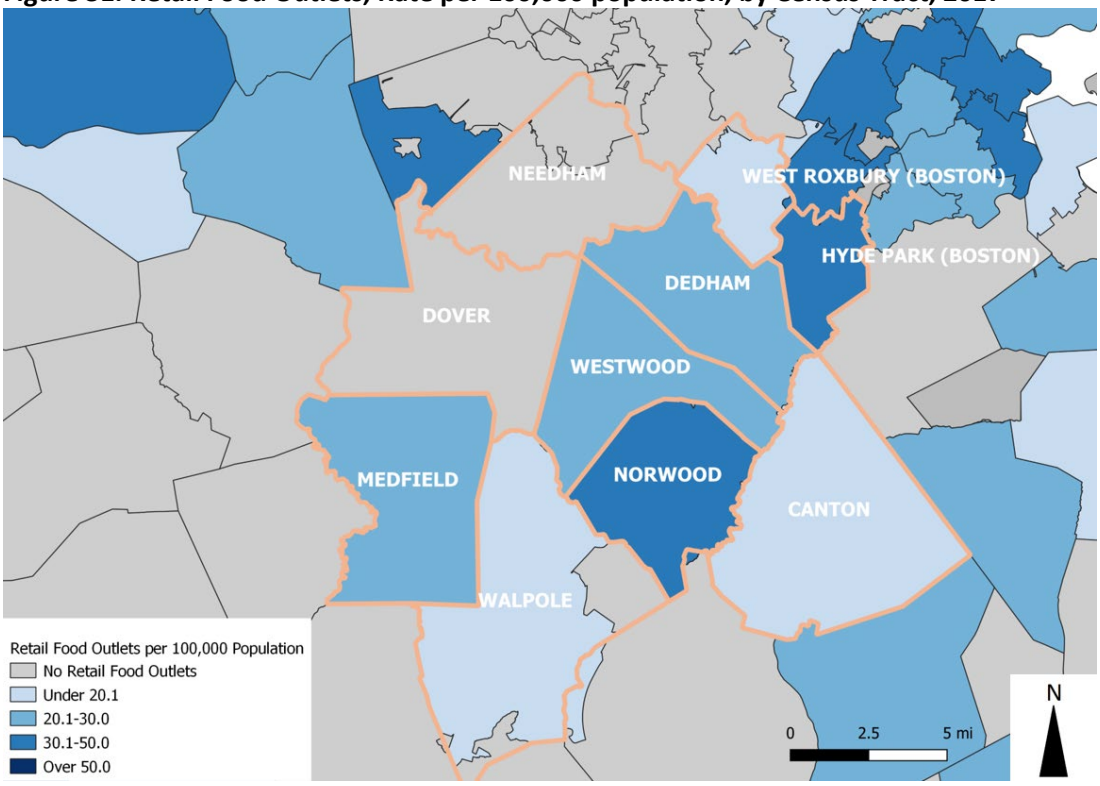


DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Executive Office of Energy and Environmental Affairs, 2020.

Overdevelopment was raised as a concern by many participants. These participants described apartments, luxury condominiums, and large houses being built in the area. For example, one participant noted that: the "*small houses in town, instead of getting redone, they are getting torn down and then big complexes go up."* Participants raised questions about how this development would impact the green space in their towns and neighborhoods, as well as whether an influx of new residents would impact the school system. For example, one participant asked: "*They're putting in all of these apartments – what will that bring? Will it overflow the school systems? Will it increase traffic?"* When discussing concerns about development some participants also raised concerns about discrimination, with one participant noting that "*Housing is controversial for many reasons. Structural racism, it's NIMBY* [Not in my Backyard]*, it's all that"* and another participant sharing that "*people are very clear about their ideas about building apartments and what kind of people that brings or what type of students will that bring."*

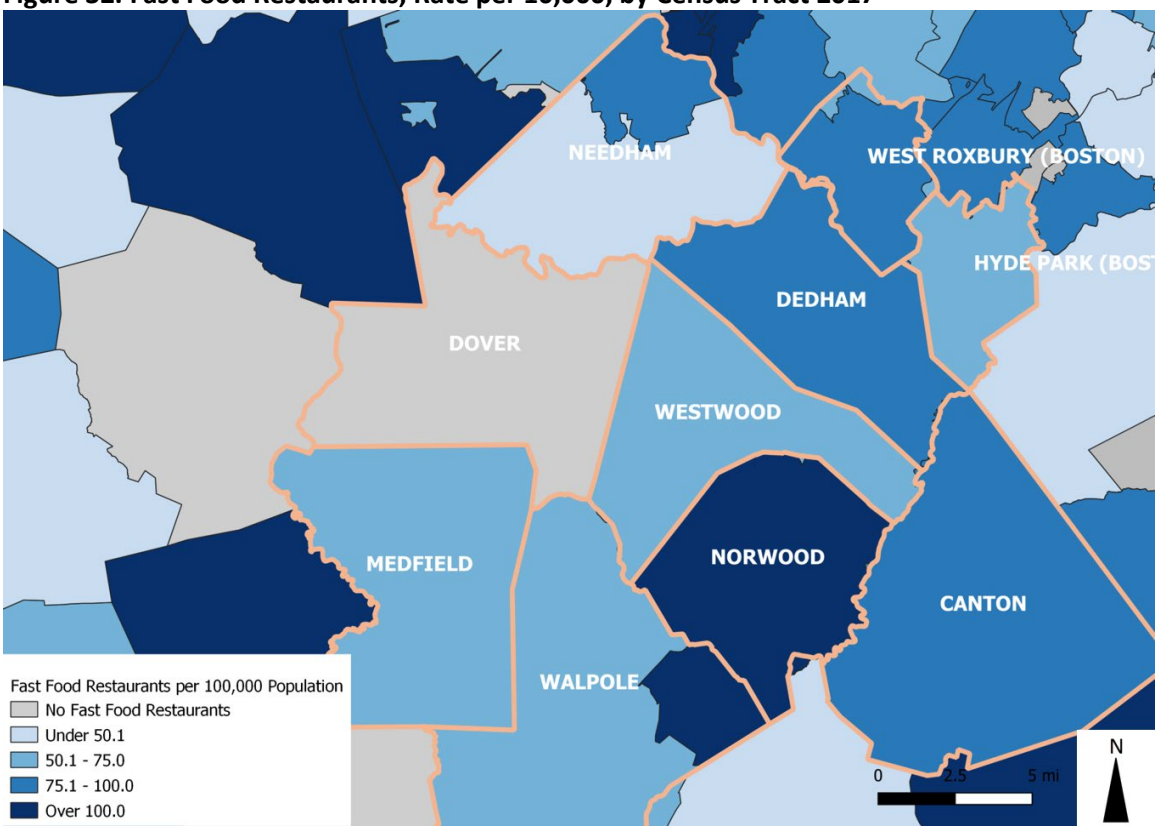
Figure 31 and Figure 32 show maps of the Westwood service area for the density of retail food outlets and fast food restaurants in the area. Several communities, such as West Roxbury, Hyde Park, and Norwood have the highest density of retail food outlets, which are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Canton and Walpole have the least density of retail food outlets. However, many of the same communities, including Canton and Dedham, also have high rates of fast food restaurants.

Figure 31. Retail Food Outlets, Rate per 100,000 population, by Census Tract, 2017



DATA SOURCE: U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2017.
NOTE: Retail food outlets are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry.

Figure 32. Fast Food Restaurants, Rate per 10,000, by Census Tract 2017



DATA SOURCE: U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2017.

Crime and Violence

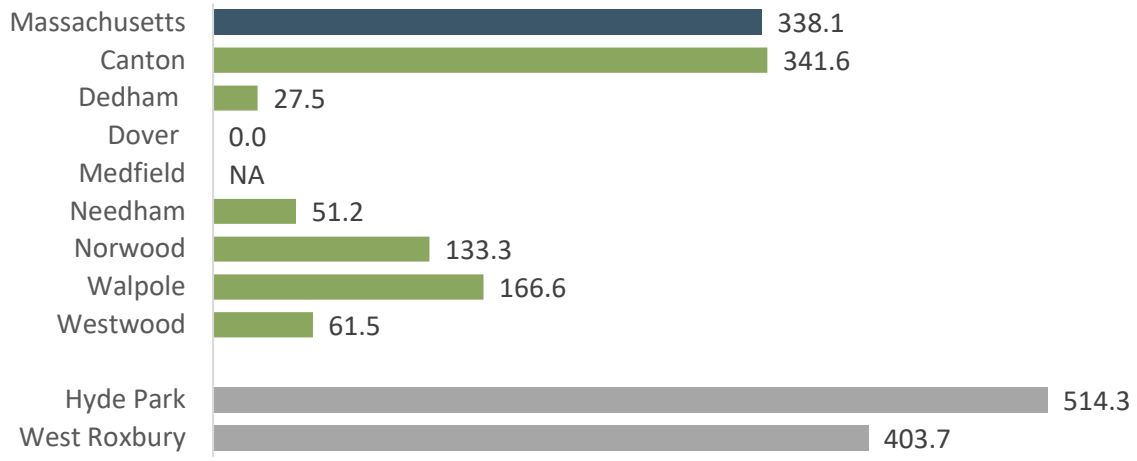
> "*The safety in the area is very welcoming. I really like that*." – Focus group participant

> "*We've seen with COVID a slight increase in domestic violence issues – people are stressed economically, socially."* – Key informant interviewee

Crime and violence were not common concerns raised by interview and focus group participants. The Westwood service area was generally described as safe. One participant noted that, compared to other neighborhoods in Boston, "*Hyde Park is safe,"* but noted that rents are higher in the area compared to other neighborhoods that may have higher levels of crime, but are also more affordable. A few interviewees did express concern about domestic violence, particularly during the pandemic. For example, one interviewee noted that "*We've seen with COVID a slight increase in domestic violence issues – people are stressed economically, socially."*

In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied strikingly across the towns within the Westwood service area. Canton was near the state average, with 341.6 incidents of violent crime per 100,000 population (Figure 33). Dedham, Dover, Medfield, Needham, and Westwood all had fewer than 100 incidents per 100,000. Hyde Park (514.3) and West Roxbury (403.7) had higher violent crime rates than the state average. (It should be noted that data for Hyde Park and West Roxbury are from a different data source given that the areas are neighborhoods of Boston.)

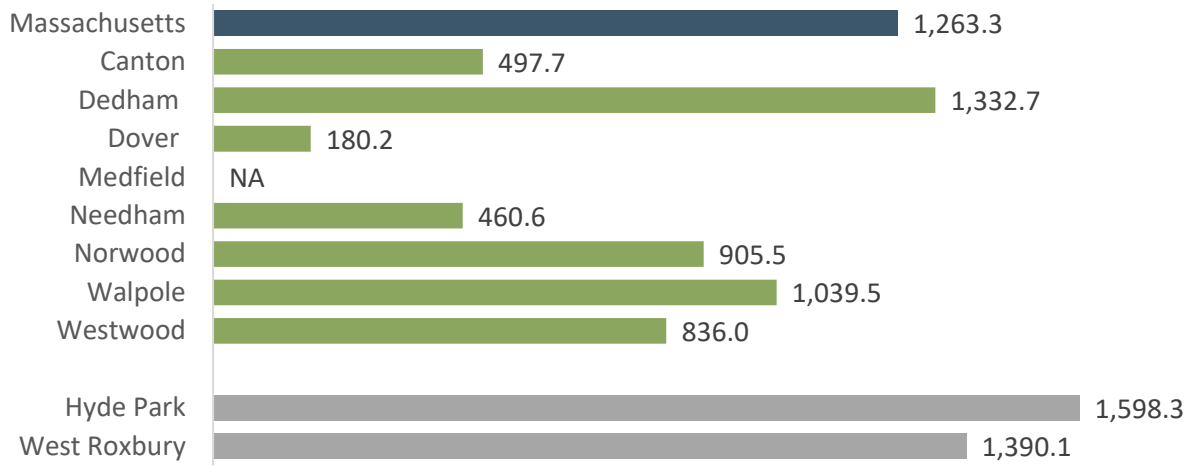
Figure 33. Violent Crime, Rate per 100,000 Population, in Massachusetts, by Town and Boston Neighborhood, 2018



DATA SOURCE: for MA and Towns: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.
* for Boston neighborhoods: Boston Police Department, Crime Statistics, Part One Crime Data by District 12-31-2018, 2018.
NOTE: Violent crime includes murder, rape, robbery, and aggravated assault.

Property crime (i.e. burglary, larceny, and auto theft) is much more common than violent crime. In 2018 in the Westwood service area, property crime was most common in Hyde Park (1598.3 per 100,000 population), West Roxbury (1390.1), and Dedham (1332.7) (Figure 34).

Figure 34. Property Crime, Rate per 100,000 Population, in Massachusetts, by Town and Boston Neighborhood, 2018



DATA SOURCE: for MA and Towns: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.
* for Boston neighborhoods: Boston Police Department, Crime Statistics, Part One Crime Data by District 12-31-2018, 2018.
NOTE: Property crime includes commercial burglary, residential burglary, other burglary, larceny from motor vehicle, other larceny, and auto theft.

Discrimination and Racism

> "*They [White residents] are good people, they're not burning crosses, but they have no idea that their White privilege has given them all that's available to them."* – Key informant interviewee

> "*Because I have kids in high school, I know there are slurs that go on the wall. Even though it is a mixed town- [the kids in the METCO program] are treated different than the residents themselves."* – Focus group participant

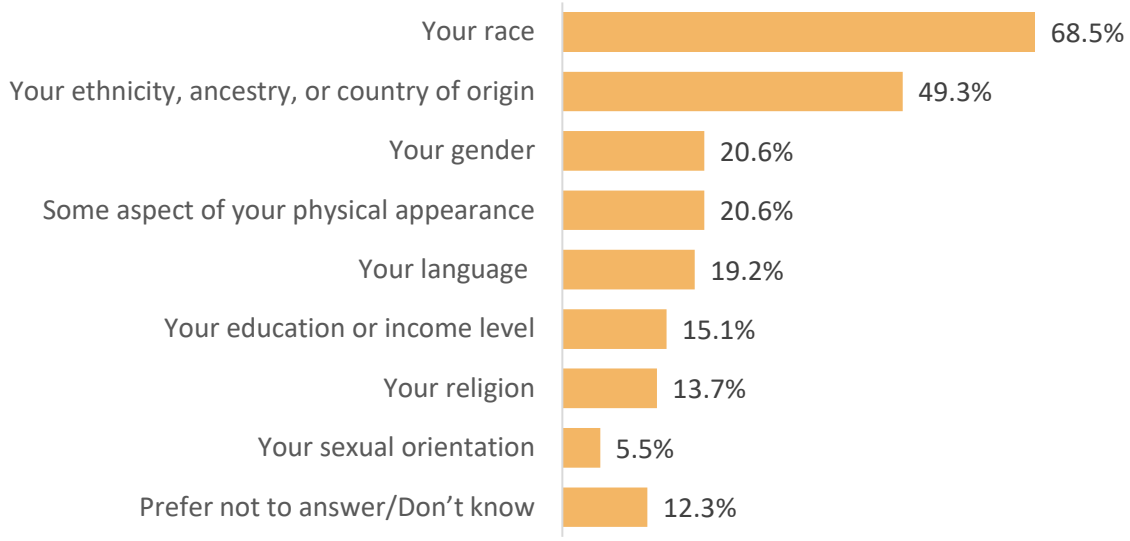
> "P*eople are so rude, 'Why don't you speak English well?' Communication breaks and you feel so bad because you can't communicate."* – Focus group participant

Many participants described the Westwood service area as an area that primarily includes "*White, affluent"* suburbs. As one parent participant shared: "*When we were looking at all the preschools websites, there were only blond hair and blue eyes. At first, I didn't notice but my six-year-old said, 'How come there is no one like me on the website?'".* In addition to concerns about discrimination in the context of development described above, some participants noted that, in some of these communities, White residents may not be aware of their privileges. For example, one participant shared that in these communities: "*They're good people, they're not burning crosses, but they have no idea that their White privilege has given them all that's available to them."* Other participants described experiences of racism due to their race and language. For example, one participant shared that: "*Because I have kids in high*

school, [I know] there are slurs that go on the wall. Even though it is a mixed town- [the kids in the METCO program] are treated different than the residents themselves." Another participant noted that: "*people are so rude, 'Why don't you speak English well?'. Communication breaks and you feel so bad because you can't communicate."* Many participants described vigils or protests held in their communities in response to the Black Lives Matter movement, and a few participants suggested that community coalitions be formed to take action around inequities and social justice.

Among the Westwood Community Priorities Survey respondents reporting that they themselves or their family members experienced discrimination in the past six months (16.2% of total sample), 68.5% of these respondents reported this was due to their race; 49.3% indicated it was due to their ethnicity, ancestry, or country of origin; and about 20% each reported it was due to their gender, physical appearance, or language spoken (Figure 35).

Figure 35. Percent of CHNA Community Priorities Survey Respondents Reporting Main Reasons for Discrimination, *among Respondents Reporting Discrimination as an Issue*, 2020 (N=73)



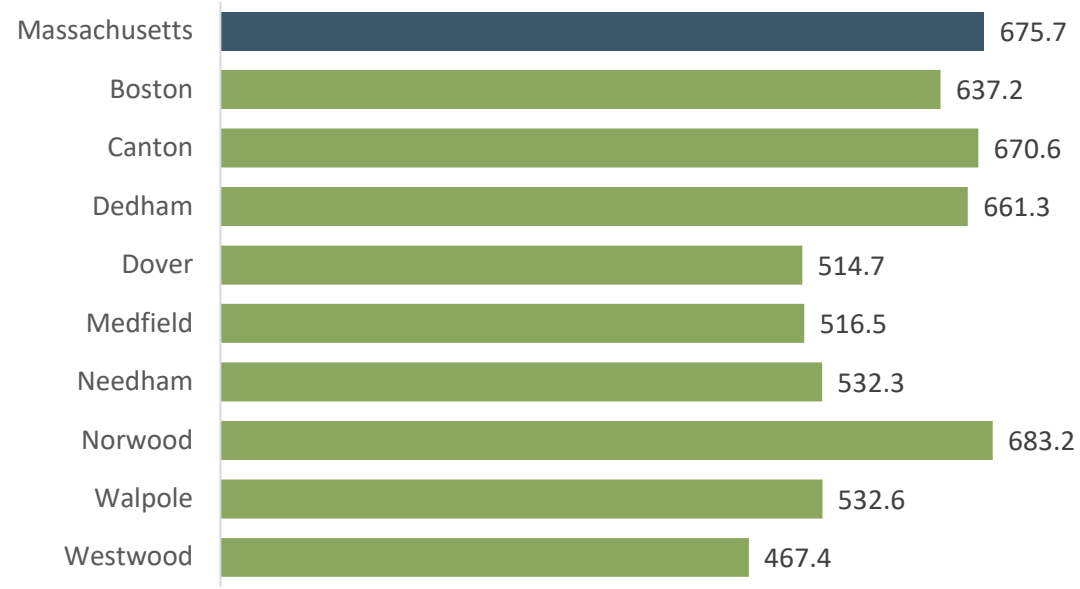
NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

COMMUNITY HEALTH ISSUES

Overall Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before age 65 years old) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted. Age-adjusted mortality rates per 100,000 population varied between towns in the Westwood area in 2017, from a low of 467.4 in Westwood to highs of 670.6 in Canton and 683.2 in Norwood (Figure 36). Only Norwood had a higher mortality rate than the Commonwealth as a whole.

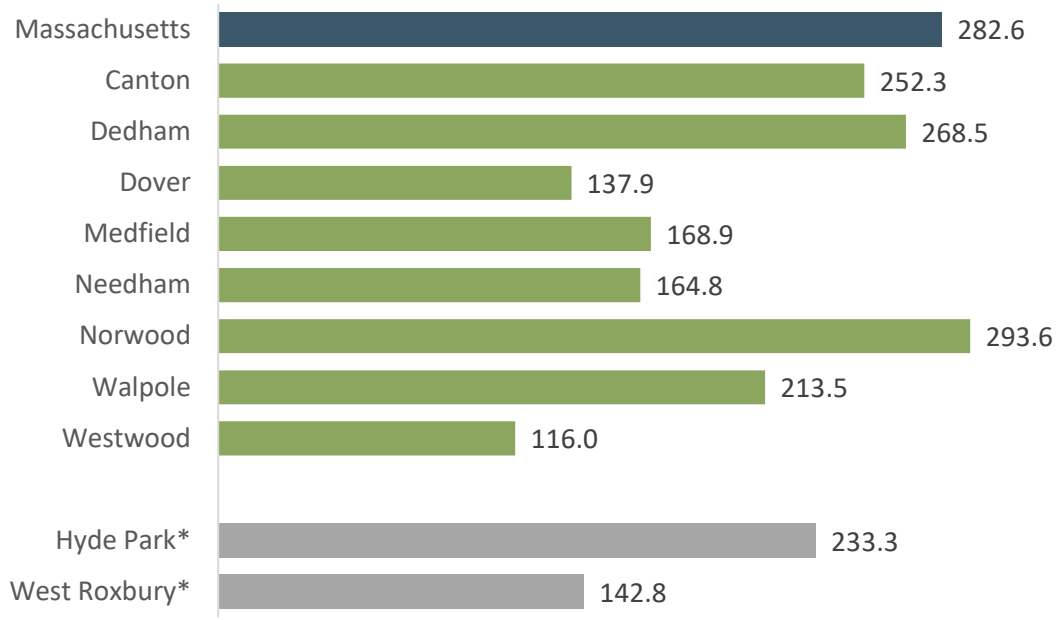
Figure 36. Overall Mortality, Age-Adjusted Rate per 100,000 Population, in Massachusetts and by Town, 2017



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

Age-adjusted premature mortality rates (deaths before age 65) in 2017 (and 2014-2016 for Boston neighborhoods) followed similar patterns (Figure 37). The lowest rates were in Westwood (116.0 per 100,000 population) and Dover (137.9), and the highest rates were in Dedham (268.5) and Norwood (293.6).

Figure 37. Premature Mortality, Age-Adjusted Rate per 100,000 Population, in Massachusetts, by Town (2017) and Boston Neighborhood (2014-2016 combined)



DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Registry of Vital Records and Statistics (2017).
* for Boston neighborhoods: Massachusetts Department of Public Health, Registry of Vital Records and Statistics (2014-2016 combined). Analysis for Boston neighborhoods done by Boston Public Health Commission, Research and Evaluation Office.

Chronic Diseases and Related Risk Factors

> *"We're pretty aligned with the state, not higher than the state…"* – Key informant interviewee
>
> *"I don't think of one illness. We could talk about arthritis, diabetes… but it's when they accumulate that there's an issue."* – Key informant interviewee
>
> *"It's the combination of Alzheimer's plus other illnesses compounding their health and wellness."* – Key informant interviewee

In general, rates of chronic disease in the Westwood service area are similar to the state overall. While interview and focus group participants did not cite specific chronic diseases as pressing concerns in their communities, as shown above, a high proportion (44.7%) of Westwood Community Priorities Survey respondents indicated that "overweight/obesity" is an issue affecting them or their family. One interview participant noted that chronic disease rates in the area are similar to those statewide or slightly higher, given the senior population in the area: *"…we're pretty aligned with the state, not higher*

than the state, same with our cancer rates. We do have heart disease, cardiovascular disease, rates a little higher for us. We have an older population…".

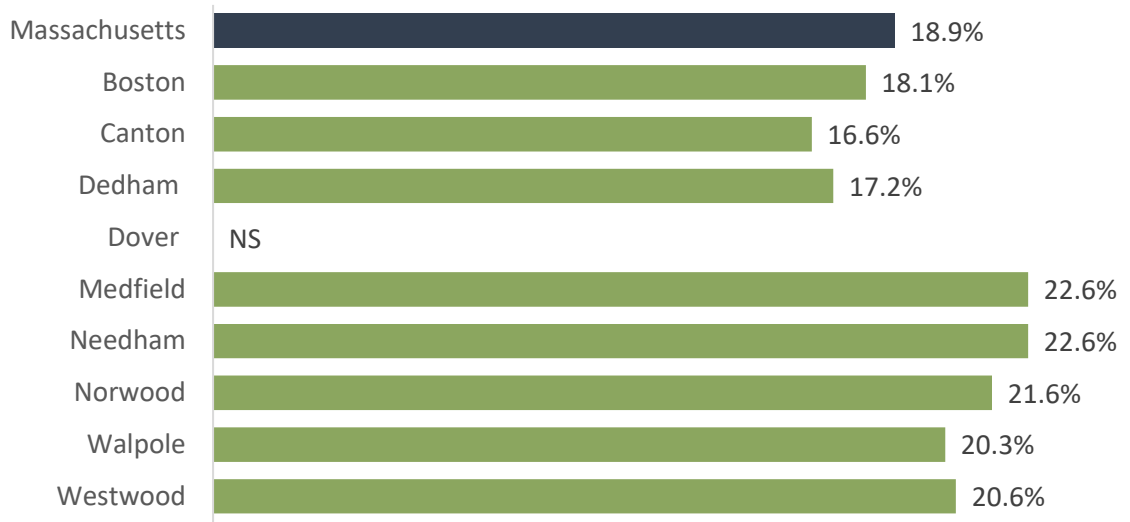
While participants did not frequently raise concerns about individual chronic diseases, some participants noted that comorbidities are a concern for their community, especially for seniors. As one participant described, "*I don't think of one illness. We could talk about arthritis, diabetes… but it's when they accumulate then there's an issue."* Some participants also expressed concern that during the COVID-19 pandemic, chronic diseases may not be appropriately managed given concerns about visiting health care facilities. For example, one participant stated that, "*I worry that people are not keeping up with their chronic conditions.*"

Alzheimer's disease and other dementias also were noted as a concern in the Westwood service area, particularly when they co-occur with other chronic conditions. When speaking about the senior population, one participant stated that "*it's the combination of Alzheimer's plus other illnesses compounding their health and wellness."* Other participants shared the perception of seeing an increase in community members with memory concerns, and also pointed to the need to support caregivers and families of persons living with dementia.

Overweight and Obesity

In 2011-2015, 18.9% of adults in Massachusetts reported consuming five or more fruits and vegetables every day (Figure 38). Percentages of this statistic were slightly lower in Boston overall, and in Canton, as well as Dedham, and higher in the other towns in the Westwood service area. However, none of the towns within the Westwood service area have greater than one quarter of the population report fruit and vegetable consumption in-line with these national guidelines.

Figure 38. Percent Adults Consuming Five or More Fruits and Vegetables Daily, in Massachusetts and by Town, 2011-2015



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2011-2015.
NOTE: Data are aggregated based on multiple years including 2011, 2013, 2015. NS = Data not shown due to insufficient sample size.

In 2012-2014, the prevalence of overweight or obesity in Massachusetts was 59.0% (Figure 39). Most towns in Westwood service area had similar prevalence, ranging from highs of 64.8% in Hyde Park and 63.6% in West Roxbury (2013-2017 data), to 50.2% in Westwood and 50.6% in Medfield.

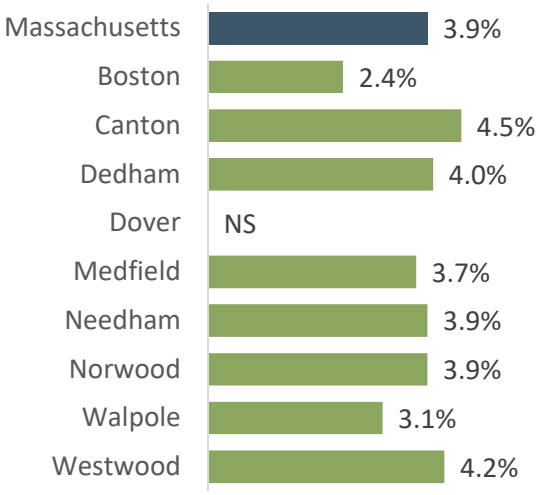
Figure 39. Percent Adults Reporting Obesity or Overweight, in Massachusetts and by Town (2012-2014) and Boston Neighborhood (2013-2017)

DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
* for Boston Neighborhoods: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2013, 2015, and 2017.
NOTE: Data are aggregated based on multiple years; including 2012-2014 for MA and Towns and 2013, 2015 and 2017 for Boston neighborhoods. NS = Data not shown due to insufficient sample size.

Heart Disease

In 2012-2014, 3.9% of adults in Massachusetts reported having angina or coronary heart disease (Figure 40). Again, prevalence in the Westwood service area spanned this statewide estimate, ranging from 2.4% in Boston to 4.5% in Canton.

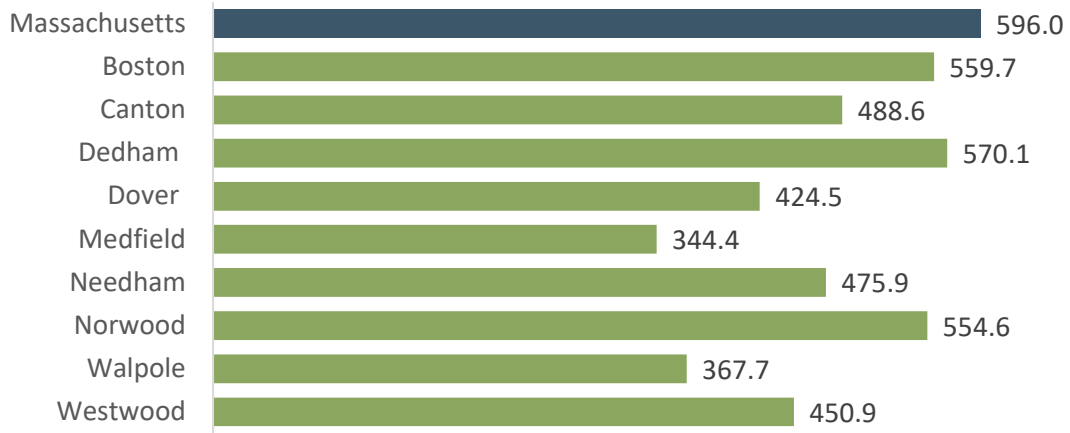
Figure 40. Percent Adults Reporting Angina or Coronary Heart Disease (CHD), in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years.

Age-adjusted rates of emergency department visits for heart disease also varied across towns in 2014. Dedham reported 570.1 visits per 100,000 residents, while Medfield only reported 344.4 visits (Figure 41).

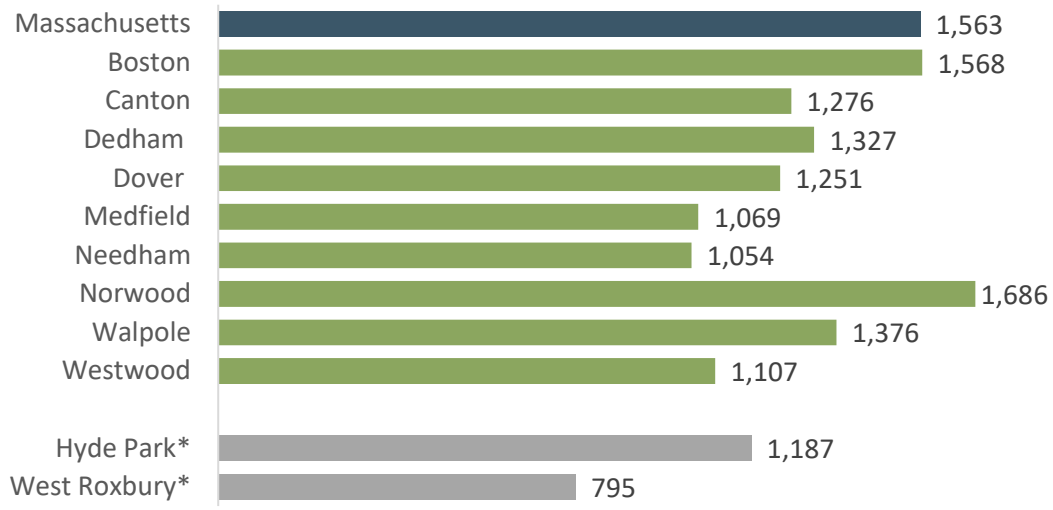
Figure 41. Heart Disease Emergency Department Visits, Age-Adjusted Rate per 100,000 Residents, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Age-adjusted rates of hospitalizations for heart disease in 2016-2017 followed a somewhat different pattern. There were 1,686 hospitalizations per 100,000 residents of Norwood. However, there were 795 heart disease hospitalizations per 100,000 residents in West Roxbury, although this neighborhood data is slightly more recent than the other town-level data (Figure 42).

Figure 42. Heart Disease Hospitalizations, Age-Adjusted Rate per 100,000 Residents, in Massachusetts and by Town (2014) and Boston Neighborhood (2016-2017 combined)

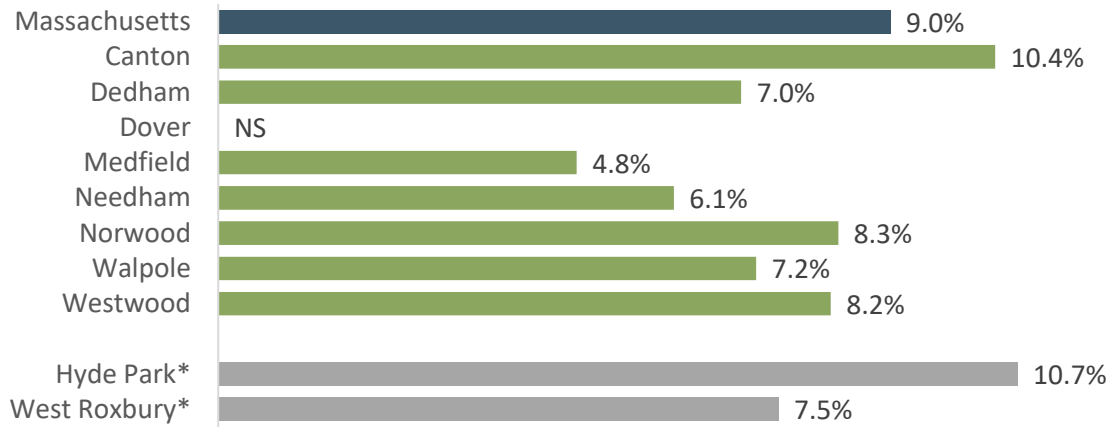


DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.
* for Boston Neighborhoods: CHIA, Boston Public Health Commission, 2016-2017 Combined.

Diabetes

Prevalence of diabetes among adults varied across the towns near Westwood in 2012-2014. The highest prevalence of this chronic condition was in Hyde Park (10.7%; 2013-2017 data) and Canton (10.4%) (Figure 43).

Figure 43. Percent Adults Reporting Diabetes, in Massachusetts and by Town (2012-2014) and Boston Neighborhood (2013-2017)



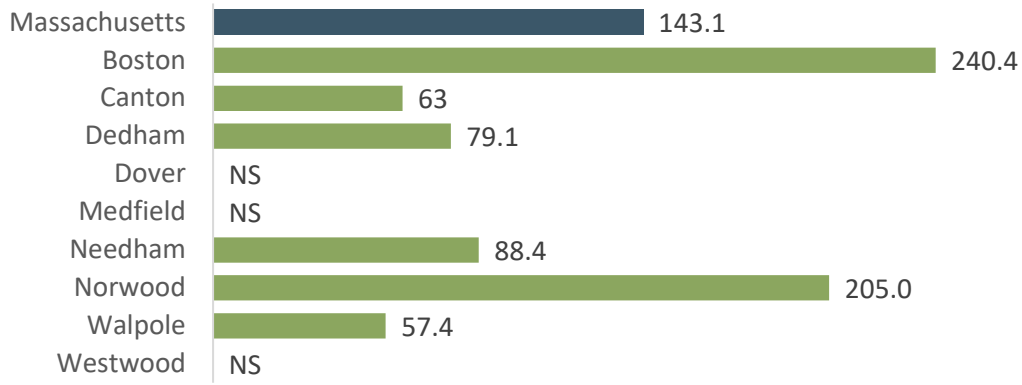
DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.

* for Boston Neighborhoods: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2013, 2015, and 2017.

NOTE: Data are aggregated based on multiple years; including 2012-2014 for MA and Towns and 2013, 2015 and 2017 for Boston neighborhoods. NS = Data not shown due to insufficient sample size.

Age-adjusted rates of emergency department visits were notably high in Norwood (205.0 per 100,000 residents) in 2014, exceeding the State's rate of 143.1 (Figure 44). Boston's rate was also high, but data were not available by specific neighborhoods.

Figure 44. Diabetes Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014

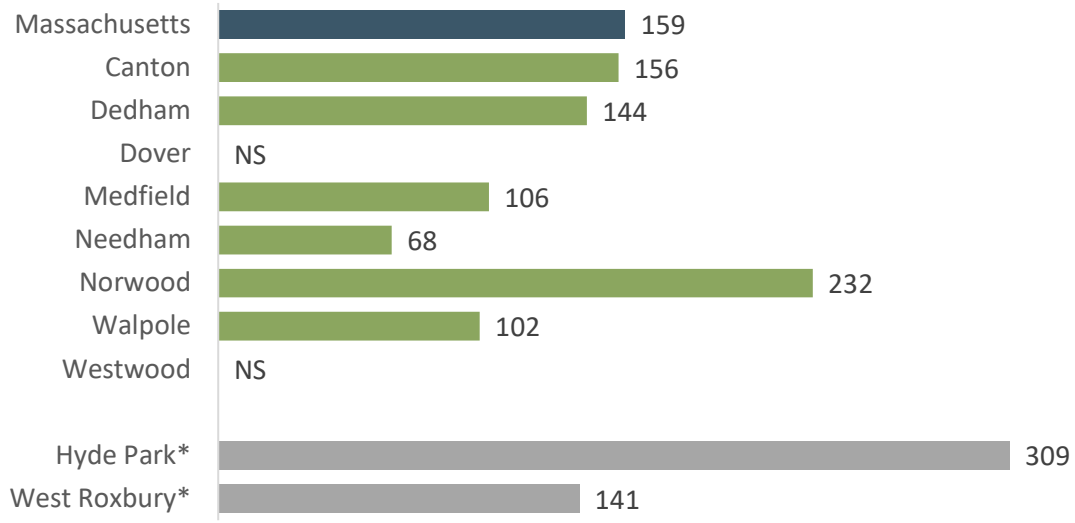


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

NOTE: NS = Data not shown due to insufficient sample size.

Age-adjusted hospitalizations for diabetes were highest in Hyde Park (309 per 100,000 population; 2016-2017 data) and Norwood (232 per 100,000; 2014 data) (Figure 45).

Figure 45. Diabetes Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town (2014) and Boston Neighborhood (2016-2017 combined)



DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.
* for Boston Neighborhoods: CHIA, Boston Public Health Commission, 2016-2017 Combined.
NOTE: NS = Data not shown due to insufficient sample size.

Cancer

Standardized Incidence Ratios (SIR) for cancer are calculated to compare local incidence rates with the expected rate for the Commonwealth overall, set at 100. In 2009-2013 in the Westwood area, the SIR for breast cancer was highest in Westwood (134), indicating the incidence of breast cancer was 34% higher than expected for a town in Massachusetts. For other cancers, the highest SIRs were 140 in Medfield for prostate cancer, 112 in Norwood for lung and bronchial cancer, and 131 in Westwood for colorectal cancer (Table 8).

Table 8. Cancer Standardized Incidence Ratios for Leading Cancer Types, 2009-2013

	Breast Cancer (female)	Prostate (male)	Lung and Bronchus	Colorectal
Boston	93	120	100	107
Canton	97	100	102	98
Dedham	119	98	107	72
Dover	111	112	62	86
Medfield	107	140	59	105
Needham	117	121	64	83
Norwood	99	88	112	126
Walpole	127	132	86	112
Westwood	134	112	90	131

DATA SOURCE: Massachusetts Department of Public Health, Massachusetts Cancer Registry, 2009-2013.

Behavioral Health

Mental Health

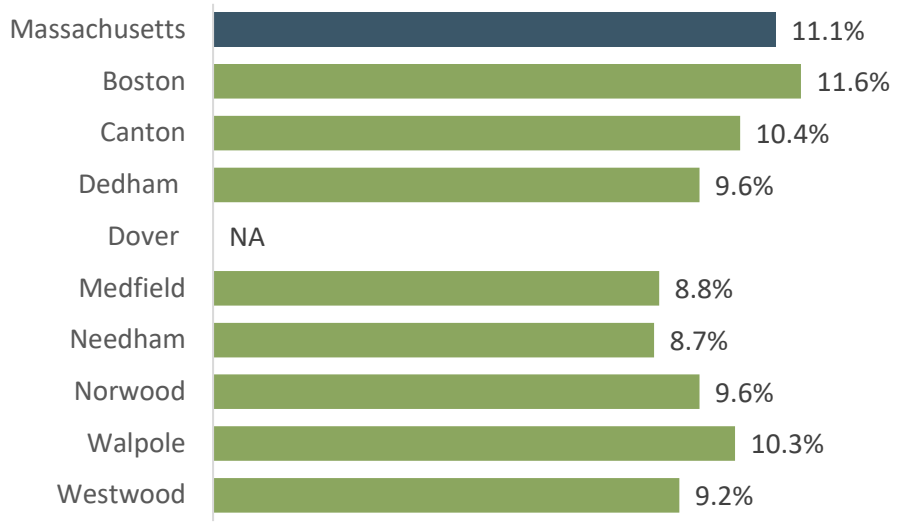
> "*Westwood has great schools, but it's also high pressure."* – Focus group participant
>
> *"Youth are being faced with isolation especially [children in] Prek-5th grade… they are missing out on a lot of social interactions that are important for development*." – Key informant interviewee
>
> "*An issue that will only get bigger during pandemic is isolation. It's always an issue for our older citizens."* – Key informant interviewee

While rates of self-reported poor mental health days in Westwood service area are similar to the state overall, mental health was raised as a pressing concern in many interviews and focus groups. Participants noted that mental health conditions are present throughout the community, "*from the kids to the seniors."* Participants described the anxiety and pressure that exists in general for community members, noting that "*one of the reasons they have the money*" to live in this area is that they "*are driven,"* which *"puts stress on marriages, teenagers, themselves…"*. Participants often described mental health concerns for specific populations: youth and seniors. Participants described anxiety, including "*achievement anxiety,"* among youth due to a high-pressure environment. For example, as one participant described, "*Westwood has great schools but it's also high pressure."* Bullying, and cyber-bullying also were specifically noted by some as concerns for youth in the area. Among seniors, participants described isolation and depression as pressing concerns. Some participants viewed mental health treatment in the area as limited, while others expressed the view that stigma is the main barrier that prevents individuals from seeking care.

Many participants expressed concern about the impact that the COVID-19 pandemic would have on mental health. Participants frequently discussed concerns related to youth, including depression and social isolation, and some noted that if youth have experienced previous trauma and related mental health concerns these would be exacerbated in the context of the pandemic. Participants noted that youth may be thinking "*about things they normally wouldn't because they're just at home, lots of depression and things can come up."* Additionally, and especially for elementary school aged children and younger, participants shared concerns related to child development in the context of COVID-19. As one participant stated: "*Youth are being faced with isolation especially [children in] Prek-5th grade… they are missing out on a lot of social interactions that are important for development*." Some participants also noted that parents are worried and stressed, and that kids understand and can be impacted by their parents' mental health. Another population that was described as particularly vulnerable to mental health issues during the pandemic was seniors, which is described in more detail in the subsequent section.

In 2012-2014, there was minor variation across the Westwood service area in the proportion of adults reporting 15 or more days of poor mental health in the past month. The highest proportion of adults reporting 15 or more days of poor mental health in the past month was in Canton (10.4%) and the lowest was in Needham (8.7%) (Figure 46). Data for Boston were not available by specific neighborhoods.

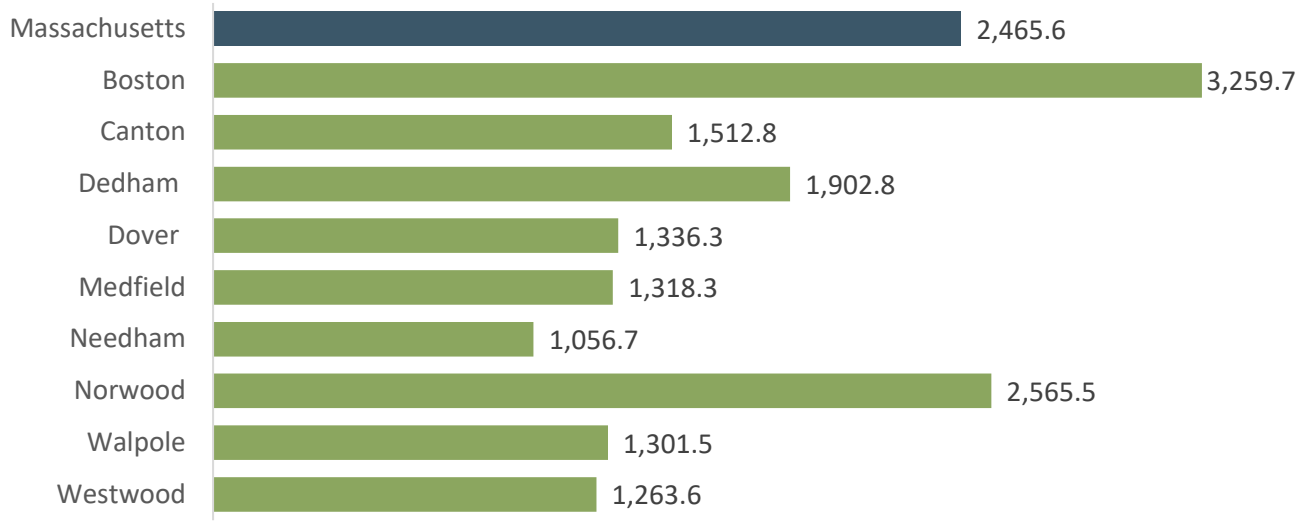
Figure 46. Percent of Adults Reporting 15 or More Days of Poor Mental Health in the Last Month, in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years.

Age-adjusted emergency department visits for mental health followed a different pattern in 2014. Norwood reported 2,565.5 visits per 100,000 residents, compared to only 1,056.7 in Needham (Figure 47).

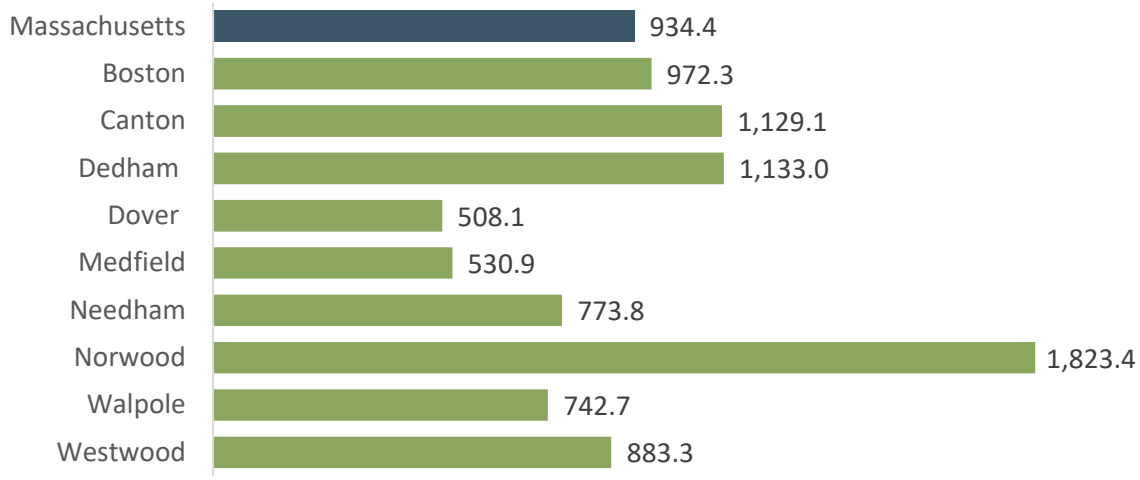
Figure 47. Mental Health Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Age-adjusted hospitalizations for mental health were also relatively high in Norwood in 2014 (1,823.4 per 100,000 residents) (Figure 48). Canton and Dedham also had rates that appeared to be above the state average.

Figure 48. Mental Health Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



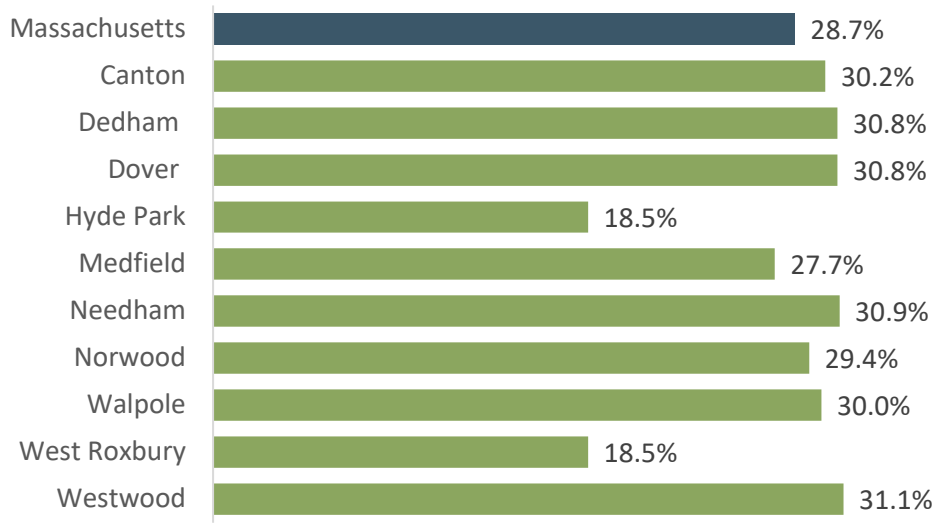
DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Mental Health among Seniors

Many participants noted that isolation can be a concern community-wide, but that seniors in particular are isolated especially during the pandemic and that this isolation can lead to a variety of mental health issues. As one participant explained: "*An issue that will only get bigger during pandemic is isolation. [It's] always an issue for our older citizens. We are a typical suburban community, you can be in your house, you don't necessarily know your neighbors, you can struggle without anyone being aware."*

Secondary data indicate that many seniors were struggling with mental health even before the pandemic. In 2018, almost one in three Massachusetts seniors 65+ years old reported having depression (Figure 49). Prevalence was similar in most towns around Westwood, with the exception of Hyde Park and West Roxbury, where only 18.5% of seniors reported having depression.

Figure 49. Percent of Adults Aged 65 years or Older with Depression, in Massachusetts, by Town and Boston Neighborhood, 2018



DATA SOURCE: Tufts Health Plan, Massachusetts Healthy Aging Data Report, 2018.

Substance Use

> "*There's definitely lots of drugs, not heroin, but all the other kinds of pills and things like that... When you have money, have access to buying things."* – Key informant interviewee
>
> "*I wasn't a big drinker before COVID but once it started, I was drinking more."* – Focus group participant

Participants expressed some concerns about substance use in the Westwood service area. Specific types of substance use mentioned as concerns by participants included: alcoholism, vaping and in particular use of Juul e-cigarettes, and access to "*pills"* and "*minor drugs."* A few participants noted that opiate use, including heroin has not been a large concern in the area, with one participant explaining: "*Opioids have not been so severe here; there have been no deaths in past years.*" This perception of limited opiate use is reflected in the secondary data below. As one participant summarized: "*There's definitely lots of drugs, not heroin, but all the other kinds of pills and things like that... When you have money, have*

access to buying things." Some participants also expressed concern about how the COVID-19 pandemic may be impacting substance use for community members. One focus group participant, for example, shared that "*I wasn't a big drinker before COVID but once it started, I was drinking more."* One participant shared that there may be misperceptions about substance use during COVID-19 and noted the importance of messaging accurate information to the community.

Opioid-related overdose deaths were very rare in the towns around Westwood in 2014-2019, with only Dedham in 2016 and Walpole in 2018 reporting 10 or more deaths (Table 9).

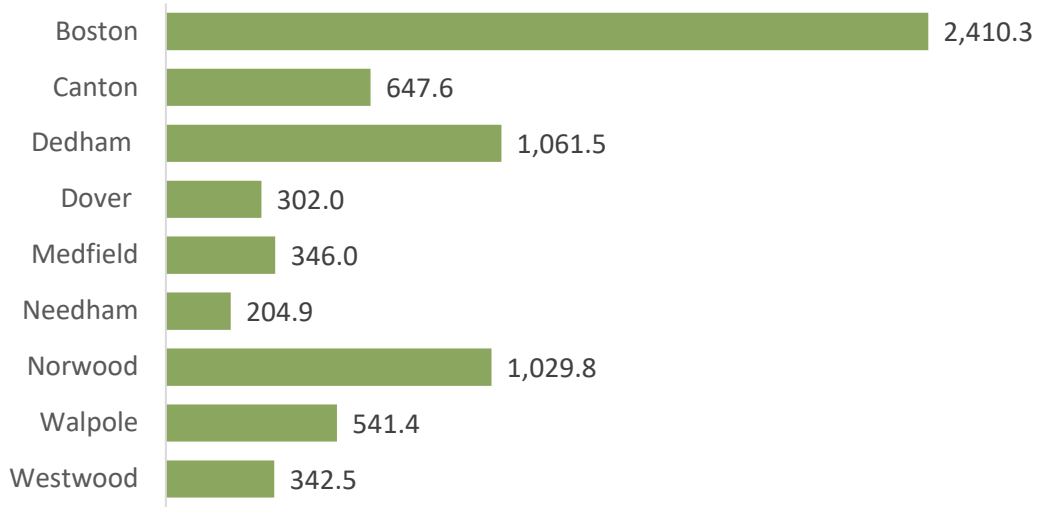
Table 9. Count of Opioid-Related Overdose Deaths, Massachusetts and by Town, 2014-2019

	2014	2015	2016	2017	2018	2019
Massachusetts	1,365	1,747	2,094	1,977	2,005	1,972
Boston	108	155	195	200	182	165
Canton	4	6	6	9	4	0
Dedham	4	5	11	3	5	3
Dover	0	0	0	1	0	1
Medfield	0	0	1	0	2	0
Needham	0	1	1	1	2	1
Norwood	5	7	6	8	6	5
Walpole	1	4	7	4	10	5
Westwood	2	1	5	0	0	0

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Number of Opioid-Related Overdose Deaths All Intents by City/Town, 2013-2019 (updated April 2020)
NOTE: Please note that 2017-2019 death data are preliminary and subject to updates. Case reviews of deaths are evaluated and updated on an ongoing basis. A large number of death certificates have yet to be assigned final cause of death codes. The information presented in this city/town table only includes confirmed cases.

In 2016-2017, there was variation in the rate of enrollment for substance addiction services in the towns around Westwood. Boston had by far the most enrollments, but data were not available by specific neighborhood. The highest rates were in Dedham (1,061.5 enrollments per 100,000 residents) and Norwood (1,029.8 enrollments) (Figure 50).

Figure 50. Bureau of Substance Addiction Services Enrollments, Rate per 100,000 population, by Town, 2016-2017



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Addiction Services, 2016-2017.

Environmental Health

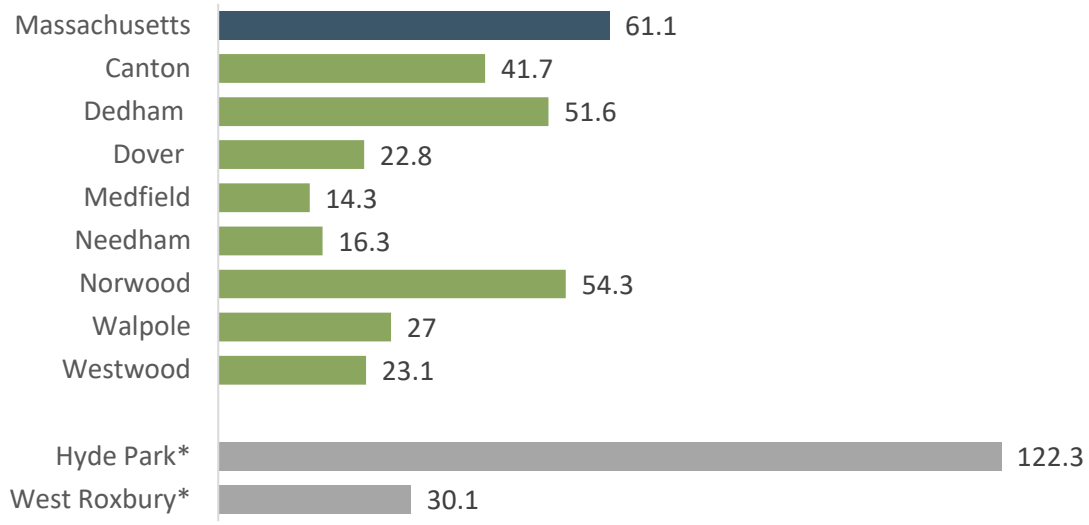
> "*There are people who have concerns [about toxic contaminants in the soil when they are] growing gardens in their backyards or playing in their yards*." – Focus group participant
>
> "*Hyde Park is very old – a lot of magnesium was dumped in our neighborhood*." – Focus group participant

Only a few interview and focus group participants shared concerns related to environmental health. One participant noted that there are contaminants in the streams and soil in the area, describing this contamination as follows: "*There was a stream behind our house that the movie Erin Brockovich is about. One of my neighbors just passed away from the contaminants. There are people who have concerns about growing gardens in their backyards or playing in their yards."* Another participant noted that their neighborhood is very old, and that "*a lot of magnesium was dumped"* in the area. However, in general, environmental health issues were not raised often by participants.

Asthma

In 2016, (Boston neighborhoods have combined 2016-2017 data), Massachusetts had an age-adjusted rate of 61.1 asthma-related visits to the emergency room per 100,000 population. The rates in towns and neighborhoods ranged from 122.3 visits per 100,000 (Hyde Park) and 54.3 visits per 100,000 (Norwood) to 14.3 visits per 100,000 (Medfield) (Figure 51).

Figure 51. Asthma Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town (2016) and Boston Neighborhood (2016-2017 combined)

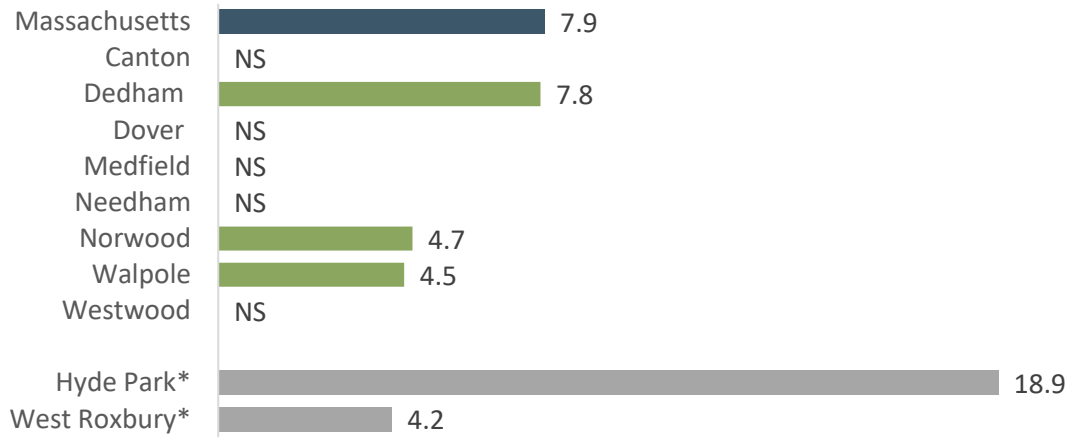


DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016.

* for Boston Neighborhoods: CHIA, Boston Public Health Commission, 2016-2017 Combined.

In 2016, (Boston neighborhoods had combined 2016-2017 data), Massachusetts had an age-adjusted rate of 7.9 asthma hospitalizations per 100,000 population. The rates in towns and neighborhoods within the Westwood service area ranged from 18.9 hospitalizations per 100,000 (Hyde Park) and 7.8 hospitalizations per 100,000 (Dedham) to 4.2 visits per 100,000 (West Roxbury). Data from several towns are not present due to insufficient sample size (Figure 52).

Figure 52. Asthma Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town (2016) and Boston Neighborhood (2016-2017 combined)



DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016.
* for Boston Neighborhoods: CHIA, Boston Public Health Commission, 2016-2017 Combined.
NOTE: NS = Data not shown due to insufficient sample size.

Air Quality

Fine particulate matter (PM2.5) is an air pollutant that is a concern for people's health when levels in air are high. PM2.5 are tiny particles in the air that reduce visibility and cause the air to appear hazy when levels are elevated. The long-term standard (annual average) for safety is 12 micrograms/cubic meter. All towns in the area were under that threshold. Data indicate that annual average PM2.5 concentrations for the area were around 7.4 for most towns, ranging from 7.8 micrograms/cubic meter in Boston to 7.2 micrograms/cubic meter in Canton (Figure 53).

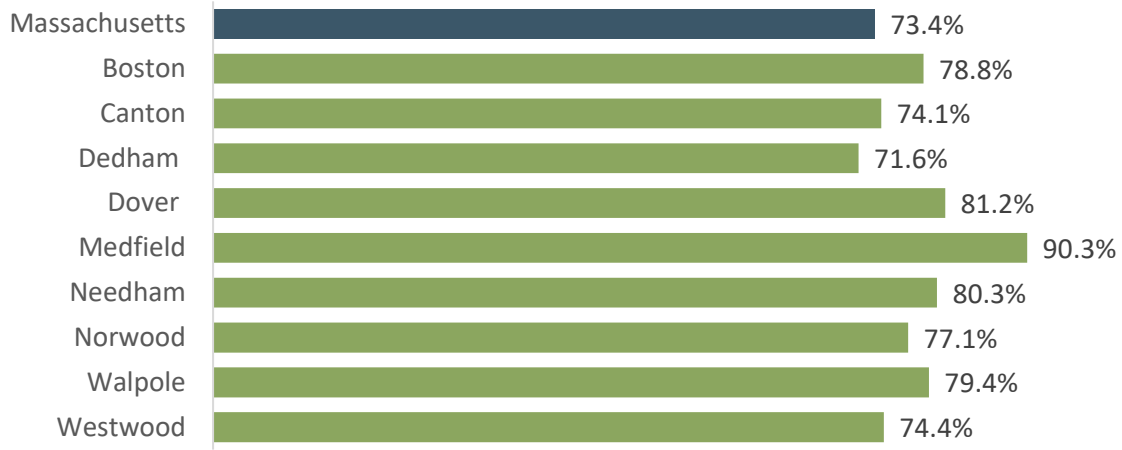
Figure 53. Air Quality Modeled Data Annual Average PM2.5 Concentrations (micrograms/cubic meter), by Town, 2014

DATA SOURCE: Massachusetts Department of Public Health, Bureau of Environmental Health, 2014.
NOTE: Air Quality is a localized measure, therefore statewide estimates are not available.

Lead

In 2013-2017, 73.4% of children aged 9-47 months were screened for lead poisoning in Massachusetts. By town, percentages of screened children ranged from 71.6% in Dedham to 90.3% in Medfield (Figure 54).

Figure 54. Percent of Children 9-47 Months Screened for Lead Poisoning, in Massachusetts and by Town, 2013-2017



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Environmental Health, Childhood Lead Poisoning Prevention Program, 2013-2017

Infectious and Communicable Disease

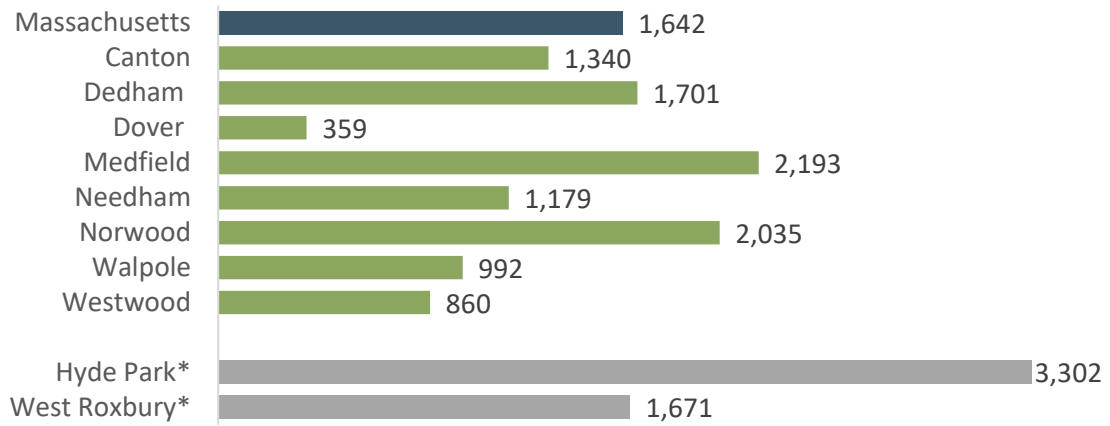
COVID-19

> *"One of the biggest issues was not being able to be tested... If we could have had the ability to test everyone it would have been greatly beneficial."* – Key informant interviewee
>
> "*In our community, there are a lot more low-wage workers when [you] look at [COVID-19] cases."* – Key informant interviewee

Interview and focus group participants shared concerns about the ongoing spread and impact of COVID-19. Some participants described frustration that residents were not following social distancing and mask-wearing recommendations and that there were no mechanisms for enforcing these recommended measures to prevent the spread of COVID-19. Many participants also shared concerns about access to testing (including whether free testing was available) and the accuracy of testing. Participants also noted that COVID-19 has disproportionately affected certain communities and populations including low-wage workers and immigrants. One interviewee who had done contact tracing and described speaking with "*one family, immigrants, non-English speaking, multi-generational family in a two-bedroom apartment"* and seeing "*how [the] virus spread within households, [because they] didn't have [the] luxury of owning a house and being able to… isolate themselves."* Another interviewee shared that *"[i]n our community, there are a lot more low-wage workers when [you] look at [COVID-19] cases."*

Through mid-August 2020, the COVID-19 case rate in MA was 1,642 cases per 100,000 population. The case rate varied across the Westwood service area, with the highest case rate occurring in Hyde Park (3,302 per 100,000 population) and the lowest case rate occurring in Dover (359 per 100,000 population).

Figure 55. Coronavirus (COVID-19) Case Rate per 100,000 Population, in Massachusetts, by Town and Boston Neighborhoods, as of mid-August 2020



DATA SOURCE: Massachusetts Department of Public Health, 2020.
* for Boston neighborhoods: Boston Public Health Commission (BPHC), Communicable Disease Control Division, 2020.
NOTE: Data for MA and towns as of August 12, 2020. Data for Boston neighborhoods as of August 6, 2020.

Vector-Borne Infectious Diseases

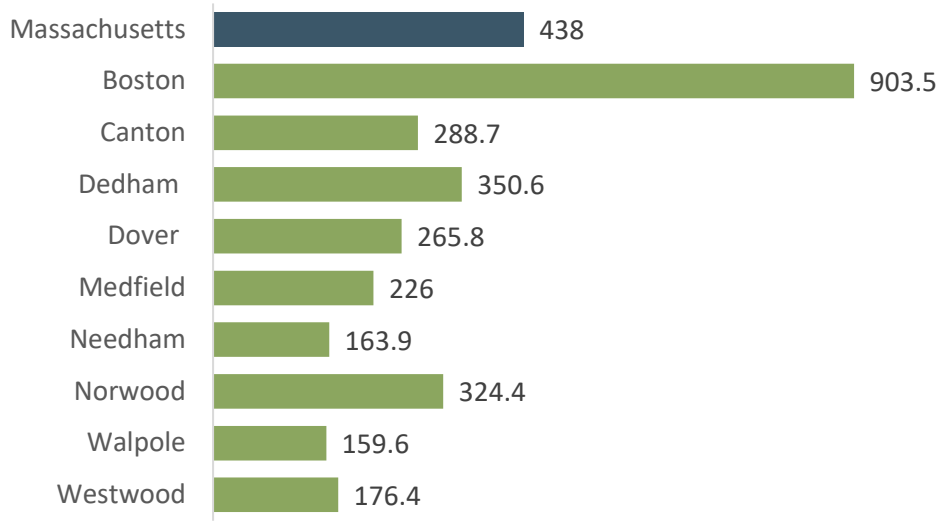
Some focus group participants described Lyme disease as a concern in their communities and one participant expressed worry about "Triple E" or Eastern Equine Encephalitis. Participants noted that Lyme disease has affected people that they know personally, with one participant sharing that "Lyme disease is a huge concern. We have so many ticks and the more people I talk to the more people I know are affected by Lyme disease." In 2019, the Massachusetts Department of Public Health reported that the rate of Emergency Department visits due to tick-borne diseases was 6.6 per 10,000 population in Norfolk County and 1.6 per 10,000 population in Suffolk County.[9]

Sexual Health and Sexually Transmitted Diseases

Sexual health concerns were not raised frequently by interview or focus group participants. One focus group participant did share that "*Sexual education is lacking*" and noted a need for more sexual education resources in schools. However, this topic was not raised in other interviews or focus groups.

In 2018, there were 438 cases of chlamydia per 100,000 population in Massachusetts. By town, the rates of chlamydia per 100,000 population ranged from 159.6 in Walpole to 903.5 in Boston (Figure 56).

Figure 56. Chlamydia Cases, Crude Rate per 100,000 population, in Massachusetts and by Town, 2018

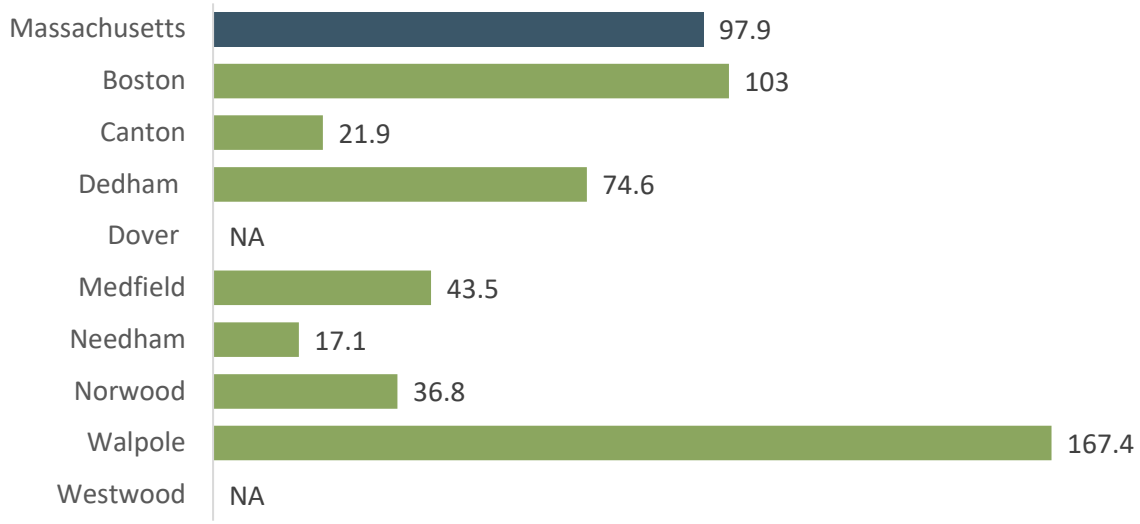


DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2018.

[9] Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2019.

In 2018, there were 97.9 cases of Hepatitis C per 100,000 population in Massachusetts. By town, the rates of Hepatitis C per 100,000 population ranged from 17.1 in Needham to 167.4 in Walpole (Figure 57).

Figure 57. Hepatitis C Cases, Crude Rate per 100,000 population, in Massachusetts and by Town, 2018

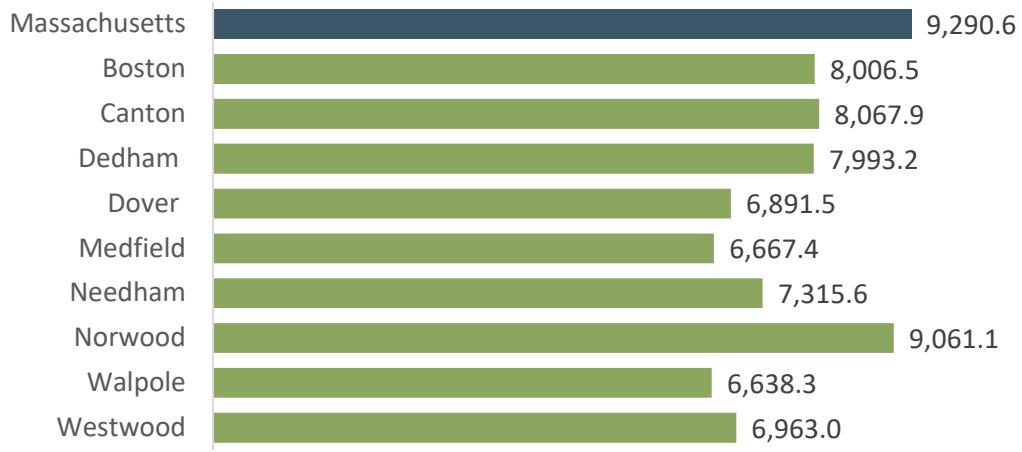


DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2018.

Injury

Interview and focus group participants did not raise injury as a concern fort their communities. In 2014, there were 9,290.6 unintentional injury emergency department visits per 100,000 in Massachusetts. By town, unintentional injury emergency department visits ranged from 6,638.3 (Walpole) to 9,061.1 (Norwood) per 100,000 population (Figure 57).

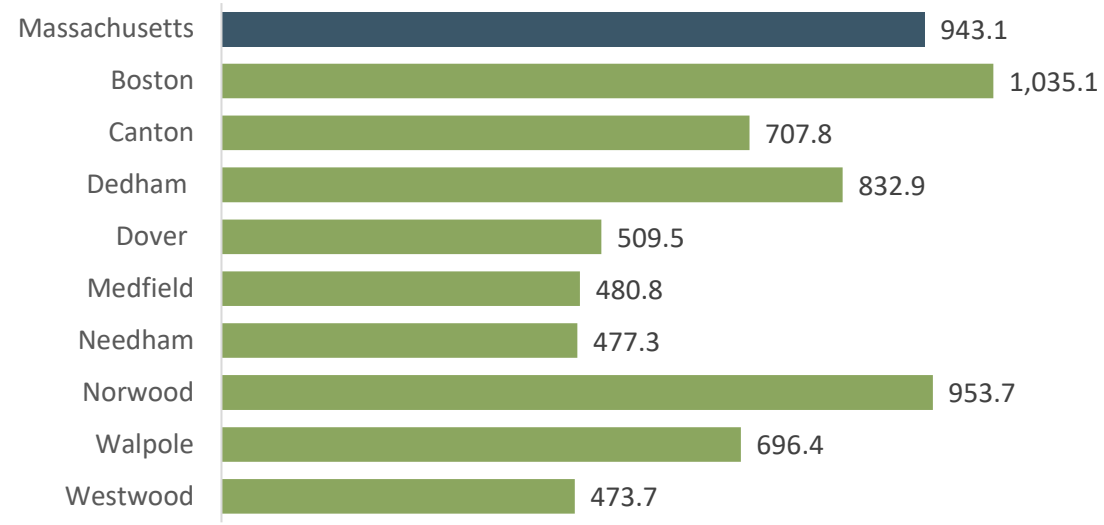
Figure 58. Unintentional Injury Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, there were 943.1 motor vehicle accidents where occupants were injured per 100,000 in Massachusetts. By town, accidents ranged from 473.7 per 100,000 population in Westwood to 1,035.1 per 100,000 population in Boston (Figure 59).

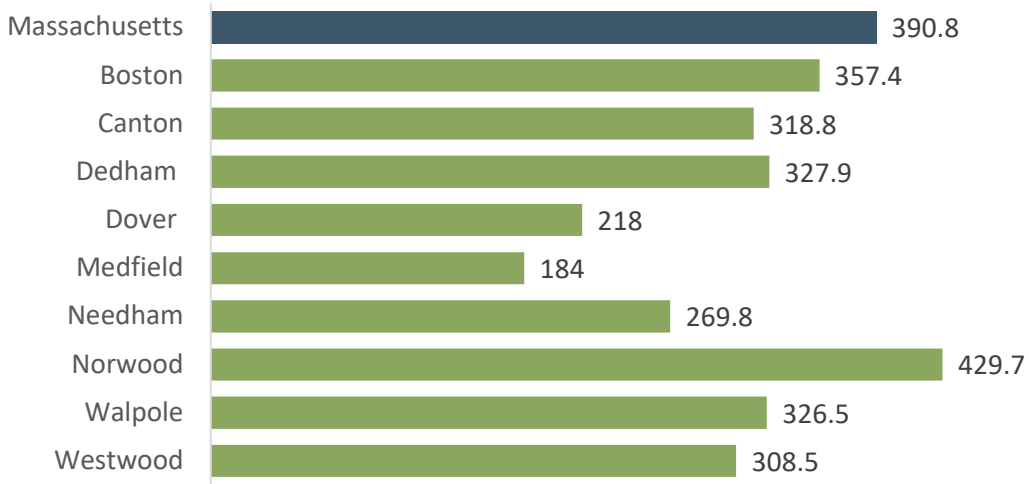
Figure 59. Motor Vehicle Accidents where Occupants are Injured, Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Falls are a particular concern of injury among the senior population. In 2014, the age-adjusted rate per 100,000 population of hospitalizations due to a fall was 390.8 in Massachusetts. By town, the age-adjusted rate per 100,000 population of fall hospitalizations ranged from 184 in Medfield to 429.7 in Norwood (Figure 60).

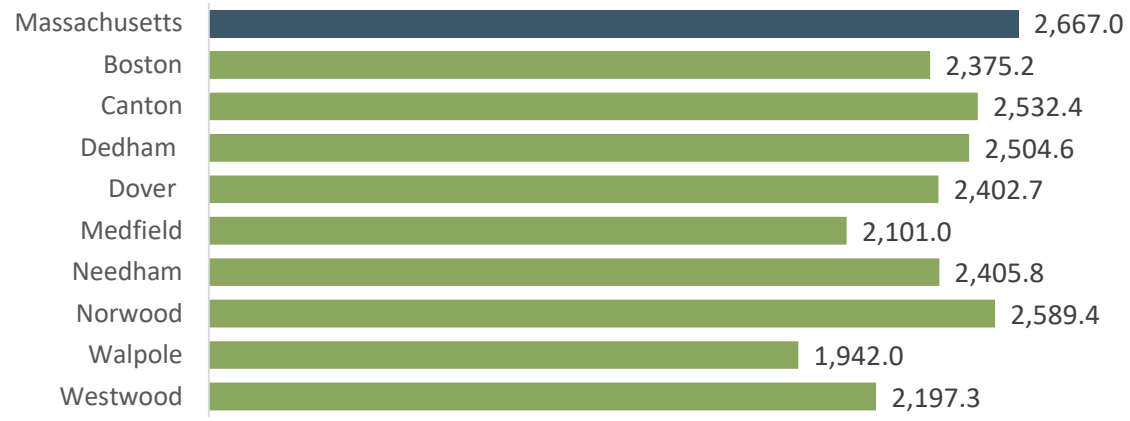
Figure 60. Falls Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, the age-adjusted rate per 100,000 population of emergency department visits due to a fall was 2,667.0 in Massachusetts. By town, the age-adjusted rate per 100,000 population of fall emergency department visits ranged from 1,942.0 in Walpole to 2,589.4 in Norwood (Figure 61).

Figure 61. Falls Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014

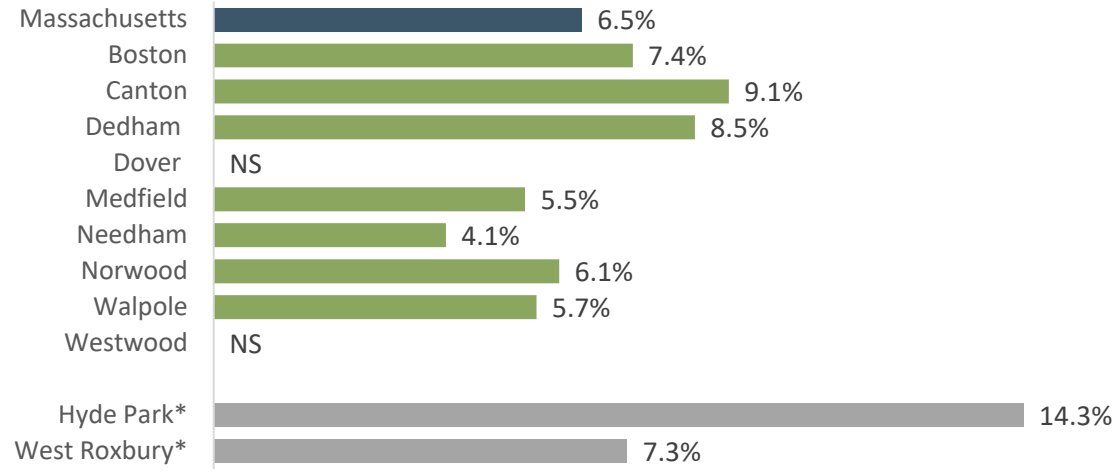


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Maternal and Infant Health

While, as described above under "mental health," concerns about child development in the context of COVID-19 and social distancing were raised, in general participants did not discuss maternal and infant health in detail. In 2015, the percent of preterm births in Massachusetts was 6.5%. By town, preterm births ranged from 4.1% Needham to 9.1% in Canton and 14.3% in Hyde Park (Boston Neighborhood data is from 2017) (Figure 62).

Figure 62. Percent Preterm Births, in Massachusetts and by Town (2015) and Boston Neighborhood (2017)



DATA SOURCE: for MA and Towns: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2015.

* for Boston neighborhoods: MDPH, Boston Public Health Commission, Boston Resident Live Births, 2017.

NOTE: Preterm birth is defined as being born before 37 weeks of gestation.

ACCESS TO SERVICES

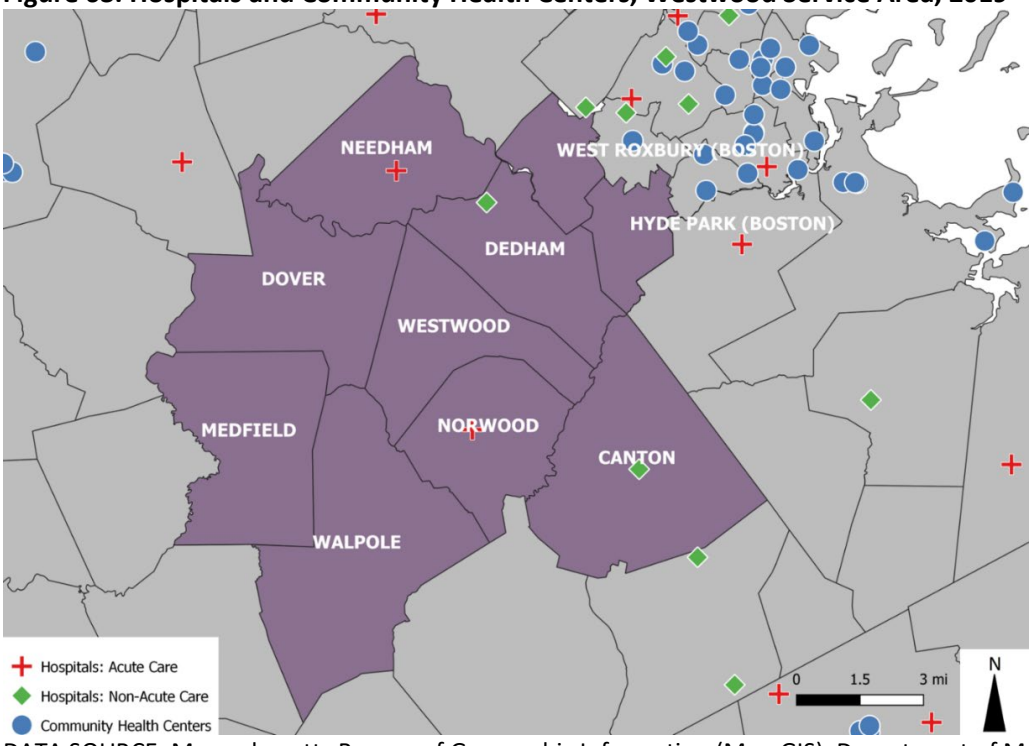
Access to Healthcare Services

> *"When I transitioned to MassHealth, I tried to find a provider in Walpole, but I couldn't find anything. I'm pregnant, and I have to go all the way to Boston to get services."* – Focus group participant

> *"We have a lot of older people in town that don't have access to the computer and can't connect with their doctors through the computer."* – Focus group participant

As noted earlier, 60.7% of Westwood Community Priorities Survey respondents indicated that being close to medical services was a strength of their community. As shown in Figure 63, there are a few acute and non-acute hospitals in the Westwood service area and numerous healthcare services in close proximity of the area in Greater Boston. County-level data also indicate that there are more per capita providers in the service area than in Massachusetts overall. Table 10 shows the ratio of population per provider (for this indicator, a lower population number indicates more providers per capita.) In 2017-2019, Massachusetts had 1 primary care provider per 970 people, whereas Norfolk County had 1 for every 790 people, and Suffolk County had 1 for every 670 people. Massachusetts had 1 dentist per 970 people, Norfolk County had 1 dentist for every 820 people, and Suffolk County had 1 dentist for every 480 people. Massachusetts had 1 mental health provider per 160 people, Norfolk County had 1 mental health provider for every 160 people, and Suffolk County had 1 mental health provider for every 120 people.

Figure 63. Hospitals and Community Health Centers, Westwood Service Area, 2019



DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Department of Mental Health (DMH) & Massachusetts Department of Public Health: Bureau of Environmental Health GIS Program League of Community Health Centers, Office of Medical Services, Center for Health Information and Analysis, 2019.

Table 10. Ratio of Population per Health Care Provider, in Massachusetts and by County, 2017-2019

	Primary Care Physicians (2017)	Dentists (2018)	Mental Health Provider (2019)
Massachusetts	970	1:970	160
Norfolk County	790	820	160
Suffolk County	670	480	120

DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, 2017-2018; Centers for Medicare & Medicaid Services, National Provider Information Registry, as reported by County Health Rankings, 2019.

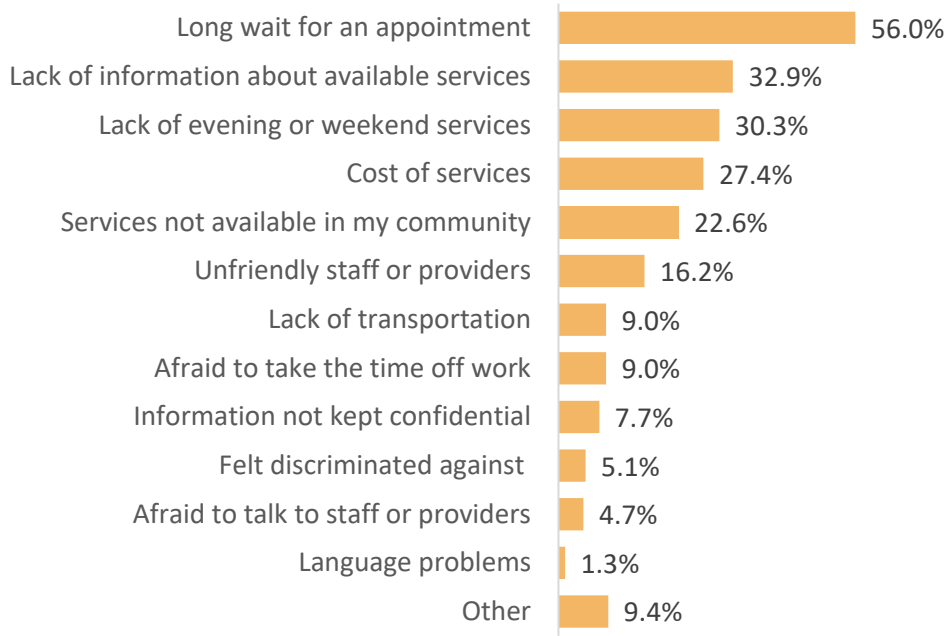
When discussing local healthcare services, in general, most participants described available local options for care, though some participants expressed a preference for traveling into Boston for care and others expressed a desire for more local care options. For example, one participant shared: "*I would like to see the mental health or maybe a surgical center. It makes life so much easier to drive three miles than to drive into Boston*." Participants did describe some specific challenges related to access including the difficulty of finding providers that accept Medicaid (MassHealth) and the lack of mental health providers. When explaining the challenges of finding providers that accept MassHealth insurance, one participant shared that "*When I transitioned to MassHealth, I tried to find a provider in Walpole, but I couldn't find anything. I'm pregnant and I have to go all the way to Boston to get services."* Many participants also stated that there are not enough mental health services in the Westwood service area.

Participants also shared perspectives on the ways in which the COVID-19 pandemic has impacted access to and the use of healthcare services. In general, many participants noted that COVID-19 has caused residents to delay seeking care, especially in-person care, and stated that "*Everything related to health care, people are pausing."* One participant familiar with the local emergency medical services (EMS) work further echoed this observation by noting that: during the pandemic, "*the call volume has gone down 25-30% but [the] acuity of issue[s] has gone up as people have waited to seek care."* Some participants also expressed concern about the home health care workforce. Participants noted that with recent restrictions on immigration, they worried about the availability of home care workers to meet the demand in the area. Another issue related to home care described by a few participants was medication management for seniors. As one participant shared: "*Medication management is a big issue... We noticed during COVID, people who needed to get their INR [international normalized ratio] levels checked [for a number of reasons, including because they are on blood thinners] and then all the sudden couldn't do that."*

Many participants noted the increase in telehealth during the pandemic. Participants indicated that telehealth is appropriate for some, but not all medical issues, and expressed concern that seniors in particular may lack access to telehealth due to limited technology literacy, as well as lack of access to devices and/or the internet. As one participant described, *"We have a lot of older people in town that don't have access to the computer and can't connect with their doctors through the computer."*

When Westwood Community Priorities Survey respondents were asked which barriers, they experienced when accessing services, 51.1% reported experiencing barriers to accessing medical, mental health, or social services in the past six months. Among these respondents, the most common barriers were long waits for appointments (56.0%), lack of information about available services (32.9%), lack of evening or weekend services (30.3%), and cost of services (27.4%) (Figure 64).

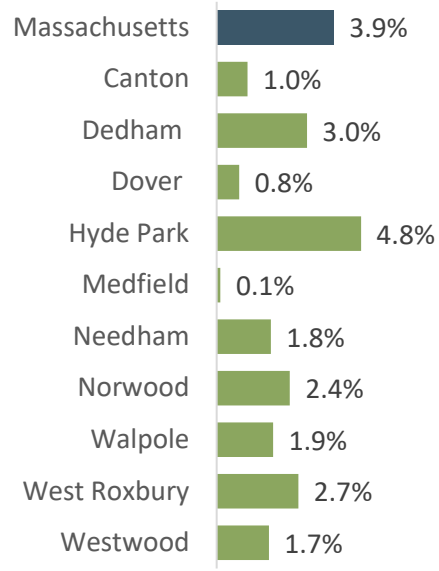
Figure 64. Percent of CHNA Community Priorities Survey Respondents Reporting Barriers to Accessing Medical, Mental Health or Social Services in the Past Six Months, among Respondents Reporting at Least One Barrier, 2020 (N=234)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

While having no health insurance was not mentioned in the Westwood Community Priorities Survey or focus group/interview discussions as a significant barrier to care among residents, secondary data indicate that uninsured rates are low overall but do vary by community. In 2014-2018, the percent of adults with no health insurance in Massachusetts was 3.9%. By town, the percent of the population with no health insurance ranged from 0.1% in Medfield to 4.8% in Hyde Park (Figure 65).

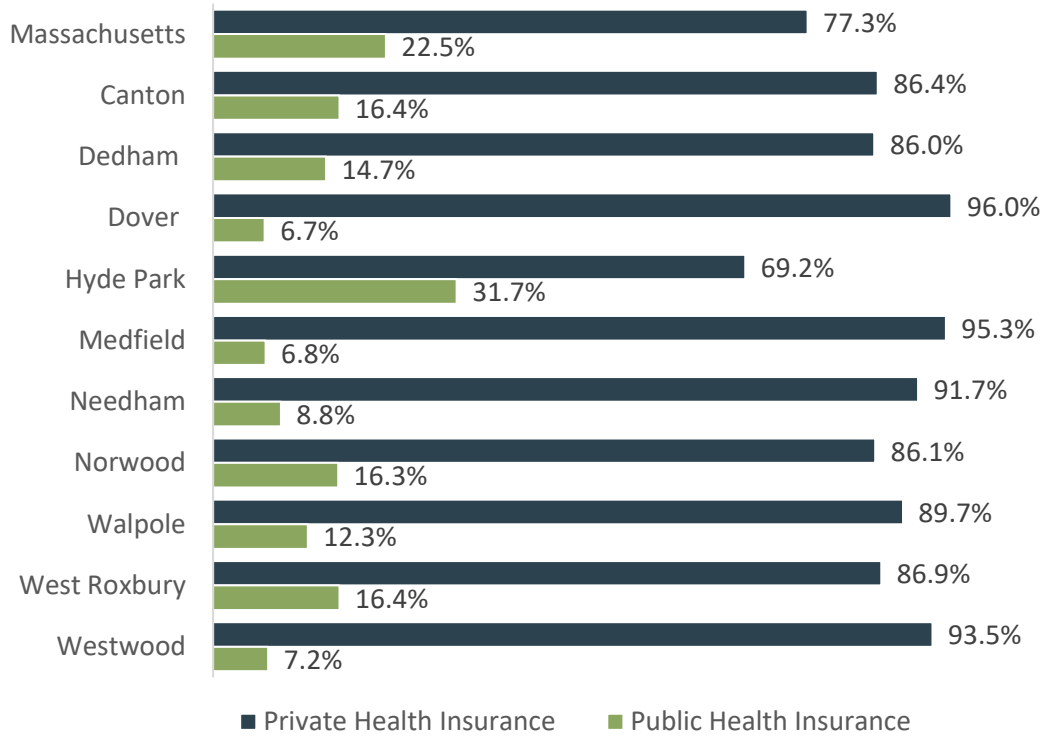
Figure 65. Percent Population 18 Years or Over with No Health Insurance, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

In 2014-2018, the percent of adults with private health insurance in Massachusetts was 77.3%. By town, the percent of the population with private health insurance ranged from 69.2% in Hyde Park to 96.0% in Dover (Figure 66). In 2014-2018, the percent of adults with public health insurance in Massachusetts was 22.5%. By town, the percent of the population with public health insurance ranged from 6.7% in Dover to 31.7% in Hyde Park (Figure 66).

Figure 66. Percent Population 18 Years or Over with Health Insurance, by Type, in Massachusetts, by Town and Boston Neighborhood, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Access to Social Services or Other Essential Services

> "*People aren't always aware of the resources, and it's hard to access the information."* – Focus group participant
>
> *"Now what we need is support for us to help our seniors during COVID. We still have programming, but we don't charge anything. We have no income stream*." – Key informant interviewee

Interview and focus group participants described availability of some social and essential services in the area, such as services for seniors, and in the context of the pandemic, food pantries. However, some participants described a need to improve communication about existing services and to ensure that information is shared with the community widely. As one participant described, "*People aren't always aware of the resources, and it's hard to access the information."* Additionally, one participant noted that some of the communities in the Westwood service area are "*stuck in the middle,"* meaning that they "*have needs for additional social services but not the volume that brings the services to the community*. "

Programming for seniors and access to technology were two types of services raised frequently during interview and focus group discussions. Across the Westwood service area, there was variation in participants' perceptions of senior services, with participants in some towns and neighborhoods expressing they were "*disappointed"* in the availability of these services while participants in other geographies noted senior services were excellent. However, even in towns with robust senior services, participants noted the need for additional support for local Councils on Aging and other senior supports. For example, one participant from an organization that provides services for seniors stated that "*Now what we need is support for us to help our seniors during COVID. We still have programming, but we don't charge anything. We have no income stream*." Lastly, some participants raised the issues of technology access for seniors, low-income housing residents, and others living in these communities. Participants pointed out the importance of technology for access to information and social connection and noted that some residents do not own devices or have access to wireless internet.

COMMUNITY PERCEPTIONS AND VISION FOR THE FUTURE

Community Perceptions of Top Issues for Action

> *"Definitely transportation… If you improve that I think it will have a ripple effect on so many other things. Better opportunities for not just surviving but thriving, better mental health, etc."* – Key informant interviewee
>
> *"I would also say perhaps a program that can help people who aren't at the bottom but in the middle… I would say broadly, but also more housing. Like what's the point of having a roof over your head if you're starving underneath it?"* – Focus group participant
>
> *"Mental health awareness and acceptance."* – Key informant interviewee

Interview and focus group participants were asked to share their perceptions of the highest priority issues for future action in their communities, thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change. Housing, transportation, and mental health were discussed frequently as high priority issues in the communities in the Westwood service area. Some participants prioritized transportation generally, while others specified that expanding transportation access was important specifically for seniors, for youth, and for transportation to medical appointments. As one interviewee shared, "*If you improve [transportation] I think it will have a ripple effect on so many other things. Better opportunities for not just surviving but thriving, better mental health, etc.*" Another issue prioritized by many participants was affordable housing, including for seniors. Participants stressed the importance of affordability; as one focus group participant shared, "*I would also say perhaps a program that can help people who aren't at the bottom but in the middle… They make just a dollar above the poverty line but they're really struggling…. I would say broadly, but also more housing. Like what's the point of having a roof over your head if you're starving underneath it?*" Mental health was another issue that many participants cited as a high priority for action. Priorities within the issue of mental health included access to mental health services and providers locally, as well as mental health promotion or "*Mental health awareness and acceptance*."

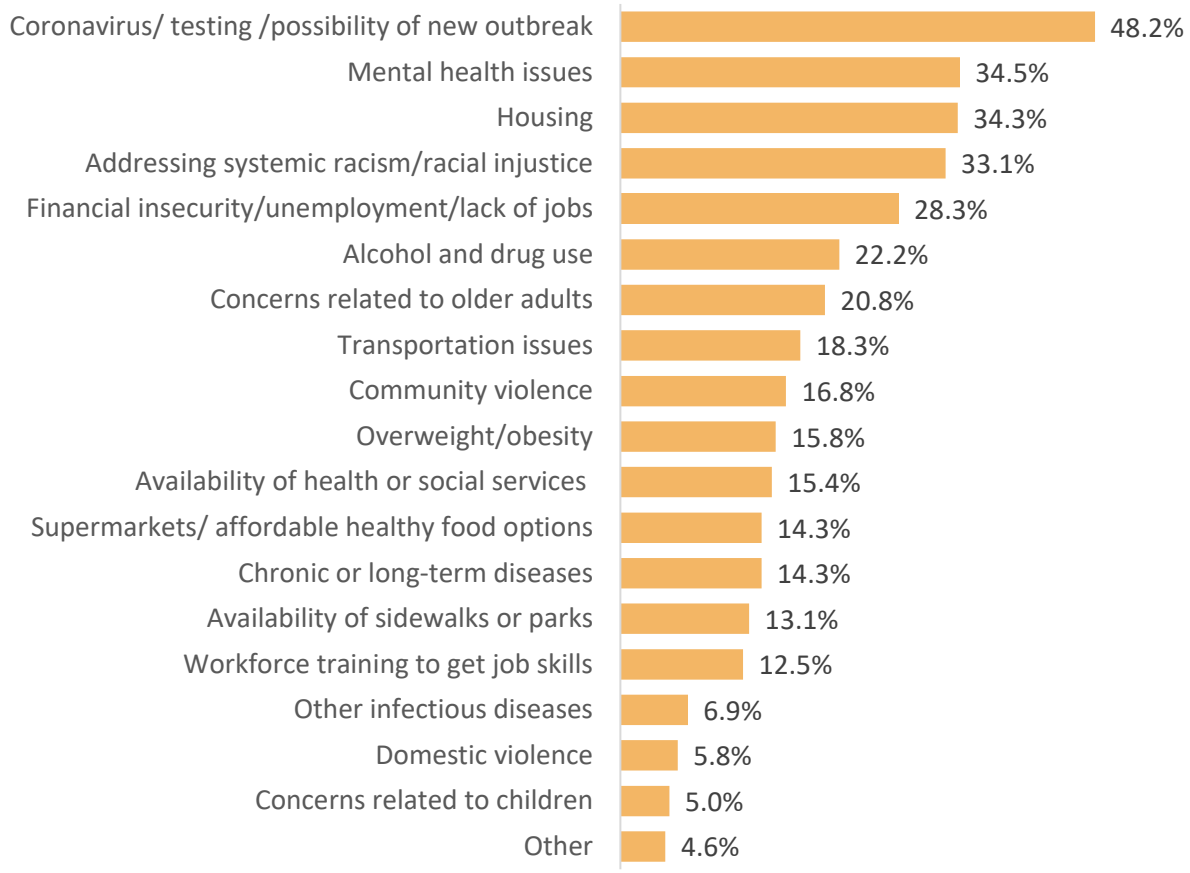
Participants also shared priorities for future action that were specific to the context of the COVID-19 pandemic. These priorities included: ensuring for the needs of seniors are met and addressing issues of isolation for seniors; supporting children and parents as they transition to online learning and providing

opportunities for social interaction that supports social and emotional development; and preparing for future pandemics. For example, as one key informant interviewee shared, "*Youth are being faced with isolation, especially [children in] Prek-5th grade. This group needs engagement from an education standpoint and social engagement*."

Some additional priority issues were raised by a few participants and included: access to childcare; aging issues; internet access; diversity; and community connectedness. A few participants described a need for more affordable childcare options, during the pandemic as well as more broadly, to support working parents. For example, one focus group participant shared that "*I'm a teacher for a Montessori school and I can't even afford to send my daughter to my school if I wanted to*." A few participants also described aging issues as high priorities for action, including aging health issues and "*retrofitting to help people age in place.*" A few participants also prioritized access to the internet across the community, and "*not just in the single-family households*." A few focus group participants stated that "*diversity*" was a priority and noted the lack of diversity in some communities and institutions such as the school system. Lastly, some focus group participants prioritized activities that would increase community connection and community enrichment. For example, one focus group participant suggested developing a "*community center*," whereas another focus group participant more generally suggested "*More closeness to communities. More activities on the weekend that are free to make neighbors feel closer*."

Westwood Community Priorities Survey respondents also were asked to consider the most important issues in their communities to take action on in the next few years. Respondents were asked to consider the importance of these issues in regard to Concern, Equity, Effectiveness, and Feasibility (see Appendix E for survey instrument) and to select the five most important issues for action. Considering these criteria, the top five issues of concern were (1) coronavirus/COVID-19 testing and/or the possibility of a new outbreak, (2) mental health issues, (3) housing, (4) addressing systemic racism/racial injustice, and (5) financial insecurity/unemployment/lack of job opportunities (Figure 67). Many of these top issues align with the themes from the qualitative data collection.

Figure 67. Percent of CHNA Community Priorities Survey Respondents Reporting Most Important Issues for Action in the Next Few Years in Their Community, 2020 (N=481)



NOTE: Question in the survey allowed for up to five responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

In sociodemographic sub-groups defined by educational attainment and race/ethnicity, all groups except non-Hispanic Blacks most commonly reported issues related to coronavirus/COVID-19 as the top priority (Figure 68). As a group, non-Hispanic Blacks ranked housing, financial insecurity, and workforce training as being higher priorities for action; they did not list addressing systemic racism as one of the top five priorities. In contrast, addressing systemic racism was one of the top five priorities for respondents with a bachelor's degree or higher, non-Hispanic Whites, and non-Black People of Color. Alcohol and drug use emerged as a top priority only among those with less than a bachelor's degree.

Figure 68. Percent of CHNA Community Priorities Survey Respondents Reporting Most Important Issues for Action in the Next Few Years in Their Community, by Selected Demographics 2020

	Less than College (N=118)	College or More (N=299)	White, Non-Hispanic (N=341)	Black, Non-Hispanic (N=33)	People of Color, Non-Black (N=42)
1	Coronavirus/ testing /possibility of new outbreak (46.6%)	Coronavirus/ testing /possibility of new outbreak (58.9%)	Coronavirus/ testing /possibility of new outbreak (56.9%)	Housing (63.6%)	Coronavirus/ testing /possibility of new outbreak (54.8%)
2	Housing (44.1%)	Addressing systemic racism/racial injustice (44.5%)	Mental health issues (41.3%)	Financial insecurity/unemployment/lack of jobs (51.5%)	Financial insecurity/unemployment/lack of jobs (42.9%)
3	Financial insecurity/unemployment/lack of jobs (38.1%)	Mental health issues (41.8%)	Housing (37.2%)	Workforce training to get job skills (42.4%)	Housing (38.1%)
4	Mental health issues (34.7%)	Housing (37.5%)	Addressing systemic racism/racial injustice (37.0%)	Coronavirus/ testing /possibility of new outbreak (39.4%)	Addressing systemic racism/racial injustice (35.7%) (tied)
5	Alcohol and drug use (30.5%)	Financial insecurity/unemployment/lack of jobs (29.8%)	Financial insecurity/unemployment/lack of jobs (29.0%)	Community violence (30.3%) (tied)	Mental health issues (35.7%) (tied)
Tie				Mental health issues (30.3%) (tied)	

NOTE: Question in the survey allowed for up to five responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Suggestions for Future Programs, Services, and Initiatives

> "*On demand transportation for seniors for medical appointments*." – Key informant interviewee

> *"Incorporate check-ins for mental health with children – maybe at school."* – Focus group participant

"*I would love to see people thriving*." – Key informant interviewee

Interview and focus group participants were asked to share suggestions for specific programs, services, and initiatives for action. Many participants specifically discussed services in relation to transportation and behavioral health. In terms of transportation, a few participants shared suggestions around developing local public transportation as well as "*on demand transportation for seniors to medical appointments"* through a public-private partnership that could provide transportation for commuters at the beginning and end of the day and "*medical and social transportation for residents around town*" during the daytime. When making recommendations related to behavioral health, in addition to noting a need for additional mental health services, one participant stressed the need to "*focus on the protective factors*" and to work on "*better mental health promotion and reducing the stigma."* Another participant suggested "*incorporating check ins for mental health with children – maybe at school*."

Participants also shared a vision for the future of their communities more broadly. Participants included in this vision improved access to services including "*help reducing barriers - funding, language, physical barriers, there's not a provider in town that takes MassHealth."* A few participants also shared a vision related to diversity and equity, with one participant stating that they would like to see that "*we've been able to ensure equity across communities, to be able to ensure access for all."* Ultimately, one participant summarized the vision for the future as follows: "*I would love to see people thriving*."

KEY THEMES AND CONCLUSIONS

This community health needs assessment for the Westwood service area provides a summary of community needs, strengths, and resources based on a review of existing data, a community survey, and discussions with community residents and key informants. This assessment was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice; findings in this report can be used to inform future planning and can be built upon through future data collection efforts. The following overarching themes emerged from this synthesis and include many upstream factors:

- **There are many assets in the Westwood service area, including high-quality schools, support for families and seniors, access to parks and green space, and overall cohesion and engagement among community members.** Many CHNA participants described the Westwood service area generally as family-oriented, and identified schools, as well as services for seniors, particularly Councils on Aging, as strengths. Many Westwood Community Priorities Survey respondents rated walkability and green space as assets. Both community survey respondents and interview and focus group participants also described community pride and support, and noted that, especially during the COVID-19 pandemic, community residents engage with and care for each other.

- **While the Westwood service area overall is affluent, some communities within the area face financial insecurity, especially in the context of the economic impact of the COVID-19 pandemic.** Across the Westwood service area, there is variation in income; in 2014-2018, median annual household income ranged from $64,784 in Hyde Park to $224,784 just 10 miles away in Dover. Key informant and focus group participants noted that, while the area has high levels of wealth, there are residents within these communities who struggle to make ends meet. Participants expressed financial insecurity concerns particularly for seniors and for residents in general in the context of COVID-19 given that unemployment rates have increased. It was noted that young people, Spanish

speakers, and parents in need of childcare may be particularly vulnerable to job loss. Many participants also noted a recent increase in food insecurity. "Financial insecurity" was one of the top issues that Westwood Community Priorities Survey respondents selected as currently affecting and/or affecting their community six months ago.

- **Housing affordability was identified as a pressing concern, particularly for young adults, single parents, and seniors.** Many participants described an extremely high cost of housing in the Westwood service area and noted that high housing prices apply to both homeowners with mortgages and renters. Participants expressed concern for the "middle class" that "*make very good money [but] are living paycheck to paycheck because it's so expensive*" to live in these communities. Quantitative data also show that many households face high housing costs: the percentage of owner-occupied households with a mortgage that spend more than 30% of their income on housing costs ranges from 23.8% in Medfield to 38.5% in Hyde Park. Participants reported that affordable housing options are limited and many expressed concerns about housing development, including luxury condominiums and large houses being built in the area.

- **Transportation is a concern for some communities, particularly for certain populations including low-wage workers, seniors, and students.** While some participants described access to public transportation as an asset (for example, in Hyde Park), many participants noted that transportation is a key concern for community residents in the Westwood service area. Public transportation options beyond commuter rail stops in general were viewed as limited, and participants expressed a desire for expanded transit options especially for low-wage workers, students, and seniors.

- **Some community members have experienced or recognized discrimination in their communities and prioritized addressing racial injustice.** Some CHNA participants shared individual experiences of discrimination based on their race, ethnicity, or language, and others noted the need to examine privilege. Some interview and focus group participants suggested forming coalitions to take action around racial injustice, and addressing systemic racism was ranked fourth by Westwood Community Priorities Survey respondents among the most important issues for future action.

- **Mental health, especially for youth and seniors and in the context of the pandemic, was a pressing concern among many community residents.** Mental health issues were the top concern that Westwood community survey respondents reported had personally affected them in the past six months, with nearly 50% of respondents noting it has affected them. Quantitative data gathered prior to the COVID-19 pandemic indicate that, across the service area, 8.7% - 10.4% of adults reported having 15 or more days in the last month during which they experienced poor mental health. Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in the community, particularly among seniors, who already tend to be socially isolated. Additionally, participants with school-age children were specifically concerned about the pandemic's effect on the development and socialization of younger children and contribution to depression among youth and young adults.

- **Substance use was also a concern, though perceptions varied by type of substance.** Substance use, particularly issues related to alcoholism, vaping and e-cigarettes, and some drugs, were noted as a concern by some focus group and interview participants. Some participants also noted that the stress of the pandemic may exacerbate substance use. However, some participants stated that opiate and heroin use were less of a concern in the Westwood area compared to other parts of the

state. In the Westwood community survey, 22.2% of respondents included alcohol and substance use as one of their top 5 community priorities for action.

- **Concerns remain about COVID-19 spread and access to testing.** Many CHNA participants commented on the ways in which the COVID-19 pandemic has impacted aspects of day-to-day life as described above, including financial security, employment, food security, housing, and mental health. Additionally, participants shared concerns about the ongoing spread and impact of COVID-19 and about access to accurate testing. COVID-19 concerns were ranked first by Westwood Community Priorities Survey respondents among the most important issues for future action.

- **Many healthcare and social services are available in the area, but there is opportunity for improving access to and communication about local options.** Interview and focus group participants described available services including local healthcare options, programming for seniors and, in the context of the pandemic, food pantries. However, challenges to accessing services included difficulty finding providers that accept Medicaid (MassHealth), lack of mental health providers, limited telehealth access, and a need for additional community-wide communication about existing services.

PRIORITY NEEDS OF THE COMMUNITY

Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. This section describes the process and outcomes of the Westwood-area CHNA prioritization process.

Westwood Service Area – Prioritization Process

Assessment Study – Primary and Secondary Data Collection
- Synthesized data on social, economic, and health issues
- CHNA participants identified areas of concern and priority via key informant interviews, focus groups, and the Community Priorities Survey

Virtual Community Prioritization Meeting
- Presented study findings and voted on priorities using selected criteria

Community Advisory Board Meeting
- Regional community leaders discussed study findings and community prioritization meeting results; refined and approved priorities

Criteria for Prioritization
When embarking on a prioritization process, using set criteria assists in providing parameters for selection. The following four criteria were used to guide prioritization discussions and voting processes with community members from the Westwood service area, as well as the Community Advisory Board who provided oversight of the CHNA.

Prioritization Criteria

- **Concern:** How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?

- **Equity:** Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?
- **Effectiveness:** Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?

Process Prioritization
The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection
During each step of the primary data collection phase of the CHNA, study participants were asked for input on the top priorities for action in their communities when considering the prioritization criteria. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities, as well as the three highest priority issues for future action and investment (Appendices C and D). Westwood Community Priorities Survey respondents also were asked to select up to five of the most important issues for future action on in their communities (Appendix E).

Based on data gathered from key informant interviews, focus group participants, and Westwood Community Priorities Survey respondents, eight major priorities were identified for the Westwood service area:

- Coronavirus/ COVID-19 *(specifically related to testing, transmission, disease mitigation, etc.)*
- Mental Health
- Housing
- Systemic Racism and Racial Injustice
- Financial Insecurity/ Unemployment
- Alcohol/Substance Use
- Issues related to Older Adults
- Transportation

Step 2: Data-Informed Voting via a Community Prioritization Meeting
The next step of the prioritization process included presenting quantitative and qualitative data from the data collection phases to community members and stakeholders in a larger forum. On, September 2, 2020, a one-hour virtual community meeting was held for the Westwood service area, so residents and stakeholders could discuss and vote on community priorities. In order to obtain as much feedback as possible on the priorities, outreach was conducted with key informant interviewees, focus group participants, staff from organizations involved in focus group recruitment and survey administration and local Boards of Health directors. Various forms of outreach were employed to reach residents and stakeholders, including email and telephonic outreach, as well as social media posts.

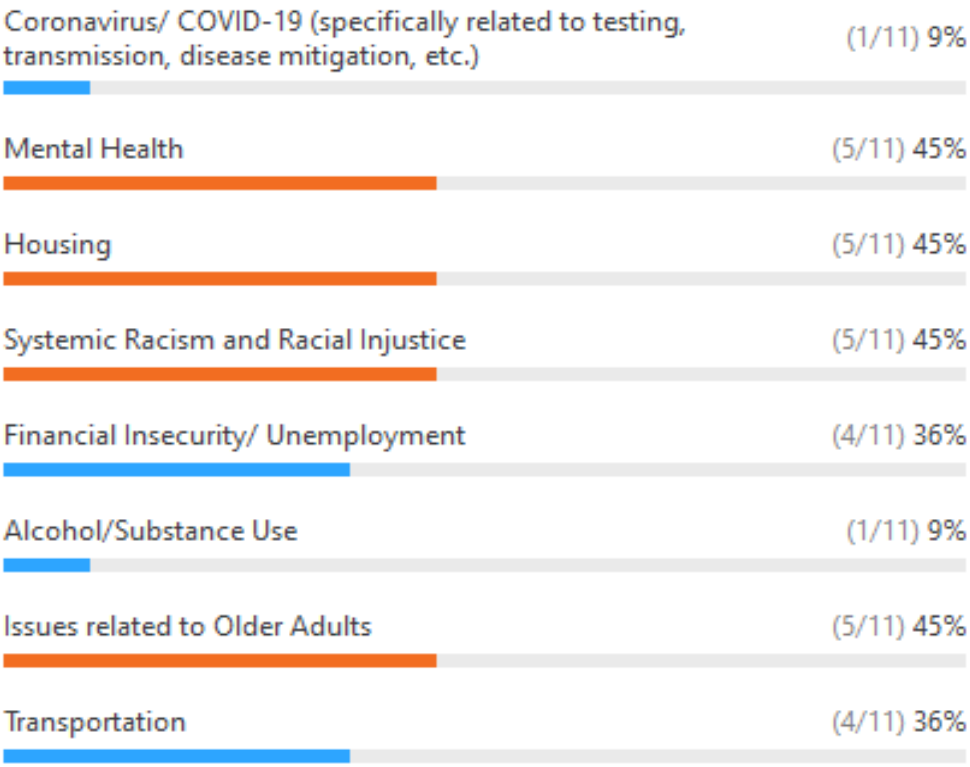
During the remote prioritization meeting, attendees heard a brief data presentation on the key findings for the Westwood service area. Next, meeting participants were divided into small groups to discuss the data and offer their own perspectives and expertise on the various priorities. Meeting participants then shared information from their discussions with the full group.

At the end of the meeting, using the Zoom polling feature, meeting participants voted for up to three of the eight priorities identified from the data and based on the specific prioritization criteria (Concern, Equity, Effectiveness, Feasibility). Participants were asked to identify any additional priorities that they

thought were missing from the data-derived list using the Chat feature of Zoom. A total of 11 community members voted during the Community Prioritization Meeting.

As seen in Figure 69, voting identified Mental Health (45%), Housing (45%), Systemic Racism and Racial Injustice (45%), and Issues Related to Older Adults (45%) as tied for the most commonly endorsed community priorities.

Figure 69: Westwood Prioritization Meeting, Zoom Poll Results, September 2, 2020



NOTE: Poll allowed for up to three responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Prioritization Meeting, 2020.

Step 3: Prioritization Refinement via Community Advisory Board Meeting

On September 9, 2020, the Partners Ambulatory Care – Community Advisory Board, who is charged with providing oversight of the CHNA process, met virtually to discuss the CHNA findings and community prioritization meeting output for the Westwood service area. The goal of this meeting was for CAB members to review the CHNA findings for the Westwood service area and amalgamate that information with the input provided from the community prioritization meeting to refine and narrow the list of priorities in alignment with the social determinants of health.

In the meeting, CAB members were presented with information on community priorities that emerged from the CHNA, the Westwood Community Priorities Survey, and the community prioritization meeting, together these prioritization steps revealed the following six priorities for the Westwood service area:

- Mental health
- Housing
- Systemic racism & racial injustice

- Issues related to older adults
- Financial insecurity
- Transportation

To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Much of the CAB's discussion focused on the inter-connectedness of the priorities and the difficulty in identifying a narrow area of focus given the need to address root causes of inequity in the social determinants of health. CAB members noted the importance of focusing on systemic racism and racial injustice given the demographics of the Westwood service area (the majority of residents identify as White). CAB members also discussed that a focus on housing could assist in addressing some of the other concerns related to financial insecurity, mental health, older adults, and systemic racism. Ultimately, the CAB retained five priorities to consider for future action:

- Mental health
- Housing
- Systemic racism & racial injustice
- Issues related to older adults
- Transportation

Financial Insecurity and Unemployment were eliminated from the list of priorities for action as these social determinants of health were determined to be embedded within other priority areas. Given the highly mutable state of current affairs, and the ability to further refine these priorities for future action, consensus among the CAB was to keep the list of priorities broader and then refine these issues at a later stage.

APPENDIX A: COMMUNITY ADVISORY BOARD MEMBERS

Name	Organization	Position
Amy Schectman	2Life Communities	President and CEO
Ann Houston	Opportunity Communities	CEO
Charles Desmond	Inversant	CEO
Charles Murphy	Montachusett Veterans Outreach Center	Executive Director
Cheryl Sbarra	Massachusetts Association of Health Boards	Senior Staff Attorney and Director of Policy and Law
Danna Mauch	Massachusetts Association for Mental Health	President and CEO
Dianne Kuzia Hills	My Brother's Table	Executive Director
Joseph D. Feaster, Jr.	Urban League of Eastern Massachusetts	Board Chairman
Laura Van Zandt	REACH (domestic violence prevention and services)	Executive Director
Mary Skelton Roberts	Barr Foundation	Co-Director of Climate
Milagros Abreu	The Latino Health Insurance Program, Inc.	Executive Director
Monica Tibbits-Nutt	128 Business Council / Fiscal Management and Control Board overseeing the MBTA	Executive Director/Vice Chair
Peter Koutoujian	Middlesex Sheriff's Office	Middlesex Sheriff

Rebecca Gallo	MetroWest Health Foundation	Senior Program Officer
Stephen J. Kerrigan	Edward M. Kennedy Community Health Center	President and CEO

APPENDIX B: KEY INFORMANT INTERVIEWEES

Name	Position	Organization
Aubrey Ciol	Program Director	Impact Norwood
Chris Colman	Town Administrator	Town of Westwood
Jared Orsini	Director	Westwood Board of Health
John Deckers	Fire Chief	Westwood Fire Department
Katherine Touafek	Director	School to Career Partnerships
Lina Arena-DeRosa	Executive Director	Westwood Council on Aging
Mary Jean McDermott	Executive Director	Sharon Elder Services
Nora Loughnane	Director, Economic Development Committee	Town of Westwood
Sandra Robinson	Executive Director	Needham Community Council, Inc.
Sigalle Reiss	Superintendent/ Director	Norwood Health Department
Tiffany McCarthy	Public Health Nurse	Town of Westwood
Tom O'Rourke	President/CEO	Neponset River Regional Chamber

APPENDIX C: KEY INFORMANT INTERVIEW GUIDE

Health Resources in Action
Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
Westborough, Westwood, and Woburn Service Areas
Key Informant Interview Guide
Guide – May 19, 2020

Goals of the Key Informant Interview

- To determine perceptions of the strengths and needs of these communities, and identify sub-populations most affected
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your family are fine during these uncertain times.

- A few months ago, Partners HealthCare began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of community residents, how health needs are currently being addressed, and whether there might be opportunities to address these issues more effectively. The data from this assessment will inform the priorities for future investments into the community in the next several years on the upstream factors that affect health.

- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.

- As part of the community health assessment process, we are conducting interviews with leaders in the community and focus groups with residents to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty. The findings from these conversations will inform decisions around future investments to improve the community's health.

- Our interview will last about 30-40 minutes. After all of the data gathering is completed, we will be writing a summary report of the general themes that have emerged during the discussions. We will not include any names or identifying information. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

1. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY OR IF COMMUNITY LEADER NOT AFFILIATED WITH ORGANIZATION]

    a. [PROBE ON ORGANIZATION: What is your organization's mission/services? What communities do you work in? Who are the main clients/audiences?]

        i. Prior to the pandemic, what were some of the biggest challenges your organization faced in conducting your work in the community?
        ii. During the pandemic, what are some of the biggest challenges your organization has faced in conducting your work in the community? What new challenges do you anticipate going forward?

    b. Do you currently partner with any other organizations or institutions in your work? Have there been any changes in these partnerships in light of the pandemic and its economic consequences?

III. COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (15-20 MINUTES)

2. How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)

    a. How have you seen the community change over the last several years?

    b. What do you consider to be the community's strongest <u>assets/strengths?</u>

    For the following questions, please consider issues and concerns your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

    c. What are some of its <u>biggest concerns/issues</u> in general? What challenges do residents face in their day-to-day lives? [PROBE ON, IF NOT YET MENTIONED: transportation; affordable housing; discrimination; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.) <u>REPEAT QUESTIONS FOR DIFFERENT ISSUES]</u>

        i. What population groups (geography, age, race/ethnicity, immigration status, gender, income/education, etc.) do you see as being most affected by these issues?

        ii. How has [ISSUE] affected their daily lives?

3. What do you think are the most pressing <u>health</u> concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICS. PROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19]

a. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]

   i. From your experience, what are peoples' biggest challenges to addressing [THIS ISSUE]?

   ii. To what extent, do you see [BARRIER] to addressing this issue among the residents you work with/your organization serves?

   [PROBE ON BARRIERS BROUGHT UP/MOST APPROPRIATE FOR POPULATION GROUP: Cost or economic hardship, transportation, stigma, attitudes towards seeking services, built environment, availability/access to resources or services, knowledge of existing resources/services, social support, discrimination, insurance coverage, etc.]

4. What are current or emerging trends that could have an impact on the public health system or the community? Has anything become apparent due to the Coronavirus pandemic?

IV. *TAILORED SECTION* - SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT YET BROUGHT UP. (5-10 MINUTES)

For Interviewees Working in Housing and Transportation

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- What barriers do you see residents experiencing around accessing affordable and healthy housing? How about with transportation?
- What has been working well in the city to improve access to healthy, affordable housing? How about related to transportation? What has been challenging or not working well? Where are the opportunities for improvement or innovation?
- Are there any approaches to improving housing or transportation access that you think will have to change in light of the pandemic, social distancing, and economic impacts?

For Interviewees Working in Financial Instability, Employment, and Workforce Development

- In the wake of the pandemic and expected ongoing social distancing measures, what challenges are residents facing regarding hiring, employment, or job security?
- Thinking back to the time before the pandemic, what were the needs in this community around workforce development? What was previously needed to improve residents' employability? What training or resources were needed?
- Now that the pandemic and social distancing measures have changed so much about the economy and employment options, what are the NEW needs in this community around workforce development? What is NOW needed to improve residents' employability? What training or resources are needed to adapt to this new reality?

For Interviewees Working with Communities where Immigration and/or Discrimination is a Concern
For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- What are some of the specific challenges around immigration issues or discrimination that your communities face? How has this changed since the pandemic?
- What should health care and social service providers consider when treating health and other issues in diverse populations? How can institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)

For Interviewees Working with Seniors/Older Adults
I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues the population you work with faces as a result of the pandemic? What do you anticipate will be the longer-term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected seniors in this region before the pandemic – and now?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working in the Areas of Violence, Trauma, and Safety
[For interviewees working on domestic violence:] I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues that the population you work with faces as a result of the pandemic, social distancing, and economic crisis? What do you anticipate will be the longer term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- In the wake of the pandemic, and expected ongoing social distancing measures, what challenges are community members facing regarding domestic or interpersonal violence?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working in the Areas of Substance Use or Mental Health
I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues the population you work with faces as a result of the pandemic, social distancing, and economic crisis? What do you anticipate will be the longer term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- In the wake of the pandemic, and expected ongoing social distancing measures, what challenges are community members facing regarding substance use or mental health?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

V. VISION FOR THE FUTURE (10-15 MINUTES)

5. I'd like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What's your vision?

    a. What do you see as the next steps in helping this vision become reality?

    b. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?

6. As you think about your vision, what do you think needs to be in place to support sustainable change?

    a. How do we move forward with lasting change across organizations and systems?

    b. Where do you see yourself or your organization in this?

7. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

VI. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. This is a very difficult time for everyone, and your perspective about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

APPENDIX D: FOCUS GROUP GUIDE

Health Resources in Action
Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
Westborough, Westwood, and Woburn Service Areas
General Focus Group Guide

Goals of the focus group:

- To determine perceptions of the strengths and needs of the community
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.

- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON AS A GROUP.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- A few months ago, Partners HealthCare began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these around the region with a wide range of people - community members, government officials, leaders in the faith community, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.

- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.

- We will be conducting several of these discussion groups around the area. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.

- We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the note-taking. No one but the analysts at Health Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me turning the recorder on now?

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS (10 minutes)

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share– such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ASSETS AND CONCERNS

1. Today, we're going to be talking a lot about the community that you live in. How would you describe your community?

For the following questions, we will be discussing the strengths and concerns in your community, both prior to the coronavirus pandemic, and now. To begin with, please think back to a time before the pandemic – for example, in December during the holiday season.

2. Thinking about a few months before the coronavirus pandemic -- If someone was thinking about moving into your community, what would you have said are some of its <u>biggest strengths about your community - or the most positive things</u> about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

    a. What would you have said were the <u>biggest problems or concerns</u> in your community back then – a few months before the pandemic? [PROBE ON ISSUES IF NEEDED – HEALTH, ECONOMIC, SOCIAL, SAFETY, ETC.]

3. What do you think were the most pressing ***<u>health</u>*** concerns in your community back in December?

    a. How did these health issues affect your community? In what way?

    b. What <u>specific population groups</u> were most at-risk for these issues?

Next, please think about the same issues, now, in the midst of the pandemic, and moving forward. RIGHT NOW….

4. What do you think are the <u>biggest strengths about your community? What are the most positive things</u> about it? Are they different than before? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

5. What do you think are the <u>biggest concerns</u> in your community now? Are they different than before?

6. What do you think are the most pressing ***health*** concerns in your community now? How are they different?

7. Social isolation, anxiety, concerned about going out

    a. How do these health issues affect your community? In what way?

        i. What are the biggest barriers or challenges that people have to seeking services for these issues?

    b. What specific population groups are most at-risk for these issues?

IV. PERCEPTIONS OF HEALTH ISSUES, HEALTH CARE AND BARRIERS

What are the top three issues that were mentioned? It would be good to discuss issues that have arisen during the current health crisis, as well as issues that were big concerns before, that are ongoing or may return. (If needed, identify together, or vote on top 3 issues.) Let's talk about some of the issues.

8. Do you agree with this list? Is there anything missing?
9. Traffic, affordable housing, accessing heath, technology – internet issues, transportation, navigating MassHealth, childcare, don't feel comfortable going out

10. What do you see as some of the biggest barriers or challenges to addressing these issues?

11. What do you think the community should do to address these issues? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

V. SPECIFIC PROBES FOR DISTINCT POPULATION GROUPS (10 minutes)

For Groups Where Housing and Transportation are a Concern

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- How much of an issue is affordable housing in your community? How has it impacted your day-to-day life?
- What barriers do residents (or you) experience around accessing affordable and healthy housing? How hard is it to find housing that is appropriate for you/your family?
- How much of an issue is accessing transportation? How has it impacted your day-to-day life?
- Are there any approaches to improving housing or transportation access that you think will have to change in light of the pandemic, social distancing, and economic impacts?

For Groups Where Financial Instability, Employment & Workforce are a Concern

- Thinking back to the time before the pandemic (for example, during the holiday season), what challenges were residents (or you) facing back then regarding hiring, employment, or job security?
    - [PROBE FOR THOSE WHERE ENGLISH ISN'T PRIMARY LANGUAGE]- How much do your language skills limit the type of job you can get?

- Now that the pandemic and social distancing measures have changed so much about the economy and employment options, what are the NEW needs in this community around employment? What is NOW needed to improve residents' employability?
- When people or families that you know are dealing with financial hardship, what are some of the issues that are most weighing on them? How do they deal with that?
- What resources or support do residents (or you) need to address financial hardship?

For Groups Where Immigration and Discrimination are Concerns
For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- Have you ever felt discriminated against because of your race, ethnicity, language, or where you were born? What specifically?
    - Have you encountered this when trying to seek specific services (e.g., housing, healthcare, employment, education)?
- What are some of the specific challenges that your community faces related to immigration issues or discrimination? How has this changed since the pandemic?
- What should health care providers consider when treating health issues in diverse populations? How can health care institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)

VI. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT

12. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?

    a. What do you think needs to happen in the community to make this vision a reality?

    b. Who should be involved in this effort?

13. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive funding?

VII. CLOSING
Thank you so much for your time. This is a very difficult time for everyone, and your perspective about the communities you live in will be a great help in determining how to improve the systems that affect the health of this population.

That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

APPENDIX E: SURVEY INSTRUMENT

Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
- Community Priorities Survey

Unformatted version of the online survey

To complete the survey in Spanish, please use the drop-down menu above to select your language.
To complete the survey in Portuguese, please use the drop-down menu above to select your language.
To complete the survey in Mandarin, please use the drop-down menu above to select your language.

Being a healthy community is about more than delivering quality health care to residents. Where you live, learn, work, and play all have an enormous impact on your health.

Partners HealthCare is hoping to get a better understanding of the health of residents in your community—including all the factors that affect a community's health—and which community needs are most important to address. Please take this survey to provide feedback. It should take no more than 5-10 minutes. Filling out the survey is voluntary, and your responses are anonymous. You will not be asked your name, address, or any other information that can identify you.

This study has been underway for several months, starting before the coronavirus spread in the U.S. We recognize this is a unique time we are in. With the coronavirus crisis, understanding the community's needs and strengths has become even more important. This survey will be asking you about your concerns now, as well as several months ago.

Thank you for your time and participation. At the end of this survey is an opportunity to enter a raffle for a $200 Amazon gift card. Thank you for your feedback to improve your community's health.

1. What zip code do you live in? _____

2. We recognize this is a unique time we are in. We would like to understand what issues have **personally affected you and your family** now and 6 months ago – around the time of the holiday season. For each issue, please check if the issue was something that affected you or your family personally now and/or 6 months ago - or has not affected you or your family at either time period. You can check any that apply.

	Currently affects me or my family.	**Affected me or my family 6 months ago**	**Does not affect me or my family now nor 6 months ago.**
Financial insecurity/unemployment/lack of job opportunities	O	O	O
Problems getting workforce training to get job skills	O	O	O

Concerns around housing (such as finding affordable housing, fear of eviction, overcrowding, housing quality)	O	O	O
Problems getting to places because of lack of transportation	O	O	O
Cannot be active/get exercise because of lack of sidewalks or parks	O	O	O
Hard to eat well because of lack of supermarkets/lack of healthy food options I can afford	O	O	O
Fear of safety in the community/community violence (gangs, robberies. etc.)	O	O	O
Fear of safety at home/domestic violence (spouse or partner abuse, child abuse)	O	O	O
Discrimination because of my race, ethnicity, gender, language, sexual orientation, country of origin, etc.	O	O	O
Mental health issues (such as depression, anxiety, etc.)	O	O	O
Alcohol and drug (marijuana, heroin, opioids, etc.) use	O	O	O
Chronic or long-term diseases (like cancer, diabetes, heart disease, stroke, etc.)	O	O	O
Overweight/obesity	O	O	O
Coronavirus/COVID-19	O	O	O
Other infectious diseases (like pneumonia, flu, etc.)	O	O	O
Concerns related to older adults (dementia/Alzheimer's, falls, etc.)	O	O	O
Concerns related to children (premature birth, developmental delays, ADHD, etc.)	O	O	O
Problems getting the health or social services I need because they are not available in my community	O	O	O
Other: _____	O	O	O

2a - If you or your family felt discriminated against recently or in the last 6 months, what do you think are the <u>main reasons</u> for these experiences? (Please check all that apply.)

☐ Your race
☐ Your ethnicity, ancestry, or country of origin

☐ Your language
☐ Your gender
☐ Your sexual orientation
☐ Your religion
☐ Your education or income level
☐ Some aspect of your physical appearance (e.g., height, weight, disability, etc.)
☐ Prefer not to answer/Don't know

3. **Either now or in the past 6 months, have any of these factors made it <u>harder</u> for you to get the medical, mental health, or social services (like housing, food, job training, etc.) you have needed? (Please check all that apply.)**

- o Services not available in my community
- o Lack of information/ I don't know what services are available or where to go
- o Lack of transportation
- o Cost of services
- o Lack of evening or weekend services
- o Unfriendly staff or providers
- o Felt discriminated against because of my race, ethnicity, gender, language, sexual orientation, country of origin, etc.
- o Afraid to ask questions or talk to staff or providers
- o Afraid if I take the time off to get services, I'll lose my job
- o Long wait for an appointment
- o My information is not kept confidential
- o Language problems/could not communicate with staff or provider
- o None of the above
- o Other (Please specify) _____

4. **Now we'd like to ask you about your community overall. Your community can be your town, your neighborhood, the group of people you care about, etc. What do you see as the overall <u>strengths</u> of your community? (Please check all that apply.)**

- o My community has medical services to address physical health conditions that people can access.
- o My community has mental health services that people can access.

- My community has social services (e.g. food, job training, etc.) that people can access.
- My community has good schools.
- My community has good public transportation.
- My community has enough parks/green space.
- My community has sidewalks so residents can take a walk easily and safely.
- My community has bike paths so residents can bike easily and safely.
- My community helps people in need.
- Neighbors know each other in this community.
- People care about improving this community.
- People feel like they belong in this community.
- My community has people of many races and cultures.
- People can deal with challenges in this community.
- When people have disagreements, they are able to resolve their differences and determine a path forward.
- There are innovations and new ideas in this community.
- People accept others who are different than themselves in this community.
- None of the above.
- Other (Please specify) _____

5. Please think about the most important issues in your community for <u>taking action</u>. Consider the following when thinking about these issues:

- **Concern:** *How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?*
- **Equity:** *Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?*
- **Effectiveness:** *Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?*
- **Feasibility:** *Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?*

Given these questions, **what are the top 5 most important issues for action in your community <u>in the next few years</u>?** (Please check 5.)

Financial insecurity/unemployment/lack of job opportunities	O
Workforce training to get job skills	O
Housing (such as finding affordable housing, fear of eviction, overcrowding, housing quality)	O
Transportation issues	O
Availability of sidewalks or parks	O
Availability of supermarkets/healthy food options people can afford	O

Safety in the community/community violence (gangs, robberies. etc.)	O
Safety in people's homes/domestic violence (spouse or partner abuse, child abuse)	O
Addressing systemic racism/racial injustice	O
Mental health issues (such as depression, anxiety, etc.)	O
Alcohol and drug use (marijuana, heroin, opioids, etc.)	O
Chronic or long-term diseases (like cancer, diabetes, heart disease, stroke, etc.)	O
Overweight/obesity	O
Coronavirus/COVID-19 testing and/or the possibility of a new outbreak	O
Other infectious diseases (like pneumonia, flu, etc.)	O
Concerns related to older adults (dementia/Alzheimer's, falls, etc.)	O
Concerns related to children (premature birth, developmental delays, ADHD, etc.)	O
Availability of health or social services in the community	O
Other (please specify): _____	O

It is helpful to get an understanding of who is answering this survey to ensure we get a cross-section of perspectives. Please answer the following questions, which are anonymous.

6. What category best describes your age?

- Under 18 years old
- 18-29 years old
- 30-49 years old
- 50-64 years old
- 65-74 years old
- 75 years old or older

7. What is your current sex or gender identity?

- Male
- Female
- Transgender Male
- Transgender Female
- Additional Gender Category: _____

8. What is your sexual orientation?

- Straight/heterosexual
- Gay or lesbian
- Bisexual
- Prefer to self-describe: _____

9. How would you describe your ethnic/racial/cultural background? (Please check all that apply.)

    - African American/Black
    - American Indian/Native American
    - East Asian /Pacific Islander (e.g. Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, the Philippines, Samoa)
    - South Asian (e.g., India, Pakistan, Bangladesh, Sri Lanka, Nepal)
    - White
    - Hispanic/Latino(a)
    - Middle Eastern/North African
    - Other (please specify) _____

10. What is the primary language(s) spoken in your home? (Please check all that apply.)

    - English
    - Spanish
    - Portuguese/Cape Verdean Creole
    - Chinese (including Mandarin and Cantonese)
    - French or Haitian Creole
    - Russian
    - Hindi
    - Arabic
    - Other (Please specify) _____

11. Were you born in the United States?

    - Yes (automatic skip pattern to Q13)
    - No (automatic skip pattern to Q12)
    - Prefer not to answer (automatic skip pattern to Q13)

12. If no, how long have you lived in the United States?

    - Less than 1 year
    - 1 year to less than 3 years
    - 3 years to less than 5 years
    - 5 years to less than 10 years
    - 10 years to less than 15 years
    - 15 years to less than 20 years
    - 20 years or more
    - Prefer not to answer

13. What is the highest level of education that you have completed?

    - Primary or middle school
    - Some high school
    - High school graduate or GED
    - Some college
    - Associate or technical degree/certificate
    - College graduate
    - Graduate or professional degree

14. What is your current employment status? (Please check all that apply)

    - Employed full-time
    - Employed part-time
    - Not employed and currently looking for work
    - Student
    - Retired
    - Stay-at-home parent / significant other
    - Unable to work

15. Has your financial situation gotten worse, improved, or stayed the same since coronavirus/COVID-19?
    - Gotten worse
    - Has improved
    - Has stayed the same

16. What was your total household income before taxes during the past 12 months?

    - Less than $25,000
    - $25,000 to $34,999
    - $35,000 to $49,999
    - $50,000 to $74,999
    - $75,000 to $99,999
    - $100,000 to $149,999
    - $150,000 to $199,999
    - $200,000 or more
    - I don't know or don't want to say

This concludes our survey. Thank you for your time. We greatly appreciate your participation. Participants who complete this survey are eligible to enter a raffle for a $200 Amazon gift card. You will be automatically redirected to a form after this survey to enter the raffle. Your name and information will not be connected to the responses on your survey.

APPENDIX F: ADDITIONAL SURVEY DATA

Appendix Table 1: CHNA Community Priorities Survey Respondent Characteristics

	Number	%
Age		
Under 18 years old	0	0.0%
18-29 years old	19	4.5%
30-49 years old	135	32.1%
50-64 years old	172	40.9%
65-74 years old	84	20.0%
75 years old or older	11	2.6%
Sex or Gender Identity		
Male	87	20.7%
Female	332	79.1%
Transgender Male	1	0.2%
Sexual Orientation		
Straight/heterosexual	396	95.2%
Gay or lesbian	8	1.9%
Bisexual	7	1.7%
Prefer to self-describe	5	1.2%
Ethnic/racial/cultural background*		
African American/Black	35	7.28%
American Indian/Native American	2	0.42%
East Asian /Pacific Islander (e.g. Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, the Philippines, Samoa)	12	2.49%
South Asian (e.g., India, Pakistan, Bangladesh, Sri Lanka, Nepal)	1	0.21%
White	346	71.93%
Hispanic/Latino(a)	20	4.16%
Middle Eastern/North African	2	0.42%
Other	5	1.04%
Primary language(s) spoken at home*		
English	410	85.2%
Spanish	10	2.1%
Portuguese/Cape Verdean Creole	1	0.2%
Chinese (including Mandarin and Cantonese)	2	0.4%
French or Haitian Creole	6	1.3%
Russian	1	0.2%
Hindi	0	0.0%
Arabic	1	0.2%
Other (Please specify	5	1.0%
Born in the United States		
Yes	390	93.5%

	Number	%
No	25	6.0%
Prefer not to answer	2	0.5%
Length of time living in the United States? **		
Less than 1 year	0	0.0%
1 year to less than 3 years	2	8.0%
3 years to less than 5 years	0	0.0%
5 years to less than 10 years	1	4.0%
10 years to less than 15 years	1	4.0%
15 years to less than 20 years	0	0.0%
20 years or more	20	80.0%
Prefer not to answer	1	4.0%
Highest level of education		
Primary or middle school	0	0.0%
Some high school	1	0.2%
High school graduate or GED	26	6.2%
Some college	60	14.4%
Associate or technical degree/certificate	31	7.4%
College graduate	159	38.1%
Graduate or professional degree	140	33.6%
Current employment status*		
Employed full-time	200	41.6%
Employed part-time	80	16.6%
Not employed and currently looking for work	30	6.2%
Student	7	1.5%
Retired	75	15.6%
Stay-at-home parent / significant other	29	6.0%
Unable to work	18	3.7%
Total household income in last 12 months		
Less than $25,000	17	4.1%
$25,000 to $34,999	24	5.8%
$35,000 to $49,999	29	7.0%
$50,000 to $74,999	48	11.6%
$75,000 to $99,999	56	13.5%
$100,000 to $149,999	77	18.6%
$150,000 to $199,999	40	9.7%
$200,000 or more	55	13.3%
I don’t know or don’t want to say	68	16.4%

NOTE: Asterisk (*) indicates the question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%; Double asterisk (**) indicates that the question includes only those who specified not being born in the United States.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Appendix Table 2: Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Type of Issue, 2020

	Number	Affected Currently Only	Affected 6 Months Ago Only	Affect Both Currently and 6 Months Ago	Never Affected
Accessing health or social services	453	8.6%	4.0%	1.6%	85.9%
Alcohol and drug use	450	6.4%	2.0%	1.6%	90.0%
Cannot be active due to lack of sidewalks or parks	457	12.0%	5.0%	2.4%	80.5%
Chronic or long-term diseases	456	19.3%	4.4%	7.9%	68.4%
Community violence	451	10.0%	3.3%	1.6%	85.1%
Concerns around housing	449	7.4%	3.1%	1.6%	88.0%
Concerns related to children	452	8.0%	1.6%	2.2%	88.3%
Concerns related to older adults	455	19.8%	5.3%	5.9%	69.0%
Coronavirus/COVID-19	454	19.8%	5.5%	2.0%	72.7%
Discrimination	451	11.3%	2.0%	2.9%	83.8%
Domestic violence	453	1.3%	0.9%	0.4%	97.4%
Financial insecurity	480	29.2%	8.3%	5.8%	56.7%
Lack of access to affordable healthy food	455	9.2%	5.9%	1.8%	83.1%
Lack of transportation	454	6.6%	4.4%	1.1%	87.9%
Mental health issues	456	32.0%	7.5%	10.3%	50.2%
Other infectious diseases	450	3.1%	10.7%	0.7%	85.6%
Overweight/obesity	459	31.2%	5.0%	8.5%	55.3%
Problems getting workforce training	488	11.6%	2.5%	1.1%	84.8%
Other issue	223	4.0%	0.5%	1.8%	93.7%

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Attachment B-3

Mass General Brigham

Woburn Service Area Community Health Needs Assessment

October 3, 2020

Mass General Brigham

Health Resources in Action

Advancing Public Health and Medical Research

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction
Mass General Brigham (formerly Partners HealthCare, 'the System') is a not-for-profit, integrated health care system that was formed in 1994 by an affiliation between The Brigham Medical Center, Inc. (now known as Brigham Health) and The Massachusetts General Hospital ("MGH"). Mass General Brigham currently operates two tertiary hospitals, six community acute care hospitals, and one acute care specialty hospital in Massachusetts; one community acute care hospital in Southern New Hampshire; one facility providing inpatient and outpatient mental health services; and three facilities providing inpatient and outpatient services in rehabilitation medicine and long-term care.

To fulfill Mass General Brigham's four-part mission of patient care, research, education and community, the organization has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics, population health, ambulatory care and insurance risk management. Developing community-based care centers that offer primary and behavioral health care, as well as specialty and surgical services also are a component of Mass General Brigham's mission.

Accordingly, the System is seeking ways to expand care options in more suburban settings, including in the Woburn service area. This potential expansion will require Mass General Brigham to fully understand the range of needs (related to health and the social determinants of health) within the Woburn service area, includes the communities of: Andover, Arlington, Bedford, Billerica, Burlington, Lexington, Lynnfield, Medford, Melrose, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn.

This community health needs assessment (CHNA or Assessment) aims to gain a greater understanding of the issues that residents within the Woburn service area face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This CHNA report provides the results from a mixed methods study aimed at identifying the most pressing social, economic, and health issues in the service area. The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the service area to inform future planning,
- Understand the current health status of residents within the service area, as well as sub-populations within their social context, and
- Engage the community to help determine community needs and social determinant of health needs.

Context
This CHNA was conducted during an unprecedented time period, due to the COVID-19 novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The COVID-19 pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity also coincided with the timeline of the CHNA and impacted the content of this report, as well as data collection processes, including the design of data collection instruments and the input that was shared during interviews and focus groups, key informant interviews, and through Woburn Community Priorities Survey responses.

Methods
The 2020 Woburn service area CHNA aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous

factors at multiple levels— from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health and social determinant of health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the Woburn service area; conducting a community survey with 552 residents of towns in the Woburn service area; conducting 8 virtual focus groups with 19 participants and 9 key informant interviews with 11 individuals representing a variety of organizations, including mental health, senior, and immigrant-focused social services; law enforcement; and the faith community.

Due to COVID-19, it should be noted that while efforts were made to engage residents through virtual qualitative and survey data collection, given the context of the pandemic the capacity of community organizations to assist with outreach and the capacity of community members to participate was limited. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

Findings

The following provides a brief overview of key findings that emerged from this assessment.

Population Characteristics

- **Demographics:** The service area for this CHNA comprises a total population of 504,680 residents. The Woburn service area includes a mix of towns with residents who work blue-collar jobs and identify as largely non-Hispanic White; affluent and very-well educated communities with large immigrant populations; and lower income towns with more racial/ethnic diversity. Notable demographic differences exist by race/ethnicity, foreign-born residents, and language in the Woburn service area. For example, Lexington had the highest proportion of non-Hispanic Asian residents (29.2%), while Medford had the largest proportion of non-Hispanic Black (9.3%) and Hispanic/Latino (5.3%) residents.[1]

Community Social and Economic Environment

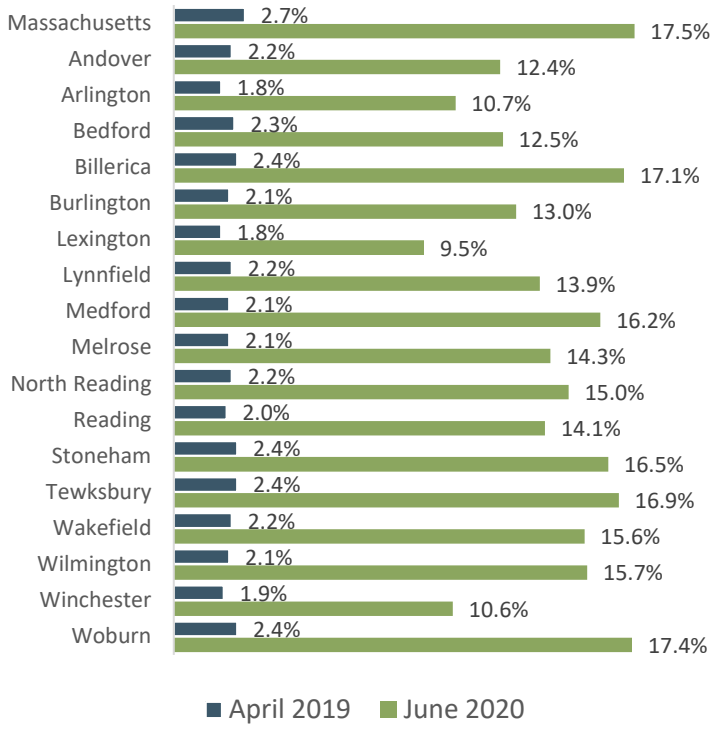
- **Community Perceptions of Need:** The most common issues that Woburn Community Priorities Survey respondents reported being affected by (either currently, 6 months ago, or at both timepoints) were mental health issues (50.6%), financial insecurity (40.8%), and overweight/obesity (38.9%). Interview and focus group participants also highlighted the particular challenges faced by seniors, parents and their young children, and low-income immigrants as a result of the Coronavirus pandemic shutdowns.

- **Community Assets:** Respondents to the Woburn Community Priorities Survey most commonly reported good schools (75.7%), safe/walkable sidewalks (72.8%), and parks/green space (72.3%) as strengths of their communities. Interview and focus group participants also noted feelings of belonging, support for vulnerable groups, youth programming, and community participation as major assets.

[1] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

- **Income and Financial Security:** The area around Woburn is largely affluent, with median annual household income in 2014-2018 ranging from almost $89,000 in Woburn to almost $173,000 in Lexington. Medford (20.3%) and Woburn (15.3%) had the largest number of residents who were low income, at <200% Federal Poverty Level, in 2014-2018. [2] Among Woburn Community Priorities Survey respondents, almost 30% reported that their financial situation had gotten worse since the coronavirus pandemic, 6.5% reported it had improved, and 63.9% reported it had stayed the same.

Percent Population Unemployed, 16 Years and Older, in Massachusetts and by Town, 2019-2020



DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.

- **Employment and Workforce:** In April 2019, all towns in the Woburn area had unemployment rates under 3%. During the pandemic, rates increased from between 7.2% in Lexington to 16.7% in Billerica.[3] Interview and focus group participants expressed concerns about the effect of the pandemic on working parents and on low-income residents who lost their jobs or had to work in risky situations in order to put food on the table for their families.

- **Education:** The area around Woburn is very well educated, on average. Among residents over 25 years of age in the Woburn region, about half of Winchester and Lexington residents had a graduate or professional degree. In contrast, Billerica and Tewksbury had the largest populations with a High School diploma or less. In 2019, high school graduation rates were 90% or higher in all towns.[4] Good schools were a top strength listed by Woburn Community Priorities Survey respondents.

- **Housing:** Housing affordability was consistently noted as a top concern among interview and focus group participants. Concerns were expressed for the ability of seniors to age in place in their communities due to a lack of affordable housing, for young families looking to buy homes in the area, and for refugee populations living in over-crowded housing and facing evictions during the pandemic. Median monthly housing costs for owner-occupied households with a mortgage ranged from $2,214 in Woburn to $3,940 in Lexington.[5]

> *"My rent is half of my paycheck. Every financial advisor will tell you that's crazy, but this is the cheapest apartment I could find".* – Focus group participant

[2] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
[3] U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.
[4] Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Cohort 2019 Graduation Rates, 2019.
[5] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

- **Transportation:** In the large area around Woburn, perceptions about transportation varied. In many towns, focus group participants agreed that transportation was almost entirely limited to use of personal vehicles. This was only seen as a concern for select populations, such as seniors who no longer drive and public housing residents. Other towns, including Arlington, Medford, and Melrose, had better access to mass transit, such as MBTA bus service, commuter rail, and the T.

- **Built Environment:** Communities around Woburn were described as having parks and playgrounds, libraries, and trails, all of which residents appreciated. Increased use of bicycles in the community due to COVID-19 has highlighted the need for more bike lanes in communities, according to participants.

- **Crime and Violence:** In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied notably across the towns around Woburn, although no towns had higher rates than the state average of 338.1 incidents per 100,000 residents. The highest violent crime rates were in Tewksbury, Wakefield, Stoneham, and Burlington.[6] Overall, focus group members and interviewees described their communities as very safe.

- **Discrimination and Racism:** Among Woburn Community Priorities Survey respondents, the second most common issue for future action was addressing systemic racism/racial injustice (38.4%). Overall, 11.2% of respondents reported experiencing discrimination in the past six months, and among these, 50.0% reported this was due to their race; 37.9% said it was due to their gender; 34.5% said it was due to their ethnicity or national origin. Participants reported that conversations about racial justice have been occurring recently in Woburn service area communities. Perceptions about the extent of discrimination and racism in the community varied. Some participants mentioned incidences in schools of anti-Semitic and racist graffiti and incidences in the larger community of racism and anti-immigrant actions. Local leaders and community-based organizations, including faith institutions, have been working to engage the community in conversations about this issue, participants reported.

Community Health Issues

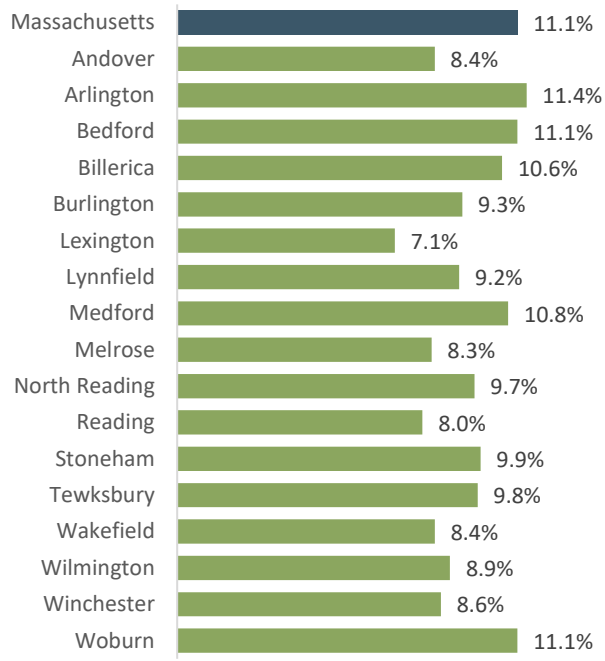
- **Overall Mortality:** Age-adjusted mortality rates per 100,000 population varied across the Woburn area in 2017, from a low of 447.0 in Lexington to a high of 743.0 in Billerica.[7]
- **Chronic Diseases and Related Risk Factors:** In general, rates of chronic disease in the Woburn service area are similar to the state overall. Interview and focus group participants did not cite specific chronic diseases as pressing concerns in their communities, and 13.2% and 11.1% of Woburn Community Priorities Survey respondents cited chronic disease and overweight/obesity as top issues for action, respectively. However, these issues were also ranked among the top five issues that have personally affected respondents in the past six months.

[6] Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.

[7] Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

- **Mental Health:** Mental health issues were the top concern that had personally affected Woburn Community Priorities Survey respondents in the past six months (50.6%) and were the fourth most commonly cited issue for future community action (35.0%). Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in the community, particularly among seniors, who already tend to be socially isolated; and among immigrants and refugees, who already face anxiety related to the current political context. Participants with school-age children shared the challenges of remote learning and the stress that comes with the uncertainty of the coming school year. Many worried about the long-term impact of the pandemic and lack of socialization on the community's children and youth. According to focus group members and interviewees, lack of mental health providers was the primary challenge in addressing mental health in the community. It was reported that the number of providers in the community is insufficient to meet the demand for services, leading to long waits for mental health services.

Percent of Adults Reporting 15 or More Days of Poor Mental Health in the Last Month, in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.

- **Substance Use:** Alcohol and drug use was not a top issue that had personally affected most Woburn Community Priorities Survey respondents in the past six months (13.0%). However, it was the sixth most common issue listed for future action (22.3%) and was more common among residents with less than a high school education. Opioid-related overdose deaths were relatively rare in the town around Woburn in the past five years and issues with substance use came up only rarely among interview and focus group participants.

- **Environmental Health:** Emergency department visits for asthma were below the Massachusetts state rate for all towns in the Woburn service area, and concerns about environmental-related health concerns were not mentioned by interview and focus group participants.

- **Infectious and Communicable Disease:** Many participants shared concerns about the ongoing spread and impact of COVID-19 and about access to accurate testing. COVID-19 concerns were ranked first by Woburn Community Priorities Survey respondents among the most important issues for future action (47.8%). Through August of 2020, the COVID-19 case rate in Massachusetts was 1,642 cases per 100,000 population. The case rate varied across the Woburn area, with the highest case rate occurring in Tewksbury (1,969 per 100,000 population) and the lowest case rate occurring in Winchester (544 per 100,000 population).[8] Sexually transmitted and other communicable diseases were not prevalent or a major concern in the area around Woburn.

- **Injury:** Interview and focus group participants did not raise injury as a concern fort their communities. Rates of emergency department visits, motor vehicle accidents, and fall hospitalization are in general fairly similar or lower among these communities when compared to the state.

[8] Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2020.

- **Maternal and Infant Health:** Interview and focus group participants did not raise maternal and infant health as a concern for their communities. In 2015, the percent of preterm births in Massachusetts was 6.5%. By town, preterm births ranged from 2.7% in Reading to 8.4% in Lexington.[9]

Access to Services

- **General Access:** Overall**,** 48.5% of Woburn Community Priorities Survey respondents reported at least one barrier to accessing medical, mental health, or social services in the past six months. Among respondents reporting at least one barrier, the most common barriers were long wait times for appointments (55.4%), cost of services (34.5%), lack of information about available services (28.7%), and lack of evening or weekend services (28.7%).

- **Healthcare Services:** Several interviewees and focus group members mentioned access to healthcare as a community health concern, including the high cost of healthcare, difficulty accessing MassHealth, and lack of dental services. Participants noted that strict income requirements to qualify for MassHealth means that some lower income residents may not qualify, and that immigrants are often not enrolled in the best coverage they have a right to. Participants also mentioned that lack of continuity of healthcare and transition to community services after a hospital stay creates challenges for seniors and others.

> *"Health care, social services, human services are each in a separate corner, and not working together in a unified manner. We've been talking about this for 20 years and there's no change."*– Key informant interviewee

- **Social and Essential Services:** Participants mentioned that lack of continuity of healthcare and transition to community services after a hospital stay creates challenges for seniors and others. The siloing of health care, social services, and human services was noted as a barrier for establishing comprehensive and continuous care. Participants suggested building coalitions of services and co-locating services, especially for underserved populations.

Community Perceptions of Issues for Action

Woburn Community Priorities Survey respondents were asked to select the top five issues for future action on the survey and most frequently reported (1) coronavirus/COVID-19 testing and/or the possibility of a new outbreak, (2) addressing systemic racism/racial injustice, (3) housing, (4) mental health issues, and (5) financial insecurity/unemployment/lack of job opportunities. Notably, although COVID-19 was the most commonly noted issue to take action on, less than half of respondents endorsed it as an issue. These survey results were largely in line with the concerns most mentioned in interviews and focus groups, as described above.

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data, a community survey, and discussions with community residents and stakeholders, this assessment report examined the current health status of the Woburn service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- There are **many assets** in the Woburn service area, including high-quality schools, access to parks and green space, access to medical services, and overall **social cohesion and community engagement**.

[9] Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2015.

- **COVID-19** remains a major concern, along with its impact on local economies, financial security, child development, social isolation of seniors, and overall mental health of community members.

- While the Woburn service area overall is affluent, some communities within the area face **unemployment and financial insecurity**, especially in the context of the economic impact of the COVID-19 pandemic.

> *"There have been quick band-aids put in place. These have alleviated the immediate problem, but we're going to see worse impacts that haven't hit yet. The effect on folks living too close to the edge will be great."*
> – Key informant interviewee

- The COVID-19 pandemic has exacerbated **pre-existing inequities in income and wealth** in the area. Increased use of food pantries, social services to support housing costs, and financial support, were expected to increase further, and there is great concern for residents already living on the edge.

- **Housing affordability** was identified as a pressing concern, particularly for seniors, racial/ethnic minorities, low-income immigrants, and young families.

- **Transportation** was a concern for some communities, particularly for certain populations including seniors and public housing residents.

- Some community members have experienced or recognized discrimination in their communities and prioritized **addressing racial injustice**.

- **Mental health** was a top concern among many community residents, especially in the context of COVID-19.

- **Alcohol and substance use** were concerns, particularly for residents with less than a high school education.

- Social isolation, difficulty in accessing services, and mental health were pressing concerns for **older adults**, particularly in the context of COVID-19.

- While **access to medical care** was seen as a strength of the area overall, there were concerns related to continuity of health care with other social services, the high cost of health care, and lack of culturally and linguistically competent mental health services.

Priority Needs of the Community

Community Prioritization Meeting

Data and themes from the CHNA report were presented to service area residents and stakeholders at a virtual community prioritization meeting in September 2020. Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. The following four criteria were used to guide prioritization discussions and voting processes:

- Concern
- Equity
- Effectiveness
- Feasibility

Meeting participants voted for up to three of the nine priorities identified from the data and based on the specific prioritization criteria. Voting identified Mental Health as the most commonly endorsed community priority (69%), followed by Coronavirus/COVID-19 (38%), Financial Insecurity/Unemployment (38%), and Issues Related to Older Adults (38%).

Community Advisory Board Meeting

The goal of this meeting was for CAB members to review the CHNA findings for the service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health. To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Ultimately, the CAB agreed on the following priorities to consider for future action:

- Coronavirus/ COVID-19 *(specifically related to testing, transmission, disease mitigation, etc.)*
- Systemic Racism and Racial Injustice
- Behavioral Health *(inclusive of mental health and substance use)*
- Issues related to Older Adults

Mass General Brigham
Partners Ambulatory Care - Woburn Service Area Community Health Needs Assessment

INTRODUCTION

Mass General Brigham (formerly Partners HealthCare, 'the System') is a not-for-profit, integrated health care system that was formed in 1994 by an affiliation between The Brigham Medical Center, Inc. (now known as Brigham Health) and The Massachusetts General Hospital MGH). Mass General Brigham currently operates two tertiary hospitals, six community acute care hospitals, and one acute care specialty hospital in Massachusetts; one community acute care hospital in Southern New Hampshire; one facility providing inpatient and outpatient mental health services; and three facilities providing inpatient and outpatient services in rehabilitation medicine and long-term care. Mass General Brigham also operates physician organizations and practices, a home health agency, nursing homes and a graduate level program for health professionals. Mass General Brigham is a non-university-based nonprofit private medical research enterprise and its academic medical centers are principal teaching affiliates of the medical and dental schools of Harvard University. Mass General Brigham provides its services to patients primarily from the Greater Boston area and eastern Massachusetts, as well as New England and beyond. Additionally, Mass General Brigham operates a licensed, not-for-profit managed care organization that provides health insurance products to the MassHealth Program (Medicaid), ConnectorCare (a series of health insurance plans for adults who meet income and other eligibility requirements) and commercial populations.

To fulfill Mass General Brigham's four-part mission of patient care; research education; and community, the organization has affirmed a system-wide strategy that is grounded in the excellence of Mass General Brigham's two academic medical centers, focused on improved patient outcomes and experience, and supported by its historical and ongoing commitment to digital health and data analytics; population health; ambulatory care; and insurance risk management. Implementation of this strategy relies on a series of synergistic priorities that include:

i. improving health outcomes across the full continuum of care with an emphasis on the development by Mass General Brigham's academic medical centers of multidisciplinary centers of excellence for tertiary and quaternary care;

ii. enhancing the patient experience, particularly for primary care and behavioral health care, by developing community-based health care settings that improve access and ease of navigation for patients;

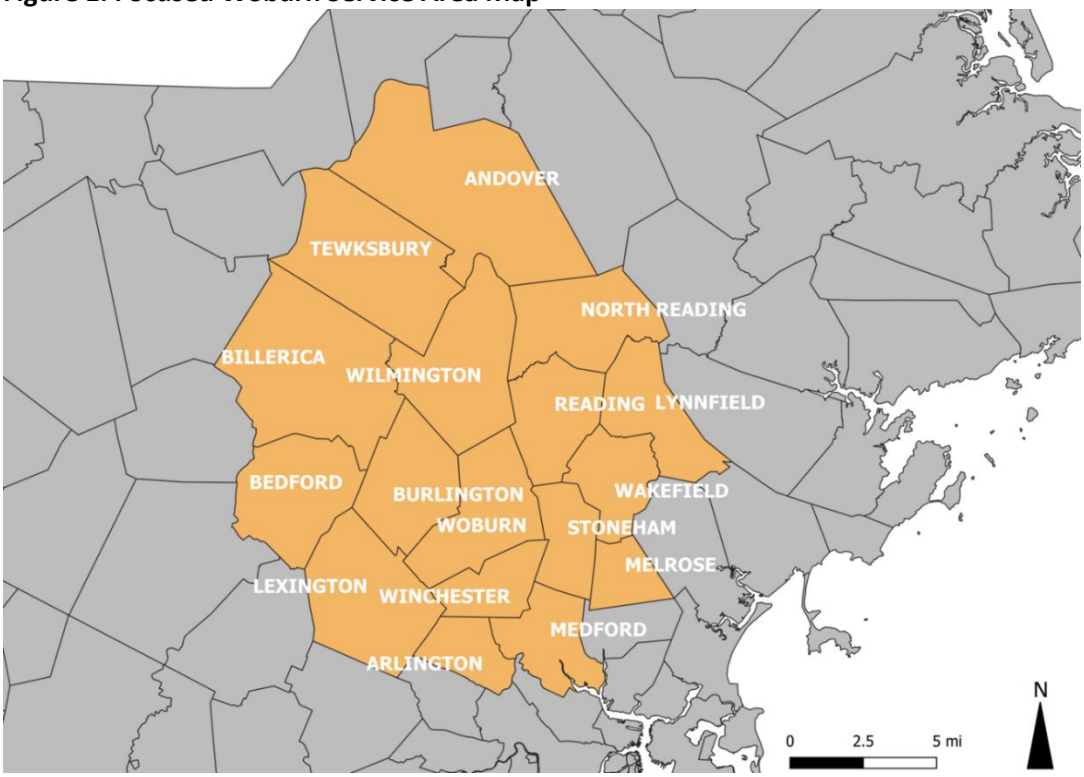
iii. reducing the total cost of health care by developing delivery models that focus on value while simultaneously improving outcomes; and

iv. investing in research and innovations that meaningfully improve the diagnosis and treatment of all forms of human illness.

Developing community-based care centers that offer primary and behavioral health care, as well as specialty and surgical services meet the second component of Mass General Brigham's mission.

Accordingly, the System is seeking ways to expand care options in more suburban settings, including in the Woburn area. This potential expansion will require Mass General Brigham to fully understand the range of needs (related to health and the social determinants of health) within the Woburn service area (including Andover, Arlington, Bedford, Billerica, Burlington, Lexington, Lynnfield, Medford, Melrose, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn). The Woburn service area is shown in Figure 1.

Figure 1. Focused Woburn Service Area Map



Purpose and Scope of the Community Health Needs Assessment

This community health needs assessment (CHNA or Assessment) aims to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the 2020 Woburn service area needs assessment processes, which were conducted between March-August 2020, and informed discussions about key community issues and concerns in the service area.

The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the community to inform future planning;
- Understand the current health status of the service area overall and its sub-populations within their social context; and
- Engage the community to help determine community needs and social determinant of health needs.

Priority social determinants of health areas include the social environment, built environment, employment, education, housing, and violence and trauma.

CONTEXT FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT

This CHNA was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice. This context had a significant impact on the assessment approach and content.

COVID-19 Pandemic

The novel coronavirus (COVID-19) pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process and topics, as well as concerns that participants put forth during discussions in focus groups and interviews. On February 1, 2020, the first confirmed case of COVID-19 in Massachusetts was announced, and on March 15, 2020, the Governor of Massachusetts issued an emergency order announcing emergency actions to address COVID-19 including school closures, business closures, and limitations on gatherings. Data collection planning (e.g., finalizing methodology, developing data collection instruments) occurred at the beginning of this state-wide shutdown. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (advisory bodies, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection was shifted to a virtual setting (e.g., telephone or video focus groups and an online survey), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a primary health concern for communities and also has exacerbated underlying inequities and social needs. The pandemic brought to light both the capabilities and gaps in the healthcare system, the public health infrastructure, and social service networks. In this context, an assessment of the community's strengths and needs, and in particular the social determinants of health, is both critically important and logistically challenging. Where possible, CHNA participants were asked to reflect on health and social issues beyond those directly related to COVID-19, yet the pandemic's short-term and long-term impacts remained at the forefront of many conversations. This CHNA should be considered a snapshot in time; consistent with public health best practices, the community can continue to be engaged to understand how identified issues may evolve and what new issues or concerns may emerge over time.

National Movement for Racial Justice

A wave of national protests for racial equity – sparked by the killing of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others – also coincided with the timeline of the CHNA. As part of a movement for racial justice, national attention was focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA, including the design of data collection instruments and the input that was shared during interviews and focus groups and through community survey responses. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in late spring 2020 in the form of protests and dialogues, locally and nationally, as context for this assessment.

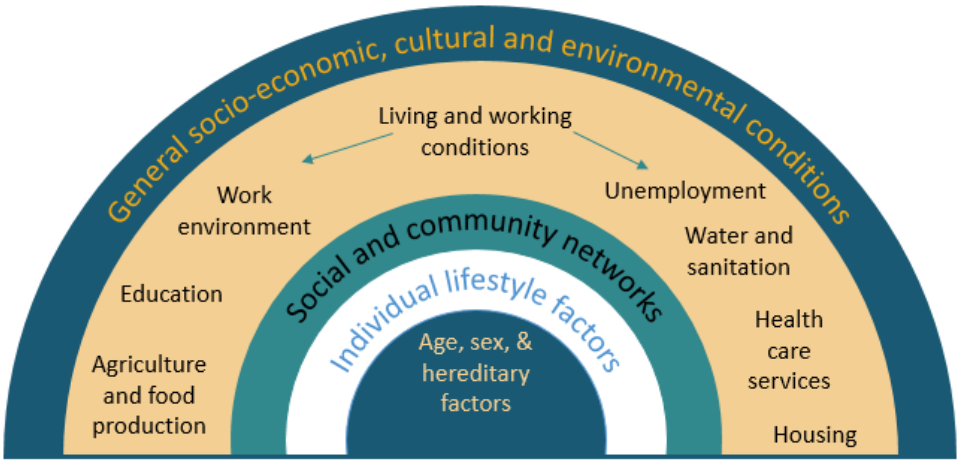
METHODS

The following section details how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

Social Determinants of Health Framework
While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health.

Upstream Approaches to Health
Having a healthy population is about more than delivering quality health care to residents. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing stock, and economic policies. Figure 2 provides a visual representation of these relationships, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors, such as employment status and educational opportunities.

Figure 2. Social Determinants of Health Framework



SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to understand the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens
The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory

policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S.

In the present report, health patterns for the Woburn CHNA service area are described overall, as well as areas of need for particular population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by a regional Community Advisory Board (CAB). Mass General Brigham hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant partner to facilitate the CHNA process, collect and analyze data, and develop the CHNA report.

Community Engagement

Community engagement is described further below under the primary data collection methods. It should be noted that, due to the COVID-19 pandemic, the community engagement for this CHNA occurred virtually. Additionally, while the CHNA aimed to engage a cross-section of individuals and to be inclusive of traditionally under-represented communities, due to the pandemic and competing priorities, community-based organizations had limited time to assist with outreach and community members had constraints on their own time for participation. Nevertheless, by engaging the community through multiple methods and in multiple languages, this CHNA aims to describe community strengths and needs during this unique time.

Community Advisory Board Engagement

As noted, a CAB provided oversight, input, and support throughout the CHNA process. The CAB was regional in focus and oversaw the work for this CHNA, as well as two other co-occurring CHNAs (taking place in the greater Westborough area and greater Westwood area). CAB members included representation from both regional groups and residents of the primary service area. The fifteen CAB members represent municipalities; the education, housing, social service, planning and transportation sectors; the private sector; community health centers; and community-based organizations. See APPENDIX A: COMMUNITY ADVISORY BOARD MEMBERS for a full list of CAB members.

The CAB was engaged throughout the CHNA process. This engagement included meeting three times (in March to provide input on the CHNA methods and timeline; in June to hear updates on the CHNA process and to discuss virtual engagement, survey dissemination, and community outreach; and in September to discuss identified priorities) and providing regular input through email correspondence and telephonic discussions. CAB input included advising on key informant interviewees and focus group segments, identifying local data sources and communication outlets for the CHNA community health survey, and providing connections to community organizations to support data collection and outreach efforts. Additionally, the members of the CAB participated in the community prioritization meetings (see below for more information).

Secondary Data: Review of Existing Secondary Data
Secondary data are data that have already been collected for another purpose. Examining secondary data helps us to understand trends, provide a baseline, and identify differences by sub-groups. It also helps in guiding where primary data collection can dive deeper or fill in gaps.

Secondary data, including information and statistics, for this CHNA were drawn from a variety of sources, including the U.S. Census American Community Survey (ACS), the U.S. Department of Labor Bureau of Labor Statistics, the Federal Bureau of Investigation Uniform Crime Reports, the MA Department of Elementary and Secondary Education, the MA Center for Health Information and Analysis (CHIA) database, and a number of other agencies and organizations. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns or with MA overall, these are lay comparisons and *not* statistically significant differences.

It should also be noted that for most social and economic indicators, the U.S. Census American Community Survey (ACS) 5-year (2014-2018) aggregate datasets were used over the one-year datasets, since many of the towns in the service area are smaller in population size. Since the ACS uses a probability sampling technique, using the five-year aggregate dataset over the one-year data provides a larger sample size and more precision in its estimates.

Primary Data Collection
Primary data are new data collected specifically for the purpose of the CHNA. Goals of the CHNA primary data were: 1) to determine perceptions of the strengths and needs within the service area, and identify sub-populations most affected; 2) to explore how these issues can be addressed in the future; and 3) to identify the gaps, challenges, and opportunities for addressing community needs more effectively. Primary data were collected using three different methods for this CHNA: key informant interviews, focus groups, and a community survey.

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews
A total of 9 key informant interviews were completed with 10 individuals by phone. Interviews were 45-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders as well as front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Interviewees were asked to share their perceptions of needs both prior to and following the start of the COVID-19 pandemic. Sectors represented in these interviews included: housing services, immigrant and refugee services, senior services, law enforcement, the faith community, and mental health. See Appendix B for the list of key informant interviewees and Appendix C for the key informant interview guide.

Focus Groups
The proposed focus group methodology for this CHNA changed during the pandemic. Rather than conducting traditional in-person focus groups of approximately eight participants each, more focus groups were conducted than originally planned, but with fewer participants in each discussion and virtually. Due to the COVID-19 pandemic, focus groups were conducted via a video conference platform or by telephone, to accommodate participants who did not have reliable internet access and/or were not familiar with video conferencing technology. Focus groups were intentionally limited in regard to the

number of participants to facilitate conversation and full participation in a virtual environment, especially since the moderator could not pick up on non-verbal cues as easily.

A total of 19 community residents participated in 8 virtual focus groups (telephone or video) conducted with specific populations of interest: seniors (ages 65+), parents of school-age children, residents living in public housing, and community college students. Focus groups were up to 60-minute semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Focus group participants were asked to share their perceptions of needs both prior to and following the start of the COVID-19 pandemic. Please see APPENDIX D: FOCUS GROUP GUIDE for the focus group facilitator's guide.

Throughout this report, service area residents and key stakeholders who participated in key informant interviews and focus groups are referred to as study 'participants.'

Analyses

The collected qualitative information was coded and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term "participants" is used to refer to key informant interview and focus group participants. Unique issues that emerged among a group of participants are specified as such. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While differences between towns and neighborhoods are noted where appropriate, analyses emphasized findings common across the Woburn service area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

Community Priorities Survey

A community priorities survey was developed and administered over six weeks from early July through mid-August 2020. The survey focused on identifying issues that had a direct impact on survey respondents, perceptions of community strengths, and important issues for community action. Given the unprecedented time, survey respondents were asked to identify current issues and concerns, as well as issues and concerns that were present around the holiday season (approximately six months ago prior to the start of the COVID-19 pandemic in the United States). The survey was administered online in four languages (English, Spanish, Portuguese, and Chinese). Please see APPENDIX E: SURVEY INSTRUMENT for the English-language version of the survey.

Extensive outreach was conducted with assistance from CAB members and organizations and through social media outreach to obtain survey responses. The survey was disseminated via email to known distribution lists of residents, as well as to individuals who attended earlier community engagement sessions for this process. Several paid Facebook ads were displayed in targeted geographic locations within the service area in all four languages to promote the survey. Additionally, several postings were run via Twitter, LinkedIn, and Facebook. Email dissemination outreach was also sent to over 50 different community-based organizations, which included local food pantries, immigrant service agencies, community centers, libraries, local news outlets, and other groups.

The final sample of the community priorities survey comprised 552 respondents who were residents of the Woburn service area. APPENDIX F: ADDITIONAL SURVEY DATA provides a table with the demographic composition of survey respondents. Respondents to the Partners Ambulatory Care (PAC)

Woburn Area CHNA survey were predominantly non-Hispanic White, female, heterosexual, and with high socioeconomic status. Almost 5% reported primarily speaking a language other than English at home. About 48% were employed full-time. Throughout this report, service area residents who participated in Community Priorities Survey are referred to as survey 'respondents.'

Analyses

Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied by question. Additionally, denominators excluded respondents who selected "prefer not to answer/don't know." For questions that allowed for multiple responses (i.e., questions that asked respondents to check all that apply), the denominator was out of the total number of respondents who selected at least one response option for the question. Stratified analyses were conducted for select questions by specific sub-groups that had large enough sample sizes (at least 30 respondents).

Data Limitations

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

With many organizations and residents focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. While extensive outreach was conducted, the overall response was not as large as expected based on previous assessment studies. Additionally, with its online administration method, the community survey used a convenience sample. Since a convenience sample is a type of non-probability sampling, there is potential selection bias in who participated or was asked to participate in the survey. Due to this potential bias, results cannot necessarily be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, focus groups and interviews were also conducted virtually, and therefore, while both video conference and telephonic options were offered, some residents who lack reliable access to the internet and/or cell phones may have experienced difficulty participating. Lastly, for the primary data collection, it should be noted that while efforts were made to engage residents through qualitative and survey data collection, given the context of the pandemic, the capacity of community organizations to assist with outreach and community members to participate was limited. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

POPULATION CHARACTERISTICS

Population Overview

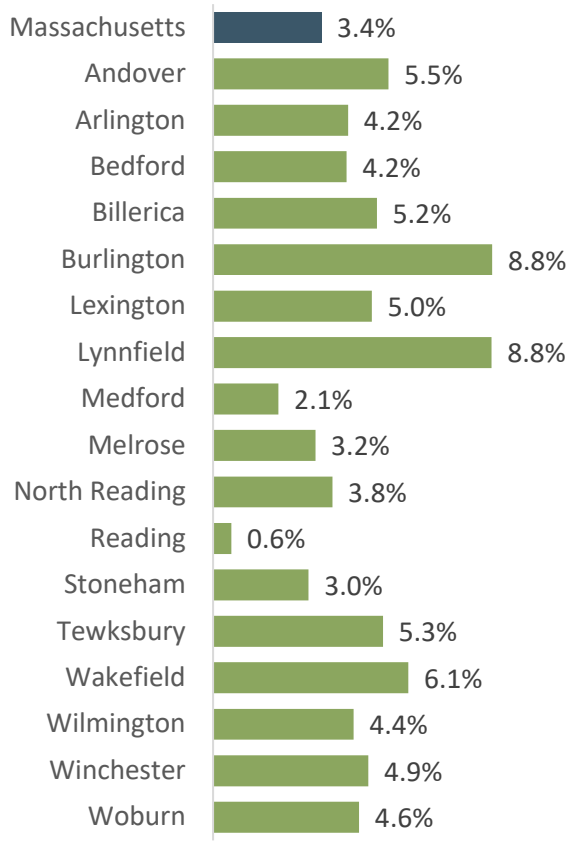
The service area for this CHNA comprises a total population of 504,680 residents. The area around Woburn is divided into towns with populations ranging from almost 12,000 residents in Lynnfield to over 56,000 in Medford (Table 1). By population size, the largest towns are Medford, Arlington, Billerica, and Woburn. Similar to the Commonwealth overall, all towns in this region experienced population growth between 2009-2013 and 2014-2018. The largest population growth occurred in Burlington and Lynnfield, both with 8.8% (Figure 3).

Table 1. Total Population, in Massachusetts and by Town, 2009-2013 and 2014-2018

	2007-2013	2014-2018
Massachusetts	6,605,058	6,830,193
Andover	33,746	35,609
Arlington	43,308	45,147
Bedford	13,557	14,126
Billerica	40,932	43,044
Burlington	24,875	27,059
Lexington	31,886	33,480
Lynnfield	11,812	12,847
Medford	56,607	57,771
Melrose	27,239	28,116
North Reading	15,076	15,642
Reading	24,957	25,100
Stoneham	21,498	22,144
Tewksbury	29,429	31,002
Wakefield	25,400	26,960
Wilmington	22,656	23,658
Winchester	21,621	22,677
Woburn	38,528	40,298

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

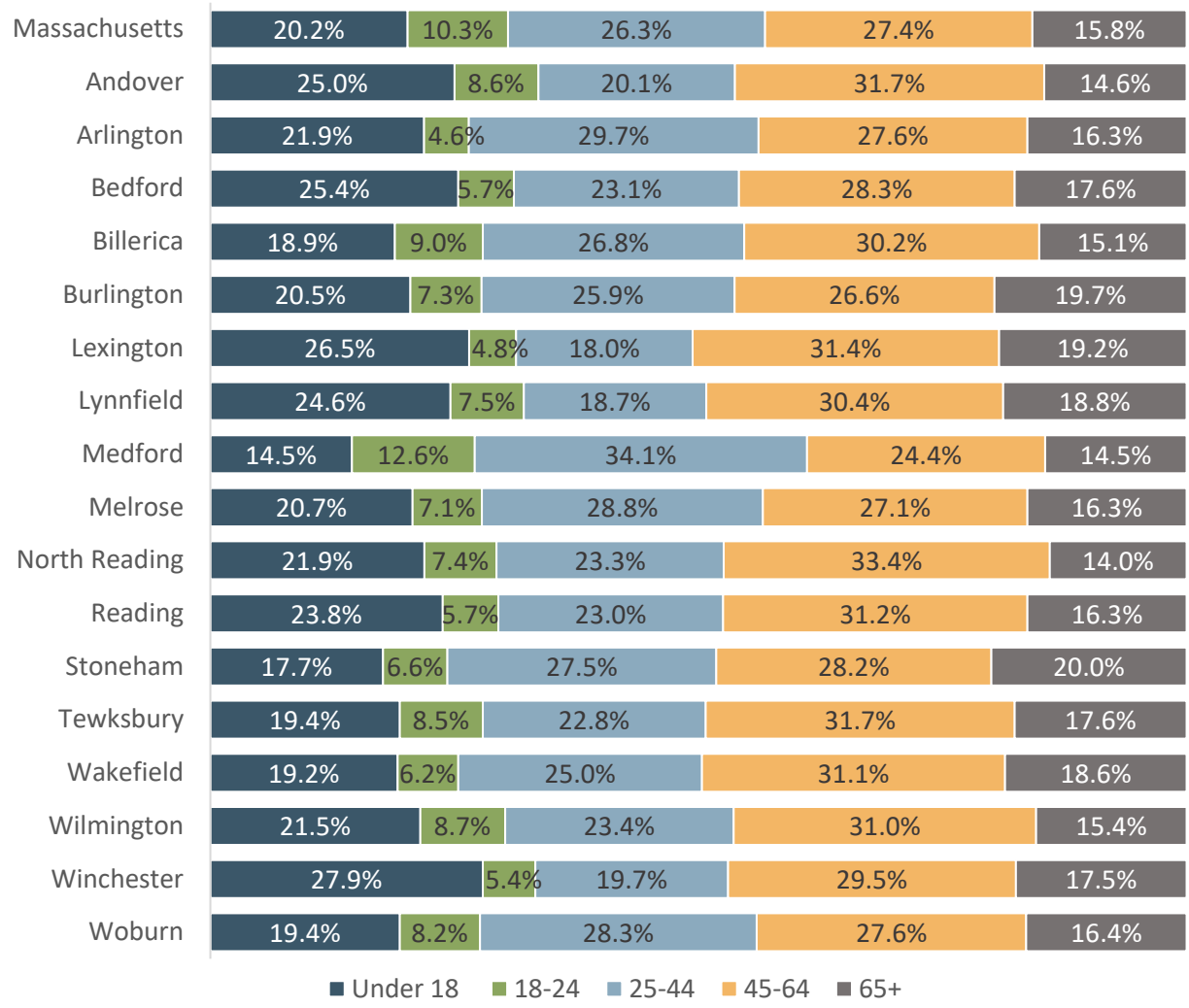
Figure 3. Percent Change in Population, in Massachusetts and by Town, 2009-2013 and 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2009-2013 and 2014-2018.

Overall, most towns in the service area had a greater proportion of both younger and older residents than Massachusetts (residents under 18 years old and 65+ years old). In 2014-2018, about one-quarter of the population of Andover, Bedford, Lexington, and Winchester was under the age of 18 (Figure 4). The largest populations over age 65 were in Stoneham (20.0%), Burlington (19.7%), and Lexington (19.2%).

Figure 4. Age Distribution, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Racial, Ethnic, and Language Diversity

Understanding the racial, ethnic, cultural and language profiles of residents within the Woburn service area assists in providing context to data about health status and the structural, discriminatory, and social factors that contribute to health inequities. Focus group members and interviewees described the Woburn service area as racially and ethnically diverse, which they saw as a positive attribute. Census data reveal that the racial and ethnic population distributions within the Woburn service area varied by town. While all towns have a majority White population, some areas have greater proportions of Asian, Black, and Latino residents. For example, Lexington (29.2%), Burlington (16.3%), and Bedford (14.7%) had the largest non-Hispanic Asian populations; while Medford (9.3%) and Woburn (6.5%) had the

largest non-Hispanic Black populations (Table 2). Moreover, similar to what is occurring nationally, numerous participants shared that conversations about racial equity were occurring in their communities, which they reported both united residents and highlighted differences.

Table 2. Racial and Ethnic Distribution, in Massachusetts and by Town, 2014-2018

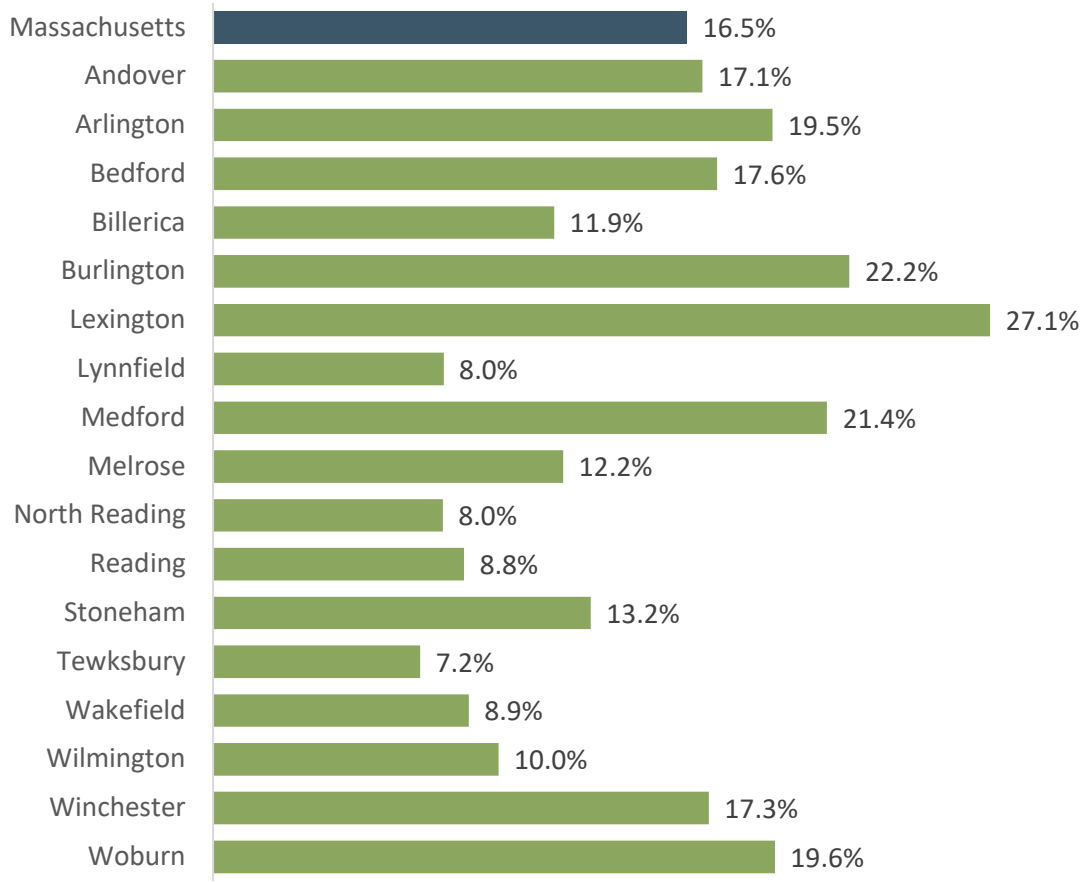
	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic	Other, Non-Hispanic
Massachusetts	6.4%	6.8%	11.6%	72.2%	3.0%
Andover	13.9%	2.7%	4.4%	77.2%	1.8%
Arlington	11.8%	2.6%	5.1%	76.5%	4.0%
Bedford	14.7%	3.6%	3.6%	76.1%	2.1%
Billerica	7.0%	3.3%	4.0%	83.9%	1.8%
Burlington	16.3%	4.9%	2.2%	73.6%	2.9%
Lexington	29.2%	0.9%	2.0%	64.2%	3.7%
Lynnfield	4.9%	1.2%	2.3%	89.5%	2.1%
Medford	10.6%	9.3%	5.3%	71.5%	3.4%
Melrose	5.9%	2.6%	3.7%	85.9%	1.8%
North Reading	4.5%	1.3%	1.4%	89.8%	2.9%
Reading	4.7%	0.4%	2.8%	91.0%	1.1%
Stoneham	3.3%	2.6%	3.7%	89.0%	1.4%
Tewksbury	3.4%	1.5%	1.6%	91.0%	2.4%
Wakefield	2.2%	1.3%	4.7%	90.4%	1.4%
Wilmington	4.9%	3.3%	1.6%	88.8%	1.3%
Winchester	12.7%	0.3%	2.1%	81.7%	3.2%
Woburn	7.9%	6.5%	4.9%	77.4%	3.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race and racial categories. Other includes non-Hispanic/Latino residents who identify as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races.

Country of Origin

In 2014-2018 within Massachusetts, 16.5% of the population was born outside of the United States (Figure 5). Within the Woburn service area, the proportion of residents that were born outside of the United States ranged from 7.2% in Tewksbury to 27.1% in Lexington. Towns with the highest proportion of foreign-born residents within the Woburn service area include Lexington (27.1%), Burlington (22.2%), Medford (21.4%), Woburn (19.6%), and Arlington (19.5%). In Lexington and Arlington, the highest proportion of individuals born outside the United States were born in China (inclusive of Hong Kong and Taiwan) (30.9% and 13.3%, respectively). In Burlington and Woburn, the highest proportion of the foreign-born population was born in India (37.3% and 18.1%, respectively). In Medford, the highest proportion of foreign-born residents were from Haiti (15.8%).

Figure 5. Percent Foreign Born Population, in Massachusetts and by Town, 2014-2018



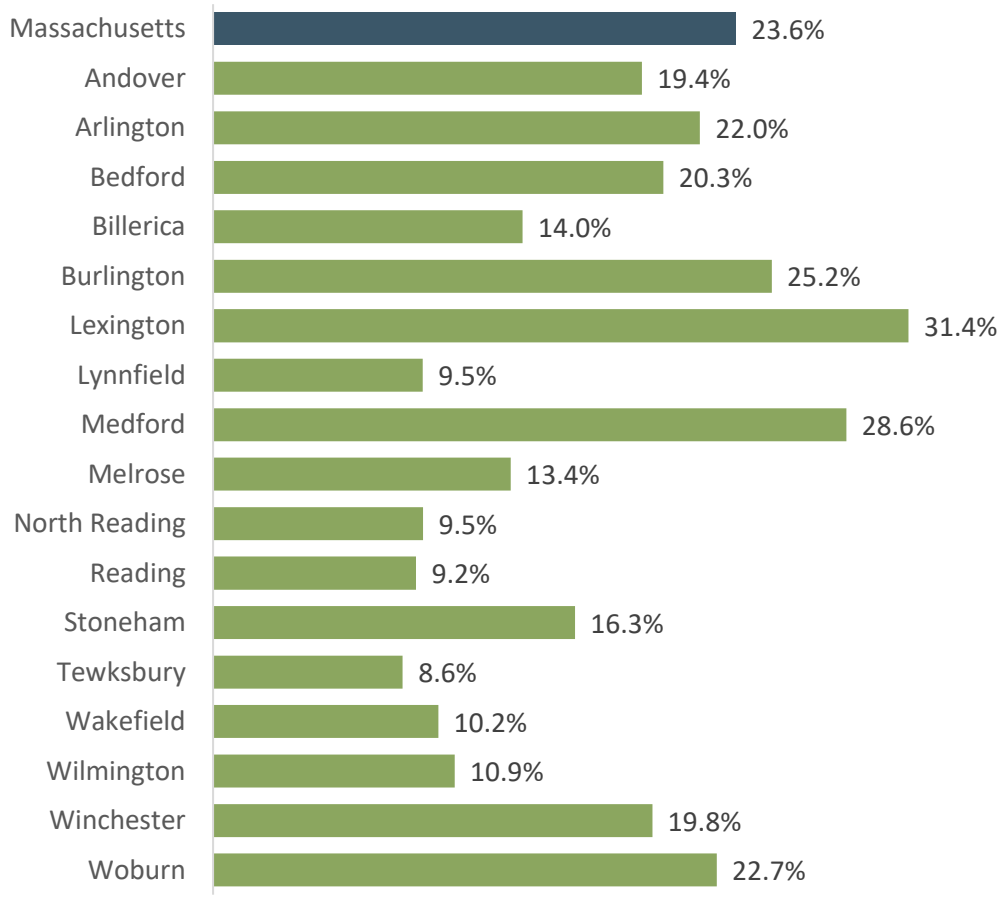
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Language

Languages spoken by community residents represent the Woburn service area's cultural diversity. However, having a primary language other than English may also serve as a potential barrier to receiving adequate health and social services. Among Massachusetts residents over age five, 23.6% reported speaking a language other than English at home in 2014-2018 (Figure 6). Of towns in the Woburn service area, Burlington, Medford, and Lexington all exceeded the overall state prevalence with over one-quarter of residents speaking a language other than English at home. The most commonly spoken languages among these residents were Spanish; the Census category of "Other Indo-European

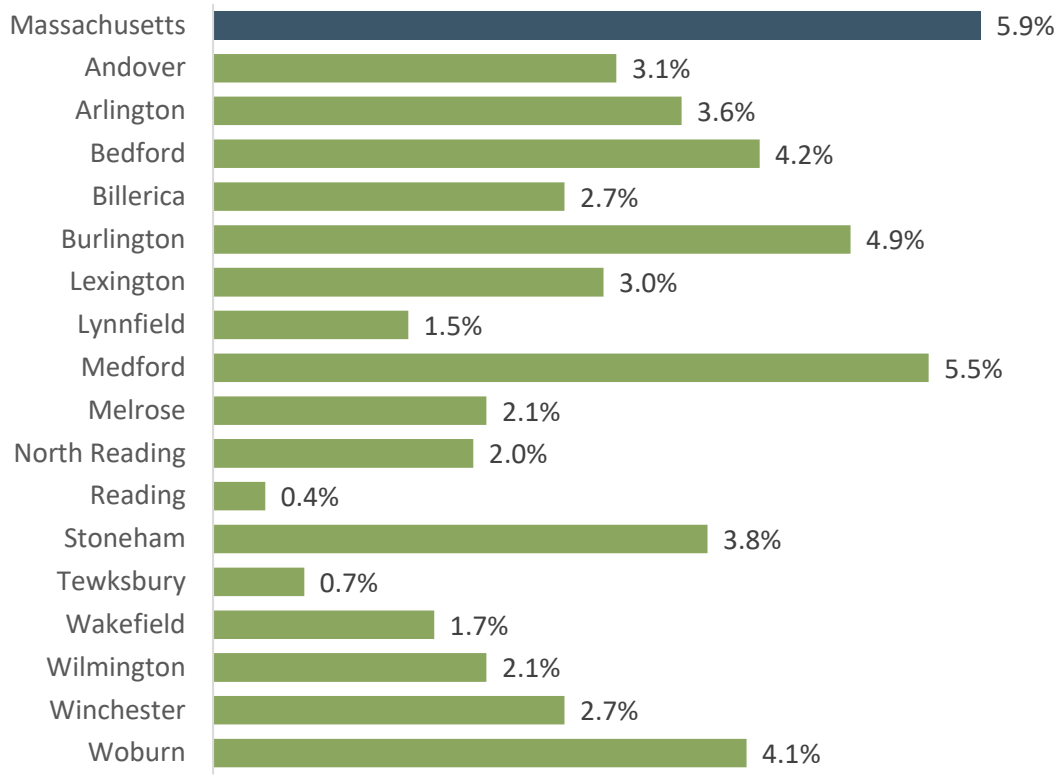
languages" (likely Portuguese); and Chinese. In contrast, towns in the Woburn service area had relatively low prevalence of limited English-speaking at home, with a range of 0.4% in Reading to 5.5% in Medford (Figure 7).

Figure 6. Percent Population 5 Years and Over Who Speak a Language Other Than English, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

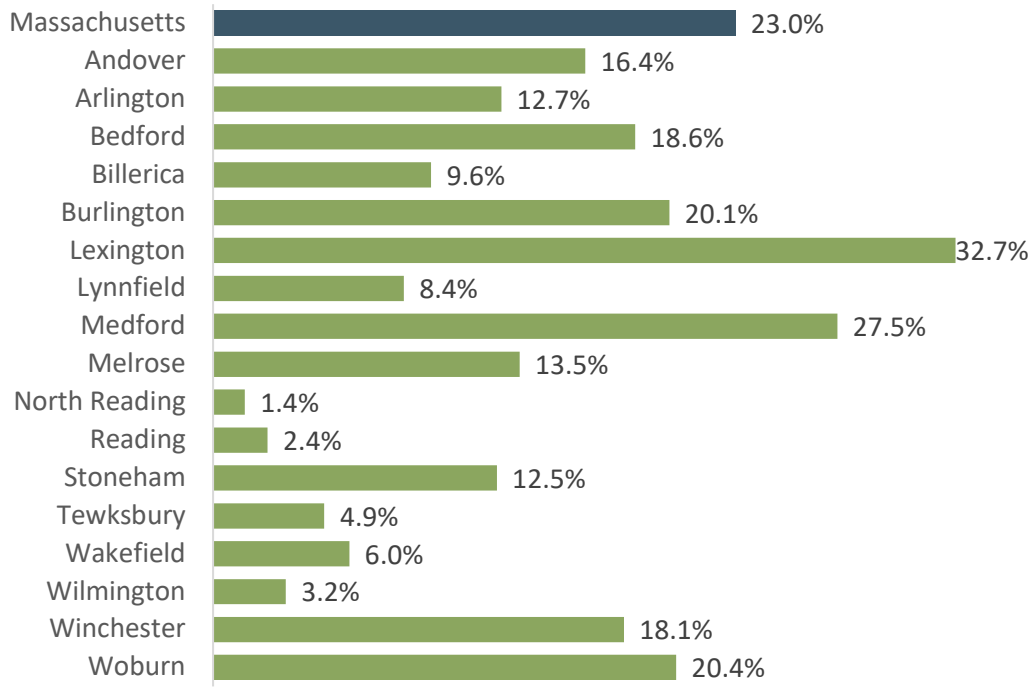
Figure 7. Percent Households Limited English-Speaking, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: A limited English-speaking household is defined as one in which no member 14 years and over speaks only English or speaks English "very well."

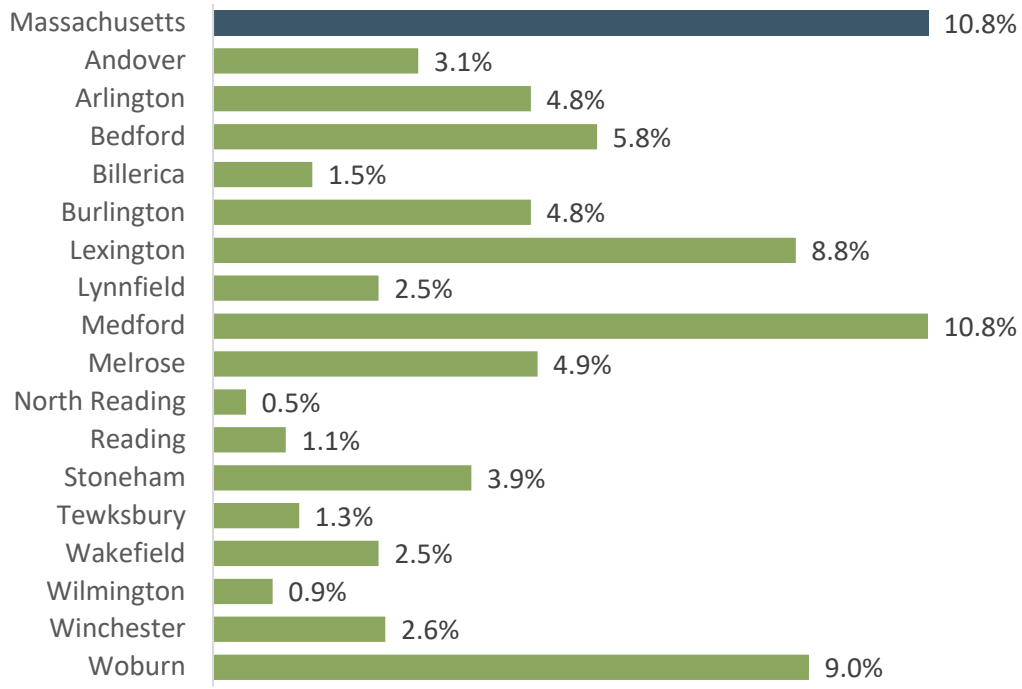
In 2020, almost one-third of public school students in Lexington and over one-quarter in Medford did not speak English as their first language (Figure 8). In Medford, 10.8% of public school students were enrolled in English language learning programs, with 9.0% in Woburn, and 8.8% in Lexington (Figure 9).

Figure 8. Percent Public School Students whose First Language is Not English, in Massachusetts and by School District, 2020



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Years represent school years (e.g., 2020 represents school year 2019-2020); First Language not English indicates the percent of enrollment whose first language is a language other than English.

Figure 9. Percent Public School Students Enrolled English Language Learner, in Massachusetts and by School District, 2020



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Years represent school years (e.g., 2020 represents school year 2019-2020); English Learners indicates the percent of enrolled students who are English learners, defined as a student whose first language is a language other than English who is unable to perform ordinary classroom work in English.

Interviewees working in social service organizations expressed concern for their clients who speak limited English, in particular immigrants and those seeking asylum. These residents, who already faced difficulties in the current political environment, have experienced additional challenges with COVID-19. Interviewees described anxiety and fear in these communities, as well as a reluctance to enroll in services that can help them meet basic needs. Limited English proficiency also is a barrier to employment, and interviewees noted a lack of employment opportunities for immigrants will likely exacerbate social determinant of health challenges within this population.

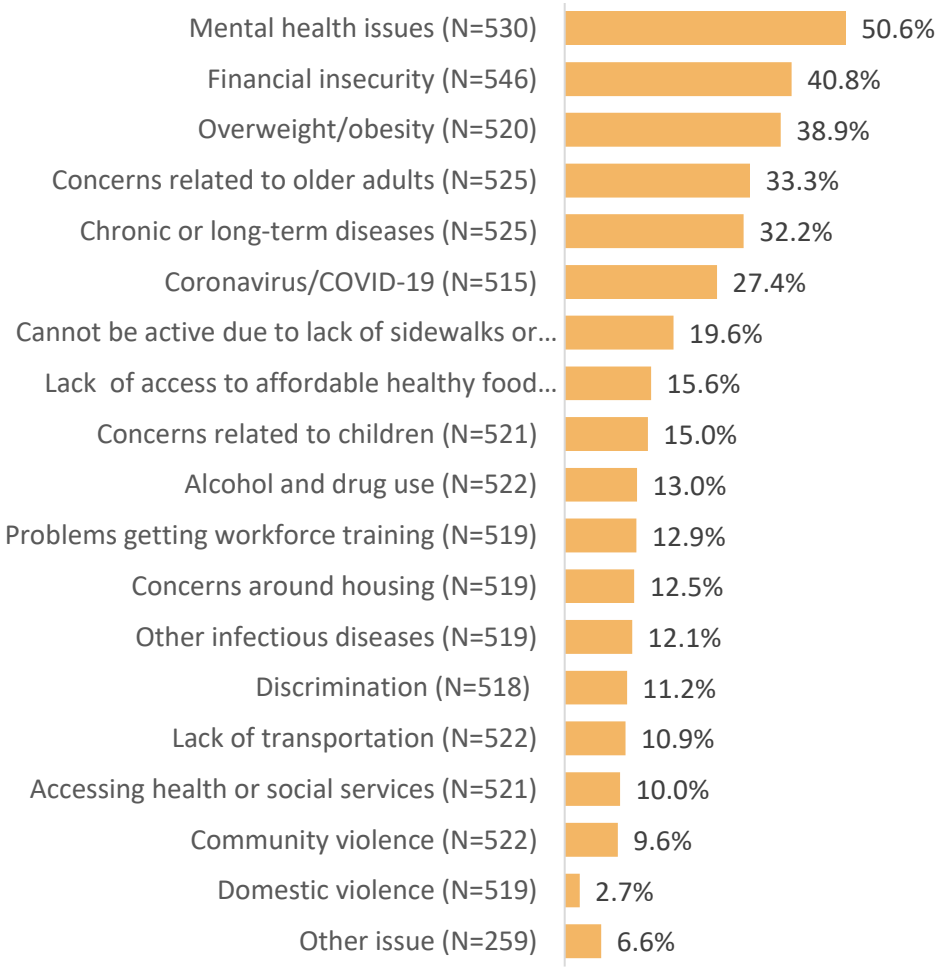
COMMUNITY SOCIAL AND ECONOMIC ENVIRONMENT

Community Perceptions of Need

Woburn Community Priorities Survey respondents were asked about a series of issues or problems that affected them or their families currently and/or prior to the start of the coronavirus pandemic. The most common issues reported were mental health (50.6%), financial insecurity (40.8%), and overweight/obesity (38.9%) (Figure 10). Over one quarter of respondents reported their family was personally affected by COVID-19 and 11.2% reported being affected by some form of discrimination. When reviewing the two time periods (current and pre-pandemic), participants were more likely to indicate that issues such as financial insecurity, mental health, chronic conditions, and overweight/obesity affected them now but not six months ago (see APPENDIX F: ADDITIONAL SURVEY

DATA for a data table that provides data on the detailed responses from Woburn Community Priorities Survey respondents on whether they were impacted by the noted issues now, six months ago, or at both times.).

Figure 10. Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Type of Issue, 2020



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

There was some variation by race/ethnicity in the top five issues that respondents reported affected them or their families over the past six months. Non-Hispanic Whites did not list discrimination as one of their top five concerns, while People of Color ranked it third (Figure 11). Overweight/obesity was more commonly endorsed by People of Color than Non-Hispanic Whites. It should be noted that racial/ethnic groups were categorized into these two groups due to small sample sizes among specific racial/ethnic groups (e.g. Latino, Black, and Asian respondents).

Figure 11. Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Selected Demographics, 2020

	White, Non-Hispanic (N=415)	People of Color (POC) (N=49)
1	Mental health issues (51.0%)	Financial insecurity (59.2%)
2	Financial insecurity (39.5%)	Overweight/obesity (54.2%)
3	Overweight/obesity (36.3%)	Discrimination (51.1%)
4	Concerns related to older adults (34.0%)	Mental health issues (51.0%)
5	Chronic or long-term diseases (32.2%)	Chronic or long-term diseases (35.4%) (tied)
Tie		Concerns related to older adults (35.4%) (tied)

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Interviews and focus group discussions reflected overall agreement with these Woburn Community Priorities Survey results. Mental health issues, concerns related to older adults, and financial insecurity were all common themes. Chronic health conditions, including overweight/obesity were not commonly referenced in the qualitative data.

Community Assets

> *"I think in Medford there definitely is a sense of community. There's a sense of belonging to this place*." – Focus group participant

An understanding of community assets, including resources and services, can help identify strengths that may be leveraged or built upon to address community needs. Focus group members and interviewees reported that they enjoyed living in their communities, which they described as a mix of families, seniors, and young professionals. These participants valued the proximity of the Woburn service area to Boston but saw their communities as quiet and peaceful, which they appreciated. One parent focus group member described Medford as follows: *"I would say it's close to Boston, but still far enough outside that we have our own community and resources."* Participants frequently mentioned that their communities were family-oriented and *"a great place to raise kids."* They appreciated the many amenities available in their communities including shopping as well as public services such as libraries, parks, good schools, programs for children and youth, and active senior centers.

Focus group members and interviewees consistently mentioned strong social ties as a key community asset. They described their neighbors as friendly and helpful. As one interviewee from Woburn stated, *"There is an incredible sense of community here. It's an incredibly close-knit city."* Participants shared several examples of this community cohesiveness including active Facebook groups that provide support to parents of young children, neighbors who check in on older residents, a community "Wine a Neighbor" gifting event, and high levels of volunteering.

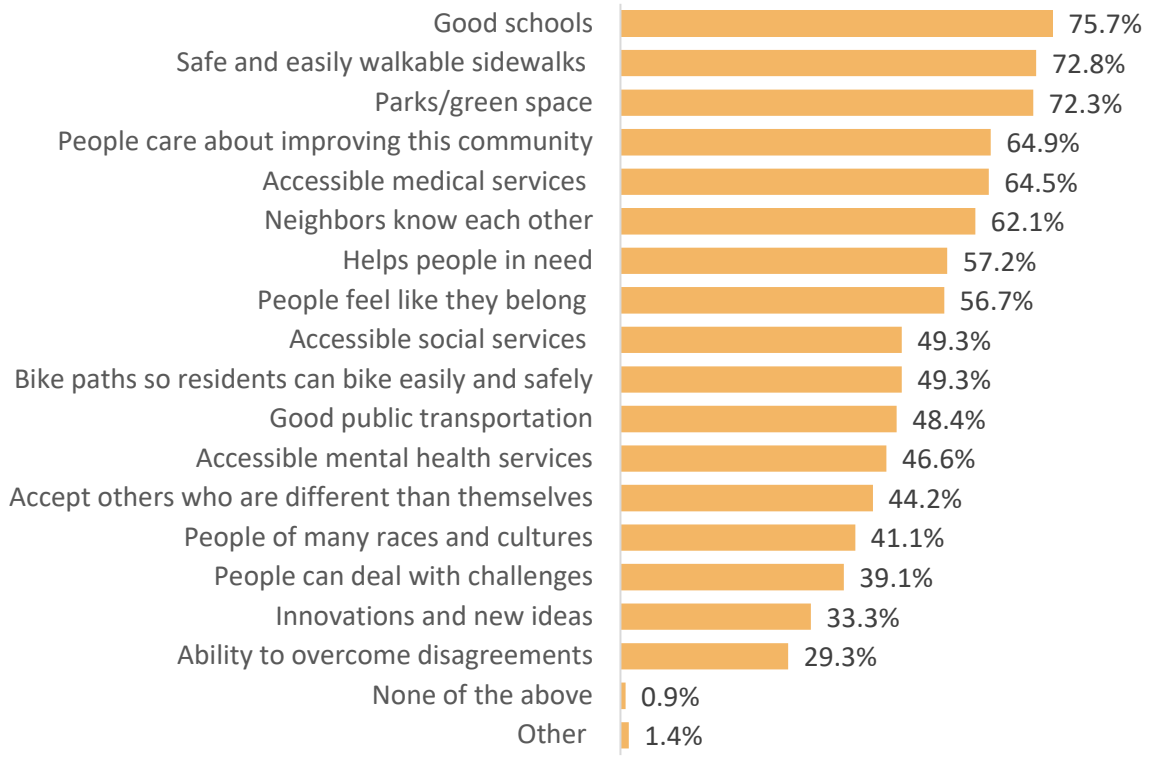
According to interviewees, this spirit of cooperation extends to community organizations as well with strong collaboration amongst government agencies, social service organizations, schools, and faith institutions. One interviewee shared an example of a collaboration between the Billerica Council on Aging and the Billerica police department – these groups are working to address elder abuse. Another interviewee mentioned a social service provider network in Arlington that meets to discuss how social service providers can work together to create a full network of services for specific clients.

> *"The Medford community has stepped up to help the residents of Medford. They've tried to make so many things accessible during this time – like a food pantry. Coronavirus in a way kind of sprang the Medford community instead of bringing it down."* — Focus group participant

Participants shared that the sense of community and willingness to help others has been magnified as a result of COVID-19. Small and large examples of neighborliness during the pandemic, included: the opening of community food pantries; ongoing checks on neighbors and students living in the area; support to neighbors who cannot leave their homes; families putting pictures of hope and encouragement in their windows; and parents organizing video playgroups.

In addition to the strengths listed by interview and focus group participants, respondents to the Woburn Community Priorities Survey were also asked about their perceptions on the strengths of the Woburn service area. The most common responses were good schools (75.7%), safe/walkable sidewalks (72.8%), and parks/green space (72.3%) (Figure 12). Only 0.9% of respondents reported none of the above, and 1.4% other.

Figure 12. Percent of CHNA Community Priorities Survey Respondents Reporting Strengths of Their Community, 2020 (N=552)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

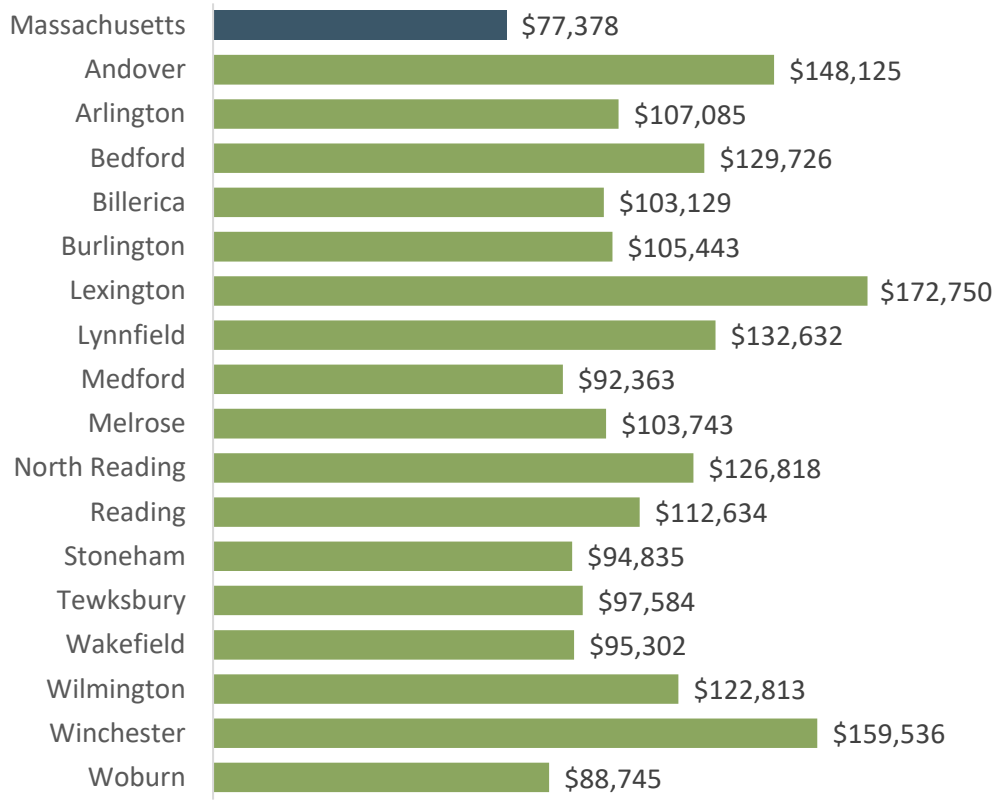
Income and Financial Security

> *"I would say that [Arlington] could be perceived as an affluent community, but there are some major economic inequities."* – Key informant interviewee

The communities within the Woburn service area were described as economically diverse by interview and focus group participants. While Arlington was seen as more affluent, Woburn was described as more working-class. A consistent theme across participants was the high cost of living in the area, attributed to expensive housing, and for those with young children, high childcare costs. As one parent focus group member explained, *"I was paying half of my income in rent and then two-thirds of the other half to daycare."*

In the Woburn service area, socioeconomic factors vary across towns. For example, the median annual household income in 2014-2018 ranged from almost $89,000 in Woburn to almost $173,000 in Lexington (Figure 13). All towns in this region had median incomes well above the state average.

Figure 13. Median Household Income, in Massachusetts and by Town, 2014-2018

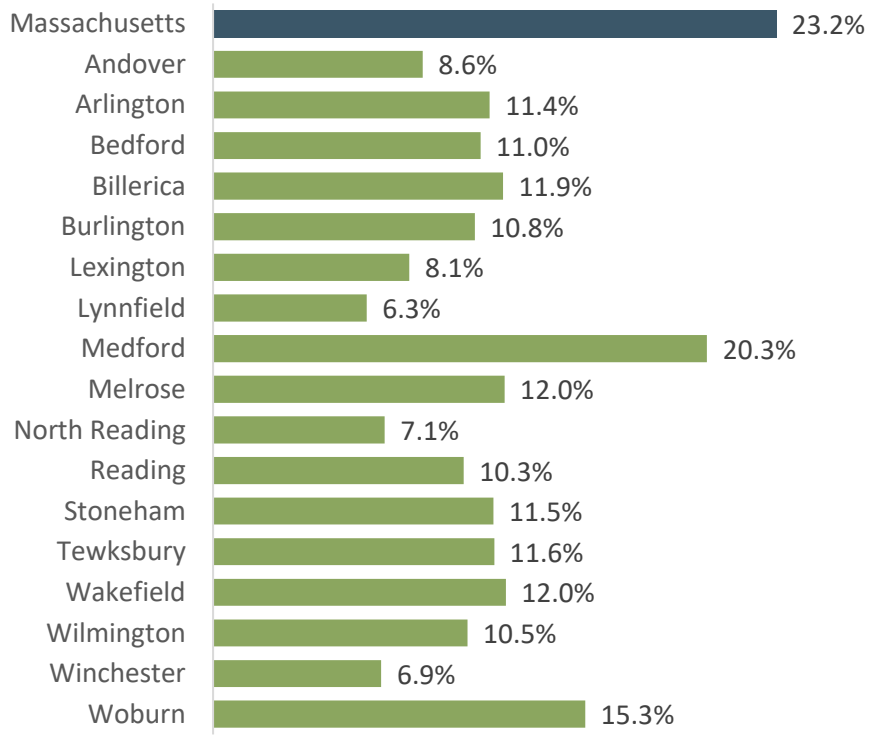


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Given the high cost of living in the Greater Boston Area and the low federal poverty line, individuals with household incomes at even 200% of the Federal Poverty Level (FPL) are at the extreme end of financial insecurity. The federal poverty line changes by household size, so in 2020, 200% FPL was the equivalent of an annual household income of $25,520 for an individual and $52,400 for a family of four.

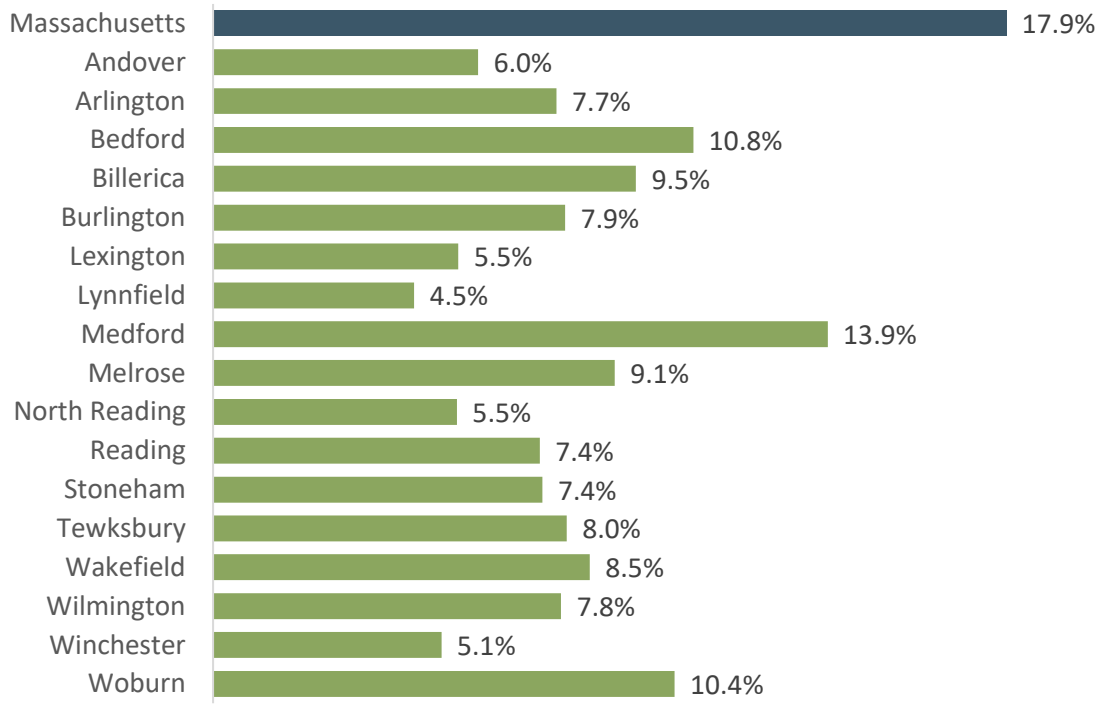
Even though the towns in the Woburn area are generally affluent, many of the towns in this area still have residents experiencing poverty, with incomes at or below 200% FPL – and it is these populations that are dealing with multiple challenges related to COVID-19, according to focus group and interview participants. Medford (20.3%) and Woburn (15.3%) had the largest number of residents in poverty, with a number of other towns within the Woburn service area having about one in ten individuals living in poverty in 2014-2018 (Figure 14). Similar patterns existed for *families* living below 200% of the FPL (Figure 15).

Figure 14. Percent Individuals Living Below 200% of Poverty Level, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

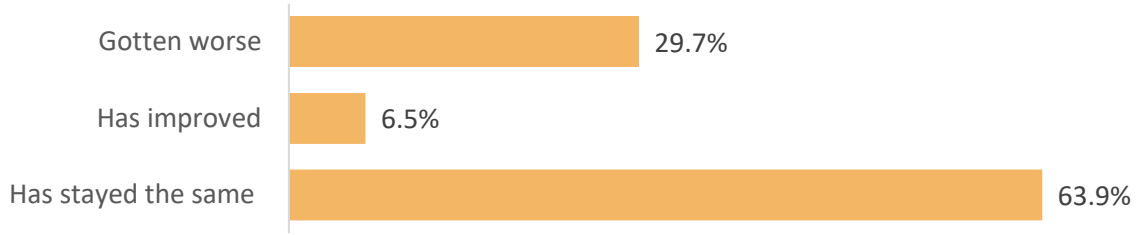
Figure 15. Percent Families Living Below 200% of Poverty Level, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

A few interviewees expressed concerns about income disparity. Inequities have been exacerbated by the pandemic, including unemployment, increased use of food pantries, and increased demand on social services for support with food, rent, and heat. As shown in Figure 16, nearly three in ten (29.7%) Woburn Community Priorities Survey respondents indicated that their financial situation has gotten worse since the COVID-19 pandemic.

Figure 16. Percent CHNA Survey Respondents Indicating Whether Their Financial Situation Has Gotten Worse, Has Improved, or Stayed the Same Due to COVID-19 (N=462)



DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Interview and focus group participants noted that immigrants have been severely impacted by the current economic situation. A large number of immigrants were employed in the construction, restaurant, and retail sectors, all of which have been harshly affected by the pandemic. Moreover, concerns about documentation and language barriers also create additional challenges to meeting this population's basic needs. Many participants expressed concern about the long-term effects of the

pandemic. As one interviewee predicted, *"There have been quick band-aids put in place. These have alleviated the immediate problem, but we're going to see worse impacts that haven't hit yet. The effect on folks living too close to the edge will be great."*

For community members living at 100% of FPL – equivalent to an annual household income of $12,760 for an individual and $26,200 for a family of four – patterns vary substantially by race/ethnicity. For example, over 18% of Hispanics/Latinos living in Burlington and Reading were living below 100% FPL in 2014-2018, relative to around 3% of the non-Hispanic White residents of these same towns (Table 3). Variation also exists within racial groups, for example 0.5% of non-Hispanic Blacks living in Andover were living in poverty compared to 44.3% of non-Hispanic Blacks in Tewksbury. Any apparent differences should be interpreted cautiously, due to small populations of residents of color and residents in poverty in some towns.

Table 3. Percent Population Living Below Poverty Level (100% FPL), by Race/Ethnicity, in Massachusetts and by Town, 2014-2018

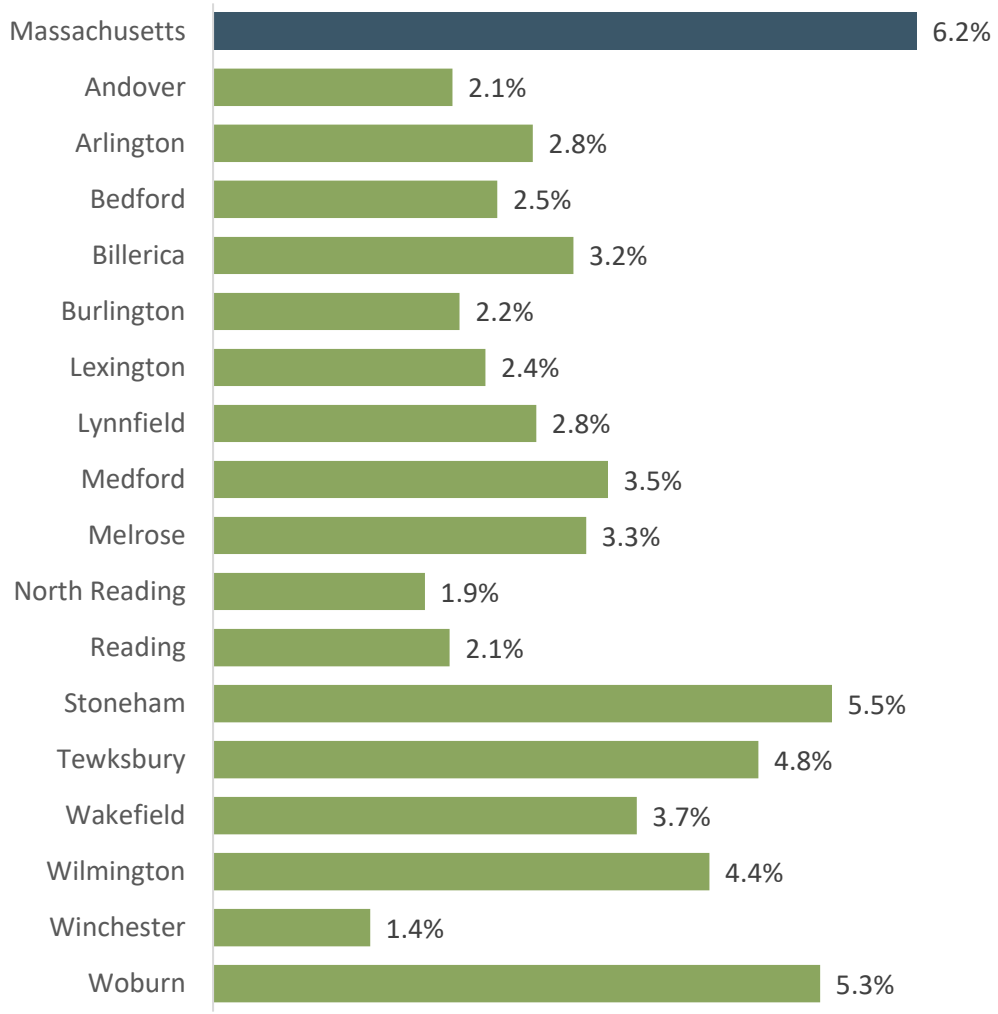
	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	13.8%	19.7%	22.8%	7.1%	26.6%
Andover	6.3%	0.5%	12.2%	3.5%	9.8%
Arlington	11.5%	2.5%	8.4%	4.3%	5.9%
Bedford	7.4%	0.6%	6.9%	2.7%	0.0%
Billerica	2.7%	7.4%	5.8%	3.7%	4.3%
Burlington	4.3%	8.5%	0.2%	3.2%	18.8%
Lexington	5.0%	2.4%	2.5%	3.1%	2.3%
Lynnfield	0.0%	3.7%	0.4%	2.0%	0.3%
Medford	16.5%	8.0%	9.9%	7.8%	17.4%
Melrose	5.5%	12.4%	0.0%	3.9%	1.8%
North Reading	0.0%	7.4%	1.2%	2.9%	14.0%
Reading	0.0%	1.1%	15.8%	2.9%	18.1%
Stoneham	13.3%	1.4%	9.8%	5.1%	8.4%
Tewksbury	4.2%	44.3%	6.3%	5.2%	0.6%
Wakefield	0.0%	1.6%	10.8%	4.0%	5.9%
Wilmington	1.9%	2.9%	0.2%	2.4%	8.7%
Winchester	5.5%	10.4%	5.5%	1.9%	0.8%
Woburn	1.2%	18.0%	18.1%	4.3%	17.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

Supplemental Security Income (SSI) is provided to adults and children with disabilities and limited income and resources, as well as to people over 65 years-old with limited wealth and resources. In 2014-2018, the proportion of households receiving SSI ranged from 1.4% in Winchester to 5.5% in

Stoneham (Figure 17). This reflects both the differing age and wealth distributions of the residents of the Woburn service area.

Figure 17. Percent Households Receiving Supplemental Social Security Income in Past 12 months, in Massachusetts and by Town, 2014-2018

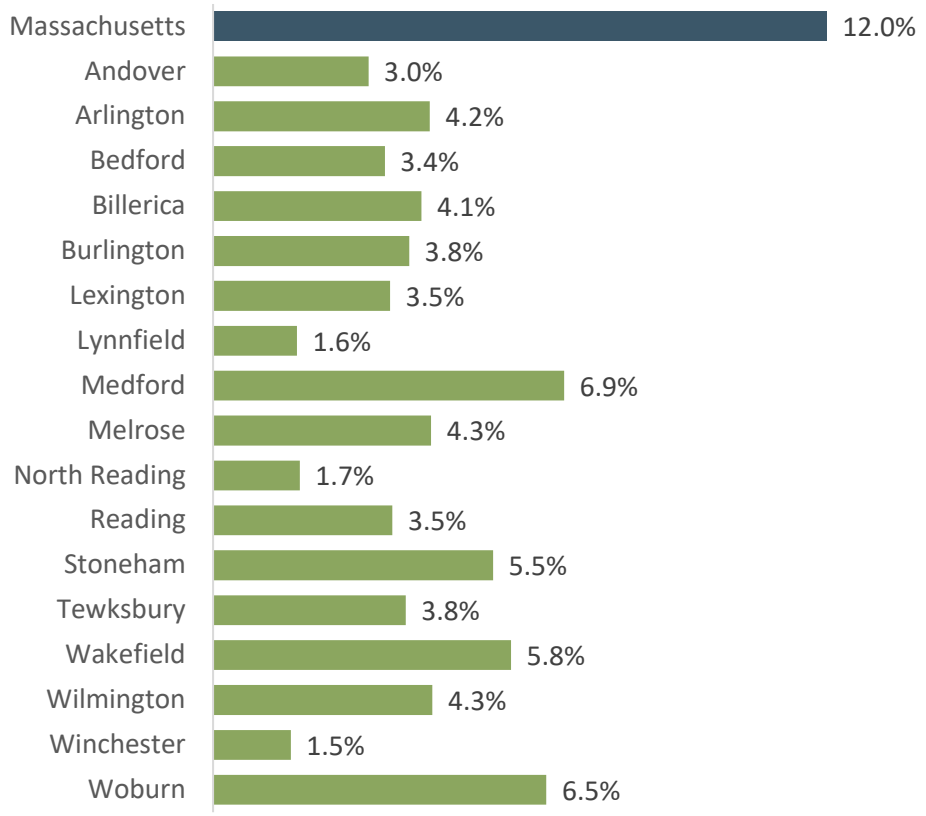


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Both interviewees and focus group participants frequently mentioned food insecurity as a community challenge and an issue that existed prior to COVID-19 but has been exacerbated by the pandemic. Low-income residents and seniors were identified as those most food insecure prior to the pandemic. Since the onset of COVID-19, participants reported, food needs across groups multiplied as residents faced unemployment and other economic challenges or were unable to obtain groceries due to a lack of transportation or safety concerns. The number of families using food pantries and seniors accessing Meals on Wheels grew substantially according to interviewees whose organizations provide these services. Participants also mentioned that school lunch programs were expanded to meet the demand for food.

In Massachusetts overall, 12.0% of households received food stamps or Supplemental Nutrition Assistance Program (SNAP) benefits in 2014-2018 (Figure 18). In the Woburn service area, households receiving the noted benefits ranged from 1.5% in Winchester and 1.6% in Lynnfield to 6.5% in Woburn and 6.9% in Medford.

Figure 18. Percent Households Receiving Food Stamps/SNAP Benefits, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Within the Woburn service area, the proportion of households receiving SNAP benefits also varied by race/ethnicity. In Massachusetts, 36.3% of Hispanic/Latino households receive food stamps, compared to only 7.9% of non-Hispanic White households, with Asian, Black, and Other race households falling in between (Table 3). In Medford, 4.7% of non-Hispanic Asians, 17.5% of non-Hispanic Blacks, 7.2% of residents identifying as "Other," 5.8% of non-Hispanic Whites, and 13.2% of Hispanics/Latinos received SNAP benefits in 2014-2018. In Woburn, prevalence was 5.0%, 9.2%, 10.2%, 5.7%, and 16.4%, respectively.

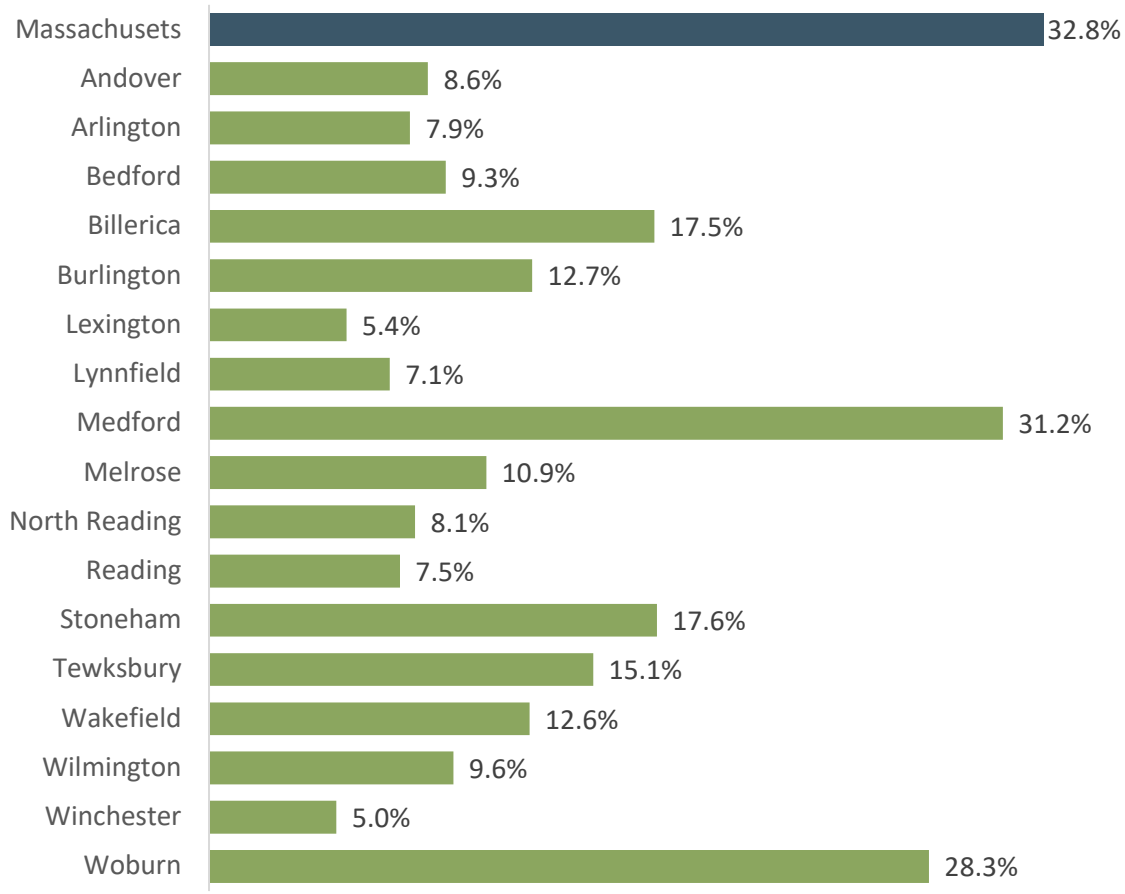
Table 4. Percent Households Receiving Food Stamps/SNAP Benefits, by Race/Ethnicity, in Massachusetts and by Town, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	11.5%	27.3%	32.2%	7.9%	36.3%
Andover	3.7%	22.4%	6.1%	2.1%	15.5%
Arlington	8.2%	26.0%	6.4%	3.5%	1.5%
Bedford	0.0%	36.6%	0.0%	1.9%	32.1%
Billerica	8.5%	0.0%	7.2%	3.9%	4.2%
Burlington	4.1%	14.3%	3.7%	2.4%	34.3%
Lexington	4.3%	4.6%	4.3%	3.2%	0.0%
Lynnfield	0.0%	0.0%	0.0%	1.8%	0.0%
Medford	4.7%	17.5%	7.2%	5.8%	13.2%
Melrose	5.7%	8.3%	4.3%	4.2%	0.0%
North Reading	0.0%	40.0%	0.0%	1.5%	0.0%
Reading	0.0%	0.0%	0.0%	3.6%	7.5%
Stoneham	10.3%	0.0%	5.7%	5.7%	2.4%
Tewksbury	0.0%	0.0%	4.3%	3.8%	0.0%
Wakefield	9.7%	6.7%	6.1%	5.9%	2.5%
Wilmington	4.9%	25.2%	6.5%	3.7%	0.0%
Winchester	4.8%	0.0%	4.1%	1.0%	14.6%
Woburn	5.0%	9.2%	10.2%	5.7%	16.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

According to the Massachusetts Department of Elementary and Secondary Education, 32.8% of Public School students in Massachusetts were economically disadvantaged during the 2019-2020 school year (Figure 19; see footer for definition). In the Woburn service area, proportions varied by town, ranging from 5.0% in Winchester and 5.4% in Lexington to 28.3% in Woburn and 31.2% in Medford.

Figure 19. Percent Public School Students Economically Disadvantaged, in Massachusetts and by School District, 2020



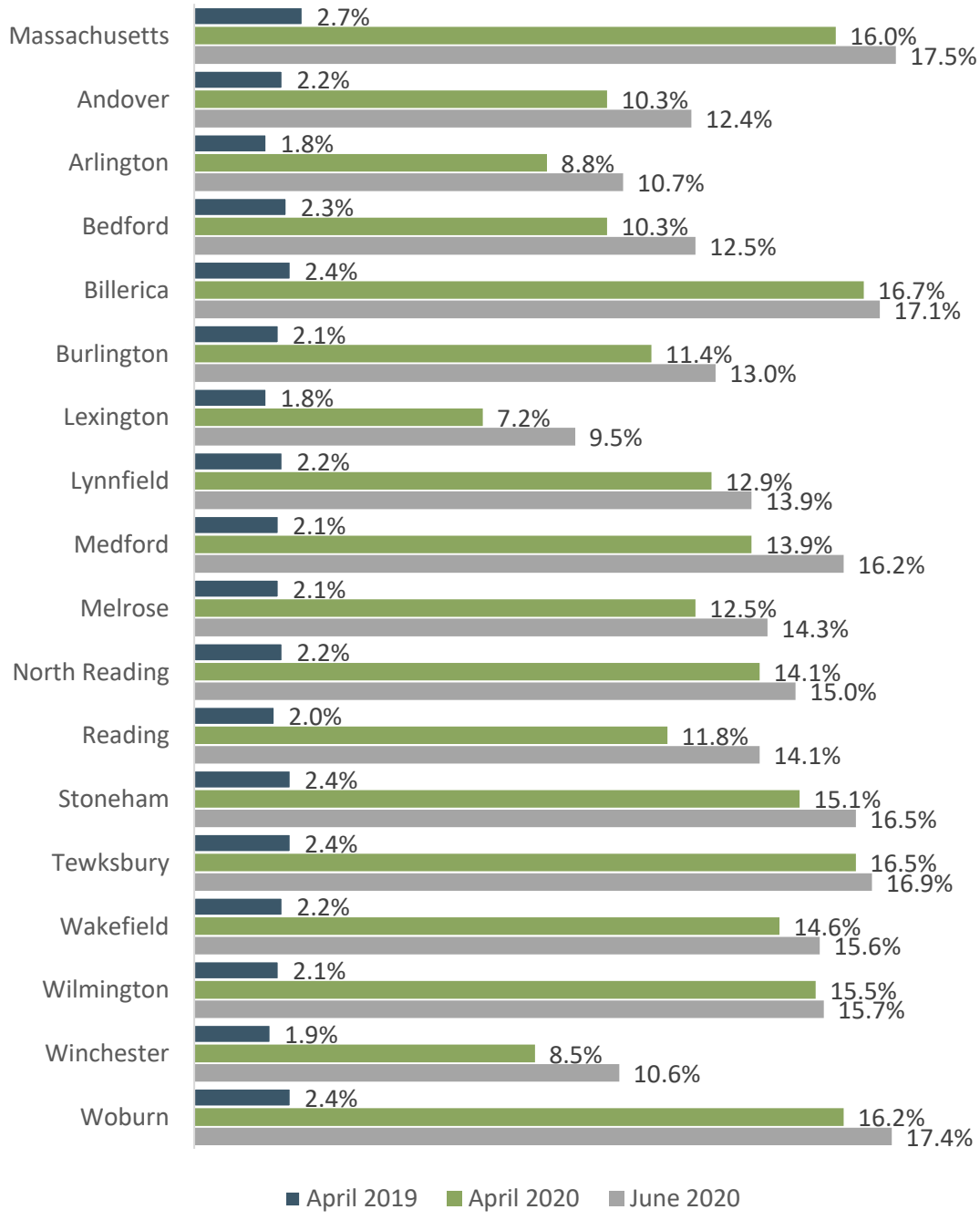
DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Selected Populations, 2020.
NOTE: Years represent school years (e.g., 2020 represents school year 2019-2020); Economically disadvantaged is determined based on a student's participation in one or more of the following state-administered programs: the Supplemental Nutrition Assistance Program (SNAP), the Transitional Assistance for Families with Dependent Children (TAFDC), the Department of Children and Families' (DCF) foster care program, and MassHealth (Medicaid).

Employment and Workforce

In the Woburn service area, the top three industries for employment are (1) Educational services, and health care and social assistance; (2) Professional, scientific, management, and administrative and waste management services; and (3) Manufacturing. The impact of the pandemic and resulting economic shutdown in many sectors are reflected in unemployment data from towns in the Woburn service area, between April 2019 and June 2020 (Figure 20). Unemployment rates continued to increase from April 2020 to June 2020 in all towns. In April 2019, Massachusetts, and each city or town in the area, had

unemployment rates under 3%, with Arlington, Lexington, and Winchester under 2%. However, during the pandemic, unemployment rates increased to 16.0% statewide in April, with similar (e.g. Billerica, 16.7%; Tewksbury, 16.5%) or lower (e.g. Lexington, 7.2%) rates in the Woburn service area.

Figure 20. Percent Population 16 Years and Over Unemployed, in Massachusetts and by Town, 2019-2020



DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2019-2020.
NOTE: Data are not seasonally adjusted; June 2020 data are preliminary and subject to revision.

Focus group members and interviewees spoke primarily about employment in the context of COVID-19, with some sharing that family members and friends had lost their jobs during the pandemic. Participants expressed uncertainty about how long unemployment may last and the status of unemployment benefits. Those with school-age children worried about how school reopening strategies would affect their children's education and their ability to work.

Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. Massachusetts stands out as a state with an exceptionally high proportion of residents with college, graduate, and professional degrees (42.9% in 2014-2018; Table 5). Among residents over 25 years of age in the Woburn service area, 45.9% of Winchester residents and 54.2% of Lexington residents had a graduate or professional degree. In contrast, Billerica and Tewksbury had the largest populations with a High School diploma or less.

Table 5. Educational Attainment for Population 25 Years and Over, in Massachusetts and by Town, 2014-2018

	Less than HS diploma	HS graduate	Some college/ Associate's degree	Bachelor's degree	Graduate or Professional Degree
Massachusetts	9.6%	24.2%	23.3%	23.8%	19.1%
Andover	2.6%	8.6%	14.9%	34.4%	39.4%
Arlington	3.4%	12.2%	13.4%	30.6%	40.5%
Bedford	3.2%	9.0%	16.9%	31.2%	39.7%
Billerica	7.3%	31.8%	26.6%	22.8%	11.5%
Burlington	4.1%	20.6%	20.5%	30.8%	24.0%
Lexington	1.7%	7.1%	9.0%	28.1%	54.2%
Lynnfield	2.3%	17.4%	22.7%	31.8%	25.8%
Medford	7.4%	21.0%	18.7%	26.3%	26.5%
Melrose	4.7%	15.9%	20.9%	30.6%	27.8%
North Reading	3.6%	23.8%	22.3%	29.4%	20.9%
Reading	3.1%	15.7%	19.3%	32.7%	29.3%
Stoneham	5.8%	24.8%	24.8%	26.3%	18.3%
Tewksbury	5.3%	30.6%	28.6%	23.3%	12.2%
Wakefield	6.8%	20.3%	21.6%	31.0%	20.5%
Wilmington	4.4%	28.2%	24.4%	24.6%	18.4%
Winchester	1.7%	11.3%	11.3%	29.9%	45.9%
Woburn	5.9%	25.5%	23.9%	27.2%	17.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Table 6 illustrates additional patterns in educational attainment across service area towns, by race/ethnicity. For some towns, data interpretation is limited given the small number of residents in certain education by race brackets. However, in other towns, findings reveal variations, for example, among Hispanics/Latinos over age 25, 33.5% in Wakefield, 16.4% in Woburn, 8.4% in Andover, and 7.6% in Medford have less than a High School diploma. Variation was also apparent by race/ethnicity *within*

towns. For example, 14.7% of non-Hispanic Asian residents of Grafton over age 25 did not have a high school diploma in 2014-2018, compared to 1.8% of non-Hispanic Other race residents and 3.7% of non-Hispanic White residents. In Medford in 2014-2018, the proportion of the population without a High School diploma ranged from 5.3% of non-Hispanic Other race residents to 13.3% of non-Hispanic Black residents.

Table 6. Percent Population 25 Years and Over with Less than High School Diploma, in Massachusetts and by Town, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	14.9%	14.8%	27.4%	6.2%	30.0%
Andover	2.7%	1.0%	14.2%	2.3%	8.4%
Arlington	6.1%	1.6%	6.8%	2.9%	8.0%
Bedford	5.6%	8.1%	18.5%	2.3%	7.3%
Billerica	8.8%	7.8%	18.5%	6.7%	14.7%
Burlington	4.1%	8.0%	0.0%	3.8%	9.6%
Lexington	1.6%	11.4%	0.0%	1.6%	0.0%
Lynnfield	0.0%	0.0%	2.3%	2.3%	23.7%
Medford	11.4%	13.3%	5.3%	6.4%	7.6%
Melrose	9.3%	7.2%	0.0%	4.6%	0.5%
North Reading	2.9%	0.0%	1.5%	3.8%	2.2%
Reading	4.1%	1.0%	10.2%	2.6%	23.4%
Stoneham	4.2%	3.8%	0.0%	6.0%	7.1%
Tewksbury	5.5%	3.3%	6.8%	5.2%	17.2%
Wakefield	7.8%	3.1%	43.9%	5.6%	33.5%
Wilmington	3.6%	16.5%	0.6%	4.1%	17.4%
Winchester	5.2%	12.8%	0.0%	1.2%	0.0%
Woburn	8.1%	10.9%	6.8%	5.0%	16.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

In contrast, Table 7 shows the percent population over age 25 with a bachelor's degree or higher, by race/ethnicity in the towns around Woburn in 2014-2018. Variation exists, for example with 80.1% of non-Hispanic Whites in Lexington having a bachelor's degree or higher, compared to 31.7% in Billerica and 34.5% in Tewksbury. For Woburn residents over age 25, 72.6% of non-Hispanic Asians, 30.9% of non-Hispanic Blacks, 41.4% of non-Hispanic Other race residents, 43.6% of non-Hispanic Whites, and 33.3% of Hispanics/Latinos had a bachelor's degree or higher.

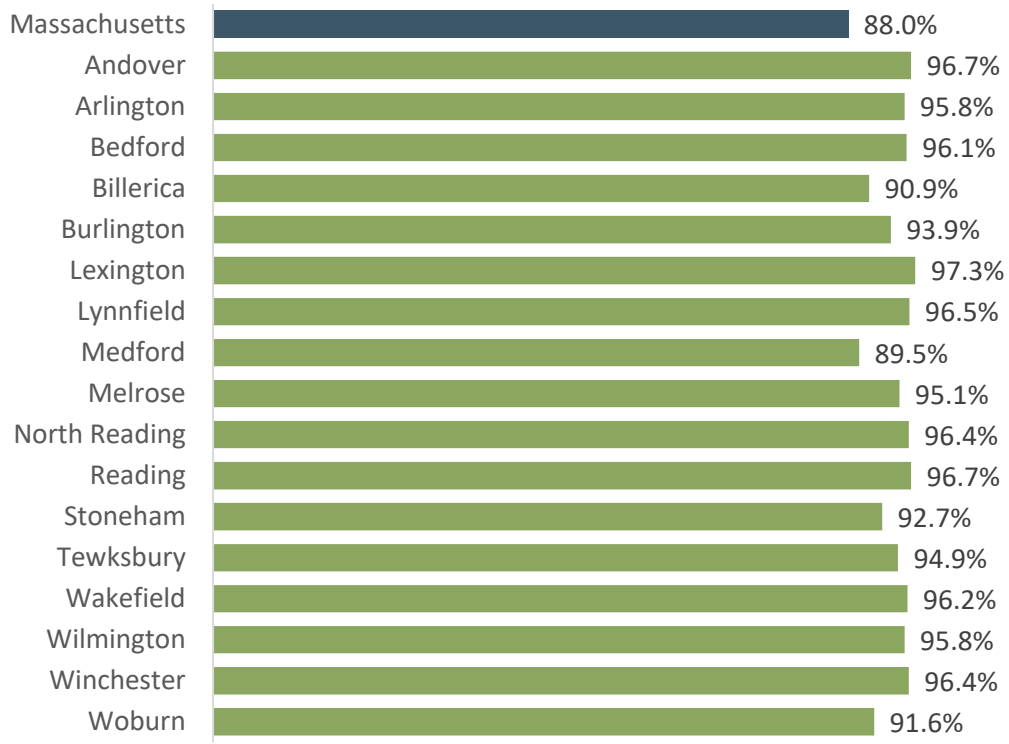
Table 7. Percent Population 25 Years and Over with Bachelor's Degree or Higher, in Massachusetts and by Town, 2014-2018

	Asian	Black	Other	White, Non-Hispanic	Hispanic/ Latino
Massachusetts	60.2%	25.6%	20.8%	46.0%	18.8%
Andover	86.9%	65.4%	58.9%	72.5%	57.4%
Arlington	76.8%	46.6%	61.3%	71.4%	55.6%
Bedford	82.7%	47.2%	38.0%	70.3%	57.1%
Billerica	73.6%	30.5%	13.4%	31.7%	19.8%
Burlington	78.5%	65.2%	74.4%	48.5%	56.9%
Lexington	88.2%	68.2%	84.8%	80.1%	84.0%
Lynnfield	85.8%	43.0%	97.7%	55.6%	54.6%
Medford	65.7%	28.7%	59.3%	53.5%	51.9%
Melrose	64.2%	39.6%	56.5%	58.4%	66.1%
North Reading	74.5%	43.6%	64.4%	48.7%	61.2%
Reading	90.4%	80.2%	64.6%	60.3%	55.5%
Stoneham	68.9%	41.7%	34.8%	44.6%	31.7%
Tewksbury	65.8%	35.3%	17.9%	34.5%	48.2%
Wakefield	74.1%	36.7%	40.9%	51.3%	41.1%
Wilmington	77.4%	37.7%	21.0%	41.4%	16.1%
Winchester	79.4%	43.6%	59.5%	75.5%	90.6%
Woburn	72.6%	30.9%	41.4%	43.6%	33.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Asian, Black and Other racial categories include residents who identify as Hispanic/Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; White, Non-Hispanic category includes residents who do not identify as Hispanic/Latino; Hispanic/Latino includes residents who identify as Hispanic/Latino regardless of race.

Among current high school students in 2019, graduation rates were high, ranging from 89.5% in Medford to 97.3% in Lexington (Figure 21). All towns in this region reported higher graduation rates than the state overall. Both interviewees and focus group members praised the school systems in the Woburn service area, which they reported were highly rated.

Figure 21. Graduation Rate among Public High School Students, in Massachusetts and by School District, 2019



DATA SOURCE: Massachusetts Department of Elementary and Secondary Education, School and District Profiles, Cohort 2019 Graduation Rates, 2019.

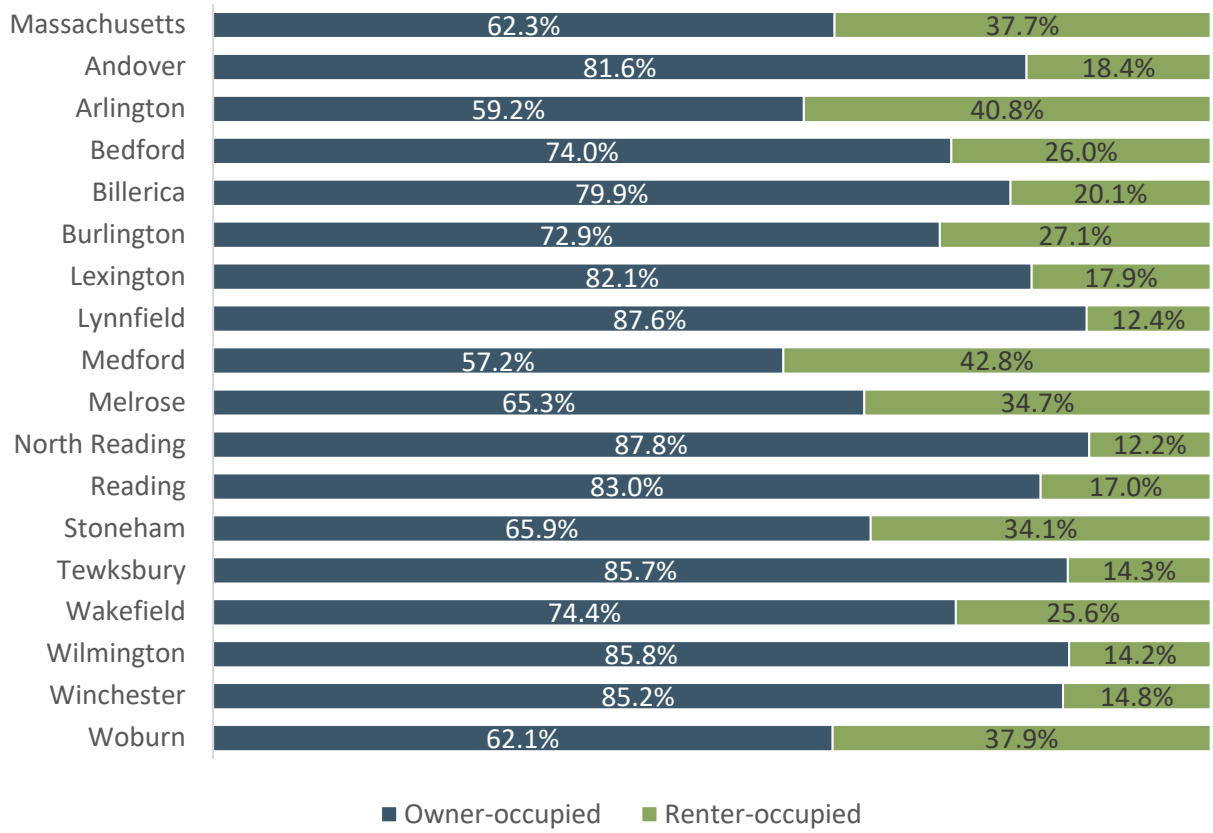
Housing

> *"My rent is half of my paycheck. Every financial advisor will tell you that's crazy, but this is the cheapest apartment I could find".* – Focus group participant
>
> *"If I were to buy a house, I would be looking outside the area*." – Focus group participant

A prominent theme in focus group discussions and interviews was the high cost of housing in the region. While Billerica and Woburn were described as more affordable than Medford or Arlington, participants consistently mentioned housing expense and high taxes as concerns that are putting housing out of reach for some and making it harder for seniors who want to stay in the area and downsize. Participants noted that high housing costs also contributed to overcrowding and rising homelessness in the larger towns within the Woburn service area. As one focus group member stated, "*I know Medford is expensive for housing. I know there are people who are trying to move to the area but can't afford it."*

In Massachusetts, 62.3% of housing units are owner-occupied versus 37.7% renter-occupied (Figure 22). In most of the towns around Woburn, owner-occupied units are more common than in the state overall, for example 87.8% in North Reading; 87.6% in Lynnfield; and 85.8% in Wilmington. The exceptions are Arlington (59.2%), Medford (57.2%), and Woburn (62.1%).

Figure 22. Percent of Housing Units Owner- or Renter-Occupied, in Massachusetts and by Town, 2014-2018

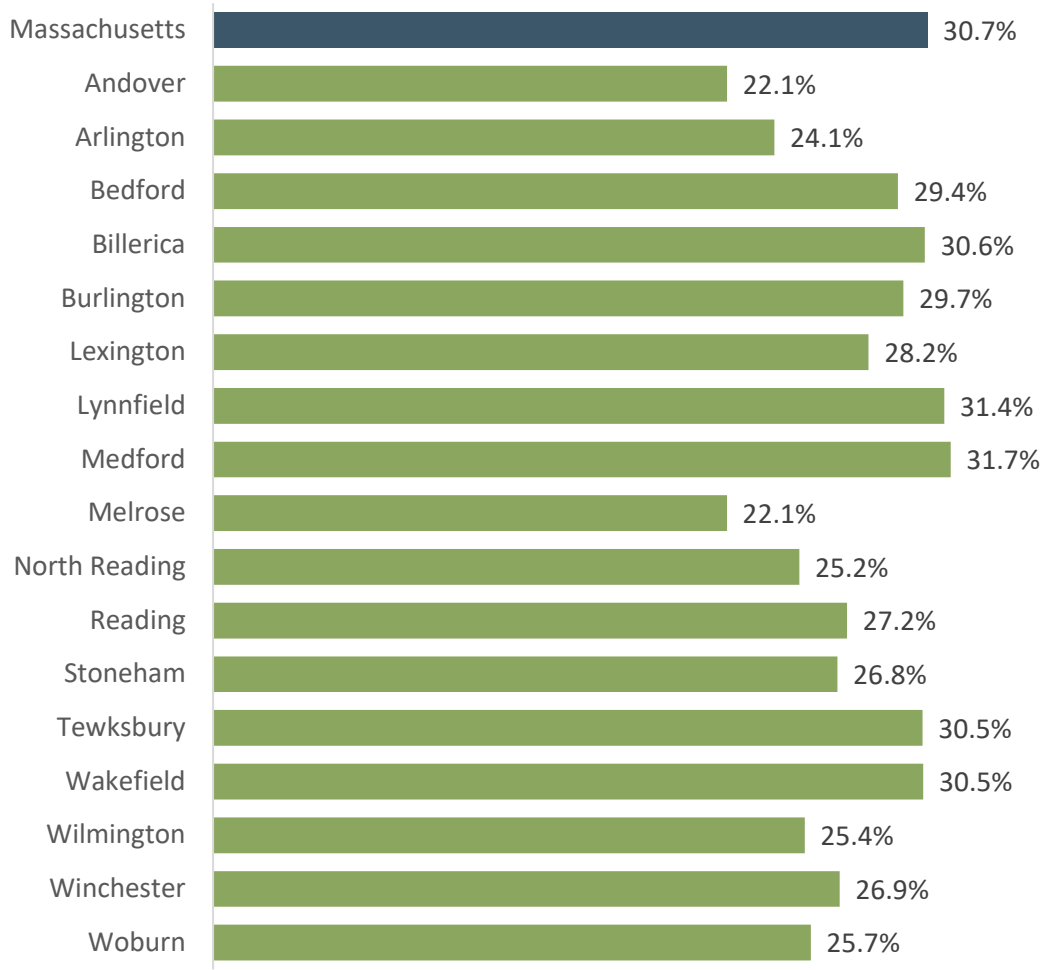


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Most participants reported that the communities within the Woburn service area lacked affordable housing. Members of the parents focus group, for example, mentioned 5-10 year wait lists to obtain affordable public housing. Seniors expressed concern about finding housing within their incomes.

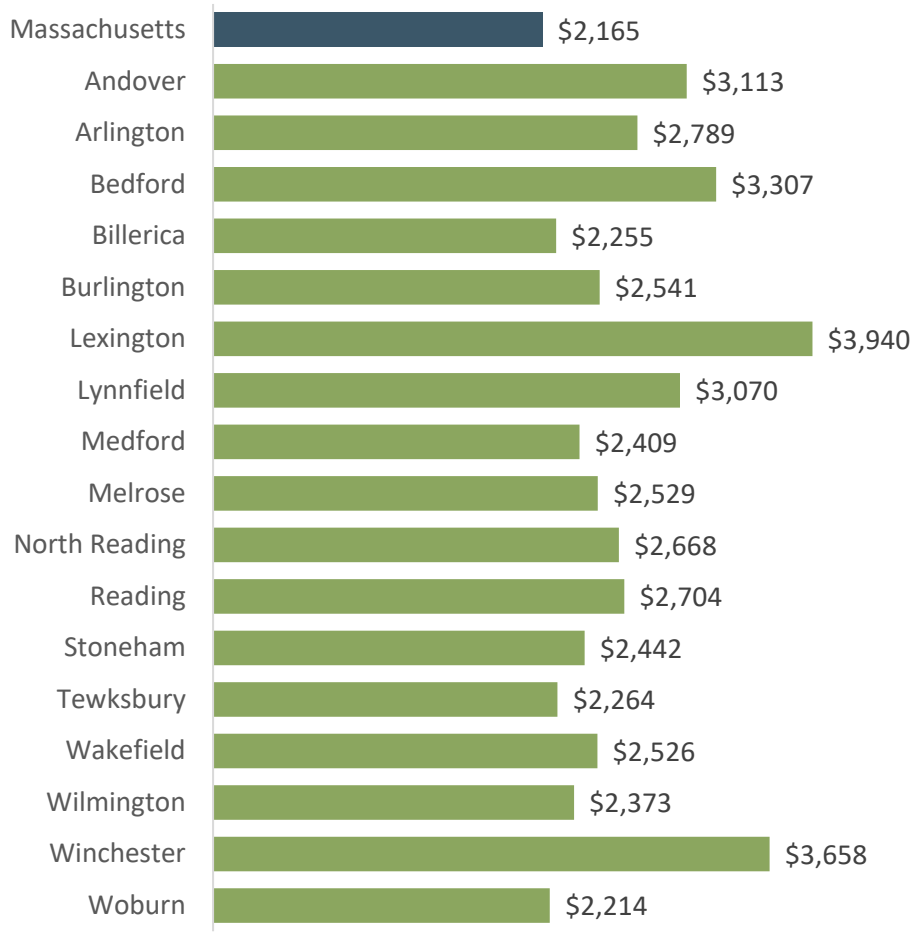
The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage spend more than 30% of their income on housing costs (Figure 23). Many of the towns in the Woburn service area are similar, with a range of 22.1% of residents in Andover and Melrose to over 31% in Lynnfield and Medford spending more than 30% of their income on housing. Median monthly housing costs for owner-occupied households with a mortgage ranged from $2,214 in Woburn to $3,940 in Lexington (Figure 24).

Figure 23. Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, by Owner-Occupied Household with a Mortgage, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

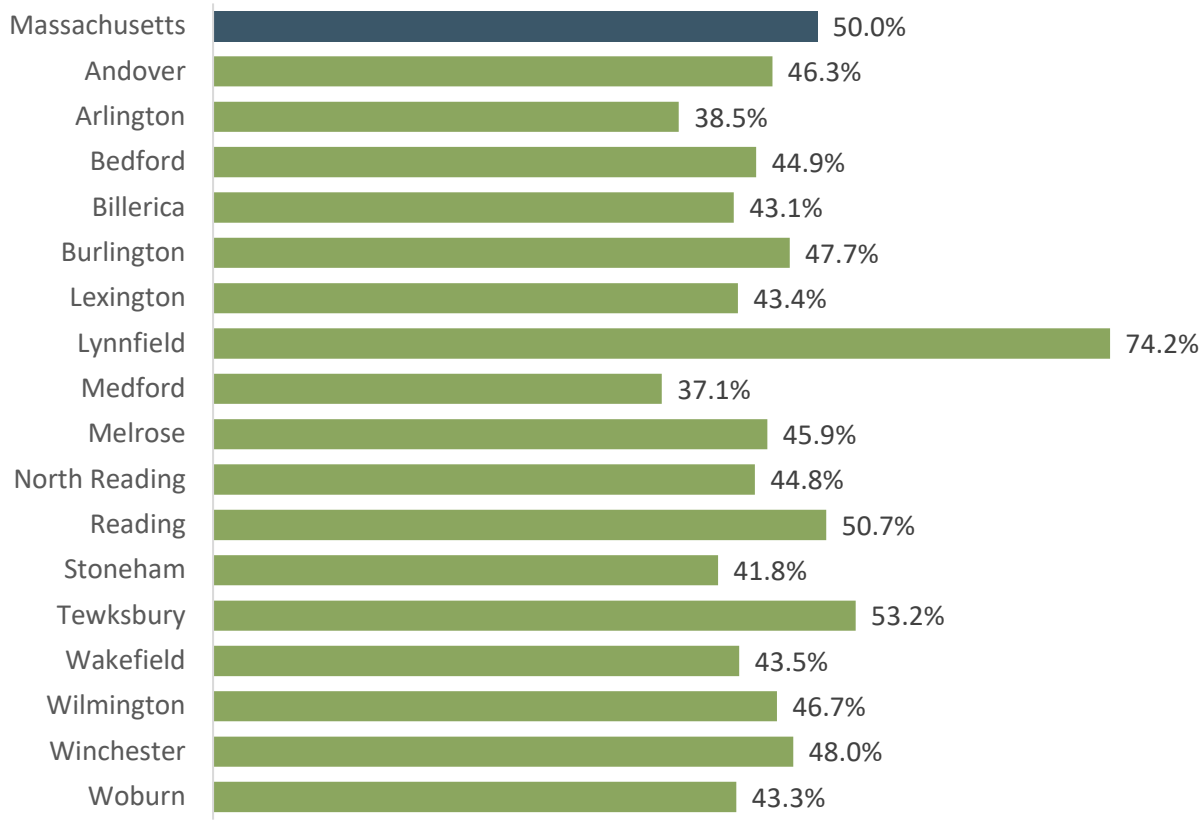
Figure 24. Median Monthly Housing Costs for Owner-Occupied Households with a Mortgage, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

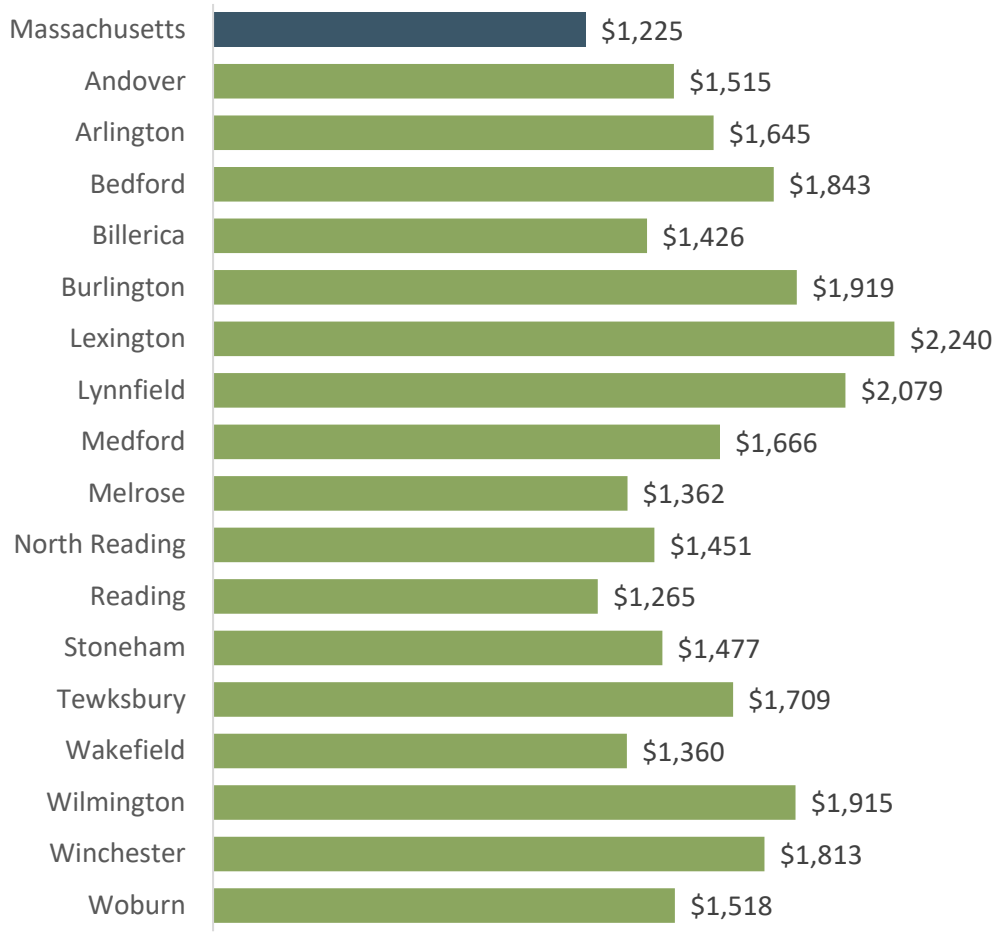
In comparison, there was a wider range in the proportion of housing units where renters spent more than 30% of income on housing costs in 2014-2018. For example, in the Woburn service area, during this timeframe, the proportion of renters spending more than 30% of their income on housing ranged from 37.1% in Medford and 38.5% in Arlington to 53.2% in Tewksbury and 74.2% in Lynnfield (Figure 25). Rates may be skewed in towns where a very small proportion of housing units are occupied by renters, such as in Lynnfield. Median monthly housing costs for renter-occupied households in 2014-2018 ranged from $1,265 in Reading to $2,240 in Lexington (Figure 26).

Figure 25. Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, by Renter, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Figure 26. Median Monthly Housing Costs for Renter-Occupied Households, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Participants shared that communities are working to address housing constraints. In Medford, participants reported, there were city-level conversations about the development of more affordable housing; these discussions were led by organizations like Medford Community Housing. Support of community residents is critical to expanded housing, many interviewees noted. In describing efforts to expand affordable housing in Arlington, for example, one interviewee shared, "*Arlington considers itself progressive. Yet when they try to build lots of new affordable housing, neighbors always don't want the new sites in their neighborhoods."* A few participants commented that some areas of Woburn and Billerica have been overdeveloped and more housing was not needed.

The longer-term impact of COVID-19 on housing also was of concern to residents. While at the time of this report, landlords could not evict their tenants for nonpayment, some focus group members reported that this was happening informally, especially among immigrant groups. Overall, focus group members and interviewees shared concerns about future potential foreclosures and the impact on local communities.

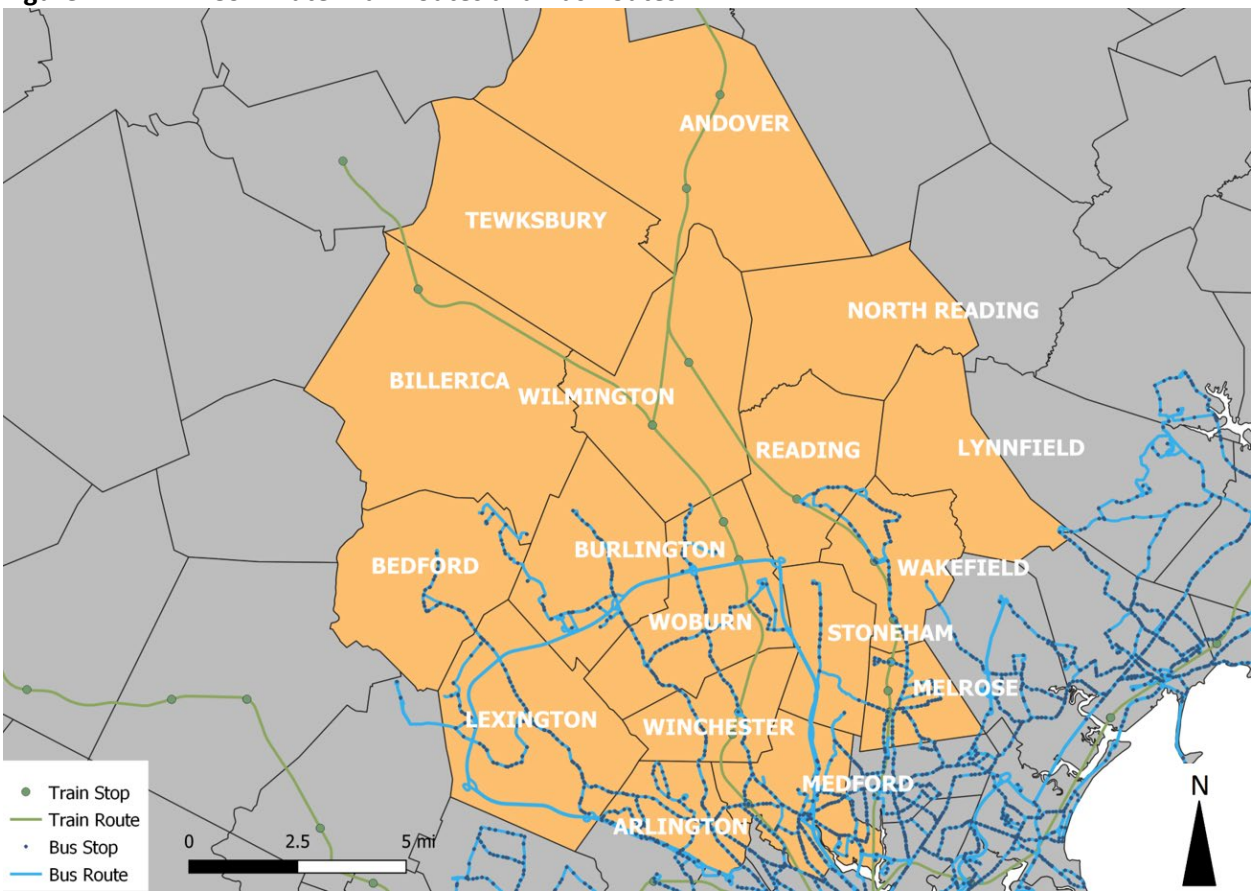
Transportation

> *"Transportation is good. The buses are right outside. They go everywhere unless you're handicapped."* – Focus group participant

When asked about transportation in the Woburn service area, focus group members and interviewees reported that most residents have access to the Massachusetts Bay Transportation Authority ('MBTA') and major bus lines, making it easy to get to Boston and other larger towns. However, not all residents have access. One interviewee reported, some public housing complexes are located far from public transit. Additionally, the timing of transit and the need to switch services can create barriers. As one parent stated, "*I'm right near a bus that goes to the T, but that adds a half hour* [of commuting time] *just waiting for the bus and then waiting for the T*."

MBTA Commuter Rail Routes and MBTA Rapid Transit are shown in Figure 29 below. In general, towns closer to Boston had both train and bus routes. Tewksbury, Billerica, North Reading, and Lynnfield appear to have limited MBTA options available.

Figure 27. MBTA Commuter Rail Routes and Bus Routes



DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Central Transportation Planning Staff, 2020.

In 2014-2018, 70.2% of people in Massachusetts over age 16 commuted to work alone in a vehicle (Table 8). In the Woburn service area, this ranged from 59.1% in Medford to 87.2% in Billerica. Public transportation was most commonly used in Arlington, Medford, and Melrose.

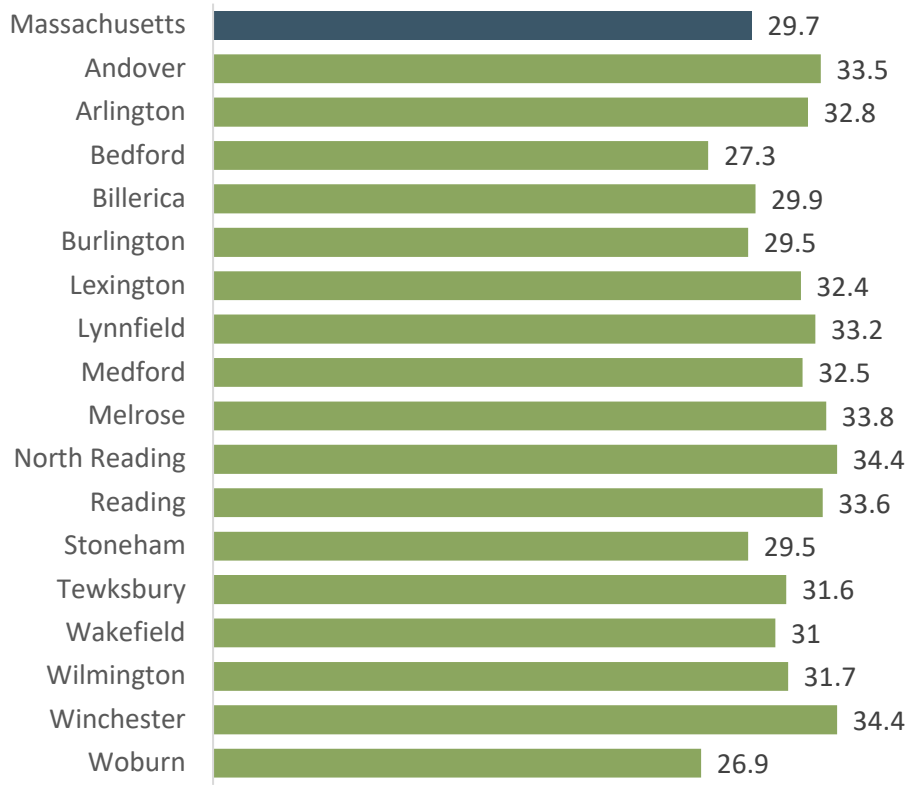
Table 8. Means of Transportation to Work for Population 16 years and Over, in Massachusetts and by Town, 2014-2018

	Car, truck, or van - alone	Car, truck, or van - carpool	Public transportation	Other
Massachusetts	70.2%	7.5%	10.2%	12.0%
Andover	74.8%	6.4%	5.1%	13.8%
Arlington	60.3%	6.6%	19.5%	13.6%
Bedford	80.0%	7.3%	2.3%	10.4%
Billerica	87.2%	5.3%	3.4%	4.1%
Burlington	82.6%	7.5%	3.7%	6.3%
Lexington	71.4%	5.8%	8.6%	14.1%
Lynnfield	80.9%	8.6%	2.4%	8.1%
Medford	59.1%	9.3%	20.7%	10.9%
Melrose	64.3%	3.8%	22.9%	9.0%
North Reading	84.2%	3.4%	3.6%	8.8%
Reading	75.2%	6.0%	10.0%	8.8%
Stoneham	82.0%	5.6%	7.3%	5.2%
Tewksbury	84.7%	6.4%	3.4%	5.5%
Wakefield	78.3%	5.7%	8.1%	7.9%
Wilmington	83.3%	6.2%	5.0%	5.5%
Winchester	71.4%	7.4%	11.1%	10.1%
Woburn	78.9%	8.9%	4.3%	7.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.
NOTE: Other includes "worked at home" category, taxicabs, motorcycle, bicycle, walked and other means.

In 2014-2018, the average time spent commuting to work for residents within the Woburn area ranged from 26.9 minutes in Woburn to 34.4 minutes in both North Reading and Winchester (Figure 28).

Figure 28. Mean Travel Time to Work (in Minutes), in Massachusetts and by Town, 2014-2018

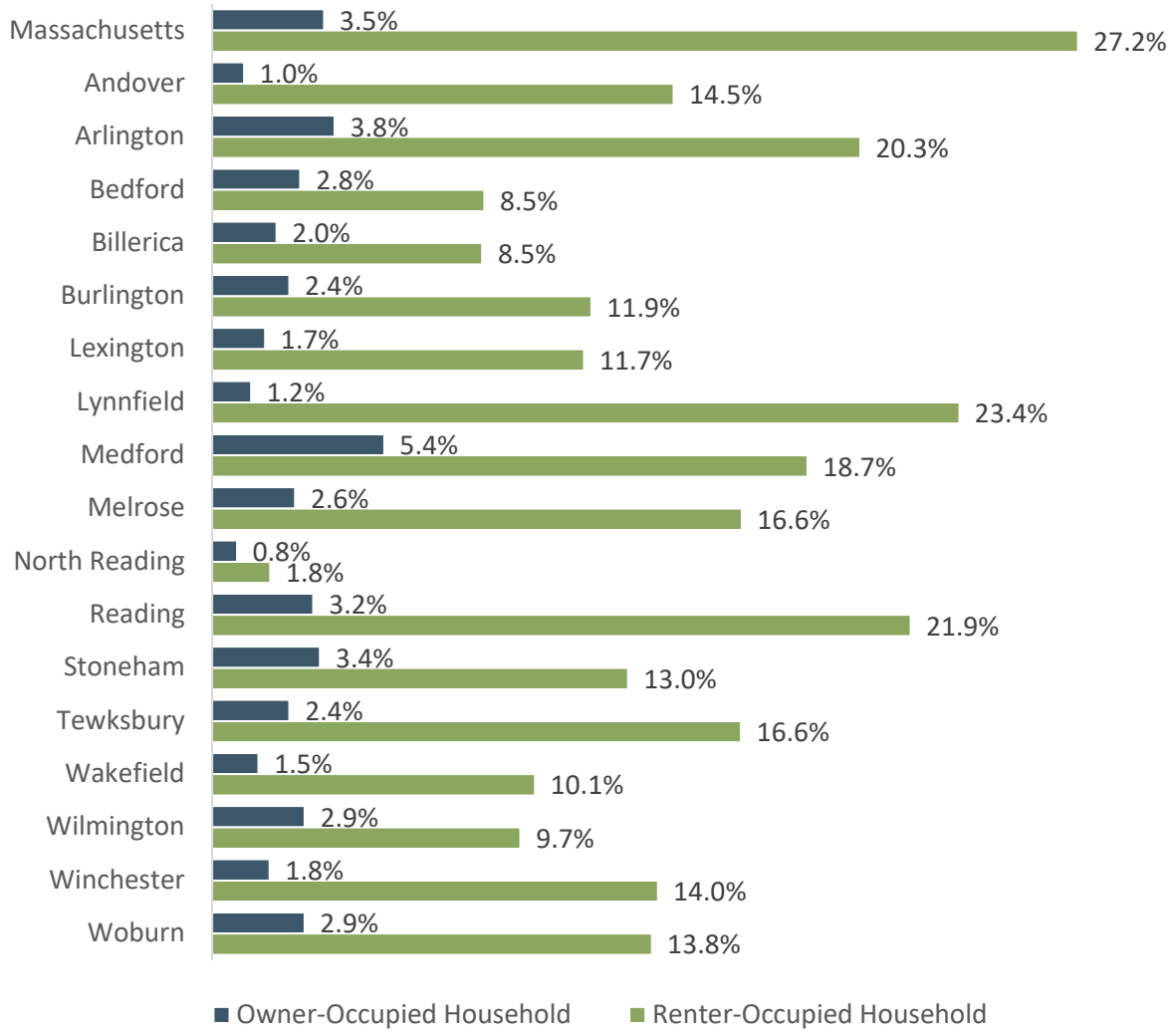


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Adding to the service area's transportation challenges, few communities have their own transit systems, and thus, a car is needed to travel. Seniors in particular expressed concerns about challenges traveling locally; several senior focus group members reported that they no longer drive, and therefore, have to rely on friends or family members. As one senior shared, "*Transportation is an issue. I don't drive anymore, so I rely on my son and his son to take me to appointments."* While some senior ride services are available through vans sponsored by senior centers and The Ride offered by the MBTA, these services were reported to be expensive.

In 2014-2018, renter-occupied households were more likely to have no vehicle available to them, across towns in the Woburn service area. In Lynnfield 23.4% and in Reading 21.9% of households with renters did not have a vehicle (Figure 29). Across the service area, very few owner-occupied households did not have access to a vehicle, with the highest proportion in Medford (5.4%).

Figure 29. Percent Households with No Vehicles Available, by Housing Tenure, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

COVID-19 substantially affected transportation in the Woburn service area. Seniors, in particular, spoke about this issue in focus groups as ride services for them were temporarily ceased or reduced at the peak of the pandemic, substantially affecting their ability to go to medical appointments; grocery stores; and receive other services. While these services have slowly restarted, capacity restrictions limit how often and for what purpose seniors may use these services.

A positive transportation development related to COVID-19 within the Woburn service that a few participants observed, is an increase in bicycling. While this was seen as a welcome change, a few people expressed concerns about road safety. As one focus group member shared, "*I think at least once*

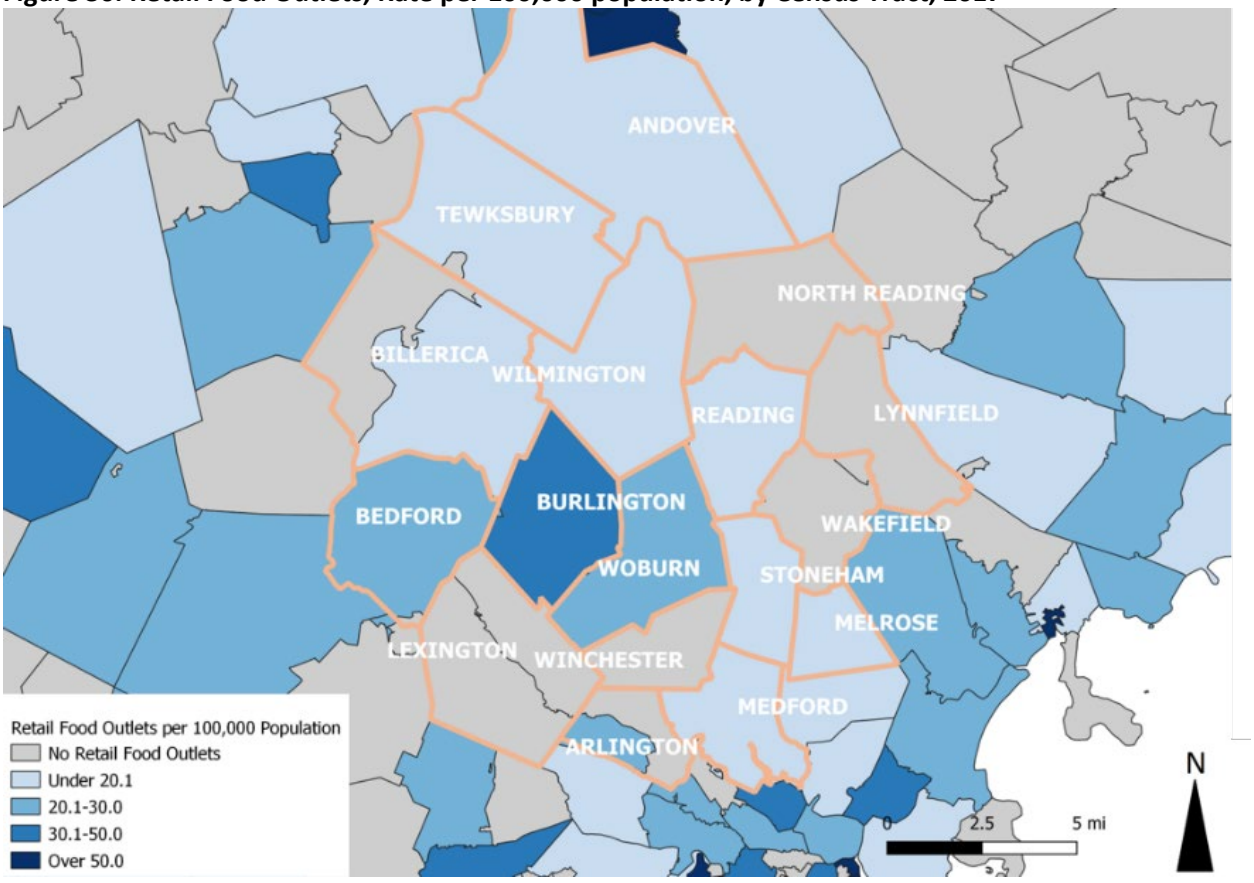
a week people post [on Facebook] about almost being hit by a car in Medford." Focus group members mentioned a need for more bike lanes in communities like Medford and Melrose.

Built Environment

Communities within the Woburn service area were described as having parks and playgrounds, libraries, and trails, which residents appreciated. Increased use of bicycles in the Woburn service area due to COVID-19 has highlighted the need for more bike lanes in communities, according to participants.

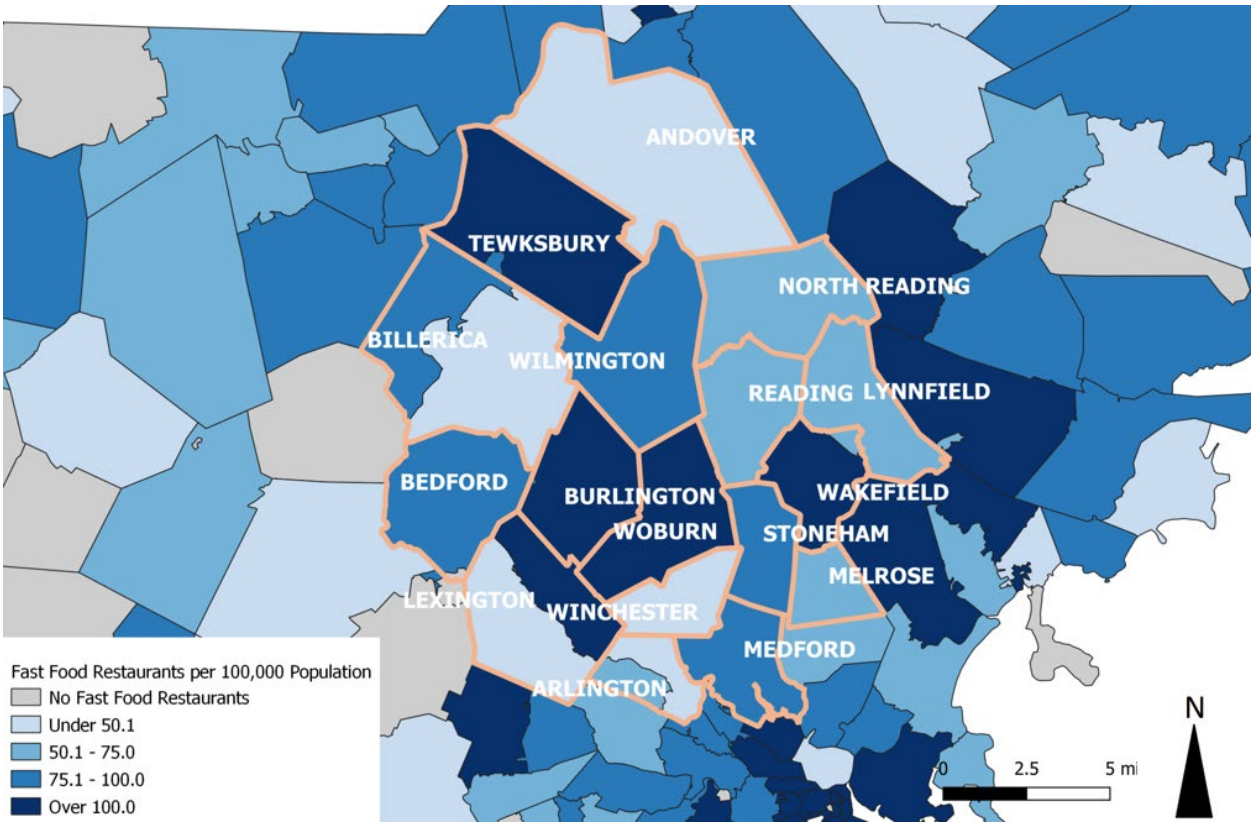
Figure 30 and Figure 31 are maps of the Woburn service area showing the density of retail food outlets and fast food restaurants in the area. Burlington has the highest density of retail food outlets, which are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; as well as fresh and prepared meats, fish, and poultry. Many of the towns in the Woburn service area have under 20 retail food outlets per 100,000 residents, and some have none at all. In contrast, many towns in the area have over 100 fast food restaurants per 100,000 residents.

Figure 30. Retail Food Outlets, Rate per 100,000 population, by Census Tract, 2017



DATA SOURCE: U.S Census Bureau, County Business Patterns, as cited by Community Commons, 2017.

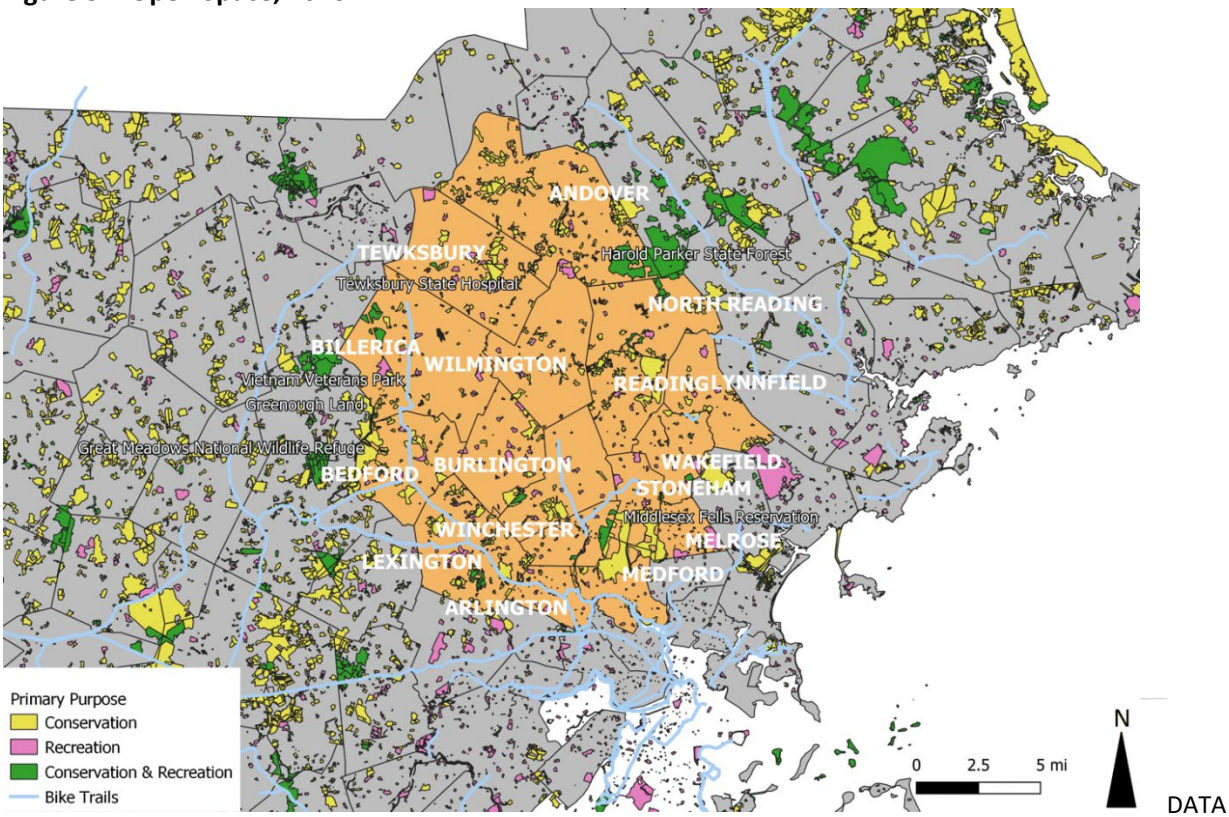
Figure 31. Fast Food Restaurants, Rate per 10,000, by Census Tract 2017



DATA SOURCE: U.S Census Bureau, County Business Patterns, as cited by Community Commons, 2017.

Figure 32 shows publicly accessible open space in the Woburn service area. Conservation land includes habitat protection with some recreation including walking trails. Recreation land includes outdoor facilities including parks, commons, playing fields, school fields, and scout camps. The bike trail lines show trails which permit bike travel or corridors with conversion potential.

Figure 32. Open Space, 2020



DATA

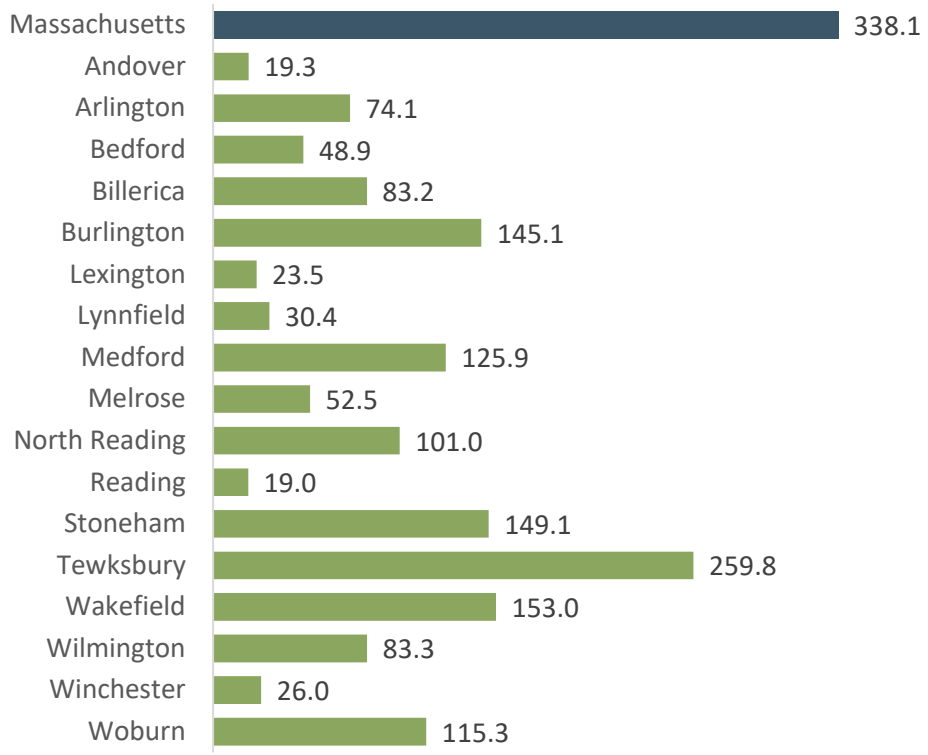
SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Executive Office of Energy and Environmental Affairs, 2020.

Crime and Violence

Overall, focus group members and interviewees described their communities as very safe. A few interviewees reported that police in the community are responding to fewer calls since COVID-19. Interpersonal violence, however, was of concern to participants, and a couple of participants feared that this violence increased during COVID-19. As one interviewee shared, *"The pandemic has increased problems of domestic violence. People are spending too much time together. And liquor stores are open and the drug trade is still on. That exacerbates problem."*

In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied notably across the towns in the Woburn service area, although no towns had higher rates of violent crime than the state average of 338.1 incidents per 100,000 residents (Figure 33). The highest violent crime rates were in Tewksbury (259.8 per 100,000 residents), Wakefield (153.0), Stoneham (149.1), and Burlington (145.1).

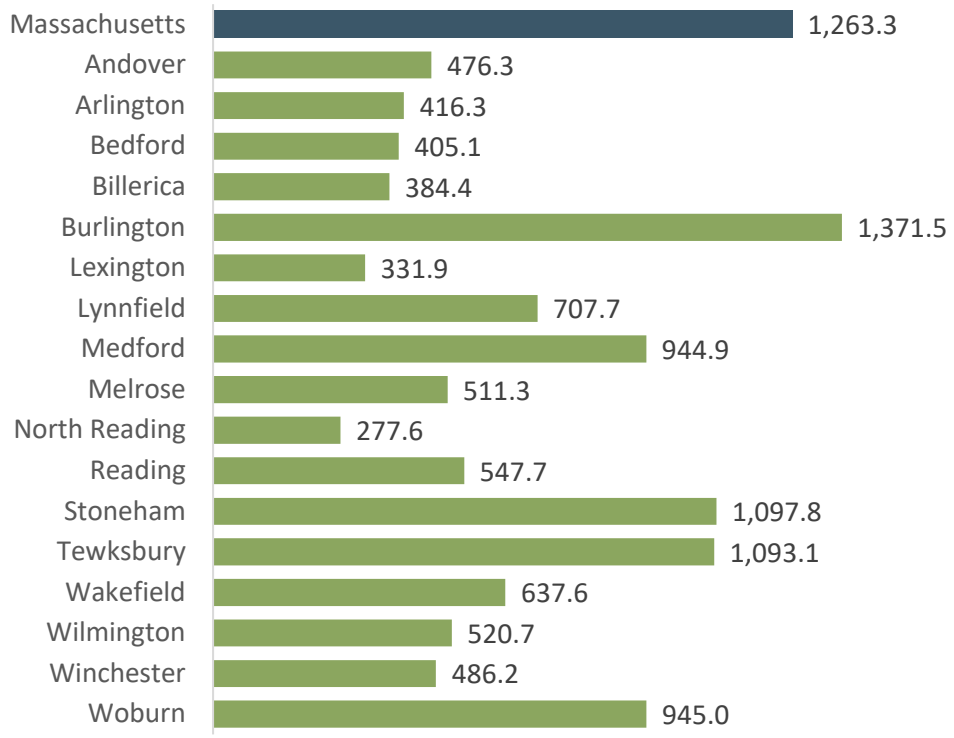
Figure 33. Violent Crime, Rate per 100,000 Population, in Massachusetts and by Town, 2018



DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.
NOTE: Violent crime includes murder, rape, robbery, and aggravated assault.

Property crime (i.e. burglary, larceny, and auto theft) is generally much more common than violent crime in the service area. In 2018, within the Woburn service area, property crime was most common in Burlington (1,371.5 per 100,000 residents); Stoneham (1,097.8); and Tewksbury (1,093.1) (Figure 34).

Figure 34. Property Crime, Rate per 100,000 Population, in Massachusetts, by Town and Boston Neighborhood, 2018



DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.
NOTE: Property crime includes commercial burglary, residential burglary, other burglary, larceny from motor vehicle, other larceny, and auto theft.

Discrimination and Racism

> *"It's eye-opening to see [racism] can happen here in this community. You always think of racism as something that happens somewhere else, in some other part of the country."* – Focus group participant

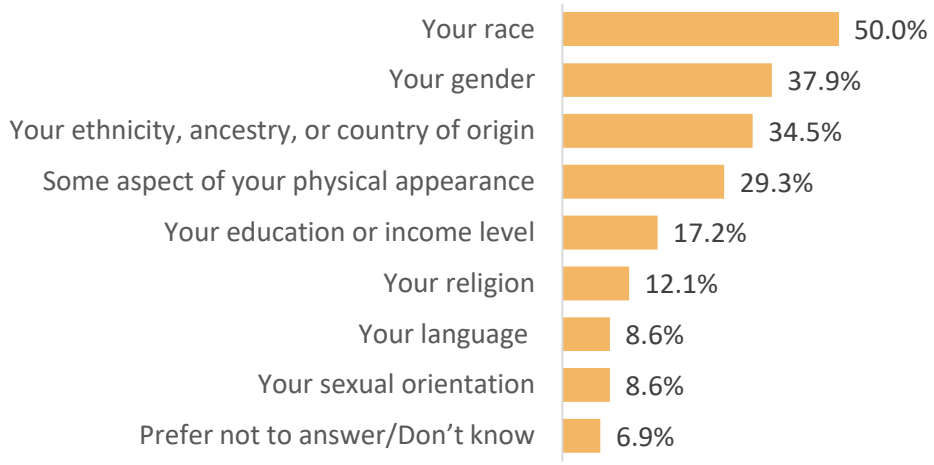
Participants reported that similar to the national dialogue—more emphasis on racial justice has been occurring in the Woburn service area. Perceptions about the extent of discrimination and racism in the community varied. Some participants mentioned incidences in schools of anti-Semitic and racist graffiti and community incidences of racism and anti-immigrant actions. As one focus group member stated, "*A lot of people were shocked to know that there's racism happening in Medford. I was shocked to know a lot of people were surprised by that – I wasn't surprised."* Other participants, however, reported that they did not see discrimination and racism as prominent community issues.

Consistently, however, participants shared that conversations about racial justice and policing have been taking place in their communities. A few residents pointed to tensions among those supporting the Black Lives Matter movement and those who disagreed with some of their stances, particularly related to the police. Local leaders and community-based organizations, including faith institutions, have been working to engage the community in conversations about this issue, participants reported. As one interviewee commented, "*People are angry, but talking."* Additionally, interviewees reported that conversations and work on addressing systemic racism has started in police departments and within schools in their communities.

While participants felt strongly about the cohesiveness of their communities, they also acknowledged that recent conversations and activism around racial justice have been difficult and some divisions have emerged. As one interviewee observed, *"It's hard to have conversations outside of groups you're familiar with talking to. In these times, cracks are opening up where people have never examined their beliefs."*

Assessment participants also noted their own experiences with discrimination. Among Woburn Community Priorities Survey respondents, 11.2% indicated that they or their family members have directly experienced discrimination in the past six months. Among that sub-sample, 50.0% reported this was due to their race; 37.9% said it was due to their gender; 34.5% said it was due to their ethnicity, ancestry, or country of origin; and 29.3% reported it was due to their physical appearance (Figure 35).

Figure 35. Percent of CHNA Community Priorities Survey Respondents Reporting Main Reasons for Discrimination, among Respondents Reporting Discrimination as an Issue, 2020 (N=58)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

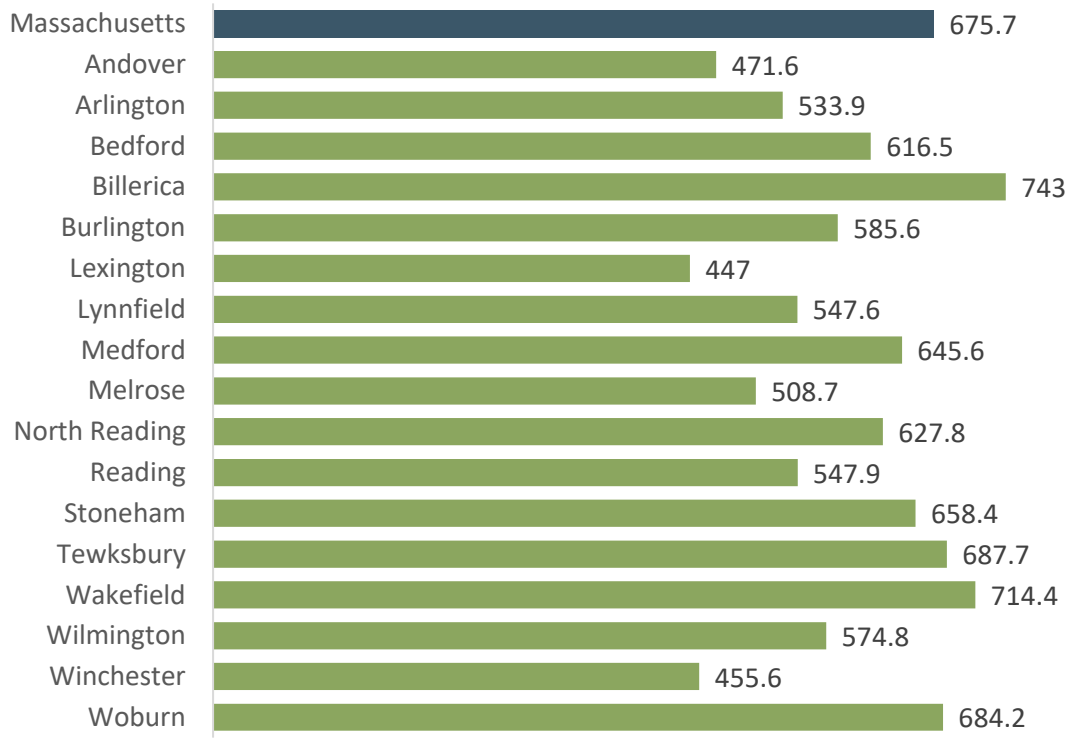
COMMUNITY HEALTH ISSUES

Overall Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before age 65 years old) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted. Age-adjusted mortality rates per 100,000 residents varied between towns in the Woburn service area in 2017, from

lows of 447.0 in Lexington, 455.6 in Winchester, and 471.6 in Andover; to highs of 743.0 in Billerica and 714.4 in Wakefield (Figure 36).

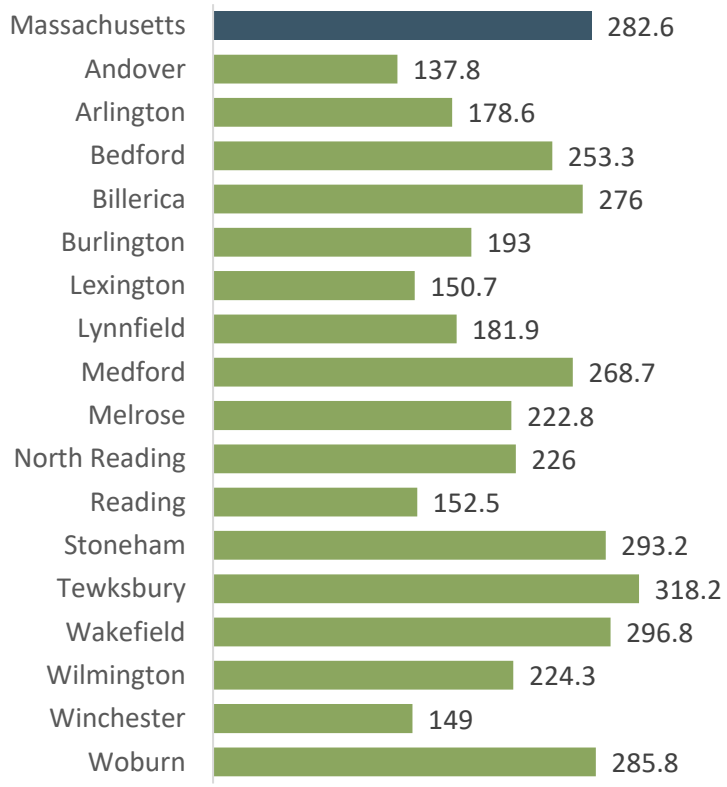
Figure 36. Overall Mortality, Age-Adjusted Rate per 100,000 Population, in Massachusetts and by Town, 2017



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

For age-adjusted premature mortality in 2017, the lowest rates of deaths before age 65 were in Andover, Winchester, Lexington, and Reading; the highest rates were in Stoneham, Wakefield, and Tewksbury (Figure 37).

Figure 37. Premature Mortality, Age-Adjusted Rate per 100,000 Population, in Massachusetts and by Town, 2017



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2017.

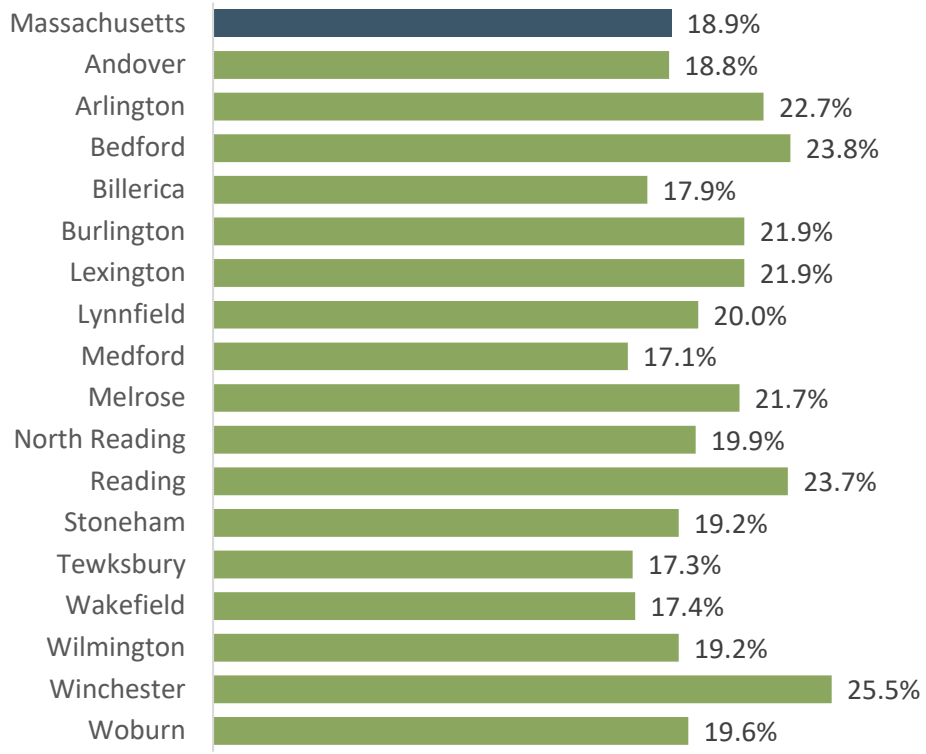
Chronic Diseases and Related Risk Factors

Overweight and Obesity

While nearly four in ten of Woburn Community Priorities Survey respondents (38.9%) indicated that overweight/obesity was an issue that affected them or their family personally in the past six months, it was not an issue brought up among focus group or interview participants. Healthy eating is a key component of maintaining a healthy weight, and overall adults in the Woburn service area reported previously that they were not likely to meet the recommended vegetable guidelines. In 2011-2015, the percent of adults consuming five or more fruits and vegetables daily in Massachusetts was 18.9%. By town, the percent of adults consuming 5 or more fruits and vegetables daily ranged from 17.1% in Medford to 25.5% in Winchester (Figure 38).

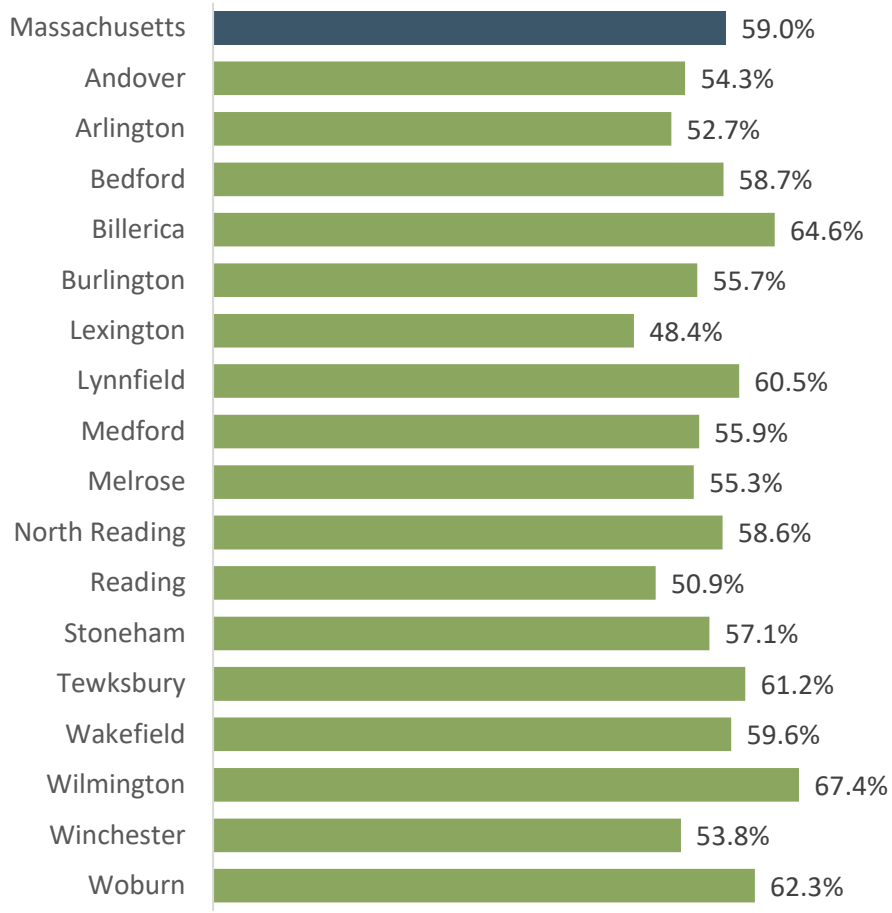
In 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 48.4% in Lexington to 67.4% in Wilmington (Figure 39).

Figure 38. Percent Adults Consuming 5 or More Fruits and Vegetables Daily, in Massachusetts and by Town, 2011-2015



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2011-2015.
NOTE: Data are aggregated based on multiple years including 2011, 2013, 2015.

Figure 39. Percent Adults Reporting Obesity or Overweight, in Massachusetts and by Town, 2012-2014

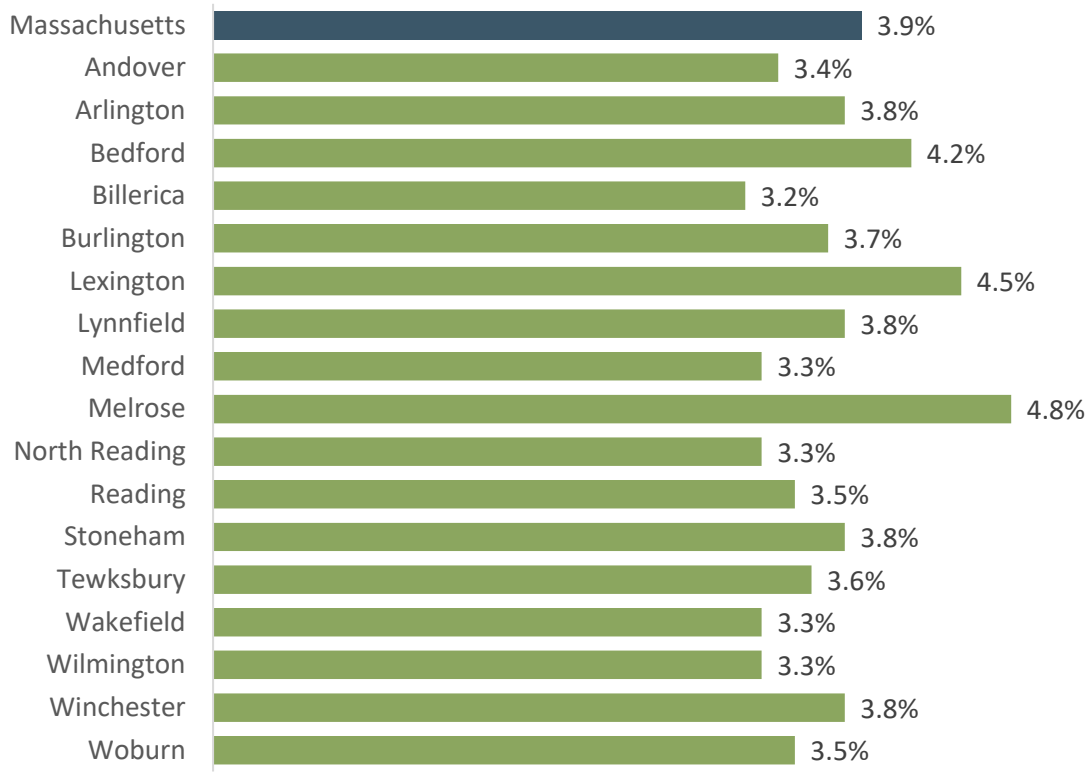


DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years including 2012-2014.

Heart Disease

Even though heart disease is the second leading cause of death in Massachusetts, it was not an issue discussed in the focus groups or interviews. In 2012-2014, the percent of adults reporting angina or coronary heart disease (CHD) in Massachusetts was 3.9%. By town, the percent of adults reporting angina or CHD ranged from 3.2% in Billerica to 4.8% in Melrose (Figure 40).

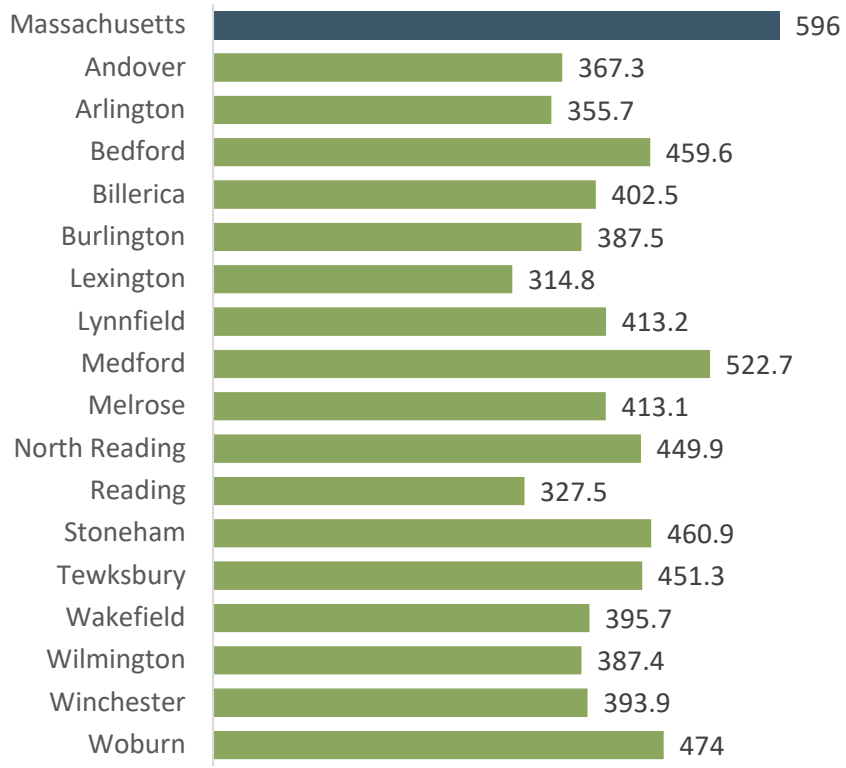
Figure 40. Percent Adults Reporting Angina or Coronary Heart Disease (CHD), in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years.

In 2014, the age-adjusted rate per 100,000 population of heart disease emergency department visits was 596 in Massachusetts. By town, the age-adjusted rate of heart disease emergency department visits ranged from 314.8 per 100,000 population in Lexington to 522.7 per 100,000 population in Medford (Figure 41).

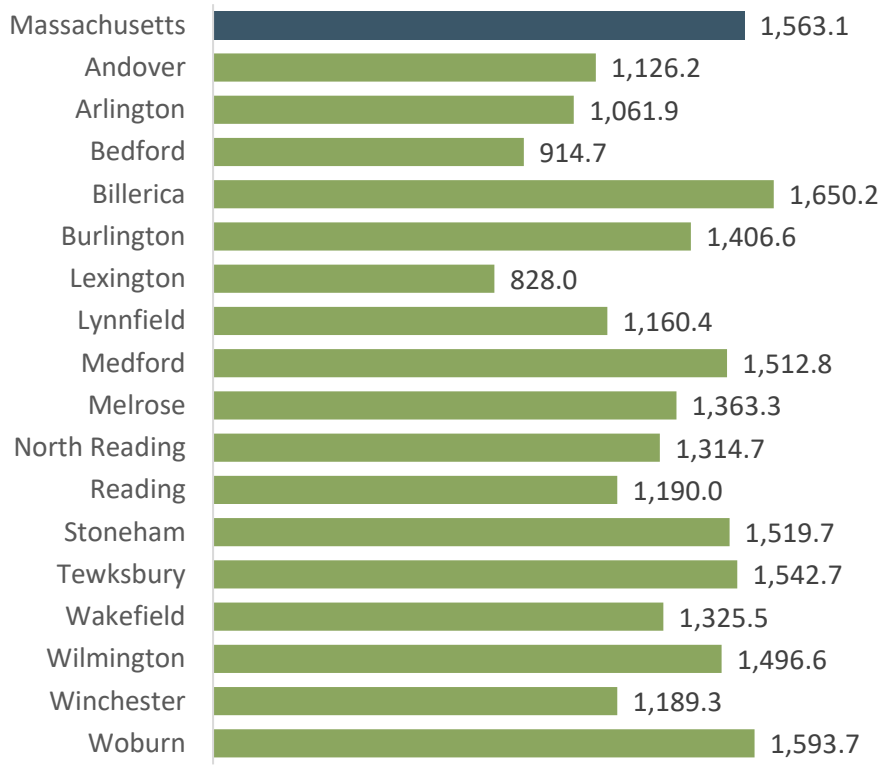
Figure 41. Heart Disease Emergency Department Visits, Age-Adjusted Rate per 100,000 Residents, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, the age-adjusted rate per 100,000 population of heart disease hospitalizations was 1,563.1 in Massachusetts. By town, the age-adjusted rate of heart disease hospitalizations ranged from 828.0 per 100,000 population in Lexington to 1,650.2 per 100,000 population in Billerica (Figure 42).

Figure 42. Heart Disease Hospitalizations, Age-Adjusted Rate per 100,000 Residents, in Massachusetts and by Town, 2014

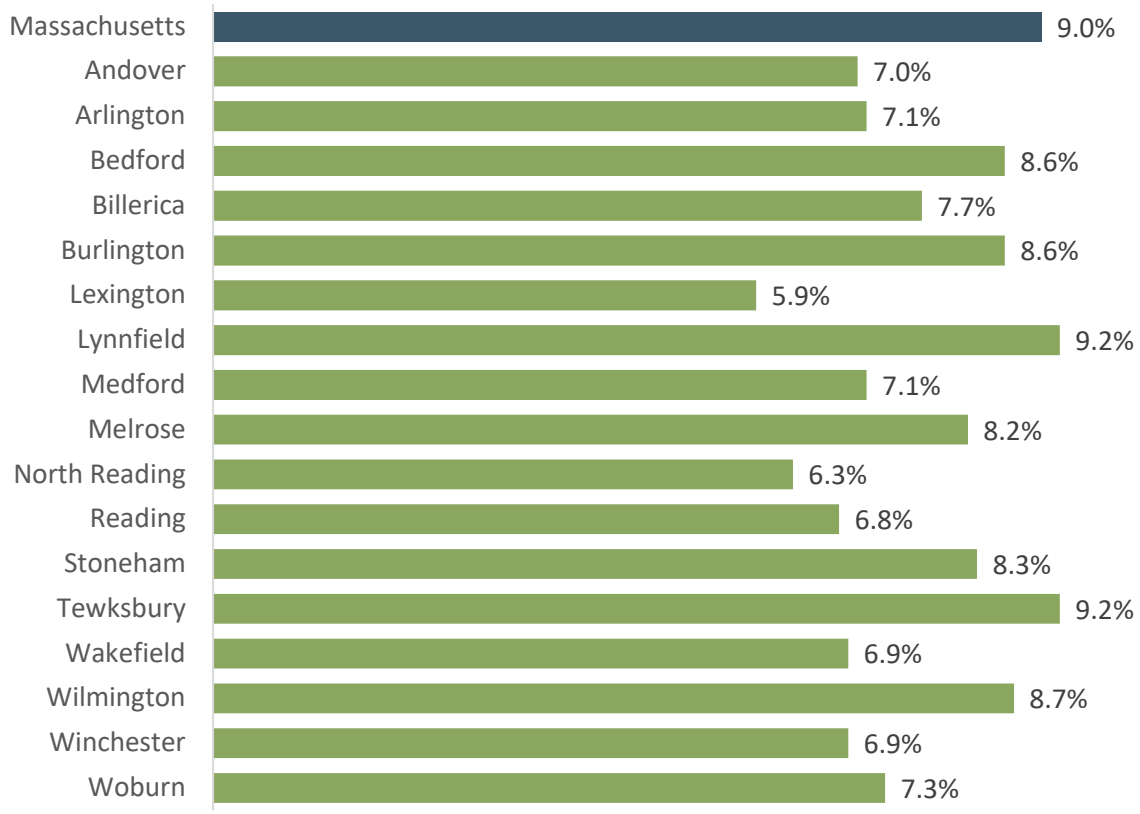


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Diabetes

In 2012-2014, the percent of adults reporting diabetes in Massachusetts was 9.0%. By town, the percent of adults reporting diabetes ranged from 5.9% in Lexington to 9.2% in Lynnfield and Tewksbury (Figure 43).

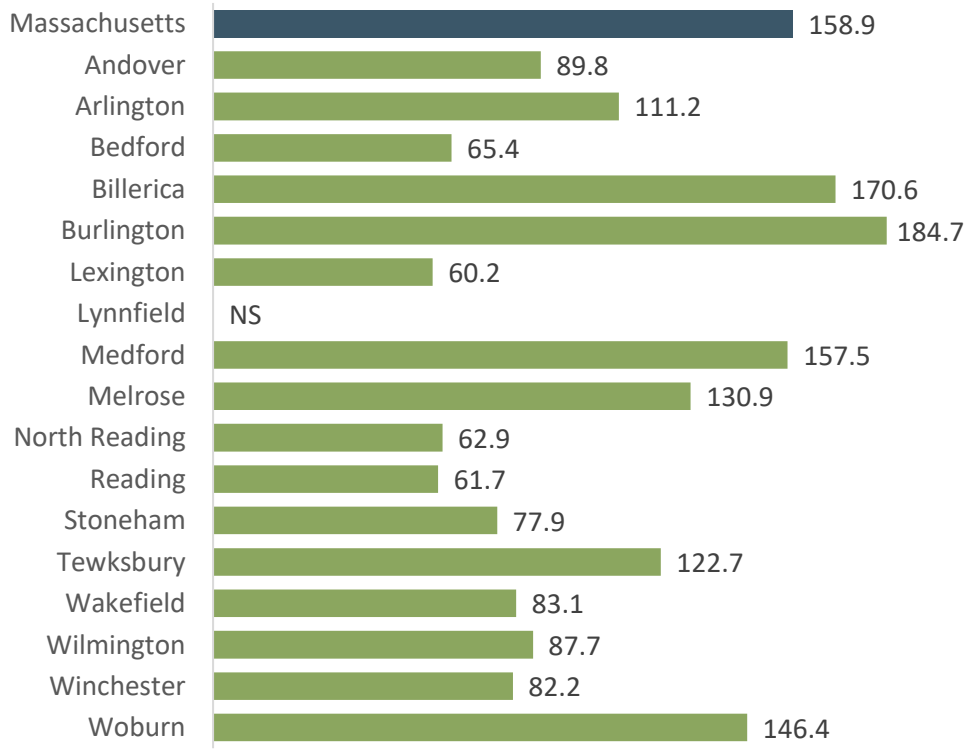
Figure 43. Percent Adults Reporting Diabetes, in Massachusetts and by Town, 2012-2014



DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years including 2012-2014.

In 2014, the age-adjusted rate of diabetes hospitalizations per 100,000 population was 158.9 in Massachusetts. By town, the age-adjusted rate of diabetes hospitalizations ranged from 60.2 per 100,000 population in Lexington to 184.7 per 100,000 population in Burlington (Figure 44).

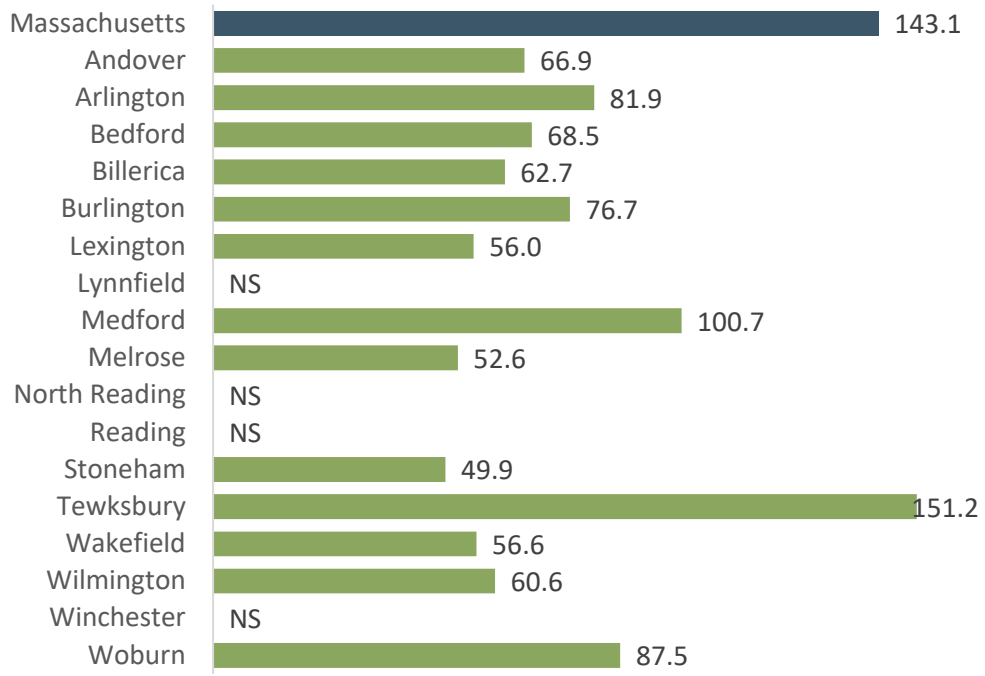
Figure 44. Diabetes Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.
NOTE: NS = Data not shown due to insufficient sample size.

In 2014, the age-adjusted rate of diabetes emergency department visits per 100,000 population was 143.1 in Massachusetts. By town, the age-adjusted rate of diabetes emergency department visits ranged from 49.9 per 100,000 population in Stoneham to 151.2 per 100,000 population in Tewksbury. Data for several towns were not reported due to insufficient sample size (Figure 45).

Figure 45. Diabetes Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.
NOTE: NS = Data not shown due to insufficient sample size.

Cancer

Cancer is the leading cause of death in Massachusetts. In 2009-2013, by town, standardized incidence ratios (SIR) for breast cancer in females ranged from 89 (Lynnfield) to 121 (Reading and Stoneham). This indicates that the incidence of breast cancer in females was 11% lower in Lynnfield and 21% higher in Reading and Stoneham than expected based on standardized rates for the state. The incidence of prostate cancer in males ranged from 37% lower than expected in Reading (SIR 63) to 3% higher than expected in Lexington and Tewksbury (SIR 103). The incidence of lung and bronchus cancer ranged from 46% lower than expected in Lexington (SIR 54) to 24% higher than expected in Billerica (SIR 124). The incidence of colorectal cancer ranged from 29% lower than expected in Lexington (SIR 71) to 18% higher than expected in Melrose (SIR 118) (Table 9).

Table 9. Cancer Standardized Incidence Ratios for Leading Cancer Types, 2009-2013

	Breast Cancer (female)	Prostate (male)	Lung and Bronchus	Colorectal
Andover	108	92	58	76
Arlington	103	99	85	80
Bedford	97	87	82	87
Billerica	95	96	124	103
Burlington	111	102	93	92
Lexington	101	103	54	71
Lynnfield	89	94	89	111
Medford	101	83	104	113
Melrose	96	92	83	118
North Reading	119	91	75	88
Reading	121	63	90	84
Stoneham	121	75	91	112
Tewksbury	98	103	118	92
Wakefield	109	82	95	109
Wilmington	116	77	118	102
Winchester	116	102	76	91
Woburn	120	92	109	115

DATA SOURCE: Massachusetts Department of Public Health, Massachusetts Cancer Registry, 2009-2013.

Behavioral Health

Mental Health

> *"Day to day we see a lot of anxiety. That continually comes up as an issue that many, if not most, families are dealing with. That's community wide."* – Key informant interviewee

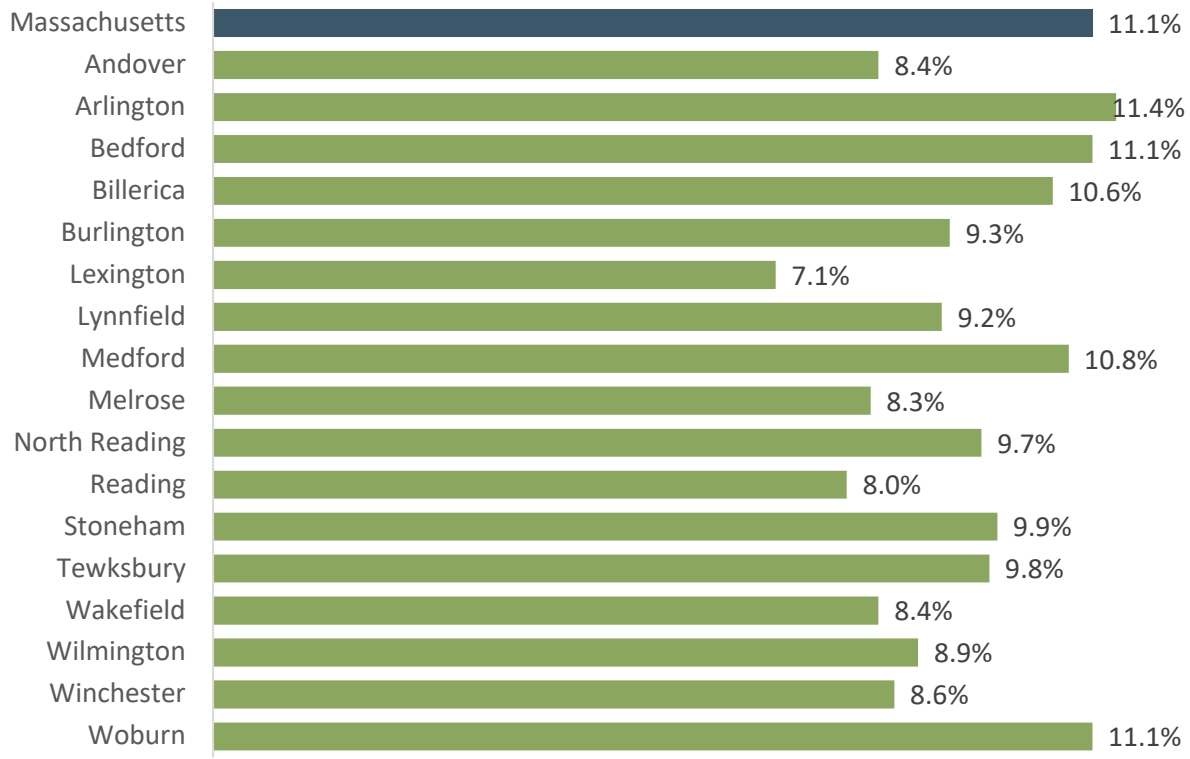
When asked to identify health issues of greatest concern to the community, focus group members and interviewees consistently mentioned mental health. Poor mental health was described as a challenge across all age groups and an issue that existed prior, but has been magnified by, the pandemic. Participants mentioned anxiety and trauma as prevalent among community members, with some suffering from more serious mental health concerns. The mental health of seniors, including depression

that comes from isolation and loneliness and the onset of dementia and Alzheimer's disease, was identified as a community concern by several participants.

Mental health concerns among immigrant and refugee populations were also highlighted. As one person described, *"For refugees and immigrants, there is a whole level of anxiety about everything in life. Almost everyone comes here with trauma. Mental health from trauma is such a huge thing. Plus, in the current context, they have anxiety every time they step out the door."* Focus group members and interviewees shared that lack of providers who speak other languages, especially for immigrants from African countries, means some groups cannot access needed services. As one interviewee stated, "*You need native speakers. You can't be 'kind of fluent' when providing mental health therapy."* One interviewee also noted that specific outreach and education should be targeted at specific groups to help overcome stigma about mental health that those communities may hold, *"In Asian cultures, it's considered shameful if you have mental health issues, so a lot of people don't go for treatment…We're doing education to reduce stigma and make people realize how important it is to address [mental health]."*

In 2012-2014, the percent of adults reporting 15 or more days of poor mental health in the last month was 11.1% in Massachusetts. By town, the percent of adults reporting 15 or more days of poor mental health in the last month ranged from 7.1% in Lexington to 11.4% in Arlington (Figure 46).

Figure 46. Percent of Adults Reporting 15 or More Days of Poor Mental Health in the Last Month, in Massachusetts and by Town, 2012-2014



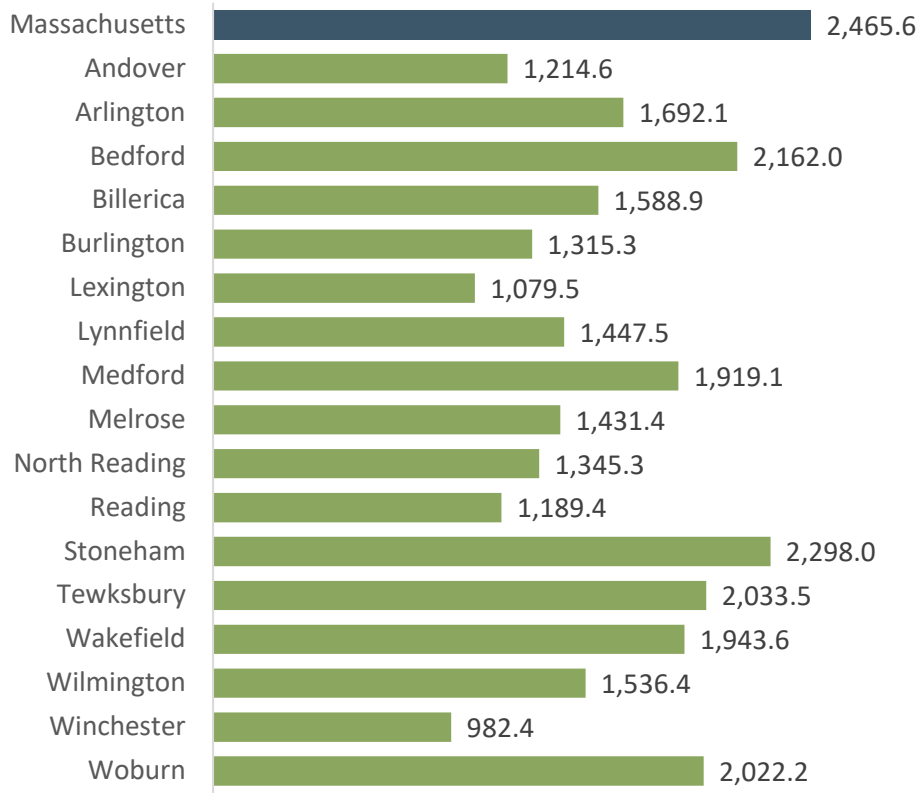
DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Small Area Estimates, 2012-2014.
NOTE: Data are aggregated based on multiple years.

According to focus group members and interviewees, lack of mental health providers was the primary challenge in addressing mental health in the community. It was reported that the number of providers in the community is insufficient to meet the demand for services, leading to long waits for mental health services. As one interviewee explained, *"When I see people, they're in crisis, so to tell them there's a wait list to see someone is really hard and not very helpful."* A lack of providers for children and adolescents was described as an especially significant challenge.

Additional mental health workforce challenges included low reimbursement for mental health services, which can make it difficult for provider organizations to fill positions when they are available. Few providers accept MassHealth, participants reported, furthering curtailing access to mental health services for lower income residents.

In 2014, the age-adjusted rate of mental health emergency department visits per 100,000 population was 2,465.6 in Massachusetts. By town, the age-adjusted rate of mental health emergency department visits ranged from 982.4 per 100,000 population in Winchester to 2,298.0 per 100,000 population in Stoneham (Figure 47).

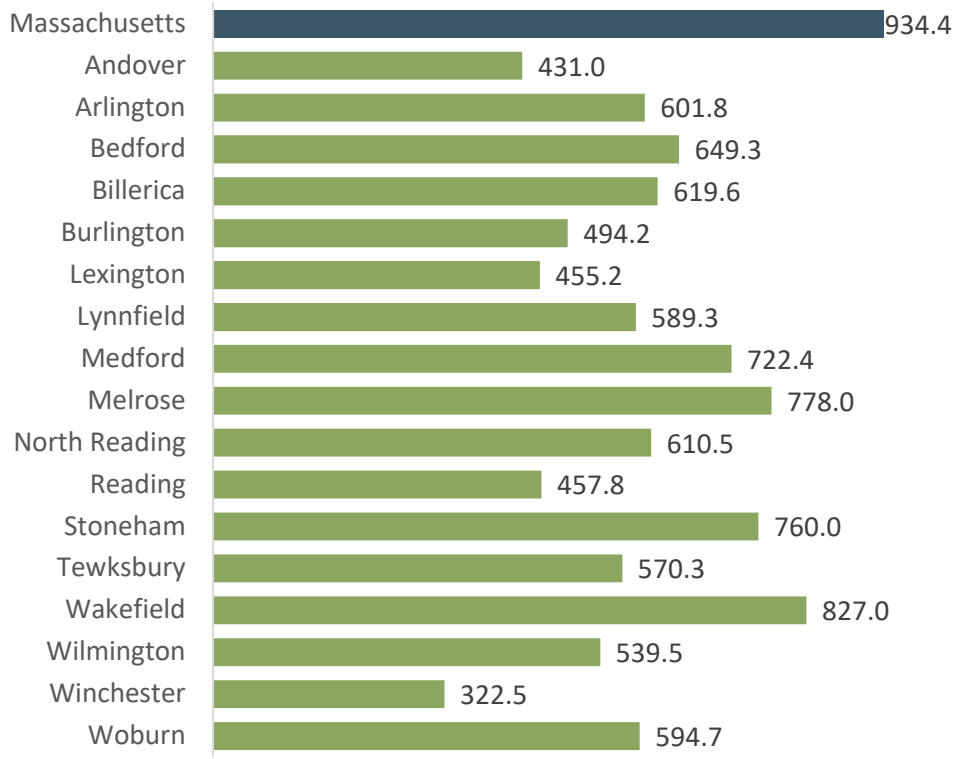
Figure 47. Mental Health Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, the age-adjusted rate of mental health hospitalizations per 100,000 population was 934.4 in Massachusetts. By town, the age-adjusted rate of mental health emergency department visits ranged from 322.5 per 100,000 population in Winchester to 827.0 per 100,000 population in Wakefield (Figure 48).

Figure 48. Mental Health Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in their communities. Depression, anxiety, stress, and trauma were most frequently mentioned. Seniors and public housing residents participating in focus groups spoke about the isolation and fear brought on by COVID-19. Those with school-age children shared the challenges of remote learning and the stress that comes with the uncertainty of the coming school year. Many worried about the long-term impact of the pandemic and lack of socialization on the community's children and youth. On a more positive note, interviewees who work in mental health services stated that the pandemic has led to greater use of telehealth to deliver mental health services, which offers the potential to address some service delivery issues in the future. However, they also noted that this model does not work for everyone, and thus, COVID-19 has interrupted mental health services to some who were receiving them.

Mental Health among Seniors

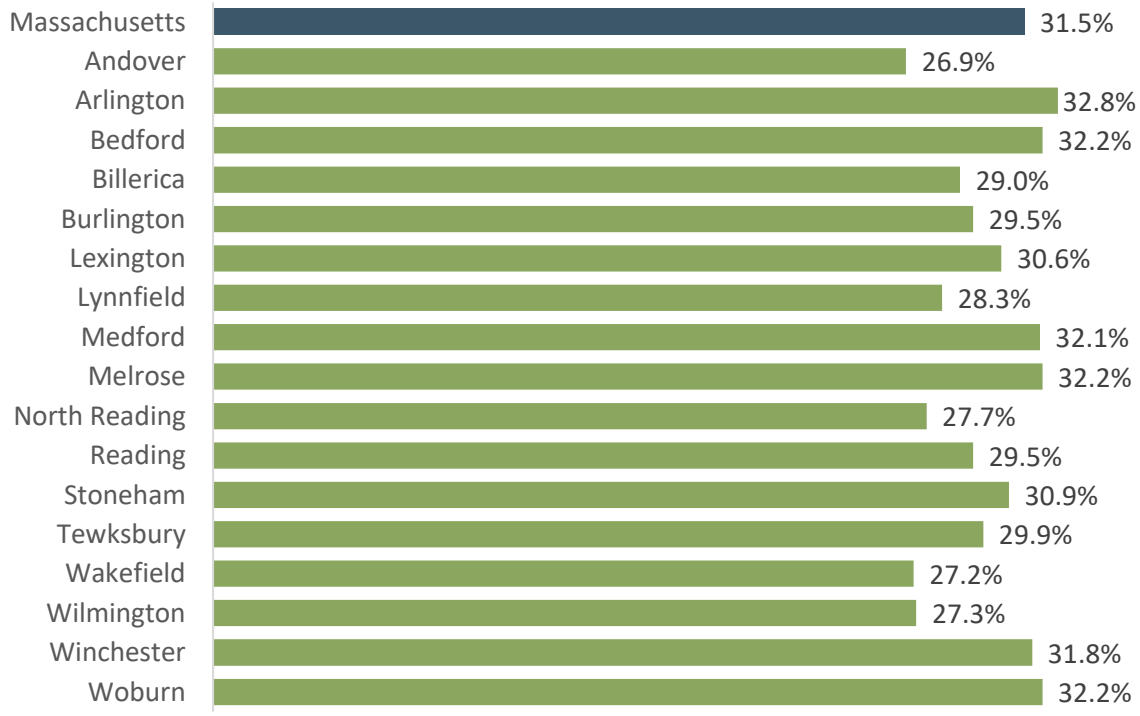
Isolation of senior residents—from services and others—was a frequently-cited concern among focus group members and interviewees. As one interviewee explained, *"People used to drop by all the time, to drop off a check or something, and then they would stay and chat. But now, we just don't hear from*

them – it's very concerning. Some of our tenants are terrified, they don't want to leave their units. So, what are they eating? what are they feeding their pets? How are they getting by?" Numerous participants spoke about not hearing from friends and neighbors with whom they regularly interacted prior to COVID-19.

Senior focus group members and interviewees who work with seniors noted that the isolation of seniors was a challenge prior to COVID-19, but worse now as seniors are afraid to leave their homes and transportation services have been curtailed, creating health and mental health challenges. As one senior shared, *"I do feel like a lot of people are down with the COVID– they want to get out of their house, they don't have a lot of people to talk to. They're very lonely."* Another participant noted a similar sentiment, "*It's a long time to not be able to talk to anyone. There are definitely people who don't have anyone to talk to or no family nearby."* Participants praised the communication and efforts of senior center staff through virtual means and socially distanced programs, although this has been difficult for seniors who do not have access to computers.

In 2018, the percent of adults 65 years or older with depression was 31.5% in Massachusetts. By town, the percent of adults 65 years or older with depression ranged from 26.9% in Andover to 32.8% in Arlington (Figure 49).

Figure 49. Percent of Adults Aged 65 years or older with Depression, in Massachusetts and by Town, 2018



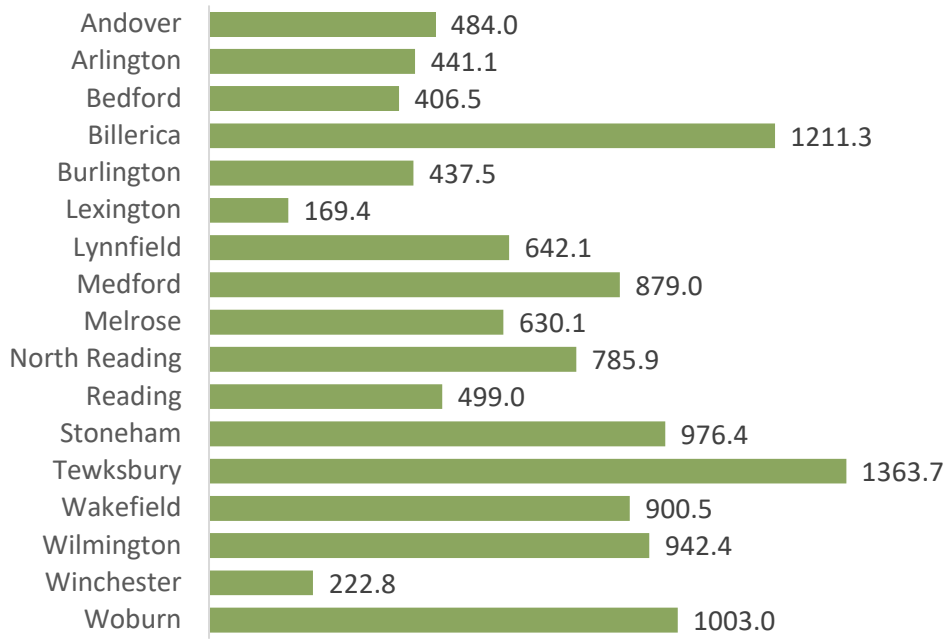
DATA SOURCE: Tufts Health Plan, Massachusetts Healthy Aging Data Report, 2018.

Substance Use

While substance use was not mentioned frequently by participants, a few interviewees stated that, as in other urban areas, opioid and prescription drug misuse were of concern in the Woburn service area. A few participants mentioned that they were concerned that COVID-19 has exacerbated substance misuse. As one interviewee reported, *"People are drowning themselves in drugs and booze."* One interviewee shared that marijuana use among young people is a growing issue in the community and one that is not receiving sufficient attention.

Participants reported that recovery programs exist in the community, although more services are needed, especially those providing residential treatment. In 2016-2017, the rate of Bureau of Substance Addiction Services Enrollments ranged from 169.4 per 100,000 population in Lexington to 1,363.7 per 100,000 population in Tewksbury (Figure 50).

Figure 50. Bureau of Substance Addiction Services Enrollments, Rate per 100,000 population, by Town, 2016-2017



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Addiction Services, 2016-2017.

From 2014-2019, Massachusetts had around 2,000 opioid-related overdose death each year, with the fewest deaths in 2014 (1,365) and the most deaths in 2016 (2,094). By town, Billerica, Medford, and Woburn all averaged more than 10 deaths per year over the 6-year period (Table 10).

Table 10. Count of Opioid-Related Overdose Deaths, Massachusetts and by Town, 2014-2018

	2014	2015	2016	2017	2018	2019
Massachusetts	1,365	1,747	2,094	1,977	2,005	1972
Andover	6	6	3	2	2	5
Arlington	5	6	6	3	3	4
Bedford	3	1	6	3	3	4
Billerica	12	14	16	14	13	11
Burlington	3	3	8	8	3	4
Lexington	2	3	2	0	3	1
Lynnfield	2	2	1	2	5	4
Medford	14	21	18	18	8	10
Melrose	4	2	10	11	8	3
North Reading	2	1	2	6	5	2
Reading	4	3	4	6	5	3
Stoneham	5	7	8	6	6	4
Tewksbury	7	9	13	11	7	6
Wakefield	5	8	10	8	10	3
Wilmington	4	8	5	6	6	5
Winchester	4	1	2	1	2	1
Woburn	5	7	17	16	14	13

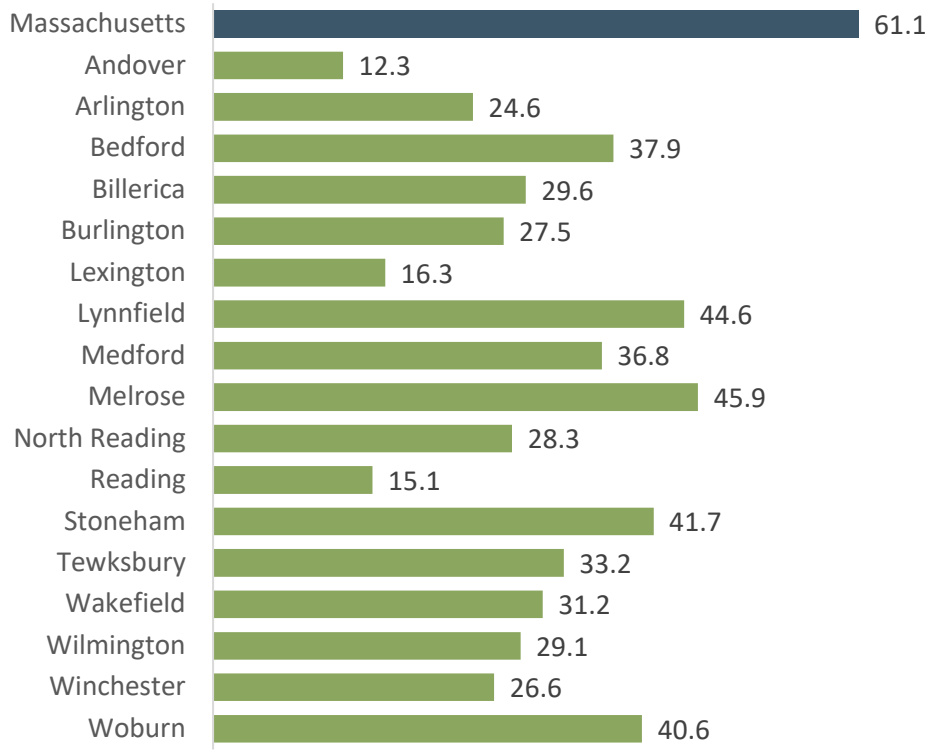
DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Number of Opioid-Related Overdose Deaths All Intents by City/Town, 2013-2019 (updated January 2020)
NOTE: Please note that 2017-2019 death data are preliminary and subject to updates. Case reviews of deaths are evaluated and updated on an ongoing basis. A large number of death certificates have yet to be assigned final cause of death codes. The information presented in this city/town table only includes confirmed cases.

Environmental Health

Asthma

Environmental health issues were not mentioned in focus group or interview discussions. However, in Massachusetts, approximately 10% of adults have asthma. In 2016, the age-adjusted rate of asthma emergency department visits per 100,000 population was 61.1 in Massachusetts. By town, the age-adjusted rate of asthma emergency department visits ranged from 12.3 per 100,000 population in Andover to 45.9 per 100,000 population in Melrose (Figure 51).

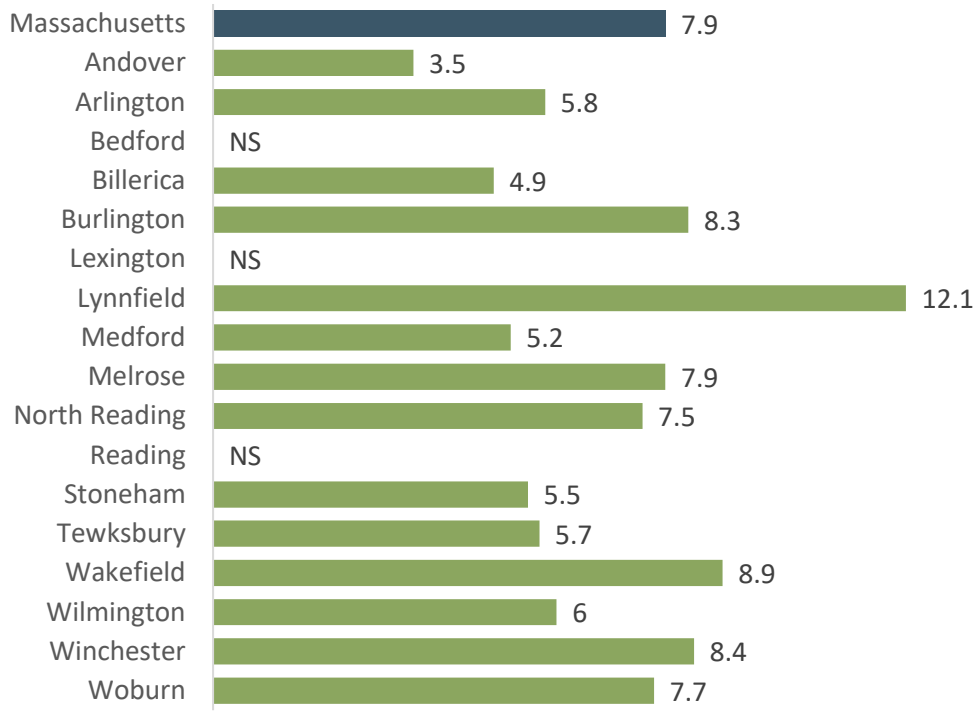
Figure 51. Asthma Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2016



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016.

In 2016, the age-adjusted rate of asthma hospitalizations per 100,000 population was 7.9 in Massachusetts. By town, the age-adjusted rate of asthma hospitalizations ranged from 3.5 per 100,000 population in Andover to 12.1 per 100,000 population in Lynnfield. Data for several towns were not reported due to insufficient sample size (Figure 52).

Figure 52. Asthma Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2016



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2016.
NOTE: NS = Data not shown due to insufficient sample size.

Air Quality

Fine particulate matter (PM)2.5 is an air pollutant that is a concern for people's health when levels in air are high. PM2.5 are tiny particles in the air that reduce visibility and cause the air to appear hazy when levels are elevated. The long-term standard (annual average) for safety is 12 micrograms/cubic meter. All towns in the area were well under the threshold. In 2014, the annual average PM2.5 concentrations were around 7.7 for most towns, ranging from 7.6 micrograms/cubic meter in Andover; Arlington; and Lexington to 7.9 micrograms/cubic meter in Bedford (Figure 53).

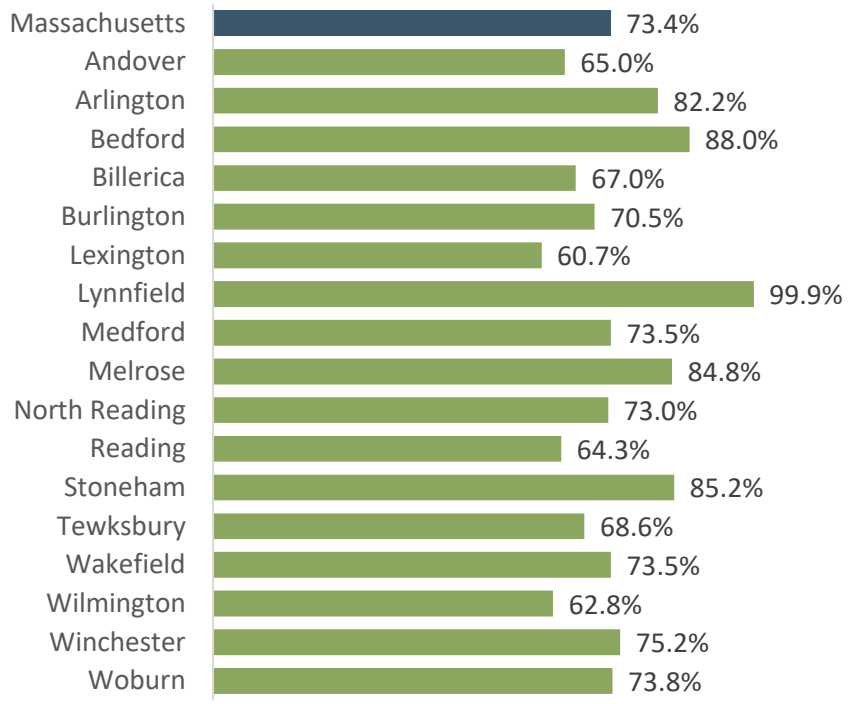
Figure 53. Air Quality Modeled Data Annual Average PM2.5 Concentrations (micrograms/cubic meter), by Towns, 2014

DATA SOURCE: Massachusetts Department of Public Health, Bureau of Environmental Health, 2014.
NOTE: Air Quality is a localized measure, therefore statewide estimates are not available.

Lead Poisoning

In 2013-2017, 73.4% of children aged 9-47 months were screened for lead poisoning in Massachusetts. By town, percentages of screened children ranged from 60.7% in Lexington to 99.9% in Lynnfield (Figure 54).

Figure 54. Percent of Children 9-47 Months Screened for Lead Poisoning, in Massachusetts and by Town, 2013-2017



DATA: Massachusetts Department of Public Health, Bureau of Environmental Health, Childhood Lead Poisoning Prevention Program, 2013-2017.

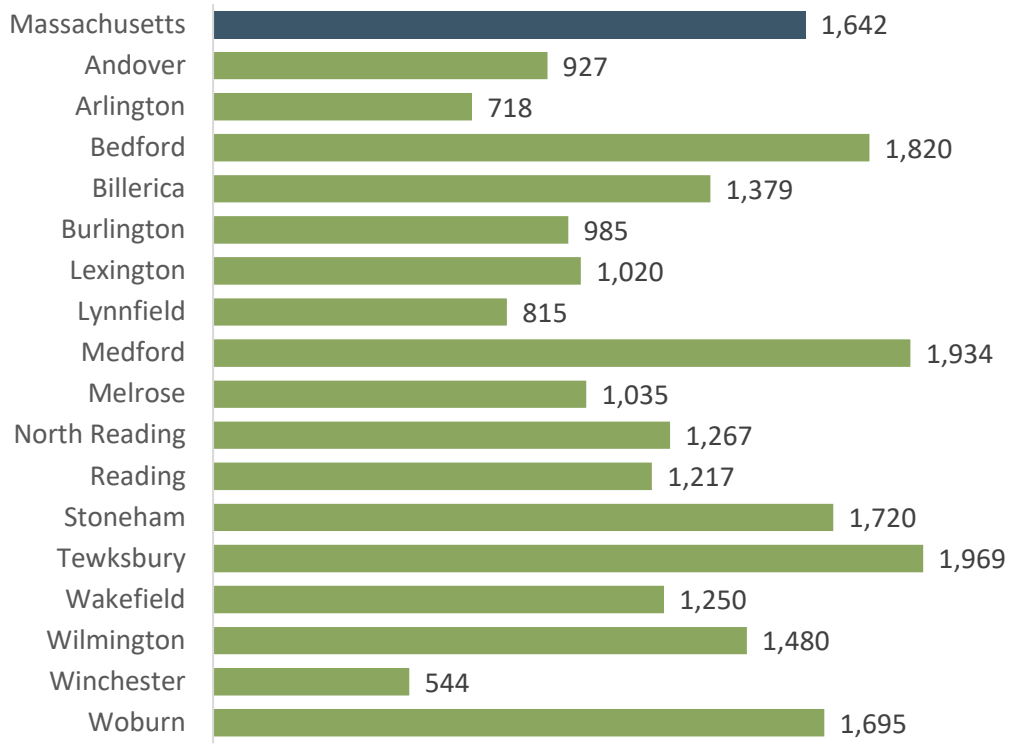
Infectious and Communicable Disease

COVID-19

Focus group members and interviewees had mixed responses about the impact of COVID-19 in their communities. Some reported it was prevalent while others stated that their communities were far less affected than others. A couple of participants reported that they were pleased with the level of COVID-19 testing in their communities. Many participants reported community compliance with mask and social distancing guidelines. As one focus group member stated, "*People in city hall and Medford have been following the guidelines, which shows [a] positive aspect of the community."* However, not all shared this view: another focus group member stated, "*I don't know if it's specific to Medford, but people are not wearing their darn masks!"*

On August 12, 2020, the COVID-19 case rate in Massachusetts was 1,642 cases per 100,000 population. The case rate varied across the Woburn service area, with the highest case rates occurring in Tewksbury (1,969 per 100,000 population) and Medford (1,934) and the lowest case rates occurring in Arlington (718) and Winchester (544) (Figure 55).

Figure 55. COVID-19 Case Rate per 100,000 Population, in Massachusetts and by Town, as of August 12, 2020



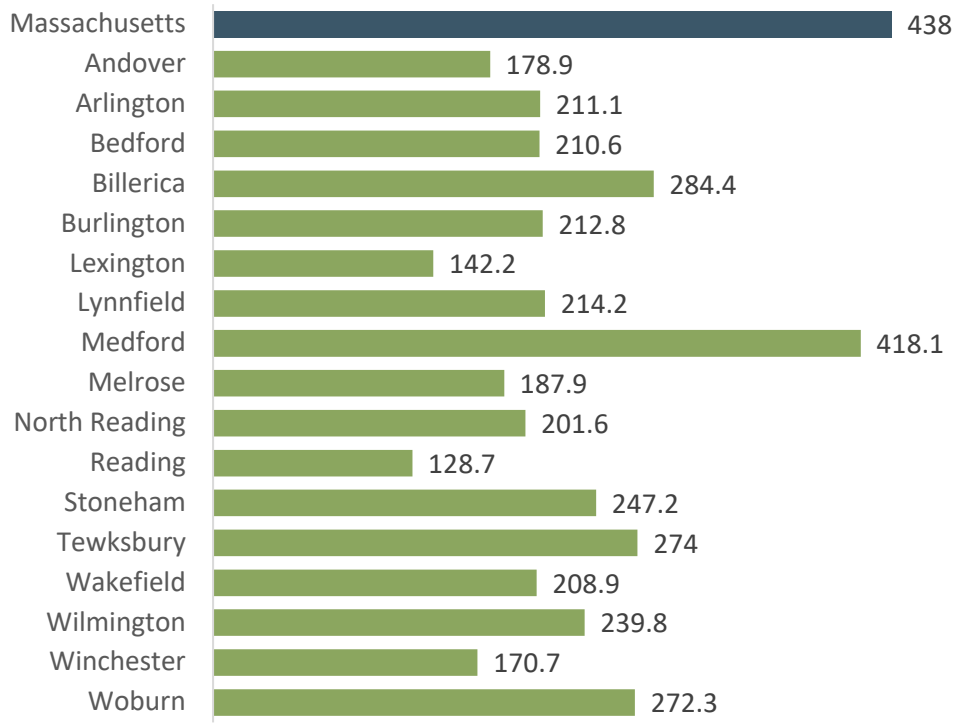
DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2020.
NOTE: Data as of August 12, 2020.

Most often, participants shared the challenges of stay-at-home mandates and closures brought on by the pandemic. They described the impact of closed libraries and other services, reduced transportation options, and lack of socialization for their children. Participants also expressed concern about the lingering effects of COVID-19 on the economy, housing, and employment. Those with school-age children described the challenges of remote learning and the stress associated with uncertainty about the coming school year. However, a few participants also shared the "*silver linings*"—greater social cohesiveness and consideration toward neighbors, more time with family, and expansion of remote interaction, including telehealth.

Sexually Transmitted Diseases

Sexual health concerns were not raised by interview or focus group participants. In 2018, there were 438 cases of chlamydia per 100,000 population in Massachusetts. By town, the rates of chlamydia per 100,000 population ranged from 128.7 in Reading to 418.1 in Medford (Figure 56).

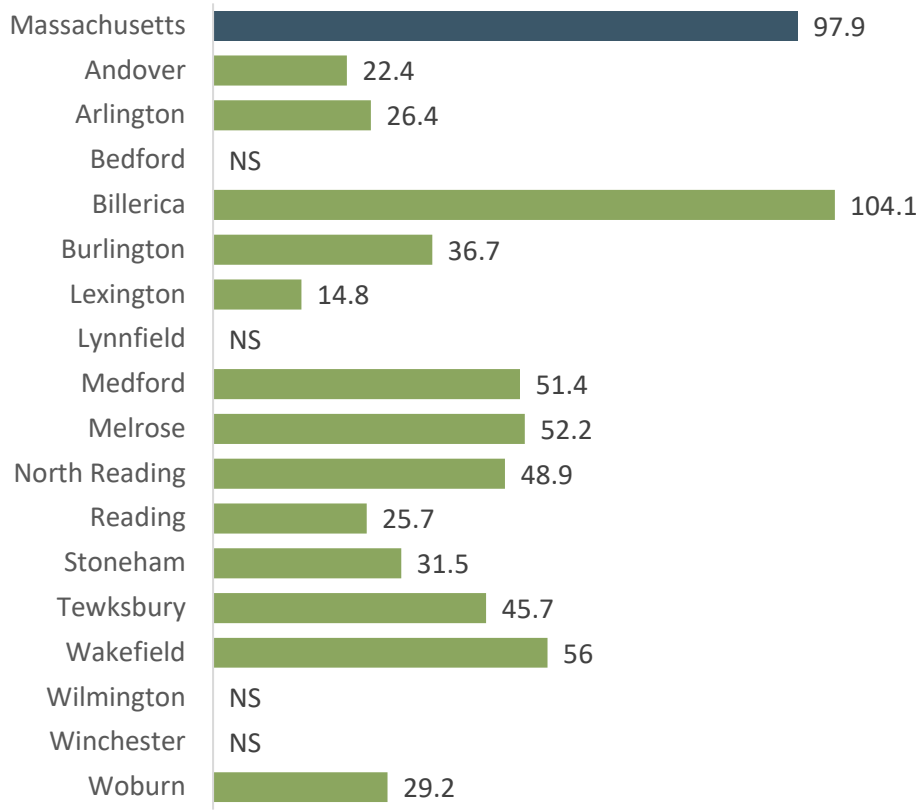
Figure 56. Chlamydia Cases, Crude Rate per 100,000 population, in Massachusetts and by Town, 2018



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2018.

In 2018, there were 97.9 cases of hepatitis C per 100,000 population in Massachusetts. By town, the rates of hepatitis C per 100,000 population ranged from 14.8 in Lexington to 104.1 in Billerica. Data from several towns are not presented due to insufficient sample (Figure 57).

Figure 57. Hepatitis C Cases, Crude Rate per 100,000 population, in Massachusetts and by Town, 2018

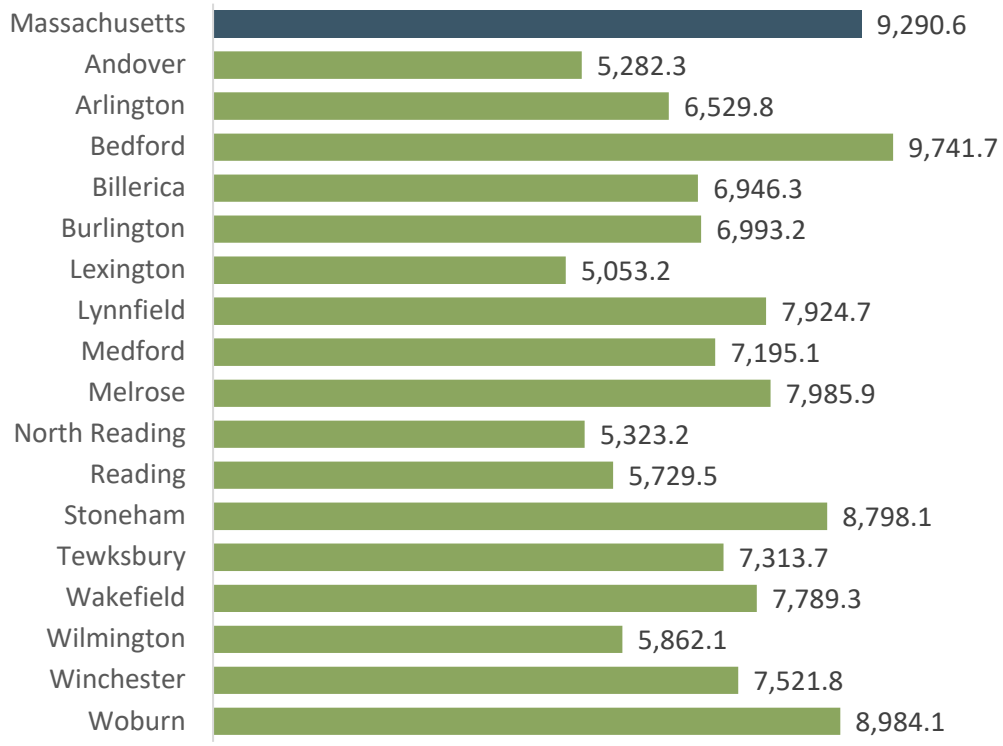


DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2018.
NOTE: NS = Data not shown due to insufficient sample size.

Injury

Interview and focus group participants did not raise injury as a concern for their communities. In 2014, there were 9,290.6 unintentional injury emergency department visits per 100,000 in Massachusetts. By town, unintentional injury emergency department visits ranged from 5,053.2 (Lexington) to 9,741.7 (Bedford) per 100,000 population **(**Figure 58).

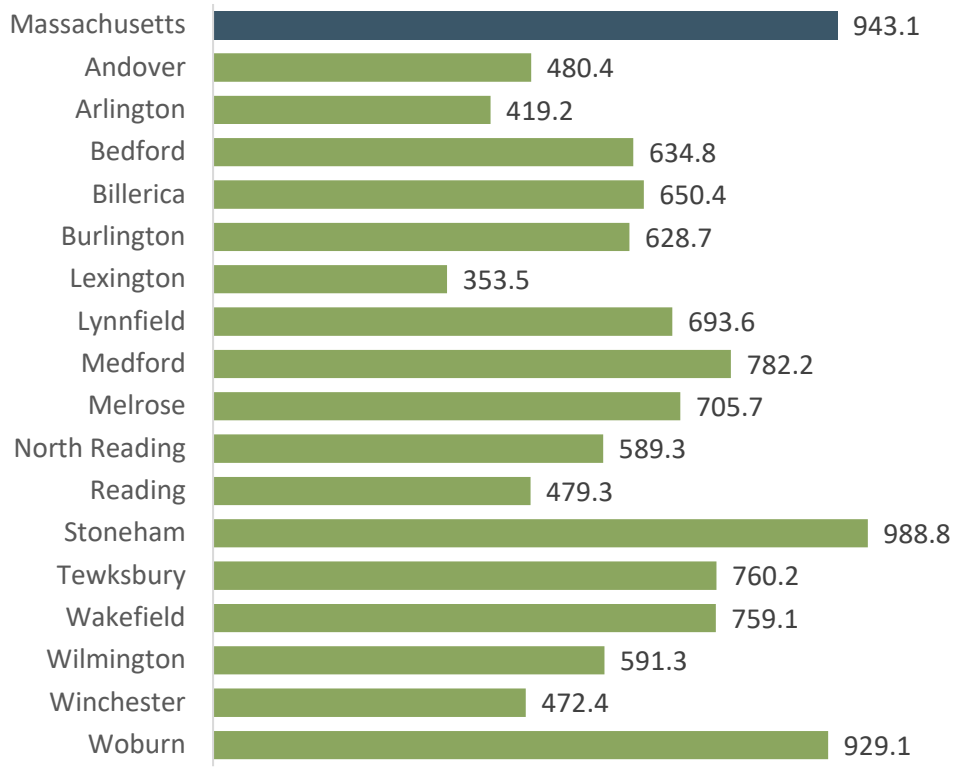
Figure 58. Unintentional Injury Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, there were 943.1 motor vehicle accidents where occupants were injured per 100,000 population in Massachusetts. By town, accidents ranged from 353.5 per 100,000 population in Lexington to 988.8 per 100,000 population in Stoneham (Figure 59).

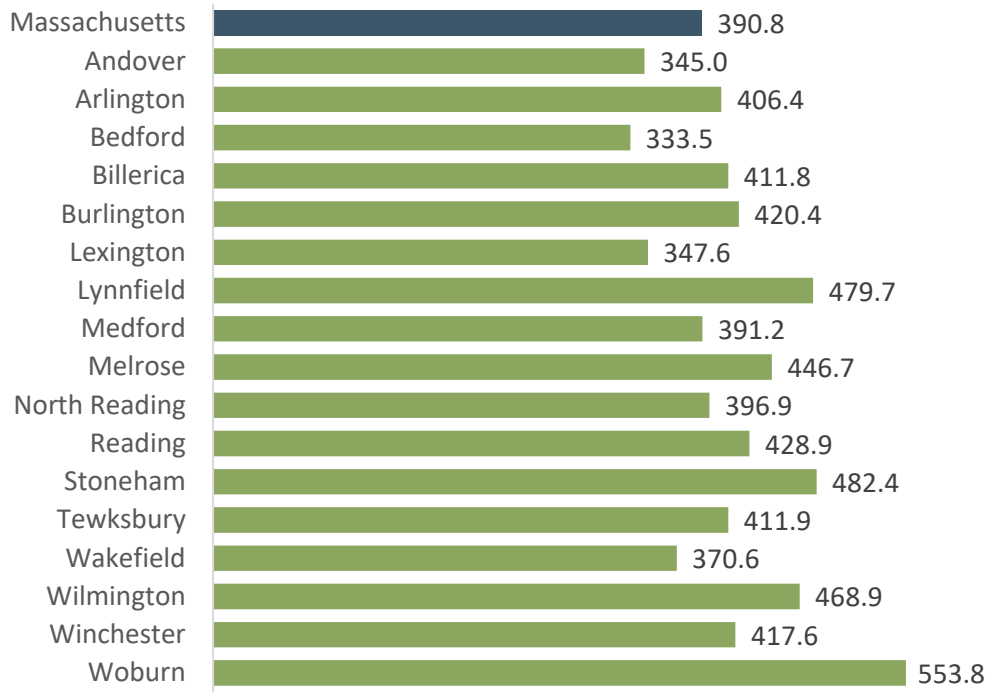
Figure 59. Motor Vehicle Accidents where Occupants are Injured, Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Falls are a particular concern of injury among the senior population. In 2014, the age-adjusted rate per 100,000 population of hospitalizations due to a fall was 390.8 in Massachusetts. By town, the age-adjusted rate per 100,000 population of fall hospitalizations ranged from 333.5 in Bedford to 553.8 in Woburn (Figure 60).

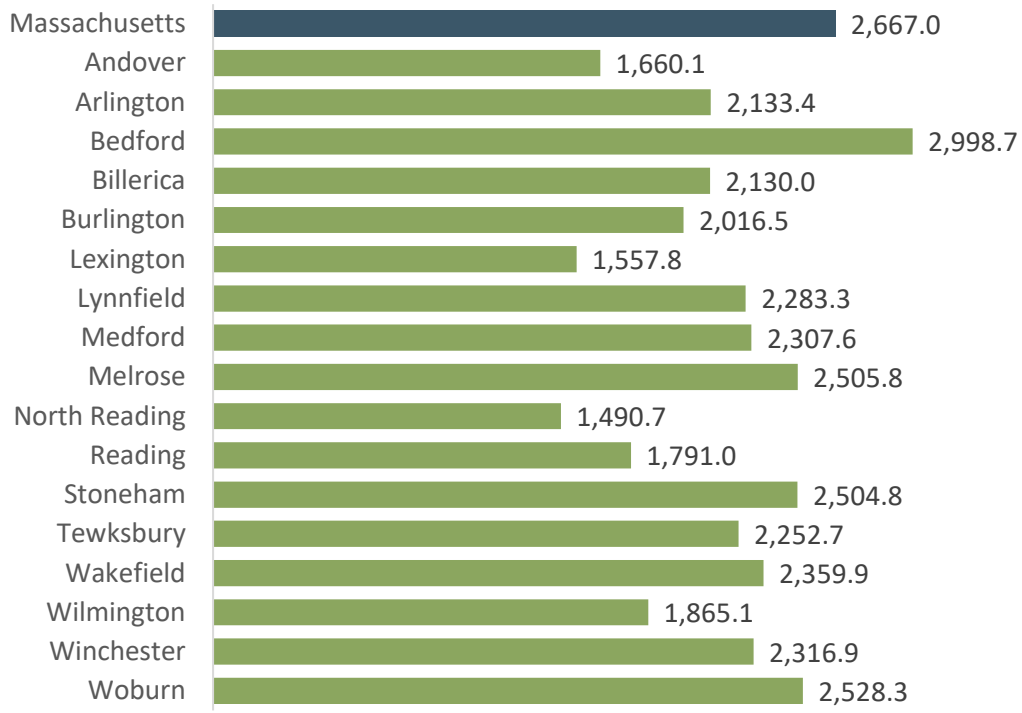
Figure 60. Falls Hospitalizations, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

In 2014, the age-adjusted rate per 100,000 population of emergency department visits due to a fall was 2,667.0 in Massachusetts. By town, the age-adjusted rate per 100,000 population of fall emergency department visits ranged from 1,490.7 in North Reading to 2,998.7 in Bedford (Figure 61).

Figure 61. Falls Emergency Department Visits, Age-Adjusted Rate per 100,000 population, in Massachusetts and by Town, 2014

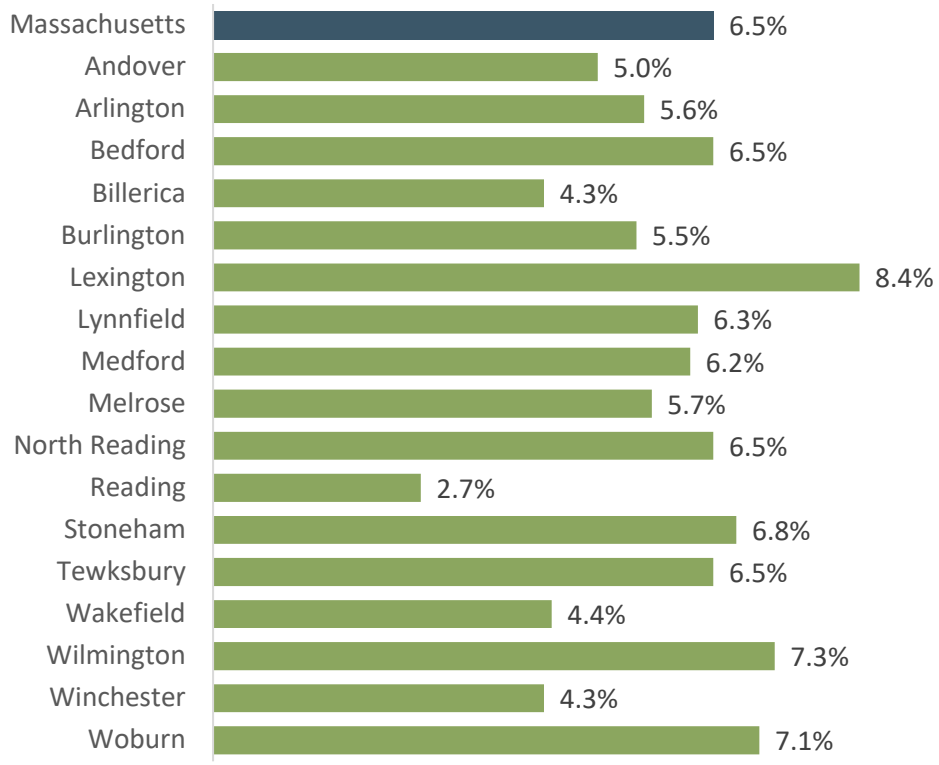


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2014.

Maternal and Infant Health

While, as described above under "mental health," concerns about child development in the context of COVID-19 and social distancing were raised, in general participants did not discuss maternal and infant health in detail. In 2015, the percent of preterm births in Massachusetts was 6.5%. By town, preterm births ranged from 2.7% in Reading to 8.4% in Lexington (Figure 62).

Figure 62. Percent Preterm Births, in Massachusetts and by Town, 2015



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2015.
NOTE: Preterm birth is defined as being born before 37 weeks of gestation.

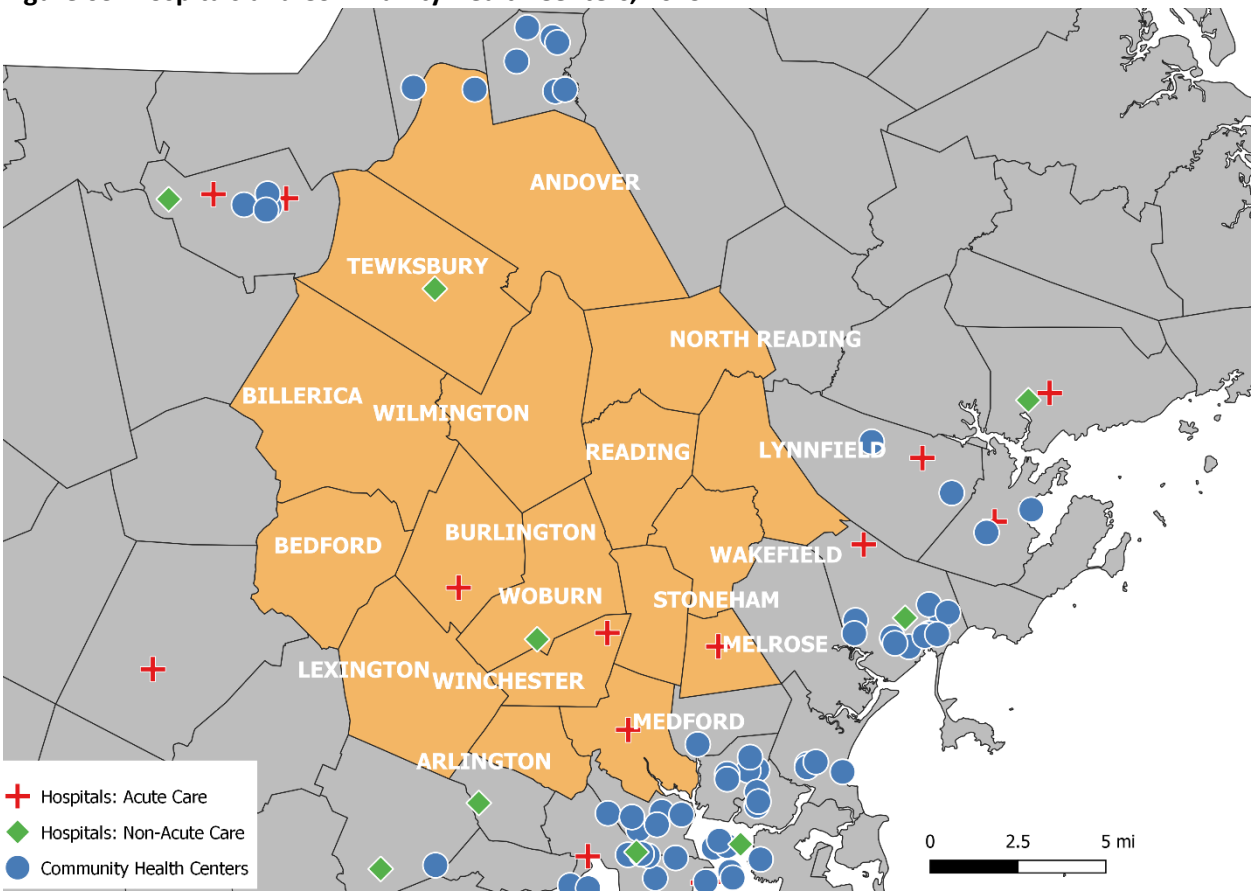
ACCESS TO SERVICES

Access to Healthcare Services

As noted earlier, 64.5% of Woburn Community Priorities Survey respondents indicated that being close to medical services was a strength of their community. As shown in Figure 63, there are a few acute and non-acute hospitals in the Woburn service area and numerous healthcare services in close proximity to the towns closer to Boston. County-level data also indicate that there are more per capita providers in the Woburn service area than Massachusetts overall. Table 11 shows the ratio of population per provider (for this indicator, a lower population number indicates more providers per capita.) In 2017-2019, Massachusetts had 1 primary care provider per 970 people; Essex County had 1 for every 1,310 people; Middlesex County had 1 for every 800 people; and Suffolk County had 1 for every 670 people. Massachusetts had 1 dentist per 970 people, Essex County had 1 dentist for every 1130 people, Middlesex had 1 dentist for every 1020 people, and Suffolk County had 1 dentist for every 480 people. Massachusetts had 1 mental health provider per 160 people, Essex County had 1 mental health provider

for every 170 people, Middlesex County had 1 mental health provider for every 170 people, and Suffolk County had 1 mental health provider for every 120 people.

Figure 63. Hospitals and Community Health Centers, 2019



DATA SOURCE: Massachusetts Bureau of Geographic Information (MassGIS), Department of Mental Health (DMH) & Massachusetts Department of Public Health: Bureau of Environmental Health GIS Program League of Community Health Centers, Office of Medical Services, Center for Health Information and Analysis, 2019.

Table 11. Ratio of Population per Health Care Provider, in Massachusetts and by County, 2017-2019

	Primary Care Physicians (2017)	Dentists (2018)	Mental Health Provider (2019)
Massachusetts	970	970	160
Essex County	1310	1130	170
Middlesex County	800	1020	170
Suffolk County	670	480	120

DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, 2017-2018; Centers for Medicare & Medicaid Services, National Provider Information Registry, as reported by County Health Rankings, 2019.

However, when discussing issues related to healthcare access, several interviewees and focus group members mentioned a number of barriers. Specifically cited were the high cost of healthcare, difficulty accessing MassHealth, and lack of dental services. A few participants shared some specific infrastructure challenges: the lack of a hospital in Arlington and a recently closed emergency room in Medford.

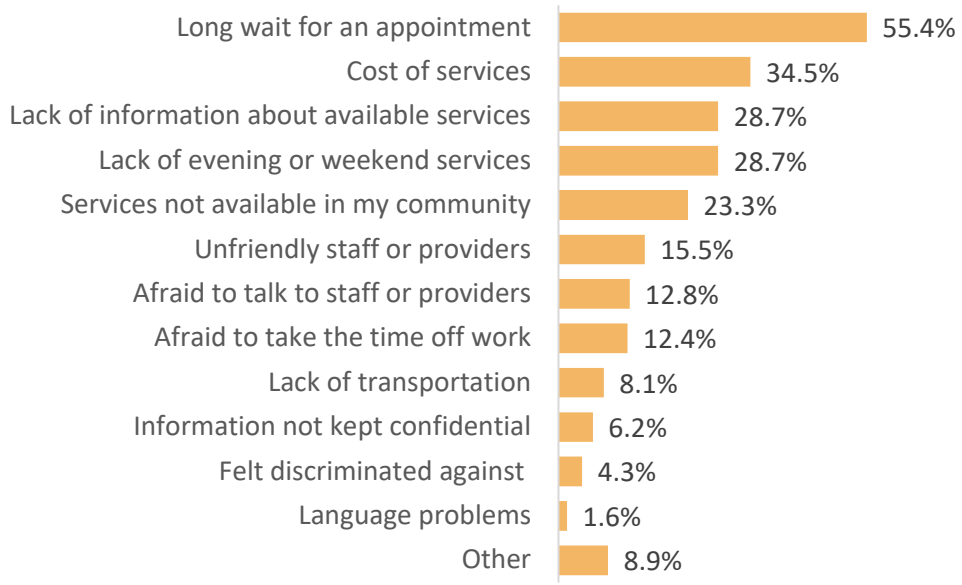
The high cost of healthcare, including health insurance and deductibles, was mentioned by a few participants. Interviewees shared that some community residents do not have a primary care physician or are from cultures in which preventative healthcare is not as common. These residents, interviewees reported, utilize the ER for healthcare, which is far more costly.

Accessing MassHealth was also described as a challenge. Focus group members from public housing, for example, noted that strict income requirements to qualify for MassHealth means that some lower income residents may not qualify. As one participant explained, "*I know people who have the situation where because of their income, they may have a couple dollars more than what would make them qualify to get MassHealth or free care. Because of that, I think a lot of people don't go to the doctor regularly.*" An interviewee shared examples of inaccurate communication and instructions about MassHealth enrollment and expressed concern that some residents who are immigrants do not receive higher levels of coverage because MassHealth enrollers do not accurately apply standards for individuals with Permanent Residence in the US Under Color of Law – PRUCOL.

Participants also shared healthcare concerns specific to seniors. Those who work and live in public housing mentioned that the isolation of seniors makes it challenging to identify health issues in a timely manner. Senior focus group members described the challenges that they faced traveling to other towns for specialty healthcare services. Participants also mentioned a lack of continuity in healthcare and transition to community services after a hospital stay, ultimately creating challenges for seniors. As one interviewee explained, *"Health care, social services, and human services are each in a separate corner, and not working together in a unified manner. We've been talking about this for 20 years and there's no change.*" Finally, participants also mentioned that a lack of dental care for seniors is a concern. As one senior focus group member shared, "*Dental health, a lot of seniors neglect it. A lot of people when they age, maybe they don't have dental insurance. I think that's an issue.*"

Woburn Community Priorities Survey respondents were asked about barriers to accessing services, including medical services, mental health, and social services. Nearly half (48.5%) of Woburn Community Priorities Survey respondents, reported experiencing at least one barrier to accessing medical, mental health, or social services in the past six months. Among respondents reporting at least one barrier, the most common barriers were long waits for appointments (55.4%); cost of services (34.5%); lack of information about available services (28.7%); and lack of evening or weekend services (28.7%) (Figure 64).

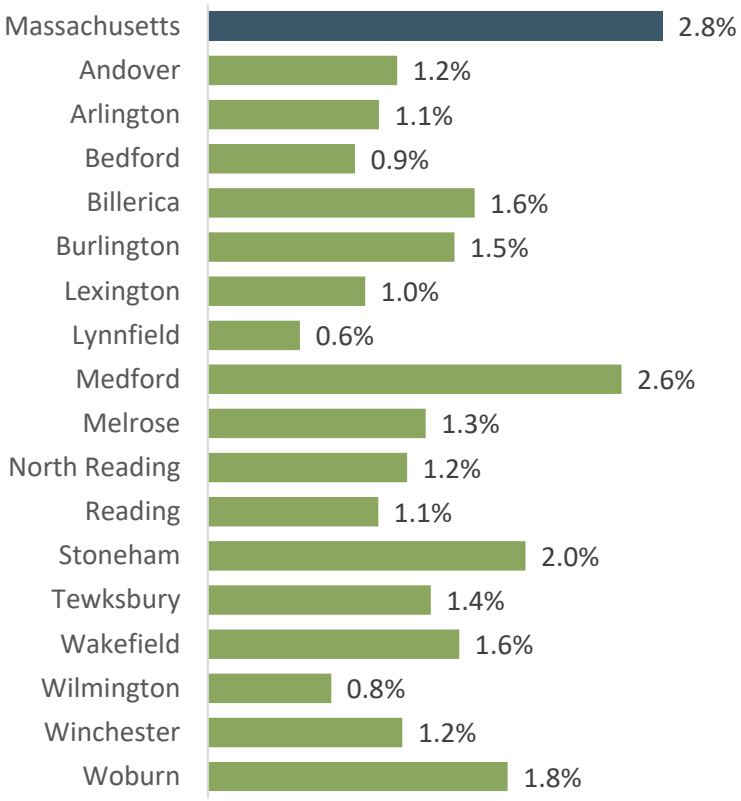
Figure 64. Percent of CHNA Community Priorities Survey Respondents Reporting Barriers to Accessing Medical, Mental Health or Social Services in the Past Six Months, among Respondents Reporting at Least One Barrier, 2020 (N=258)



NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

While having no health insurance was not mentioned in the Woburn Community Priorities Survey or focus group/interview discussions as a significant barrier to care among residents, secondary data indicate that uninsured rates are low overall but do vary by community. In 2014-2018, the percent of the population with no health insurance in Massachusetts was 2.8%. By town, the percent of the population with no health insurance ranged from 0.6% in Lynnfield to 2.6% in Medford (Figure 65).

Figure 65. Percent Population with No Health Insurance, in Massachusetts and by Town, 2014-2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018.

Access to Social Services or Other Essential Services

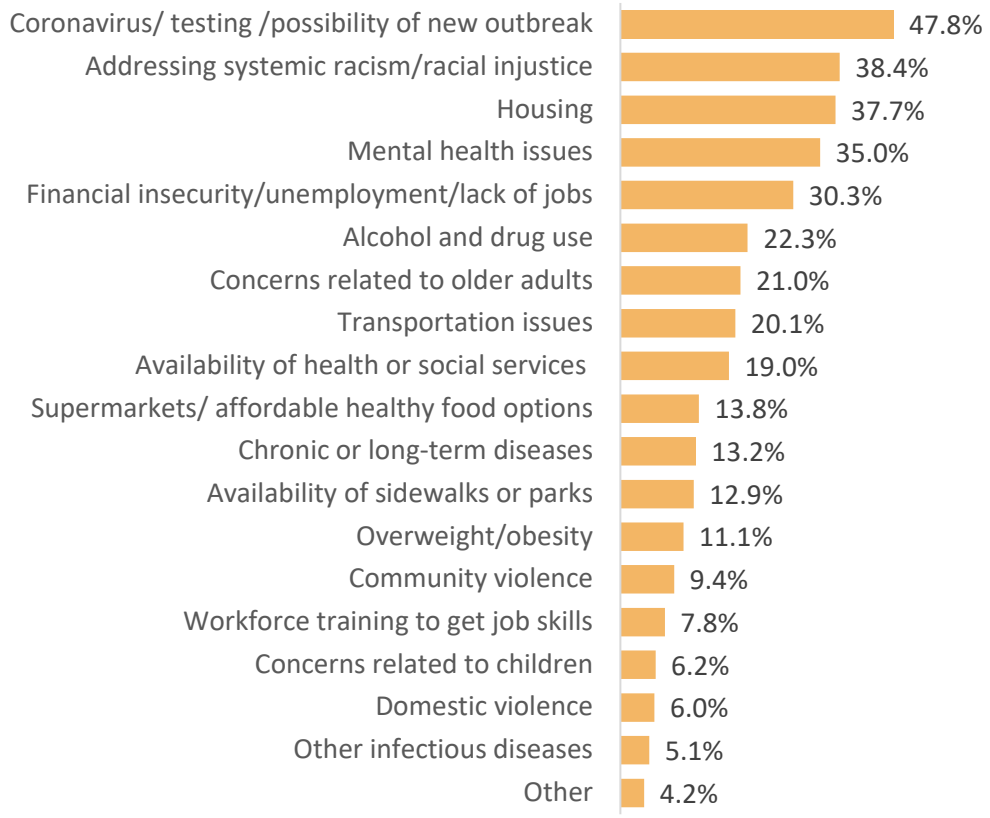
When asked about challenges to accessing social or other essential services, participants spoke in terms of challenges during the COVID-19 pandemic. Participants reported that some services were curtailed at the height of the pandemic. Accessing services during this period was primarily electronic which created difficulties, participants reported, for those without computers or internet access or who did not speak English. Service providers shared that they have worked to bring services online as much as possible and have been working hard to reach out to clients to ensure that their needs are being met. As services have slowly reopened, some residents faced challenges with transportation as options for services were limited. Some participants reported that they continue to fear spending too much time in public which has prevented them from accessing services.

COMMUNITY PERCEPTIONS AND VISION FOR THE FUTURE

Top Issues for Action

Woburn Community Priorities Survey respondents were asked to consider the most important issues in their communities to take action on in the next few years. Respondents were asked to consider the importance of these issues in regard to Concern, Equity, Effectiveness, and Feasibility (see Appendix E for the survey instrument) and to select the five most important issues for action. Taken together, the top five issues of concern were (1) coronavirus/COVID-19 testing and/or the possibility of a new outbreak; (2) addressing systemic racism/racial injustice; (3) housing; (4) mental health issues; and (5) financial insecurity/unemployment/lack of job opportunities (Figure 66). These priorities were very similar issues that focus group and interview participants mentioned when discussing their biggest concerns in the community.

Figure 66. Percent of CHNA Community Priorities Survey Respondents Reporting Most Important Issues for Action in the Next Few Years in Their Community, 2020 (N=552)



NOTE: Question in the survey allowed for up to five responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

There was variation in the top five priorities of concern in sub-groups defined by educational attainment. Both respondents with less than a bachelor's degree and a bachelor's degree or higher most commonly ranked issues related to coronavirus/COVID-19 as the top priority (Figure 67). However, those without a bachelor's degree ranked alcohol and drug use as one of their five top priorities, while those with a bachelor's degree or higher ranked addressing systemic racism as a top priority.

Figure 67. Percent of CHNA Community Priorities Survey Respondents Reporting Most Important Issues for Action in the Next Few Years in Their Community, by Selected Demographics, 2020

	Less than College (N=93)	College or More (N=369)
1	Coronavirus/ testing /possibility of new outbreak (53.8%)	Coronavirus/ testing /possibility of new outbreak (56.6%)
2	Financial insecurity/unemployment/lack of jobs (43.0%)	Addressing systemic racism/racial injustice (50.1%)
3	Housing (32.3%)	Housing (46.6%)
4	Mental health issues (31.2%)	Mental health issues (43.1%)
5	Alcohol and drug use (30.1%)	Financial insecurity/unemployment/lack of jobs (33.6%)

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Suggestions for Future Programs, Services, and Initiatives

Interviewees and focus group members were asked about their vision for the next five years, including suggestions for future programs, services, and initiatives. Several suggestions emerged, including more affordable housing, expanded mental health services, stronger collaboration across organizations and agencies, greater efforts related to racial justice, and more services for seniors.

Housing

Housing was overwhelmingly identified by focus group members and interviewees as a top issue to address in the Woburn service area. As one focus group member stated, *"Housing will continue to be an issue – the rents will be even higher."* Participants expressed concern about the lingering effects of COVID-19 on foreclosures and housing; worried about rising rents and long wait lists for public housing. Overall, participants suggested increased attention to meeting the diverse housing needs of community members including the construction of more affordable housing. Those living in public housing mentioned a need to update current buildings and seniors expressed a desire for better quality senior housing. One interviewee suggested that more funding is needed, so people can stay in housing, including an expansion of the Section 8 program.

Mental Health Services

Increasing access to mental health services was another prominent theme among focus group members and interviewees. While participants shared that restrictions due to COVID-19 have enhanced the use of telehealth for the delivery of mental health services, this new way of providing services has not worked for everyone. Participants cited a need for more providers and services, particularly for children and

adolescents, including residential services, to reduce waitlists and ensure those in crisis have immediate access to services. One interviewee stated that a future goal is to "*Somehow eliminate our waitlist and ensure that families and children that need mental health services are able to connect immediately.*" Key to achieving this goal, according to one interviewee, is increasing reimbursement rates for mental health services and continuing to expand the use of telehealth where appropriate. Hiring providers who speak other languages also was described as critical. Participants also suggested greater integration of mental health services into schools and community programs for youth.

Collaboration to Increase Services

While participants praised current levels of collaboration among community organizations, they also suggested more could be done to maximize and enhance the availability and efficiency of services to community members. Interviewees working in social services described a need for more resources for organizations working to meet community members' basic needs, especially since these have increased as a result of COVID-19. These interviewees recommended more work across different entities including government, hospitals and healthcare providers, social services, and faith institutions to ensure that residents have seamless access to the services that they need. Local government leadership was seen as essential. One interviewee recommended *"Continuing to build connection across disciplines so problems can be solved."* Specific examples included collaboration between senior centers and libraries and recreation departments to offer programming for younger seniors, intergenerational programming, and continuing work between police, community organizations, and schools.

Racial Justice

Several participants expressed hope that the current momentum around racial justice will continue. These participants saw a need for more education and community conversation relative to systemic racism. As one student focus group member shared, "*We need to have more open conversations [about racism]. We used to look at it from the outside as happening somewhere else. But it's happening in Woburn, and we need to talk about it in a public forum.*" A few focus group members expressed hope that in the future, city government and police workforces would be more diverse. One interviewee shared this same vision for the community, *"Asian-Americans are an integral part of the town, but right now, city employees and teachers don't reflect that. Thirty percent of the town is Asian-American, but we're underrepresented within the town's employees."*

More Senior Services

Seniors who participated in the focus groups and interviewees who work with seniors envisioned a future with more programs and services for the older and aging residents. These participants stated that senior center buildings need to be expanded and that senior centers should do more to attract younger seniors to participate, through a greater variety of programming, more flexible hours, and opportunities for continuing mental stimulation. Participants also saw a need for a greater continuum of supports for aging residents, one that begins by engaging younger seniors and supports "aging in place," but also includes adult day programs; supports for those with dementia and Alzheimer's; and programs for caregivers. As one interviewee described, "*We need to integrate understanding among these different stages of support. You need to understand who your partners are, so you can start planning for next higher level of support. Eventually, people may need assisted living. But there are steps to get there, and you need to understand different parts of the continuum.*"

Other Areas for Focus

Transportation: Some participants in the parent and senior focus groups suggested greater access to public transportation, especially within towns. As one parent suggested, "*Better access to public transportation – that's a big one. Maybe just even more frequent and reliable buses."*

Support for Parents: Parent focus group members saw a need for more support for those with school-aged children. Suggestions included more parenting education, such as that offered by the Medford Family Network and expanded youth and family programming.

More Community Events/Efforts that Promote Social Cohesion: A couple of participants suggested a need for a community center with activities and programs. Suggestions also included events, such as movie nights and concerts. As one senior focus group member stated, "*It's important to get people together*."

Connection to Health Insurance: One interviewee reported that more should be done to ensure that people are appropriately connected to MassHealth and more outreach is conducted to ensure that people are knowledgeable and feel comfortable applying to MassHealth, including outreach to immigrant populations. Specific suggestions included pop-up enrollment centers or centers co-located with other services including schools, and a need for navigators who are embedded in vulnerable communities. As the interviewee described, *"The system is there. It's just about making easy access."*

Youth Programming: Focus group members with children saw a need for more programming for children and youth including sports and other activities. Seniors suggested intergenerational programming.

Support for Small Business: Participants recognized the economic impact of COVID-19 on small businesses that are so valuable in their communities. A few suggested that more funding should be made available to support these businesses. As one interviewee stated, ***"****Small businesses support a lot people in the community. I don't think we appreciate this. They are vital to communities."*

Support for Young Families: A parent focus group member stated, "*I would love to see early literacy programing in Medford change."* Another parent stated that more daycare options were needed to meet demand and reduce current waitlists.

KEY THEMES AND CONCLUSIONS

This community health needs assessment for the Woburn service area provides a summary of community needs, strengths, and resources based on a review of existing data, a community survey, and discussions with community residents and key informants. This assessment was conducted during an unprecedented time, given the COVID-19 pandemic, and the national movement for racial justice; findings in this report can be used to inform future planning and can be built upon through future data collection efforts. The following overarching themes emerged from this synthesis and include many upstream factors:

- **There are many assets in the Woburn service area, including high-quality schools, access to parks and green space, access to medical services, and overall social cohesion and community engagement**. Many CHNA participants described the towns within the Woburn service area as a great place to live. Participants reported a strong sense of community and belonging, and a great

place to raise a family. These individuals noted that support and help for each other has particularly come to light during the pandemic. Other community strengths included schools, parks, access to medical services, and proximity to Boston.

- **COVID-19 remains a major concern, along with its impact on local economies, financial security, child development, social isolation of seniors, and overall mental health of community members.** During this unprecedented time, the pandemic and its social and economic impacts were unsurprisingly at the forefront of community members' concerns. While the virus itself had not strongly impacted most of these communities as of August 2020, residents expressed widespread feelings of anxiety about the future. Specifically, concerns were raised about the social and emotional development of children, social isolation among seniors, and the financial impact of the economic shut-down for local business and families.

- **While Woburn service area overall is affluent, some communities within the area face unemployment and financial insecurity, especially in the context of the economic impact of the COVID-19 pandemic.** Prior to the pandemic, median household incomes in the Woburn area were generally higher than the state average, and unemployment was less than 3% in all towns. Within the Woburn service area, Medford (20.3%) and Woburn (15.3%) had the largest number of residents in poverty (<200% FPL) in 2014-2018; and in some towns, almost 20% of Hispanics/Latinos were living in poverty (<100% FPL), relative to 3% of non-Hispanic Whites. CHNA participants expressed concerns about increased pandemic-related unemployment, which was especially apparent in data for Billerica and Woburn.

- **The COVID-19 pandemic exacerbated pre-existing inequities in income and wealth in the area. Increased use of food pantries, social services to support housing costs, and government financial support, were expected to increase further, and there was great concern for community members already living on the edge.** Almost 30% of Woburn Community Priorities Survey respondents reported that their financial situation had gotten worse since the onset of the pandemic, 6.5% reported it had improved, and 63.9% reported it had stayed the same. These data highlight the pre-existing socioeconomic disparities in the Woburn service area, with some residents losing work and others being able to transition to work from home. CHNA participants expressed concerns about already vulnerable community members, including low-income seniors, racial/ethnic minorities, and immigrants and refugees.

- **Housing affordability was identified as a pressing concern, particularly for seniors, racial/ethnic minorities, low-income immigrants, and young families.** In most towns within the Woburn service area, owner-occupied units were more common than rental units, compared to the state overall, with notable exceptions in Arlington; Medford; and Woburn. Lack of affordable housing was a common concern among participants and was ranked the third highest priority for action (37.7%) among Woburn Community Priorities Survey respondents.

- **Transportation is a concern for some communities, particularly for certain populations including seniors and public housing residents.** In 2014-2018, between 60-90% of residents in the Woburn service area commuted to work alone in a vehicle. Transportation issues ranked as the eighth most common priority among Woburn Community Priorities Survey respondents. However, these overall responses belie the lack of access to public transportation among certain residents, in particular seniors who do not drive and residents of public housing. Other towns, including Arlington,

Medford, and Melrose, had better access to mass transit, such as MBTA bus service; commuter rail; and the subway.

- **Some community members have experienced or recognized discrimination in their communities and prioritized addressing racial injustice.** Among Woburn Community Priorities Survey respondents, the second most common issue for future action was addressing systemic racism/racial injustice (38.4%). Overall, 11.2% of respondents reported experiencing discrimination in the past six months, and among these individuals, 50.0% reported this was due to their race; 37.9% said it was due to their gender; 34.5% said it was due to their ethnicity. Participants reported that conversations about racial justice were occurring in their communities, similar to national discussions. Perceptions about the extent of discrimination and racism in the community varied. Participants reported that local leaders and community-based organizations, including faith institutions, were working to engage the community in conversations about this issue.

- **Mental health is a top concern among many community residents, especially in the context of COVID-19.** Mental health issues were the top concern that had personally affected Woburn Community Priorities Survey respondents in the past six months (50.6%) and were the fourth most commonly cited issue for future action (35.0%). Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in the community, particularly among seniors, who already tend to be socially isolated; and among immigrants and refugees, who already face anxiety related to the current political context. Participants with school-age children shared the challenges of remote learning and the stress that comes with the uncertainty of the coming school year. Many worried about the long-term impact of the pandemic and lack of socialization on the community's children and youth. According to focus group members and interviewees, a lack of mental health providers was the primary challenge in addressing mental health in the community. It was reported that the number of providers in the community is insufficient to meet the demand for services, leading to long waits for mental health services.

- **Alcohol and substance use are a concern, particularly for residents with less than a high school education.** Alcohol and drug use were not top issues that had personally affected most Woburn Community Priorities Survey respondents in the past six months (13.0%). However, substance use was the sixth most common issue listed for future action (22.3%) and was more common among residents with less than a high school education. Opioid-related overdose deaths were relatively rare in the Woburn service area in the past five years and issues with substance use came up only rarely among interview and focus group participants.

- **Social isolation, difficulty in accessing services, and mental health are pressing concerns for older adults, particularly in the context of COVID-19.** Many participants expressed deep concern with how the pandemic affected older adults in myriad ways. Most concerning was social isolation, which was already an issue for elders in the service area prior to the pandemic. While local Councils on Aging provide excellent services to seniors, outreach and activities have been hindered by the pandemic, especially for vulnerable populations. Seniors are isolated at home, unable to attend medical and social service appointments, and often limited in their use of technology, making communication with friends, family and medical providers challenging.

- **While access to medical care was seen as a strength of the area overall, there are concerns related to continuity of health care with other social services, the high cost of health care, and lack of culturally and linguistically competent mental health services.** Among Woburn Community

Priorities Survey respondents, 64.5% listed accessible medical services as a community strength. However, participants also reported concerns with the high cost of healthcare, difficulty obtaining appropriate MassHealth coverage, a lack of dental and mental health services, and a lack of continuity of care and transition to community services.

COMMUNITY PRIORITIES FOR ACTION

Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. This section describes the process and outcomes of the Woburn-area CHNA prioritization process.

Woburn Service Area – Prioritization Process

Assessment Study – Primary and Secondary Data Collection

- Synthesized data on social, economic, and health issues
- CHNA participants identified areas of concern and priority, via key informant interviews, focus groups, and the Community Priorities Survey

Virtual Community Prioritization Meeting

- Presented study findings and voted on priorities using selected criteria

Community Advisory Board Meeting

- Regional community leaders discussed study findings and community prioritization meeting results; refined and approved priorities

Criteria for Prioritization
When embarking on a prioritization process, using set criteria assists in providing parameters for selection. The following four criteria were used to guide prioritization discussions and voting processes with community members from the Woburn service area, as well as the Community Advisory Board who provided oversight of the CHNA.

Prioritization Criteria

- **Concern:** How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?
- **Equity:** Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?
- **Effectiveness:** Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?

Prioritization Process
The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection
During each step of the primary data collection phase of the CHNA, study participants were asked for input on the top priorities for action in their communities when considering the prioritization criteria. Key informant interviewees and focus group participants were asked about the most pressing concerns

in their communities, as well as the three highest priority issues for future action and investment (Appendices C and D). Community Priorities Survey respondents also were asked to select up to five of the most important issues for future action on in their communities (Appendix E).

Based on data gathered from key informant interviews, focus group participants, and Woburn Community Priorities Survey respondents, nine major priorities were identified for the Woburn service area:

- Coronavirus/ COVID-19 *(specifically related to testing, transmission, disease mitigation, etc.)*
- Financial Insecurity / Unemployment
- Housing
- Transportation
- Systemic Racism and Racial Injustice
- Mental Health
- Alcohol/Substance Use
- Issues related to Older Adults
- Access to Care

Step 2: Data-Informed Voting via a Community Prioritization Meeting

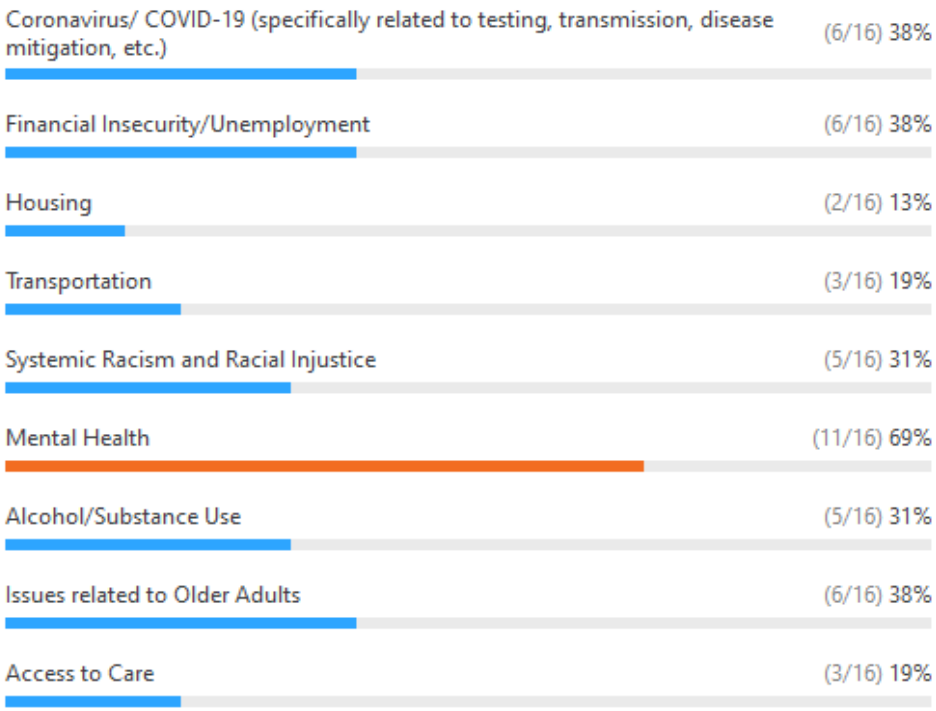
The next step of the prioritization process included presenting quantitative and qualitative data from the data collection phases to community members and stakeholders in a larger forum. On, September 1, 2020, a one-hour virtual community meeting was held for the Woburn service area, so residents and stakeholders could discuss and vote on community priorities. In order to obtain as much feedback as possible on the priorities, outreach was conducted with key informant interviewees, focus group participants, staff from organizations involved in focus group recruitment and survey administration and local Boards of Health directors. Various forms of outreach were employed to reach residents and stakeholders, including email and telephonic outreach, as well as social media posts.

During the remote prioritization meeting, attendees heard a brief data presentation on the key findings for the Woburn service area. Next, meeting participants were divided into small groups to discuss the data and offer their own perspectives and expertise on the various priorities. Meeting participants then shared information from their discussions with the full group.

At the end of the meeting, using the Zoom polling feature, meeting participants voted for up to three of the nine priorities identified from the data and based on the specific prioritization criteria (Concern, Equity, Effectiveness, Feasibility). Participants were asked to identify any additional priorities that they thought were missing from the data-derived list using the Chat feature of Zoom. A total of 16 community members voted during the Community Prioritization Meeting.

As seen in Figure 68, voting identified Mental Health as the most commonly endorsed community priority (69%), followed by Coronavirus/COVID-19 (38%), Financial Insecurity/Unemployment (38%), and Issues Related to Older Adults (38%).

Figure 68: Woburn Prioritization Meeting, Zoom Poll Results, September 1, 2020



NOTE: Poll allowed for up to three responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Prioritization Meeting, 2020.

Step 3: Prioritization Refinement via Community Advisory Board Meeting

On September 9, 2020, the Partners Ambulatory Care – Community Advisory Board, who is charged with providing oversight of the CHNA process, met virtually to discuss the CHNA findings and community prioritization meeting output for the Woburn service area. The goal of this meeting was for CAB members to review the CHNA findings for the Woburn service area and amalgamate that information with the input provided from the community prioritization meeting to refine and narrow the list of priorities in alignment with the social determinants of health.

In the meeting, CAB members were presented with information on community priorities that emerged from the CHNA, the community priorities survey, and the community prioritization meeting, together these prioritization steps revealed the following six priorities for the Woburn service area:

- Coronavirus/ COVID-19 *(specifically related to testing, transmission, disease mitigation, etc.)*
- Financial Insecurity / Unemployment
- Systemic Racism and Racial Injustice
- Mental Health
- Alcohol/Substance Use
- Issues related to Older Adults

To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Much of the CAB's discussion focused on the inter-connectedness of the priorities and the difficulty in identifying a narrow area of focus given the need to address root causes of inequity in the social determinants of health. CAB members noted the importance of focusing on systemic racism and racial injustice given the demographics of the Woburn service area (the majority of residents identify as White) CAB members also discussed that a focus on housing could assist in addressing some of the other concerns related to financial insecurity, behavioral health (mental health and substance use), older adults, and systemic racism. Ultimately, the CAB agreed on the following priorities to consider for future action:

- Coronavirus/ COVID-19 *(specifically related to testing, transmission, disease mitigation, etc.)*
- Systemic Racism and Racial Injustice
- Behavioral Health *(inclusive of mental health and substance use)*
- Issues related to Older Adults

Financial Insecurity and Unemployment were eliminated from the list of priorities for action as these social determinants of health were determined to be embedded within other priority areas. Given the highly mutable state of current affairs, and the ability to further refine these priorities for future action, consensus among the CAB was to keep the list of priorities broader and then refine these issues at a later stage.

APPENDIX A: COMMUNITY ADVISORY BOARD MEMBERS

Name	Organization	Position
Amy Schectman	2Life Communities	President and CEO
Ann Houston	Opportunity Communities	CEO
Charles Desmond	Inversant	CEO
Charles Murphy	Montachusett Veterans Outreach Center	Executive Director
Cheryl Sbarra	Massachusetts Association of Health Boards	Senior Staff Attorney and Director of Policy and Law
Danna Mauch	Massachusetts Association for Mental Health	President and CEO
Dianne Kuzia Hills	My Brother's Table	Executive Director
Joseph D. Feaster, Jr.	Urban League of Eastern Massachusetts	Board Chairman
Laura Van Zandt	REACH (domestic violence prevention and services)	Executive Director
Mary Skelton Roberts	Barr Foundation	Co-Director of Climate
Milagros Abreu	The Latino Health Insurance Program, Inc.	Founder and Executive Director
Monica Tibbits-Nutt	128 Business Council / Fiscal Management and Control Board overseeing the MBTA	Executive Director / Vice Chair
Peter Koutoujian	Middlesex Sheriff's Office	Middlesex Sheriff

Rebecca Gallo	MetroWest Health Foundation	Senior Program Officer
Stephen J. Kerrigan	Edward M. Kennedy Community Health Center	President and CEO

APPENDIX B: KEY INFORMANT INTERVIEWEES

Name	Position	Organization
Rev. Dr. Katherine Adams	Senior Pastor	First Congregational Church of Billerica
Jean Bushnell	Director	Billerica Council on Aging
Elizabeth Dray	Volunteer	ArCS Cluster
Pamela Hallett	Executive Director	Housing Corporation of Arlington
Colleen Leger	Executive Director	Arlington Youth Counseling Center
Melanie Lin	Vice President	Chinese American Association of Lexington
Robert Rufo	Chief of Police	Woburn Police Department
Lisa Tonello; Barbara Fleming	ROSS Coordinator; Director of Resident Services	Medford Housing Authority
Rebecca Wolfe	Clinical Responder	Jail Diversion Program/Arlington Police Department

APPENDIX C: KEY INFORMANT INTERVIEW GUIDE

Health Resources in Action
Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
Westborough, Westwood, and Woburn Service Areas
Key Informant Interview Guide
Guide – May 19, 2020

Goals of the Key Informant Interview

- To determine perceptions of the strengths and needs of these communities, and identify sub-populations most affected
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your family are fine during these uncertain times.

- A few months ago, Partners HealthCare began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of community residents, how health needs are currently being addressed, and whether there might be opportunities to address these issues more effectively. The data from this assessment will inform the priorities for future investments into the community in the next several years on the upstream factors that affect health.

- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.

- As part of the community health assessment process, we are conducting interviews with leaders in the community and focus groups with residents to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty. The findings from these conversations will inform decisions around future investments to improve the community's health.

- Our interview will last about 30-40 minutes. After all of the data gathering is completed, we will be writing a summary report of the general themes that have emerged during the discussions. We will not include any names or identifying information. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

1. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY OR IF COMMUNITY LEADER NOT AFFILIATED WITH ORGANIZATION]

a. [PROBE ON ORGANIZATION: What is your organization's mission/services? What communities do you work in? Who are the main clients/audiences?]

   i. Prior to the pandemic, what were some of the biggest challenges your organization faced in conducting your work in the community?
   ii. During the pandemic, what are some of the biggest challenges your organization has faced in conducting your work in the community? What new challenges do you anticipate going forward?

b. Do you currently partner with any other organizations or institutions in your work? Have there been any changes in these partnerships in light of the pandemic and its economic consequences?

III. COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (15-20 MINUTES)

2. How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)

c. How have you seen the community change over the last several years?

d. What do you consider to be the community's strongest <u>assets/strengths?</u>

For the following questions, please consider issues and concerns your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

e. What are some of its <u>biggest concerns/issues</u> in general? What challenges do residents face in their day-to-day lives? [PROBE ON, IF NOT YET MENTIONED: transportation; affordable housing; discrimination; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.) <u>REPEAT QUESTIONS FOR DIFFERENT ISSUES]</u>

   i. What population groups (geography, age, race/ethnicity, immigration status, gender, income/education, etc.) do you see as being most affected by these issues?

   ii. How has [ISSUE] affected their daily lives?

3. What do you think are the most pressing health concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICS. PROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19]

    a. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]

        i. From your experience, what are peoples' biggest challenges to addressing [THIS ISSUE]?

        ii. To what extent, do you see [BARRIER] to addressing this issue among the residents you work with/your organization serves?

    [PROBE ON BARRIERS BROUGHT UP/MOST APPROPRIATE FOR POPULATION GROUP: Cost or economic hardship, transportation, stigma, attitudes towards seeking services, built environment, availability/access to resources or services, knowledge of existing resources/services, social support, discrimination, insurance coverage, etc.]

4. What are current or emerging trends that could have an impact on the public health system or the community? Has anything become apparent due to the Coronavirus pandemic?

IV. *TAILORED SECTION* - SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT YET BROUGHT UP. (5-10 MINUTES)

For Interviewees Working in Housing and Transportation

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- What barriers do you see residents experiencing around accessing affordable and healthy housing? How about with transportation?
- What has been working well in the city to improve access to healthy, affordable housing? How about related to transportation? What has been challenging or not working well? Where are there opportunities for improvement or innovation?
- Are there any approaches to improving housing or transportation access that you think will have to change in light of the pandemic, social distancing, and economic impacts?

For Interviewees Working in Financial Instability, Employment, and Workforce Development

- In the wake of the pandemic and expected ongoing social distancing measures, what challenges are residents facing regarding hiring, employment, or job security?
- Thinking back to the time before the pandemic, what were the needs in this community around workforce development? What was previously needed to improve residents' employability? What training or resources were needed?
- Now that the pandemic and social distancing measures have changed so much about the economy and employment options, what are the NEW needs in this community around workforce

development? What is NOW needed to improve residents' employability? What training or resources are needed to adapt to this new reality?

For Interviewees Working with Communities where Immigration and/or Discrimination is a Concern
For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- What are some of the specific challenges around immigration issues or discrimination that your communities face? How has this changed since the pandemic?
- What should health care and social service providers consider when treating health and other issues in diverse populations? How can institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)

For Interviewees Working with Seniors/Older Adults
I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues the population you work with faces as a result of the pandemic? What do you anticipate will be the longer-term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected seniors in this region before the pandemic – and now?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working in the Areas of Violence, Trauma, and Safety
[For interviewees working on domestic violence:] I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues that the population you work with faces as a result of the pandemic, social distancing, and economic crisis? What do you anticipate will be the longer term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- In the wake of the pandemic, and expected ongoing social distancing measures, what challenges are community members facing regarding domestic or interpersonal violence?
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working in the Areas of Substance Use or Mental Health
I expect that the past weeks and months have been very difficult, considering the work you do. Thank you again for providing your unique perspective to this important work.

- Could you describe the emerging issues the population you work with faces as a result of the pandemic, social distancing, and economic crisis? What do you anticipate will be the longer term needs?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- In the wake of the pandemic, and expected ongoing social distancing measures, what challenges are community members facing regarding substance use or mental health?

- What are your major concerns for the future? What has been going "right" that could be built on going forward?

V. VISION FOR THE FUTURE (10-15 MINUTES)

5. I'd like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What's your vision?

    a. What do you see as the next steps in helping this vision become reality?

    b. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?

6. As you think about your vision, what do you think needs to be in place to support <u>sustainable</u> change?

    a. How do we move forward with lasting change across <u>organizations and systems</u>?

    b. Where do you see yourself or your organization in this?

7. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

VI. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. This is a very difficult time for everyone, and your perspective about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

APPENDIX D: FOCUS GROUP GUIDE

Health Resources in Action
Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
Westborough, Westwood, and Woburn Service Areas
General Focus Group Guide

Goals of the focus group:

- To determine perceptions of the strengths and needs of the community
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.

- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON AS A GROUP.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- A few months ago, Partners HealthCare began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these around the region with a wide range of people - community members, government officials, leaders in the faith community, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.

- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.

- We will be conducting several of these discussion groups around the area. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.

- We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the note-taking. No one but the analysts at Health Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me turning the recorder on now?

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS (10 minutes)

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share– such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ASSETS AND CONCERNS

1. Today, we're going to be talking a lot about the community that you live in. How would you describe your community?

For the following questions, we will be discussing the strengths and concerns in your community, both prior to the coronavirus pandemic, and now. To begin with, please think back to a time before the pandemic – for example, in December during the holiday season.

2. Thinking about a few months before the coronavirus pandemic -- If someone was thinking about moving into your community, what would you have said are some of its biggest strengths about your community - or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

    a. What would you have said were the biggest problems or concerns in your community back then – a few months before the pandemic? [PROBE ON ISSUES IF NEEDED – HEALTH, ECONOMIC, SOCIAL, SAFETY, ETC.]

3. What do you think were the most pressing *health* concerns in your community back in December?

    a. How did these health issues affect your community? In what way?

    b. What specific population groups were most at-risk for these issues?

Next, please think about the same issues, now, in the midst of the pandemic, and moving forward. RIGHT NOW….

4. What do you think are the biggest strengths about your community? What are the most positive things about it? Are they different than before? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

5. What do you think are the biggest concerns in your community now? Are they different than before?

6. What do you think are the most pressing ***health*** concerns in your community now? How are they different?

7. Social isolation, anxiety, concerned about going out

    a. How do these health issues affect your community? In what way?

        i. What are the biggest barriers or challenges that people have to seeking services for these issues?

    b. What specific population groups are most at-risk for these issues?

IV. PERCEPTIONS OF HEALTH ISSUES, HEALTH CARE AND BARRIERS

What are the top three issues that were mentioned? It would be good to discuss issues that have arisen during the current health crisis, as well as issues that were big concerns before, that are ongoing or may return. (If needed, identify together or vote on top 3 issues.) Let's talk about some of the issues.

8. Do you agree with this list? Is there anything missing?
9. Traffic, affordable housing, accessing heath, technology – internet issues, transportation, navigating MassHealth, childcare, don't feel comfortable going out

10. What do you see as some of the biggest barriers or challenges to addressing these issues?

11. What do you think the community should do to address these issues? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

V. SPECIFIC PROBES FOR DISTINCT POPULATION GROUPS (10 minutes)

For Groups Where Housing and Transportation are a Concern
For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- How much of an issue is affordable housing in your community? How has it impacted your day-to-day life?
- What barriers do residents (or you) experience around accessing affordable and healthy housing? How hard is it to find housing that is appropriate for you/your family?
- How much of an issue is accessing transportation? How has it impacted your day-to-day life?
- Are there any approaches to improving housing or transportation access that you think will have to change in light of the pandemic, social distancing, and economic impacts?

For Groups Where Financial Instability, Employment & Workforce are a Concern

- Thinking back to the time before the pandemic (for example, during the holiday season), what challenges were residents (or you) facing back then regarding hiring, employment, or job security?

- [PROBE FOR THOSE WHERE ENGLISH ISN'T PRIMARY LANGUAGE]- How much do your language skills limit the type of job you can get?

- Now that the pandemic and social distancing measures have changed so much about the economy and employment options, what are the NEW needs in this community around employment? What is NOW needed to improve residents' employability?
- When people or families that you know are dealing with financial hardship, what are some of the issues that are most weighing on them? How do they deal with that?
- What resources or support do residents (or you) need to address financial hardship?

For Groups Where Immigration and Discrimination are Concerns

For the following questions, please consider issues your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

- Have you ever felt discriminated against because of your race, ethnicity, language, or where you were born? What specifically?
  - Have you encountered this when trying to seek specific services (e.g., housing, healthcare, employment, education)?
- What are some of the specific challenges that your community faces related to immigration issues or discrimination? How has this changed since the pandemic?
- What should health care providers consider when treating health issues in diverse populations? How can health care institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)

VI. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT

12. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?

    a. What do you think needs to happen in the community to make this vision a reality?

    b. Who should be involved in this effort?

13. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive funding?

VII. CLOSING

Thank you so much for your time. This is a very difficult time for everyone, and your perspective about the communities you live in will be a great help in determining how to improve the systems that affect the health of this population.

That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

APPENDIX E: SURVEY INSTRUMENT

Partners Ambulatory Care (PAC) Mass General Brigham CHNAs
- Community Priorities Survey

Unformatted version of the online survey

To complete the survey in Spanish, please use the drop-down menu above to select your language.
To complete the survey in Portuguese, please use the drop-down menu above to select your language.
To complete the survey in Mandarin, please use the drop-down menu above to select your language.

Being a healthy community is about more than delivering quality health care to residents. Where you live, learn, work, and play all have an enormous impact on your health.

Partners HealthCare is hoping to get a better understanding of the health of residents in your community—including all the factors that affect a community's health—and which community needs are most important to address. Please take this survey to provide feedback. It should take no more than 5-10 minutes. Filling out the survey is voluntary, and your responses are anonymous. You will not be asked your name, address, or any other information that can identify you.

This study has been underway for several months, starting before the coronavirus spread in the U.S. We recognize this is a unique time we are in. With the coronavirus crisis, understanding the community's needs and strengths has become even more important. This survey will be asking you about your concerns now, as well as several months ago.

Thank you for your time and participation. At the end of this survey is an opportunity to enter a raffle for a $200 Amazon gift card. Thank you for your feedback to improve your community's health.

1. What zip code do you live in? _____

2. We recognize this is a unique time we are in. We would like to understand what issues have **personally affected you and your family** now and 6 months ago – around the time of the holiday season. For each issue, please check if the issue was something that affected you or your family personally now and/or 6 months ago - or has not affected you or your family at either time period. You can check any that apply.

	Currently affects me or my family.	**Affected me or my family 6 months ago**	**Does not affect me or my family now nor 6 months ago.**
Financial insecurity/unemployment/lack of job opportunities	O	O	O
Problems getting workforce training to get job skills	O	O	O

Concerns around housing (such as finding affordable housing, fear of eviction, overcrowding, housing quality)	O	O	O
Problems getting to places because of lack of transportation	O	O	O
Cannot be active/get exercise because of lack of sidewalks or parks	O	O	O
Hard to eat well because of lack of supermarkets/lack of healthy food options I can afford	O	O	O
Fear of safety in the community/community violence (gangs, robberies. etc.)	O	O	O
Fear of safety at home/domestic violence (spouse or partner abuse, child abuse)	O	O	O
Discrimination because of my race, ethnicity, gender, language, sexual orientation, country of origin, etc.	O	O	O
Mental health issues (such as depression, anxiety, etc.)	O	O	O
Alcohol and drug (marijuana, heroin, opioids, etc.) use	O	O	O
Chronic or long-term diseases (like cancer, diabetes, heart disease, stroke, etc.)	O	O	O
Overweight/obesity	O	O	O
Coronavirus/COVID-19	O	O	O
Other infectious diseases (like pneumonia, flu, etc.)	O	O	O
Concerns related to older adults (dementia/Alzheimer's, falls, etc.)	O	O	O
Concerns related to children (premature birth, developmental delays, ADHD, etc.)	O	O	O
Problems getting the health or social services I need because they are not available in my community	O	O	O
Other: _____	O	O	O

2a - If you or your family felt discriminated against recently or in the last 6 months, what do you think are the <u>main reasons</u> for these experiences? (Please check all that apply.)

- o Your race
- o Your ethnicity, ancestry, or country of origin

- Your language
- Your gender
- Your sexual orientation
- Your religion
- Your education or income level
- Some aspect of your physical appearance (e.g., height, weight, disability, etc.)
- Prefer not to answer/Don't know

3. Either now or in the past 6 months, have any of these factors made it <u>harder</u> for you to get the medical, mental health, or social services (like housing, food, job training, etc.) you have needed? (Please check all that apply.)

- Services not available in my community
- Lack of information/ I don't know what services are available or where to go
- Lack of transportation
- Cost of services
- Lack of evening or weekend services
- Unfriendly staff or providers
- Felt discriminated against because of my race, ethnicity, gender, language, sexual orientation, country of origin, etc.
- Afraid to ask questions or talk to staff or providers
- Afraid if I take the time off to get services, I'll lose my job
- Long wait for an appointment
- My information is not kept confidential
- Language problems/could not communicate with staff or provider
- None of the above
- Other (Please specify) _____

4. Now we'd like to ask you about your community overall. Your community can be your town, your neighborhood, the group of people you care about, etc. What do you see as the overall **strengths** of your community? (Please check all that apply.)

- o My community has medical services to address physical health conditions that people can access.
- o My community has mental health services that people can access.
- o My community has social services (e.g. food, job training, etc.) that people can access.
- o My community has good schools.
- o My community has good public transportation.
- o My community has enough parks/green space.
- o My community has sidewalks so residents can take a walk easily and safely.
- o My community has bike paths so residents can bike easily and safely.
- o My community helps people in need.
- o Neighbors know each other in this community.
- o People care about improving this community.
- o People feel like they belong in this community.
- o My community has people of many races and cultures.
- o People can deal with challenges in this community.
- o When people have disagreements, they are able to resolve their differences and determine a path forward.
- o There are innovations and new ideas in this community.
- o People accept others who are different than themselves in this community.
- o None of the above.
- o Other (Please specify) _____

5. Please think about the most important issues in your community for taking action. Consider the following when thinking about these issues:

   - **Concern:** *How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?*
   - **Equity:** *Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?*
   - **Effectiveness:** *Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?*
   - **Feasibility:** *Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?*

Given these questions, **what are the top 5 most important issues for action in your community <u>in the next few years</u>?** (Please check 5.)

Financial insecurity/unemployment/lack of job opportunities	O
Workforce training to get job skills	O
Housing (such as finding affordable housing, fear of eviction, overcrowding, housing quality)	O
Transportation issues	O
Availability of sidewalks or parks	O
Availability of supermarkets/healthy food options people can afford	O
Safety in the community/community violence (gangs, robberies. etc.)	O
Safety in people's homes/domestic violence (spouse or partner abuse, child abuse)	O
Addressing systemic racism/racial injustice	O
Mental health issues (such as depression, anxiety, etc.)	O
Alcohol and drug use (marijuana, heroin, opioids, etc.)	O
Chronic or long-term diseases (like cancer, diabetes, heart disease, stroke, etc.)	O
Overweight/obesity	O
Coronavirus/COVID-19 testing and/or the possibility of a new outbreak	O
Other infectious diseases (like pneumonia, flu, etc.)	O
Concerns related to older adults (dementia/Alzheimer's, falls, etc.)	O
Concerns related to children (premature birth, developmental delays, ADHD, etc.)	O
Availability of health or social services in the community	O
Other (please specify): _____	O

It is helpful to get an understanding of who is answering this survey to ensure we get a cross-section of perspectives. Please answer the following questions, which are anonymous.

6. What category best describes your age?

- ○ Under 18 years old
- ○ 18-29 years old
- ○ 30-49 years old
- ○ 50-64 years old
- ○ 65-74 years old
- ○ 75 years old or older

7. What is your current sex or gender identity?

- Male
- Female
- Transgender Male
- Transgender Female
- Additional Gender Category: _____

8. What is your sexual orientation?

- Straight/heterosexual
- Gay or lesbian
- Bisexual
- Prefer to self-describe: _____

9. How would you describe your ethnic/racial/cultural background? (Please check all that apply.)

- African American/Black
- American Indian/Native American
- East Asian /Pacific Islander (e.g. Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, the Philippines, Samoa)
- South Asian (e.g., India, Pakistan, Bangladesh, Sri Lanka, Nepal)
- White
- Hispanic/Latino(a)
- Middle Eastern/North African
- Other (please specify) _____

10. What is the primary language(s) spoken in your home? (Please check all that apply.)

- English
- Spanish
- Portuguese/Cape Verdean Creole
- Chinese (including Mandarin and Cantonese)
- French or Haitian Creole
- Russian
- Hindi
- Arabic
- Other (Please specify) _____

11. Were you born in the United States?

- Yes (automatic skip pattern to Q13)
- No (automatic skip pattern to Q12)
- Prefer not to answer (automatic skip pattern to Q13)

12. If no, how long have you lived in the United States?

- Less than 1 year
- 1 year to less than 3 years
- 3 years to less than 5 years
- 5 years to less than 10 years
- 10 years to less than 15 years
- 15 years to less than 20 years
- 20 years or more
- Prefer not to answer

13. What is the highest level of education that you have completed?

- Primary or middle school
- Some high school
- High school graduate or GED
- Some college
- Associate or technical degree/certificate
- College graduate
- Graduate or professional degree

14. What is your current employment status? (Please check all that apply)

- Employed full-time
- Employed part-time
- Not employed and currently looking for work
- Student
- Retired
- Stay-at-home parent / significant other
- Unable to work

15. Has your financial situation gotten worse, improved, or stayed the same since coronavirus/COVID-19?

- Gotten worse
- Has improved
- Has stayed the same

16. What was your total household income before taxes during the past 12 months?

- Less than $25,000
- $25,000 to $34,999
- $35,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 to $199,999
- $200,000 or more
- I don’t know or don’t want to say

This concludes our survey. Thank you for your time. We greatly appreciate your participation. Participants who complete this survey are eligible to enter a raffle for a $200 Amazon gift card. You will be automatically redirected to a form after this survey to enter the raffle. Your name and information will not be connected to the responses on your survey.

APPENDIX F: ADDITIONAL SURVEY DATA

Appendix Table 1: CHNA Community Priorities Survey Respondent Characteristics

	Number	%
Age		
Under 18 years old	0	0.0%
18-29 years old	26	5.6%
30-49 years old	177	37.8%
50-64 years old	171	36.5%
65-74 years old	86	18.4%
75 years old or older	8	1.7%
Sex or Gender identity		
Male	108	23.2%
Female	355	76.2%
Transgender Male	1	0.2%
Other Gender Cat	2	0.4%
Sexual Orientation		
Straight/heterosexual	437	93.8%
Gay or lesbian	12	2.6%
Bisexual	13	2.8%
Prefer to self-describe	4	0.9%
Ethnic/racial/cultural background*		
African American/Black	10	1.8%
American Indian/Native American	1	0.2%
East Asian /Pacific Islander	16	2.9%
South Asian	6	1.1%
White	425	77.0%
Hispanic/Latino(a)	12	2.2%
Middle Eastern/North African	3	0.5%
Other	3	0.5%
Primary language(s) spoken at home*		
English	457	82.8%
Spanish	8	1.4%
Portuguese/Cape Verdean Creole	3	0.5%
Chinese (including Mandarin and Cantonese)	3	0.5%
French or Haitian Creole	2	0.4%
Russian	1	0.2%
Hindi	1	0.2%
Arabic	0	0.0%
Other (Please specify	8	1.4%

	Number	%
Born in the United States		
Yes	429	93.1%
No	30	6.5%
Prefer not to answer	2	0.4%
Length of time living in the United States**		
Less than 1 year	0	0.0%
1 year to less than 3 years	0	0.0%
3 years to less than 5 years	0	0.0%
5 years to less than 10 years	1	3.3%
10 years to less than 15 years	3	10.0%
15 years to less than 20 years	5	16.7%
20 years or more	20	66.7%
Prefer not to answer	1	3.3%
Highest level of education		
Primary or middle school	1	0.2%
Some high school	1	0.2%
High school graduate or GED	14	3.0%
Some college	44	9.5%
Associate or technical degree/certificate	33	7.1%
College graduate	162	35.1%
Graduate or professional degree	207	44.8%
Current employment status*		
Employed full-time	262	47.5%
Employed part-time	72	13.0%
Not employed and currently looking for work	31	5.6%
Student	11	2.0%
Retired	73	13.2%
Stay-at-home parent / significant other	21	3.8%
Unable to work	14	2.5%
Total household income in last 12 months		
Less than $25,000	18	4.0%
$25,000 to $34,999	14	3.1%
$35,000 to $49,999	17	3.7%
$50,000 to $74,999	52	11.4%
$75,000 to $99,999	56	12.3%
$100,000 to $149,999	101	22.2%
$150,000 to $199,999	70	15.4%
$200,000 or more	60	13.2%
I don’t know or don’t want to say	68	14.9%

NOTE: Asterisk (*) indicates the question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%; Double asterisk (**) indicates that the question includes only those who specified not being born in the United States.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Appendix Table 2: Percent of CHNA Community Priorities Survey Respondents Reporting Being Affected Currently and/or 6 months ago by Issues, by Type of Issue, 2020

	Number	Affected Currently Only	Affected 6 Months Ago Only	Affect Both Currently and 6 Months Ago	Never Affected
Accessing health or social services	521	6.0%	2.1%	1.9%	90.0%
Alcohol and drug use	522	7.1%	3.5%	2.5%	87.0%
Cannot be active due to lack of sidewalks or parks	521	14.0%	4.0%	1.5%	80.4%
Chronic or long-term diseases	525	22.3%	2.7%	7.2%	67.8%
Community violence	522	5.8%	2.5%	1.3%	90.4%
Concerns around housing	519	6.6%	4.2%	1.7%	87.5%
Concerns related to children	521	8.6%	1.7%	4.6%	85.0%
Concerns related to older adults	525	21.1%	3.4%	8.8%	66.7%
Coronavirus/COVID-19	515	19.8%	4.5%	3.1%	72.6%
Discrimination	518	5.2%	2.5%	3.5%	88.8%
Domestic violence	519	0.8%	1.4%	0.6%	97.3%
Financial insecurity	546	29.1%	7.1%	4.6%	59.2%
Lack of access to affordable healthy food	521	8.1%	5.8%	1.7%	84.5%
Lack of transportation	522	6.3%	2.7%	1.9%	89.1%
Mental health issues	530	33.0%	7.0%	10.6%	49.4%
Other infectious diseases	519	3.1%	8.5%	0.6%	87.9%
Overweight/obesity	520	26.0%	3.5%	9.4%	61.2%
Problems getting workforce training	519	8.5%	3.7%	0.8%	87.1%
Other issue	259	6.2%	0.0%	0.4%	93.4%

NOTE: Question in the survey allowed for multiple responses; therefore, percentages may not add up to 100%.
DATA SOURCE: PAC CHNA Community Priorities Survey, 2020.

Attachment C-1

Massachusetts Department of Public Health
Determination of Need
Community Health Initiative
CHNA / CHIP Self Assessment

Version: 8-1-17

This self-assessment form is to understand the Community Engagement process that has led/ will lead to the identification of priorities for community health planning processes. It is being used to demonstrate to DPH that an existing community health planning process adequately meets DPH standards for community engagement specific to Determination of Need, Community Health Initiative purposes.

This form will provide the basic elements that the Department will use to determine if additional community engagement activities will be required. When submitting this form to DPH, please also submit your IRS Form 990 and Schedule H CHNA/CHIP and/or current CHNA/ CHIP that was submitted to the Massachusetts Attorney General's Office. Additionally, the Applicant is responsible for ensuring that the Department receives Stakeholder-Assessments from the stakeholders involved in the CHNA / CHIP process.

All questions in the form, unless otherwise stated, must be completed.

Approximate DoN Application Date: 01/21/2021 DoN Application Type: Ambulatory Surgery and Clinic Substantial Capital Expenditure

What CHI Tier is the project? ○ Tier 1 ○ Tier 2 ◉ Tier 3

1. DoN Applicant Information

Applicant Name: Mass General Brigham Incorporated

Mailing Address: 800 Boylston Street, Suite 1150

City: Boston State: Massachusetts Zip Code: 02199

2. Community Engagement Contact Person

Contact Person: Kristen Barnicle Title: Executive Director for Community Health

Mailing Address: 399 Revolution Drive, 10W70-17, Suite 1005

City: Somerville State: Massachusetts Zip Code: 02145

Phone: 8572821421 Ext: E-mail: kmmason@partners.org

3. About the Community Engagement Process

Please indicate what community engagement process (e.g. the name of the CHNA/CHIP) the following form relates to. This will be use as a point of reference for the following questions and does not need to be a fully completed CHNA or implemented CHIP.
(please limit the name to the following field length as this will be used throughout this form):

2020 Westborough CHNA

4. Associated Community Health Needs Assessments

In addition to the above engagement process, please list Community Health Needs Assessments and/or Community Health Improvement Planning Processes, if any that the Applicant been involved with in the past 5 years (i.e. CHNA/CHIP processes not led by the Applicant bur where the Applicant was involved?

(Please see page 22 of the Community-Based Health Initiative Guidelines for reference http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf)

Add/ Del Rows	Lead Organization Name / CHNA/CHIP Name	Years of Collaboration	Name of Lead Organizer	Phone Number	Email Address of Lead Organizer
+ -					

5. CHNA Analysis Coverage

Within the 2020 Westborough CHNA , please describe how the following DPH Focus Issues were analyzed DoN Health Priorities and Focus Issues (please provide summary information including types of data used and references to where in the submitted CHNA/CHIP documents these issues are discussed):

5.1 Built Environment

In regard to data, the 2020 Westborough service area CHNA aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels—from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality) - which have an impact on the community's health.

To identify the health and social determinant of health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the Westborough service area; conducting a community priorities survey with 159 residents (in multiple languages, including: English, Spanish, Portuguese, and Chinese); facilitating 8 virtual focus groups with specific populations of interest (e.g. parents of school-age children; residents seeking essential services; residents who are immigrants; and youth); and conducting 12 key informant interviews with key stakeholders in the community. In addition, data collected for the 2019 MetroWest Community Health Assessment (CHA)—an extensive process that engaged 22 communities in the Westborough service area—were also used for this report, including data from the MetroWest Adolescent Health Surveys.

Built Environment:
Many Westborough Community Priorities Survey respondents and focus groups participants described access to green space as an asset to their community, describing ample access to parks and recreational activities. However, this perspective differed from youth focus group participants and some residents from Westborough, Northborough, and Hopkinton who reported the need for more bicycle and hiking trails. One shared, "I wish we had bike trails. There's one in Marlborough but it's too far for me to access. There's some hiking trails but it's not safe to go biking there." Figure 23 on page 34 shows an open space map of the service area that identifies all of the bike trails around Westborough.

Figure 24 on page 35 and Figure 25 on page 36 provide maps of the density of retail food outlets and fast food restaurants throughout the service area. Several communities, Framingham and Marlborough, have the highest density of retail food outlets, which are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry, as well as the most density of retail fast food outlets.

Information regarding the Built Environment may be found on the following pages of the CHNA report: vii, 33-36.

Transportation:
Mirroring findings from the 2019 MetroWest CHA, transportation was identified as one of the top day-to-day concerns for many residents who participated in the assessment. Youth focus group participants, immigrants, and residents seeking essential services expressed concern about the timeliness and accessibility of public transportation, especially for those who were essential workers and for young people. One youth focus group participant explained, "If you're going someplace, you have to take [multiple] buses just to get there. There's not a lot of stops and the buses pass by once in a blue moon. When I have to get to work at 3pm, but the bus only comes at 1pm or 4pm, I either have to leave 2 hours earlier or be late." Residents suggested considering creative solutions to transportation challenges, such as investing in bicycle share programs, electronic scooters, and alternatives to single-occupancy vehicles.

According to the Census Bureau's American Community Survey, in 2014-2018, 70.2% of people in Massachusetts over the age of 16 commuted to work alone in a vehicle. In the Westborough service area, this figure ranges from 66.1% in Westborough to 85.3% in Berlin. Public transportation was most commonly used in Westborough. In 2014-2018 the average time spent commuting to work for residents in the Westborough service area ranged from 29.2 minutes in Hudson to 37.6 and 37.8 minutes in Hopkinton and Bolton, respectively.

Information regarding Transportation may be found on the following pages of the CHNA report: iv, vii, viii and 32-33.

Food Access and Insecurity Information:
When asked about challenges to accessing social or other essential services, participants spoke in terms of challenges during the COVID-19 pandemic, reporting many services being curtailed at the height of the pandemic. The most frequently described challenge related to seeking essential services was access to food and childcare. One interviewee summarized, "After the pandemic, residents became worried about food. Our agency didn't do that before, but now we've had to create an emergency food bank. We've been working on food access since April and have made thousands of food bags for residents since then."

Key informant interviewees explained how residents have now started prioritizing basic needs over other essentials needs, e.g. telephone and internet, which limits their ability to stay employed, and connected to healthcare, social services, and education. One interviewee shared "What we've begun to see over the last two weeks is that there is no phone in the household. People have used their resources for food and shelter and these other things are secondary in terms of what they're dealing with. The phone becomes the obstacle with really being able to communicate with families."

In addition, interviewees noted the need to offer more culturally sensitive services. For example, in regard to food access, one interviewee shared, "We have a large immigrant population and there's a misalignment with the food that's delivered to them. Providing culturally appropriate food has been a challenge and we don't have it. We get caught between the mindset of 'any kind of food is good because it's food' versus giving out a product that actually makes sense." Key informant interviews also discussed limited resources at community-based organizations and social service agencies for linguistic services.

Access to Basic Needs Including Healthy Food
Increased supports for navigating health and social service landscapes were suggested by several assessment participants, namely those who were seeking essential services and parents. As previously mentioned, accessing healthy food was a frequent concern raised by interviewees and focus group participants alike. Suggestions were made to expand food services and modernize systems that currently limit capacity, so community-based groups may address the magnitude of needs. For example, multiple key informants expressed the desire for an automated system that can be used at food pantries. One summarized, "Our food pantries in the area need to have delivery systems. That would begin to level the playing field. Why can't someone who is poor or in need have food brought to their house the way I do from Wegman's or Instacart? Instead they have to wait hours in line or hours in a parking lot. How many things would that solve in the sense of a dignity standpoint, from an equity standpoint…an efficiency standpoint?"

Information regarding Food Access and Insecurity may be found on the following pages of the CHNA report: vi, vii, 73, 75, 76 and 79.

5.2 Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. Massachusetts stands out as a state with an exceptionally high proportion of residents with college, graduate, and professional degrees (42.9% in 2014-2018; Figure 17 on page 26). In the Westborough region, from 2014-2018, Bolton (31.4%), Hopkinton (31.8%), and Westborough (31.2%) had the largest number of residents, age 25 and over, with a graduate or professional degree. Berlin, Framingham, Hudson, Marlborough, and Milford had the largest populations with a high school diploma or less. Focus group participants who were parents, as well as those who were immigrants, described the education system as an asset of these communities. One shared, "We have a ton of different school choices and they all offer different programs." Other focus group participants agreed that education was a strength of their community, but perceived that the high demand was burdening the school system, sharing "People are flocking here for the education. The schools are really good and well-ranked, but they're already bursting at the seams even though the buildings are brand new."

While there is an increased incidence of higher educational levels in the region, it still varies by race/ethnicity. Table 4 on page 27 shows the proportion of residents over the age of 25 with a bachelor's degree or higher by race and ethnicity between 2014-2018. In Bolton, 66.5% of non-Hispanic Whites had a bachelor's degree or higher, compared to 39.0% in Milford. In Northborough, 89.7% of non-Hispanic Black residents over age 25 had a bachelor's degree or higher, compared to 23.6% in Grafton.

In terms of education and COVID-19, assessment participants discussed concerns with the re-opening of schools. Many participants noted challenges for both students and parents coping with uncertainty about the school year. One parent shared, "Remote learning is impossible if you have [multiple] kids. Hopkinton is going to a hybrid version of school, but there are still a lot of issues. My son's attention space is not good to just stare at a screen and try to stay focused." Children in need of special education services and early intervention were described as especially vulnerable during this uncertain time.

Information regarding Education may be found on the following pages of the CHNA report: iv, vi, viii, 26 and 27.

5.3 Employment

Economic uncertainty due to loss of employment was discussed in focus groups with residents seeking essential services and across all interviews. Participants shared experiences of struggling to meet basic needs, such as housing and accessing healthy food. A lack of employment opportunities was described as especially difficult for young people, seniors, and immigrants. As one youth focus group participant described, "It's difficult because people my age [20] want to be getting jobs but the only places you can get them are in retail and that's where people are not wearing masks. So, if you want to work, you're signing up to be an essential worker." Access to meaningful employment for young people, especially teenagers and young adults, was identified as a critical gap to address in multiple

conversations.

Assessment participants also shared their perspectives on how COVID-19 has disproportionately impacted vulnerable groups, such as undocumented immigrants, sharing, "At the beginning of COVID, we were seeing a whole underground of [undocumented] people who were housekeepers and factory workers and landscapers who did not have access to any of the stimulus money. They were not in the position to be waiting for a check."

Multiple interviewees from social service agencies described the challenges of retaining staff, particularly employees of color, because of the inability to offer adequate compensation. Due to low pay, they are struggling to make ends meet and need to balance multiple jobs. One interviewee summarized, "We don't have adequate funding to pay our essential workers a living wage. Most of our staff have 2-3 jobs. The staff employed at human service organizations also are economically disadvantaged—many of them are people of color—and are disproportionately affected by COVID-19 because of their race and socioeconomic status."

The impact of the COVID-19 pandemic and resulting economic shutdown in many sectors is reflected in unemployment data from towns in the Westborough service area, between April 2019 and June 2020 (Figure 16 on page 25). Unemployment rates continued to increase from April 2020 to June 2020 in all towns except Hudson. In April 2019, Massachusetts as a whole, and each city or town in the area had unemployment rates under 3%. However, during the pandemic, unemployment rates increased to 17.5% statewide in June 2020, with similar patterns in the majority of towns in the service area, particularly Milford (16.1%), Marlborough (15.8%), Hudson (15.8%) Framingham (15.2%).

Information regarding Employment and Workforce may be found on the following pages of the CHNA report: iii, iv, viii, x, 23-25.

5.4 Housing

Safe and affordable housing is integral to the daily lives, health, and well-being of a community. The high and rising cost of housing in the Westborough service area was a frequent theme to emerge from qualitative discussions. Participants expressed concern for seniors and "middle class" residents that are struggling to afford the price of living in the Westborough service area. One focus group participant shared, "There's not enough affordable housing for seniors in the MetroWest area. For an older adult who is also say—an immigrant as well—it's tough for them because there's not a lot of [affordable housing] options around. You have to maintain your home with less cash and rely on local nonprofits to help."

Participants also noted that affordable housing in the Westborough area is limited and wait lists for subsidized housing are long. One interview participant explained, "New apartment complexes are being developed in South Framingham, basically gentrification happening right in front of them. The cost of living there is not what they can afford. Even what's considered affordable units is not what they can pay." Given the high cost of housing and limited affordable options, residents in these areas are often forced to live in tight quarters and overcrowded conditions, making them more vulnerable to COVID-19.

Interviewees reported that immigrants are currently at-risk of being housing insecure because of tenancy-at-will situations—or agreements between tenants and landlords where there is no formal contract specifying the length of time during which the tenancy will take place. One interview participant explained, "[Most of our COVID- 19] cases in Framingham are in the immigrant community because they live in tight quarters. Those tenants are at will and that situation does not afford eviction protection. They pay high rates and then are being legally fleeced because they sign an agreement but they're being taken advantage of." Another interviewee added, "We have a fair number of people who do not live in traditional places with a lease. They're in a room in a house with a landlord who didn't give them a lease, and so they come home one day, and their locks are changed…their stuff is gone. And they're unable to have any recourse for that."

In Massachusetts, 62.3% of housing units were owner-occupied versus 37.7% renter-occupied (Figure 18, page 29). In most of the towns around Westborough, owner-occupied units were more common than in the state overall, for example 93.0% in Bolton and 89.6% in Southborough. The exceptions were Framingham (55.1%), Marlborough (57.1%), and Westborough (62.3%).

The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage and 50% of all renters in Massachusetts reported spending spend more than 30% of their income on housing costs (Figure 19, page 30). Many of the towns around Westborough are similar in regard to owner-occupied units, with a range of 16.0% in Shrewsbury to 38.5% in Berlin. In Bolton, 68.4% of renters are considered housing insecure and spend more than 30% of their income on housing.

Median monthly housing costs for owner-occupied households with a mortgage ranged from $1,966 in Milford to $3,222 in Bolton

(Figure 20 on page 31). Median monthly housing costs for renter-occupied households in 2014-2018 ranged from $849 in Upton to $1,740 in Hopkinton (Figure 21 on page 31).

Access to affordable housing was among the most commonly discussed issues in qualitative discussions and Westborough Community Priorities Survey findings. Not only are housing options limited for low to moderate income individuals, but there are many community members who are in nontraditional homes without leases. Suggestions were made to increase legal protections for tenants who may be in these at-will tenancy agreements. Residents also expressed a desire for more affordable housing for seniors that could facilitate the growing population's ability to age in place. One interviewee explained, "There's an increased demand [for housing] as people remain in the community and age in place. It's expensive to live in MetroWest and there's not a lot of options. Seniors have to maintain their homes with less cash." In terms of COVID-19, residents expressed concern about the lingering economic impact of the pandemic on housing affordability, foreclosures, and homelessness.

Information regarding Housing may be found on the following pages of the CHNA report: iv, vii, viii, x, 27-31, and 75-77.

5.5 Social Environment

Various aspects of the community social and economic environment for the Westborough service area are described throughout pages 16-39 of the CHNA Report.

Specifically, issues around Discrimination and Racism are discussed on pages 39-40 of the report. Participants reported that similar to the national dialogue—more emphasis on racial justice has been occurring in the Westborough service area. Perceptions related to discrimination and racism varied throughout qualitative discussions. Focus group participants who identified as people of color mentioned incidences of being discriminated against because of their race or nationality. For example, a young person shared, "I don't know if it's a string of bad luck, but I see a lot of discrimination against me and my mom. We're both immigrants, and English isn't our first language. She speaks with an accent, and we speak Spanish together, and people automatically assume things about us." Other participants validated the experience and added that residents may not identify with the terms "discrimination" and "racism." "A lot of people don't call it discrimination and racism…they'll say they've been treated poorly. They won't outwardly say the word bias, but they'd say they're being looked at."

The assessment survey supports these findings. Among the Westborough Community Priorities Survey respondents reporting that they themselves or their family members experienced discrimination in the past six months (15.7% of total sample), more than 59% of community survey respondents reported themselves or their family being affected by discrimination in the past six months. Similarly, more than half of respondents indicated being affected by discrimination because of their ethnicity, ancestry, or country of origin; and 33.3% reported it was due to their gender (Figure 30 on page 40).

As at the national level, conversations about racial justice and policing have been taking place in the Westborough service area. Multiple assessment participants described vigils or protests in their communities in response to the killing of Black Americans at the hands of police. A few pointed to tensions around police sentiments and the Black Lives Matter movement. Community leaders interviewed for the assessment described their commitment to addressing racial injustice and systemic racism. One shared, "Everything we do moving forward will be focused on an anti-racism agenda. For any entity that wants to expand to our community, we'll be asking "tell us what you're thinking about anti-racism, and what is your internal and external agenda for the community."

5.6 Violence and Trauma

Assessment participants generally described the Westborough service area as a safe place to live and work. However, several key informants described concerns that cases of domestic violence and neglect would worsen during the pandemic. One key informant shared, "We think there's more domestic abuse. There's a lot going on now with the lack of trust with police. We're really concerned that things are happening at home and they're not calling police because they're afraid of them." No secondary data related to domestic violence were available at the local level. However, Jane Doe Inc.—the statewide coalition against sexual and domestic violence—reports that as of December 15, 2019, there were 24 domestic violence homicide incidents, resulting in 28 domestic violence victims and 7 perpetrator suicides or death across Massachusetts.

In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied strikingly across the towns around Westborough. Framingham (348.9) and Marlborough (417.0) both had rates higher than the state average of 338.1 incidents per 100,000 residents (Figure 26 on page 37). Property crime (i.e. burglary, larceny, and auto theft) is much more common than violent crime. In 2018, in the area around Westborough, property crime was most common in Marlborough (1,138.5 per 100,000 residents), Framingham (1,130.9), and Berlin (1,024.2) (Figure 27 on page 37). In 2018, burglary was most common in Westborough (197.6 per 100,000 population; and larceny was most common in Marlborough (943.8).

Data from the MetroWest Adolescent Health Surveys show that the percent of high school and middle school students reporting violent

behaviors in the MetroWest region has been trending down since 2012 (Figure 28 on page 38). Though physical violence seems to be declining, in 2012-2018, between one third and one quarter of MetroWest middle school students reported being victims of bullying (Figure 29 on page 39). The prevalence of bullying was consistently lower among high school students. Prevalence of cyber-bullying was below 22% for both Middle and High School students.

Information regarding Crime and Violence may be found on the following pages of the CHNA report: iv and 36-39.

5.7 The following specific focus issues

a. Substance Use Disorder

Participants expressed some concerns about substance use in the Westborough service area, though it was not a key theme discussed in most groups. This result differs from findings from the 2016 and 2019 MetroWest CHA, where substance use was ranked as the greatest health concern by community health respondents in 2016 and 2019. Specific types of substance use mentioned as concerns by participants included: alcoholism, vaping, and misuse of prescription medication. One focus group participant who was a parent shared, “Alcohol is always an issue here because it’s the most accessible. I think the way that parents are coping with that stress is alcohol. I think that it’s a big problem in suburbia and I think the kids feel that.” Underage drinking was also discussed as a concern, though quantitative data show that the percent of students reporting alcohol use in the MetroWest area has decreased since 2012 (Figure 48 on page 57). Similar to state trends, prescription drug misuse has steadily decreased among high school students in the area from 8.8% in 2012 to 4.8% in 2018 (Figure 47 on page 56).

While concern about opioids was mentioned among some assessment participants, data indicate that there have been several opioid overdose related deaths in the region in some towns. From 2014-2019, Massachusetts had around 2,000 opioid-related overdose death each year, with the fewest deaths in 2014 (1,365) and the most deaths in 2016 (2,094). By town, Framingham, Marlborough, and Hudson had the largest number of opioid overdose related deaths in the region (Table 6 on page 57).

Opioids were discussed by a few assessment participants who reported that use is more prevalent in rural areas. There were perceptions that Marijuana use has been normalized and concerns about it being a “gateway drug” for youth. In 2012, 2.4% of middle school and 21.5% of high school students reported current marijuana use, highlighting this developmental stage as a key point of marijuana initiation. Though youth focus group participants did not identify Marijuana as a concern and more frequently discussed electronic cigarettes as an issue in their communities. Quantitative data support these findings. While secondary data show cigarette use decreasing among youth, vaping use has substantially increased since 2014, with 18.4% of MetroWest high school students reporting active use in 2014, versus 28.1% in 2018 (Figure 48 on page 57).

Concerns about whether there is adequate treatment available for substance use was mentioned. Figure 49 on page 58 shows the rate of Bureau of Substance Addiction Services Enrollments in 2016-2017 for the region. These rates ranged from 344.4 per 100,000 population in Southborough to 1,195.6 per 100,000 population in Milford, with high substance use addiction service enrollment rates in Framingham and Hudson as well.

Information regarding Substance Use Disorders may be found on the following pages of the CHNA report: v and 55-58.

b. Mental Illness and Mental Health

Similar to key findings from the 2019 MetroWest CHA, when asked to identify health issues of greatest concern in the community, the majority of focus group participants and interviewees mentioned mental health. Stress, anxiety, depression, and isolation were the most frequently cited challenges among the Westborough service area, with residents describing how COVID-19 has exacerbated mental health issues in the community. These issues were noted as particularly problematic for young people, seniors, those who identified as LGBTQ, and immigrants. As described in the Top Issues Affecting the Community section, concern for mental health was the leading health issue reported by Westborough Community Priorities Survey respondents. However, between 2012-2014, the percent of adults reporting 15 or more days of poor mental health in the last month was lower in the Westborough service area than the state overall. By town, the percent of adults reporting 15 or more days of poor mental health in the last month ranged from 7.8% in Westborough to 10.2% in Framingham, compared to 11.1% in Massachusetts (Figure 42 on page 51).

Similarly, mental health hospitalizations in the area were slightly lower than the state overall, except in Marlborough. In 2014, the age-adjusted rate of mental health hospitalizations per 100,000 population was 934.4 in Massachusetts. By town, the age-adjusted rate of mental health emergency department visits ranged from 401.0 per 100,000 population in Upton to 1,100.0 per 100,000 population in Marlborough (Figure 43 on page 52).

In focus group and interview discussions, mental health concerns among youth were mentioned frequently. Those youth from more affluent communities described "achievement anxiety" among youth due to high-pressure environments. Residents from these areas described a culture of competition that negatively impacts young people. One shared "There's this 'keeping up with the Jones' mentality in Hopkinton…an appearance to keep up with." Another parent agreed and added, "My high schoolers are overwhelmed- getting panic attacks about all of the events and activities. Most families I know are in a large amount of activities like sports, arts, enrichment classes, scouting. There's very little downtime for kids. So when the pandemic hit, you can imagine how drastic the shift was." This is supported by quantitative data gathered even before the pandemic. Youth participating in the MetroWest Adolescent Health Surveys who report that their lives have been "very stressful" has steadily increased since 2012, from 28.9% to 36% in 2018 (Figure 44 on page 53).

In 2012, 12.8% of middle school and 19.7% of high school students in MetroWest reported depressive symptoms in the past 30 days. In 2018, prevalence was 14.3% and 19.7%, respectively. Riskier behaviors, such as self-injury among youth, also are a concern. In 2012, 7.8% of middle school and 15.6% of high school students in MetroWest reported engaging in intentional self-injurious behaviors in the past 12 months (Figure 45 on page 54). In 2018, prevalence was 9.7% and 13.5%, respectively. Statewide, self-injury was reported by 14.5% of high school students and 16.8% of middle school students in 2017. Findings from the 2018 MetroWest Adolescent Health Surveys reveal disparate mental health findings for a number of sub-groups. Specifically, the report notes that "females continue to report depressive symptoms and self-injury around twice as much as males" (in 2018, self-injury was reported by 19% of females and 8% of males). Additionally, LGBTQ youth report elevated levels of mental health problems. Compared with heterosexual cisgender youth, these youth are more than 2.5 times as likely to report depressive symptoms (41% vs. 16%) and more than three times as likely to report self-injury (35% vs. 10%), seriously considering suicide (32% vs. 10%), and attempting suicide (10% vs. 3%)." These data are validated by experiences shared by focus group participants. For example, one LGBTQ identifying youth shared, "The suicide rate is high. I've had 9 close friends of mine commit suicide and I'm only 19 years old. They were all LGBTQ."

Many focus group and interview participants discussed how their concerns around youth mental health are exacerbated with the pandemic. Those with school-age children shared the challenges of remote learning and the stress that comes with the uncertainty of the coming school year. Participants shared that these challenges further increase when there is more than one child in the household. Many worried about the long-term impact of the pandemic and lack of socialization on the community's children and youth.

Focus group participants who were parents also discussed the importance of digital wellness—which refers to preventative measures aimed at regulating and improving the healthy use of technology, especially in light of COVID-19. One focus group participant shared, "Technology and digital wellness is a major problem. Kids are getting smart phones when they are really young. They have free access to the internet, and they are getting addicted to the devices." Another parent agreed and added, "The digital world makes everything harder. Kids are more distracted, and they are constantly comparing themselves to others on [social media]."

Trauma was also discussed among interview and focus group participants in regard to mental health. Participants described caregivers as a group that have experienced high levels of trauma during the pandemic, with one sharing, "There's a degree of trauma associated with caregivers throughout the pandemic. I can't tell you how many people we have die in residential services. For essential workers, our residential staff, ER staff, and health care providers, there's a grief associated with the number of people lost in our community."

Systemic issues to adequately address mental health concerns in the community were discussed by multiple key informants. Mental health workforce challenges included low reimbursement for mental health services, which makes it difficult for provider organizations to recruit and retain qualified staff. One participant summarized, "There are funding structures in place that are not adequate, and it makes it hard for social service agencies to have ready access to highly trained clinicians. If you have a rate that is not sufficient, then you can't pay people as much as you would like, and there's always [financial] losses for the agency."

Information regarding Mental Health may be found on the following pages of the CHNA report: ii, v, vii, ix, x and 50-55, 75, 77 and 81.

c. Housing Stability / Homelessness

Access to affordable housing was among the most commonly discussed issues in qualitative discussions and

Westborough Community Priorities Survey findings. Not only are housing options limited for low to moderate income individuals, but there are many community members who are in nontraditional homes without leases. Suggestions were made to increase legal protections for tenants who may be in these at-will tenancy agreements. Residents also expressed a desire for more affordable housing for seniors that could facilitate the growing population's ability to age in place. One interviewee explained, "There's an increased demand [for housing] as people remain in the community and age in place. It's expensive to live in MetroWest and there's not a lot of options. Seniors have to maintain their homes with less cash." In terms of COVID-19, residents expressed concern about the lingering economic impact of the pandemic on housing affordability, foreclosures, and homelessness.

Housing affordability and transportation continue to be concerns in the Westborough service area. Consistent with findings from the 2019 MetroWest CHA, housing affordability was identified as a pressing concern, particularly for seniors and "middle class" residents. Many renters across the area, especially in towns, such as Bolton (68.4%) and Hopkinton (52.1%), are spending more than 30% of their income on housing costs. Tenancy-at-will situations—or agreements between tenants and landlords where there is no formal contract specifying the length of time during which the tenancy will take place – negatively impact already-vulnerable residents, such as undocumented immigrants and seniors. In terms of public transportation, participants described limited options that are often unreliable and cumbersome. Suggestions to invest in alternate modes of transportation, such as bicycle share programs and incentives to reduce single-occupancy vehicles.

Information regarding Housing Stability and Homelessness may be found on the following pages of the CHNA report: 75-77.

d. Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes

Assessment participants did not cite specific chronic diseases as pressing concerns in their communities, with the exception of a few focus group participants who discussed obesity, cardiovascular disease, and cancer. Cognitive issues including Alzheimer's disease and dementia were also noted as a concern for the growing senior community. One interviewee summarized, "We have a growing senior community and as they age will need substantial supports. We're already seeing a lot of issues with aging like dementia and other memory loss impairments at the ages of 85 and up. Whether it's mild or huge it takes a toll on older adults."

Overweight and Obesity:
In 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 49.7% in Bolton to 64.2% in Milford (Figure 34 on page 44). The percent of adults consuming five or more fruits and vegetables daily in Massachusetts was 18.9% in 2011-2015. By town, the percent of adults consuming 5 or more fruits and vegetables daily ranged from 15.7% in Milford to 23.6% in Shrewsbury (Figure 33 on page 43). Overweight and obesity was mentioned by a few assessment participants who were parents, especially as it related to childhood obesity and COVID-19. One focus group participant shared, "I worry about the kids who aren't able to play sports anymore because of COVID and the impact it will have on the kids' health and childhood obesity."

Among public school students in the MetroWest region, about 80% of middle school students were achieving at least 20 minutes of exercise on 3 or more days per week between 2012 and 2018 (Figure 35 on page 44). For high school students, the physical activity target is higher (at least 60 minutes on 5 or more days per week). About half of students achieved this target between 2012 and 2018.

Heart Disease:
While focus group and interview participants mentioned issues related to obesity and healthy eating, they did not discuss any specific chronic conditions such as heart disease, cancer, or diabetes as significant issues of concern. However, cancer and heart disease are still considered the top two leading causes of death in the Westborough service area. In 2012-2014, the percent of adults reporting angina or coronary heart disease (CHD) in Massachusetts was 3.9%. By town, the percent of adults reporting angina or CHD ranged from 2.9% in Ashland and Hopkinton to 3.7% in Framingham (Figure 36 on page 45).

In 2014, the age-adjusted rate per 100,000 population of heart disease emergency department visits was 596.0 in Massachusetts. By town, the age-adjusted rate of heart disease emergency department visits ranged from 279.4 per 100,000 population in Southborough to 723.6 per 100,000 population in Milford (Figure 37 on page 46).

In 2014, the age-adjusted rate per 100,000 population of heart disease hospitalizations was 1,563.1 in Massachusetts. By town, the age-adjusted rate of heart disease hospitalizations ranged from 1,046.3 per 100,000 population in

Southborough to 1,828.2 per 100,000 population in Milford (Figure 38 on page 47).

Diabetes:
In 2012-2014, the percent of adults reporting diabetes in Massachusetts was 9.0%. By town, the percent of adults reporting diabetes ranged from 5.5% in Grafton to 8.4% in Marlborough (Figure 39 on page 48).

In 2014, the age-adjusted rate of diabetes hospitalizations per 100,000 population was 158.9 in Massachusetts. By town, the age-adjusted rate of diabetes hospitalizations ranged from 53.5 per 100,000 population in Grafton to 188.2 per 100,000 population in Upton. Data for several towns are not reported due to insufficient sample size (Figure 40 on page 48).

In 2014, the age-adjusted rate of diabetes emergency department visits per 100,000 population was 143.1 in Massachusetts. By town, the age-adjusted rate of diabetes emergency department visits ranged from 55.2 per 100,000 population in Grafton to 161.9 per 100,000 population in Hudson. Data for several towns were not reported due to insufficient sample size (Figure 41 on page 49).

Cancer:
Cancer continues to be the leading cause of death in Massachusetts. In 2009-2013, by town, standardized incidence ratios (SIR) for breast cancer in females ranged from 88 (Milford) to 120 (Upton). These ratios indicate that the incidence of breast cancer in females was 12% lower in Milford and 20% higher in Upton than expected based on standardized rates for the state of Massachusetts (expected rate is 100). The incidence of prostate cancer in males ranged from 27% lower than expected in Ashland (SIR 73) to 20% higher than expected in Milford (SIR 120). The incidence of lung and bronchus cancer ranged from 43% lower than expected in Bolton (SIR 57) to 16% higher than expected in Billerica (SIR 116). The incidence of colorectal cancer ranged from 29% lower than expected in Upton (SIR 72) to 16% higher than expected in Grafton (SIR 116) (Table 5 on page 50).

In a few interviews, the concern around cancer was mentioned specifically related to poor working conditions. It was perceived that there was an increase of lung cancer in domestic workers due to the harsh chemicals in the cleaning products. One interviewee explained, “We started seeing an increase of Brazilian women who clean houses get cancer because of exposure to cleaning agents. Cleaning agents were designed for 1-time use…they have ammonia; but if you’re using it all day, there’s accumulation in your lungs.”

Information regarding Chronic Diseases may be found on the following pages of the CHNA report: 5 and 42-50

6. Community Definition

Specify the community(ies) identified in the Applicant's 2020 Westborough CHNA

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
+ -	Berlin	
+ -	Bolton	
+ -	Grafton	
+ -	Northborough	
+ -	Shrewsbury	
+ -	Upton	
+ -	Westborough	

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
+ -	Framingham	
+ -	Ashland	
+ -	Hopkinton	
+ -	Hudson	
+ -	Malborough	
+ -	Milford	
+ -	Southborough	

7. Local Health Departments

Please identify the local health departments that were included in your 2020 Westborough CHNA . Indicate which of these local health departments were engaged in this 2020 Westborough CHNA . For example, this could mean participation on an advisory committee, included in key informant interviewing, etc. (*Please see page 24 in the Communit further description of this requirement* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf.)

Add/ Del Rows	Municipality	Name of Local Health Dept	Name of Primary Contact	*Email address*	Describe how the health department was involved
+ -	Hudson	Hudson Board of Health	Christie Vaillancourt		Key informant interviewee
+ -	Framingham	Framingham Board of Health	Sam Wong		Key informant interviewee

8. CHNA / CHIP Advisory Committee

Please list the community partners involved in the CHNA/CHIP Advisory Committee that guided the 2020 Westborough CHNA . (please see the required list of sectorial representation in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) Please note that these individuals are those who should complete the *Stakeholder Engagement Assessment* form. It is the responsibility of the Applicant to ensure that DPH receives the completed *Stakeholder Engagement Assessment* form:

Add/Del Rows	Sector Type	Organization Name	Name of Primary Contact	Title in Organization	Email Address	Phone Number
	Municipal Staff	See Attachment A				
	Education					
	Housing					
	Social Services					
	Planning + Transportation					
	Private Sector/ Business					
	Community Health Center					
	Community Based Organizations					
+ -						

8a. Community Health Initiative

For Tier 2 and Tier 3 CHI Projects, is the the Applicant's CHNA / CHIP Advisory Board the same body that will serve as the CHI advisory committee as outlined in the Table 1 of the Determination of Need Community-Based Health Initiative Guideline (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-chi-planning.pdf)?

(●) Yes ( ) No

9. Engaging the Community At Large

Thinking about the extent to which the community has been or currently is involved in the 2020 Westborough CHNA , please choose one response for each engagement activity below. Please also check the box to the left to indicate whether that step is complete or not. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
☒ Assess Needs and Resources	○	○	○	○	○	○
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	See Attachment B-1					
☒ Focus on What's Important	○	○	○	○	○	○
Please describe the engagement process employed during the "Focus on What's Important" phase.	See Attachment B-1					
☒ Choose Effective Policies and Programs	○	○	○	○	○	○
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	See Attachment B-1					
☒ Act on What's Important	○	○	○	○	○	○
Please describe the engagement process employed during the "Act on What's Important" phase.	See Attachment B-1					
☒ Evaluate Actions	○	○	○	○	○	○
Please describe the engagement process employed during the "Evaluate Actions" phase.	See see Attachment B-1					

10. Representativeness

Approximately, how many community agencies are currently involved in 2020 Westborough CHNA within the engagement of the community at large?

12 Agencies

Approximately, how many people were engaged in the process (please include team members from all relevant agencies and independent community members from the community at large)?

200 Individuals

Please describe the diversity of the people who have been engaged in the process both within the CHNA/CHIP Advisory Committee and the community at large. Explicitly describe how the process included diverse representation from different groups/individuals with varied gender, sexual orientation, race/ethnicity, disability status, international status and age. Please see page 10 and Appendix A of *the Community Engagement Standards for Community Health Planning Guideline* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) for further explanation of this.

First, the CAB is comprised of diverse individuals representing different races and ethnicities, as well as sexual orientation and genders. These CAB members bring different perspectives to the CHI and these diverse opinions lead to more equitable processes. Second, Mass General Brigham and Health Resources in Action sought to engage a diverse group of stakeholders in the Westborough service area through community surveys conducted in multiple languages, diverse focus groups and key informant interviews. For more information on the diversity of participants in the CHNA process, please see the CHNA Report.

Please describe the type of representation that was/is employed in the community engagement process and the rationale for that type of representation. For more information on types of representation and representativeness, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines (*http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf*)*. Please include descriptions of both the Advisory Board and the Community at large.

For the 2020 PAC - Westborough CHNA, staff used both a grass tops and grassroots approach. In regard to grass tops efforts, staff ensured that "varied and representative sectorial diversity was present to encourage innovation, build and enhance pre-existing work, provide sufficient representation and understand the levers by which population health could be improved." Consequently, many individuals from diverse groups were included in the overall strategy, data collection and engagement aspects of the CHNA, including school districts, public health departments, community-based organizations, private sector entities, municipal representatives, etc. By collaborating with these individuals from diverse groups, new perspectives were provided on all areas of the needs assessment processes.

Additionally, MGB also used a grassroots approach engaging the public whenever possible, but specifically in the public prioritization meetings to determine the needs of the service area. This process will be expanded upon if the DoN is approved through the utilization of Ad Hoc Subcommittees. These Submcommittees will be comprised of stakeholders from the service area who will advise the Community Advisory Board on local needs and priorities.

To your best estimate, of the people engaged in 2020 Westborough CHNA approximately how many: Please indicate the number of individuals.

Number of people who reside in rural area	0
Number of people who reside in urban area	0
Number of people who reside in suburban area	191

11. Resource and Power Sharing

For more information on Power Sharing, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

By community partners, we mean agencies, organizations, tribal community, health departments, or other entities representing communities.

By Applicant partners, we mean the hospital / health care system applying for the approval of a DoN project

	Community Partners	Applicant Partners	Both	Don't Know	Not Applicable
Which partner hires personnel to support the community engagement activities?	○	◉	○	○	○
Who decides the strategic direction of the engagement process?	○	○	◉	○	○
Who decides how the financial resources to facilitate the engagement process are shared?	○	◉	○	○	○
Who decides which health outcomes will be measured to inform the process?	○	○	◉	○	○

12. Transparency

Please describe the efforts being made to ensure that the engagement process is transparent. For more information on transparency, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines*.

Focus groups, interviews and surveys were conducted with the community at large and publicized by Health Resources in Action and the organization's community partners. The community survey was translated into multiple languages (English, Spanish, Portuguese, and Chinese) and focus groups and interviews with non-English speaking residents were conducted in the common language of choice. Community focus groups were open to the public and sought to reduce barriers to participation by having groups at different times of day, etc. Finally, participants from the service area were engaged in all elements of the CHNA, including the prioritization meetings.

13. Formal Agreements

Does / did the 2020 Westborough CHNA have written formal agreements such as a Memorandum of Agreement/ Understanding (MOU) or Agency Resolution?

○ Yes, there are written formal agreements ◉ No, there are no written formal agreements

Did decision making through the engagement process involve a verbal agreement between partners?

○ Yes, there are verbal agreements ◉ No, there are no verbal agreements

14. Formal Agreement Specifics

Thinking about your MOU or other formal agreement(s), does it include any provisions or language about:

	Yes	No	Don't Know	Doesn't Apply
Distribution of funds	○	○	○	○
Written Objectives	○	○	○	○
Clear Expectations for Partners' Roles	○	○	○	○
Clear Decision Making Process (e.g. Consensus vs. Voting	○	○	○	○
Conflict resolution	○	○	○	○
Conflict of Interest Paperwork	○	○	○	○

15. Document Ready for Filing

When the document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to DPH" button.

This document is ready to file: ☐ Date/time Stamp:

E-mail submission to DPH

E-mail submission to Stakeholders and CHI Advisory Board

When providing the Stakeholder Assessment Forms to the community advisory board members(individuals identified in Section 8 of this form), please include the following information in your correspondence with them. This will aid in their ability to complete the form:

A) Community Engagement Process: 2020 Westborough CHNA

B) Applicant: Mass General Brigham Incorporated

C) A link to the DoN CHI Stakeholder Assessment

Attachment C-2

Massachusetts Department of Public Health
Determination of Need
Community Health Initiative
CHNA / CHIP Self Assessment

Version: 8-1-17

This self-assessment form is to understand the Community Engagement process that has led/ will lead to the identification of priorities for community health planning processes. It is being used to demonstrate to DPH that an existing community health planning process adequately meets DPH standards for community engagement specific to Determination of Need, Community Health Initiative purposes.

This form will provide the basic elements that the Department will use to determine if additional community engagement activities will be required. When submitting this form to DPH, please also submit your IRS Form 990 and Schedule H CHNA/CHIP and/or current CHNA/ CHIP that was submitted to the Massachusetts Attorney General's Office. Additionally, the Applicant is responsible for ensuring that the Department receives Stakeholder-Assessments from the stakeholders involved in the CHNA / CHIP process.

All questions in the form, unless otherwise stated, must be completed.

Approximate DoN Application Date: 01/21/2021

DoN Application Type: Ambulatory Surgery and Clinic Substantial Capital Expenditure

What CHI Tier is the project? ○ Tier 1 ○ Tier 2 ◉ Tier 3

1. DoN Applicant Information

Applicant Name: Mass General Brigham Incorporated

Mailing Address: 800 Boylston Street, Suite 1150

City: Boston State: Massachusetts Zip Code: 02199

2. Community Engagement Contact Person

Contact Person: Kristen Barnicle Title: Executive Director for Community Health

Mailing Address: 399 Revolution Drive, 10W70-17, Suite 1005

City: Somerville State: Massachusetts Zip Code: 02145

Phone: 8572821421 Ext: E-mail: kmmason@partners.org

3. About the Community Engagement Process

Please indicate what community engagement process (e.g. the name of the CHNA/CHIP) the following form relates to. This will be use as a point of reference for the following questions and does not need to be a fully completed CHNA or implemented CHIP.
(please limit the name to the following field length as this will be used throughout this form):

2020 Westwood CHNA

4. Associated Community Health Needs Assessments

In addition to the above engagement process, please list Community Health Needs Assessments and/or Community Health Improvement Planning Processes, if any that the Applicant been involved with in the past 5 years (i.e. CHNA/CHIP processes not led by the Applicant bur where the Applicant was involved?

(Please see page 22 of the Community-Based Health Initiative Guidelines for reference http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf)

Add/ Del Rows	Lead Organization Name / CHNA/CHIP Name	Years of Collaboration	Name of Lead Organizer	Phone Number	Email Address of Lead Organizer
+ -					

5. CHNA Analysis Coverage

Within the 2020 Westwood CHNA , please describe how the following DPH Focus Issues were analyzed DoN Health Priorities and Focus Issues (please provide summary information including types of data used and references to where in the submitted CHNA/CHIP documents these issues are discussed):

5.1 Built Environment

In regard to data, the 2020 Westwood service area Community Health Needs Assessments (CHNA) aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels— from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health. To identify the health and social determinant of health needs of the Westwood service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the service area; conducting a community survey (in multiple languages, including: English, Spanish, Portuguese, and Chinese) with 481 respondents from the Westwood service area; conducting 8 virtual focus groups with 27 participants and 10 key informant interviews with 12 individuals representing a variety of organizations, such as local non-profits including those serving youth and seniors, local health departments, and town administrators and services. Due to COVID-19, it should be noted that while efforts were made to engage residents through virtual qualitative and survey data collection, the capacity of community organizations to assist with outreach and the capacity of community members to participate was limited. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

Built Environment:
In regard to the Built Environment, many participants described access to green and recreational space as an asset to the communities of the Westwood service area. This perspective was shared by community members who described their towns as "suburban" or "rural", as well as participants who lived in Boston neighborhoods, such as Hyde Park, "a small town in the middle of the city." Some participants also noted that, during the COVID-19 pandemic, they saw more residents biking and walking; other participants stated that outdoor recreation can be challenging, particularly for seniors or for residents who have trouble wearing masks. When discussing the built environment, one participant also noted that this area has "a fair amount of shopping and grocery stores." Figure 30 on page 57 of the CHNA Report illustrates recreational space, conservation space, and bike trails in the Westwood service area.

Overdevelopment was raised as a concern by many participants. These participants described apartments, luxury condominiums, and large houses being built in the area. For example, one participant noted that: the "small houses in town, instead of getting redone, they are getting torn down and then big complexes go up." Participants raised questions about how this development would impact the green space in their towns and neighborhoods, as well as whether an influx of new residents would impact the school system. For example, one participant asked: "They're putting in all of these apartments – what will that bring? Will it overflow the school systems? Will it increase traffic?" When discussing concerns about development some participants also raised concerns about discrimination, with one participant noting that "Housing is controversial for many reasons. Structural racism, it's NIMBY [Not in my Backyard], it's all that" and another participant sharing that "people are very clear about their ideas about building apartments and what kind of people that brings or what type of students will that bring."

Figure 31 on page 38 and Figure 32 on page 39 of the CHNA Report show maps of the Westwood service area for the density of retail food outlets and fast food restaurants in the area. Several communities, such as West Roxbury, Hyde Park, and Norwood have the highest density of retail food outlets, which are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Canton and Walpole have the least density of retail food outlets. However, many of the same communities, including Canton and Dedham, also have high rates of fast food restaurants.

Information regarding the Built Environment may be found on the following pages of the CHNA report: iv, 37-39.

Transportation:
Perceptions of transportation access differed among communities in the Westwood service area. In some communities, such as Hyde Park, participants described public transportation as an asset of the community. For example, one participated stated that "one of the things that I like the best of living in Hyde Park is that there's a lot of access to transportation, like the bus routes." However, many participants described transportation as a major concern for towns in the Westwood service area. Participants noted that public transportation is limited and, while there are some taxi voucher programs, vans, and The Ride, these transit options are still limited and/or irregular. While many of the communities in the Westwood service area have a commuter rail or bus stop, participants were concerned about the "first mile, last mile" and how residents could get to these transit stops. As one participated described: "if you don't have a vehicle then you're not getting around Needham."

Participants described specific transportation concerns, as well as concerns for certain populations including low-wage workers, seniors, and students. For example, in Norwood, participants noted that “Route 1 divides the town” and that “A lot of the industries that lower income workers work in are located on Route 1… [so] people have to walk across Route 1… because [there is] no transportation from residential areas.” Some participants also noted that transportation for students is needed, with one interviewee stating that the community needs “transportation for students; that’s been a hurdle.” Lastly, transportation for seniors was a common concern, with participants describing a need for additional on demand transportation to medical appointments (including in Boston), as well as transportation for seniors to do social activities.

In 2014-2018, 70.2% of people in Massachusetts over age 16 commuted to work alone in a vehicle (Table 7, page 35). In Westwood service area, this ranged from 61.2% in the Hyde Park neighborhood of Boston to 74.7% in Walpole and 74.6% in Norwood. Commuting by public transportation was most common in Hyde Park (25.3%), Westwood (17.3%), and West Roxbury (17.1%).

Information regarding Transportation may be found on the following pages of the CHNA report: ii, iv, vii, viii, and 34-36.

Food Insecurity:
Within in the Income and Financial Security Section of the CHNA Report, food insecurity was discussed. The reports states, "Many interview and focus group participants expressed concern about food insecurity in the Westwood service area. Interview participants who run food pantries and home-delivered meal programs described a notable increase in use of their services during the pandemic. As one interviewee remarked when describing the increase in food insecurity due to COVID-19: 'There were people right on the edge that have been pushed over due to the pandemic.'"Again, participants highlighted seniors, as well as families, who may have been relying on schools for their children’s meals, as particularly vulnerable groups.

Information regarding Food Insecurity may be found on the following page of the CHNA report: 22.

5.2 Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. As described above, many focus group and interview participants viewed the school systems as strong assets in the Westwood service area. Some participants cited the area’s school systems, and the opportunities they offer for students, as a reason that they moved to or remained in these communities. In addition to strong academics, some participants also noted that the school systems foster a sense of community and, in the words of one participant, “really focus on a student as a whole person… [and want] to develop social and emotional skills.” However, some participants pointed to a lack of diversity within these communities and within the school system, and one participant noted that some families come to these communities “for the schooling and then they leave.”
CConcerns about education in the context of the COVID-19 pandemic were raised by many participants. Many participants noted the challenges for both parents and students alike coping with the uncertainty of what the school systems will look like for the 2020-2021 school year. Participants expressed concerns about the challenges of social distancing if students return to in-person education, with one noting that “They aren’t going to be wearing masks how they should”. However, participants also expressed concerns about the challenges of virtual learning and social and emotional development if students participate in online learning, with one parent noting that “[I’m] worried about the learning aspect for next school year – from a developmental and social aspect of it.” Participants in particular expressed concern for students who may have underlying health conditions and for students who have special needs, such as autism.

Echoing perceptions of area school systems in the Westwood service area, Massachusetts stands out as a state with an exceptionally high proportion of residents with college, graduate, and professional degrees (42.9%; Figure 20, page 27). In the Westwood service area, Dover (49.9%), Needham (44.9%), and Medfield (37.9%) had the largest proportions of residents with a graduate or professional degree in 2014-2018. In contrast, Hyde Park (25.9%), Norwood (22.2%), Dedham (21.0%), and Walpole (20.0%), had the highest proportions of residents with no more than a High School diploma among those 25 years and older.

Table 5 on page 28 of the CHNA Report illustrates additional patterns in educational attainment across towns, by race/ethnicity. For some towns, interpretation is limited given the small number of residents by race in certain educational brackets. Other findings reveal considerable variations among different demographic groups, for example 7.4% of non-Hispanic White residents of Hyde Park over age 25 did not have a High School diploma in 2014-2018, compared with only 1.4% in Dover and 1.2% in Medfield. In Norwood, only 3.7% of Asian residents did not graduate High School, compared to 23.7% in Hyde Park. In Walpole and West Roxbury, about 30% of Hispanics/Latinos did not graduate High School, compared to only 5.2% in Canton. Again, these data illustrate the striking socioeconomic variation within broad categorizations of race/ethnicity in this region.

In contrast, Table 6 (page 29) shows the percent population over age 25 with a bachelor’s degree or higher by race/ethnicity in the Westwood service area in 2014-2018. Wide variation is again apparent, with over 90% of Asians in Dover and over 80% of Asians in

Norwood and Walpole having a bachelor's degree or higher, compared to only 39.9% of those in Hyde Park and 65.9% of those in West Roxbury. In Dover 81.6% and in Needham 76.5% of non-Hispanic Whites have a bachelor's degree or higher, compared to 45.7% of Whites in Norwood and 52.2% of Whites in Walpole. In Medfield and Walpole, less than 20% of Black residents have a bachelor's degree or higher, compared to 47.3% in Needham and 56.2% in Canton.

Among current public high school students in 2019, graduation rates were high across the region, ranging from 90.7% in Dedham to 98.1% in Westwood (Figure 21, page 30). Graduation rates were lower for Boston Public School students overall (73.2%) which is not specific to the two Boston neighborhoods in this service area (neighborhood data unavailable).

Information regarding Education may be found on the following pages of the CHNA report: iii and 26-30.

5.3 Employment

While unemployment rates in the Westwood service area have historically been low, employment status has been impacted by the COVID-19 pandemic, as reflected in both the qualitative and quantitative data. Many focus group and interview participants shared their perspectives on how COVID-19 has impacted employment in the Westwood service area. Participants noted that some community members have experienced job loss and others had their employment hours reduced, both of which impact financial security. As one focus group participant described, "In my job, they cut my hours to half and that really affected me financially. No one is prepared to lose half of their wages overnight."

Some focus group participants suggested that virtual trainings or skill-building sessions be developed for community members who have lost jobs and may even need to consider a career change. Participants also expressed concern for essential workers, naming cashiers and restaurant workers in particular, and noted that these essential workers are often paid low wages even while they are risking their lives. For example, one focus group participant stated: "The essential workers are getting paid so much less than people who work from home… It's like our lives are less important but they give us this term 'essential'?"

Participants also shared the perspective that certain populations, including young people, Spanish speakers, and parents in need of childcare, may be particularly vulnerable to job loss. One focus group participant described the importance of youth employment to the financial security of a household as follows: "Lots of teenagers help their families with finances and if they don't have that help, they can sink quickly." Participants also noted that finding employment can be particularly challenging for community members who do not speak English fluently. For example, one focus group participant stated that: "So many people that I know don't have a job anymore. They had to look for other jobs but there are none, especially if you don't speak English fluently." Lastly, many participants noted that when schools and daycares are closed, parents are unable to return to work in-person and also face challenges working remotely. Some participants stated that colleagues or community members have left the workforce due to a lack of childcare during the pandemic. One focus group participant described the situation as follows: "The majority of Latinos can't work from home, and who is supposed to take care of their children? They can't decide if it's better to have school from home because they need to work."

The impact of the coronavirus pandemic and resulting economic shutdown in many sectors are reflected in unemployment data from towns in the area around Westwood, between April 2019 and April 2020. Unemployment rates continued to increase from April 2020 to June 2020. In 2019, Massachusetts as a whole, and each city or town in the service area had unemployment rates under 3%, and in one case (Needham), under 2% (Figure 19, page 26). However, during the pandemic, unemployment rates increased significantly to 16.0% statewide in April, with similar (e.g. Norwood, 15.9%) or lower (e.g. Needham, 8.4%) rates in the Westwood service area. As with other measures, Dover, Needham, and Westwood appear to be faring better than other towns during this economic crisis.

Information regarding Employment and Workforce may be found on the following pages of the CHNA report: iii and 24-26.

5.4 Housing

Housing affordability in the Westwood service area was raised as a concern in most of the interviews and focus groups. Many participants described an extremely high cost of housing in the Westwood service area and noted that high housing prices apply to both homeowners with mortgages and renters. Participants expressed concern for the "middle class" that "make very good money [but] are living paycheck to paycheck because it's so expensive" to live in these communities. Many participants stated that the area is not affordable for young adults, single parents, or seniors. For example, when describing Hyde Park, one focus group participant stated that "Single parents couldn't afford to live here." Participants noted that recent housing developments, such as condominiums and apartment complexes, have made these areas even more unaffordable (see "Built Environment" below for more information on development in these areas).

Participants also stated that affordable housing in these communities is very limited, and that wait lists are very long for the affordable housing that does exist. As one participant described, "Needham doesn't have a lot of affordable housing and the [wait] list is very long."

Given the high cost of housing and the lack of affordable housing options, participants noted that some families are living in crowded or doubled-up situations in order to afford rent. Additionally, in the context of the COVID-19 pandemic, some participants expressed concerns about an increase in homelessness as a result of rising unemployment. For example, one focus group participant stated: "I'm sure that a lot of people are on the verge of homelessness."

In Massachusetts, 62.3% of housing units are owner-occupied versus 37.7% renter-occupied (Figure 22, page 31). In most of the towns around Westwood, owner-occupied units are more common than in the state overall, for example 92.2% of housing units in Dover and 87.0% of housing units in Medfield are owner-occupied. The exceptions to this statistic are Hyde Park and Norwood, where 52.3% and 58.3% of housing units are owner-occupied, respectively.
The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage spend more than 30% of their income on housing costs (Figure 23, page 32). Many of the towns around Westwood are similar, with a range of 23.8% in Medfield to 38.5% in Hyde Park.

Cost burden may not be associated with housing affordability in especially wealthy areas. For example Dover (27.3%) and Dedham (26.3%) have similar proportions of owner-occupied units spending over 30% of their income on housing, even though median housing costs are much higher in Dover ($4,000/month) than Dedham ($2,437/month) (Figure 24, page 32).

In comparison, more renters tend to spend more than 30% of their income on housing costs compared to homeowners, even though their median monthly housing costs are lower. In the Westwood service area, 72.0% of rental units in Dover and 63.8% of rental units in Medfield were occupied by residents who spent over 30% of their income on housing costs (Figure 25, page 33). In Norwood, this was only 39.7%.

Information regarding Housing may be found on the following pages of the CHNA report: iv, viii, and 30-33.

5.5 Social Environment

Various aspects of the community social and economic environment for the Westwood service area are described throughout pages 13-42 of the CHNA Report.

Specifically, issues around Discrimination and Racism are discussed on pages 41-42 of the report. Many participants described the Westwood service area as an area that primarily includes "White, affluent" suburbs. As one parent participant shared: "When we were looking at all the preschools websites, there were only blond hair and blue eyes. At first, I didn't notice but my six-year-old said, 'How come there is no one like me on the website?.' In addition to concerns about discrimination in the context of development described above, some participants noted that, in some of these communities, White residents may not be aware of their privileges. For example, one participant shared that in these communities: "They're good people, they're not burning crosses, but they have no idea that their White privilege has given them all that's available to them." Other participants described experiences of racism due to their race and language. For example, one participant shared that: "Because I have kids in high school, [I know] there are slurs that go on the wall. Even though it is a mixed town- [the kids in the METCO program] are treated different than the residents themselves." Another participant noted that: "people are so rude, 'Why don't you speak English well?' Communication breaks and you feel so bad because you can't communicate." Many participants described vigils or protests held in their communities in response to the Black Lives Matter movement, and a few participants suggested that community coalitions be formed to take action around inequities and social justice.

Among the Westwood Community Priorities Survey respondents reporting that they themselves or their family members experienced discrimination in the past six months (16.2% of total sample), 68.5% of these respondents reported this was due to their race; 49.3% indicated it was due to their ethnicity, ancestry, or country of origin; and about 20% each reported it was due to their gender, physical appearance, or language spoken (Figure 35, page 42).

5.6 Violence and Trauma

Crime and violence in the service area are noted on pages 39-41. Crime and violence were not common concerns raised by interview and focus group participants. The Westwood service area was generally described as safe. One participant noted that, compared to other neighborhoods in Boston, "Hyde Park is safe," but noted that rents are higher in the area compared to other neighborhoods that may have higher levels of crime, but are also more affordable. A few interviewees did express concern about domestic violence, particularly during the pandemic. For example, one interviewee noted that "We've seen with COVID a slight increase in domestic violence issues – people are stressed economically, socially."

In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied strikingly across the towns within the Westwood

service area. Canton was near the state average, with 341.6 incidents of violent crime per 100,000 population (Figure 33, page 40). Dedham, Dover, Medfield, Needham, and Westwood all had fewer than 100 incidents per 100,000. Hyde Park (514.3) and West Roxbury (403.7) had higher violent crime rates than the state average. (It should be noted that data for Hyde Park and West Roxbury are from a different data source given that the areas are neighborhoods of Boston.)

Property crime (i.e. burglary, larceny, and auto theft) is much more common than violent crime. In 2018 in the Westwood service area, property crime was most common in Hyde Park (1598.3 per 100,000 population), West Roxbury (1390.1), and Dedham (1332.7) (Figure 34, page 41).

5.7 The following specific focus issues

a. Substance Use Disorder

Participants expressed some concerns about substance use in the Westwood service area. Specific types of substance use mentioned as concerns by participants included: alcoholism, vaping and in particular use of Juul e-cigarettes, and access to "pills" and "minor drugs." A few participants noted that opiate use, including heroin has not been a large concern in the area, with one participant explaining: "Opioids have not been so severe here; there have been no deaths in past years." This perception of limited opiate use is reflected in the secondary data below. As one participant summarized: "There's definitely lots of drugs, not heroin, but all the other kinds of pills and things like that... When you have money, have access to buying things." Some participants also expressed concern about how the COVID-19 pandemic may be impacting substance use for community members. One focus group participant, for example, shared that "I wasn't a big drinker before COVID but once it started, I was drinking more." One participant shared that there may be misperceptions about substance use during COVID-19 and noted the importance of messaging accurate information to the community.

Opioid-related overdose deaths were very rare in the towns around Westwood in 2014-2019, with only Dedham in 2016 and Walpole in 2018 reporting 10 or more deaths (Table 9, page 55).

In 2016-2017, there was variation in the rate of enrollment for substance addiction services in the towns around Westwood. Boston had by far the most enrollments, but data were not available by specific neighborhood. The highest rates were in Dedham (1,061.5 enrollments per 100,000 residents) and Norwood (1,029.8 enrollments) (Figure 50, page 56).

Information regarding Substance Use Disorders may be found on the following pages of the CHNA report: 54-56.

b. Mental Illness and Mental Health

While rates of self-reported poor mental health days in Westwood service area are similar to the state overall, mental health was raised as a pressing concern in many interviews and focus groups. Participants noted that mental health conditions are present throughout the community, "from the kids to the seniors." Participants described the anxiety and pressure that exists in general for community members, noting that "one of the reasons they have the money" to live in this area is that they "are driven," which "puts stress on marriages, teenagers, themselves…". Participants often described mental health concerns for specific populations: youth and seniors. Participants described anxiety, including "achievement anxiety," among youth due to a high-pressure environment. For example, as one participant described, "Westwood has great schools but it's also high pressure." Bullying, and cyber-bullying also were specifically noted by some as concerns for youth in the area. Among seniors, participants described isolation and depression as pressing concerns. Some participants viewed mental health treatment in the area as limited, while others expressed the view that stigma is the main barrier that prevents individuals from seeking care.

Many participants expressed concern about the impact that the COVID-19 pandemic would have on mental health. Participants frequently discussed concerns related to youth, including depression and social isolation, and some noted that if youth have experienced previous trauma and related mental health concerns these would be exacerbated in the context of the pandemic. Participants noted that youth may be thinking "about things they normally wouldn't because they're just at home, lots of depression and things can come up." Additionally, and especially for elementary school aged children and younger, participants shared concerns related to child development in the context of COVID-19. As one participant stated: "Youth are being faced with isolation especially [children in] Prek-5th grade… they are missing out on a lot of social interactions that are important for development." Some participants also noted that parents are worried and stressed, and that kids understand and can be impacted by their parents' mental health. Another population that was described as particularly vulnerable to mental health issues during the pandemic was seniors, which is described in more detail in the subsequent section.

In 2012-2014, there was minor variation across the Westwood service area in the proportion of adults reporting 15 or more

days of poor mental health in the past month. The highest proportion of adults reporting 15 or more days of poor mental health in the past month was in Canton (10.4%) and the lowest was in Needham (8.7%) (Figure 46, page 52). Data for Boston were not available by specific neighborhoods.

Age-adjusted emergency department visits for mental health followed a different pattern in 2014. Norwood reported 2,565.5 visits per 100,000 residents, compared to only 1,056.7 in Needham (Figure 47, page 53). Age-adjusted hospitalizations for mental health were also relatively high in Norwood in 2014 (1,823.4 per 100,000 residents) (Figure 48, page 53). Canton and Dedham also had rates that appeared to be above the state average.

Mental Health among Seniors:
Many participants noted that isolation can be a concern community-wide, but that seniors in particular are isolated especially during the pandemic and that this isolation can lead to a variety of mental health issues. As one participant explained: "An issue that will only get bigger during pandemic is isolation. [It's] always an issue for our older citizens. We are a typical suburban community, you can be in your house, you don't necessarily know your neighbors, you can struggle without anyone being aware."

Secondary data indicate that many seniors were struggling with mental health even before the pandemic. In 2018, almost one in three Massachusetts seniors 65+ years old reported having depression (Figure 49, page 54). Prevalence was similar in most towns around Westwood, with the exception of Hyde Park and West Roxbury, where only 18.5% of seniors reported having depression.

Information regarding Mental Health may be found on the following pages of the CHNA report: 51-54.

c. Housing Stability / Homelessness

Housing affordability in the Westwood service area was raised as a concern in most of the interviews and focus groups. Many participants described an extremely high cost of housing in the Westwood service area and noted that high housing prices apply to both homeowners with mortgages and renters. Participants expressed concern for the "middle class" that "make very good money [but] are living paycheck to paycheck because it's so expensive" to live in these communities. Many participants stated that the area is not affordable for young adults, single parents, or seniors. For example, when describing Hyde Park, one focus group participant stated that "Single parents couldn't afford to live here." Participants noted that recent housing developments, such as condominiums and apartment complexes, have made these areas even more unaffordable (see "Built Environment" below for more information on development in these areas).

Participants also stated that affordable housing in these communities is very limited, and that wait lists are very long for the affordable housing that does exist. As one participant described, "Needham doesn't have a lot of affordable housing and the [wait] list is very long." Given the high cost of housing and the lack of affordable housing options, participants noted that some families are living in crowded or doubled-up situations in order to afford rent. Additionally, in the context of the COVID-19 pandemic, some participants expressed concerns about an increase in homelessness as a result of rising unemployment. For example, one focus group participant stated: "I'm sure that a lot of people are on the verge of homelessness."

In Massachusetts, 62.3% of housing units are owner-occupied versus 37.7% renter-occupied (Figure 22, page 31). In most of the towns around Westwood, owner-occupied units are more common than in the state overall, for example 92.2% of housing units in Dover and 87.0% of housing units in Medfield are owner-occupied. The exceptions to this statistic are Hyde Park and Norwood, where 52.3% and 58.3% of housing units are owner-occupied, respectively.
The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage spend more than 30% of their income on housing costs (Figure 23, page 32). Many of the towns around Westwood are similar, with a range of 23.8% in Medfield to 38.5% in Hyde Park.

Cost burden may not be associated with housing affordability in especially wealthy areas. For example Dover (27.3%) and Dedham (26.3%) have similar proportions of owner-occupied units spending over 30% of their income on housing, even though median housing costs are much higher in Dover ($4,000/month) than Dedham ($2,437/month) (Figure 24, page 32).

In comparison, more renters tend to spend more than 30% of their income on housing costs compared to homeowners,

even though their median monthly housing costs are lower. In the Westwood service area, 72.0% of rental units in Dover and 63.8% of rental units in Medfield were occupied by residents who spent over 30% of their income on housing costs (Figure 25, page 33). In Norwood, this was only 39.7%.

Information regarding Housing Stability and Homelessness may be found on the following pages of the CHNA report: iv, viii, and 30-33.

d. Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes

In general, rates of chronic disease in the Westwood service area are similar to the state overall. While interview and focus group participants did not cite specific chronic diseases as pressing concerns in their communities, as shown above, a high proportion (44.7%) of Westwood Community Priorities Survey respondents indicated that "overweight/obesity" is an issue affecting them or their family. One interview participant noted that chronic disease rates in the area are similar to those statewide or slightly higher, given the senior population in the area: "…we're pretty aligned with the state, not higher than the state, same with our cancer rates. We do have heart disease, cardiovascular disease, rates a little higher for us. We have an older population…."

While participants did not frequently raise concerns about individual chronic diseases, some participants noted that comorbidities are a concern for their community, especially for seniors. As one participant described, "I don't think of one illness. We could talk about arthritis, diabetes… but it's when they accumulate then there's an issue." Some participants also expressed concern that during the COVID-19 pandemic, chronic diseases may not be appropriately managed given concerns about visiting health care facilities. For example, one participant stated that, "I worry that people are not keeping up with their chronic conditions."

Alzheimer's disease and other dementias also were noted as a concern in the Westwood service area, particularly when they co-occur with other chronic conditions. When speaking about the senior population, one participant stated that "it's the combination of Alzheimer's plus other illnesses compounding their health and wellness." Other participants shared the perception of seeing an increase in community members with memory concerns, and also pointed to the need to support caregivers and families of persons living with dementia.

Overweight and Obesity:
In 2011-2015, 18.9% of adults in Massachusetts reported consuming five or more fruits and vegetables every day (Figure 38, page 45). Percentages of this statistic were slightly lower in Boston overall, and in Canton, as well as Dedham; and higher in the other towns in the Westwood service area. However, none of the towns within the Westwood service area have greater than one quarter of the population report fruit and vegetable consumption in-line with these national guidelines. In 2012-2014, the prevalence of overweight or obesity in Massachusetts was 59.0% (Figure 39, page 46). Most towns in Westwood service area had similar prevalence, ranging from highs of 64.8% in Hyde Park and 63.6% in West Roxbury (2013-2017 data), to 50.2% in Westwood and 50.6% in Medfield.

Heart Disease:
In 2012-2014, 3.9% of adults in Massachusetts reported having angina or coronary heart disease (Figure 40, page 47). Again, prevalence in the Westwood service area spanned this statewide estimate, ranging from 2.4% in Boston to 4.5% in Canton. Age-adjusted rates of emergency department visits for heart disease also varied across towns in 2014. Dedham reported 570.1 visits per 100,000 residents, while Medfield only reported 344.4 visits (Figure 41, page 47). Age-adjusted rates of hospitalizations for heart disease in 2016-2017 followed a somewhat different pattern. There were 1,686 hospitalizations per 100,000 residents of Norwood. However, there were 795 heart disease hospitalizations per 100,000 residents in West Roxbury, although this neighborhood data is slightly more recent than the other town-level data (Figure 42, page 48).

Diabetes:
Prevalence of diabetes among adults varied across the towns near Westwood in 2012-2014. The highest prevalence of this chronic condition was in Hyde Park (10.7%; 2013-2017 data) and Canton (10.4%) (Figure 43, page 49). Age-adjusted rates of emergency department visits were notably high in Norwood (205.0 per 100,000 residents) in 2014, exceeding the State's rate of 143.1 (Figure 44, page 49). Boston's rate was also high, but data were not available by specific neighborhoods. Age-adjusted hospitalizations for diabetes were highest in Hyde Park (309 per 100,000 population; 2016-2017 data) and Norwood (232 per 100,000; 2014 data) (Figure 45 page 50).

Cancer:
Standardized Incidence Ratios (SIR) for cancer are calculated to compare local incidence rates with the expected rate for the Commonwealth overall, set at 100. In 2009-2013 in the Westwood area, the SIR for breast cancer was highest in

Westwood (134), indicating the incidence of breast cancer was 34% higher than expected for a town in Massachusetts. For other cancers, the highest SIRs were 140 in Medfield for prostate cancer, 112 in Norwood for lung and bronchial cancer, and 131 in Westwood for colorectal cancer (Table 8, page 50).

Information regarding Chronic Diseases may be found on the following pages of the CHNA report: 43-50.

6. Community Definition

Specify the community(ies) identified in the Applicant's 2020 Westwood CHNA

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
+ -	Canton	Hyde Park
+ -	Dedham	
+ -	Dover	
+ -	Boston	
+ -	Medfield	
+ -	Needham	
+ -	Norwood	
+ -	Walpole	
+ -	West Roxbury	
+ -	Westwood	

7. Local Health Departments

Please identify the local health departments that were included in your 2020 Westwood CHNA . Indicate which of these local health departments were engaged in this 2020 Westwood CHNA . For example, this could mean participation on an advisory committee, included in key informant interviewing, etc. (*Please see page 24 in the Communit further description of this requirement* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf.)

Add/ Del Rows	Municipality	Name of Local Health Dept	Name of Primary Contact	*Email address*	Describe how the health department was involved
+ -	Westwood	Westwood Board of Health	Jared Orsini		Key informant interviewee
+ -	Norwood	Norwood Board of Health	Sigalle Reiss		Key informant interviewee

8. CHNA / CHIP Advisory Committee

Please list the community partners involved in the CHNA/CHIP Advisory Committee that guided the 2020 Westwood CHNA . (please see the required list of sectorial representation in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) Please note that these individuals are those who should complete the *Stakeholder Engagement Assessment* form. It is the responsibility of the Applicant to ensure that DPH receives the completed *Stakeholder Engagement Assessment* form:

Add/Del Rows	Sector Type	Organization Name	Name of Primary Contact	Title in Organization	Email Address	Phone Number
	Municipal Staff	See Attachment A				
	Education					
	Housing					
	Social Services					
	Planning + Transportation					
	Private Sector/ Business					
	Community Health Center					
	Community Based Organizations					
+ -						

8a. Community Health Initiative

For Tier 2 and Tier 3 CHI Projects, is the the Applicant's CHNA / CHIP Advisory Board the same body that will serve as the CHI advisory committee as outlined in the Table 1 of the Determination of Need Community-Based Health Initiative Guideline (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-chi-planning.pdf)?

(●) Yes ( ) No

9. Engaging the Community At Large

Thinking about the extent to which the community has been or currently is involved in the 2020 Westwood CHNA , please choose one response for each engagement activity below. Please also check the box to the left to indicate whether that step is complete or not. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
☒ Assess Needs and Resources	○	○	○	○	○	○
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	See Attachment B-2					
☒ Focus on What's Important	○	○	○	○	○	○
Please describe the engagement process employed during the "Focus on What's Important" phase.	See Attachment B-2					
☒ Choose Effective Policies and Programs	○	○	○	○	○	○
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	See Attachment B-2					
☒ Act on What's Important	○	○	○	○	○	○
Please describe the engagement process employed during the "Act on What's Important" phase.	See Attachment B-2					
☒ Evaluate Actions	○	○	○	○	○	○
Please describe the engagement process employed during the "Evaluate Actions" phase.	See Attachment B-2					

10. Representativeness

Approximately, how many community agencies are currently involved in 2020 Westwood CHNA within the engagement of the community at large?

11 Agencies

Approximately, how many people were engaged in the process (please include team members from all relevant agencies and independent community members from the community at large)?

520 Individuals

Please describe the diversity of the people who have been engaged in the process both within the CHNA/CHIP Advisory Committee and the community at large. Explicitly describe how the process included diverse representation from different groups/individuals with varied gender, sexual orientation, race/ethnicity, disability status, international status and age. Please see page 10 and Appendix A of *the Community Engagement Standards for Community Health Planning Guideline* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) for further explanation of this.

First, the CAB is comprised of diverse individuals representing different races and ethnicities, as well as sexual orientation and genders. These CAB members bring different perspectives to the CHI and these diverse opinions lead to more equitable processes. Second, Mass General Brigham and Health Resources in Action sought to engage a diverse group of stakeholders in the Westwood service area through community surveys conducted in multiple languages, diverse focus groups and key informant interviews. For more information on the diversity of participants in the CHNA process, please see the CHNA Report.

Please describe the type of representation that was/is employed in the community engagement process and the rationale for that type of representation. For more information on types of representation and representativeness, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines (*http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf*)*. Please include descriptions of both the Advisory Board and the Community at large.

For the 2020 PAC - Westwood CHNA, staff used both a grass tops and grassroots approach. In regard to grass tops efforts, staff ensured that "varied and representative sectorial diversity were present to encourage innovation, build and enhance pre-existing work, provide sufficient representation and understand the levers by which population health could be improved." Consequently, many individuals from diverse groups were included in the overall strategy, data collection and engagement aspects of the CHNA, including school districts, public health departments, community-based organizations, private sector entities, municipal representatives, etc. By collaborating with these individuals from diverse groups, new perspectives were provided on all areas of the needs assessment processes.

Additionally, MGB also used a grassroots approach engaging the public whenever possible, but specifically in the public prioritization meetings to determine the needs of the service area and its various towns. This process will be expanded upon if the DoN is approved through the utilization of Ad Hoc Subcommittees.

To your best estimate, of the people engaged in 2020 Westwood CHNA approximately how many: Please indicate the number of individuals.

Number of people who reside in rural area	0
Number of people who reside in urban area	0
Number of people who reside in suburban area	520

11. Resource and Power Sharing

For more information on Power Sharing, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

By community partners, we mean agencies, organizations, tribal community, health departments, or other entities representing communities.

By Applicant partners, we mean the hospital / health care system applying for the approval of a DoN project

	Community Partners	Applicant Partners	Both	Don't Know	Not Applicable
Which partner hires personnel to support the community engagement activities?	○	◉	○	○	○
Who decides the strategic direction of the engagement process?	○	○	◉	○	○
Who decides how the financial resources to facilitate the engagement process are shared?	○	◉	○	○	○
Who decides which health outcomes will be measured to inform the process?	○	○	◉	○	○

12. Transparency

Please describe the efforts being made to ensure that the engagement process is transparent. For more information on transparency, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines*.

Focus groups, interviews and surveys were conducted with the community at large and publicized by Health Resources in Action and the organization's community partners. The community survey was translated into multiple languages (English, Spanish, Portuguese, and Chinese) and focus groups and interviews with non-English speaking residents were conducted in the common language of choice. Community focus groups were open to the public and sought to reduce barriers to participation by having groups at different times of day, etc. Finally, participants from the service area were engaged in all elements of the CHNA, including the prioritization meetings.

13. Formal Agreements

Does / did the 2020 Westwood CHNA have written formal agreements such as a Memorandum of Agreement/ Understanding (MOU) or Agency Resolution?

○ Yes, there are written formal agreements ◉ No, there are no written formal agreements

Did decision making through the engagement process involve a verbal agreement between partners?

○ Yes, there are verbal agreements ◉ No, there are no verbal agreements

14. Formal Agreement Specifics

Thinking about your MOU or other formal agreement(s), does it include any provisions or language about:

	Yes	No	Don't Know	Doesn't Apply
Distribution of funds	○	○	○	○
Written Objectives	○	○	○	○
Clear Expectations for Partners' Roles	○	○	○	○
Clear Decision Making Process (e.g. Consensus vs. Voting	○	○	○	○
Conflict resolution	○	○	○	○
Conflict of Interest Paperwork	○	○	○	○

15. Document Ready for Filing

When the document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to DPH" button.

This document is ready to file: ☐ Date/time Stamp:

E-mail submission to DPH

E-mail submission to Stakeholders and CHI Advisory Board

When providing the Stakeholder Assessment Forms to the community advisory board members(individuals identified in Section 8 of this form), please include the following information in your correspondence with them. This will aid in their ability to complete the form:

A) Community Engagement Process: 2020 Westwood CHNA

B) Applicant: Mass General Brigham Incorporated

C) A link to the DoN CHI Stakeholder Assessment

Attachment C-3

Massachusetts Department of Public Health
Determination of Need
Community Health Initiative
CHNA / CHIP Self Assessment

Version: 8-1-17

This self-assessment form is to understand the Community Engagement process that has led/ will lead to the identification of priorities for community health planning processes. It is being used to demonstrate to DPH that an existing community health planning process adequately meets DPH standards for community engagement specific to Determination of Need, Community Health Initiative purposes.

This form will provide the basic elements that the Department will use to determine if additional community engagement activities will be required. When submitting this form to DPH, please also submit your IRS Form 990 and Schedule H CHNA/CHIP and/or current CHNA/ CHIP that was submitted to the Massachusetts Attorney General's Office. Additionally, the Applicant is responsible for ensuring that the Department receives Stakeholder-Assessments from the stakeholders involved in the CHNA / CHIP process.

All questions in the form, unless otherwise stated, must be completed.

Approximate DoN Application Date: 01/21/2021

DoN Application Type: Ambulatory Surgery and Clinic Substantial Capital Expenditure

What CHI Tier is the project? ○ Tier 1 ○ Tier 2 ◉ Tier 3

1. DoN Applicant Information

Applicant Name: Mass General Brigham Incorporated

Mailing Address: 800 Boylston Street, Suite 1150

City: Boston State: Massachusetts Zip Code: 02199

2. Community Engagement Contact Person

Contact Person: Kristen Barnicle Title: Executive Director for Community Health

Mailing Address: 399 Revolution Drive, 10W70-17, Suite 1005

City: Somerville State: Massachusetts Zip Code: 02145

Phone: 8572821421 Ext: E-mail: kmmason@partners.org

3. About the Community Engagement Process

Please indicate what community engagement process (e.g. the name of the CHNA/CHIP) the following form relates to. This will be use as a point of reference for the following questions and does not need to be a fully completed CHNA or implemented CHIP.
(please limit the name to the following field length as this will be used throughout this form):

2020 Woburn CHNA

4. Associated Community Health Needs Assessments

In addition to the above engagement process, please list Community Health Needs Assessments and/or Community Health Improvement Planning Processes, if any that the Applicant been involved with in the past 5 years (i.e. CHNA/CHIP processes not led by the Applicant bur where the Applicant was involved?

(Please see page 22 of the Community-Based Health Initiative Guidelines for reference http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf)

Add/ Del Rows	Lead Organization Name / CHNA/CHIP Name	Years of Collaboration	Name of Lead Organizer	Phone Number	Email Address of Lead Organizer
+ -					

5. CHNA Analysis Coverage

Within the 2020 Woburn CHNA , please describe how the following DPH Focus Issues were analyzed DoN Health Priorities and Focus Issues (please provide summary information including types of data used and references to where in the submitted CHNA/CHIP documents these issues are discussed):

5.1 Built Environment

The 2020 Woburn service area CHNA aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels— from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health and social determinant of health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the Woburn service area; conducting a community survey with 552 residents of towns in the Woburn service area (in English, Spanish, Portuguese or Chinese); conducting 8 virtual focus groups with 19 participants and 9 key informant interviews with 11 individuals representing a variety of organizations, including mental health, senior, and immigrant-focused social services; law enforcement; and the faith community.

Built Environment:
In regard to the Built Environment, communities within the Woburn service area were described as having parks and playgrounds, libraries, and trails, which residents appreciated. Increased use of bicycles in the Woburn service area due to COVID-19 has highlighted the need for more bike lanes in communities, according to participants.

Figure 30 (page 44) and Figure 31 (page 45) are maps of the Woburn service area showing the density of retail food outlets and fast food restaurants in the area. Burlington has the highest density of retail food outlets, which are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; as well as fresh and prepared meats, fish, and poultry. Many of the towns in the Woburn service area have under 20 retail food outlets per 100,000 residents, and some have none at all. In contrast, many towns in the area have over 100 fast food restaurants per 100,000 residents.

Figure 32 on page 46 shows publicly accessible open space in the Woburn service area. Conservation land includes habitat protection with some recreation including walking trails. Recreation land includes outdoor facilities including parks, commons, playing fields, school fields, and scout camps. The bike trail lines show trails which permit bike travel or corridors with conversion potential.

Information regarding the Built Environment may be found on the following pages of the CHNA report: iv, 44-46.

Transportation:
When asked about transportation in the Woburn service area, focus group members and interviewees reported that most residents have access to the Massachusetts Bay Transportation Authority ('MBTA') and major bus lines, making it easy to get to Boston and other larger towns. However, not all residents have access. One interviewee reported, some public housing complexes are located far from public transit. Additionally, the timing of transit and the need to switch services can create barriers. As one parent stated, "I'm right near a bus that goes to the T, but that adds a half hour [of commuting time] just waiting for the bus and then waiting for the T."

MBTA Commuter Rail Routes and MBTA Rapid Transit are shown in Figure 29 on page 40. In general, towns closer to Boston had both train and bus routes. Tewksbury, Billerica, North Reading, and Lynnfield appear to have limited MBTA options available.

In 2014-2018, 70.2% of people in Massachusetts over age 16 commuted to work alone in a vehicle (Table 8 on page 41). In the Woburn service area, residents that commuted to work alone ranged from 59.1% in Medford to 87.2% in Billerica. Public transportation was most commonly used in Arlington, Medford, and Melrose.

In 2014-2018, the average time spent commuting to work for residents within the Woburn service area ranged from 26.9 minutes in Woburn to 34.4 minutes in both North Reading and Winchester (see Figure 28 on page 42).

Adding to the service area's transportation challenges, few communities have their own transit systems, and thus, a car is needed to travel. Seniors in particular expressed concerns about challenges traveling locally; several senior focus group members reported that they no longer drive, and therefore, have to rely on friends or family members. As one senior shared, "Transportation is an issue. I don't drive anymore, so I rely on my son and his son to take me to appointments." While some senior ride services are available through vans sponsored by senior centers and The Ride offered by the MBTA, these services were reported to be expensive.

In 2014-2018, renter-occupied households were more likely to have no vehicle available to them, across towns in the Woburn service area. In Lynnfield 23.4% and in Reading 21.9% of households with renters did not have a vehicle (Figure 29 on page 43). Across the service area, very few owner-occupied households did not have access to a vehicle, with the highest proportion in Medford (5.4%).

COVID-19 substantially affected transportation in the Woburn service area. Seniors, in particular, spoke about this issue in focus groups as ride services for them were temporarily ceased or reduced at the peak of the pandemic, substantially affecting their ability to go to medical appointments; grocery stores; and receive other services. While these services have slowly restarted, capacity restrictions limit how often and for what purpose seniors may use these services.

A positive transportation development related to COVID-19 within the Woburn service that a few participants observed, is an increase in bicycling. While this was seen as a welcome change, a few people expressed concerns about road safety. As one focus group member shared, "I think at least once a week people post [on Facebook] about almost being hit by a car in Medford." Focus group members mentioned a need for more bike lanes in communities like Medford and Melrose.
Information regarding Transportation may be found on the following pages of the CHNA report: iv, vii, and 40-44.

Food Insecurity:
Both interviewees and focus group participants frequently mentioned food insecurity as a community challenge and an issue that existed prior to COVID-19 but has been exacerbated by the pandemic. Low-income residents and seniors were identified as those most food insecure prior to the pandemic. Since the onset of COVID-19, participants reported, food needs across groups multiplied as residents faced unemployment and other economic challenges or were unable to obtain groceries due to a lack of transportation or safety concerns. The number of families using food pantries and seniors accessing Meals on Wheels grew substantially according to interviewees whose organizations provide these services. Participants also mentioned that school lunch programs were expanded to meet the demand for food.

In Massachusetts overall, 12.0% of households received food stamps or Supplemental Nutrition Assistance Program (SNAP) benefits in 2014-2018 (Figure 18 on page 27). In the Woburn service area, households receiving the noted benefits ranged from 1.5% in Winchester and 1.6% in Lynnfield to 6.5% in Woburn and 6.9% in Medford.

Information regarding Food Insecurity may be found on the following pages of the CHNA report: 26 and 27.

5.2 Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. Massachusetts stands out as a state with an exceptionally high proportion of residents with college, graduate, and professional degrees (42.9% in 2014-2018; Table 5 on page 31). Among residents over 25 years of age in the Woburn service area, 45.9% of Winchester residents and 54.2% of Lexington residents had a graduate or professional degree. In contrast, Billerica and Tewksbury had the largest populations with a High School diploma or less.

Table 6 illustrates additional patterns in educational attainment across service area towns, by race/ethnicity. For some towns, data interpretation is limited given the small number of residents in certain education by race brackets. However, in other towns, findings reveal variations, for example, among Hispanics/Latinos over age 25, 33.5% in Wakefield, 16.4% in Woburn, 8.4% in Andover, and 7.6% in Medford have less than a High School diploma. Variation was also apparent by race/ethnicity within towns. For example, 14.7% of non-Hispanic Asian residents of Grafton over age 25 did not have a high school diploma in 2014-2018, compared to 1.8% of non-Hispanic Other race residents and 3.7% of non-Hispanic White residents. In Medford in 2014-2018, the proportion of the population without a High School diploma ranged from 5.3% of non-Hispanic Other race residents to 13.3% of non-Hispanic Black residents.

In contrast, Table 7 on page 33 shows the percent population over age 25 with a bachelor's degree or higher, by race/ethnicity in the towns around Woburn in 2014-2018. Variation exists, for example with 80.1% of non-Hispanic Whites in Lexington having a bachelor's degree or higher, compared to 31.7% in Billerica and 34.5% in Tewksbury. For Woburn residents over age 25, 72.6% of non-Hispanic Asians, 30.9% of non-Hispanic Blacks, 41.4% of non-Hispanic Other race residents, 43.6% of non-Hispanic Whites, and 33.3% of Hispanics/Latinos had a bachelor's degree or higher.

Among current high school students in 2019, graduation rates were high, ranging from 89.5% in Medford to 97.3% in Lexington (Figure 21 on page 34). All towns in this region reported higher graduation rates than the state overall. Both interviewees and focus group members praised the school systems in the Woburn service area, which they reported were highly rated.

Information regarding Education may be found on the following pages of the CHNA report: iii and 31-34.

5.3 Employment

In the Woburn service area, the top three industries for employment are (1) Educational services, and health care and social assistance; (2) Professional, scientific, management, and administrative and waste management services; and (3) Manufacturing. The impact of the pandemic and resulting economic shutdown in many sectors are reflected in unemployment data from towns in the Woburn service area, between April 2019 and June 2020 (Figure 20 on page 30). Unemployment rates continued to increase from April 2020 to June 2020 in all towns. In April 2019, Massachusetts, and each city or town in the area, had unemployment rates under 3%, with Arlington, Lexington, and Winchester under 2%. However, during the pandemic, unemployment rates increased to 16.0% statewide in April, with similar (e.g. Billerica, 16.7%; Tewksbury, 16.5%) or lower (e.g. Lexington, 7.2%) rates in the Woburn service area.

Focus group members and interviewees spoke primarily about employment in the context of COVID-19, with some sharing that family members and friends had lost their jobs during the pandemic. Participants expressed uncertainty about how long unemployment may last and the status of unemployment benefits. Those with school-age children worried about how school reopening strategies would affect their children's education and their ability to work.

Information regarding Employment and Workforce, as well as Financial Insecurity and Unemployment may be found on the following pages of the CHNA report: iii, vi-viii, 29-31, 83, 84, 87, 90 and 91.

5.4 Housing

A prominent theme in focus group discussions and interviews was the high cost of housing in the region. While Billerica and Woburn were described as more affordable than Medford or Arlington, participants consistently mentioned housing expense and high taxes as concerns that are putting housing out of reach for some and making it harder for seniors who want to stay in the area and downsize. Participants noted that high housing costs also contributed to overcrowding and rising homelessness in the larger towns within the Woburn service area. As one focus group member stated, "I know Medford is expensive for housing. I know there are people who are trying to move to the area but can't afford it."

In Massachusetts, 62.3% of housing units are owner-occupied versus 37.7% renter-occupied (Figure 22 on page 35). In most of the towns around Woburn, owner-occupied units are more common than in the state overall, for example 87.8% in North Reading; 87.6% in Lynnfield; and 85.8% in Wilmington. The exceptions are Arlington (59.2%), Medford (57.2%), and Woburn (62.1%).
Most participants reported that the communities within the Woburn service area lacked affordable housing. Members of the parents focus group, for example, mentioned 5-10 year wait lists to obtain affordable public housing. Seniors expressed concern about finding housing within their incomes.

The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage spend more than 30% of their income on housing costs (Figure 23 on page 36). Many of the towns in the Woburn service area are similar, with a range of 22.1% of residents in Andover and Melrose to over 31% in Lynnfield and Medford spending more than 30% of their income on housing. Median monthly housing costs for owner-occupied households with a mortgage ranged from $2,214 in Woburn to $3,940 in Lexington (Figure 24 on page 37).

In comparison, there was a wider range in the proportion of housing units where renters spent more than 30% of income on housing costs in 2014-2018. For example, in the Woburn service area, during this timeframe, the proportion of renters spending more than 30% of their income on housing ranged from 37.1% in Medford and 38.5% in Arlington to 53.2% in Tewksbury and 74.2% in Lynnfield (Figure 25 on page 38). Rates may be skewed in towns where a very small proportion of housing units are occupied by renters, such as in Lynnfield. Median monthly housing costs for renter-occupied households in 2014-2018 ranged from $1,265 in Reading to $2,240 in Lexington (Figure 26 on page 39).

Participants shared that communities are working to address housing constraints. In Medford, participants reported, there were city-level conversations about the development of more affordable housing; these discussions were led by organizations like Medford Community Housing. Support of community residents is critical to expanded housing, many interviewees noted. In describing efforts to expand affordable housing in Arlington, for example, one interviewee shared, "Arlington considers itself progressive. Yet when they try to build lots of new affordable housing, neighbors always don't want the new sites in their neighborhoods." A few participants commented that some areas of Woburn and Billerica have been overdeveloped and more housing was not needed.

The longer-term impact of COVID-19 on housing also was of concern to residents. While at the time of this report, landlords could not evict their tenants for nonpayment, some focus group members reported that this was happening informally, especially among immigrant groups. Overall, focus group members and interviewees shared concerns about future potential foreclosures and the impact on local communities.

Information regarding Housing may be found on the following pages of the CHNA report: iii, vi, vii and 34-39.

5.5 Social Environment

Various aspects of the community social and economic environment for the Woburn service area are described throughout pages 17-48 of the CHNA Report.

Specifically, issues around Discrimination and Racism are discussed on pages 48-49 of the report. Participants reported that similar to the national dialogue—more emphasis on racial justice has been occurring in the Woburn service area. Perceptions about the extent of discrimination and racism in the community varied. Some participants mentioned incidences in schools of anti-Semitic and racist graffiti and community incidences of racism and anti-immigrant actions. As one focus group member stated, "A lot of people were shocked to know that there's racism happening in Medford. I was shocked to know a lot of people were surprised by that – I wasn't surprised." Other participants, however, reported that they did not see discrimination and racism as prominent community issues.

Consistently, however, participants shared that conversations about racial justice and policing have been taking place in their communities. A few residents pointed to tensions among those supporting the Black Lives Matter movement and those who disagreed with some of their stances, particularly related to the police. Local leaders and community-based organizations, including faith institutions, have been working to engage the community in conversations about this issue, participants reported. As one interviewee commented, "People are angry, but talking." Additionally, interviewees reported that conversations and work on addressing systemic racism has started in police departments and within schools in their communities.

While participants felt strongly about the cohesiveness of their communities, they also acknowledged that recent conversations and activism around racial justice have been difficult and some divisions have emerged. As one interviewee observed, "It's hard to have conversations outside of groups you're familiar with talking to. In these times, cracks are opening up where people have never examined their beliefs."

Assessment participants also noted their own experiences with discrimination. Among Woburn Community Priorities Survey respondents, 11.2% indicated that they or their family members have directly experienced discrimination in the past six months. Among that sub-sample, 50.0% reported this was due to their race; 37.9% said it was due to their gender; 34.5% said it was due to their ethnicity, ancestry, or country of origin; and 29.3% reported it was due to their physical appearance (Figure 35 on page 49).

5.6 Violence and Trauma

Overall, focus group members and interviewees described their communities as very safe. A few interviewees reported that police in the community are responding to fewer calls since COVID-19. Interpersonal violence, however, was of concern to participants, and a couple of participants feared that this violence increased during COVID-19. As one interviewee shared, "The pandemic has increased problems of domestic violence. People are spending too much time together. And liquor stores are open and the drug trade is still on. That exacerbates problem."

In 2018, rates of violent crime (i.e. murder, rape, robbery, aggravated assault) varied notably across the towns in the Woburn service area, although no towns had higher rates of violent crime than the state average of 338.1 incidents per 100,000 residents (Figure 33 on page 47). The highest violent crime rates were in Tewksbury (259.8 per 100,000 residents), Wakefield (153.0), Stoneham (149.1), and Burlington (145.1).

Property crime (i.e. burglary, larceny, and auto theft) is generally much more common than violent crime in the service area. In 2018, within the Woburn service area, property crime was most common in Burlington (1,371.5 per 100,000 residents); Stoneham (1,097.8); and Tewksbury (1,093.1) (Figure 34 on page 48). For additional information on Trauma, see the Mental Health Section below.

Information regarding Violence and Trauma may be found on the following pages of the CHNA report: iv and 46-48.

5.7 The following specific focus issues

a. Substance Use Disorder

While substance use was not mentioned frequently by participants, a few interviewees stated that, as in other urban areas, opioid and prescription drug misuse were of concern in the Woburn service area. A few participants mentioned that they were concerned that COVID-19 has exacerbated substance misuse. As one interviewee reported, "People are drowning themselves in drugs and booze." One interviewee shared that marijuana use among young people is a growing issue in

the community and one that is not receiving sufficient attention.

Participants reported that recovery programs exist in the community, although more services are needed, especially those providing residential treatment. In 2016-2017, the rate of Bureau of Substance Addiction Services Enrollments ranged from 169.4 per 100,000 population in Lexington to 1,363.7 per 100,000 population in Tewksbury (Figure 50 on page 65).

From 2014-2019, Massachusetts had around 2,000 opioid-related overdose death each year, with the fewest deaths in 2014 (1,365) and the most deaths in 2016 (2,094). By town, Billerica, Medford, and Woburn all averaged more than 10 deaths per year over the 6-year period (Table 10 on page 66).

Information regarding Substance Use Disorders may be found on the following pages of the CHNA report: v, vii, viii, 65, 66 90 and 91.

b. Mental Illness and Mental Health

When asked to identify health issues of greatest concern to the community, focus group members and interviewees consistently mentioned mental health. Poor mental health was described as a challenge across all age groups and an issue that existed prior, but has been magnified by, the pandemic. Participants mentioned anxiety and trauma as prevalent among community members, with some suffering from more serious mental health concerns. The mental health of seniors, including depression that comes from isolation and loneliness and the onset of dementia and Alzheimer's disease, was identified as a community concern by several participants.

Mental health concerns among immigrant and refugee populations were also highlighted.
As one person described, "For refugees and immigrants, there is a whole level of anxiety about everything in life. Almost everyone comes here with trauma. Mental health from trauma is such a huge thing. Plus, in the current context, they have anxiety every time they step out the door." Focus group members and interviewees shared that lack of providers who speak other languages, especially for immigrants from African countries, means some groups cannot access needed services. As one interviewee stated, "You need native speakers. You can't be 'kind of fluent' when providing mental health therapy." One interviewee also noted that specific outreach and education should be targeted at specific groups to help overcome stigma about mental health that those communities may hold, "In Asian cultures, it's considered shameful if you have mental health issues, so a lot of people don't go for treatment…We're doing education to reduce stigma and make people realize how important it is to address [mental health]."

In 2012-2014, the percent of adults reporting 15 or more days of poor mental health in the last month was 11.1% in Massachusetts. By town, the percent of adults reporting 15 or more days of poor mental health in the last month ranged from 7.1% in Lexington to 11.4% in Arlington (Figure 46 on page 61).

According to focus group members and interviewees, lack of mental health providers was the primary challenge in addressing mental health in the community. It was reported that the number of providers in the community is insufficient to meet the demand for services, leading to long waits for mental health services. As one interviewee explained, "When I see people, they're in crisis, so to tell them there's a wait list to see someone is really hard and not very helpful." A lack of providers for children and adolescents was described as an especially significant challenge.

Additional mental health workforce challenges included low reimbursement for mental health services, which can make it difficult for provider organizations to fill positions when they are available. Few providers accept MassHealth, participants reported, furthering curtailing access to mental health services for lower income residents.

In 2014, the age-adjusted rate of mental health emergency department visits per 100,000 population was 2,465.6 in Massachusetts. By town, the age-adjusted rate of mental health emergency department visits ranged from 982.4 per 100,000 population in Winchester to 2,298.0 per 100,000 population in Stoneham (Figure 47 on page 62).

In 2014, the age-adjusted rate of mental health hospitalizations per 100,000 population was 934.4 in Massachusetts. By town, the age-adjusted rate of mental health emergency department visits ranged from 322.5 per 100,000 population in Winchester to 827.0 per 100,000 population in Wakefield (Figure 48 on page 63).

Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in their communities. Depression, anxiety, stress, and trauma were most frequently mentioned. Seniors and public housing residents participating in focus groups spoke about the isolation and fear brought on by COVID-19. Those with school-age children shared the challenges of remote learning and the stress that comes with the uncertainty of the coming school year. Many

worried about the long-term impact of the pandemic and lack of socialization on the community's children and youth. On a more positive note, interviewees who work in mental health services stated that the pandemic has led to greater use of telehealth to deliver mental health services, which offers the potential to address some service delivery issues in the future. However, they also noted that this model does not work for everyone, and thus, COVID-19 has interrupted mental health services to some who were receiving them.

Mental Health among Seniors
Isolation of senior residents—from services and others—was a frequently-cited concern among focus group members and interviewees. As one interviewee explained, "People used to drop by all the time, to drop off a check or something, and then they would stay and chat. But now, we just don't hear from them – it's very concerning. Some of our tenants are terrified, they don't want to leave their units. So, what are they eating? what are they feeding their pets? How are they getting by?" Numerous participants spoke about not hearing from friends and neighbors with whom they regularly interacted prior to COVID-19.

Senior focus group members and interviewees who work with seniors noted that the isolation of seniors was a challenge prior to COVID-19, but worse now as seniors are afraid to leave their homes and transportation services have been curtailed, creating health and mental health challenges. As one senior shared, "I do feel like a lot of people are down with the COVID– they want to get out of their house, they don't have a lot of people to talk to. They're very lonely." Another participant noted a similar sentiment, "It's a long time to not be able to talk to anyone. There are definitely people who don't have anyone to talk to or no family nearby." Participants praised the communication and efforts of senior center staff through virtual means and socially distanced programs, although this has been difficult for seniors who do not have access to computers.

In 2018, the percent of adults 65 years or older with depression was 31.5% in Massachusetts. By town, the percent of adults 65 years or older with depression ranged from 26.9% in Andover to 32.8% in Arlington (Figure 49 on page 64).

For additional information regarding challenges accessing mental health services see pages 78-81 of the report. For additional information on mental health as a key theme, conclusions and prioritization see pages 87-92 of the report.

Information regarding Mental Health may be found on the following pages of the CHNA report: ii, v-viii, 17, 19, 60-64, 78,79, 81, 84, 85, 87-92.

c. Housing Stability / Homelessness

A prominent theme in focus group discussions and interviews was the high cost of housing in the region. While Billerica and Woburn were described as more affordable than Medford or Arlington, participants consistently mentioned housing expense and high taxes as concerns that are putting housing out of reach for some and making it harder for seniors who want to stay in the area and downsize. Participants noted that high housing costs also contributed to overcrowding and rising homelessness in the larger towns within the Woburn service area. As one focus group member stated, "I know Medford is expensive for housing. I know there are people who are trying to move to the area but can't afford it."

In Massachusetts, 62.3% of housing units are owner-occupied versus 37.7% renter-occupied (Figure 22 on page 35). In most of the towns around Woburn, owner-occupied units are more common than in the state overall, for example 87.8% in North Reading; 87.6% in Lynnfield; and 85.8% in Wilmington. The exceptions are Arlington (59.2%), Medford (57.2%), and Woburn (62.1%).

Most participants reported that the communities within the Woburn service area lacked affordable housing. Members of the parents focus group, for example, mentioned 5-10 year wait lists to obtain affordable public housing. Seniors expressed concern about finding housing within their incomes.

The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. It is recommended that households spend no more than 30% of their incomes on housing costs, in order to avoid cost burdens. In the Commonwealth overall, 30.7% of owner-occupied households with a mortgage spend more than 30% of their income on housing costs (Figure 23). Many of the towns in the Woburn service area are similar, with a range of 22.1% of residents in Andover and Melrose to over 31% in Lynnfield and Medford spending more than 30% of their income on housing. Median monthly housing costs for owner-occupied households with a mortgage ranged from $2,214 in Woburn to $3,940 in Lexington (Figure 24 on page 36).

Participants shared that communities are working to address housing constraints. In Medford, participants reported, there were city-level conversations about the development of more affordable housing; these discussions were led by organizations like Medford Community Housing. Support of community residents is critical to expanded housing, many interviewees noted. In describing efforts to expand affordable housing in Arlington, for example, one interviewee shared, "Arlington considers itself progressive. Yet when they try to build lots of new affordable housing, neighbors always don't want the new sites in their neighborhoods." A few participants commented that some areas of Woburn and Billerica have been overdeveloped and more housing was not needed.

The longer-term impact of COVID-19 on housing also was of concern to residents. While at the time of this report, landlords could not evict their tenants for nonpayment, some focus group members reported that this was happening informally, especially among immigrant groups. Overall, focus group members and interviewees shared concerns about future potential foreclosures and the impact on local communities.

Information regarding Housing Stability and Homelessness may be found on the following pages of the CHNA report: 34-39.

d. Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes

In general, rates of chronic disease in the Woburn service area are similar to the state overall. Interview and focus group participants did not cite specific chronic diseases as pressing concerns in their communities, and 13.2% and 11.1% of Woburn Community Priorities Survey respondents cited chronic disease and overweight/obesity as top issues for action, respectively. However, these issues were also ranked among the top five issues that have personally affected respondents in the past six months.

Overweight and Obesity:
While nearly four in ten of Woburn Community Priorities Survey respondents (38.9%) indicated that overweight/obesity was an issue that affected them or their family personally in the past six months, it was not an issue brought up among focus group or interview participants. Healthy eating is a key component of maintaining a healthy weight, and overall adults in the Woburn service area reported previously that they were not likely to meet the recommended vegetable guidelines. In 2011-2015, the percent of adults consuming five or more fruits and vegetables daily in Massachusetts was 18.9%. By town, the percent of adults consuming 5 or more fruits and vegetables daily ranged from 17.1% in Medford to 25.5% in Winchester (Figure 38 on page 52).

In 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 48.4% in Lexington to 67.4% in Wilmington (Figure 39 on page 53).

Heart Disease:
Even though heart disease is the second leading cause of death in Massachusetts, it was not an issue discussed in the focus groups or interviews. In 2012-2014, the percent of adults reporting angina or coronary heart disease (CHD) in Massachusetts was 3.9%. By town, the percent of adults reporting angina or CHD ranged from 3.2% in Billerica to 4.8% in Melrose (Figure 40 on page 54).

In 2014, the age-adjusted rate per 100,000 population of heart disease emergency department visits was 596 in Massachusetts. By town, the age-adjusted rate of heart disease emergency department visits ranged from 314.8 per 100,000 population in Lexington to 522.7 per 100,000 population in Medford (Figure 41 on page 55).

Diabetes:
In 2012-2014, the percent of adults reporting diabetes in Massachusetts was 9.0%. By town, the percent of adults reporting diabetes ranged from 5.9% in Lexington to 9.2% in Lynnfield and Tewksbury (Figure 43 on page 57).

In 2014, the age-adjusted rate of diabetes hospitalizations per 100,000 population was 158.9 in Massachusetts. By town, the age-adjusted rate of diabetes hospitalizations ranged from 60.2 per 100,000 population in Lexington to 184.7 per 100,000 population in Burlington (Figure 44 on page 58).

In 2014, the age-adjusted rate of diabetes emergency department visits per 100,000 population was 143.1 in Massachusetts. By town, the age-adjusted rate of diabetes emergency department visits ranged from 49.9 per 100,000 population in Stoneham to 151.2 per 100,000 population in Tewksbury. Data for several towns were not reported due to insufficient sample size (Figure 45 on page 59).

Cancer:
Cancer is the leading cause of death in Massachusetts. In 2009-2013, by town, standardized incidence ratios (SIR) for breast cancer in females ranged from 89 (Lynnfield) to 121 (Reading and Stoneham). This indicates that the incidence of breast cancer in females was 11% lower in Lynnfield and 21% higher in Reading and Stoneham than expected based on standardized rates for the state. The incidence of prostate cancer in males ranged from 37% lower than expected in Reading (SIR 63) to 3% higher than expected in Lexington and Tewksbury (SIR 103). The incidence of lung and bronchus cancer ranged from 46% lower than expected in Lexington (SIR 54) to 24% higher than expected in Billerica (SIR 124). The incidence of colorectal cancer ranged from 29% lower than expected in Lexington (SIR 71) to 18% higher than expected in Melrose (SIR 118) (Table 9 on page 6).

Information regarding Chronic Diseases may be found on the following pages of the CHNA report: iv and 51-60.

6. Community Definition

Specify the community(ies) identified in the Applicant's 2020 Woburn CHNA

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
+ -	Andover	
+ -	Arlington	
+ -	Bedford	
+ -	Billerica	
+ -	Burlington	
+ -	Lexington	
+ -	Lynnfield	
+ -	Medford	
+ -	Melrose	
+ -	North Reading	
+ -	Reading	
+ -	Stoneham	
+ -	Tewksbury	
+ -	Wakefield	
+ -	Wilmington	
+ -	Winchester	
+ -	Woburn	

7. Local Health Departments

Please identify the local health departments that were included in your 2020 Woburn CHNA . Indicate which of these local health departments were engaged in this 2020 Woburn CHNA . For example, this could mean participation on an advisory committee, included in key informant interviewing, etc. (*Please see page 24 in the Communit further description of this requirement* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf.)

Add/ Del Rows	Municipality	Name of Local Health Dept	Name of Primary Contact	*Email address*	Describe how the health department was involved
+ -	Wilmington	Willmington Board of Health	Shelly Newhouse		Participated in the Prioritization Session
+ -	Medford	Medford Board of Health	MaryAnn O'Connor		Participated in the Prioritization Session

8. CHNA / CHIP Advisory Committee

Please list the community partners involved in the CHNA/CHIP Advisory Committee that guided the 2020 Woburn CHNA . (please see the required list of sectorial representation in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) Please note that these individuals are those who should complete the *Stakeholder Engagement Assessment* form. It is the responsibility of the Applicant to ensure that DPH receives the completed *Stakeholder Engagement Assessment* form:

Add/Del Rows	Sector Type	Organization Name	Name of Primary Contact	Title in Organization	Email Address	Phone Number
	Municipal Staff	See Attachment A				
	Education					
	Housing					
	Social Services					
	Planning + Transportation					
	Private Sector/ Business					
	Community Health Center					
	Community Based Organizations					
+ -						

8a. Community Health Initiative

For Tier 2 and Tier 3 CHI Projects, is the the Applicant's CHNA / CHIP Advisory Board the same body that will serve as the CHI advisory committee as outlined in the Table 1 of the Determination of Need Community-Based Health Initiative Guideline (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-chi-planning.pdf)?

(●) Yes ( ) No

9. Engaging the Community At Large

Thinking about the extent to which the community has been or currently is involved in the 2020 Woburn CHNA , please choose one response for each engagement activity below. Please also check the box to the left to indicate whether that step is complete or not. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
☒ Assess Needs and Resources	○	○	○	○	○	○
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	See Attachment B-3					
☒ Focus on What's Important	○	○	○	○	○	○
Please describe the engagement process employed during the "Focus on What's Important" phase.	See Attachment B-3					
☒ Choose Effective Policies and Programs	○	○	○	○	○	○
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	See Attachment B-3					
☒ Act on What's Important	○	○	○	○	○	○
Please describe the engagement process employed during the "Act on What's Important" phase.	See Attachment B-3					
☒ Evaluate Actions	○	○	○	○	○	○
Please describe the engagement process employed during the "Evaluate Actions" phase.	See Attachment B-3					

10. Representativeness

Approximately, how many community agencies are currently involved in 2020 Woburn CHNA within the engagement of the community at large?

15 Agencies

Approximately, how many people were engaged in the process (please include team members from all relevant agencies and independent community members from the community at large)?

590 Individuals

Please describe the diversity of the people who have been engaged in the process both within the CHNA/CHIP Advisory Committee and the community at large. Explicitly describe how the process included diverse representation from different groups/individuals with varied gender, sexual orientation, race/ethnicity, disability status, international status and age. Please see page 10 and Appendix A of *the Community Engagement Standards for Community Health Planning Guideline* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) for further explanation of this.

First, the CAB is comprised of diverse individuals representing different races and ethnicities, as well as sexual orientation and genders. These CAB members also work in various industries, consequently, the members bring different perspectives to the CHI and these diverse opinions lead to more equitable processes. Second, Mass General Brigham and Health Resources in Action sought to engage a diverse group of stakeholders in the Woburn service area through community surveys conducted in multiple languages, diverse focus groups and key informant interviews. For more information on the diversity of participants in the CHNA process, please see the CHNA Report.

Please describe the type of representation that was/is employed in the community engagement process and the rationale for that type of representation. For more information on types of representation and representativeness, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines (*http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf*)*. Please include descriptions of both the Advisory Board and the Community at large.

For the 2020 Woburn CHNA, staff used both a grasstops and grassroots approach. In regard to grass tops efforts, staff ensured that "varied and representative sectorial diversity was present to encourage innovation, build and enhance pre-existing work, provide sufficient representation and understand the levers by which population health could be improved." Consequently, many individuals from diverse groups were included in the overall strategy, data collection and engagement aspects of the CHNA, including school districts, public health departments, community-based organizations, private sector entities, municipal representatives, etc. By collaborating with these individuals from diverse groups, new perspectives were provided on all areas of the needs assessment processes.

Additionally, MGB also used a grassroots approach engaging the public whenever possible, but specifically in the public prioritization meetings to determine the needs of the service area. This process will be expanded upon if the DoN is approved through the utilization of Ad Hoc Subcommittees.

To your best estimate, of the people engaged in 2020 Woburn CHNA approximately how many: Please indicate the number of individuals.

Number of people who reside in rural area	0
Number of people who reside in urban area	0
Number of people who reside in suburban area	590

11. Resource and Power Sharing

For more information on Power Sharing, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

By community partners, we mean agencies, organizations, tribal community, health departments, or other entities representing communities.

By Applicant partners, we mean the hospital / health care system applying for the approval of a DoN project

	Community Partners	Applicant Partners	Both	Don't Know	Not Applicable
Which partner hires personnel to support the community engagement activities?	○	◉	○	○	○
Who decides the strategic direction of the engagement process?	○	○	◉	○	○

Who decides how the financial resources to facilitate the engagement process are shared?	○	◉	○	○	○
Who decides which health outcomes will be measured to inform the process?	○	○	◉	○	○

12. Transparency

Please describe the efforts being made to ensure that the engagement process is transparent. For more information on transparency, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines*.

Focus groups, interviews and surveys were conducted with the community at large and publicized by Health Resources in Action and the organization's community partners. The community survey was translated into multiple languages (English, Spanish, Portuguese, and Chinese) and focus groups and interviews with non-English speaking residents were conducted in the common language of choice. Community focus groups were open to the public and sought to reduce barriers to participation by having groups at different times of day, etc. Finally, participants from the service area were engaged in all elements of the CHNA, including the prioritization meetings.

13. Formal Agreements

Does / did the 2020 Woburn CHNA have written formal agreements such as a Memorandum of Agreement/ Understanding (MOU) or Agency Resolution?

○ Yes, there are written formal agreements ◉ No, there are no written formal agreements

Did decision making through the engagement process involve a verbal agreement between partners?

○ Yes, there are verbal agreements ◉ No, there are no verbal agreements

14. Formal Agreement Specifics

Thinking about your MOU or other formal agreement(s), does it include any provisions or language about:

	Yes	No	Don't Know	Doesn't Apply
Distribution of funds	○	○	○	○
Written Objectives	○	○	○	○
Clear Expectations for Partners' Roles	○	○	○	○
Clear Decision Making Process (e.g. Consensus vs. Voting	○	○	○	○
Conflict resolution	○	○	○	○
Conflict of Interest Paperwork	○	○	○	○

15. Document Ready for Filing

When the document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to DPH" button.

This document is ready to file: ☐ Date/time Stamp:

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E-mail submission to Stakeholders and CHI Advisory Board

When providing the Stakeholder Assessment Forms to the community advisory board members(individuals identified in Section 8 of this form), please include the following information in your correspondence with them. This will aid in their ability to complete the form:

A) Community Engagement Process: 2020 Woburn CHNA

B) Applicant: Mass General Brigham Incorporated

C) A link to the DoN CHI Stakeholder Assessment

Attachment D-1

Section 9: Engaging the Community at Large – Thinking about the extent to which the community has been or currently is involved in the 2020 Westborough CHNA Process, please choose one response for each engagement activity below.

Background Information:
To ensure that a robust community health needs assessment ("CHNA") process was carried out, Mass General Brigham ("MGB") worked with Health Resources in Action ("HRiA"), a non-profit, public health consulting organization known for its needs assessment work. Additionally, MGB sought to develop a diverse Community Advisory Board ("CAB"). The CAB provides oversight of CHNA processes, advises on DoN community engagement activities, and selects health priorities and strategies for CHI funding. The CAB is comprised of individuals representing the constituencies outlined in the Department of Public Health's *Community Engagement Standards for Community Health Planning Guideline*. CAB members represent regional groups with some Board members and/or their organizations residing in the noted primary service areas. If the DoN is approved, the CAB will establish Ad Hoc Subcommittees comprised of representatives from the primary service areas for the proposed ambulatory care sites. These Ad Hoc Subcommittees will include representation from local stakeholders aware of the service area's needs, including staff from the local public health department(s). Members of the Ad Hoc Subcommittees will provide context and additional recommendations to the CAB regarding health priorities and strategies for the Westborough primary service area.

In general, the CAB is tasked with reviewing the DoN sub-regulatory guidelines, outlining roles and responsibilities for the group, developing a charter/mission statement, and reviewing the CHNAs to determine health priorities and strategies for CHI funding. The CAB will utilize the guiding questions within the racial justice reframing at each of its meetings to evaluate the group's decision making processes. This framework is critically important to ensure fairness in the selection of health priorities and strategies, as well as the distribution of CHI funding. Post-selection of health priorities and strategies, CAB members will participate in a conflict of interest process, with those individuals without conflicts participating in an Allocation Committee to disburse CHI funding.

Context:
This CHNA was conducted during an unprecedented time, due to the novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that participants raised in focus groups and key informant interviews. A wave of national protests for racial equity also coincided with the timeline of the CHNA and impacted the content of this report, as well as data collection processes, including the design of data collection instruments and the input that was shared during focus groups, key informant interviews, and through community survey responses.

The CHNA stages of engagement are outlined below.

Assess the Needs and Resources:

To assess the needs and resources within the Westborough service area, including the communities of: Berlin; Bolton; Grafton; Northborough; North Grafton; Shrewsbury; Upton; Westborough; Framingham; Ashland; Hopkinton; Hudson; Marlborough; Milford; Southborough, MGB sought to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels – from lifestyle behaviors (e.g., healthy eating and active living) to clinical care

(e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health and social determinant of health needs of the Westborough service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing secondary data on social, economic, and health indicators in the service area; conducting a community priorities survey with 159 residents; facilitating 8 virtual focus groups with specific populations of interest (e.g. parents of school-age children; residents seeking essential services; residents who are immigrants; and youth); and conducting 12 key informant interviews with key stakeholders in the community. In addition, data collected for the 2019 MetroWest Community Health Assessment (CHA)—an extensive process that engaged 22 communities in the Westborough service area—were also used for this report, including data from the MetroWest Adolescent Health Surveys.

Accordingly, based on the methods used for this phase, **MGB reached the "Involve" level of engagement.**

Key Themes and Conclusions from Assessing the Needs and Resources:
Through the aforementioned methods, this assessment report examined the current health status of the Westborough service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- Overall, the Westborough service area was reported as a highly educated, high-income community, however, there are pockets of vulnerable populations across the region—particularly youth, immigrants, and older adults. Findings from this assessment show that some residents in the Westborough service area are struggling with basic needs including access to food, shelter, and childcare. Interview participants discussed a collaborative network of community-based organizations working to alleviate some of these immediate needs, but many indicated a need for more support and coordination to address the magnitude of the situation.

- Some residents are struggling with lack of employment and economic opportunities, especially in light of COVID-19. During the pandemic, unemployment rates increased across the service area, particularly in Milford (16.1%), Marlborough (15.8%), Hudson (15.8%) and Framingham (15.2%). Young people, immigrant communities, and non-English speaking communities who are more likely to work as essential workers were identified as facing unique challenges related to social and economic factors. More resources for career transitions and job training, technology, and language classes were identified as critical to addressing these issues.

- Housing affordability and transportation continue to be concerns in the Westborough service area. Housing affordability was identified as a pressing concern, particularly for seniors and "middle class" residents. Many renters across the area, especially in towns, such as Bolton (68.4%) and Hopkinton (52.1%), are spending more than 30% of their income on housing costs. Tenancy-at-will situations—or agreements between tenants and landlords, where there is no formal contract, negatively impacts already-vulnerable residents, such as undocumented immigrants and seniors. In terms of public transportation, suggestions to invest in alternative modes of transportation, such as

bicycle share programs and incentives to reduce single-occupancy vehicles were shared by focus group participants.

- As happening at the national level, conversations about racial justice and policing have been taking place in the Westborough service area. Perceptions related to discrimination and racism varied throughout qualitative discussions. Addressing systemic racism was a theme that emerged across interviews, focus groups, and the community survey. Community leaders that were interviewed for the assessment described their commitment to addressing racial injustice and systemic oppression. Westborough Community Priorities Survey respondents ranked 'Addressing Systemic Racism/Racial Justice' as the 4th highest priority for action in the next few years.

- Rates of obesity/overweight were higher in the majority of Westborough service area towns than the state overall. Between 2012-2014, the percent of adults reporting obesity or overweight in Massachusetts was 59.0%. By town, the percent of adults reporting obesity or overweight ranged from 49.7% in Bolton to 64.2% in Milford. Approximately one in every three Westborough Community Priorities Survey respondents reported overweight/obesity (34.3%) as an issue that has impacted them in the last 6 months, however, it did not rise up as a key theme from qualitative discussions.

- Across all methods, the majority of assessment participants identified mental health as a priority health concern. Stress, anxiety, depression, and isolation were the most frequently cited challenges among the Westborough service area, with residents describing how COVID-19 has exacerbated mental health issues in the community. Young people and seniors were identified as the populations most impacted by mental health challenges in the Westborough service area. Quantitative data from the MetroWest Adolescent Health Surveys show that the number of high school students that reported their lives have been "very stressful" has steadily increased from 28.9% in 2012 to 36% in 2018.

- Proximity of health care services was noted as a key strength of the Westborough service area by community survey respondents, but access to those services is a challenge for some residents. Respondents to the Westborough Community Priorities Survey ranked 'accessible medical services' as the second strongest asset of the region (68.9%). However, themes that emerged from qualitative discussions highlight barriers that still persist for some residents, including being underinsured, challenges for non-English speakers, navigating services, and lack of culturally sensitive approaches to care. In addition, the Westborough service area could benefit from additional services for the growing senior population to help facilitate aging in place.

Focus on What's Important:

MGB sought to determine the greatest needs of the Westborough service area through community and CAB member prioritization processes.

First, data and themes from the CHNA report were presented to service area residents and stakeholders at a virtual community prioritization meeting in September 2020. Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning

efforts. The following four criteria were used to guide prioritization discussions and voting processes:

- **Concern:** How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?
- **Equity:** Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?
- **Effectiveness:** Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?

Meeting participants voted for up to three of the eight priorities identified from the data and based on the specific prioritization criteria. Voting identified Mental Health (71%) as the most commonly endorsed community priority, followed by Systemic Racism and Racial Injustice (57%), Financial Insecurity/Unemployment (43%), and Housing (43%).

Second, CAB members reviewed priorities for the service area and conducted their own prioritization session. The goal of this meeting was for CAB members to review the CHNA findings for the service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health. To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, and Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Ultimately, the CAB identified four priorities to consider for future action:

- Mental health
- Access to services
- Systemic racism & racial injustice
- Housing

For this phase, **MGB reached the "Collaborate" level of engagement.**

Choose Effective Policies and Programs and Act on What's Important:

Based on the selected health priorities that were chosen by service area residents and CAB members during the *Focus on What's Important Phase*, the CAB will develop specific strategies for implementation throughout the CHI process. These strategies will impact the major health and social determinant of health needs of the Westborough service area. Through the CHI process, MGB will work with partner organizations (that receive CHI funding) to develop aspirational goals, measurable objectives, strategies to address the goals, and metrics to define success. These strategies will seek to identify opportunities for partnership, new ideas, and leveraging existing efforts to enhance collective impact. Selected health and social determinant of health priority areas were based on consensus building and participatory decision making.

For these phases, **MGB reached/will reach the "Collaborate" level of engagement**.

Evaluate Actions:

Through ongoing implementation efforts, MGB will evaluate progress on its CHI strategies continually, monitoring and evaluating community partner efforts on an ongoing basis. Moreover, MGB will report on its progress annually to the Department of Public Health.

For this phase, **MGB will reach the "Consult" level of engagement.**

Attachment D-2

Section 9: Engaging the Community at Large – Thinking about the extent to which the community has been or currently is involved in the 2020 Westwood CHNA Process, please choose one response for each engagement activity below.

Background Information:
To ensure that a robust community health needs assessment ("CHNA") process was carried out, Mass General Brigham ("MGB") worked with Health Resources in Action ("HRiA"), a non-profit, public health consulting organization known for its needs assessment work. Additionally, MGB sought to develop a diverse Community Advisory Board ("CAB"). The CAB provides oversight of CHNA processes, advises on DoN community engagement activities, and selects health priorities and strategies for CHI funding. The CAB is comprised of individuals representing the constituencies outlined in the Department of Public Health's *Community Engagement Standards for Community Health Planning Guideline*. CAB members represent regional groups with some Board members and/or their organizations residing in the noted primary service areas. If the DoN is approved, the CAB will establish Ad Hoc Subcommittees comprised of representatives from the primary service areas for the proposed ambulatory care sites. These Ad Hoc Subcommittees will include representation from local stakeholders aware of the service area's needs, including staff from the local public health department(s). Members of the Ad Hoc Subcommittees will provide context and additional recommendations to the CAB regarding health priorities and strategies for the Westwood primary service area.

In general, the CAB is tasked with reviewing the DoN sub-regulatory guidelines, outlining roles and responsibilities for the group, developing a charter, and reviewing the CHNAs to determine health priorities and strategies for CHI funding. The CAB will utilize the guiding questions within the racial justice reframing at each of its meetings to evaluate the group's decision making processes. This framework is critically important to ensure fairness in the selection of health priorities and strategies, as well as the distribution of CHI funding. Post- selection of health priorities and strategies, CAB members will participate in a conflict of interest process, with those individuals without conflicts participating in an Allocation Committee to disburse CHI funding.

Context:
This CHNA was conducted during an unprecedented time, due to the novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that participants raised in focus groups and key informant interviews. A wave of national protests for racial equity also coincided with the timeline of the CHNA and impacted the content of this report, as well as data collection processes, including the design of data collection instruments and the input that was shared during focus groups, key informant interviews, and through community survey responses.

The CHNA stages of engagement are outlined below.

Assess the Needs and Resources:

To assess the needs and resources within the Westwood service area, including the communities of: Canton; Dedham; Dover; Hyde Park (Boston); Medfield; Needham; Norwood; Walpole; West Roxbury (Boston); and Westwood, MGB sought to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels – from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social

and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health and social determinant of health needs of the Westwood service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing secondary data on social, economic, and health indicators in the service area; conducting a community survey with 481 respondents from the Westwood service area; conducting 8 virtual focus groups with 27 participants and 10 key informant interviews with 12 individuals representing a variety of organizations, such as local non-profits including those serving youth and seniors, local health departments, and town administrators and services. For more detailed information on the Methods used to assess the needs and resources of the Westwood service area see pages 4-8 of the CHNA Report.

Accordingly, based on the methods used for this phase, **MGB reached the "Involve" level of engagement.**

Key Themes and Conclusions from Assessing the Needs and Resources:
Through the aforementioned methods, this assessment report examined the current health status of the Westwood service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- There are many assets in the greater Westwood community, including high-quality schools, support for families and seniors, access to parks and green space, and overall cohesion and engagement among community members. Many CHNA participants described the Westwood area generally as family-oriented, and identified schools, as well as services for seniors, particularly Councils on Aging, as strengths. Many community survey respondents rated walkability and green space as assets. Both survey respondents and interview and focus group participants also described community pride and support, and noted that, especially during the COVID-19 pandemic, community residents engage with and care for each other.

- While greater Westwood overall is affluent, some communities within the area face financial insecurity, especially in the context of the economic impact of the COVID-19 pandemic. Prior to the pandemic, there was great variation in income across the area, with median annual household income ranging from about $65,000 in Hyde Park to $225,000 in Dover just a few miles away. However, income is not equally distributed across populations; additionally, assessment participants noted that the pandemic has exacerbated the financial insecurity of residents and the inequities between them. Nearly 43% of Westwood community survey respondents indicated that they or their families are impacted by financial insecurity. Unemployment rates have increased recently, likely due to the pandemic, and focus group and interview participants were concerned about this rising unemployment, particularly for Spanish speakers, service workers, young families, and seniors.

- Housing affordability was identified as a pressing concern, particularly for young adults, single parents, and seniors. Housing affordability was noted as a concern in most of the interviews and focus groups, where participants described high housing prices, limited affordable housing options, and ongoing development as priority issues. Quantitative

data show that many owner-occupied households in the area (ranging from 23.8% in Medfield to 38.5% in Hyde Park) are cost-burdened (spending more than 30% of their income on housing costs). Given the high cost of housing and the lack of affordable housing options, participants noted that some families are living in crowded or "doubled-up" situations in order to afford rent. Additionally, in the context of the COVID-19 pandemic, some participants expressed concerns about an increase in homelessness as a result of rising unemployment.

- Transportation was a concern for some communities, particularly for certain populations including low-wage workers, seniors, and students. Perceptions of transportation access differed among communities in the greater Westwood area. In some communities, such as Hyde Park, participants described public transportation as an asset of the community. Pre-COVID data from the Census showed that 25.3% of Hyde Park residents and 17.3% and 17.1% of residents in Westwood and West Roxbury, respectively, took public transportation to work. However, many interview and focus group participants who live further outside of Boston described transportation as a major concern and noted specific challenges for low-wage workers, seniors, students, and residents that do not own a vehicle.

- Some community members have experienced or recognized discrimination in their communities and prioritized addressing racial injustice. Some assessment participants discussed facing discrimination themselves. Overall, 16.2% of Westwood community survey respondents reported experiencing discrimination in the past six months; among these respondents, 68.5% reported this was due to their race and nearly 49.3% reported this was due to their ethnicity or country of origin. A few focus group participants discussed being on the receiving end of anti-immigrant sentiments or hearing about discrimination in schools. Assessment participants noted that examining privilege and addressing systemic racism as a community is critical. While participants described how some conversations are happening, they also noted that there is more work to be done around taking action to address racial injustice.

- Mental health, especially for youth and seniors and in the context of the pandemic, was a pressing concern among many community residents. Mental health issues were the top concern that Westwood community survey respondents reported had personally affected them in the past six months, with nearly 50% of respondents noting it has affected them. Quantitative data gathered prior to the COVID-19 pandemic indicate that, across the service area, 8.7% - 10.4% of adults reported having 15 or more days in the last month during which they experienced poor mental health. Focus group participants and interviewees stated that COVID-19 exacerbated mental health issues in the community, particularly among seniors, who already tend to be socially isolated. Additionally, participants with school-age children were specifically concerned about the pandemic's effect on the development and socialization of younger children and contribution to depression among youth and young adults.

- Substance use was also a concern, though perceptions varied by type of substance. Substance use, particularly issues related to alcoholism, vaping and e-cigarettes, and some drugs, were noted as a concern by some focus group and interview participants. Some participants also noted that the stress of the pandemic may exacerbate substance use. However, some participants stated that opiate and heroin use were less of a concern in the Westwood area compared to other parts of the state. In the Westwood

community survey, 22.2% of respondents included alcohol and substance use as one of their top 5 community priorities for action.

- Concerns remain about COVID-19 spread and access to testing. Among Westwood community survey respondents, 27.3% indicated that they or their families have been directly impacted by COVID-19 in the last 6 months. Focus group and interview participants expressed concern about the accuracy and availability of COVID testing and about disease transmission due to a lack of consistent social distancing and wearing of masks. However, most of the concerns shared by assessment participants related to the COVID-19 pandemic focused on the effects it had on other aspects of residents' lives. These specific concerns included: the effect on mental health among parents, seniors, and youth; the impact on youth development; and the impact on financial insecurity and concerns about the current and cascading effects on the economy – particularly for low wage workers.

- Many healthcare and social services are available in the area, but there is opportunity for improving access to and communication about local options. Interview and focus group participants described available services including local healthcare options, programming for seniors, and in the context of the pandemic, food pantries. However, challenges to accessing services included difficulty finding providers that accept Medicaid (MassHealth), lack of mental health providers, limited telehealth access, and a need for additional community-wide communication about existing services.

Focus on What's Important:

MGB sought to determine the greatest needs of the Westwood service area through community and CAB member prioritization processes.

First, data and themes from the CHNA report were presented to service area residents and stakeholders at a virtual community prioritization meeting in September 2020. Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. The following four criteria were used to guide prioritization discussions and voting processes:

- **Concern:** How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?
- **Equity:** Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?
- **Effectiveness:** Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?

Meeting participants voted for up to three of the eight priorities identified from the data and based on the specific prioritization criteria. Voting identified Mental Health (45%), Housing (45%), Systemic Racism and Racial Injustice (45%), and Issues Related to Older Adults (45%) as tied for the most commonly endorsed community priorities.

Second, CAB members reviewed priorities for the service area and conducted their own prioritization session. The goal of this meeting was for CAB members to review the CHNA findings for the service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health. To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Ultimately, the CAB identified five priorities to consider for future action:

- Mental health
- Housing
- Systemic racism & racial injustice
- Issues related to older adults
- Transportation

For this phase, **MGB reached the "Collaborate" level of engagement.**

Choose Effective Policies and Programs and Act on What's Important:

Based on the selected health priorities that were chosen by service area residents and CAB members during the *Focus on What's Important Phase*, the CAB will develop specific strategies for implementation throughout the CHI process. These strategies will impact the major health and social determinant of health needs of the Westwood service area. Through the CHI process, MGB will work with partner organizations (that receive CHI funding) to develop aspirational goals, measurable objectives, strategies to address the goals, and metrics to define success. These strategies will seek to identify opportunities for partnership, new ideas, and leveraging existing efforts to enhance collective impact. Selected health and social determinant of health priority areas were based on consensus building and participatory decision making.

For these phases, **MGB reached/will reach the "Collaborate" level of engagement**.

Evaluate Actions:

Through ongoing implementation efforts, MGB will evaluate progress on its CHI strategies continually, monitoring and evaluating community partner efforts on an ongoing basis. Moreover, MGB will report on its progress annually to the Department of Public Health.

For this phase, **MGB will reach the "Consult" level of engagement.**

Attachment D-3

Section 9: Engaging the Community at Large – Thinking about the extent to which the community has been or currently is involved in the 2020 Woburn CHNA Process, please choose one response for each engagement activity below.

Background Information:
To ensure that a robust community health needs assessment ("CHNA") process was carried out, Mass General Brigham ("MGB") worked with Health Resources in Action ("HRiA"), a non-profit, public health consulting organization and a leader in community health needs assessments. Additionally, MGB sought to develop a diverse Community Advisory Board ("CAB"). The CAB provides oversight of CHNA processes, advises on DoN community engagement activities, and selects health priorities and strategies for CHI funding. The CAB is comprised of individuals representing the constituencies outlined in the Department of Public Health's *Community Engagement Standards for Community Health Planning Guideline*. CAB members represent regional groups with some Board members and/or their organizations residing in the noted primary service areas. If the DoN is approved, the CAB will establish Ad Hoc Subcommittees comprised of representatives from the primary service area for the proposed ambulatory care site. These Ad Hoc Subcommittees will include representation from local stakeholders aware of the service area's needs, including staff from the local public health department(s). Members of the Ad Hoc Subcommittees will provide context and additional recommendations to the CAB regarding health priorities and strategies for the Woburn primary service area.

In general, the CAB is tasked with reviewing the DoN sub-regulatory guidelines, outlining roles and responsibilities for the group, developing a charter/mission statement, and reviewing the CHNAs to determine health priorities and strategies for CHI funding. The CAB will utilize the guiding questions within the racial justice reframing at each of its meetings to evaluate the group's decision making processes. This framework is critically important to ensure fairness in the selection of health priorities and strategies, as well as the distribution of CHI funding. Post-selection of health priorities and strategies, CAB members will participate in a conflict of interest process, with those individuals without conflicts participating in an Allocation Committee to disburse CHI funding.

Context:
This CHNA was conducted during an unprecedented time, due to the novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that participants raised in focus groups and key informant interviews. A wave of national protests for racial equity also coincided with the timeline of the CHNA and impacted the content of this report, as well as data collection processes, including the design of data collection instruments and the input that was shared during focus groups, key informant interviews, and through community survey responses.

The CHNA stages of engagement are outlined below.

Assess the Needs and Resources:

To assess the needs and resources within the Woburn service area, including the communities of: Andover, Arlington, Bedford, Billerica, Burlington, Lexington, Lynnfield, Medford, Melrose, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn, MGB sought to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes

numerous factors at multiple levels – from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

To identify the health and social determinant of health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the Woburn service area; conducting a community survey with 552 residents of towns in the Woburn service area (in English, Spanish, Portuguese or Chinese); conducting 8 virtual focus groups with 19 participants and 9 key informant interviews with 11 individuals representing a variety of organizations, including mental health, senior, and immigrant-focused social services; law enforcement; and the faith community.

Accordingly, based on the methods used for this phase, **MGB reached the "Involve" level of engagement.**

Key Themes and Conclusions from Assessing the Needs and Resources:
Through the aforementioned methods, this assessment report examined the current health status of the Woburn service area during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- There are many assets in the Woburn service area, including high-quality schools, access to parks and green space, access to medical services, and overall social cohesion and community engagement.

- COVID-19 remains a major concern, along with its impact on local economies, financial security, child development, social isolation of seniors, and overall mental health of community members.

- While the Woburn service area overall is affluent, some communities within the area face unemployment and financial insecurity, especially in the context of the economic impact of the COVID-19 pandemic.

- The COVID-19 pandemic has exacerbated pre-existing inequities in income and wealth in the area. Increased use of food pantries, social services to support housing costs, and financial support, were expected to increase further, and there is great concern for residents already living on the edge.

- Housing affordability was identified as a pressing concern, particularly for seniors, racial/ethnic minorities, low-income immigrants, and young families.

- Transportation was a concern for some communities, particularly for certain populations including seniors and public housing residents.

- Some community members have experienced or recognized discrimination in their communities and prioritized addressing racial injustice.

- Mental health was a top concern among many community residents, especially in the context of COVID-19.

- Alcohol and substance use were concerns, particularly for residents with less than a high school education.

- Social isolation, difficulty in accessing services, and mental health were pressing concerns for older adults, particularly in the context of COVID-19.

- While access to medical care was seen as a strength of the area overall, there were concerns related to continuity of health care with other social services, the high cost of health care, and lack of culturally and linguistically competent mental health services.

Focus on What's Important:

MGB sought to determine the greatest needs of the Woburn service area through community and CAB member prioritization processes (for a detail description of the prioritization process, see pages 89-92 of the CHNA Report).

First, data and themes from the CHNA report were presented to service area residents and stakeholders at a virtual community prioritization meeting in September 2020. Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. The following four criteria were used to guide prioritization discussions and voting processes:

- **Concern:** How much does this issue affect our community? How urgent is this issue? How much does this issue impact people's lives?
- **Equity:** Will addressing this issue substantially benefit those most in need? Does this issue address the root causes of inequities?
- **Effectiveness:** Can we make a difference if we work on this issue? Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Can we do it? Is it possible to address this issue in our community given the infrastructure, capacity, and community commitment?

Meeting participants voted for up to three of the nine priorities identified from the data and based on the specific prioritization criteria. Voting identified Mental Health as the most commonly endorsed community priority (69%), followed by Coronavirus/COVID-19 (38%), Financial Insecurity/Unemployment (38%), and Issues Related to Older Adults (38%).

Second, CAB members reviewed priorities for the service area and conducted their own prioritization session. The goal of this meeting was for CAB members to review the CHNA findings for the service area and amalgamate that information with the input provided from the community prioritization meeting, to refine and narrow the list of priorities in alignment with the social determinants of health. To determine priorities for the CHNA, CAB members were asked to consider the same prioritization criteria (Concern, Equity, Effectiveness, and Feasibility) that were used by the community members during the remote prioritization meeting and come to a consensus about priorities for future action. Ultimately, the CAB agreed on the following priorities to consider for future action:

- Coronavirus/ COVID-19 (specifically related to testing, transmission, disease mitigation, etc.)
- Systemic Racism and Racial Injustice
- Behavioral Health (inclusive of mental health and substance use)
- Issues related to Older Adults

For this phase, **MGB reached the "Collaborate" level of engagement.**

Choose Effective Policies and Programs and Act on What's Important:

Based on the selected health priorities that were chosen by service area residents and CAB members during the *Focus on What's Important Phase*, the CAB will develop specific strategies for implementation throughout the CHI process. These strategies will impact the major health and social determinant of health needs of the Woburn service area. Through the CHI process, MGB will work with partner organizations (that receive CHI funding) to develop aspirational goals, measurable objectives, strategies to address the goals, and metrics to define success. These strategies will seek to identify opportunities for partnership, new ideas, and leveraging existing efforts to enhance collective impact. Selected health and social determinant of health priority areas were based on consensus building and participatory decision making.

For these phases, **MGB reached the "Collaborate" level of engagement**.

Evaluate Actions:

Through ongoing implementation efforts, MGB will evaluate progress on its CHI strategies continually, monitoring and evaluating community partner efforts on an ongoing basis. Moreover, MGB will report on its progress annually to the Department of Public Health.

For this phase, **MGB will reach the "Consult" level of engagement.**

Attachment E

Massachusetts Department of Public Health
Determination of Need
Community Health Initiative
Community Engagement Plan

Version: 8-1-2017

The Community Engagement Plan is intended for those Applicants with CHIs that require further engagement above and beyond the regular and routine CHNA/CHIP processes. For further guidance, please see the *Community Engagement Standards for Community Health Planning Guidelines* and its appendices for clarification around any of the following terms and questions.

All questions in the form, unless otherwise stated, must be completed.

Approximate DoN Application Date: 01/21/2021

DoN Application Type: Ambulatory Surgery, DoN Required Equipment, and Clinic Substantial Capital Expenditure

Applicant Name: Mass General Brigham Incorporated

What CHI Tier is the project? ○ Tier 1 ○ Tier 2 ◉ Tier 3

1. Community Engagement Contact Person

Contact Person: Kristen Barnicle

Title: Executive Director for Community Health

Mailing Address: 399 Revolution Drive, 10W70-17, Suite 1005

City: Somerville

State: Massachusetts

Zip Code: 02145

Phone: 8572821421

Ext:

E-mail: kmmason@partners.org

2. Name of CHI Engagement Process

Please indicate what community engagement process (e.g. the name DoN CHI Initiative associated with the CHI amount) the following form relates to. This will be use as a point of reference for the following questions.
(please limit the name to the following field length as this will be used throughout this form):

2020 IC/AmSurg DoN CHI

3. CHI Engagement Process Overview and Synergies with Broader CHNA /CHIP

Please briefly describe your overall plans for the CHI engagement process and specific how this effort that will build off of the CHNA / CHIP community engagement process as is stated in the *DoN Community-Based Health Initiative Planning Guideline.*

See the attached addendum.

4. CHI Advisory Committee

In the CHNA/CHIP Self Assessment, you listed (or will list) the community partners that will be involved in the CHI Advisory Committee to guide the 2020 IC/AmSurg DoN CHI . As a reminder:

For Tier 2 DON CHI Applicants: The CHI Advisory Committee is tasked with helping select DoN Health Priorities based on the CHNA / CHIP unless the Applicant is directed by DPH to conduct additional community engagement. If so, the advisory committee's role is to guide that additional work.

For Tier 3 DON CHI Applicants: The CHI Advisory Committee is to select DoN Health Priorities based on**, but not exclusive to,** the CHNA / CHIP. This includes the additional community engagement that must occur to develop the issue priorities.

5. Focus Communities for CHI Engagement

Within the 2020 IC/AmSurg DoN CHI , please specify the target community(ies), please consider the community(ies) represented in the CHNA / CHIP processes where the Applicant is involved.

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
+ -	Westwood	The primary service area for this site includes the following zip codes: 02021, 02026, 02030, 02032, 02052, 02062, 02081, 02132, 02136, 02492, 02494 and 02090
+ -	Westborough	The primary service area for this site includes the following zip codes: 01503, 01519, 01532, 01536, 01545, 01568, 01581, 01701, 01702, 01721, 01740, 01745, 01748, 01749, 01752, 01757, and 01772
+ -	Woburn	The primary service area for this site includes the following zip codes: 01730, 01731 01801, 01810, 01821, 02420, 02421, 02474, 02476, 01876, 01803, 01867, 01880, 01887, 01890, 01940, 02153, 02155, 02176, 02180 and 01864

6. Reducing Barriers

Identify the resources needed to reduce participation barriers (e.g., translation, interpreters, child care, transportation, stipend). For more information on participation barriers that could exist, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf

Applicant staff have reviewed Appendix A to the Community Engagement Standards from the Community Health Planning Guideline to understand participation barriers to community engagement. Consequently, to reduce barriers within this CHI process, Applicant staff and contractors will implement the following strategies:

1. For public meetings, such as a Bidders Conferences associated with a Request for Proposal ("RFP") process, Applicant staff will ensure meeting spaces are handicap accessible, close to public transportation, with free parking. Moreover, Applicant staff will ensure that public meetings are "family friendly," allowing for children and older adults to come to the meetings. Interpreter services, for the most common languages spoken in the target communities, also will be available upon request and when necessary.

2. Any and all RFPs associated with the CHI will be available electronically on the Mass General Brigham web site and via hard copy available in the Applicant's offices.

3. The RFP Announcement will be translated into Spanish (and other appropriate languages) and published in certain print media.

4. Applicant staff, in conjunction with the Community Advisory Board ("CAB"), will ensure that any alternative transparent funding processes also reduce barriers to participation.

These combined steps will ensure a reduction in participation barriers.

7. Communication

Identify the communication channels that will be used to increase awareness of this project or activity:

The Applicant is committed to a transparent process and ongoing communication to ensure stakeholders are informed, engaged and have opportunities to provide feedback and participate as partners to shape Applicant's CHI strategy. Applicant staff anticipate that the CHI process will provide an opportunity to deepen community understanding of the impact of the social determinants of health and staff will take every opportunity to build these messages into communication processes. The communication channels that will be utilized are described in detail in question #11.

8. Build Leadership Capacity

Are there opportunities with this project or activity to build community leadership capacity? (•) Yes ( ) No

If yes, please describe how.

Throughout each aspect of the CHI process, Applicant staff and the CAB, in tandem with evaluation staff, will determine what leadership opportunities are available, and seek to work with community partners to bolster their leadership capacity. Given the procurement and evaluation aspects of the CHI, there are potential opportunities for building community leadership capacity. During the procurement phase, Allocation Committee members will be directly involved in all aspects of the solicitation process. This experience builds their capacity in the decision-making process and engages them as equal and valued partners in the effort.

9. Evaluation

Identify the mechanisms that will be used to evaluate the planning process, engagement outcome, and partner perception and experience:

The evaluation design for this CHI is anticipated to have specific objectives (or similar objectives) as described below. As indicated MGB will hire a third-party evaluator to conduct the evaluation process.

It is anticipated that the following evaluation objectives will form the basis of the evaluation plan:

Objective #1 – Assess and provide data-driven feedback regarding the community engagement process and strategies used over the course of the CHI.

Objective #2- Inform future practice and innovation by monitoring and documenting the process of grant implementation for the DoN and at the grant recipient level.

Objective #3 - Assess grant-level program health equity impacts by working with grant recipients to identify, measure, and report outcomes at key points in the grant process.

Objective # 4 - Assess the impact of CHI funding and how funded projects address the social determinants of health.

Objective #5 – Build evaluation capacity among grant recipients and awareness among DoN stakeholders.

The mechanisms to evaluate the planning process, engagement outcome(s), as well as partner perception and experience will involve collaborative consultation with the CAB and Allocation Committee members, as well as grant recipients to develop program-specific processes and outcomes measures, data collection plans, and reporting templates. Through this collaborative consultation, evaluators will aim to build grantee capacity to engage in program evaluation and use results to inform practice(s). Mixed methods approaches will be considered to gather all necessary data relevant to the priority areas and key measures appropriate to the initiative at both the overall DoN level and grant recipient level.

10. Reporting

Identify the mechanisms that will be used for reporting the outcomes of this project or activity to different groups within the community:

Residents of Color

Applicant staff will submit press releases to local newspapers that reach communities of color, as well as post information on Facebook, Instagram, coalition websites, and community pages that are viewed by diverse groups. Additionally, staff will identify and recruit champions in communities of color to to serve as ambassadors and repost information to their networks.

Residents who speak a primary language other than English

Applicant staff will submit press releases to local newspapers that reach non-English speaking residents, as well as post information on Facebook, Instagram, coalition websites, and community pages that are viewed by diverse groups. Additionally, staff will identify and recruit champions that speak English as a second language to to serve as ambassadors and repost information to their networks.

Aging population

Applicant staff will submit updates to local organizations working with older adults for inclusion in newsletters, as well as post

information on coalition websites and community pages that are viewed by diverse groups. Additionally, staff will identify and recruit senior champions to serve as ambassadors and repost information to their networks.

Youth

Applicant staff will post information on Facebook, Instagram, coalition websites, and community pages that are viewed by youth. Additionally, staff will ask youth champions, often from coalition youth groups, to serve as ambassadors and repost information to their networks.

Residents Living with Disabilities

Applicant staff will submit updates to local organizations working with residents that have disabilities, as well as post information on Facebook, Instagram, coalition websites, and community pages that are viewed by diverse groups.

GLBTQ Community

Applicant staff will submit information to organizations that work with LGBTQ community members and post information on Facebook, Instagram, coalition websites, and community pages that are viewed by diverse groups. PAC staff will ensure members of the LGBTQ community are on coalition distribution lists, so these individuals receive all communications.

Residents with Low Incomes

Applicant staff will submit updates to community groups that work with residents that are underserved and/or considered low income. CCHI staff also will post information on Facebook, Instagram, coalition websites, and community pages that are viewed by diverse groups.

Other Residents

Applicant staff will discuss with the CAB any additional groups that should be aware of the project outcomes. Once these groups are identified, Applicant staff will submit press releases to local newspapers and send updates to community groups that work with the noted groups. Applicant staff also will post information on Facebook, Instagram, coalition websites, and community pages that are viewed by diverse groups.

11. Engaging the Community At Large

Which of the stages of a CHNA/CHIP process will the 2020 IC/AmSurg DoN CHI focus on? Please describe specific activities within each stage and what level the community will be engaged during the 2020 IC/AmSurg DoN CHI. While the step(s) you focus on are dependent upon your specific community engagement needs as a result of your previous CHNA/CHIP work, for tier 3 applicants the CHI community engagement process must at a minimum include the "Focus on What's Important," "Choose Effective Policies and Programs" and "Act on What's Important" stages. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
☒ Assess Needs and Resources	○	◉	○	○	○	○
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	Applicant conducted three community health needs assessment ("CHNAs") to access the needs and resources of the area. The CHNAs consist of both quantitative and qualitative components. Please see the attached Community Engagement Plan Form Section 3 Supplement narrative.					
☒ Focus on What's Important	○	○	○	◉	○	○

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
Please describe the engagement process employed during the “Focus on What's Important” phase.	Applicant held prioritization meetings with local residents, resident groups, community-based organizations and other interested parties to receive feedback on the documented needs for each service area. Through these meetings, prioritization of the communities' health needs was conducted via a systematic voting process that was participatory and data-informed. Furthermore, if approval of the DoN is obtained from the Public Health Council, Ad Hoc Subcommittees will be formed for each of the three service areas. These committees will be comprised of local stakeholders, such as staff from the local public health departments familiar with community health issues. The committees will share their thoughts on the critical health priorities and strategies for the area with the CAB. The CAB also will determine if alternative allocation processes (beyond a request for proposal process) should be used for the distribution of CHI funding. Please see the attached Community Engagement Plan Form Section 3 Supplement narrative.					
☒ Choose Effective Policies and Programs	○	○	○	◉	○	○
Please describe the engagement process employed during the “Choose Effective Policies and Programs” phase.	The CAB will utilize the key findings from prioritization meetings and each CHNA to develop health priorities and strategies. Based on these priorities and strategies, the Allocation Committee will develop the CHI RFP processes. Overall, these activities will allow Applicant to reach the "Collaborate" level of engagement for this work with the CAB and Allocation Committees given their consensus building efforts and participatory decision-making in determining health priorities and strategies for the CHI and the overall RFP process. The CAB also will explore alternative, accountable and transparent processes for distributing CHI monies as a potential alternative to an RFP process.					
☒ Act on What's Important	○	○	◉	○	○	○
Please describe the engagement process employed during the “Act on What's Important” phase.	The Allocation Committee will develop transparent funding and allocation processes. This Committee is tasked with developing sound solicitation processes including Bidders Conferences that allows potential grantees to inquire about questions on the RFP. Additionally, the Allocation Committee will ensure that technical assistance resources are available during the RFP process, so as many applicants as possible may submit viable proposals. The Allocation Committee also will ensure there are no conflicts of interest with the distribution of funds. For the procurement process aspect of this phase, Applicant will reach the “Involve” level of engagement. Additionally, for the CHI implementation aspect of this phase, where CHI funds are distributed to organizations and CHI projects are implemented, Applicant will reach the “Consult” level of engagement.					
☒ Evaluate Actions	○	◉	○	○	○	○
Please describe the engagement process employed during the “Evaluate Actions” phase.	Post-Public Health Council approval, Applicant will be selecting an evaluator to work with on the CHI. The evaluator will be tasked with monitoring and evaluating the CHI grantees on an ongoing basis and reporting progress to Applicant and the CAB on CHI activities on an annual basis. Post-review, these reports will be submitted to the Department of Public Health. For this phase, Applicant will reach the “Consult” level of engagement. Furthermore, Applicant will have the evaluator review the processes that the CAB uses to make decisions, determine health priorities and strategies and how the Allocation Committee distributes funding.					

12. Document Ready for Filing

When the document is complete, click on "document is ready to file". This will lock in the responses, and Date/Time stamp the form. To make changes to the document, un-check the "document is ready to file" box. Edit the document, then lock file and submit. Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to DPH" button.

This document is ready to file: ☒

E-mail submission to DPH

Date/Time Stamp: 12/21/2020 10:27 am

Attachment E-1

Attachment D: Community Engagement Plan Form Section 3 Supplement

The Community Health Initiative ("CHI") process and community engagement for the proposed Determination of Need ("DoN") will be conducted by Mass General Brigham Incorporated ("Applicant" or "MGB") staff and contractors. Through this DoN, the Applicant through Mass General Brigham Integrated Care, Inc. ("IC") and Mass General Brigham AmSurg, Inc. ("AmSurg") (collectively the "Proposed Licensees") are seeking to establish three ambulatory care sites in: (1) Westwood, (2) Westborough and (3) Woburn with various services provided at each site. Consequently, three community health needs assessments ("CHNAs") were conducted, one for each of the proposed ambulatory care site's primary service areas (see Attachments C 1-3: CHNA Reports). To ensure a robust CHI engagement process, MGB through Proposed Licensee staff will carry out the following activities:

1. *Development of a DoN – Community Advisory Board ("CAB"):* The Applicant developed a CAB comprised of regional and local members (residents that live within the primary service area of one of the proposed ambulatory care sites) that serve as representatives from the noted constituencies outlined in the *Community Engagement Standards for Community Health Planning Guideline.* Given their various expertise, CAB members have an understanding of the barriers to care that many local residents face, as well as the necessary social supports that are needed to ensure each resident has equal access to healthcare. The CAB is tasked with selecting the health priorities and strategies for the CHI based on key themes from the 2020 CHNAs, as well as feedback from engaged residents and key informants at community prioritization sessions. Given that some members of the CAB have a regional focus, upon DoN approval, the Applicant will establish Ad Hoc Subcommittees to the CAB. These Committees will be comprised of representatives from the primary service areas for the proposed ambulatory care sites and include representation from local stakeholders aware of each service area's needs, including staff from the local health department(s). Members of the Ad Hoc Subcommittees will provide recommendations to the CAB regarding health priorities and strategies for each primary service area. Once decisions are made about health priorities and strategies, the CAB will engage in a conflict of interest process to determine which members of the group are eligible for participation in the Allocation Committee. After approval of the Health Priorities and Strategies Form by the Department of Public Health, the Allocation Committee will develop a request for proposal ("RFP") for each primary service area to distribute CHI funding.

2. *Development of a DoN Allocation Committee:* As discussed, this Committee is charged with facilitating transparent RFP processes (or an equivalent transparent process) and allocating funds to selected organizations.

3. *Assessing Needs and Resources:* To commence the 2020 CHNA processes, the Applicant and Health Resources in Action ("HRiA") met with the CAB, so members could provide feedback on the following: 1) Identification of potential key informant interviewees and focus groups; and 2) Recruitment of partners to host focus groups. Moreover, as the CHNA processes continued, HRiA discussed with the CAB, the following draft documents: a) List of secondary data indicators; b) An outline of the CHNA Report; and c) How feedback should be provided on CHNA Reports and CHNA Key Findings.

Focus Groups and Key Informant Interviews: HRiA conducted 8 focus groups and up to 12 key informant interviews per service area. Focus group discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all focus groups to ensure consistency in the topics covered. The moderator's guide was translated

into appropriate languages for each service area. Each focus group was facilitated by a trained moderator, and detailed notes were taken during each discussion. On average, focus groups lasted 90 minutes and included 3-5 participants.

MGB met the "Consult" level of engagement for this phase.

4. *Focusing on What's Important and Choosing Effective Policies and Procedures:* HRiA hosted three prioritization sessions (one for each primary service area) with community members, stakeholders, and CAB members to discuss the key findings from the service areas' data. At these meetings, the prioritization of needs was conducted via a systematic voting process that was participatory and data-informed.

MGB met the "Collaborate" level of engagement for this phase.

5. *Choosing Effective Policies and Programs and Act on What's Important:* Based on the selected health priorities that were chosen by service area residents and CAB members during the *Focus on What's Important Phase*, the CAB will develop specific strategies to address priorities throughout the CHI process. These strategies will impact the major health and social determinant of health needs of the primary service areas. Through the CHI process, MGB will work with partner organizations (that receive CHI funding) to develop aspirational goals, measurable objectives, strategies to address the goals, and metrics to define success. These strategies will seek to identify opportunities for partnership, new ideas, and leveraging existing efforts to enhance collective impact.

The Allocation Committee will develop transparent funding and allocation processes. This Committee is tasked with developing a sound solicitation process, (or an equivalent, transparent process) including a Bidders Conference, which allows potential grantees to inquire about questions on the RFP. Additionally, the Allocation Committee will ensure that technical assistance resources are available during the RFP process, so as many applicants as possible may submit viable proposals. The Allocation Committee also will ensure there are no conflicts of interest with the distribution of funds.

MGB will meet the "Collaborate" level of engagement for the Choosing Effective Policies and Programs phase and the "Involve" level of engagement for the Act on What's Important phase.

6. *Evaluate Actions:* For this CHI, the Applicant will select an evaluator. This group will be tasked with monitoring and evaluating community partners on an ongoing basis and reporting progress on activities. Post-review, these reports will be submitted to the Department of Public Health.

MGB will meet the "Consult" level of engagement for this phase.

Attachment F

Name	Organization	Position
Amy Schectman	2Life Communities	President and CEO
Ann Houston	Opportunity Communities	CEO
Charles Desmond	Inversant	CEO
Charles Murphy	Montachusett Veterans Outreach Center	Executive Director
Cheryl Sbarra	Massachusetts Association of Health Boards	Senior Staff Attorney and Director of Policy and Law
Danna Mauch	Massachusetts Association for Mental Health	President and CEO
Dianne Kuzia Hills	My Brother's Table	Executive Director
Joseph D. Feaster, Jr.	Urban League of Eastern Massachusetts	Board Chairman
Laura Van Zandt	REACH (domestic violence prevention and services)	Executive Director
Mary Skelton Roberts	Barr Foundation	Co-Director of Climate
Milagros Abreu	The Latino Health Insurance Program, Inc.	Founder and Executive Director
Monica Tibbits-Nutt	128 Business Council / Fiscal Management and Control Board overseeing the MBTA	Executive Director/Vice Chair
Peter Koutoujian	Middlesex Sheriff's Office	Middlesex Sheriff

Rebecca Gallo	MetroWest Health Foundation	Senior Program Officer
Stephen J. Kerrigan	Edward M. Kennedy Community Health Center	President and CEO

Attachment 7

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

July 30, 2020

Department of Treasury
Internal Revenue Service Center
Ogden, UT 84201-0027

Mass General Brigham Incorporated
399 Revolution Drive, Suite 645
Somerville, MA 02145-1446

Re: Form 990 - Return of Organization Exempt From Income Tax Electronic Filing Waiver Request

Reason For Waiver Request

The taxpayer changed its name and is not eligible to e-file. Therefore, the taxpayer respectfully requests a waiver to e-file the 2018 Form 990. Attached please find the original Form 990 Return of Organization Exempt From Income Tax.

Very truly yours,

Ramzi J. Hanania
Tax Director – Mass General Brigham Incorporated

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2018 calendar year, or tax year beginning OCT 1, 2018 and ending SEP 30, 2019

B Check if applicable:
- [ ] Address change
- [X] Name change
- [ ] Initial return
- [ ] Final return/ terminated
- [ ] Amended return
- [ ] Application pending

C Name of organization
MASS GENERAL BRIGHAM INCORPORATED

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) 399 REVOLUTION DRIVE

Room/suite 645

City or town, state or province, country, and ZIP or foreign postal code SOMERVILLE, MA 02145

F Name and address of principal officer: ANNE KLIBANSKI, M.D.
800 BOYLSTON STREET, BOSTON, MA 02199

D Employer identification number
04-3230035

E Telephone number
857-282-0747

G Gross receipts $ 1,128,839,125.

H(a) Is this a group return for subordinates? [ ] Yes [X] No

H(b) Are all subordinates included? [ ] Yes [ ] No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: [X] 501(c)(3) [ ] 501(c) ( ) ◀ (insert no.) [ ] 4947(a)(1) or [ ] 527

J Website: ▶ HTTPS://WWW.MASSGENERALBRIGHAM.ORG/

K Form of organization: [X] Corporation [ ] Trust [ ] Association [ ] Other ▶

L Year of formation: 1993

M State of legal domicile: MA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: PATIENT CARE, TEACHING, RESEARCH AND SERVING THE COMMUNITY.

2 Check this box ▶ [ ] if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	7360
6	Total number of volunteers (estimate if necessary)	6	16
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	9,244,182.
b	Net unrelated business taxable income from Form 990-T, line 38	7b	1,399,583.

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)	284,715,358.	205,843,904.
9	Program service revenue (Part VIII, line 2g)	871,158,461.	899,331,514.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	161,771,759.	-190,413,284.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,963,839.	9,087,717.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,319,609,417.	923,849,851.
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	73,540,901.	530,144,805.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	567,534,312.	584,284,056.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 804,387.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	537,434,493.	553,014,511.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	1,178,509,706.	1,667,443,372.
19	Revenue less expenses. Subtract line 18 from line 12	141,099,711.	-743,593,521.

		Beginning of Current Year	End of Year
Net Assets or Fund Balances			
20	Total assets (Part X, line 16)	5,788,383,697.	6,381,428,341.
21	Total liabilities (Part X, line 26)	6,273,928,070.	8,916,598,390.
22	Net assets or fund balances. Subtract line 21 from line 20	-485,544,373.	-2,535,170,049.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date 8/14/20

▶ PETER K. MARKELL, EXEC. VP, CFO, & TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
			[ ]	

Firm's name ▶ — Firm's EIN ▶

Firm's address ▶ — Phone no.

May the IRS discuss this return with the preparer shown above? (see instructions) [ ] Yes [ ] No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
SEE SCHEDULE O

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: _____) (Expenses $ 722,008,556. including grants of $ 530,144,805.) (Revenue $ 896,366,478.)
SEE SCHEDULE O

4b (Code: _____) (Expenses $ _____ including grants of $ _____) (Revenue $ _____)

4c (Code: _____) (Expenses $ _____ including grants of $ _____) (Revenue $ _____)

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 722,008,556.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b	X	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a		X
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b		
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b	X	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	5994		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	

Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

				Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	7360		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		**2b**	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		**3a**	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*		**3b**	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		**4a**		X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		**5b**		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		**7a**	X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		**7b**	X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		**8**		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?		**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		**9b**		
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?		**13a**		
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*		**14b**		
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.		**15**	X	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		**16**		X

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	18		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a	X	
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	X	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ AL,AZ,CA,CT,DE,FL,GA,HI,ID,IL,IN,KS

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶

MASS GENERAL BRIGHAM FINANCE - TAX DIRECTOR - 857-282-0747

399 REVOLUTION DRIVE SUITE 645, SOMERVILLE, MA 02145

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) YOLONDA LORIG COLSON, MD,	1.00									
DIRECTOR UNTIL 6/30/2019	50.00	X						0.	466,708.	64,422.
(2) WILLIAM MAURICE COWAN	1.00									
DIRECTOR UNTIL 6/30/2019	1.00	X						0.	0.	0.
(3) ANNE M. FINUCANE	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(4) JOHN F. FISH	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(5) WYCLIFFE K. GROUSBECK	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(6) SUSAN J. HOCKFIELD, PHD	1.00									
DIRECTOR	0.00	X						0.	0.	0.
(7) RICHARD E. HOLBROOK	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(8) ALBERT A. HOLMAN III	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(9) JAMES L. KAPLAN, PHD	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(10) ANNE KLIBANSKI, MD	50.00									
PRES/CEO ON 6/25/19 DIR ON 3/1/19	1.00	X		X				0.	1,075,660.	63,555.
(11) JONATHAN A. KRAFT	1.00									
DIRECTOR 7/1/2019	1.00	X						0.	0.	0.
(12) CARL J. MARTIGNETTI	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(13) CATHY E. MINEHAN	1.00									
DIRECTOR UNTIL 9/30/2019	1.00	X						0.	0.	0.
(14) DIANE B. PATRICK, ESQ	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(15) DAVID W. RATTNER, MD	1.00									
DIRECTOR UNTIL 7/31/2019	50.00	X						0.	891,638.	63,692.
(16) PAMELA D. A. REEVE	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(17) ALI SALIM, MD	1.00									
DIRECTOR 7/1/2019	50.00	X						0.	630,572.	51,013.

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) SCOTT A. SCHOEN	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(19) SCOTT M. SPERLING	1.00									
CHAIRMAN	0.00	X						0.	0.	0.
(20) ALEXANDER L. THORNDIKE	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(21) DAVID F. TORCHIANA, MD	50.00									
PRES., CEO AND DIR. UNTIL 2/28/19	1.00	X		X				3,903,975.	0.	67,867.
(22) GWILL YORK	1.00									
DIRECTOR	1.00	X						0.	0.	0.
(23) PETER K. MARKELL	50.00									
EVP, CFO & TREASURER	1.00			X				2,815,230.	0.	58,040.
(24) MAUREEN GOGGIN	50.00									
SECRETARY	0.00			X				172,677.	0.	40,761.
(25) JOHN R. BARKER	50.00									
CHIEF INVESTMENT OFFICER	0.00				X			2,842,953.	0.	29,507.
(26) GREGG S. MEYER, MD	50.00									
CHIEF CLINICAL OFFICER	1.00				X			1,475,455.	0.	592,152.
1b Sub-total ▶								11,210,290.	3,064,578.	1,031,009.
c Total from continuation sheets to Part VII, Section A ▶								7,279,533.	0.	410,431.
d Total (add lines 1b and 1c) ▶								18,489,823.	3,064,578.	1,441,440.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 1,405

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
MCKINSEY & CO INC 280 CONGRESS STREET #1100, BOSTON, MA 02210	CONSULTING SERVICES	12,266,665.
RANDSTAD HEALTHCARE, P.O. BOX 7247-6655, PHILADELPHIA, PA 19170-6655	STAFFING SERVICES	9,908,098.
DEIULIS BROTHERS CONSTRUCTION CO INC 31 COLLINS STREET TERRACE, LYNN, MA 01902	CONSTRUCTION SERVICES	5,666,806.
HEALTH CATALYST, 3165 MILLROCK DRIVE, SALT LAKE CITY, UT 84121	TECHNOLOGY SERVICES	4,565,681.
ACCENTURE LLP P.O. BOX 70629, CHICAGO, IL 60673	CONSULTING SERVICES	4,477,413.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 138

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) JAMES W. NOGA	50.00									
VICE PRESIDENT AND CIO	0.00				X			1,173,722.	0.	69,131.
(28) ROSEMARY R. SHEEHAN	50.00									
CHIEF HUMAN RESOURCES OFFICER	0.00				X			776,363.	0.	66,513.
(29) LAURA PEABODY	50.00									
CHIEF LEGAL OFFICER & GEN. COUNS.	0.00					X		1,420,710.	0.	60,037.
(30) ELIZABETH L. BALDWIN	50.00									
PORTFOLIO MANAGER	0.00					X		1,252,198.	0.	63,366.
(31) KATHERINE L. KAMM	50.00									
PORTFOLIO MANAGER	0.00					X		931,960.	0.	32,040.
(32) CHRISTOPHER M. COBURN	50.00									
CHIEF INNOVATION OFFICER	1.00					X		883,599.	0.	55,793.
(33) SEAN P. BLATCHLEY	50.00									
PORTFOLIO MANAGER	0.00					X		840,981.	0.	63,551.
Total to Part VII, Section A, line 1c								7,279,533.		410,431.

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns 1a				
	b Membership dues 1b				
	c Fundraising events 1c				
	d Related organizations 1d 205,843,904.				
	e Government grants (contributions) 1e				
	f All other contributions, gifts, grants, and similar amounts not included above 1f				
	g Noncash contributions included in lines 1a-1f: $				
	h **Total.** Add lines 1a-1f ▶	205,843,904.			
Program Service Revenue		**Business Code**			
	2a ADMINISTRATIVE FEE	561000 899,331,514.	896,331,908.	2,999,606.	
	b				
	c				
	d				
	e				
	f All other program service revenue				
	g **Total.** Add lines 2a-2f ▶	899,331,514.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶	14,575,990.		6,281,779.	8,294,211.
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties ▶	1,555,408.			1,555,408.
		(i) Real (ii) Personal			
	6a Gross rents 582,104.				
	b Less: rental expenses 0.				
	c Rental income or (loss) 582,104.				
	d Net rental income or (loss) ▶	582,104.		-2,633.	584,737.
		(i) Securities (ii) Other			
	7a Gross amount from sales of assets other than inventory				
	b Less: cost or other basis and sales expenses 204,989,274.				
	c Gain or (loss) -204989274.				
	d Net gain or (loss) ▶	-204,989,274.			-204,989,274.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 a				
	b Less: direct expenses b				
	c Net income or (loss) from fundraising events ▶				
	9a Gross income from gaming activities. See Part IV, line 19 a				
	b Less: direct expenses b				
	c Net income or (loss) from gaming activities ▶				
	10a Gross sales of inventory, less returns and allowances a				
	b Less: cost of goods sold b				
	c Net income or (loss) from sales of inventory ▶				
	Miscellaneous Revenue	**Business Code**			
	11a OTHER REVENUE	900099 2,707,776.			2,707,776.
	b CHILD CARE REVENUE	624410 2,177,799.			2,177,799.
	c PARKING INCOME	812930 2,064,630.			2,064,630.
	d All other revenue				
	e **Total.** Add lines 11a-11d ▶	6,950,205.			
	12 **Total revenue.** See instructions ▶	923,849,851.	896,366,478.	9,244,182.	-187,604,713.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	530,144,805.	530,144,805.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	13,160,375.		13,160,375.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	433,521,935.		433,230,127.	291,808.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	34,818,075.	9,663,714.	25,154,361.	
9 Other employee benefits	67,402,605.	18,707,510.	48,600,253.	94,842.
10 Payroll taxes	35,381,066.	9,819,971.	25,561,095.	
11 Fees for services (non-employees):				
a Management				
b Legal	9,326,454.	2,588,546.	6,737,908.	
c Accounting	1,631,124.	452,716.	1,178,408.	
d Lobbying	1,580,023.		1,580,023.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	62,689,593.	17,399,419.	45,067,193.	222,981.
12 Advertising and promotion	1,405,307.	390,041.	1,015,266.	
13 Office expenses	23,864,350.	6,623,521.	17,140,026.	100,803.
14 Information technology	109,278,642.	30,330,152.	78,948,490.	
15 Royalties				
16 Occupancy	14,395,165.	3,995,360.	10,339,607.	60,198.
17 Travel	2,055,560.	570,518.	1,481,598.	3,444.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	522,535.	145,029.	377,302.	204.
20 Interest	217,095,056.	60,254,465.	156,840,591.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	68,366,151.	18,974,941.	49,391,210.	
23 Insurance	1,567,703.	435,114.	1,132,589.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a UNRELATED BUSINESS TAX	861,781.		861,781.	
b PROGRAM SUPPORT/SUBSIDY	24,639,936.	6,838,784.	17,801,152.	
c MISCELLANEOUS EXPENSES	9,466,299.	3,489,141.	5,977,158.	
d MEALS	3,108,365.	862,723.	2,218,511.	27,131.
e All other expenses	1,160,467.	322,086.	835,405.	2,976.
25 **Total functional expenses.** Add lines 1 through 24e	1,667,443,372.	722,008,556.	944,630,429.	804,387.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing			1	
	2	Savings and temporary cash investments		-70,748,306.	2	-81,102,507.
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		84,143,832.	4	77,649,064.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L			6	
	7	Notes and loans receivable, net		3,723,220,108.	7	3,877,972,708.
	8	Inventories for sale or use			8	
	9	Prepaid expenses and deferred charges		18,414,886.	9	25,604,828.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 926,170,658.			
	b	Less: accumulated depreciation	10b 210,672,981.	715,405,465.	10c	715,497,677.
	11	Investments - publicly traded securities			11	
	12	Investments - other securities. See Part IV, line 11		1,114,036,987.	12	1,455,967,943.
	13	Investments - program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		203,910,725.	15	309,838,628.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		5,788,383,697.	16	6,381,428,341.
Liabilities	17	Accounts payable and accrued expenses		874,315,649.	17	3,122,442,890.
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		3,431,371,716.	20	3,603,717,554.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		1,968,240,705.	25	2,190,437,946.
	26	**Total liabilities.** Add lines 17 through 25		6,273,928,070.	26	8,916,598,390.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		-486,823,449.	27	-2,536,440,982.
	28	Temporarily restricted net assets		129,076.	28	120,933.
	29	Permanently restricted net assets		1,150,000.	29	1,150,000.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		-485,544,373.	33	-2,535,170,049.
	34	Total liabilities and net assets/fund balances		5,788,383,697.	34	6,381,428,341.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	923,849,851.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,667,443,372.
3	Revenue less expenses. Subtract line 2 from line 1	3	-743,593,521.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	-485,544,373.
5	Net unrealized gains (losses) on investments	5	77,244.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-1,306,109,399.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-2,535,170,049.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	X	

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization	Employer identification number
MASS GENERAL BRIGHAM INCORPORATED	04-3230035

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
7 ☒ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
10 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
f Enter the number of supported organizations .....
g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")	183,067,721.	225,341,569.	268,658,863.	284,715,358.	205,843,904.	1167627415.
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3	183,067,721.	225,341,569.	268,658,863.	284,715,358.	205,843,904.	1167627415.
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						1167627415.

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
7 Amounts from line 4	183,067,721.	225,341,569.	268,658,863.	284,715,358.	205,843,904.	1167627415.
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources	61,995,189.	6,775,055.	903,879.	3,344,453.	10,454,503.	83,473,079.
9 Net income from unrelated business activities, whether or not the business is regularly carried on			429,083.	3,382,175.	1,399,583.	5,210,841.
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						1256311335.

12 Gross receipts from related activities, etc. (see instructions) ▶ 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) 14 92.94 %

15 Public support percentage from 2017 Schedule A, Part II, line 14 15 92.48 %

16a **33 1/3% support test - 2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☒

b **33 1/3% support test - 2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2018 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2017 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2018** (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from **2017** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2018.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* **Part VI** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* **Part VI** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* **Part VI** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* **Part VI** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* **Part VI** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* **Part VI** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* **Part VI,** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* **Part VI.**	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* **Part VI.**	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* **Part VI.**	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* **Part VI.**	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV Supporting Organizations *(continued)*

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* **Part VI.**	11c		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* **Part VI** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* **Part VI** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* **Part VI** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	1		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* **Part VI** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* **Part VI** *the role the organization's supported organizations played in this regard.*	3		

Section E. Type III Functionally Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year* **(see instructions).**

a ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* **line 3** *below.*

c ☐ The organization supported a governmental entity. *Describe in* **Part VI** *how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. **Answer (a) and (b) below.**			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* **Part VI identify those supported organizations and explain** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* **Part VI** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations. **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* **Part VI.**	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* **Part VI** *the role played by the organization in this regard.*	3b		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI.) **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	**1**		
2 Recoveries of prior-year distributions	**2**		
3 Other gross income (see instructions)	**3**		
4 Add lines 1 through 3	**4**		
5 Depreciation and depletion	**5**		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	**6**		
7 Other expenses (see instructions)	**7**		
8 **Adjusted Net Income** (subtract lines 5, 6, and 7 from line 4)	**8**		

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d **Total** (add lines 1a, 1b, and 1c)	**1d**		
e **Discount** claimed for blockage or other factors (explain in detail in **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d	**3**		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by .035	**6**		
7 Recoveries of prior-year distributions	**7**		
8 **Minimum Asset Amount** (add line 7 to line 6)	**8**		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	**1**		
2 Enter 85% of line 1	**2**		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	**3**		
4 Enter greater of line 2 or line 3	**4**		
5 Income tax imposed in prior year	**5**		
6 **Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	**6**		

7 ☐ Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).

Part V **Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations** *(continued)*

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2018 from Section C, line 6	
10	Line 8 amount divided by line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2018	(iii) Distributable Amount for 2018
1	Distributable amount for 2018 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2018 (reasonable cause required- explain in **Part VI**). See instructions.			
3	Excess distributions carryover, if any, to 2018			
a	From 2013			
b	From 2014			
c	From 2015			
d	From 2016			
e	From 2017			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2018 distributable amount			
i	Carryover from 2013 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2018 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2018 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2018, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in **Part VI.** See instructions.			
6	Remaining underdistributions for 2018. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in **Part VI**. See instructions.			
7	**Excess distributions carryover to 2019.** Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2014			
b	Excess from 2015			
c	Excess from 2016			
d	Excess from 2017			
e	Excess from 2018			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a, and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**
▶ **Go to www.irs.gov/Form990 for the latest information.**

OMB No. 1545-0047

2018

Name of the organization	**Employer identification number**
MASS GENERAL BRIGHAM INCORPORATED	04-3230035

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[ ] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[X] For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** $5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling $5,000 or more during the year ..... ▶ $ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

If the organization answered "Yes," on Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," on Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," on Form 990, Part IV, line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
MASS GENERAL BRIGHAM INCORPORATED	04-3230035

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.

2 Political campaign activity expenditures ▶ $

3 Volunteer hours for political campaign activities

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?	X		
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		1,580,023.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?		X	
j Total. Add lines 1c through 1i			1,580,023.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political campaign activity expenditures from the prior year?	3		

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

LOBBYING EXPENSES

THE CORPORATION MAY ON OCCASION CONTACT ITS EMPLOYEES WITH A VOLUNTARY

OPPORTUNITY TO PARTICIPATE IN THE CONVERSATION TO PROTECT AGAINST CUTS IN

FEDERAL FUNDING THAT WOULD HAVE AN ADVERSE IMPACT ON THE CORPORATION AND

ITS AFFILIATES AS WELL AS THE PACE OF MEDICAL ADVANCES, THE ECONOMY, AND

THE GLOBAL COMPETITIVENESS OF THE CORPORATION. THE CORPORATION MAY ON

Part IV Supplemental Information *(continued)*

OCCASION REVIEW PROPOSED LEGISLATION FOR THE PURPOSE OF DETERMINING THE EFFECT UPON ITS TAX-EXEMPT PURPOSES. THE CORPORATION MAY ON OCCASION ALSO APPEAR BEFORE A LEGISLATIVE COMMITTEE, CONFER WITH LEGISLATORS OR OTHERWISE ATTEMPT TO INFLUENCE LEGISLATION. HOWEVER, IT WILL NOT PARTICIPATE, IN ANY WAY, IN POLITICAL CAMPAIGNS. THE CORPORATION'S INVOLVEMENT IN LEGISLATIVE ACTIVITIES CONSTITUTES AN INSUBSTANTIAL PART OF ITS ACTIVITIES.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Preservation of a historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	10,313,374.	9,793,133.	18,832,078.	11,088,489.	6,562,989.
b Contributions	297,434.	276,966.	-9,637,179.	7,313,016.	5,072,977.
c Net investment earnings, gains, and losses	390,831.	669,855.	1,760,903.	977,078.	-260,929.
d Grants or scholarships					
e Other expenditures for facilities and programs	451,322.	426,580.	1,162,669.	546,505.	286,548.
f Administrative expenses					
g End of year balance	10,550,317.	10,313,374.	9,793,133.	18,832,078.	11,088,489.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 88.06 %
b Permanent endowment ▶ 10.90 %
c Temporarily restricted endowment ▶ 1.04 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)		X
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land	13,601,826.	58,165,612.		71,767,438.
b Buildings	32,204,351.	514,303,189.	75,421,023.	471,086,517.
c Leasehold improvements		8,953,691.	6,482,033.	2,471,658.
d Equipment		280,216,504.	128,769,925.	151,446,579.
e Other		18,725,485.		18,725,485.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				715,497,677.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) INV IN PARTNERS POOLED INV ACC	26,394,841.	END-OF-YEAR MARKET VALUE
(B) INV IN PARTNERS POOLED INV HOLDING		
(C) LLC	1,429,573,102.	END-OF-YEAR MARKET VALUE
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	1,455,967,943.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X Other Liabilities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) SETTLEMENTS - THIRD PARTY PAYORS	61,793,946.
(3) TAXABLE BONDS	2,128,644,000.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	2,190,437,946.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☐

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

INTENDED USE OF ENDOWMENT FUNDS

THE ENDOWMENT FUNDS OF MASS GENERAL BRIGHAM INCORPORATED ARE USED IN

FURTHERANCE OF THE ORGANIZATION'S TAX-EXEMPT MISSION.

FIN 48 FOOTNOTE

MASS GENERAL BRIGHAM INCORPORATED DOES NOT HAVE A FIN 48 FOOTNOTE

DISCLOSURE IN THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS.

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.**

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

MASS GENERAL BRIGHAM INCORPORATED

Employer identification number

04-3230035

Part I General Information on Activities Outside the United States.

Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... ☐ **Yes** ☐ **No**

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	**(b)** Number of offices in the region	**(c)** Number of employees, agents, and independent contractors in the region	**(d)** Activities conducted in the region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	**(e)** If activity listed in (d) is a program service, describe specific type of service(s) in the region	**(f)** Total expenditures for and investments in the region
CENTRAL AMERICA/CARIBBEAN	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	70.
CENTRAL AMERICA/CARIBBEAN	0	0	PROGRAM SERVICES	JOINTLY OWNED FOREIGN INSURANCE	618,464.
EAST ASIA AND THE PACIFIC	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	444,357.
EUROPE	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	1,001,593.
MIDDLE EAST AND NORTH AFRICA	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	34,465.
NORTH AMERICA	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	171,133.
RUSSIA AND NEIGHBORING STATES	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	6,387.
SOUTH AMERICA	0	0	PROGRAM SERVICES	PAT,CARE,RESEARCH & EDUCATION	98,049.
3 a Subtotal	0	0			2,374,518.
b Total from continuation sheets to Part I	0	0			327,097.
c **Totals** (add lines 3a and 3b)	0	0			2,701,615.

Part I **Continuation of Activities per Region.** (Schedule F (Form 990), Part I, line 3)

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
SOUTH ASIA	0	0	PROGRAM SERVICES	PAT,CARE,RESEARCH & EDUCATION	58,606.
SUB-SAHARAN AFRICA	0	0	PROGRAM SERVICES	PAT. CARE, RESEARCH & EDUCATION	268,491.
Totals ▶					327,097.

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 **(a)** Name of organization	**(b)** IRS code section and EIN (if applicable)	**(c)** Region	**(d)** Purpose of grant	**(e)** Amount of cash grant	**(f)** Manner of cash disbursement	**(g)** Amount of noncash assistance	**(h)** Description of noncash assistance	**(i)** Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ▶

3 Enter total number of other organizations or entities ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	**(b)** Region	**(c)** Number of recipients	**(d)** Amount of cash grant	**(e)** Manner of cash disbursement	**(f)** Amount of noncash assistance	**(g)** Description of noncash assistance	**(h)** Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	[X] Yes	[ ] No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)*	[ ] Yes	[X] No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations (see Instructions for Form 5471)*	[X] Yes	[ ] No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*	[X] Yes	[ ] No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	[X] Yes	[ ] No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990)*	[X] Yes	[ ] No

Part V Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

ACCOUNTING METHOD

THE ORGANIZATION USES THE ACCRUAL METHOD TO REPORT FOREIGN

EXPENDITURES TO BE CONSISTENT WITH THE REPORTING USED FOR THE FINANCIAL

STATEMENTS.

SCHEDULE I
(Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
HARVARD MEDICAL SCHOOL 25 SHATTUCK STREET BOSTON, MA 02115	04-2103580	501(C)(3)	9,431,898.	0.			COMMUNITY BENEFIT PROGRAM
RIZE 101 HUNTINGTON AVE BOSTON, MA 02199	83-0989395	501(C)(3)	3,333,333.	0.			COMMUNITY BENEFIT PROGRAM
LYNN COMMUNITY HEALTH CENTER 269 UNION STREET LYNN, MA 01901	04-2525066	501(C)(3)	806,364.	0.			COMMUNITY BENEFIT PROGRAM
MASS LEAGUE OF COMMUNITY HEALTH CENTERS - 40 COURT STREET - BOSTON, MA 02108	04-2507409	501(C)(3)	277,230.	0.			COMMUNITY BENEFIT PROGRAM
CAMP HARBOR VIEW 200 CLARENDON ST., 60TH FLOOR BOSTON, MA 02116	75-3235491	501(C)(3)	255,000.	0.			COMMUNITY BENEFIT PROGRAM
HEALTH CARE FOR ALL ONE FEDERAL STREET, 5TH FLOOR BOSTON, MA 02110	04-3071598	501(C)(3)	208,855.	0.			COMMUNITY BENEFIT PROGRAM

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... ▶ 80.

3 Enter total number of other organizations listed in the line 1 table ..... ▶ 10.

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MATTAPAN COMMUNITY HEALTH CENTER 1425 BLUE HILL AVENUE MATTAPAN, MA 02126	04-2544151	501(C)(3)	157,500.	0.			COMMUNITY BENEFIT PROGRAM
EAST BOSTON COMMUNITY HEALTH CENTER - 10 GOVE STREET - EAST BOSTON, MA 02128	23-7425849	501(C)(3)	100,000.	0.			COMMUNITY BENEFIT PROGRAM
JOHN HANCOCK (MLK SUMMER SCHOLARS) 197 CLARENDON STREET, 5TH FLOOR BOSTON, MA 02116	04-1414660		100,000.	0.			COMMUNITY BENEFIT PROGRAM
SCHOLAR ATHLETES PROGRAM 57 MAGAZINE STREET BOSTON, MA 02119	27-3987854	501(C)(3)	100,000.	0.			COMMUNITY BENEFIT PROGRAM
SOUTH BOSTON COMMUNITY HEALTH CENTER - 409 WEST BROADWAY STREET - SOUTH BOSTON, MA 02127	04-2682152	501(C)(3)	50,000.	0.			COMMUNITY BENEFIT PROGRAM
HEALTH CAREER CONNECTION INC PO BOX 398731 SAN FRANCISCO, CA 94139	25-1904312	501(C)(3)	48,300.	0.			COMMUNITY BENEFIT PROGRAM
EMK COMMUNITY HEALTH CENTER 650 LINCOLN STREET WORCESTER, MA 01605	04-2513817	501(C)(3)	40,000.	0.			COMMUNITY BENEFIT PROGRAM
GLAAD 30 WINTER STREET, SUITE 800 BOSTON, MA 02108	04-2660498	501(C)(3)	35,000.	0.			COMMUNITY BENEFIT PROGRAM
PROJECT BREAD 145 BORDER STREET EAST BOSTON, MA 02128	04-2931195	501(C)(3)	35,000.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
VICTORY PROGRAMS 965 MASSACHUSETTS AVENUE BOSTON, MA 02118	04-2575322	501(C)(3)	35,000.	0.			COMMUNITY BENEFIT PROGRAM
EDWARD M. KENNEDY INSTITUTE FOR THE UNITED STATES SENATE - 210 MORRISSEY BOULEVARD - BOSTON, MA 02125	27-0963869	501(C)(3)	33,334.	0.			COMMUNITY BENEFIT PROGRAM
HEALTH LAW ADVOCATES 1 FEDERAL STREET, 5TH FLOOR BOSTON, MA 02110	04-3298116	501(C)(3)	30,000.	0.			COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS PUBLIC HEALTH ASSOCIATION - 50 FEDERAL STREET, 8TH FLOOR - BOSTON, MA 02110	04-2326503	501(C)(3)	30,000.	0.			COMMUNITY BENEFIT PROGRAM
GREATER BOSTON CHAMBER OF COMMERCE 265 FRANKLIN STREET, 12TH FLOOR BOSTON, MA 02110	04-1103090	501(C)(6)	28,500.	0.			COMMUNITY BENEFIT PROGRAM
EMMANUEL COLLEGE 400 THE FENWAY BOSTON, MA 02115	04-2105769	501(C)(3)	25,000.	0.			COMMUNITY BENEFIT PROGRAM
HEALTHCARE WITHOUT WALLS 148 LINDEN STREET, SUITE 208 WELLESLEY, MA 02482	04-3487205	501(C)(3)	25,000.	0.			COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH - 130 BOWDOIN STREET, SUITE 309 - BOSTON, MA 02110	04-2104711	501(C)(3)	25,000.	0.			COMMUNITY BENEFIT PROGRAM
MY BROTHER'S TABLE 98 WILLOW STREET LYNN, MA 01901	04-2794047	501(C)(3)	25,000.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE BASE 150 SHIRLEY STREET ROXBURY, MA 02119	46-1856641	501(C)(3)	25,000.	0.			COMMUNITY BENEFIT PROGRAM
HOME BASE 55 FRUIT STREET BOSTON, MA 02114	04-1564655	501(C)(3)	25,000.	0.			COMMUNITY BENEFIT PROGRAM
THE SCHWARTZ CENTER FOR COMPASSIONATE HEALTHCARE - 100 CAMBRIDGE STREET, SUITE 2100 - BOSTON, MA 02114	04-1564655	501(C)(3)	23,750.	0.			COMMUNITY BENEFIT PROGRAM
ABCD 178 TREMONT STREET BOSTON, MA 02111	04-2304133	501(C)(3)	20,000.	0.			COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS LAW REFORM INSTITUTE INC - 40 COURT STREET, SUITE 800 - BOSTON, MA 02108	04-6004303	501(C)(3)	20,000.	0.			COMMUNITY BENEFIT PROGRAM
THE NEW ENGLAND COUNCIL 98 NORTH WASHINGTON ST., STE 201 BOSTON, MA 02114	04-1661090	501(C)(3)	20,000.	0.			COMMUNITY BENEFIT PROGRAM
THE BOSTON FOUNDATION 75 ARLINGTON STREET, 3RD FLOOR BOSTON, MA 02116	04-2104021	501(C)(3)	19,445.	0.			COMMUNITY BENEFIT PROGRAM
HEALTH RESOURCES IN ACTION (HRIA) 95 BERKELEY STREET BOSTON, MA 02116	04-2229839	501(C)(3)	16,668.	0.			COMMUNITY BENEFIT PROGRAM
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVENUE DALLAS, TX 75231	13-5613797	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BIG SISTER ASSOCIATION 20 PARK PLAZA, SUITE 1420 BOSTON, MA 02116	04-2150651	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
HEALTHCARE WITHOUT HARM 12355 SUNRISE VALLEY DR, SUITE 680 RESTON, VA 20191	52-2358837	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS BUDGET AND POLICY CENTER - ONE STATE STREET, SUITE 1250 - BOSTON, MA 02109	04-2967537	501(C)(1)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
PROJECT PLACE 1145 WASHINGTON STREET BOSTON, MA 02118	34-2026629	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
SOUTH END CHC 1601 WASHINGTON STREET BOSTON, MA 02118	04-2456134	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
THE FOUNDATION FOR BOSTON CENTERS FOR YOUTH AND FAMILIES - 1483 TREMONT STREET - BOSTON, MA 02120	04-2602576	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
UNITED WAY OF MASSACHUSETTS BAY 51 SLEEPER STREET BOSTON, MA 02210	04-2382233	501(C)(3)	15,000.	0.			COMMUNITY BENEFIT PROGRAM
BOSTON CENTER FOR INDEPENDENT LIVING - 60 TEMPLE PLACE, 5TH FLOOR - BOSTON, MA 02111	04-2546595	501(C)(3)	12,500.	0.			COMMUNITY BENEFIT PROGRAM
ROCA 101 PARK STREET CHELSEA, MA 02150	22-3223641	501(C)(3)	12,500.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) - SCHRAFFT'S CENTER, 529 MAIN STREET, SUITE 1M17 - CHARLESTOWN, MA 02129	04-2777012	501(C)(3)	11,250.	0.			COMMUNITY BENEFIT PROGRAM
CARE 2 COMMUNITIES (HAITIAN RELIEF) - 24 SCHOOL STREET - BOSTON, MA 02108	26-4369180	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
JANE DOE, INC. 745 ATLANTIC AVENUE BOSTON, MA 02111	04-2676138	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
NATIONAL ASSOCIATION OF HEALTH SERVICES EXECUTIVES - 1050 CONNECTICUT AVE, NW, FLOOR 10 - WASHINGTON, DC 20036	62-1312239	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
SAINT JOHN PAUL CATHOLIC ACADEMY 2200 DORCHESTER AVENUE DORCHESTER, MA 02124	26-2607406	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
URBAN LEAGUE OF BOSTON 88 WARREN STREET ROXBURY, MA 02119	23-7349132	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
WHITTIER STREET HC 1290 TREMONT STREET ROXBURY, MA 02120	04-2619517	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
MORGAN MEMORIAL GOODWILL INDUSTRIES INC - 1010 HARRISON AVENUE - BOSTON, MA 02119	04-2106765	501(C)(3)	10,000.	0.			COMMUNITY BENEFIT PROGRAM
PARTNERS IN HEALTH INC 800 BOYLSTON STREET, SUITE 300 BOSTON, MA 02199	04-3567502	501(C)(3)	8,334.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HARVARD STREET NEIGHBORHOOD CENTER 632 BLUE HILL AVENUE DORCHESTER, MA 02121	04-2600042	501(C)(3)	7,500.	0.			COMMUNITY BENEFIT PROGRAM
ALPFA INC 1717 W. 6TH STREET, SUITE 410 AUSTIN, TX 78703	32-0178401	501(C)(3)	7,000.	0.			COMMUNITY BENEFIT PROGRAM
SIMMONS UNIVERSITY 300 FENWAY BOSTON, MA 02115	04-2103629	501(C)(3)	6,750.	0.			COMMUNITY BENEFIT PROGRAM
YEAR UP, INC. 45 MILK STREET, 9TH FLOOR BOSTON, MA 02109	04-3534407	501(C)(3)	6,000.	0.			COMMUNITY BENEFIT PROGRAM
NATIONAL ASSOCIATION OF CORPORATE DIRECTORS - 1515 N. COURTHOUSE ROAD, SUITE 1200 - ARLINGTON, VA 22201	04-3370584	501(C)(3)	5,834.	0.			COMMUNITY BENEFIT PROGRAM
ACCELERATED COLLEGE EXPERIENCES INC - 251 HEATH STREET, APT. 207 - JAMAICA PLAIN, MA 02130	45-4101866	501(C)(3)	138,050.	0.			COMMUNITY BENEFIT PROGRAM
UNIVERSITY OF MASSACHUSETTS BOSTON 100 MORRISSEY BOULEVARD BOSTON, MA 02125	04-3167352	STATE OF MA	58,500.	0.			COMMUNITY BENEFIT PROGRAM
UASPIRE 31 MILK STREET, #900 BOSTON, MA 02109	04-3564307	501(C)(3)	53,500.	0.			COMMUNITY BENEFIT PROGRAM
HEALTH RESOURCES IN ACTION (HRIA) 95 BERKELEY STREET BOSTON, MA 02116	04-2229839	501(C)(3)	46,250.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TUFTS UNIVERSITY 419 BOSTON AVENUE MEDFORD, MA 02155	04-2103634	501(C)(3)	29,000.	0.			COMMUNITY BENEFIT PROGRAM
UNIVERSITY OF MASSACHUSETTS LOWELL 1 UNIVERSITY AVENUE LOWELL, MA 01854	04-3167352	STATE OF MA	29,000.	0.			COMMUNITY BENEFIT PROGRAM
BOSTON UNIVERSITY ONE SILBER WAY BOSTON, MA 02215	04-2103547	501(C)(3)	27,000.	0.			COMMUNITY BENEFIT PROGRAM
UNIVERSITY OF MASSACHUSETTS DARTMOUTH - 285 OLD WESTPORT ROAD - NORTH DARTMOUTH, MA 02747	04-3167352	STATE OF MA	27,000.	0.			COMMUNITY BENEFIT PROGRAM
SIMMONS UNIVERSITY 300 FENWAY BOSTON, MA 02115	04-2103629	501(C)(3)	25,500.	0.			COMMUNITY BENEFIT PROGRAM
BUNKER HILL COMMUNITY COLLEGE 250 NEW RUTHERFORD AVENUE BOSTON, MA 02129	04-2710011	STATE OF MA	23,000.	0.			COMMUNITY BENEFIT PROGRAM
SALEM STATE UNIVERSITY 352 LAFAYETTE STREET SALEM, MA 01970	04-2325342	STATE OF MA	21,000.	0.			COMMUNITY BENEFIT PROGRAM
NORTHEASTERN UNIVERSITY 360 HUNTINGTON AVENUE BOSTON, MA 02115	04-1679980	501(C)(3)	19,500.	0.			COMMUNITY BENEFIT PROGRAM
UNIVERSITY OF MASSACHUSETTS AMHERST - 181 PRESIDENT'S DRIVE - AMHERT, MA 01003	54-2084125	STATE OF MA	19,500.	0.			COMMUNITY BENEFIT PROGRAM

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MASSACHUSETTS COLLEGE OF PHARMACY AND HEALTH SCIENCES - 179 LONGWOOD AVENUE - BOSTON, MA 02115	04-2104700	501(C)(3)	19,000.	0.			COMMUNITY BENEFIT PROGRAM
CURRY COLLEGE 1071 BLUE HILL AVENUE MILTON, MA 02186	04-2199867	501(C)(3)	12,000.	0.			COMMUNITY BENEFIT PROGRAM
LESLEY UNIVERSITY 29 EVERETT STREET CAMBRIDGE, MA 02138	04-2103589	501(C)(3)	10,500.	0.			COMMUNITY BENEFIT PROGRAM
RHODE ISLAND COLLEGE 600 MOUNT PLEASANT AVENUE PROVIDENCE, RI 02908	05-6016315	STATE OF RI	9,000.	0.			COMMUNITY BENEFIT PROGRAM
DARTMOUTH COLLEGE 6024 MCNUTT HALL HANOVER, NH 03755	02-0222111	501(C)(3)	8,000.	0.			COMMUNITY BENEFIT PROGRAM
MILLS COLLEGE 5000 MACARTHUR BOULEVARD OAKLAND, CA 94613	94-1156566	501(C)(3)	5,500.	0.			COMMUNITY BENEFIT PROGRAM
WESTERN NEW ENGLAND UNIVERSITY 1215 WILBRAHAM ROAD SPRINGFIELD, MA 01119	04-2108376	501(C)(3)	5,500.	0.			COMMUNITY BENEFIT PROGRAM
WHEATON COLLEGE 26 E MAIN STREET NORTON, MA 02766	04-2103638	501(C)(3)	5,500.	0.			COMMUNITY BENEFIT PROGRAM
THE MASSACHUSETTS GENERAL HOSPITAL 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	04-1564655	501(C)(3)	233338789	0.			EXEMPT AFFILIATE SUPPORT

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE BRIGHAM AND WOMEN'S HOSPITAL, INC. - 399 REVOLUTION DRIVE, SUITE 645 - SOMERVILLE, MA 02145	04-2312909	501(C)(3)	167198601	0.			EXEMPT AFFILIATE SUPPORT
MASSACHUSETTS EYE & EAR INFIRMARY 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	04-2103591	501(C)(3)	24,239,908.	0.			EXEMPT AFFILIATE SUPPORT
PARTNERS CONTINUING CARE, INC. 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	26-0003495	501(C)(3)	20,690,000.	0.			EXEMPT AFFILIATE SUPPORT
NORTH SHORE MEDICAL CENTER, INC. 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	04-3399616	501(C)(3)	19,028,465.	0.			EXEMPT AFFILIATE SUPPORT
COOLEY DICKINSON HOSPITAL, INC. 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	22-2617175	501(C)(3)	15,929,495.	0.			EXEMPT AFFILIATE SUPPORT
MASS GENERAL BRIGHAM URGENT CARE, LLC - 399 REVOLUTION DRIVE, SUITE 645 - SOMERVILLE, MA 02145	47-1683619	501(C)(3)	8,500,000.	0.			EXEMPT AFFILIATE SUPPORT
PARTNERS COMMUNITY PHYSICIANS ORGANIZATION, INC. - 399 REVOLUTION DRIVE, SUITE 645 - SOMERVILLE, MA 02145	04-3236175	501(C)(3)	8,324,350.	0.			EXEMPT AFFILIATE SUPPORT
THE GENERAL HOSPITAL CORPORATION 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	04-2697983	501(C)(3)	7,942,179.	0.			EXEMPT AFFILIATE SUPPORT
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC. - 399 REVOLUTION DRIVE, SUITE 645 - SOMERVILLE, MA 02145	04-3466314	501(C)(3)	6,649,699.	0.			EXEMPT AFFILIATE SUPPORT

Part II **Continuation of Grants and Other Assistance to Governments and Organizations in the United States** (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NORTH SHORE PHYSICIANS GROUP, INC. 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	04-3080484	501(C)(3)	987,132.	0.			EXEMPT AFFILIATE SUPPORT
THE MCLEAN HOSPITAL CORPORATION 399 REVOLUTION DRIVE, SUITE 645 SOMERVILLE, MA 02145	04-2697981	501(C)(3)	868,706.	0.			EXEMPT AFFILIATE SUPPORT
THE SPAULDING REHABILITATION HOSPITAL - 399 REVOLUTION DRIVE, SUITE 645 - SOMERVILLE, MA 02145	04-2551124	501(C)(3)	182,836.	0.			EXEMPT AFFILIATE SUPPORT

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance

Part IV **Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

SCHEDULE I, PART I, LINE 2

MASS GENERAL BRIGHAM INCORPORATED MAKES DONATIONS TO VARIOUS TAX-EXEMPT

ORGANIZATIONS. THESE DONATIONS CAN BE USED BY THE RECIPIENT ONLY IN

FURTHERANCE OF THEIR TAX-EXEMPT MISSION.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

MASS GENERAL BRIGHAM INCORPORATED

Employer identification number

04-3230035

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	[X] First-class or charter travel	[ ] Housing allowance or residence for personal use		
	[X] Travel for companions	[ ] Payments for business use of personal residence		
	[ ] Tax indemnification and gross-up payments	[ ] Health or social club dues or initiation fees		
	[ ] Discretionary spending account	[ ] Personal services (such as maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**2**	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	[X] Compensation committee	[ ] Written employment contract		
	[X] Independent compensation consultant	[X] Compensation survey or study		
	[X] Form 990 of other organizations	[X] Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		X
b	Any related organization?	**6b**		X
	If "Yes" on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**	X	
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		X
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) YOLONDA LORIG COLSON, MD,	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR UNTIL 6/30/2019	(ii)	431,282.	13,355.	22,071.	37,584.	26,838.	531,130.	0.
(2) ANNE KLIBANSKI, MD	(i)	0.	0.	0.	0.	0.	0.	0.
PRES/CEO ON 6/25/19 DIR ON 3/1/19	(ii)	787,074.	168,846.	119,740.	37,582.	25,973.	1,139,215.	0.
(3) DAVID W. RATTNER, MD	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR UNTIL 7/31/2019	(ii)	730,883.	43,993.	116,762.	37,583.	26,109.	955,330.	0.
(4) ALI SALIM, MD	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR 7/1/2019	(ii)	519,858.	33,945.	76,769.	24,750.	26,263.	681,585.	0.
(5) DAVID F. TORCHIANA, MD	(i)	2,314,640.	700,000.	889,335.	30,250.	37,617.	3,971,842.	0.
PRES., CEO AND DIR. UNTIL 2/28/19	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) PETER K. MARKELL	(i)	1,888,600.	369,994.	556,636.	30,250.	27,790.	2,873,270.	0.
EVP, CFO & TREASURER	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) MAUREEN GOGGIN	(i)	152,102.	500.	20,075.	19,436.	21,325.	213,438.	0.
SECRETARY	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) JOHN R. BARKER	(i)	567,819.	2,186,078.	89,056.	22,000.	7,507.	2,872,460.	0.
CHIEF INVESTMENT OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) GREGG S. MEYER, MD	(i)	1,155,400.	228,733.	91,322.	555,748.	36,404.	2,067,607.	0.
CHIEF CLINICAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JAMES W. NOGA	(i)	735,925.	77,500.	360,297.	30,250.	38,881.	1,242,853.	0.
VICE PRESIDENT AND CIO	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) ROSEMARY R. SHEEHAN	(i)	637,430.	65,000.	73,933.	30,250.	36,263.	842,876.	0.
CHIEF HUMAN RESOURCES OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) LAURA PEABODY	(i)	960,905.	350,000.	109,805.	24,750.	35,287.	1,480,747.	0.
CHIEF LEGAL OFFICER & GEN. COUNS.	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ELIZABETH L. BALDWIN	(i)	332,027.	901,750.	18,421.	16,500.	46,866.	1,315,564.	0.
PORTFOLIO MANAGER	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) KATHERINE L. KAMM	(i)	272,842.	618,500.	40,618.	16,500.	15,540.	964,000.	0.
PORTFOLIO MANAGER	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) CHRISTOPHER M. COBURN	(i)	617,257.	190,800.	75,542.	27,500.	28,293.	939,392.	0.
CHIEF INNOVATION OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) SEAN P. BLATCHLEY	(i)	263,802.	564,250.	12,929.	24,750.	38,801.	904,532.	0.
PORTFOLIO MANAGER	(ii)	0.	0.	0.	0.	0.	0.	0.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

TRUSTEE COMPENSATION

TRUSTEES RECEIVE NO COMPENSATION OR CONTRIBUTIONS TO EMPLOYEE BENEFIT PLANS FOR SERVICE ON THE BOARD OR ITS COMMITTEES. BOARD MEMBERS WHO ARE ALSO EMPLOYED BY THE CORPORATION OR A MASS GENERAL BRIGHAM INCORPORATED AFFILIATE RECEIVE COMPENSATION ONLY FOR THEIR SERVICES AS EMPLOYEES.

PART I, LINE 1A

FIRST CLASS TRAVEL

FIRST CLASS TRAVEL WAS PROVIDED TO AN OFFICER LISTED ON FORM 990, PART VII. THIS BENEFIT WAS PROVIDED PURSUANT TO A WRITTEN POLICY AND TREATED AS NON-TAXABLE BUSINESS EXPENSES. THE BENEFIT WAS REVIEWED AND APPROVED BY THE MASS GENERAL BRIGHAM INCORPORATED COMPENSATION COMMITTEE.

TRAVEL FOR COMPANIONS

TRAVEL FOR COMPANIONS WAS PROVIDED TO AN OFFICER LISTED ON FORM 990, PART VII AS THE COMPANIONS ATTENDANCE WAS REQUIRED TO FULFILL A BONA

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

FIDE BUSINESS PURPOSE. THESE PAYMENTS WERE PROVIDED PURSUANT TO A

WRITTEN POLICY AND WERE TREATED AS NON-TAXABLE BUSINESS EXPENSES.

PART I, LINE 4B

PARTICIPATION IN A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

DAVID F. TORCHIANA, M.D. - $786,176

GREGG S. MEYER, M.D - $525,498

PETER K. MARKELL - $466,454

JAMES W. NOGA - $280,084

PART I, LINE 7

CERTAIN EMPLOYEES RECEIVED INCENTIVE COMPENSATION BASED ON ACHIEVEMENT

OF ORGANIZATIONAL AND INDIVIDUAL GOALS.

THE COMPENSATION COMMITTEE OF MASS GENERAL BRIGHAM INCORPORATED OR THE

COMPENSATION COMMITTEES OF MASS GENERAL BRIGHAM INCORPORATED

SUBORDINATE ENTITIES HAVE THE FINAL AUTHORITY FOR SUCH PAYMENTS.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART II

DR. KLIBANSKI BECAME INTERIM PRESIDENT, CEO AND DIRECTOR ON 03/01/2019

AND THEN ASSUMED THE TITLE OF PRESIDENT AND CEO ON 06/25/2019.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047
2018
Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MHEFA PARTNERS HEALTHCARE SYSTEM, INC. SERIES F	04-2456011	57586CGW9	06/10/05	411,566,153.	SERIES F - SEE SCHEDULE K PART VI		X		X		X
B	MHEFA PARTNERS HEALTHCARE SER G-1,G-2,G-3,G-4,G-6	04-2456011	57586CZW8	06/07/07	380,000,000.	SERIES G - SEE SCHEDULE K PART VI		X		X		X
C	MHEFA PARTNERS HEALTHCARE SYSTEM, INC SERIES H	04-2456011	57586CW27	04/01/08	171,320,000.	SERIES H - SEE SCHEDULE K PART VI		X		X		X
D	MHEFA PARTNERS HEALTHCARE SYSTEM, INC SERIES I	04-2456011	57586EHR5	05/14/09	229,977,036.	SERIES I - SEE SCHEDULE K PART VI		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	176,225,000.	305,000,000.	3,620,000.	206,825,000.
2	Amount of bonds legally defeased				
3	Total proceeds of issue	419,448,101.	386,190,828.	171,320,000.	229,981,250.
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds	18,398,432.	20,479,076.		
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	2,671,595.	2,776,551.	420,000.	2,556,080.
8	Credit enhancement from proceeds	2,650,000.	4,696,147.		116,071.
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	326,493,380.	358,239,054.		227,309,098.
11	Other spent proceeds	69,234,694.		170,900,000.	
12	Other unspent proceeds				
13	Year of substantial completion	2007	2009	2009	2009
		Yes / No	Yes / No	Yes / No	Yes / No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X	X	X	X
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?	X	X	X	X
16	Has the final allocation of proceeds been made?	X	X	X	X
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X	X	X	X

ENTITY 2

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047
2018
Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MHEFA PARTNERS HEALTHCARE SYSTEM, INC SERIES J	04-2456011	57586ENK3	01/05/10	509,178,736.	SERIES J - SEE SCHEDULE K PART VI		X		X		X
B	MDFA PARTNERS HEALTHCARE SYSTEM, INC SERIES K	04-3431814	57583R6W0	01/13/11	436,019,104.	SERIES K - SEE SCHEDULE K PART VI	X			X		X
C	MDFA PARTNERS HEALTHCARE SYSTEM, INC. SERIES L	04-3431814	57583UMV7	01/04/12	353,501,227.	SERIES L - SEE SCHEDULE K PART VI	X			X		X
D	MDFA PARTNERS HEALTHCARE SYSTEM, INC SERIES M	04-3431814	57583UG77	01/30/14	510,376,675.	SERIES M - SEE SCHEDULE K PART VI		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	450,375,000.	255,995,000.	37,465,000.	201,040,000.
2	Amount of bonds legally defeased		45,000,000.	206,150,000.	
3	Total proceeds of issue	509,258,319.	436,030,814.	353,570,173.	510,376,950.
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	5,151,067.	3,523,063.	3,056,210.	4,042,015.
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	249,983,765.	201,342,457.	260,903,277.	360,854,935.
11	Other spent proceeds	254,123,487.	231,165,294.	89,610,686.	145,480,000.
12	Other unspent proceeds				
13	Year of substantial completion	2010	2011	2012	2014

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X		X		X	
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X	X		X			X
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**
▶ **Attach to Form 990.** ▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047
2018
Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MDFA PARTNERS HEALTHCARE SYSTEM SERIES N-1 AND N-2	04-3431814	NONE	08/27/14	141,350,000.	SERIES N - SEE SCHEDULE K PART VI		X		X		X
B	MDFA PARTNERS HEALTHCARE SYSTEM SERIES O	04-3431814	57583UW20	01/29/15	357,583,529.	SERIES O - SEE SCHEDULE K PART VI		X		X		X
C	MDFA PARTNERS HEALTHCARE SYSTEM SERIES Q	04-3431814	57584XJG7	01/28/16	491,625,624.	SERIES Q - SEE SCHEDULE K PART VI		X		X		X
D	MDFA PARTNERS HEALTHCARE SYSTEM SERIES R-1 AND R-2	04-3431814	NONE	03/31/16	100,000,000.	SERIES R - SEE SCHEDULE K PART VI		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	10,050,000.	9,775,000.	3,710,000.	
2	Amount of bonds legally defeased				
3	Total proceeds of issue	141,350,000.	359,440,557.	492,608,063.	100,000,000.
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds		2,813,646.	3,731,911.	
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		214,703,942.	402,774,737.	100,000,000.
11	Other spent proceeds	141,350,000.	141,922,969.	86,101,415.	
12	Other unspent proceeds				
13	Year of substantial completion	2009	2015	2016	2016

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X			X	X			X
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X	X		X			X
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

ENTITY 4

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**
▶ **Attach to Form 990.** ▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047
2018
Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MDFA PARTNERS HEALTHCARE SYSTEM SERIES S	04-3431814	57584X8W4	12/28/17	1,187,892,482.	SERIES S - SEE SCHEDULE K PART VI		X		X		X
B	MDFA PARTNERS HEALTHCARE SYSTEM SERIES T-1 AND T-2	04-3431814	57584YPF0	01/29/19	158,250,000.	SERIES T - SEE SCHEDULE K PART VI		X		X		X
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	7,415,000.			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	1,206,974,819.	158,250,000.		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	304,531,101.			
7	Issuance costs from proceeds	5,920,978.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds	896,522,741.	158,250,000.		
12	Other unspent proceeds				
13	Year of substantial completion	2016			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X					
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?	X		X					
16	Has the final allocation of proceeds been made?	X		X					
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		X
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		X
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6	Total of lines 4 and 5		%		%		%		%
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X		X		X		X
b	Exception to rebate?	X		X		X		X	
c	No rebate due?	X		X		X		X	
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X		X		X		X	

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		X
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		X
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6	Total of lines 4 and 5		%		%		%		%
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X		X		X		X
b	Exception to rebate?	X		X		X		X	
c	No rebate due?	X		X		X		X	
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X	X			X	X	

Part III Private Business Use

		A		B		C		D	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		X
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		X
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6	Total of lines 4 and 5		%		%		%		%
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV Arbitrage

		A		B		C		D	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X	X		X		X	
b	Exception to rebate?	X			X		X		X
c	No rebate due?	X			X		X		X
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X		X			X	X	

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X				
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6	Total of lines 4 and 5	%		%		%		%	
7	Does the bond issue meet the private security or payment test?		X		X				
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X					
b	Exception to rebate?		X		X				
c	No rebate due?		X		X				
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X		X					

Part IV Arbitrage *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X			X	X	
b	Name of provider	BEAR STEARNS CAPITAL		GOLDMAN SACHS CAPITA				MERRILL LYNCH CAPITA	
c	Term of hedge	35.0000000		35.0000000				35.0000000	
d	Was the hedge superintegrated?		X		X				X
e	Was the hedge terminated?		X		X				X
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?	X		X		X			X
b	Name of provider	XL ASSET FUNDING COM		CITIGROUP FINANCIAL		CITIGROUP FINANCIAL			
c	Term of GIC	1.8000000		1.7000000		.8000000			
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?	X		X		X			
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7	Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?	Yes	No	Yes	No	Yes	No	Yes	No
	X		X		X		X	

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

PART I BOND ISSUES (F) DESCRIPTION OF PURPOSE

(A)

FINANCING A PORTION OF THE FOLLOWING PROJECTS: TENANT IMPROVEMENTS AND FIT OUT OF LEASED SPACE; CONSTRUCTION AND RENOVATION OF OPERATING ROOMS AT AN AMBULATORY SURGERY CENTER; RENOVATIONS TO VARIOUS CLINICAL AREAS.

FINANCING A PORTION OF THE FOLLOWING PROJECTS: ACQUISITION OF A FACILITY AND A SMALL PARCEL OF VACANT LAND; CONSTRUCTION OF A CARDIOVASCULAR CENTER; THE ACQUISITION AND INSTALLATION OF CAPITAL EQUIPMENT AND CONSTRUCTION OF IMPROVEMENTS AND RENOVATIONS TO VARIOUS EXISTING FACILITIES.
FINANCING A PORTION OF THE CONSTRUCTION AND RENOVATION OF FACILITIES.
FINANCING THE ACQUISITION AND IMPROVEMENTS OF A PORTION OF A BUILDING AND INSTALLATION OF CAPITAL EQUIPMENT THEREIN.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY REVENUE BONDS, NEWTON-WELLESLEY HOSPITAL ISSUE, SERIES E, ISSUED 9/20/95.

(B)

FINANCING A PORTION OF CONSTRUCTION OF A CARDIOVASCULAR CENTER.

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part IV Arbitrage *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X			X	X	
b Name of provider			MERRILL LYNCH CAPITA				BEAR STEARNS CAPITAL	
c Term of hedge			35.0000000				35.0000000	
d Was the hedge superintegrated?				X				X
e Was the hedge terminated?				X				X
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?	X		X		X		X	

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part IV Arbitrage *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X			X	X	
b	Name of provider	BANK OF AMERICA N.A		BEAR STEARNS CAPITAL				BANK OF AMERICA N.A.	
c	Term of hedge	35.0000000		35.0000000				36.0000000	
d	Was the hedge superintegrated?		X		X				X
e	Was the hedge terminated?		X		X				X
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7	Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?	X		X		X		X	

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part IV Arbitrage *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X					
b	Name of provider	BANK OF AMERICA N.A		JPMORGAN CHASE BANK					
c	Term of hedge	27.0000000		29.4000000					
d	Was the hedge superintegrated?		X		X				
e	Was the hedge terminated?		X		X				
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X				
7	Has the organization established written procedures to monitor the requirements of section 148?	X		X					

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?	X		X					

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

PART I BOND ISSUES (F) DESCRIPTION OF PURPOSE

(A)

FINANCING A PORTION OF THE FOLLOWING PROJECTS: TENANT IMPROVEMENTS AND FIT OUT OF LEASED SPACE; CONSTRUCTION AND RENOVATION OF OPERATING ROOMS AT AN AMBULATORY SURGERY CENTER; RENOVATIONS TO VARIOUS CLINICAL AREAS.

FINANCING A PORTION OF THE FOLLOWING PROJECTS: ACQUISITION OF A FACILITY AND A SMALL PARCEL OF VACANT LAND; CONSTRUCTION OF A CARDIOVASCULAR CENTER; THE ACQUISITION AND INSTALLATION OF CAPITAL EQUIPMENT AND CONSTRUCTION OF IMPROVEMENTS AND RENOVATIONS TO VARIOUS EXISTING FACILITIES.

FINANCING A PORTION OF THE CONSTRUCTION AND RENOVATION OF FACILITIES.

FINANCING THE ACQUISITION AND IMPROVEMENTS OF A PORTION OF A BUILDING AND INSTALLATION OF CAPITAL EQUIPMENT THEREIN.

REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY REVENUE BONDS, NEWTON-WELLESLEY HOSPITAL ISSUE, SERIES E, ISSUED 9/20/95.

(B)

FINANCING A PORTION OF CONSTRUCTION OF A CARDIOVASCULAR CENTER.

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions *(Continued)*

FINANCING THE FOLLOWING PROJECTS: A PORTION OF THE CONSTRUCTION OF A BUILDING AND A RECEIVING DOCK; A PORTION OF THE COST OF ACQUISITION OF CONDOMINIUM UNITS; AND RENOVATIONS TO CLINICAL SPACE.
FINANCING RENOVATIONS AND IMPROVEMENTS TO INPATIENT CLINICAL AREAS.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: CONSTRUCTION AND EQUIPPING OF AN AMBULATORY CARE CENTER; THE ACQUISITION AND INSTALLATION OF A SYSTEM-WIDE REVENUE MANAGEMENT SYSTEM.

(C)
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES G-1 AND G-3, ISSUED 6/28/07.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY VARIABLE RATE DEMAND REVENUE BONDS, NEWTON-WELLESLEY HOSPITAL ISSUE, SERIES F, ISSUED 11/16/1995.

(D)
FINANCING A PORTION OF THE FIT-OUT AND EQUIPPING OF AN AMBULATORY CARE CENTER.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE CONSTRUCTION OF A BUILDING AND A RECEIVING DOCK; CONSTRUCTION AND EQUIPPING OF A MULTI-SPECIALTY AMBLUATORY CARE CENTER; AND RENOVATIONS TO CLINICAL SPACE.
FINANCING RENOVATIONS AND IMPROVEMENTS TO INPATIENT CLINICAL AREAS.
FINANCING A PORTION OF THE COST OF RENOVATIONS, EQUIPPING AND FURNISHING OF CLINICAL SPACE TO HOUSE A CANCER CENTER.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE ACQUISITION AND INSTALLATION OF A SYSTEM-WIDE REVENUE MANAGEMENT SYSTEM AND AN ACUTE CARE DOCUMENTATION MANAGEMENT SYSTEM.

(E)
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE CONSTRUCTION OF A BUILDING AND A RECEIVING DOCK; CONSTRUCTION AND EQUIPPING OF A MULTI-SPECIALTY AMBULATORY CARE CENTER; AND RENOVATIONS TO CLINICAL SPACE.
FINANCING RENOVATIONS AND IMPROVEMENTS TO INPATIENT CLINICAL AREAS.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE ACQUISITION AND INSTALLATION OF A SYSTEM-WIDE REVENUE MANAGEMENT SYSTEM AND AN ACUTE CARE DOCUMENTATION MANAGEMENT SYSTEM.
FINANCING RENOVATIONS AND IMPROVEMENTS TO AN EMERGENCY DEPARTMENT.
FINANCING THE ACQUISITION OF AND IMPROVEMENTS TO A HOSPITAL FACILITY.

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions *(Continued)*

FINANCING PLANNING COSTS INCLUDING ENVIRONMENTAL REMEDIATION COSTS
ASSOCIATED WITH THE DEVELOPMENT OF A NEW REHABILITATION HOSPITAL
FACILITY.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES G-4.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES A.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES B.

(F)
FINANCING RENOVATIONS AND IMPROVEMENTS TO AN EMERGENCY DEPARTMENT.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE CONSTRUCTION OF A
BUILDING AND A RECEIVING DOCK; CONSTRUCTION AND EQUIPPING OF A
MULTI-SPECIALTY AMBLUATORY CARE CENTER; AND RENOVATIONS TO CLINICAL
SPACE.
FINANCING PLANNING COSTS INCLUDING ENVIRONMENTAL REMEDIATION COSTS
ASSOCIATED WITH THE DEVELOPMENT OF A NEW REHABILITATION HOSPITAL
FACILITY.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE ACQUISITION AND
INSTALLATION OF A SYSTEM-WIDE REVENUE MANAGEMENT SYSTEM AND AN ACUTE
CARE DOCUMENTATION MANAGEMENT SYSTEM.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES C.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES D-1, D-2 & D-4.

(G)
FINANCING RENOVATIONS AND IMPROVEMENTS TO AN EMERGENCY DEPARTMENT.
FINANCING PLANNING COSTS INCLUDING ENVIRONMENTAL REMEDIATION COSTS
ASSOCIATED WITH THE DEVELOPMENT OF A NEW REHABILITATION HOSPITAL
FACILITY.
FINANCING A PORTION OF THE FOLLOWING PROJECTS: THE ACQUISITION AND
INSTALLATION OF A SYSTEM-WIDE REVENUE MANAGEMENT SYSTEM AND AN ACUTE
CARE DOCUMENTATION MANAGEMENT SYSTEM.
FINANCING PLANNING COSTS AND CONSTRUCTION OF BUILDING TO HOUSE CLINICAL
AND RESEARCH SPACE AND UNDERGROUND PARKING SPACES.
FINANCING THE CONSTRUCTION OF AN UNDERGROUND PARKING FACILITY.
FINANCING THE ACQUISITION OF LAND AND BUILDING TO HOUSE WET AND DRY
RESEARCH SPACE, AND PARKING GARAGE.
FINANCING THE ACQUISITION, RENOVATION, EQUIPPING AND FURNISHING OF AN

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions *(Continued)*

OUTPATIENT SURGICAL CENTER.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES B.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES C.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES E.
PART I BOND ISSUES (F) DESCRIPTION OF PURPOSE (CONTINUE)
(H)
FINANCING THE CONSTRUCTION OF A NEW BUILDING AT BRIGHAM AND WOMEN'S
HOSPITAL'S MAIN CAMPUS AND A NEW BUILDING TO HOUSE A 132-BED
REPLACEMENT FACILITY FOR SPAULDING REHABILITATION HOSPITAL.
FINANCING THE CONSTRUCTION OF AN UNDERGROUND PARKING FACILITY.
FINANCING THE ACQUISITION AND INSTALLATION OF A SYSTEM-WIDE REVENUE
MANAGEMENT AND CLINICAL APPLICATION SYSTEM.
FINANCING THE CONSTRUCTION OF A TWO STORY DATA CENTER AND A NEW POWER
PLANT.
FINANCING THE RENOVATION, EQUIPPING AND FURNISHING OF VARIOUS
FACILITIES.
REFINANCING MASSACHUSETTS DEVELOPMENT FINANCE AGENCY, PARTNERS
HEALTHCARE SYSTEM ISSUE, SERIES K-3.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY,
PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES D-3.

(I)
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES F-4.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES I-1.

(J)
FINANCING THE CONSTRUCTION OF A NEW BUILDING AT BRIGHAM AND WOMEN'S
HOSPITAL'S MAIN CAMPUS.
FINANCING THE CONSTRUCTION OF AN UNDERGROUND PARKING FACILITY.
FINANCING THE CONSTRUCTION OF A TWO STORY DATA CENTER AND A NEW POWER
PLANT.
FINANCING THE ACQUISITION AND INSTALLATION OF A SYSTEM-WIDE REVENUE
MANAGEMENT AND CLINICAL APPLICATION SYSTEM.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES F-5.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions *(Continued)*

REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES G-5.

(K)
FINANCING THE CONSTRUCTION OF A NEW BUILDING AT BRIGHAM AND WOMEN'S
HOSPITAL'S MAIN CAMPUS.
FINANCING THE RENOVATION OF A NEONATAL INTENSIVE CARE UNIT AND
CONSTRUCTION OF A SPECIAL CARE NURSERY.
FINANCING THE CONSTRUCTION OF A TWO STORY DATA CENTER.
FINANCING THE ACQUISITION AND INSTALLATION OF A SYSTEM-WIDE REVENUE
MANAGEMENT AND CLINICAL APPLICATION SYSTEM.
REFINANCING INTERIM BORROWING MASSACHUSETTS HEALTH & EDUCATIONAL
FACILITIES AUTHORITY REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE,
SERIES K-4.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES F-5.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES G-5.

(L)
FINANCING THE CONSTRUCTION OF A NEW BUILDING AT BRIGHAM AND WOMEN'S
HOSPITAL'S MAIN CAMPUS.
FINANCING THE CONSTRUCTION OF AN UNDERGROUND PARKING FACILITY.
FINANCING THE CONSTRUCTION OF A TWO STORY DATA CENTER.
PART I BOND ISSUES (F) DESCRIPTION OF PURPOSE (CONTINUE)
(M)
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES G-5.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES G-6.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES I-2 & I-3.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, PARTNERS HEALTHCARE SYSTEM ISSUE, SERIES J-1.
REFINANCING MASSACHUSETTS DEVELOPMENT FINANCE AGENCY, PARTNERS
HEALTHCARE SYSTEM ISSUE, SERIES K-5.
REFINANCING MASSACHUSETTS DEVELOPMENT FINANCE AGENCY, PARTNERS
HEALTHCARE SYSTEM ISSUE, SERIES L.
REFINANCING MASSACHUSETTS DEVELOPMENT FINANCE AGENCY, PARTNERS
HEALTHCARE SYSTEM ISSUE, SERIES M-3 & M-5.
REFINANCING NEW HAMPSHIRE HEALTH AND EDUCATION FACILITIES AUTHORITY
REVENUE BONDS, WENTWORTH-DOUGLAS HOSPITAL ISSUE, SERIES 2011 A.

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions *(Continued)*

REFINANCING NEW HAMPSHIRE HEALTH AND EDUCATION FACILITIES AUTHORITY
REVENUE BONDS, WENTWORTH-DOUGLAS HOSPITAL ISSUE, SERIES 2016 A & B.

(N)
REFINANCING LINE OF CREDIT DRAW, WHICH WAS USED TO FINANCE A PORTION OF
THE COSTS OF CONSTRUCTION, IMPROVEMENT, RENOVATION AND EQUIPPING OF
CERTAIN MASSACHUSETTS EYE AND EAR (MEE) FACILITIES.
REFINANCING MASSACHUSETTS HEALTH & EDUCATIONAL FACILITIES AUTHORITY
REVENUE BONDS, MASSACHUSETTS EYE AND EAR INFIRMARY ISSUE, SERIES D.
REFINANCING MASSACHUSETTS DEVELOPMENT FINANCE AGENCY, PARTNERS
HEALTHCARE SYSTEM ISSUE, SERIES M-2.
PART II PROCEEDS (3)
TOTAL PROCEEDS INCLUDE INVESTMENT EARNINGS.

PART III, LINE 9
WITH RESPECT TO PROPERTY FOR WHICH POTENTIAL PRIVATE USE HAS BEEN
IDENTIFIED AT THE TIME OF ISSUANCE OR MAY BE ANTICIPATED, MASS GENERAL
BRIGHAM INCORPORATED DOES NOT UTILIZE TAX-EXEMPT BOND FINANCING FOR
THAT PORTION OF THE PROPERTY. MASS GENERAL BRIGHAM INCORPORATED HAS
PROCEDURES IN PLACE THAT PERMITS MONITORING OF ANY PRIVATE USES ARISING
POST-ISSUANCE.
PART IV ARBITRAGE (1)
FORM 8038-T HAS NOT BEEN FILED AS ARBITRAGE REBATE PAYMENTS HAVE NOT
BEEN REQUIRED.
A 9/9/2010
B 8/3/2012
C 5/8/2013
D 6/19/2014
E 2/9/2015
F 2/19/2016
G 2/9/2017
H 1/25/2019
I 10/11/2019

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047

2018

Open To Public Inspection

Name of the organization

MASS GENERAL BRIGHAM INCORPORATED

Employer identification number

04-3230035

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 **(a)** Name of disqualified person	**(b)** Relationship between disqualified person and organization	**(c)** Description of transaction	**(d)** Corrected? Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	**(b)** Relationship with organization	**(c)** Purpose of loan	**(d)** Loan to or from the organization? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of assistance	**(d)** Type of assistance	**(e)** Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
T. BYRNE	FAMILY - HOCKFIELD	33,320.	SALARY-MGPO		X
R. SOBERMAN	FAMILY - KLIBANSKI	160,499.	SALARY-MGPO		X
B. BLANCHFIELD	FAMILY - MEYER	71,410.	SALARY-BWH		X
A. THORNDIKE	FAMILY - THORNDIKE	191,950.	SALARY-MGPO		X
NPP DEVELOPMENT	DIRECTOR - KRAFT	4,633,500.	LEASE		X
SUFFOLK CONSTRUCTION	DIRECTOR - FISH	41,479,753.	CONSTR. SER		X

Part V Supplemental Information.

Provide additional information for responses to questions on Schedule L (see instructions).

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

MASS GENERAL BRIGHAM INCORPORATED ESTABLISHED IN MARCH 1994,

IS THE CORPORATION OVERSEEING THE AFFILIATION OF BRIGHAM HEALTH, THE

MASSACHUSETTS GENERAL HOSPITAL, NSMC HEALTHCARE, INC., NEWTON-WELLESLEY

HEALTH CARE SYSTEM, INC., PARTNERS CONTINUING CARE, INC., ALLWAYS

HEALTH PARTNERS, INC., AND THE FOUNDATION OF THE MASSACHUSETTS EYE AND

EAR INFIRMARY, INC. MASS GENERAL BRIGHAM IS DEVELOPING AN INTEGRATED

HEALTH CARE DELIVERY SYSTEM THROUGHOUT THE REGION THAT OFFERS PATIENTS

A CONTINUUM OF COORDINATED, HIGH-QUALITY CARE. THE SYSTEM INCLUDES

PRIMARY CARE PHYSICIANS AND SPECIALISTS, COMMUNITY HOSPITALS, THE TWO

FOUNDING ACADEMIC MEDICAL CENTERS (MGH AND BWH) AND OTHER

HEALTH-RELATED ENTITIES. MASS GENERAL BRIGHAM IS CREATING A FRAMEWORK

IN WHICH ALL ASPECTS OF THE HEALTH CARE DELIVERY SYSTEM ARE COORDINATED

BETWEEN AND AMONG PROVIDERS AND FACILITIES. MASS GENERAL BRIGHAM

IMPROVES THE QUALITY OF HEALTH CARE AND FURTHER SERVES THE PUBLIC AT

LARGE BY SUPPORTING ITS MEMBER ORGANIZATIONS SO THAT THEY MAY PURSUE

THEIR PATIENT CARE, TEACHING AND

RESEARCH MISSIONS.

THE MEMBER ORGANIZATIONS OF MASS GENERAL BRIGHAM HAVE JOINED TOGETHER

IN A COMMITMENT TO SERVE THE COMMUNITY. TOGETHER, THESE ORGANIZATIONS

ARE DEDICATED TO ENHANCING PATIENT CARE, TEACHING AND RESEARCH, AND TO

TAKING A LEADERSHIP ROLE AS AN INTEGRATED HEALTH CARE SYSTEM.

MASS GENERAL BRIGHAM IS COMMITTED TO LEADING THE WAY IN DESIGNING

INTEGRATED PATIENT AND FAMILY-CENTERED CARE WITH THE GOALS OF ENHANCING

THE QUALITY OF PATIENT CARE AND SLOWING THE INCREASE IN HEALTH CARE

COSTS.

Name of the organization: MASS GENERAL BRIGHAM INCORPORATED

Employer identification number: 04-3230035

MASS GENERAL BRIGHAM INCORPORATED IS COMMITTED TO WORKING WITH COMMUNITY RESIDENTS AND ORGANIZATIONS TO MAKE MEASURABLE, SUSTAINABLE IMPROVEMENTS IN THE HEALTH STATUS OF UNDERSERVED POPULATIONS. MASS GENERAL BRIGHAM AND ITS HOSPITALS ARE MAKING A DIFFERENCE IN THE COMMUNITIES IN WHICH WE LIVE AND WORK THROUGH INITIATIVES ON WORKFORCE DEVELOPMENT, PREVENTION AND ACCESS TO HEALTH CARE. IN ADDITION, MASS GENERAL BRIGHAM HOSPITALS HAVE PROVIDED CARE TO MORE THAN 100,000 UNINSURED AND MEDICAID PATIENTS ANNUALLY. MASS GENERAL BRIGHAM COMMUNITY BENEFIT PROGRAMS AND GRANTS FOCUS ON THREE IMPORTANT AREAS:

ENHANCING ACCESS TO HEALTH CARE

- MASS GENERAL BRIGHAM AND ITS HOSPITALS ARE COMMITTED TO WORKING WITH COMMUNITY RESIDENTS AND ORGANIZATIONS TO MAKE MEASURABLE AND SUSTAINABLE IMPROVEMENTS IN THE HEALTH STATUS OF UNDERSERVED POPULATIONS. WE SEEK TO INCREASE ACCESS TO QUALITY CARE REGARDLESS OF PATIENTS' ABILITY TO PAY, INSURANCE STATUS, OR OTHER POTENTIAL BARRIERS TO CARE.
- MASS GENERAL BRIGHAM LICENSED AND AFFILIATED HEALTH CENTERS PROVIDE CARE TO 325,000 PATIENTS.
- SINCE 1998, MASS GENERAL BRIGHAM HAS COMMITTED A TOTAL OF MORE THAN $83 MILLION TO ENSURE THAT HEALTH CENTERS HAVE THE SPACE AND TECHNOLOGY THEY NEED TO PROVIDE THEIR PATIENTS WITH EXCELLENT CARE.
- MASS GENERAL BRIGHAM INVESTS MORE THAN $27 MILLION ANNUALLY IN OPERATING FUNDS TO STRENGTHEN COMMUNITY HEALTH CENTERS.

BUILDING TOMORROW'S HEALTH CARE WORKFORCE

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

- MASS GENERAL BRIGHAM INCORPORATED'S COMMITMENT TO PROVIDING ACCESS TO JOBS WITH FAMILY-SUSTAINING WAGES, EXCELLENT BENEFITS, AND OPPORTUNITIES FOR ADVANCEMENT IS A FOUNDATIONAL PRINCIPLE FOR MASS GENERAL BRIGHAM'S WORKFORCE DEVELOPMENT PROGRAMS. THROUGH CAREER PIPELINES FOR YOUTH, ADULT COMMUNITY RESIDENTS, AND CURRENT WORKERS, MBG CREATES EMPLOYMENT, TRAINING, AND EDUCATIONAL OPPORTUNITIES FOR INDIVIDUALS AND CONTRIBUTES TO THE ECONOMIC HEALTH OF COMMUNITIES IN WHICH THEY LIVE.

- THOUSANDS OF MASS GENERAL BRIGHAM EMPLOYEES HAVE PARTICIPATED IN INTERNAL SKILL DEVELOPMENT OPPORTUNITIES.

- MORE THAN 600 ADULT COMMUNITY RESIDENTS HAVE GRADUATED FROM OUR HEALTH CARE TRAINING AND EDUCATION PROGRAM OVER THE PAST 14 YEARS.

- MORE THAN 400 STUDENTS EACH YEAR ARE EMPLOYED BY BRIGHAM AND WOMEN'S HOSPITAL (BWH), BRIGHAM AND WOMEN'S FAULKNER HOSPITAL (BWFH), MASSACHUSETTS GENERAL HOSPITAL (MGH), AND NORTH SHORE MEDICAL CENTER (NSMC) DURING THE SUMMER. MASS GENERAL BRIGHAM OFFERS MENTORING, ACADEMIC TUTORING, CAREER EXPOSURE, AND SCHOLARSHIP PROGRAMS TO AREA HIGH SCHOOL STUDENTS

IMPROVING HEALTH THROUGH PREVENTION

- MASS GENERAL BRIGHAM AND ITS HOSPITALS PROVIDE EFFECTIVE, COORDINATED, AND MEASURABLE LOCAL SUPPORT TO ADDRESS AND PREVENT SOCIO-MEDICAL PROBLEMS THAT FACE OUR COMMUNITIES. WE RAISE AWARENESS, ADVOCATE FOR PUBLIC POLICY CHANGES, IMPLEMENT PREVENTION PROGRAMS, AND SUCCESSFULLY DEVELOP ADDITIONAL TREATMENT RESOURCES TO HELP COMMUNITY RESIDENTS STAY HEALTHY.

- MASS GENERAL BRIGHAM HOSPITALS' DOMESTIC VIOLENCE PROGRAMS HAVE SERVED 17,000 CLIENTS SINCE 1997.

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

- OVER THE PAST 13 YEARS THE REVERE CARES SUBSTANCE ABUSE PREVENTION PROGRAM HAS HELPED REDUCE BINGE DRINKING BY 39% AND SMOKING BY 32% AMONG REVERE HIGH SCHOOL STUDENTS.

CLINICIAN-LED INITIATIVES

MASS GENERAL BRIGHAM'S PEOPLE SHARE A PASSIONATE COMMITMENT TO HEAL AND TO CARE FOR THOSE IN NEED. MASS GENERAL BRIGHAM SUPPORTS THE PASSION OF DEDICATED CLINICIANS BOTH DIRECTLY AND BY "SEEDING" THEIR START-UP INITIATIVES SO THEY CAN TACKLE COMPLEX HEALTH CARE CHALLENGES AND HELP MEET THE EVOLVING MEDICAL NEEDS OF THE GLOBAL COMMUNITY.

FROM RESEARCH ON INFECTIOUS DISEASES INCLUDING HIV/AIDS AND TUBERCULOSIS AND BUILDING COMMUNITY-BASED TREATMENT PROGRAMS FOR THESE DISEASES, TO BUILDING CARDIAC SURGERY CENTERS IN RWANDA AND TRAINING PHYSICIANS IN UGANDA, INITIATIVES FUNDED BY MASS GENERAL BRIGHAM HAVE GROWN INTO WORLD-CLASS INSTITUTES SUPPORTED BY MAJOR PHILANTHROPISTS AND FOUNDATIONS.

PLEASE VISIT:

HTTPS://WWW.PARTNERS.ORG/ABOUT/PHILANTHROPY/COMMUNITY-PROGRAMS.ASPX

FOR MORE INFORMATION ABOUT SPECIFIC MASS GENERAL BRIGHAM'S PROGRAMS AND INITIATIVES.

FORM 990, PART VI, SECTION A, LINE 2:

BUSINESS AND FAMILY RELATIONSHIPS

PETER MARKELL, RICHARD HOLBROOK & WILLIAM MAURICE COWAN - BUSINESS RELATIONSHIP

DAVID TORCHIANA, PETER MARKELL & GREGG MEYER - BUSINESS RELATIONSHIP

Name of the organization
MASS GENERAL BRIGHAM INCORPORATED

Employer identification number
04-3230035

FORM 990, PART VI, SECTION A, LINE 6:

DECISIONS OF GOVERNING BODY SUBJECT TO MEMBER APPROVAL

PURSUANT TO THE CORPORATE BYLAWS OF THE ORGANIZATION, THE AUTHORITY FOR THE FOLLOWING ACTIONS IS RESERVED TO THE MEMBERS OF THE ORGANIZATION:

- MEMBERS SHALL DETERMINE THE NUMBER OF MASS GENERAL BRIGHAM DIRECTORS AND SHALL ELECT MASS GENERAL BRIGHAM DIRECTORS. MEMBERS MAY, BY A VOTE, INCREASE THE NUMBER OF MASS GENERAL BRIGHAM DIRECTORS.

- MEMBERS MAY DECREASE THE NUMBER OF MASS GENERAL BRIGHAM DIRECTORS, BUT ONLY TO ELIMINATE VACANCIES EXISTING BY REASON OF THE DEATH, RESIGNATION OR REMOVAL OF ONE OR MORE ELECTED MASS GENERAL BRIGHAM DIRECTORS.

- MEMBERS MAY REMOVE A MASS GENERAL BRIGHAM DIRECTOR WITH OR WITHOUT CAUSE BY VOTE.

- MEMBERS MAY AMEND MASS GENERAL BRIGHAM BYLAWS IN WHOLE OR IN PART OR MAY REPEAL AND ADOPT NEW BYLAWS. MEMBERS MAY ADOPT, AMEND OR REPEAL ANY BYLAW, INCLUDING ANY BYLAWS ADOPTED, AMENDED OR REPEALED BY THE DIRECTORS.

PURSUANT TO THE LAWS OF MASSACHUSETTS, THE AUTHORITY FOR THE FOLLOWING ACTIONS IS RESERVED TO THE MEMBER OF THE ORGANIZATION:

- AMEND OR RESTATE THE ARTICLES OF ORGANIZATION

- CONSOLIDATION OR MERGER

- SALE, LEASE, EXCHANGE OR DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE ORGANIZATIONS PROPERTY OR ASSETS.

FORM 990, PART VI, SECTION A, LINE 7A:

EXECUTIVE COMMITTEE

THE EXECUTIVE COMMITTEE HAS ALL OF THE RESPONSIBILITIES AND AUTHORITY OF

Name of the organization: MASS GENERAL BRIGHAM INCORPORATED

Employer identification number: 04-3230035

THE DIRECTORS DURING INTERVALS BETWEEN MEETINGS OF THE DIRECTORS EXCEPT FOR THE POWERS SPECIFIED IN SECTION 55 OF MASSACHUSETTS GENERAL LAWS, CHAPTER 156B. THE COMMITTEE CONSISTS OF THREE TO FIVE DIRECTORS OF THE CORPORATION APPOINTED ANNUALLY BY THE BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION A, LINE 7B:

SEE STATEMENT ON QUESTION 6

FORM 990, PART VI, SECTION B, LINE 11B:

FORM 990 REVIEW

THE FORM 990 WAS PREPARED AND REVIEWED BY THE MASS GENERAL BRIGHAM TAX DEPARTMENT. CERTAIN KEY SECTIONS WERE ALSO REVIEWED BY THE MASS GENERAL BRIGHAM EXECUTIVE VICE PRESIDENT OF ADMINISTRATION AND FINANCE, CFO AND TREASURER; AND BY THE MASS GENERAL BRIGHAM GENERAL COUNSEL. THE EXECUTIVE VICE PRESIDENT OF ADMINISTRATION AND FINANCE, CFO AND TREASURER REVIEWED AND SIGNED THE FORM 990. THE COMPENSATION DISCLOSURES WERE PRESENTED TO AND DISCUSSED WITH THE MASS GENERAL BRIGHAM COMPENSATION COMMITTEE AT THE APRIL 27, 2020 MEETING. THE PROCESS FOR PREPARING AND REVIEWING FORM 990 WAS DISCUSSED AT THE MAY 6, 2020 MEETING OF THE AUDIT AND COMPLIANCE COMMITTEE OF THE MASS GENERAL BRIGHAM BOARD OF DIRECTORS. THE FINAL FILING VERSION OF THE FORM 990 WAS PROVIDED TO EACH VOTING BOARD MEMBER PRIOR TO FILING.

FORM 990, PART VI, SECTION B, LINE 12C:

CONFLICT OF INTEREST POLICY

FOR PURPOSES OF ITS ANNUAL TAX FILING, MASS GENERAL BRIGHAM INCORPORATED HAS AN ANNUAL QUESTIONNAIRE PROCESS FOR OBTAINING INFORMATION ON INTERESTS

Name of the organization: MASS GENERAL BRIGHAM INCORPORATED

Employer identification number: 04-3230035

THAT MAY GIVE RISE TO CONFLICTS FROM ALL OFFICERS, DIRECTORS, TRUSTEES AND KEY EMPLOYEES. IN ADDITION, IN CONNECTION WITH MASS GENERAL BRIGHAM'S CONFLICT OF INTEREST POLICY, THE MASS GENERAL BRIGHAM OFFICE FOR INTERACTIONS WITH INDUSTRY AND OFFICE OF THE GENERAL COUNSEL WORK TOGETHER TO PERIODICALLY DISTRIBUTE, COLLECT AND REVIEW DISCLOSURE STATEMENTS FROM THESE INDIVIDUALS. THE INFORMATION ON EACH SUCH DISCLOSURE IS REVIEWED BY EACH INDIVIDUAL'S SUPERVISOR (WHO IN THE CASE OF DIRECTORS AND TRUSTEES IS DEEMED TO CONSIST OF THE CHAIRMAN OF THE BOARD AND THE ENTITY'S PRESIDENT/CEO, WHO REVIEW THE DISCLOSURES WITH THE ASSISTANCE OF THE GENERAL COUNSEL OR ATTORNEY REPRESENTATIVES OF HER OFFICE).

MASS GENERAL BRIGHAM HAS A CONFLICT OF INTEREST POLICY THAT APPLIES TO ALL ENTITIES IN THE SYSTEM*, AND WHICH IS DESIGNED TO:

(1) IDENTIFY RELATIONSHIPS AND CONDUCT THAT CREATE EITHER CONFLICTS OF INTEREST OR CONFLICTS OF COMMITMENT;

(2) ESTABLISH A SYSTEM FOR DISCLOSING AND RESOLVING POTENTIAL CONFLICTS; AND

(3) ENSURE THAT TRANSACTIONS ARE NEGOTIATED AT ARM'S LENGTH AND THAT PAYMENTS ARE AT FAIR MARKET VALUE. UNDER OUR POLICY, WHEN A CONFLICT ARISES, THE INDIVIDUAL ASSOCIATED WITH THE OUTSIDE ENTITY IN QUESTION MUST PROVIDE FULL DISCLOSURE AND COMPLETELY RECUSE HIM/HERSELF FROM ANY INSTITUTIONAL DECISION-MAKING ABOUT THE TRANSACTION.

IN APPROPRIATE CIRCUMSTANCES,

(I) THE CORPORATION MUST CONSIDER AT LEAST TWO ALTERNATIVE DISINTERESTED COMPETITIVE PROPOSALS; OR MUST DETERMINE THAT TWO SUCH COMPETITIVE PROPOSALS DO NOT EXIST OR THAT IT WOULD BE IMPRACTICAL TO ELICIT OR CONSIDER SUCH COMPETITIVE PROPOSALS; AND

(II) THE CORPORATION MUST DETERMINE THAT, NOTWITHSTANDING THE APPARENT

Name of the organization: MASS GENERAL BRIGHAM INCORPORATED

Employer identification number: 04-3230035

CONFLICT, THE TRANSACTION IS FAIR AND REASONABLE TO THE CORPORATION AND IS IN THE BEST INTERESTS OF THE CORPORATION.

A WRITTEN RECORD MUST BE MADE OF THESE DETERMINATIONS. FURTHERMORE, TRANSACTIONS THAT PRESENT PARTICULARLY SIGNIFICANT CONFLICTS ARE REVIEWED BY AN INDEPENDENT COMMITTEE OF MASS GENERAL BRIGHAM, WHICH REVIEW IS ALSO DOCUMENTED. CONFLICTS OF COMMITMENT BY THE MASS GENERAL BRIGHAM PRESIDENT AND CEO ARE ADDRESSED BY REQUIRING OUTSIDE ACTIVITIES TO BE APPROVED BY THE MASS GENERAL BRIGHAM BOARD CHAIR.

* AS INSTITUTIONS ARE ADDED TO MASS GENERAL BRIGHAM INCORPORATED THERE IS A TRANSITION PERIOD.

FORM 990, PART VI, SECTION B, LINE 15:

PROCESS FOR DETERMINING COMPENSATION

THE ORGANIZATION HAS A BOARD LEVEL COMPENSATION COMMITTEE THAT REVIEWS AND APPROVES THE COMPENSATION FOR ALL LISTED OFFICERS AND KEY EMPLOYEES EXCEPT THE SECRETARY. THE COMMITTEE IS COMPRISED OF MEMBERS OF THE BOARD WHO ARE NOT EMPLOYED BY THE ORGANIZATION, AND NO MEMBER MAY PARTICIPATE IN THE REVIEW AND APPROVAL OF COMPENSATION IF THE MEMBER HAS A CONFLICT OF INTEREST WITH RESPECT TO THAT COMPENSATION ARRANGEMENT. THE COMMITTEE RELIES ON DATA, PROVIDED BY AN INDEPENDENT COMPENSATION CONSULTANT, WHICH INCLUDES COMPARABLE COMPENSATION FOR SIMILARLY QUALIFIED PERSONS, IN FUNCTIONALLY COMPARABLE POSITIONS, AT SIMILARLY SITUATED ORGANIZATIONS. THE DELIBERATIONS AND DECISIONS OF THE COMMITTEE ARE DOCUMENTED IN MINUTES OF THE MEETING. THIS REVIEW PROCESS OCCURS ON AN ANNUAL BASIS.

Name of the organization: MASS GENERAL BRIGHAM INCORPORATED

Employer identification number: 04-3230035

FORM 990, PART VI, LINE 17, LIST OF STATES RECEIVING COPY OF FORM 990:

AL,AZ,CA,CT,DE,FL,GA,HI,ID,IL,IN,KS,LA,MA,MD,MI,MN,MO,MT,NC,ND,NE,NH,NV,NY

SC,TX,VA,WV,WY

FORM 990, PART VI, SECTION C, LINE 18:

N/A

FORM 990, PART VI, SECTION C, LINE 19:

PUBLIC AVAILABILITY OF FINANCIAL STATEMENTS AND GOVERNING DOCUMENTS

THE ORGANIZATION'S GOVERNING DOCUMENTS ARE FILED WITH THE MASSACHUSETTS SECRETARY OF STATE AND THE FINANCIAL STATEMENTS ARE FILED WITH THE MASSACHUSETTS ATTORNEY GENERAL, ALL OF WHICH ARE OPEN TO PUBLIC INSPECTION. THE ORGANIZATION'S CONFLICT OF INTEREST POLICY IS AVAILABLE ON THE ORGANIZATION'S WEBSITE.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN FUNDED STATUS OF DEFINED BENEFIT PLANS	-1,388,554,608.
OTHER CHANGES IN NET ASSETS	-17,554,791.
RETURN OF RISK BASED CAPITAL GUARANTY	100,000,000.
TOTAL TO FORM 990, PART XI, LINE 9	-1,306,109,399.

FORM 990, PART XII, LINE 2C:

NO CHANGES FROM PRIOR YEAR.

ITEM B, NAME OF ORGANIZATION

THE ORGANIZATION CHANGED ITS LEGAL NAME FROM PARTNERS HEALTHCARE SYSTEM, INC. TO MASS GENERAL BRIGHAM INCORPORATED EFFECTIVE MAY 1,

Name of the organization: MASS GENERAL BRIGHAM INCORPORATED

Employer identification number: 04-3230035

2020. PLEASE SEE ATTACHED ARTICLES OF AMENDMENT AS FILED WITH THE

MASSACHUSETTS SECRETARY OF STATE.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

MASS GENERAL BRIGHAM INCORPORATED

Employer identification number

04-3230035

Part I **Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
PARTNERS HEALTHCARE INTERNATIONAL, LLC - 20-5281203, 800 BOYLSTON STREET, BOSTON, MA 02199	GLOBAL HEALTH CARE	MASSACHUSETTS	13,521,993.	15,374,573.	MASS GENERAL BRIGHAM
MERRIMACK VALLEY ENDOSCOPY, LLC - 04-3578297 ONE PARKWAY HAVERHILL, MA 01830	MEDICAL SERVICES	MASSACHUSETTS	3,231,855.	33,587.	PCPO
PARTNERS INNOVATION II, LLC - 81-4444790 800 BOYLSTON STREET BOSTON, MA 02199	INVESTMENTS	MASSACHUSETTS	5,865,934.	18,262,919.	MASS GENERAL BRIGHAM
PARTNERS INNOVATION MANAGEMENT COMPANY, LLC - 81-4431654, 800 BOYLSTON STREET, BOSTON, MA 02199	INVESTMENTS	MASSACHUSETTS	0.	0.	MASS GENERAL BRIGHAM

Part II **Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
THE MASSACHUSETTS GENERAL HOSPITAL (MGH) - 04-1564655, 55 FRUIT STREET, BOSTON, MA 02114	HEALTHCARE	MASSACHUSETTS	501(C)(3)	7	MASS GENERAL BRIGHAM	X	
THE GENERAL HOSPITAL COPORATION (GHC) - 04-2697983, 55 FRUIT STREET, BOSTON, MA 02114	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	MGH	X	
MASSACHUSETTS GENERAL PHYSICIANS ORG.(MGPO) - 04-2807148, 55 FRUIT STREET, BOSTON, MA 02114	HEALTHCARE	MASSACHUSETTS	501(C)(3)	10	MGH	X	
THE MGH HEALTH SERVICES CORPORATION (HSC) - 22-2717383, 55 FRUIT STREET, BOSTON, MA 02114	HEALTHCARE	MASSACHUSETTS	501(C)(3)	12A	MGH	X	

Part I **Continuation of Identification of Disregarded Entities**

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
MASSACHUSETTS EYE & EAR ASSOCIATES, LLC - 47-4262843, 243 CHARLES STREET, BOSTON, MA 02114	BILLING SERVICES	MASSACHUSETTS	745,472.	0.	MEEA
WDPC ORTHOPEDICS, LLC - 82-4754998 789 CENTRAL AVENUE DOVER, NH 03820	BILLING SERVICES	NEW HAMPSHIRE	0.	0.	WDH
PORTLAND INVESTMENTS-PIA, LLC 101 MERRIMAC STREET BOSTON, MA 02114	INVESTMENTS	MAINE	0.	0.	PIA
PORTLAND INVESTMENTS-EP, LLC 101 MERRIMAC STREET BOSTON, MA 02114	INVESTMENTS	MAINE	0.	0.	PIA
MASS GENERAL INTERNATIONAL, LLC - 83-1131673 55 FRUIT STREET BOSTON, MA 02114	GLOBAL HEALTH CARE	MASSACHUSETTS	1,127,000.	5,382,000.	MGPO
CODAMETRIX LLC - 82-3924135 55 FRUIT STREET BOSTON, MA 02114	MEDICAL CODING SOFTWARE	MASSACHUSETTS	340,000.	1,558,000.	MGPO
COCHECO DEVELOPMENT, LLC 95 MARKET STREET MANCHESTER, NH 03101	ACQUISITION ENTITY	NEW HAMPSHIRE	0.	264,022.	WDH
BRIGHAM HEALTH INTERNATIONAL - 83-1118331 75 FRANCIS STREET BOSTON, MA 02115	GLOBAL HEALTH CARE	MASSACHUSETTS	3,412,000.	4,098,000.	BH
SPAULDING INTERNATIONAL, LLC - 83-1146009 300 FIRST AVENUE CHARLESTOWN, MA 02129	GLOBAL HEALTH CARE	MASSACHUSETTS	659,000.	547,000.	SRH
PARTNERS HEALTHCARE INSURANCE HOLDING COMPANY, LLC - 83-1039882, 399 REVOLUTION DRIVE, SOMERVILLE, MA 02145	HOLDING COMPANY	MASSACHUSETTS	0.	5,639,000.	MASS GENERAL BRIGHAM

Part I **Continuation of Identification of Disregarded Entities**

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
MCLEAN INTERNATIONAL, LLC - 37-1930840 399 REVOLUTION DRIVE SOMERVILLE, MA 02145	GLOBAL HEALTH CARE	MASSACHUSETTS	290,000.	153,000.	MCLEAN
MEEA - CAPE COD PHO, LLC - 83-3091607 243 CHARLES STREET BOSTON, MA 02114	BILLING SERVICES	MASSACHUSETTS	50,557.	0.	MEEA
MEEA - WINCHESTER PHO, LLC - 83-3077580 243 CHARLES STREET BOSTON, MA 02114	BILLING SERVICES	MASSACHUSETTS	0.	0.	MEEA
MCLEAN HOUSTON OCD PROGRAM, LLC - 84-3042963 115 MILL STREET BELMONT, MA 02478	PSYCHIATRIC TREATMENT FACILLITY	MASSACHUSETTS	0.	0.	MCLEAN

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
THE MGH INSTITUTE OF HEALTH PROFESSIONS(IHP) - 04-2868893, 36 FIRST AVENUE, CHARLESTOWN, MA 02129	MED EDUCATION	MASSACHUSETTS	501(C)(3)	2	MGH	X	
MCLEAN HEALTHCARE, INC (MHC) - 20-4572876 115 MILL STREET BELMONT, MA 02478	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	12A	MGH	X	
THE MCLEAN HOSPITAL CORPORATION (MCL) - 04-2697981, 115 MILL STREET, BELMONT, MA 02478	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	MHC	X	
MARTHA'S VINEYARD HOSPITAL, INC. (MVH) - 04-2104691, LINTON LANE, P.O. BOX 1477, OAK BLUFFS, MA 02557	HEALTHCARE	MASSACHUSETTS	501(C)(3)	3	MGH	X	
WNR, INC. (WNR) - 04-3419920 1 LINTON LANE OAK BLUFFS, MA 02557	NURSING SVCS.	MASSACHUSETTS	501(C)(3)	10	MVH	X	
NANTUCKET COTTAGE HOSPITAL (NCH) - 04-2103823, 57 PROSPECT STREET, NANTUCKET, MA 02554	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	MGH	X	
NANTUCKET COTTAGE HOSPITAL FOUNDATION (NCHF) - 04-3829745, 57 PROSPECT STREET, NANTUCKET, MA 02554	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	12A	NCH	X	
BRIGHAM HEALTH (BH) - 04-2921338 75 FRANCIS STREET BOSTON, MA 02115	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	7	MASS GENERAL BRIGHAM	X	
THE BRIGHAM AND WOMEN'S HOSPITAL (BWH) - 04-2312909, 75 FRANCIS STREET, BOSTON, MA 02115	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	BH	X	
BIOSCIENCES RESEARCH FOUNDATION, INC. (BRF) - 22-2483849, 75 FRANCIS STREET, BOSTON, MA 02115	PROMOTE RES.	MASSACHUSETTS	501(C)(3)	12A	BH	X	
BWH RESEARCH, INC. (BWHR) - 04-3011445 75 FRANCIS STREET BOSTON, MA 02115	MED RESEARCH	MASSACHUSETTS	501(C)(3)	12A	BH	X	
BRIGHAM COMMUNITY PRACTICES, INC. (BCP) - 22-2588069, 75 FRANCIS STREET, BOSTON, MA 02115	HEALTHCARE	MASSACHUSETTS	501(C)(3)	10	BH	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
BRIGHAM AND WOMEN'S PHYS. ORG. (BWPO) - 04-3466314, 75 FRANCIS STREET, BOSTON, MA 02115	HEALTHCARE	MASSACHUSETTS	501(C)(3)	10	BH	X	
BRIGHAM MEDICAL RES. & EDU. FOUNDATION (MED) - 04-3539249, 75 FRANCIS STREET, BOSTON, MA 02115	MED RES & EDU	MASSACHUSETTS	501(C)(3)	12A	BWPO	X	
BRIGHAM AND WOMEN'S FAULKNER HOSP.(BWFH) - 04-2768256, 1153 CENTRE STREET, BOSTON, MA 02130	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	BH	X	
PARTNERS CONTINUING CARE, INC. (PCC) - 26-0003495, PRUDENTIAL TOWER, 800 BOYLSTON STREET, BOSTON, MA 02199	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	12A	MASS GENERAL BRIGHAM	X	
THE SPAULDING REHABILITATION HOSPITAL (SRH) - 04-2551124, 300 FIRST AVENUE, CHARLESTOWN, MA 02129	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	PCC	X	
REHAB. HOSPITAL OF THE CAPE & ISLANDS (RHCI) - 04-3071419, 311 SERVICE ROAD, EAST SANDWICH, MA 02537	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	PCC	X	
SHAUGHNESSY-KAPLAN REHABILITATION HOSP.(SKRH) - 04-3067082, DOVE AVENUE, SALEM, MA 01970	HEALTHCARE	MASSACHUSETTS	501(C)(3)	3	PCC	X	
PARTNERS HOME CARE, INC. (PHC) - 04-2918280 281 WINTER STREET WALTHAM, MA 02451	HOME HEALTH	MASSACHUSETTS	501(C)(3)	10	PCC	X	
FRC, INC. (FRC) - 22-2632121 101 MERRIMAC STREET BOSTON, MA 02114	HEALTHCARE	MASSACHUSETTS	501(C)(3)	3	PCC	X	
NSMC HEALTHCARE, INC. (NSHC) - 04-3294420 81 HIGHLAND AVENUE SALEM, MA 01970	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	12A	MASS GENERAL BRIGHAM	X	
NORTH SHORE MEDICAL CENTER, INC. (NSMC) - 04-3399616, 81 HIGHLAND AVENUE, SALEM, MA 01970	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	NSHC	X	
NORTH SHORE PHYSICIANS GROUP, INC. (NSPG) - 04-3080484, 81 HIGHLAND AVENUE, SALEM, MA 01970	HEALTHCARE	MASSACHUSETTS	501(C)(3)	12A	NSHC	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
NEWTON-WELLESLEY HEALTHCARE SYSTEM(NWHC) - 20-4295282, 2014 WASHINGTON STREET, NEWTON, MA 02462	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	12A	MASS GENERAL BRIGHAM	X	
NEWTON-WELLESLEY HOSPITAL (NWH) - 04-2103611 2014 WASHINGTON STREET NEWTON, MA 02462	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	NWHC	X	
NEWTON-WELLESLEY MEDICAL GROUP (NWMG) - 22-2560501, 2014 WASHINGTON STREET, NEWTON, MA 02462	HEALTHCARE	MASSACHUSETTS	501(C)(3)	12A	NWHC	X	
PARTNERS MEDICAL INTERNATIONAL, INC. (PMI) - 04-3197711, 100 CAMBRIDGE STREET, BOSTON, MA 02114	MED. TRAINING	MASSACHUSETTS	501(C)(3)	12A	MASS GENERAL BRIGHAM	X	
SPAULDING HOSPITAL - CAMBRIDGE, INC. (SHC) - 27-0273715, 1575 CAMBRIDGE STREET, CAMBRIDGE, MA 02138	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	PCC	X	
NANTUCKET PHYSICIAN ORGANIZATION, INC.(NPO) - 26-4349357, 57 PROSPECT STREET, NANTUCKET, MA 02554	HEALTHCARE	MASSACHUSETTS	501(C)(3)	10	MGH	X	
ALLWAYS HEALTH PARTNERS, INC. (AHP) - 04-2932021, 253 SUMMER STREET, BOSTON, MA 02210	INSURANCE	MASSACHUSETTS	501(C)(4)	NONE	MASS GENERAL BRIGHAM	X	
COMMUNITY MEDICAL ALLIANCE, INC. (CMA) - 04-3454185, 253 SUMMER STREET, BOSTON, MA 02210	INSURANCE	MASSACHUSETTS	501(C)(3)	12A	AHP	X	
COOLEY DICKINSON HOSPITAL, INC. (CDH) - 22-2617175, 30 LOCUST STREET, NORTHAMPTON, MA 01060	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	CDHC	X	
VNA & HOSPICE OF COOLEY DICKINSON, INC. (VHCD) - 04-2104788, 168 INDUSTRIAL DRIVE, NORTHAMPTON, MA 01060	HOME HEALTH	MASSACHUSETTS	501(C)(3)	10	CDHC	X	
COOLEY DICKINSON HEALTH CARE CORP. (CDHC) - 04-2103561, 30 LOCUST STREET, NORTHAMPTON, MA 01060	ADMIN SUPPORT	MASSACHUSETTS	501(C)(3)	12B	MGH	X	
CD PRACTICE ASSOCIATES, INC. (CDPA) - 04-3194547, P.O.BOX 911, NORTHAMPTON, MA 01060	HEALTHCARE	MASSACHUSETTS	501(C)(3)	10	CDHC	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
WENTWORTH DOUGLASS HOSPITAL (WDH) - 02-0260334, 789 CENTRAL AVE, DOVER, NH 03820	HOSPITAL	NEW HAMPSHIRE	501(C)(3)	3	MGH	X	
WENTWORTH-DOUGLASS PHYSICIAN CORPORATION (WDPC) - 02-0497927, 789 CENTRAL AVE, DOVER, NH 03820	HEALTHCARE	NEW HAMPSHIRE	501(C)(3)	3	WDH	X	
WENTWORTH-DOUGLASS HOSPITAL AND HEALTH FOUNDATION (WDHF) - 51-0491062, 789 CENTRAL AVE, DOVER, NH 03820	SUPPORT	NEW HAMPSHIRE	501(C)(3)	12B	WDH	X	
FOUNDATION OF THE MASSACHUSETTS EYE AND EAR INFIMARY, INC (FMMEI) - 04-27854, 243 CHARLES STREET, BOSTON, MA 02114	SUPPORT	MASSACHUSETTS	501(C)(3)	7	MASS GENERAL BRIGHAM	X	
MASSACHUSETTS EYE & EAR INFIRMARY (MEEI) - 04-2103591, 243 CHARLES STREET, BOSTON, MA 02114	HOSPITAL	MASSACHUSETTS	501(C)(3)	3	FMEEI	X	
MASSACHUSETTS EYE & EAR ASSOCIATES, INC. (MEEA) - 22-2658209, 243 CHARLES STREET, BOSTON, MA 02114	HEALTHCARE	MASSACHUSETTS	501(C)(3)	10	FMEEI	X	
PARTNERS POOLED INVESTMENT HOLDINGS, LLC (PPIH) - 82-1715859, 800 BOYLSTON STREET, BOSTON, MA 02199	SUPPORT ORGANIZATION - HOLDS INTERESTS IN PPIA	MASSACHUSETTS	501(C)(3)	12A	MASS GENERAL BRIGHAM	X	
PARTNERS HEALTHCARE SP, INC. (PHSSP) - 82-1707493, 800 BOYLSTON STREET, BOSTON, MA 02199	SPECIALTY PHARMACY	MASSACHUSETTS	501(C)(3)	12A	MASS GENERAL BRIGHAM	X	
MASS GENERAL BRIGHAM URGENT CARE, LLC (MGBUC) - 47-1683619, 920 WINTER STREET, WALTHAM, MA 02451	URGENT CARE CENTERS	MASSACHUSETTS	501(C)(3)	10	MASS GENERAL BRIGHAM	X	
HARBOR MEDICAL ASSOCIATES, INC. (HMA) - 04-2702579, 541 MAIN STREET, SUITE 400, SO. WEYMOUTH, MA 02190	PROVIDES PHYSICIAN SERVICES TO PATIENTS	MASSACHUSETTS	501(C)(3)	10	BH	X	
SOUTH SHORE ENDOSCOPY CENTER, INC. (SSEC) - 04-3306443, 541 MAIN STREET, SUITE 400, SO. WEYMOUTH, MA 02190	PROVIDES PHYSICIAN SERVICES TO PATIENTS	MASSACHUSETTS	501(C)(3)	10	BH	X	
PARTNERS COMMUNITY PHYSICIANS ORGANIZATION, INC. (PCPO) - 04-3236175, 800 BOYLSTON STREET, BOSTON, MA 02199	ORGANIZE AND OPERATE PHYSICIAN NETWORK	MASSACHUSETTS	501(C)(3)	10	MASS GENERAL BRIGHAM	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) No
EMBANKMENT SERVICES, INC. (ESI) - 04-3272965 14 DAVID MUGAR WAY BOSTON, MA 02114	SUPPORT ORGANIZATION	MASSACHUSETTS	501(C)(3)	12A	FMEEI	X	
CIRCLE COMPANY, INC. (CCI) - 04-2801797 243 CHARLES STREET BOSTON, MA 02114	TITLE HOLDING COMPANY	MASSACHUSETTS	501(C)(25)	NONE	FMEEI	X	
SCHEPENS EYE RESEARCH INSTITUTE, INC. (SERI) - 04-2129889, 20 STANIFORD STREET, BOSTON, MA 02114	RESEARCH	MASSACHUSETTS	501(C)(3)	7	FMEEI	X	
PARTNERS AMBULATORY CARE, INC. (PAC) - 84-1908707, 800 BOYLSTON STREET, BOSTON, MA 02199	AMBULATORY CARE CENTERS	MASSACHUSETTS	501(C)(3)	10	MASS GENERAL BRIGHAM	X	
FRIENDS OF MASS GENERAL CANADA, INC. 160 ELGIN STREET, SUITE 2600 OTTAWA, ONTARIO, CANADA	ADVANCE EDUCATION THROUGH RESEARCH AT MGH	CANADA		12A	MGH	X	

Part III **Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) Disproportionate allocations? No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) General or managing partner? No	(k) Percentage ownership
PHS BAY COLONY FUND - 13-3887448, 245 PARK AVENUE, NEW YORK, NY 10167	INVESTMENTS	DE	PPIA	EXCLUDED	-29,249.	223,295.		X	N/A		X	93.75%
PARTNERS HEALTHCARE SYSTEM POOLED INVEST - 04-3268842, 101 MERRIMAC STREET, BOSTON, MA 02114	INVESTMENTS	MA	MASS GENERAL BRIGHAM	EXCLUDED	47,719,402.	10712592181.		X	N/A	X		100%
PARTNERS INNOVATION FUND, LLC - 26-2899986, 101 HUNTINGTON AVENUE, BOSTON, MA 02199	INVESTMENTS	MA	MASS GENERAL BRIGHAM	EXCLUDED	-10,985.	35,965,259.		X	N/A	X		100%
RADIATION THERAPY OF SOUTHEASTERN MA, LLC - 01-0873580, 375 LONGWOOD AVENUE, BOSTON, MA 02115	RADIATION THERAPY SERVICES	MA	BH	EXCLUDED	232,174.	1,410,983.		X	N/A	X		51.00%

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) Section 512(b)(13) controlled entity? No
NEWTON-WELLESLEY PHYSICIAN HOSPITAL ORG. - 04-3209749, 2014 WASHINGTON STREET, NEWTON, MA 02462	HEALTHCARE	MA	NWHC	C CORP	2,077,000.	6,679,200.	100%		X
ALLWAYS HEALTH PARTNERS INSURANCE COMPANY - 83-0970929, 399 REVOLUTION DRIVE, SOMERVILLE, MA 02145	INSURANCE COMPANY	MA	MASS GENERAL BRIGHAM	C CORP	17,233.	4,017,223.	100%		X

SEE PART VII FOR CONTINUATIONS

Part III **Continuation of Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) Disproportionate allocations? No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) General or managing partner? No	(k) Percentage ownership
PARTNERS HEALTHCARE ACCOUNTABLE CARE ORGANIZATION, LLC - 81-2762122, 399 REVOLUTION	ACCOUNTABLE CARE ORGANIZATION	MA	MASS GENERAL BRIGHAM	EXCLUDED	-3,285,394.	18,448,383.		X	N/A	X		100%

Part V **Transactions With Related Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	1a	X	
b Gift, grant, or capital contribution to related organization(s)	1b	X	
c Gift, grant, or capital contribution from related organization(s)	1c	X	
d Loans or loan guarantees to or for related organization(s)	1d	X	
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j		X
k Lease of facilities, equipment, or other assets from related organization(s)	1k	X	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	X	
o Sharing of paid employees with related organization(s)	1o	X	
p Reimbursement paid to related organization(s) for expenses	1p		X
q Reimbursement paid by related organization(s) for expenses	1q		X
r Other transfer of cash or property to related organization(s)	1r		X
s Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	THE MASSACHUSETTS GENERAL HOSPITAL	A	30,760,503.	FMV
(2)	THE GENERAL HOSPITAL CORPORATION	A	18,023,480.	FMV
(3)	NEWTON-WELLESLEY HOSPITAL	A	5,425,632.	FMV
(4)	THE BRIGHAM AND WOMEN'S HOSPITAL, INC.	A	58,211,393.	FMV
(5)	THE MCLEAN HOSPITAL CORPORATION	A	3,156,166.	FMV
(6)	THE SPAULDING REHABILITATION HOSPITAL CORPORATION	A	307,868.	FMV

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORP.	A	224,036.	FMV
(8) BRIGHAM AND WOMEN'S FAULKNER HOSPITAL, INC.	A	470,774.	FMV
(9) NORTH SHORE MEDICAL CENTER, INC.	A	24,489,658.	FMV
(10) THE MGH INSTITUTE OF HEALTH PROFESSIONS, INC.	A	41,951.	FMV
(11) FRC, INC.	A	99,491.	FMV
(12) COOLEY DICKINSON HOSPITAL, INC.	A	1,904,381.	FMV
(13) PARTNERS CONTINUING CARE, INC.	A	9,266.	FMV
(14) MASSACHUSETTS EYE & EAR INFIRMARY	A	4,956,498.	FMV
(15) WENTWORTH-DOUGLASS HOSPITAL	A	4,290,276.	FMV
(16) PARTNERS CONTINUING CARE, INC.	B	20,690,000.	FMV
(17) THE SPAULDING REHABILITATION HOSPITAL CORPORATION	B	182,836.	FMV
(18) MASS GENERAL BRIGHAM URGENT CARE, LLC	B	8,500,000.	FMV
(19) BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC.	B	6,649,699.	FMV
(20) THE MASSACHUSETTS GENERAL HOSPITAL	B	233,338,789.	FMV
(21) MASSACHUSETTS EYE & EAR INFIRMARY	B	24,239,908.	FMV
(22) THE GENERAL HOSPITAL CORPORATION	B	7,942,179.	FMV
(23) THE MCLEAN HOSPITAL CORPORATION	B	868,706.	FMV
(24) COOLEY DICKINSON HOSPITAL, INC.	B	15,929,495.	FMV

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) THE BRIGHAM AND WOMEN'S HOSPITAL, INC.	B	167,198,601.	FMV
(8) NORTH SHORE MEDICAL CENTER, INC.	B	19,028,465.	FMV
(9) NORTH SHORE PHYSICIANS GROUP, INC.	B	987,132.	FMV
(10) THE MASSACHUSETTS GENERAL HOSPITAL	C	62,319,599.	FMV
(11) PARTNERS CONTINUING CARE, INC.	C	7,387,235.	FMV
(12) MCLEAN HEALTHCARE, INC.	C	3,474,771.	FMV
(13) BRIGHAM HEALTH, INC.	C	53,315,152.	FMV
(14) NSMC HEALTHCARE, INC.	C	8,890,568.	FMV
(15) NEWTON-WELLESLEY HEALTHCARE SYSTEM, INC.	C	9,982,007.	FMV
(16) NANTUCKET COTTAGE HOSPITAL	C	964,375.	FMV
(17) MARTHA'S VINEYARD HOSPITAL	C	1,240,124.	FMV
(18) COOLEY DICKINSON HEALTH CARE CORPORATION	C	3,839,005.	FMV
(19) ALLWAYS HEALTH PARTNERS, INC.	C	102,243,000.	FMV
(20) MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION, INC.	C	198,939.	FMV
(21) NEWTON-WELLESLEY HOSPITAL	C	4,114,360.	FMV
(22) NEWTON-WELLESLEY MEDICAL GROUP, INC.	C	223,148.	FMV
(23) THE BRIGHAM AND WOMEN'S HOSPITAL, INC.	D	181,330,000.	FMV
(24) THE MCLEAN HOSPITAL CORPORATION	D	4,970,000.	FMV

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) NORTH SHORE MEDICAL CENTER, INC.	D	140,880,000.	FMV
(8) THE GENERAL HOSPITAL CORPORATION	D	11,250,000.	FMV
(9) NEWTON-WELLESLEY HOSPITAL	D	21,800,000.	FMV
(10) MASSACHUSETTS EYE & EAR INFIRMARY	D	7,000,000.	FMV
(11) THE MASSACHUSETTS GENERAL HOSPITAL	K	1,348,306.	FMV
(12) THE MASSACHUSETTS GENERAL HOSPITAL	L	68,381,064.	FMV
(13) THE GENERAL HOSPITAL CORPORATION	L	255,008,122.	FMV
(14) MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION, INC.	L	12,540,226.	FMV
(15) THE SPAULDING REHABILITATION HOSPITAL CORPORATION	L	12,860,697.	FMV
(16) PARTNERS HOME CARE, INC.	L	5,077,512.	FMV
(17) FRC, INC.	L	1,648,965.	FMV
(18) SPAULDING HOSPITAL - CAMBRIDGE, INC.	L	4,063,626.	FMV
(19) PARTNERS CONTINUING CARE, INC.	L	8,524,524.	FMV
(20) REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORP.	L	2,835,587.	FMV
(21) NANTUCKET COTTAGE HOSPITAL	L	2,694,816.	FMV
(22) THE MCLEAN HOSPITAL CORPORATION	L	18,245,893.	FMV
(23) THE MGH INSTITUTE OF HEALTH PROFESSIONS, INC.	L	1,122,248.	FMV
(24) WENTWORTH-DOUGLASS HOSPITAL	L	388,338.	FMV

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

	(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7)	COOLEY DICKINSON HOSPITAL, INC.	L	7,379,293.	FMV
(8)	THE BRIGHAM AND WOMEN'S HOSPITAL, INC.	L	202,551,356.	FMV
(9)	BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC.	L	8,824,923.	FMV
(10)	BRIGHAM AND WOMEN'S FAULKNER HOSPITAL, INC.	L	20,775,668.	FMV
(11)	NORTH SHORE MEDICAL CENTER, INC.	L	45,673,388.	FMV
(12)	NORTH SHORE PHYSICIANS GROUP, INC.	L	916,652.	FMV
(13)	NEWTON-WELLESLEY HOSPITAL	L	31,728,955.	FMV
(14)	NEWTON-WELLESLEY MEDICAL GROUP, INC.	L	10,017,051.	FMV
(15)	PARTNERS COMMUNITY PHYSICIANS ORGANIZATION, INC.	L	4,610,820.	FMV
(16)	ALLWAYS HEALTH PARTNERS, INC.	L	4,346,850.	FMV
(17)	MARTHA'S VINEYARD HOSPITAL	L	4,255,045.	FMV
(18)	BRIGHAM HEALTH, INC.	L	47,561,982.	FMV
(19)	MASSACHUSETTS EYE & EAR INFIRMARY	L	1,519,085.	FMV
(20)				
(21)				
(22)				
(23)				
(24)				

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information.

Provide additional information for responses to questions on Schedule R. See instructions.

PART III, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS PARTNERSHIP:

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

PARTNERS HEALTHCARE ACCOUNTABLE CARE ORGANIZATION, LLC

EIN: 81-2762122

399 REVOLUTION DRIVE

SOMERVILLE, MA 02145

IDENTIFICATION
no. 04-3230035
Filing Fee: $15.00

Examiner

Name Approved

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Room 1717, Boston, Massachusetts 02108-1512

ARTICLES OF AMENDMENT
(General Laws, Chapter 180, Section 7)

We, Anne Klibanski, M.D., *President / ~~*Vice President,~~

and Maureen Goggin, *Clerk / ~~*Assistant Clerk,~~

of Partners HealthCare System, Inc.,
(Exact name of corporation)

located at 800 Boylston Street, Suite 1150, Boston, Massachusetts 02199,
(Address of corporation in Massachusetts)

do hereby certify that these Articles of Amendment affecting articles numbered:

I, II and IV
(Number those articles 1, 2, 3, and/or 4 being amended)

of the Articles of Organization were duly adopted at a meeting held on April 21, 20 20, by vote of:

347 members, _____ directors, or _____ shareholders**,

☑ Being at least two-thirds of its members legally qualified to vote in meetings of the corporation; OR

☐ Being at least two-thirds of its directors where there are no members pursuant to General Laws, Chapter 180, Section 3; OR

☐ In the case of a corporation having capital stock, by the holders of at least two-thirds of the capital stock having the right to vote therein.

Delete Articles I, II and IV in their entirety and insert in place thereof the following:

Article I

The name of the corporation is:
Mass General Brigham Incorporated

C ☐
P ☐
M ☐
R.A. ☐

*Delete the inapplicable words.
**Check only one box that applies.
Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

P.C.

Article II

The purpose of the corporation is to engage in the following activities:

2.1 To organize, operate, direct and coordinate a comprehensive, integrated healthcare delivery system comprising hospital, physician and other healthcare provider organizations, managed care and other health insurance organizations and other charitable, scientific, educational, research and community organizations (i) that are controlled directly or indirectly by the corporation (collectively, the "Affiliated Organizations") and (ii) with which the corporation and the Affiliated Organizations collaborate through clinical and care management, research and other affiliations and contractual arrangements (the "Collaborative Organizations").

2.2 To promote, sponsor, support, conduct and/or provide, either alone or in conjunction with the Affiliated Organizations and/or the Collaborative Organizations, (i) healthcare services to improve the health and welfare of all persons, regardless of their ability to pay; (ii) research for the prevention, diagnosis, treatment and cure of all forms of human illness; (iii) education and training for physicians and other healthcare providers; and (iv) programs and services that address the healthcare needs of the communities served by the corporation, the Affiliated Organizations and/or the Collaborative Organizations.

2.3 To assist and support the Affiliated Organizations and the Collaborative Organizations in fulfilling their respective missions and purposes including, without limitation, by lending, leasing and donating funds and other assets to, and by guaranteeing the obligations of, the Affiliated Organizations and/or the Collaborative Organizations.

2.4 To engage in any activity that may be lawfully carried on by a corporation that is formed under Chapter 180 of the Massachusetts General Laws ("MGL") and that is exempt from federal income tax under Section 501(a) of the Internal Revenue Code ("IRC") as an organization described in Section 501(c)(3) of the IRC.

Article IV

4.1. The corporation shall have in furtherance of its corporate purposes all of the powers specified in Section 6 of MGL Chapter 180 and in Sections 9 and 9A of MGL Chapter 156B (except those powers described in paragraph (m) of said Section 9). The corporation may carry on any operation or activity referred to in Article II of these Articles of Organization to the same extent as might an individual, either alone or in a partnership or joint venture or other arrangement with others, or through a wholly or partly owned or controlled corporation; provided, however, that no such power shall be exercised by the corporation in a manner inconsistent with MGL Chapter 180 or any other chapter of the MGL or with exemption from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.2. The bylaws of the corporation (the "Bylaws") may authorize the Board of Directors to make, amend or repeal the Bylaws in whole or in part, except with respect to any provision thereof which by law, these Articles of Organization or the Bylaws requires action by the members.

4.3. To the fullest extent permitted under Section 3 of MGL Chapter 180, no director or officer of the corporation shall be personally liable to the corporation or its members for monetary damages for breach of fiduciary duty as a director or officer notwithstanding any provision of law imposing such liability.

4.4. The corporation shall have the power to indemnify to the extent specified in the Bylaws (i) its members, directors, officers, employees, agents and volunteers, (ii) persons who serve at its request as a member, director, trustee or officer of another organization and (iii) persons who serve on its behalf in any capacity with respect to any employee benefit plan; provided that any such indemnity shall be limited to the extent necessary to protect the corporation's status as exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.5. No part of the net assets or net earnings of the corporation shall inure to the benefit of, or be distributable to, any member, director, officer or employee of the corporation or to any other person; provided that the corporation shall be authorized and empowered (i) to pay reasonable compensation for services actually rendered and (ii) to make payments and distributions in furtherance of the corporation's purposes set forth in Article II hereof.

4.6 No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting, to influence legislation, except to the extent permitted by Section 501(h) of the IRC. The corporation shall not participate or intervene (including the publishing or distributing of statements) in any political campaign on behalf of (or in opposition to) any candidate for public office.

4.7 It is intended that the corporation shall be entitled to exemption from federal income tax under Section 501(c)(3) of the IRC and shall not be a private foundation under Section 509(a) of the IRC. However, during any period of time in which the corporation is, or is deemed to be, a private foundation (as that term is defined in Section 509 of the IRC), notwithstanding any other provisions of these Articles of Organization or the Bylaws, the corporation shall at all times conduct its affairs as follows:

(i) the income of the corporation for each taxable year shall be distributed at such time and in such manner as not to subject the corporation to the tax on undistributed income imposed by Section 4942 of the IRC; and

(ii) the corporation shall not (1) engage in any act of self-dealing (as defined in Section 4941(d) of the IRC); (2) retain any excess business holdings (as defined in Section 4943(c) of the IRC); (3) make any investments in such manner as to subject the corporation to tax under Section 4944 of the IRC; or (4) make any taxable expenditures (as defined in Section 4945(d) of the IRC).

4.8 Upon the liquidation or dissolution of the corporation, after having paid (or made due provision for) all of the liabilities of the corporation, all of the remaining assets of the corporation shall be distributed pursuant to Section 11A of MGL Chapter 180 to Brigham Health, Inc.("BH") (if at such time BH is exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC) and to The Massachusetts General Hospital ("MGH") (if at such time MGH is exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC); or, if at such time neither BH nor MGH is so exempt, such distributions shall be made to one or more of the Affiliated Organizations that are then exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.9. All references herein (i) to the IRC or to any section thereof shall be deemed to refer to the IRC of 1986 as now in force or hereafter amended, or to the corresponding provisions of any subsequent federal income tax laws; and (ii) to the MGL or to any chapter or section thereof shall be deemed to refer to said MGL as now in force or hereafter amended, or to the corresponding provisions of any subsequent Massachusetts laws.

The foregoing amendment(s) will become effective when these Articles of Amendment are filed in accordance with General Laws, Chapter 180, Section 7 unless these articles specify, in accordance with the vote adopting the amendment, a *later* effective date not more than *thirty days* after such filing, in which event the amendment will become effective on such later date.

Later effective date: May 1, 2020 .

SIGNED UNDER THE PENALTIES OF PERJURY, this 22nd day of April , 20 20

, *President / *~~Vice President,~~

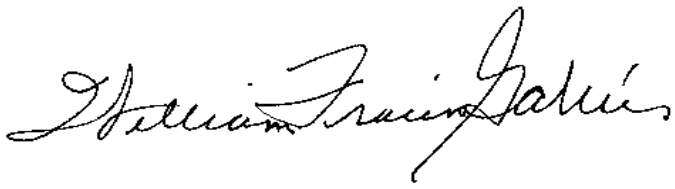
, *Clerk / *~~Assistant Clerk.~~

*Delete the inapplicable words.

THE COMMONWEALTH OF MASSACHUSETTS

I hereby certify that, upon examination of this document, duly submitted to me, it appears that the provisions of the General Laws relative to corporations have been complied with, and I hereby approve said articles; and the filing fee having been paid, said articles are deemed to have been filed with me on:

April 23, 2020 04:14 PM



WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

Form **5713**

(Rev. December 2010)

Department of the Treasury
Internal Revenue Service

International Boycott Report

For tax year beginning 10/01/ , **20** 18 ,
and ending 09/30/ , **20** 19 .

▶ **Controlled groups, see instructions.**

OMB No. 1545-0216

Attachment Sequence No. 123

Paper filers must file in duplicate (see **When and Where to File** in the instructions)

Name	Identifying number
Mass General Brigham Incorporated	04-3230035

Number, street, and room or suite no. If a P.O. box, see instructions.

399 Revolution Drive, Suite 645

City or town, state, and ZIP code

Somerville, MA 02145-1446

Address of service center where your tax return is filed

Ogden, UT 84201

Type of filer (check one):

☐ Individual ☐ Partnership ☐ Corporation ☐ Trust ☐ Estate ☒ Other

1 **Individuals—**Enter adjusted gross income from your tax return (see instructions)

2 **Partnerships and corporations:**

a Partnerships—Enter each partner's name and identifying number.

b Corporations—Enter the name and employer identification number of each member of the controlled group (as defined in section 993(a)(3)). Do not list members included in the consolidated return; instead, attach a copy of Form 851. List all other members of the controlled group not included in the consolidated return.
If you list any corporations below or if you attach Form 851, you must designate a common tax year. Enter on line 4b the name and employer identification number of the corporation whose tax year is designated.

Name	Identifying number

If more space is needed, attach additional sheets and check this box . . . . . ▶ ☐

	Code	Description
c Enter principal business activity code and description (see instructions)		
d IC-DISCs—Enter principal product or service code and description (see instructions)		

3 **Partnerships—**Each partnership filing Form 5713 must give the following information:

a Partnership's total assets (see instructions) . . . . . .

b Partnership's ordinary income (see instructions) . . . . . .

4 **Corporations—**Each corporation filing Form 5713 must give the following information:

a Type of form filed (Form 1120, 1120-FSC, 1120-IC-DISC, 1120-L, 1120-PC, etc.) . . .

b Common tax year election (see instructions)
(1) Name of corporation ▶
(2) Employer identification number . . . . . .
(3) Common tax year beginning , 20 , and ending , 20 .

c Corporations filing this form enter:
(1) Total assets (see instructions) . . . . . .
(2) Taxable income before net operating loss and special deductions (see instructions) . .

5 **Estates or trusts—**Enter total income (Form 1041, page 1) . . . . . .

6 Enter the total amount (before reduction for boycott participation or cooperation) of the following tax benefits (see instructions):

a Foreign tax credit . . . . . .

b Deferral of earnings of controlled foreign corporations . . . . . .

c Deferral of IC-DISC income . . . . . .

d FSC exempt foreign trade income . . . . . .

e Foreign trade income qualifying for the extraterritorial income exclusion . . . . .

Please Sign Here

Under penalties of perjury, I declare that I have examined this report, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete.

▶ **Signature** **Date** ▶ Exec. VP, CFO & Treasurer **Title**

For Paperwork Reduction Act Notice, see separate instructions. Form **5713** (Rev. 12-2010)

ISA

		Yes	No
7a	Are you a U.S. shareholder (as defined in section 951(b)) of any foreign corporation (including a FSC that does not use the administrative pricing rules) that had operations reportable under section 999(a)?		X
b	If the answer to question 7a is "Yes," is any foreign corporation a controlled foreign corporation (as defined in section 957(a))?		
c	Do you own any stock of an IC-DISC?		X
d	Do you claim any foreign tax credit?		X
e	Do you control (within the meaning of section 304(c)) any corporation (other than a corporation included in this report) that has operations reportable under section 999(a)?	X	
	If "Yes," did that corporation participate in or cooperate with an international boycott at any time during its tax year that ends with or within your tax year?	X	
f	Are you controlled (within the meaning of section 304(c)) by any person (other than a person included in this report) who has operations reportable under section 999(a)?		X
	If "Yes," did that person participate in or cooperate with an international boycott at any time during its tax year that ends with or within your tax year?		
g	Are you treated under section 671 as the owner of a trust that has reportable operations under section 999(a)?		X
h	Are you a partner in a partnership that has reportable operations under section 999(a)?		X
i	Are you a foreign sales corporation (FSC) (as defined in section 922(a), as in effect before its repeal)?		X
j	Are you excluding extraterritorial income (defined in section 114(e), as in effect before its repeal) from gross income?		X

Part I Operations in or Related to a Boycotting Country (see instructions)

		Yes	No
8	**Boycott of Israel—**Did you have any operations in or related to any country (or with the government, a company, or a national of that country) associated in carrying out the boycott of Israel which is on the list maintained by the Secretary of the Treasury under section 999(a)(3)? (See **Boycotting Countries** in the instructions.)	X	

If "Yes," complete the following table. If more space is needed, attach additional sheets using the exact format and check this box ▶ ☐

Name of country (1)	Identifying number of person having operations (2)	Principal business activity Code (3)	Principal business activity Description (4)	IC-DISCs only—Enter product code (5)
a Iraq	04-2312909	611000	Medical Education	
b Saudi Arabia	04-2312909	611000	Medical Education	
c United Arab Emirates	04-2312909	611000	Medical Education	
d Kuwait	04-2697983	611000	Medical Education	
e Lebanon	04-2697983	611000	Medical Education	
f Saudi Arabia	04-2697983	611000	Medical Education	
g Saudi Arabia	04-2868893	611000	Medical Education	
h United Arab Emirates	04-2697981	611000	Medical Education	
i Kuwait	04-2103591	611000	Medical Education	
j Saudi Arabia	04-3230035	611000	Medical Education	
k United Arab Emirates	04-3230035	611000	Medical Education	
l United Arab Emirates	26-0003495	611000	Medical Education	
m				
n				
o				

	Yes	No
9 **Nonlisted countries boycotting Israel—** Did you have operations in any nonlisted country which you know or have reason to know requires participation in or cooperation with an international boycott directed against Israel?		

If "Yes," complete the following table. If more space is needed, attach additional sheets using the exact format and check this box . . . . . ▶ ☐

	Name of country (1)	Identifying number of person having operations (2)	Principal business activity Code (3)	Principal business activity Description (4)	IC-DISCs only—Enter product code (5)
a					
b					
c					
d					
e					
f					
g					
h					

	Yes	No
10 **Boycotts other than the boycott of Israel—**Did you have operations in any other country which you know or have reason to know requires participation in or cooperation with an international boycott other than the boycott of Israel?		

If "Yes," complete the following table. If more space is needed, attach additional sheets using the exact format and check this box . . . . . ▶ ☐

	Name of country (1)	Identifying number of person having operations (2)	Principal business activity Code (3)	Principal business activity Description (4)	IC-DISCs only—Enter product code (5)
a					
b					
c					
d					
e					
f					
g					
h					

	Yes	No
11 Were you requested to participate in or cooperate with an international boycott?		
If "Yes," attach a copy (in English) of any and all such requests received during your tax year. If the request was in a form other than a written request, attach a separate sheet explaining the nature and form of any and all such requests. (See instructions.)		
12 Did you participate in or cooperate with an international boycott?		

If "Yes," attach a copy (in English) of any and all boycott clauses agreed to, and attach a general statement of the agreement. If the agreement was in a form other than a written agreement, attach a separate sheet explaining the nature and form of any and all such agreements. (See instructions.)

Note: *If the answer to either question 11 or 12 is "Yes," you must complete the rest of Form 5713. If you answered "Yes" to question 12, you must complete Schedules A and C or B and C (Form 5713).*

Part II **Requests for and Acts of Participation in or Cooperation With an International Boycott**

	Requests		Agreements	
	Yes	No	Yes	No
13a Did you receive requests to enter into, or did you enter into, any agreement (see instructions):				
(1) As a condition of doing business directly or indirectly within a country or with the government, a company, or a national of a country to—				
(a) Refrain from doing business with or in a country which is the object of an international boycott or with the government, companies, or nationals of that country?				
(b) Refrain from doing business with any U.S. person engaged in trade in a country which is the object of an international boycott or with the government, companies, or nationals of that country?				
(c) Refrain from doing business with any company whose ownership or management is made up, in whole or in part, of individuals of a particular nationality, race, or religion, or to remove (or refrain from selecting) corporate directors who are individuals of a particular nationality, race, or religion?				
(d) Refrain from employing individuals of a particular nationality, race, or religion?				
(2) As a condition of the sale of a product to the government, a company, or a national of a country, to refrain from shipping or insuring products on a carrier owned, leased, or operated by a person who does not participate in or cooperate with an international boycott?				

b **Requests and agreements—**if the answer to any part of 13a is "Yes," complete the following table. If more space is needed, attach additional sheets using the exact format and check this box . . . . . ▶ ☐

	Name of country (1)	Identifying number of person receiving the request or having the agreement (2)	Principal business activity		IC-DISCs only—Enter product code (5)	Type of cooperation or participation			
						Number of requests		Number of agreements	
			Code (3)	Description (4)		Total (6)	Code (7)	Total (8)	Code (9)
a									
b									
c									
d									
e									
f									
g									
h									
i									
j									
k									
l									
m									
n									
o									
p									

Attachment 8

Examiner

Name Approved

The Commonwealth of Massachusetts

OFFICE OF THE MASSACHUSETTS SECRETARY OF STATE
MICHAEL J. CONNOLLY, Secretary
ONE ASHBURTON PLACE, BOSTON, MASSACHUSETTS 02108

ARTICLES OF ORGANIZATION

(Under G.L. Ch. 180)

ARTICLE I

The name of the corporation is:

MGH/BRIGHAM HEALTH CARE SYSTEM, INC.

ARTICLE II

The purpose of the corporation is to engage in the following activities:

(i) To organize, operate and support a comprehensive health care system, including without limitation hospital and other health care services for all persons, and education and research for the prevention, diagnosis, treatment and cure of all forms of human illness; (ii) to improve the health and welfare of all persons; (iii) to operate for the benefit of and to support The Massachusetts General Hospital, The Brigham Medical Center, Inc., their respective affiliated corporations and such other charitable, scientific or educational organizations which are or are affiliated with teaching hospitals in the Greater Boston Area; and (iv) to carry on any other activity that may lawfully be carried on by a corporation formed under Chapter 180 of the Massachusetts General Laws which is exempt under section 501(c)(3) of the Internal Revenue Code.

93-349060

C ☐
P ☑
M ☐
R.A. ☐

10

P.C.

Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on separate 8½ x 11 sheets of paper leaving a left hand margin of at least 1 inch. Additions to more than one article may be continued on a single sheet so long as each article requiring each such addition is clearly indicated.

IDENTIFICATION
no. 04-3230035
Filing Fee: $15.00

Examiner

Name Approved

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Room 1717, Boston, Massachusetts 02108-1512

ARTICLES OF AMENDMENT
(General Laws, Chapter 180, Section 7)

We, Anne Klibanski, M.D., *President / ~~*Vice President,~~

and Maureen Goggin, *Clerk / ~~*Assistant Clerk,~~

of Partners HealthCare System, Inc.,
(Exact name of corporation)

located at 800 Boylston Street, Suite 1150, Boston, Massachusetts 02199,
(Address of corporation in Massachusetts)

do hereby certify that these Articles of Amendment affecting articles numbered:

I, II and IV
(Number those articles 1, 2, 3, and/or 4 being amended)

of the Articles of Organization were duly adopted at a meeting held on April 21, 20 20, by vote of:

347 members, _____ directors, or _____ shareholders**,

☑ Being at least two-thirds of its members legally qualified to vote in meetings of the corporation; OR

☐ Being at least two-thirds of its directors where there are no members pursuant to General Laws, Chapter 180, Section 3; OR

☐ In the case of a corporation having capital stock, by the holders of at least two-thirds of the capital stock having the right to vote therein.

Delete Articles I, II and IV in their entirety and insert in place thereof the following:

Article I

The name of the corporation is:
Mass General Brigham Incorporated

C ☐
P ☐
M ☐
R.A. ☐

*Delete the inapplicable words.
**Check only one box that applies.
Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

P.C.

Article II

The purpose of the corporation is to engage in the following activities:

2.1 To organize, operate, direct and coordinate a comprehensive, integrated healthcare delivery system comprising hospital, physician and other healthcare provider organizations, managed care and other health insurance organizations and other charitable, scientific, educational, research and community organizations (i) that are controlled directly or indirectly by the corporation (collectively, the "Affiliated Organizations") and (ii) with which the corporation and the Affiliated Organizations collaborate through clinical and care management, research and other affiliations and contractual arrangements (the "Collaborative Organizations").

2.2 To promote, sponsor, support, conduct and/or provide, either alone or in conjunction with the Affiliated Organizations and/or the Collaborative Organizations, (i) healthcare services to improve the health and welfare of all persons, regardless of their ability to pay; (ii) research for the prevention, diagnosis, treatment and cure of all forms of human illness; (iii) education and training for physicians and other healthcare providers; and (iv) programs and services that address the healthcare needs of the communities served by the corporation, the Affiliated Organizations and/or the Collaborative Organizations.

2.3 To assist and support the Affiliated Organizations and the Collaborative Organizations in fulfilling their respective missions and purposes including, without limitation, by lending, leasing and donating funds and other assets to, and by guaranteeing the obligations of, the Affiliated Organizations and/or the Collaborative Organizations.

2.4 To engage in any activity that may be lawfully carried on by a corporation that is formed under Chapter 180 of the Massachusetts General Laws ("MGL") and that is exempt from federal income tax under Section 501(a) of the Internal Revenue Code ("IRC") as an organization described in Section 501(c)(3) of the IRC.

Article IV

4.1. The corporation shall have in furtherance of its corporate purposes all of the powers specified in Section 6 of MGL Chapter 180 and in Sections 9 and 9A of MGL Chapter 156B (except those powers described in paragraph (m) of said Section 9). The corporation may carry on any operation or activity referred to in Article II of these Articles of Organization to the same extent as might an individual, either alone or in a partnership or joint venture or other arrangement with others, or through a wholly or partly owned or controlled corporation; provided, however, that no such power shall be exercised by the corporation in a manner inconsistent with MGL Chapter 180 or any other chapter of the MGL or with exemption from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.2. The bylaws of the corporation (the "Bylaws") may authorize the Board of Directors to make, amend or repeal the Bylaws in whole or in part, except with respect to any provision thereof which by law, these Articles of Organization or the Bylaws requires action by the members.

4.3. To the fullest extent permitted under Section 3 of MGL Chapter 180, no director or officer of the corporation shall be personally liable to the corporation or its members for monetary damages for breach of fiduciary duty as a director or officer notwithstanding any provision of law imposing such liability.

4.4. The corporation shall have the power to indemnify to the extent specified in the Bylaws (i) its members, directors, officers, employees, agents and volunteers, (ii) persons who serve at its request as a member, director, trustee or officer of another organization and (iii) persons who serve on its behalf in any capacity with respect to any employee benefit plan; provided that any such indemnity shall be limited to the extent necessary to protect the corporation's status as exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.5. No part of the net assets or net earnings of the corporation shall inure to the benefit of, or be distributable to, any member, director, officer or employee of the corporation or to any other person; provided that the corporation shall be authorized and empowered (i) to pay reasonable compensation for services actually rendered and (ii) to make payments and distributions in furtherance of the corporation's purposes set forth in Article II hereof.

4.6 No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting, to influence legislation, except to the extent permitted by Section 501(h) of the IRC. The corporation shall not participate or intervene (including the publishing or distributing of statements) in any political campaign on behalf of (or in opposition to) any candidate for public office.

4.7 It is intended that the corporation shall be entitled to exemption from federal income tax under Section 501(c)(3) of the IRC and shall not be a private foundation under Section 509(a) of the IRC. However, during any period of time in which the corporation is, or is deemed to be, a private foundation (as that term is defined in Section 509 of the IRC), notwithstanding any other provisions of these Articles of Organization or the Bylaws, the corporation shall at all times conduct its affairs as follows:

(i) the income of the corporation for each taxable year shall be distributed at such time and in such manner as not to subject the corporation to the tax on undistributed income imposed by Section 4942 of the IRC; and

(ii) the corporation shall not (1) engage in any act of self-dealing (as defined in Section 4941(d) of the IRC); (2) retain any excess business holdings (as defined in Section 4943(c) of the IRC); (3) make any investments in such manner as to subject the corporation to tax under Section 4944 of the IRC; or (4) make any taxable expenditures (as defined in Section 4945(d) of the IRC).

4.8 Upon the liquidation or dissolution of the corporation, after having paid (or made due provision for) all of the liabilities of the corporation, all of the remaining assets of the corporation shall be distributed pursuant to Section 11A of MGL Chapter 180 to Brigham Health, Inc.("BH") (if at such time BH is exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC) and to The Massachusetts General Hospital ("MGH") (if at such time MGH is exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC); or, if at such time neither BH nor MGH is so exempt, such distributions shall be made to one or more of the Affiliated Organizations that are then exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.9. All references herein (i) to the IRC or to any section thereof shall be deemed to refer to the IRC of 1986 as now in force or hereafter amended, or to the corresponding provisions of any subsequent federal income tax laws; and (ii) to the MGL or to any chapter or section thereof shall be deemed to refer to said MGL as now in force or hereafter amended, or to the corresponding provisions of any subsequent Massachusetts laws.

The foregoing amendment(s) will become effective when these Articles of Amendment are filed in accordance with General Laws, Chapter 180, Section 7 unless these articles specify, in accordance with the vote adopting the amendment, a *later* effective date not more than *thirty days* after such filing, in which event the amendment will become effective on such later date.

Later effective date: May 1, 2020 .

SIGNED UNDER THE PENALTIES OF PERJURY, this 22nd day of April , 20 20

, *President / *~~Vice President~~,

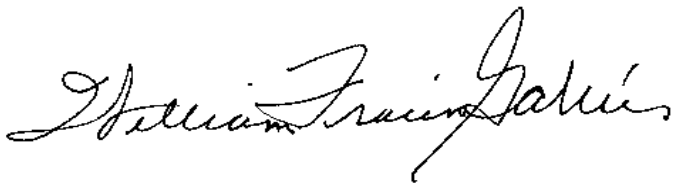
, *Clerk / *~~Assistant Clerk~~.

*Delete the inapplicable words.

THE COMMONWEALTH OF MASSACHUSETTS

I hereby certify that, upon examination of this document, duly submitted to me, it appears that the provisions of the General Laws relative to corporations have been complied with, and I hereby approve said articles; and the filing fee having been paid, said articles are deemed to have been filed with me on:

April 23, 2020 04:14 PM



WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

ARTICLE III

If the corporation has one or more classes of members, the designation of such classes, the manner of election or appointments, the duration of membership and the qualification and rights, including voting rights, of the members of each class, may be set forth in the by-laws of the corporation or may be set forth below:

The designation of classes of members, if any, the manner of election or appointment, the term of office, and the qualifications and rights of members are set forth in the by-laws of the Corporation.

ARTICLE IV

* Other lawful provisions, if any, for the conduct and regulation of the business and affairs of the corporation, for its voluntary dissolution, or for limiting, defining, or regulating the powers of the corporation, or of its directors or members, or of any class of members, are as follows:

See Continuation Sheets IV-A through IV-D attached hereto and incorporated herein by reference.

* . If there are no provisions, state "None".

Note: The preceding four (4) articles are considered to be permanent and may ONLY be changed by filing appropriate Articles of Amendment.

IV. Other Lawful Provisions for Conduct and Regulation of the Business and Affairs of the Corporation, for its Voluntary Dissolution, and for Limiting, Defining and Regulating the Powers of the Corporation and of its Trustees and Members.

4.1. The corporation shall have in furtherance of its corporate purposes all of the powers specified in Section 6 of Chapter 180 and in Sections 9 and 9A of Chapter 156B of the Massachusetts General Laws (except those provided in paragraph (m) of said Section 9) as now in force or as hereafter amended, and may carry on any operation or activity referred to in Article 2 to the same extent as might an individual, either alone or in a joint venture or other arrangement with others, or through a wholly or partly owned or controlled corporation; provided, however, that no such power shall be exercised in a manner inconsistent with said Chapter 180 or any other chapter of the Massachusetts General Laws or which would deprive it of exemption from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code.

4.2. The by-laws may authorize the trustees to make, amend or repeal the by-laws in whole or in part, except with respect to any provision thereof which by law, the articles of organization or the by-laws requires action by the members.

4.3. Meetings of the members may be held anywhere in the United States.

4.4. No trustee or officer of the corporation shall be personally liable to the corporation or its members for monetary damages for breach of fiduciary duty as such trustee or officer notwithstanding any provision of law imposing such liability, except to the extent that such exemption from liability is not permitted under Chapter 180 of the Massachusetts General Laws.

4.5.(a) The corporation shall, to the extent legally permissible, indemnify each person who serves as one of its members, trustees or officers, or who serves at its request as a member, trustee or officer of another organization or in a capacity with respect to any employee benefit plan (each such person being called in this Section 4.5 a "Person") against all liabilities and expenses, including amounts paid in satisfaction of judgments, in compromise or as fines and penalties, and

counsel fees, reasonably incurred by such Person in connection with the defense or disposition of any action, suit or other proceeding, whether civil or criminal, in which such Person may be involved or with which such Person may be threatened, while in office or thereafter, by reason of being or having been such a Person, except with respect to any matter as to which such Person shall have been adjudicated in any proceeding not to have acted in good faith in the reasonable belief that his or her action was in the best interests of the corporation or, to the extent that such matter relates to service at the request of the corporation for another organization or an employee benefit plan, in the best interests of such organization or of the participants or beneficiaries of such employee benefit plan. Such best interests shall be deemed to be the best interests of the corporation for the purposes of this Section 4.5.

(b) Notwithstanding the foregoing, as to any matter disposed of by a compromise payment by any Person, pursuant to a consent decree or otherwise, no indemnification either for said payment or for any other expenses shall be provided unless such compromise shall be approved as in the best interests of the corporation, after notice that it involves such indemnification, (a) by a disinterested majority of the trustees then in office; or (b) by a majority of the disinterested trustees then in office, provided that there has been obtained an opinion in writing of independent legal counsel to the effect that such Person appears to have acted in good faith in the reasonable belief that his or her action was in the best interests of the corporation; or (c) by a majority of the disinterested members entitled to vote, voting as a single class.

(c) Expenses, including counsel fees, reasonably incurred by any Person in connection with the defense or disposition of any such action, suit or other proceeding may be paid from time to time by the corporation in advance of the final disposition thereof upon receipt of an undertaking by such Person to repay the amounts so paid if such Person ultimately shall be adjudicated to be not entitled to indemnification under this Section 4.5. Such an undertaking may be accepted without reference to the financial ability of such Person to make repayment.

(d) The right of indemnification hereby provided shall not be exclusive. Nothing contained in this Section shall affect any other rights to indemnification to which any Person or other corporate personnel may be entitled by contract or otherwise under law.

(e) As used in this Section 4.5, the term "Person" includes such Person's respective heirs, executors and administrators, and

a "disinterested" member, trustee or officer is one against whom in such capacity the proceeding in question, or another proceeding on the same or similar grounds, is not then pending.

4.6.(a) No person shall be disqualified from holding any office by reason of any interest. In the absence of fraud, any trustee, officer or member of this corporation, or any concern in which any such trustee, officer or member has any interest, may be a party to, or may be pecuniarily or otherwise interested in, any contract, act or other transaction (collectively called a "transaction") of this corporation, and

(1) such transaction shall not be in any way invalidated or otherwise affected by that fact; and

(2) no such trustee, officer, member or concern shall be liable to account to this corporation for any profit or benefit realized through any such transaction;

provided, however, that such transaction either was fair at the time it was entered into or is authorized or ratified either (i) by a majority of the trustees who are not so interested and to whom the nature of such interest has been disclosed, or (ii) by vote of a majority of each class of members of the corporation entitled to vote for trustees, at any meeting of members the notice of which, or an accompanying statement, summarizes the nature of such transaction and such interest. No interested trustee or member of this corporation may vote or may be counted in determining the existence of a quorum at any meeting at which such transaction shall be authorized, but may participate in discussion thereof.

(b) For purposes of this Section 4.6, the term "interest" shall include personal interest and also interest as a trustee, officer, stockholder, shareholder, director, member or beneficiary of any concern; and the term "concern" shall mean any corporation, association, trust, partnership, firm, person or other entity other than this corporation.

(c) No transaction shall be avoided by reason of any provisions of this paragraph 4.6 which would be valid but for such provisions.

4.7. No part of the assets or net earnings of the corporation shall inure to the benefit of any member, officer or trustee of the corporation or any individual; no substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting, to influence legislation except to the extent permitted by Section 501(h) of the Internal Revenue Code; and the corporation shall not participate in, or

intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. It is intended that the corporation shall be entitled to exemption from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code and shall not be a private foundation under Section 509(a) of the Internal Revenue Code.

4.8. If and so long as the corporation is a private foundation (as that term is defined in Section 509 of the Internal Revenue Code), then notwithstanding any other provisions of the articles of organization or the by-laws of the corporation, the following provisions shall apply:

A) the income of the corporation for each taxable year shall be distributed at such time and in such manner as not to subject the corporation to the tax on undistributed income imposed by Section 4942 of the Internal Revenue Code, and

B) the corporation shall not engage in any act of self dealing (as defined in Section 4941(d) of the Internal Revenue Code), nor retain any excess business holdings (as defined in Section 4943(c) of the Internal Revenue Code), nor make any investments in such manner as to subject the corporation to tax under Section 4944 of the Internal Revenue Code, nor make any taxable expenditures (as defined in Section 4945(d) of the Internal Revenue Code).

4.9. Upon the liquidation or dissolution of the corporation, after payment of all of the liabilities of the corporation or due provision therefor, all of the assets of the corporation shall be disposed of pursuant to Massachusetts General Laws, Chapter 180, Section 11A, to The Massachusetts General Hospital and The Brigham Medical Center, Inc. if exempt from taxation as organizations described in Section 501(c)(3) of the Internal Revenue Code or, if both are not, to one or more organizations with similar purposes and similar tax exemption.

4.10. All references herein: (i) to the Internal Revenue Code shall be deemed to refer to the Internal Revenue Code of 1986, as now in force or hereafter amended; (ii) to the General Laws of The Commonwealth of Massachusetts, or any chapter thereof, shall be deemed to refer to said General Laws or chapter as now in force or hereafter amended; and (iii) to particular sections of the Internal Revenue Code or said General Laws shall be deemed to refer to similar or successor provisions hereafter adopted.

MGH/BRIGHAM HEALTH CARE SYSTEM, INC.

Continuation Sheet VII(b)

	Name	Residence or Post Office Address
Officers		
Vice-President	J. Robert Buchanan, M.D.	25 Commonwealth Avenue Boston, MA 02116
President	H. Richard Nesson, M.D.	565 Boylston Street Brookline, MA 02146
Treasurer	Richard A. Spindler	210 Schoolmaster Lane Dedham, MA 02026
Clerk	David M. Donaldson	22 Weston Road Lincoln Center, MA 01773
Trustees	W. Gerald Austen, M.D.	163 Wellesley Street Weston, MA 02193
	Eugene Braunwald, M.D.	75 Scotch Pine Road Weston, MA 02193
	J. Robert Buchanan, M.D.	25 Commonealth Avenue Boston, MA 02116
	Francis H. Burr	44 Prince Street Beverly, MA 01915
	Ferdinand Colloredo-Mansfeld	Winthrop Street Hamilton, MA 01982

MGH/BRIGHAM HEALTH CARE SYSTEM, INC.

Continuation Sheet VII(b)

Name	Residence or Post Office Address
John H. McArthur	Fowler 10 Soldiers Field Boston, MA 02134
H. Richard Nesson, M.D.	565 Boylston Street Brookline, MA 02146
Richard A. Spindler	210 Schoolmaster Lane Dadham, MA 02026

ARTICLE V

By-laws of the corporation have been duly adopted and the initial directors, president, treasurer and clerk or other presiding, financial or recording officers, whose names are set out below, have been duly elected.

ARTICLE VI

The effective date of organization of the corporation shall be the date of filing with the Secretary of the Commonwealth or if a later date is desired, specify date, (not more than 30 days after date of filing).

The information contained in ARTICLE VII is NOT a PERMANENT part of the Articles of Organization and may be changed ONLY by filing the appropriate form provided therefor.

ARTICLE VII

a. The post office address of the initial principal office of the corporation IN MASSACHUSETTS is:

c/o Ropes & Gray, One International Place, Boston, MA 02110

b. The name, residence and post office address of each of the initial directors and following officers of the corporation are as follows:

	NAME	RESIDENCE	POST OFFICE ADDRESS
President:	See Continuation Sheet VII(b) attached hereto and incorporated herein by reference.		
Treasurer:			
Clerk:			

Directors: (or officers having the powers of directors).

NAME	RESIDENCE	POST OFFICE ADDRESS
See Continuation Sheet VII(b) attached hereto and incorporated herein by reference.		

c. The fiscal year of the corporation shall end on the last day of the month of: September

d. The name and BUSINESS address of the RESIDENT AGENT of the corporation, if any, is:

I/ We the below-signed INCORPORATORS do hereby certify under the pains and penalties of perjury that I/ We have not been convicted of any crimes relating to alcohol or gaming within the past ten years. I/ We do hereby further certify that to the best of my/our knowledge the above-named principal officers have not been similarly convicted. If so convicted, explain.

IN WITNESS WHEREOF and under the pains and penalties of perjury, I/WE, whose signature(s) appear below as incorporator(s) and whose names and business or residential address(es) ARE CLEARLY TYPED OR PRINTED beneath each signature do hereby associate with the intention of forming this corporation under the provisions of General Laws Chapter 180 and do hereby sign these Articles of Organization as incorporator(s) this 9th day of December, 19 93

David M. Donaldson

David M. Donaldson

Ropes & Gray
One International Place
Boston, MA 02110

NOTE: If an already-existing corporation is acting as incorporator, type in the exact name of the corporation, the state or other jurisdiction where it was incorporated, the name of the person signing on behalf of said corporation and the title he/she holds or other authority by which such action is taken.

SECRETARY OF STATE
RECEIVED
1993 DEC 15 PM 1:39
CORPORATION DIVISION

449104

THE COMMONWEALTH OF MASSACHUSETTS

ARTICLES OF ORGANIZATION

GENERAL LAWS, CHAPTER 180

I hereby certify that, upon an examination of the within-written articles of organization, duly submitted to me, it appears that the provisions of the General Laws relative to the organization of corporations have been complied with, and I hereby approve said articles; and the filing fee in the amount of $35.00 having been paid, said articles are deemed to have been filed with me this 15TH day of December 1993.

Effective date

Michael Joseph Connolly

MICHAEL J. CONNOLLY
Secretary of State

A PHOTOCOPY OF THESE ARTICLES OF ORGANIZATION SHALL BE RETURNED

TO: David M. Donaldson, Esq.
Ropes & Gray
One International Place, Boston, MA 02110

Telephone: (617) 951-7250

FEE: $15.00

The Commonwealth of Massachusetts

MICHAEL J. CONNOLLY
Secretary of State
ONE ASHBURTON PLACE, BOSTON, MASS. 02108

FEDERAL IDENTIFICATION NO. 000449104

ARTICLES OF AMENDMENT

General Laws, Chapter 180, Section 7

This certificate must be submitted to the Secretary of the Commonwealth within sixty days after the date of the vote of members or stockholders adopting the amendment. The fee for filing this certificate is $15.00 as prescribed by General Laws, Chapter 180, Section 11C(b). Make check payable to the Commonwealth of Massachusetts.

We, H. Richard Nesson, President/~~Vice President~~, and
David M. Donaldson, Clerk/~~Assistant Clerk~~ of

MGH/BRIGHAM HEALTH CARE SYSTEM, INC.
(Name of Corporation)

located at One International Place, Boston, MA 02110

do hereby certify that the following amendment to the articles of organization of the corporation was duly adopted at a meeting held on March 14, 19 94, by vote of all members/

~~XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX~~

That the Articles of Organization of this corporation be and they hereby are amended to change the name of the corporation to "Partners HealthCare System, Inc."

Examined

Name Approved

C

P.C.

Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on separate 8½ x 11 sheets of paper leaving a left hand margin of at least 1 inch for binding. Additions to more than one article may be continued on a single sheet so long as each article requiring each such addition is clearly indicated.

The foregoing amendment will become effective when these articles of amendment are filed in accordance with Chapter 180, Section 7 of the General Laws unless these articles specify, in accordance with the vote adopting the amendment, a later effective date not more than thirty days after such filing, in which event the amendment will become effective on such later date.

IN WITNESS WHEREOF AND UNDER THE PENALTIES OF PERJURY, we have hereto signed our names this 18th day of March, in the year 1994

H. Richard Nesson ..... President/~~Vice President~~

..... Clerk/~~Assistant Clerk~~

459052

SECRETARY OF STATE
RECEIVED

1994 MAR 18 PM 4:10

CORPORATION DIVISION

THE COMMONWEALTH OF MASSACHUSETTS

ARTICLES OF AMENDMENT

(General Laws, Chapter 180, Section 7)

I hereby approve the within articles of amendment and, the filing fee in the amount of $ 15 having been paid, said articles are deemed to have been filed with me this 18th day of March, 1994

Michael Joseph Connolly

MICHAEL J. CONNOLLY

Secretary of State

TO BE FILLED IN BY CORPORATION

PHOTO COPY OF AMENDMENT TO BE SENT

TO: John E. Beard

Ropes & Gray

One International Place, Boston 02110

Telephone 617-951-7411

Copy Mailed

FEDERAL IDENTIFICATION NO. 04-2335
Fee: $15.00

Examiner

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

Name Approved

ARTICLES OF AMENDMENT
(General Laws, Chapter 180, Section 7)

We, Samuel O. Thier, M.D., *President / ~~Vice President~~,

and Ernest M. Haddad, Secretary ~~Assistant Clerk~~,

of Partners HealthCare System, Inc.,
(Exact name of corporation)

located at 800 Boylston Street, Suite 1150, Boston, MA 02199,
(Address of corporation in Massachusetts)

do hereby certify that these Articles of Amendment affecting articles numbered:

II and IV
(Number those articles 1, 2, 3, and/or 4 being amended)

of the Articles of Organization were duly adopted at a meeting held on May 4, 1998, by vote of:

277 members, ~~of the directors; or of shareholders~~

being at least two-thirds of its members/directors legally qualified to vote in meetings of the corporation ~~(or of the holders of at least two-thirds of the shares of stock having the right to vote)~~:

1. Delete Article II and insert in place thereof the following:

Article II

(i) To organize, operate and support a comprehensive health care system, including without limitation hospital and other health care services for all persons, and education and research for the prevention, diagnosis, treatment and cure of all forms of human illness: (ii) to improve the health and welfare of all persons: (iii) to operate for the benefit of and to support The Massachusetts General Hospital, The Brigham Medical Center, Inc., The North Shore Medical Center, Inc., their respective affiliated corporations, such other hospitals, charitable, scientific or educational organizations, and their affiliated corporations that become affiliated with Partners HealthCare System, Inc.

C ☐
P ☐
M ☐
R.A. ☐

3
P.C.

*Delete the inapplicable words.
Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

(collectively, the "Partners Affiliated Corporations") and such other charitable, scientific or educational organizations which are or are affiliated with teaching hospitals in the Greater Boston Area; and (iv) to carry on any other activity that may lawfully be carried on by a corporation formed under Chapter 180 of the Massachusetts General Laws which is exempt under Section 501(c)(3) of the Internal Revenue Code; and in furtherance of the foregoing purposes to:

(a) Serve as the controlling and coordinating organization for the Partners Affiliated Corporations in order to assure the consistency and appropriateness of their respective missions, activities, governance and administration;

(b) Solicit and receive devises of real property and grants, donations and bequests of money and other property to be used to further the foregoing purposes and those of the Partners Affiliated Corporations; and

(c) Support the Partners Affiliated Corporations by loan, lease or donation of funds or other assets, by guaranty of obligations or by other action.

2. Delete Section 4.5. of Article IV.

The foregoing amendment(s) will become effective when these Articles of Amendment are filed in accordance with General Laws, Chapter 180, Section 7 unless these articles specify, in accordance with the vote adopting the amendment, a *later* effective date not more than *thirty days* after such filing, in which event the amendment will become effective on such later date.

[redacted]: _____

SIGNED UNDER THE PENALTIES OF PERJURY, this 29TH day of May, 1998.

_____, *President [redacted]

_____, Secretary *[redacted]

*Delete the inapplicable words.

THE COMMONWEALTH OF MASSACHUSETTS

ARTICLES OF AMENDMENT

(General Laws, Chapter 180, Section 7)

S18710

SECRETARY OF THE COMMONWEALTH
98 JUN -2 AM 9:52

I hereby approve the within Articles of Amendment and, the filing fee in the amount of $ 150 having been paid, said articles are deemed to have been filed with me this 2ND day of JUNE 19 98.

Effective date: _____

William Francis Galvin

WILLIAM FRANCIS GALVIN
Secretary of the Commonwealth

TO BE FILLED IN BY CORPORATION
Photocopy of document to be sent to:

Ernest M. Haddad, Esq.
Partners HealthCare System, Inc.
800 Boylston Street, Ste. 1150
Boston, MA 02199

Telephone: (617) 278-1065

AACR.6

FEDERAL IDENTIFICATION NO. 04-3230035 ✓
Fee: $15.00

Examiner

N/A
Name Approved

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

ARTICLES OF AMENDMENT
(General Laws, Chapter 180, Section 7)

042

We, Samuel O. Thier, M.D. , *President / ~~Vice President~~,

and Ernest M. Haddad , Secretary *~~Clerk / Assistant Clerk~~,

of Partners HealthCare System, Inc. ,
(Exact name of corporation)

located at 800 Boylston Street, Suite 1150, Boston, MA 02199 ,
(Address of corporation in Massachusetts)

do hereby certify that these Articles of Amendment affecting articles numbered:

II
(Number those articles 1, 2, 3, and/or 4 being amended)

of the Articles of Organization were duly adopted at a meeting held on May 3 19 99 , by vote of:

293 members, ~~of the directors, or of the shareholders,~~

being at least two-thirds of its members/directors legally qualified to vote in meetings of the corporation ~~(OR in the case of a corporation having capital stock, by the holders of at least two-thirds of the capital stock having the right to vote thereon)~~:

Delete Article II and insert in place thereof the following:

Article II

The purpose of the corporation is to engage in the following activities:

(i) To organize, operate, coordinate and support a comprehensive integrated health care delivery system (the "System") that provides, without limitation, hospital, physician and other health care services for all persons and education and research for the prevention, diagnosis, treatment and cure of all forms of human illness; (ii) to improve the health and welfare of all persons; (iii) to serve as the controlling and coordinating organization for the System and its member institutions and entities including Brigham and Women's/Faulkner Hospitals, Inc., The Massachusetts General Hospital, The North Shore Medical Center, Inc., Newton-Wellesley Health Care System, Inc., and such other hospital, physician, charitable, scientific, educational,

C ☐
P ☐
M ☐
R.A. ☐

3

*Delete the inapplicable words.
Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

research and other institutions and entities that are controlled, directly or indirectly, through sole corporate membership, stock ownership or otherwise, by the Corporation (collectively, the "Affiliated Organizations"); (iv) to assist and support the Affiliated Organizations in fulfilling their respective purposes, missions and objectives in a manner consistent with the purposes, missions and objectives of the Corporation and the System; and (v) to carry on any other activity that may lawfully be carried on by a corporation formed under Chapter 180 of the Massachusetts General Laws which is exempt under Section 501(c)(3) of the Internal Revenue Code; and in furtherance of the foregoing purposes to:

(a) Solicit and receive devises of real property and grants, donations and bequests of money and other property to be used to further the foregoing purposes; and

(b) Support the Affiliated Organizations by loan; lease or donation of funds or other assets; and

(c) Support the Affiliated Organizations by guaranty of the obligations of the Affiliated Organizations or by other action.

The foregoing amendment(s) will become effective when these Articles of Amendment are filed in accordance with General Laws, Chapter 180, Section 7 unless these articles specify, in accordance with the vote adopting the amendment, a *later* effective date not more than *thirty days* after such filing, in which event the amendment will become effective on such later date.

~~Later effective date:~~ XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SIGNED UNDER THE PENALTIES OF PERJURY, this 24th day of May, 19 99,

[signature], *President/~~Vice President~~,

[signature], Secretary ~~*Clerk/Assistant Clerk~~.

Delete the inapplicable words.

660922

THE COMMONWEALTH OF MASSACHUSETTS

ARTICLES OF AMENDMENT

(General Laws, Chapter 180, Section 7)

I hereby approve the within Articles of Amendment and, the filing fee in the amount of $ 15.00 having been paid, said articles are deemed to have been filed with me this 26th day of May 19 99.

99 MAY 26 AM 9:24

Effective date: _____

William Francis Galvin

WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

TO BE FILLED IN BY CORPORATION

Photocopy of document to be sent to:

Mary LaLonde

Partners HealthCare System

Office of the General Counsel
50 Stanford St., 10th floor
Boston, MA 02114

Telephone: 617-726-5315

The Commonwealth of Massachusetts
William Francis Galvin

Minimum Fee: $15.00

Secretary of the Commonwealth, Corporations Division
One Ashburton Place, 17th floor
Boston, MA 02108-1512
Telephone: (617) 727-9640

Articles of Amendment
(General Laws, Chapter 180, Section 7)

Identification Number: 043230035

We, BRENT L. HENRY __ **President** X **Vice President,**

and MARY C. LALONDE __ **Clerk** X **Assistant Clerk ,**

of PARTNERS HEALTHCARE SYSTEM, INC.
located at: 800 BOYLSTON ST., SUITE 1150 BOSTON , MA 02199 USA

do hereby certify that these Articles of Amendment affecting articles numbered:

__ Article 1 X Article 2 __ Article 3 __ Article 4

(Select those articles 1, 2, 3, and/or 4 that are being amended)

of the Articles of Organization were duly adopted at a meeting held on 4/19/2016 , by vote of: 197 members, 0 directors, or 0 shareholders,
being at least two-thirds of its members/directors legally qualified to vote in meetings of the corporation (or, in the case of a corporation having capital stock, by the holders of at least two thirds of the capital stock having the right to vote therein):

ARTICLE I

The exact name of the corporation, ***as amended***, is:
(Do not state Article I if it has not been amended.)

ARTICLE II

The purpose of the corporation, ***as amended***, is to engage in the following business activities:
(Do not state Article II if it has not been amended.)

THE PURPOSE OF THE CORPORATION IS TO ENGAGE IN THE FOLLOWING ACTIVITIES: (I) TO ORGANIZE, OPERATE, COORDINATE AND SUPPORT A COMPREHENSIVE INTEGRATED HEAL TH CARE DELIVERY SYSTEM (THE "SYSTEM") THAT PROVIDES, WITHOUT LIMITATION, HOS PITAL, PHYSICIAN AND OTHER HEALTH CARE SERVICES FOR ALL PERSONS AND EDUCATI ON AND RESEARCH FOR THE PREVENTION, DIAGNOSIS, TREATMENT AND CURE OF ALL FO RMS OF HUMAN ILLNESS; (II) TO IMPROVE THE HEALTH AND WELFARE OF ALL PERSONS A ND TO CONDUCT AND SUPPORT EDUCATION, RESEARCH AND OTHER ACTIVITIES RELATIN G THERE TO, (III) TO SERVE AS THE CONTROLLING AND COORDINATING ORGANIZATION F OR THE SYSTEM AND ITS MEMBER INSTITUTIONS AND ENTITIES INCLUDING BRIGHAM AN D WOMEN'S HEALTH CARE, INC., THE MASSACHUSETTS GENERAL HOSPITAL, NSMC HEALT HCARE, INC., NEWTON WELLESLEY HEALTH CARE SYSTEM, INC., PARTNERS COMMUNITY PHYSICIANS ORGANIZATION, INC., PARTNERS CONTINUING CARE, INC., NEIGHBORHOOD HEALTH PLAN, INC. AND SUCH OTHER HOSPITAL, PHYSICIAN, CHARITABLE, SCIENTIFIC, E

DUCATIONAL, RESEARCH AND OTHER INSTITUTIONS AND ENTITIES THAT ARE CONTROLLED, DIRECTLY OR INDIRECTLY, THROUGH SOLE CORPORATE MEMBERSHIP, STOCK OWNERSHIP OR OTHERWISE, BY THE CORPORATION (COLLECTIVELY, THE "AFFILIATED ORGANIZATIONS"); (IV) TO ASSIST AND SUPPORT THE AFFILIATED ORGANIZATIONS IN FULFILLING THEIR RESPECTIVE PURPOSES, MISSIONS AND OBJECTIVES IN A MANNER CONSISTENT WITH THE PURPOSES, MISSIONS AND OBJECTIVES OF THE CORPORATION AND THE SYSTEM; AND (V) TO CARRY ON ANY OTHER ACTIVITY THAT MAY LAWFULLY BE CARRIED ON BY A CORPORATION FORMED UNDER CHAPTER 180 OF THE MASSACHUSETTS GENERAL LAWS WHICH IS EXEMPT UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE; AND IN FURTHERANCE OF THE FOREGOING PURPOSES TO: (A) SOLICIT AND RECEIVE DEVISES OF REAL PROPERTY AND GRANTS, DONATIONS AND BEQUESTS OF MONEY AND OTHER PROPERTY TO BE USED TO FURTHER THE FOREGOING PURPOSES; AND (B) SUPPORT THE AFFILIATED ORGANIZATIONS BY LOAN, LEASE OR DONATION OF FUNDS OR OTHER ASSETS; AND (C) SUPPORT THE AFFILIATED ORGANIZATIONS BY GUARANTY OF THE OBLIGATIONS OF THE AFFILIATED ORGANIZATIONS OR BY OTHER ACTION.

ARTICLE III

A corporation may have one or more classes of members. ***As amended,*** the designation of such classes, the manner of election or appointments, the duration of membership and the qualifications and rights, including voting rights, of the members of each class, may be set forth in the by-laws of the corporation or may be set forth below:

ARTICLE IV

As amended, other lawful provisions, if any, for the conduct and regulation of the business and affairs of the corporation, for its voluntary dissolution, or for limiting, defining, or regulating the powers of the business entity, or of its directors or members, or of any class of members, are as follows:
(If there are no provisions state "NONE")

The foregoing amendment(s) will become effective when these Articles of Amendment are filed in accordance with General Laws, Chapter 180, Section 7 unless these articles specify, in accordance with the vote adopting the amendment, a *later* effective date not more than *thirty days* after such filing, in which event the amendment will become effective on such later date.

Later Effective Date:

Signed under the penalties of perjury, this 20 Day of April, 2016, BRENT L. HENRY , its , President / Vice President,
MARY C. LALONDE , Clerk / Assistant Clerk.

THE COMMONWEALTH OF MASSACHUSETTS

I hereby certify that, upon examination of this document, duly submitted to me, it appears that the provisions of the General Laws relative to corporations have been complied with, and I hereby approve said articles; and the filing fee having been paid, said articles are deemed to have been filed with me on:

April 20, 2016 04:09 PM

WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

IDENTIFICATION
no. 04-3230035
Filing Fee: $15.00

Examiner

Name Approved

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Room 1717, Boston, Massachusetts 02108-1512

ARTICLES OF AMENDMENT
(General Laws, Chapter 180, Section 7)

We, Anne Klibanski, M.D., *President / ~~*Vice President,~~

and Maureen Goggin, *Clerk / ~~*Assistant Clerk,~~

of Partners HealthCare System, Inc.,
(Exact name of corporation)

located at 800 Boylston Street, Suite 1150, Boston, Massachusetts 02199,
(Address of corporation in Massachusetts)

do hereby certify that these Articles of Amendment affecting articles numbered:

I, II and IV
(Number those articles 1, 2, 3, and/or 4 being amended)

of the Articles of Organization were duly adopted at a meeting held on April 21, 20 20, by vote of:

347 members, _____ directors, or _____ shareholders**,

☑ Being at least two-thirds of its members legally qualified to vote in meetings of the corporation; OR

☐ Being at least two-thirds of its directors where there are no members pursuant to General Laws, Chapter 180, Section 3; OR

☐ In the case of a corporation having capital stock, by the holders of at least two-thirds of the capital stock having the right to vote therein.

Delete Articles I, II and IV in their entirety and insert in place thereof the following:

Article I

The name of the corporation is:
Mass General Brigham Incorporated

C ☐
P ☐
M ☐
R.A. ☐

*Delete the inapplicable words.
**Check only one box that applies.
Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

P.C.

Article II

The purpose of the corporation is to engage in the following activities:

2.1 To organize, operate, direct and coordinate a comprehensive, integrated healthcare delivery system comprising hospital, physician and other healthcare provider organizations, managed care and other health insurance organizations and other charitable, scientific, educational, research and community organizations (i) that are controlled directly or indirectly by the corporation (collectively, the "Affiliated Organizations") and (ii) with which the corporation and the Affiliated Organizations collaborate through clinical and care management, research and other affiliations and contractual arrangements (the "Collaborative Organizations").

2.2 To promote, sponsor, support, conduct and/or provide, either alone or in conjunction with the Affiliated Organizations and/or the Collaborative Organizations, (i) healthcare services to improve the health and welfare of all persons, regardless of their ability to pay; (ii) research for the prevention, diagnosis, treatment and cure of all forms of human illness; (iii) education and training for physicians and other healthcare providers; and (iv) programs and services that address the healthcare needs of the communities served by the corporation, the Affiliated Organizations and/or the Collaborative Organizations.

2.3 To assist and support the Affiliated Organizations and the Collaborative Organizations in fulfilling their respective missions and purposes including, without limitation, by lending, leasing and donating funds and other assets to, and by guaranteeing the obligations of, the Affiliated Organizations and/or the Collaborative Organizations.

2.4 To engage in any activity that may be lawfully carried on by a corporation that is formed under Chapter 180 of the Massachusetts General Laws ("MGL") and that is exempt from federal income tax under Section 501(a) of the Internal Revenue Code ("IRC") as an organization described in Section 501(c)(3) of the IRC.

Article IV

4.1. The corporation shall have in furtherance of its corporate purposes all of the powers specified in Section 6 of MGL Chapter 180 and in Sections 9 and 9A of MGL Chapter 156B (except those powers described in paragraph (m) of said Section 9). The corporation may carry on any operation or activity referred to in Article II of these Articles of Organization to the same extent as might an individual, either alone or in a partnership or joint venture or other arrangement with others, or through a wholly or partly owned or controlled corporation; provided, however, that no such power shall be exercised by the corporation in a manner inconsistent with MGL Chapter 180 or any other chapter of the MGL or with exemption from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.2. The bylaws of the corporation (the "Bylaws") may authorize the Board of Directors to make, amend or repeal the Bylaws in whole or in part, except with respect to any provision thereof which by law, these Articles of Organization or the Bylaws requires action by the members.

4.3. To the fullest extent permitted under Section 3 of MGL Chapter 180, no director or officer of the corporation shall be personally liable to the corporation or its members for monetary damages for breach of fiduciary duty as a director or officer notwithstanding any provision of law imposing such liability.

4.4. The corporation shall have the power to indemnify to the extent specified in the Bylaws (i) its members, directors, officers, employees, agents and volunteers, (ii) persons who serve at its request as a member, director, trustee or officer of another organization and (iii) persons who serve on its behalf in any capacity with respect to any employee benefit plan; provided that any such indemnity shall be limited to the extent necessary to protect the corporation's status as exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.5. No part of the net assets or net earnings of the corporation shall inure to the benefit of, or be distributable to, any member, director, officer or employee of the corporation or to any other person; provided that the corporation shall be authorized and empowered (i) to pay reasonable compensation for services actually rendered and (ii) to make payments and distributions in furtherance of the corporation's purposes set forth in Article II hereof.

4.6 No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting, to influence legislation, except to the extent permitted by Section 501(h) of the IRC. The corporation shall not participate or intervene (including the publishing or distributing of statements) in any political campaign on behalf of (or in opposition to) any candidate for public office.

4.7 It is intended that the corporation shall be entitled to exemption from federal income tax under Section 501(c)(3) of the IRC and shall not be a private foundation under Section 509(a) of the IRC. However, during any period of time in which the corporation is, or is deemed to be, a private foundation (as that term is defined in Section 509 of the IRC), notwithstanding any other provisions of these Articles of Organization or the Bylaws, the corporation shall at all times conduct its affairs as follows:

(i) the income of the corporation for each taxable year shall be distributed at such time and in such manner as not to subject the corporation to the tax on undistributed income imposed by Section 4942 of the IRC; and

(ii) the corporation shall not (1) engage in any act of self-dealing (as defined in Section 4941(d) of the IRC); (2) retain any excess business holdings (as defined in Section 4943(c) of the IRC); (3) make any investments in such manner as to subject the corporation to tax under Section 4944 of the IRC; or (4) make any taxable expenditures (as defined in Section 4945(d) of the IRC).

4.8 Upon the liquidation or dissolution of the corporation, after having paid (or made due provision for) all of the liabilities of the corporation, all of the remaining assets of the corporation shall be distributed pursuant to Section 11A of MGL Chapter 180 to Brigham Health, Inc.("BH") (if at such time BH is exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC) and to The Massachusetts General Hospital ("MGH") (if at such time MGH is exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC); or, if at such time neither BH nor MGH is so exempt, such distributions shall be made to one or more of the Affiliated Organizations that are then exempt from federal income tax under Sections 501(a) and 501(c)(3) of the IRC.

4.9. All references herein (i) to the IRC or to any section thereof shall be deemed to refer to the IRC of 1986 as now in force or hereafter amended, or to the corresponding provisions of any subsequent federal income tax laws; and (ii) to the MGL or to any chapter or section thereof shall be deemed to refer to said MGL as now in force or hereafter amended, or to the corresponding provisions of any subsequent Massachusetts laws.

The foregoing amendment(s) will become effective when these Articles of Amendment are filed in accordance with General Laws, Chapter 180, Section 7 unless these articles specify, in accordance with the vote adopting the amendment, a *later* effective date not more than *thirty days* after such filing, in which event the amendment will become effective on such later date.

Later effective date: May 1, 2020 .

SIGNED UNDER THE PENALTIES OF PERJURY, this 22nd day of April , 20 20

, *President / *~~Vice President~~,

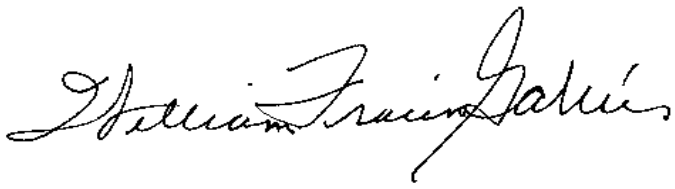
, *Clerk / *~~Assistant Clerk~~.

*Delete the inapplicable words.

THE COMMONWEALTH OF MASSACHUSETTS

I hereby certify that, upon examination of this document, duly submitted to me, it appears that the provisions of the General Laws relative to corporations have been complied with, and I hereby approve said articles; and the filing fee having been paid, said articles are deemed to have been filed with me on:

April 23, 2020 04:14 PM



WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

Attachment 9

The Commonwealth of Massachusetts
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MASSACHUSETTS 02109
(617) 979-1400

STUART H. ALTMAN
CHAIR

DAVID M. SELTZ
EXECUTIVE DIRECTOR

December 23, 2019

Esther Kim
Partners HealthCare System, Inc.
800 Boylston Street, 11TH Floor
Boston, MA 02199

RE: ACO Certification

Dear Ms. Kim:

Congratulations! The Health Policy Commission (HPC) is pleased to inform you that Partners HealthCare System meets the requirements for ACO Certification. This certification is effective from the date of this letter through December 31, 2021.

The ACO Certification program, in alignment with other state agencies including MassHealth, is designed to accelerate care delivery transformation in Massachusetts and promote a high quality, efficient health system. ACOs participating in the program have met a set of objective criteria focused on core ACO capabilities including supporting patient-centered care and governance, using data to drive quality improvement, and investing in population health. Partners HealthCare System meets those criteria.

The HPC will promote Partners HealthCare System as a Certified ACO on our website and in our marketing and public materials. In addition, a logo is enclosed for your use in accordance with the attached Terms of Use. We hope you will use the logo to highlight the ACO Certification to your patients, payers, and others.

The HPC looks forward to your continued engagement in the ACO Certification program over the next two years.

Thank you for your dedication to providing accountable, coordinated health care to your patients. If you have any questions about this letter or the ACO Certification program, please do not hesitate to contact Mike Stanek, Manager, at HPC-Certification@mass.gov or (617) 757-1649.

Best wishes,

David Seltz
Executive Director

Attachment 10

AROUND DEDHAM, NORWOOD AND WESTWOOD

Note: In response to concerns about the coronavirus, area events may be subject to cancellation, postponement or attendance limits. Please contact organizers to confirm event details.

Christmas Tree Pickup: The Norwood DPW will be picking up Christmas trees on the same day as your regular trash pickup through Jan. 15. No pickup Jan. 9. Please remove all tree bags, tinsel, ornaments and lights. No wreaths, please (wire frame damages the chipping equipment).

Adopt a Fire Hydrant This Winter: The Dedham Fire Department is asking residents to help clear fire hydrants of snow and ice this winter.

Christmas Tree Collection: Christmas trees will be collected by the Dedham DPW through the month of January or later (until all trees are collected). Trees may not be collected on your regular trash day. Please place your tree curbside free of tinsel, garland, lights, ornaments and plastic.

Open Burn season in Westwood: From Jan. 15 to May 1, but you don't have to wait to apply for your permit. Apply online now and you will be notified when your permit has been approved. There's no fee! http://town.westwood.ma.us

Yoga program moves indoors: The Yoga in the Park series is moving to the Dolan Recreation Center in Dedham monthly on Sundays from 6-7 p.m. This class is suitable for all levels and will encompass meditation, lots of movement and time for relaxing during our savasana at the end of class. Please note, due to COVID-19 safety precautions and social distancing requirements, classes will be limited to eight individuals to ensure everyone has plenty of space while practicing. Please bring your own yoga mat, towel and water. If available, please also bring yoga blocks and a strap. Information: https://dedham.activityreg.com/ClientPage_t2.wcs

Skate Classes: The 2020-21 skating season is about to begin. Bay State Skating School have taught skate classes to children age 4-18 in the greater Boston area for over 50 years. Bay State Skating School is compliant with the commonwealth of Massachusetts COVID-19 guidelines. The number of students allowed on the ice will be limited. Professional Instructors teach recreational, figure and hockey skating skills to the beginner, intermediate and advanced skaters. Students can wear either figure, recreational or hockey skates. Lessons are held at 10 greater Boston rink locations including: Brookline-Cleveland Circle, Cambridge, Medford, Newton-Brighton, Quincy, Somerville, Waltham, West Roxbury and Weymouth. For information, call 781-890-8480 or visit http://BayStateSkatingSchool.org.

"History in the Making: Recording the COVID-19 Pandemic:" The Dedham Historical Society is collecting stories and images about the pandemic. Information: https://dedhamhistorical.org/

T-Shirts: Dedham Square Circle is selling T-shirts featuring an original design by Peter H. Reynolds. The shirts cost $19, with $10 to benefit Dedham Square Circle. For information, visit https://www.dedhamsquarecircle.org/

Virtual NAMI Support Group: The virtual NAMI Family Support Group will be held on the second Tuesday of each month at 7:30 p.m. using zoom.us. We will offer this until we are able to meet in person again. This group is for caregivers of persons with mental illness. See namimass.org for information regarding peer groups for people themselves experiencing a mental illness. To get the information to enter this group, we need your email address. Please email us at info@naminw.org., and add your phone number in case we need to reach you

Legal Notices

Legal Notices

WESTWOOD
100 BRIGHAM WAY

LEGAL NOTICE

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199, intends to file an Application for Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial change in service and substantial capital expenditure for the (i) construction and development of a freestanding ambulatory surgery center ("ASC"), clinic space, and the acquisition of 1 magnetic resonance imaging ("MRI") unit and 1 computed tomography ("CT") unit at 1400 West Park Drive, Westborough, MA 01581; (ii) construction and development of an ASC and the acquisition of 2 MRI units and 2 CT units at 100 Brigham Way, Westwood, MA 02090; and (iii) construction and development of an ASC, clinic space, and the acquisition of 2 MRI units and 2 CT units at 2 Hill Street, Woburn, MA 01801. The total value of the Proposed Project based on the maximum capital expenditure is $223,724,658. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten taxpayers of Massachusetts may register in connection with the intended Application by no later than February 22, 2021, or 30 days from the filing date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 4th Floor, Boston, MA 02108 or dph.don@state.ma.us.

AD#13933795
Transcript Bulletin 1/7/2021

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420 PROVIDENCE HWY

LEGAL NOTICE
TOWN OF WESTWOOD
NOTICE OF PUBLIC HEARING
WESTWOOD BOARD OF APPEALS

Pursuant to Chapter 40A, §9, the Board of Appeals will hold a public hearing on Wednesday, January 20, 2021 at 7:00 PM. The public hearing will be a remote meeting through Zoom due to the COVID-19 state of emergency and in compliance with the Governor's March 12, 2020 Executive Order suspending certain provisions of the Open Meeting Law MGL C. 30A, §18 and the Governor's March 23 Emergency Order imposing limitations on the number of people that may gather in one place. Those wishing to participate are encouraged to use Zoom.

To Join Zoom Webinar by Computer:
https://us02web.zoom.us/j/82448407413?pwd=c200NlRuS056VnJZOVNTSW1kZVl6QT09
Enter your Email, Name, and Password: 619513
Or Telephone: 888 475 4499 (Toll Free) or 877 853 5257 (Toll Free)
Webinar ID: 824 4840 7413

The Board shall hear an application filed by AMR Auto Holdings-PA,LLC(Prime Motor Group) to alter a Special Permit previously issued by the Board on January 10, 2005 and amended September 18, 2007 and again on May 13, 2011. The original special permit was granted pursuant to the previous Westwood Zoning Bylaw Sections § 4.4, 4.1.1, 4.12, 4.1.5.8, 4.1.5.9, 4.1.5.10, 6.2.2.8, 6.2.15. and 6.2.17 [Automotive Uses, Signage]. The applicant proposes to amend the existing special permit to allow for a change in use of the dealership to the Mazda brand, with minor changes to the building and change of signage. Property is located in the Highway Business District.

Land affected: 420 Providence Highway
Map 24 Lot 083

Any zoning relief that may be required in adherence to the Westwood Zoning Bylaw shall be considered by the Board.

Should any person or party desire for any written material, including legal arguments or positions, to be considered by the Zoning Board of Appeals in connection with any petition before the Board, such material shall be submitted to the clerk of the Board no later than five (5) calendar days before the public hearing on the petition, or such material shall not be considered.

The application is available for inspection during stated business hours at the office of the Board of Appeals and on the Zoning Board's webpage under "Current Application Links" at www.westwoodpermit.org

Interested persons are encouraged to attend the public hearing and make their views known to the Board of Appeals.

John Lally, Chairman
Douglas Stebbins
Michael McCusker

AD# 13933163
Transcript Bulletin 12/31 & 01/07/2021

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11 WESTLAND AVE

LEGAL NOTICE
TOWN OF WESTWOOD
LEGAL NOTICE OF PUBLIC HEARING
WESTWOOD BOARD OF APPEALS

Pursuant to Chapter 40A, §9, the Board of Appeals will hold a public hearing on Wednesday, January 20, 2021 at 7:00 PM. The public hearing will be a remote meeting through Zoom due to the COVID-19 state of emergency and in compliance with the Governor's March 12, 2020 Executive Order suspending certain provisions of the Open Meeting Law MGL C. 30A, §18 and the Governor's March 23 Emergency Order imposing limitations on the number of people that may gather in one place. Those wishing to participate are encouraged to use Zoom.

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Enter your Email, Name, and Password: 619513
Or Telephone: 888 475 4499 (Toll Free) or 877 853 5257 (Toll Free)
Webinar ID: 824 4840 7413

The Board shall hear an application filed by Kelli Rixon for a Special Permit pursuant to the Westwood Zoning Bylaw Section §4.5.3.2.2 [Special Permit Alterations to Nonconforming Structures] to construct a second story addition raising the height of the existing single family home in the setback. Property is located in the Single Residential C District.

Land affected: 11 Westland Avenue
Map 28 Lot 072

Any zoning relief that may be required in adherence to the Westwood Zoning Bylaw shall be considered by the Board.

Should any person or party desire for any written material, including legal arguments or positions, to be considered by the Zoning Board of Appeals in connection with any petition before the Board, such material shall be submitted to the clerk of the Board no later than five (5) calendar days before the public hearing on the petition, or such material shall not be considered.

The application is available for inspection during stated business hours at the office of the Board of Appeals and on the Zoning Board's webpage under "Current Application Links" at www.westwoodpermit.org

Interested persons are encouraged to attend the public hearing and make their views known to the Board of Appeals.

John Lally, Chairman
Douglas Stebbins
Michael McCusker

AD# 13933159
Transcript Bulletin 12/31 & 01/07/2021

NORWOOD
310 DEAN STREET

LEGAL NOTICE
NOTICE OF MORTGAGEE'S SALE OF REAL ESTATE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by Robert M. Cuddy to Mortgage Electronic Registration Systems, Inc. as nominee for Novastar Mortgage, Inc. dated April 13, 2005, recorded at the Norfolk County Registry of Deeds in Book 22291, Page 548, as affected by a Home Affordable Modification Agreement dated June 29, 2012 and recorded at Book 30206, Page 153; said mortgage was then assigned to Deutsche Bank National Trust Company as Trustee for Soundview Home Loan Trust 2005-4 by virtue of an assignment dated March 12, 2008, and recorded in Book 25601, Page 128; and further assigned to JPMorgan Chase Bank, N.A. by virtue of an assignment dated July 10, 2012, and recorded in Book 30206, Page 151; and further assigned to Deutsche Bank National Trust Company as Trustee for Soundview Home Loan Trust 2005-4, Asset-Backed Certificates, Series 2005-4 by virtue of an assignment dated June 13, 2016, and recorded in Book 34501, Page 531; of which mortgage the undersigned is the present holder for breach of conditions of said mortgage and for the purpose of foreclosing the same will be sold at PUBLIC AUCTION at 01:00 PM on February 9, 2021, on the mortgaged premises. This property has the address of 310 Dean Street, Norwood, MA 02062. The entire mortgaged premises, all and singular, the premises as described in said mortgage:

The land in Norwood, Norfolk County, Massachusetts, with the buildings thereon, shown as Lot 2 on Plan No. 944 of 1947 in Book 2714, Page 577 of Norfolk County Registry of Deeds. Said Lot 2 is bounded and described as follows: SOUTHERLY by Dean Street seventy-six and 04/100 (76.04) feet, as shown on said plan; SOUTHWESTERLY by Dean Street and unnamed street, now Glendale Road, on a curve of a radius of twenty-five (25.00) feet, a distance of thirty-eight and 29/100 (38.29) feet, as shown on said plan; WESTERLY by said unnamed street, seventy-six and 73/100 (76.73) feet, as shown on said plan; NORTHERLY by land unmarked, now or formerly of William Goos et ux, one hundred (100) feet, as shown on said plan, and EASTERLY by said unmarked land and Lot 3, one hundred four and 68/100 (104.68) feet as shown on said plan. For title reference see Deed dated October 17, 2000 and recorded Book 14499, Page 389

Subject to and with the benefit of easements, reservation, restrictions, and taking of record, if any, insofar as the same are now in force and applicable. In the event of any typographical error set forth herein in the legal description of the premises, the description as set forth and contained in the mortgage shall control by reference. Together with all the improvements now or hereafter erected on the property and all easements, rights, appurtenances, rents, royalties, mineral, oil and gas rights and profits, water rights and stock and all fixtures now or hereafter a part of the property. All replacements and additions shall also be covered by this sale.

Terms of Sale: Said premises will be sold subject to any and all unpaid taxes and assessments, tax sales, tax titles and other municipal liens and water or sewer liens and State or County transfer fees, if any there are, and TEN THOUSAND DOLLARS ($10,000.00) in cashier's or certified check will be required to be paid by the purchaser at the time and place of the sale as a deposit and the balance in cashier's or certified check will be due in thirty (30) days, at the offices of Doonan, Graves & Longoria, LLC ("DG&L"), time being of the essence. The Mortgagee reserves the right to postpone the sale to a later date by public proclamation at the time and date appointed for the sale and to further postpone at any adjourned saledate by public proclamation at the time and date appointed for the adjourned sale date. The premises is to be sold subject to and with the benefit of all easements, restrictions, leases, tenancies, and rights of possession, building and zoning laws, encumbrances, condominium liens, if any and all other claim in the nature of liens, if any there be.

In the event that the successful bidder at the foreclosure sale shall default in purchasing the within described property according to the terms of this Notice of Sale and/or the terms of the Memorandum of Sale executed at the time of foreclosure, the Mortgagee reserves the right to sell the property by foreclosure deed to the second highest bidder, providing that said second highest bidder shall deposit with the Mortgagee's attorneys, the amount of the required deposit as set forth herein. If the second highest bidder declines to purchase the within described property, the Mortgagee reserves the right to purchase the within described property at the amount bid by the second highest bidder. The foreclosure deed and the consideration paid by the successful bidder shall be held in escrow by DG&L, (hereinafter called the "Escrow Agent") until the deed shall be released from escrow to the successful bidder at the same time as the consideration is released to the Mortgagee, whereupon all obligations of the Escrow Agent shall be deemed to have been properly fulfilled and the Escrow Agent shall be discharged. Other terms, if any, to be announced at the sale.

Dated: December 29, 2020 Deutsche Bank National Trust Company as Trustee for Soundview Home Loan Trust 2005-4, Asset-Backed Certificates, Series 2005-4

By its Attorney DOONAN, GRAVES & LONGORIA, LLC, 100 Cummings Center, Suite 225D, Beverly, MA 01915 (978) 921-2670 www.dgandl.com 53633 (CUDDY)

AD#13933869
Transcript Bulletin 1/7, 1/14, 1/21/2021

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29 PEAR TREE DR

LEGAL NOTICE
TOWN OF WESTWOOD
NOTICE OF PUBLIC HEARING
WESTWOOD BOARD OF APPEALS

Pursuant to Chapter 40A, §9, the Board of Appeals will hold a public hearing on Wednesday, January 20, 2021 at 7:00 PM. The public hearing will be a remote meeting through Zoom due to the COVID-19 state of emergency and in compliance with the Governor's March 12, 2020 Executive Order suspending certain provisions of the Open Meeting Law MGL C. 30A, §18 and the Governor's March 23 Emergency Order imposing limitations on the number of people that may gather in one place. Those wishing to participate are encouraged to use Zoom.

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Enter your Email, Name, and Password: 619513
Or Telephone: 888 475 4499 (Toll Free) or 877 853 5257 (Toll Free)
Webinar ID: 824 4840 7413

The Board shall hear an application filed by Matthew Fermino for a Special Permit pursuant to the Westwood Zoning Bylaw Section §4.3.3.12 and 8.5 [Accessory Uses, Accessory Apartments] to construct an accessory apartment addition to the existing single family home. Property is located in the Single Residential C District.

Land affected: 29 Pear Tree Drive.
Map 32 Lot 148

Any zoning relief that may be required in adherence to the Westwood Zoning Bylaw shall be considered by the Board.

Should any person or party desire for any written material, including legal arguments or positions, to be considered by the Zoning Board of Appeals in connection with any petition before the Board, such material shall be submitted to the clerk of the Board no later than five (5) calendar days before the public hearing on the petition, or such material shall not be considered.

The application is available for inspection during stated business hours at the office of the Board of Appeals and on the Zoning Board's webpage under "Current Application Links" at www.westwoodpermit.org

Interested persons are encouraged to attend the public hearing and make their views known to the Board of Appeals.

John Lally, Chairman
Douglas Stebbins
Michael McCusker

AD# 13933157
Transcript Bulletin 12/31 & 01/07/2021

NORWOOD
284 PROSPECT STREET

LEGAL NOTICE
COMMONWEALTH OF MASSACHUSETTS

LAND COURT
DEPARTMENT OF THE TRIAL COURT

Docket 20 SM 001772

ORDER OF NOTICE

TO: **Ellen E. Ransow ; Frederick D. Ransow** and to all persons entitled to the benefit of the Servicemembers Civil Relief Act:, 50 U.S.C.c. 50 §3901 (et seq): **Federal Home Loan Mortgage Corporation as Trustee for Seasoned Credit Risk Transfer Trust, Series 2017-1,** claiming to have an interest in a Mortgage covering real property in **Norwood,** numbered **284 Prospect Street,** given by **Grace L. Brown to Washington Mutual Bank, FA, dated August 14, 2007, and recorded in Norfolk County Registry of Deeds in Book 25100, Page 102,** and now held by plaintiff by assignment, has/have filed with this court a complaint for determination of Defendant's/Defendants' Servicemembers status.

If you now are, or recently have been, in the active military service of the United States of America, then you may be entitled to the benefits of the Servicemembers Civil Relief Act. If you object to a foreclosure of the above-mentioned property on that basis, then you or your attorney must file a written appearance and answer in this court at **Three Pemberton Square, Boston, MA 02108** on or before February 1, 2021 or you may lose the opportunity to challenge the foreclosure on the ground of noncompliance with the Act.

Witness, **GORDON H. PIPER** Chief Justice of this Court on December 18, 2020

Attest:

Deborah J. Patterson
Recorder

(19-003488 Orlans)

AD#13933303
Transcript Bulletin 1/7/2021

BLOOMFIELD ESTATE

LEGAL NOTICE
Commonwealth of Massachusetts
The Trial Court
Norfolk Probate and Family Court
35 Shawmut Road
Canton, MA 02021
(781) 830-1200
Docket No. NO20P2333EA

INFORMAL PROBATE PUBLICATION NOTICE

Estate of: Caroline Bloomfield

Also known as: Caroling L (Lichtenberg) Bloomfield

Date of Death: August 26, 2020

To all persons interested in the above-captioned estate, by Petition of Petitioner **Samuel J. Bloomfield** of **Sharon MA.**

Samuel J. Bloomfield of **Sharon MA** has been informally appointed as the Personal Representative of the estate to serve without surety on the bond.

The estate is being administered under informal procedure by the Personal Representative under the Massachusetts Uniform Probate Code without supervision by the Court. Inventory and accounts are not required to be filed with the Court, but interested parties are entitled to notice regarding the administration from the Personal Representative and can petition the Court in any matter relating to the estate, including distribution of assets and expenses of administration. Interested parties are entitled to petition the Court to institute formal proceedings and to obtain orders terminating or restricting the powers of Personal Representatives appointed under informal procedure. A copy of the Petition and Will, if any, can be obtained from the Petitioner.

AD#13933333
Trranscript Bulletin 1/7/2021

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493 GAY ST

LEGAL NOTICE
TOWN OF WESTWOOD
NOTICE OF PUBLIC HEARING
WESTWOOD BOARD OF APPEALS

Pursuant to Chapter 40A, §9, the Board of Appeals will hold a public hearing on Wednesday, January 20, 2021 at 7:00 PM. The public hearing will be a remote meeting through Zoom due to the COVID-19 state of emergency and in compliance with the Governor's March 12, 2020 Executive Order suspending certain provisions of the Open Meeting Law MGL C. 30A, §18 and the Governor's March 23 Emergency Order imposing limitations on the number of people that may gather in one place. Those wishing to participate are encouraged to use Zoom.

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https://us02web.zoom.us/j/82448407413?pwd=c200NlRuS056VnJZOVNTSW1kZVl6QT09
Enter your Email, Name, and Password: 619513
Or Telephone: 888 475 4499 (Toll Free) or 877 853 5257 (Toll Free)
Webinar ID: 824 4840 7413

The Board shall hear an application filed by Matt Sly of Isaksen Solar for a Special Permit pursuant to the Westwood Zoning Bylaw Section §4.3.2.7 [Ground Mounted Solar] to construct a ground mounted solar array in the yard of a single family residential property. Property is located in the Single Residential E District.

Land affected: 493 Gay Street
Map 22 Lot 070

Any zoning relief that may be required in adherence to the Westwood Zoning Bylaw shall be considered by the Board.

Should any person or party desire for any written material, including legal arguments or positions, to be considered by the Zoning Board of Appeals in connection with any petition before the Board, such material shall be submitted to the clerk of the Board no later than five (5) calendar days before the public hearing on the petition, or such material shall not be considered.

The application is available for inspection during stated business hours at the office of the Board of Appeals and on the Zoning Board's webpage under "Current Application Links" at www.westwoodpermit.org

Interested persons are encouraged to attend the public hearing and make their views known to the Board of Appeals.

John Lally, Chairman
Douglas Stebbins
Michael McCusker

AD# 13933166
Transcript Bulletin 12/31 & 01/07/2021

WESTWOOD
36 WOODRIDGE ROAD

LEGAL NOTICE
WESTWOOD CONSERVATION COMMISSION
NOTICE OF PUBLIC HEARING
36 Woodridge Road

The Westwood Conservation Commission will hold a public hearing on Wednesday, January 13, 2021 at 7:00 PM. This will be a remote meeting through Zoom due to the COVID-19 state of emergency and in compliance with the Governor's March 12, 2020 Order suspending certain provisions of the Open Meeting Law MGL C. 30A, §18 and the Governor's March 23 Emergency Order imposing limitations on the number of people that may gather in one place. Those wishing to participate are encouraged to use Zoom.
Please click the link below to join the webinar:
https://us02web.zoom.us/j/88229216867?pwd=N09ybzR6YXQyVDBDeW5Xd0FyL1Q2UT09
Passcode: 832729
Or Telephone:
888 475 4499 (Toll Free) or 877 853 5257 (Toll Free)
Webinar ID: 882 2921 6867
An application has been filed by Ron Ifrah for a Notice of Intent under the Mass. Wetland Protection Act and the Westwood wetland bylaw. The applicant proposes the installation of an in-ground swimming pool, within a resource area. The property is located at 36 Woodridge Road, Westwood also known as Assessor's Map 42, Lot 16.

The plans and application are available for viewing on the Town's website under "Current Applications Link" for the Conservation Commission at www.westwoodpermit.org and click on "Conservation Commission Applications".

Individuals wishing to send comments in writing please email the Conservation Commission at kcatrone@townhall.westwood.ma.us preferably three business days in advance to ensure receipt by all board members.

Westwood Conservation Commission

AD#13933296
Transcript Bulletin 1/7/2021

PEREZ ESTATE

LEGAL NOTICE
Commonwealth of Massachusetts
The Trial Court
Norfolk Probate and Family Court
35 Shawmut Road
Canton, MA 02021
(781) 830-1200
Docket No. NO20P2639EA

INFORMAL PROBATE PUBLICATION NOTICE

Estate of: Robert Peter Perez

Also known as: Robert P. Perez

Date of Death: November 07, 2019

To all persons interested in the above-captioned estate, by Petition of Petitioner **Lynne M. Perez** of **Dedham MA.**

Lynne M. Perez of **Dedham MA** has been informally appointed as the Personal Representative of the estate to serve without surety on the bond.

The estate is being administered under informal procedure by the Personal Representative under the Massachusetts Uniform Probate Code without supervision by the Court. Inventory and accounts are not required to be filed with the Court, but interested parties are entitled to notice regarding the administration from the Personal Representative and can petition the Court in any matter relating to the estate, including distribution of assets and expenses of administration. Interested parties are entitled to petition the Court to institute formal proceedings and to obtain orders terminating or restricting the powers of Personal Representatives appointed under informal procedure. A copy of the Petition and Will, if any, can be obtained from the Petitioner.

AD#13934168
Transcript Bulletin 1/7/2021

Project No. BOS-21-R-004

LEGAL ADVERTISEMENT
TOWN OF WESTWOOD
MASSACHUSETTS
ADVERTISMENT FOR PROPOSALS

Project No. BOS-21-R-004
Disposition of Laura Lane Property

The Town of Westwood Board seeks proposals for the disposition of land at Laura Lane. The Town has determined the property is not required to serve any municipal use. The Town is ready to dispose of the parcel of land offering the property to those who can most effectively use it.

The Town of Westwood Massachusetts requests proposals to be submitted **no later than 11:00am on January 22, 2021** to the Westwood Procurement Department, Westwood Town Hall, 580 High Street, Westwood MA 02090. Proposals delivered after that time will not be accepted.

The RFP may be obtained electronically from the Town of Westwood website at: http://www.townhall.westwood.ma.us. The "Bid Documents" tab can be accessed by using the magnifying glass icon on the front page of the website.

The Town of Westwood may cancel this Quote, or reject in whole or in part any and all bids, if the Town determines that cancellation or rejection serves the best interests of the Town.

TOWN ADMINISTRATOR
TOWN OF WESTWOOD,
MASSACHUSETTS

AD#13932661
T&B 12/31/20, 1/7/21

Westwood Police Logs: Dec. 23-27: K9 unit assists in searches

The following are excerpts from the Westwood Police log from Dec. 23-28. The logs are public record.

Updates

Westwood detectives, with help from the MBTA Police, arrested a man from East Boston on charges of open and gross lewd and lascivious behavior from an incident on March 23, 2019, at Marshalls. The man allegedly exposed himself to a shopper.

In July 2020, there were several locker break-ins at Lifetime Fitness, part of a nationwide wave of break-ins at fitness centers. A California man and Florida woman have been arrested in connection with the local break-ins. The man was charged with four counts of misuse of credit cards over $1,200 and three counts of receiving stolen property. The woman was changed with two counts of conspiracy.

A Quincy man was arrested and charged with operating an unregistered motor vehicle and attaching the wrong plates following a hit-and-run at Washington Street on Sept. 28. The vehicle apparently sideswiped another vehicle and took off.

On the unemployment fraud front, there have been fewer incidents over the past couple of weeks, but residents are still reporting claims being made in their names. Police advise that claims be reported to the state's Department of Unemployment Assistance, as well as notify credit reporting agencies, banks and the Internal Revenue Service.

Wednesday, Dec. 23

12:50 p.m.: A resident of Loring Street reported a large bag of packages on their driveway. Police managed to locate the FedEx driver, and they retrieved the bag.
12:57 p.m.: The Animal Control officer helped corral a small black Labrador running around on Dover Road near Lorraine Road. The dog was reunited with their owner.
1:40 p.m.: A resident of Westview Terrace reported kids skating on the pond nearby. The Fire Department sent a vehicle, and advised the young skaters to get off the ice.
3:08 p.m.: A "known party" was caught shoplifting for the second time at Wegmans on University Avenue. Two days before, the person was caught with $400 worth of items. This time, the person had items concealed in the cart. The person has been barred from Wegman's for two years, and charges are pending.
9:05 p.m.: The K9 unit assisted Norwood Police in searching for a person involved in a hit-and-run on Upland Road. The person had fled into Westwood; that person was later discovered to have been picked up by a relative and taken to a local hospital.
10:26 p.m.: A resident of Highland Glen reported having no heat in their apartment due to a broken thermostat, and they were unable to contact maintenance. Dispatch assisted in locating maintenance.

Thursday, Dec. 24

1:40 p.m.: One vehicle rear-ended another at University Avenue. There were no injuries, and minor damage to both vehicles.
5:18 p.m.: Westwood Police assisted Dover Police in apparent suspicious activity at Stonegate Road. A resident reported someone peering through windows. It turned out to be a delivery person needing a signature for a package.

Friday, Dec. 25

Police took two reports of signs down because of the storm – one at the East Street Rotary, the other at Endicott Street at Weatherbee Drive.
9:43 p.m.: A resident of Hartford Street sought police assistance with an intoxicated male trying to get into his vehicle. When police arrived, the male was back in the house, and the resident reported no further problems.

Saturday, Dec. 26

12:24 a.m.: A resident of Westwood Glen reported that the walls were vibrating and shaking. Police arrived and found nothing.
1 a.m.: An off-duty officer heading home to Canton observed a blue Honda Fit driving erratically. The officer called Canton Police, then followed the vehicle at a safe distance until Canton Police arrived.
9:55 a.m.: A vehicle stopped at Carroll Court was cited for speeding.
2:12 p.m.: A customer at Wegman's reported their purse had been taken from their carriage. The customer had gone to an adjacent aisle and left the purse in the carriage.
5:14 p.m.: Fireworks were reported at Colburn Street. Police searched the area to no avail.
7:09 p.m.: The K9 unit assisted Norwood Police in a search for a missing juvenile. The child was found by a Norwood Police officer.
7:59 p.m.: Police assisted in corralling a loose boxer on Harvard Street.

Sunday, Dec. 27

2:42 p.m.: Police stopped a vehicle going the wrong way on University Avenue. The operator of the vehicle said they were confused by the traffic islands.
3:08 p.m.: Police mediated a dispute at Yankee Candle on University Avenue. A customer kept pulling their mask down in order to smell the candles, and the management objected. The customer was advised to keep their mask on, but was not trespassed.
8:29 p.m.: A female employee at Target was indecently assaulted by a customer. Police took a report and watched the video of the incident; the case remains under investigation.

WESTWOOD POLICE LOGS: DEC. 28-JAN. 2

The following are excerpts from the Westwood Police logs from Dec. 28, 2020 to Jan. 2, 2021. The logs are public record.

Monday, Dec. 28

1:06 p.m.: Police assisted Highland Glen in trespassing a person from the property.
1:36 p.m.: Police were summoned to the Shell station on Route 1 southbound on a report of a person trying to break into a vehicle. The person was suffering from a medical issue, and was transported to a local hospital by Fire Department paramedics.

Tuesday, Dec. 29

3:56 p.m.: Police at University Avenue issued a citation for failure to display a handicapped placard.
4:20 p.m.: Police at University Station issued a citation for misuse of a handicapped placard.
4:22 p.m.: A large tree branch fell across Clapboardtree Street. The DPW was notified.
8:21 p.m.: Police assisted Boston Police in tracking a missing juvenile thought to be with an acquaintance in Westwood. The juvenile was not there, but was found in Roslindale.
9:02 p.m.: A tractor-trailer sideswiped a Kia sedan while both vehicles were in the eastbound lane of University Avenue heading toward Route 95. The Kia was totaled; the operator of the Kia was cited for operating with a suspended license.
9:43 p.m.: The K9 unit was called to the Home Depot to assist in a search of two people trying to get a refund for merchandise that had been stolen from another Home Depot. The unit searched the store to no avail; an employee later noted that one of them had slipped out a side door. The search outside was also unsuccessful.

Wednesday, Dec. 30

9:56 a.m.: A resident of High Street reported a suspicious vehicle in their driveway. The vehicle belonged to a construction worker, on a project next door, who had parked in the wrong spot. The vehicle was moved.
11:38 a.m.: A black and white dog was running loose on Hawktree Drive. The dog was reunited with their owner.
1:15 p.m.: Police received a report of late-night bonfires and drinking at Storrow Pond at Hale Reservation. Patrols to the area were increased.
4:12 p.m.: An officer conducting stationary traffic enforcement at Nahatan Street observed a vehicle going 45 miles per hour in a 30-mph zone. The vehicle was stopped; the vehicle was found to have a revoked registration because of lack of insurance. The operator said they had restored it, but police proved otherwise, The operator was cited for operating an uninsured vehicle, operating a vehicle with a revoked registration and speeding. The vehicle was towed.
7:34 p.m.: Police conducted a well-being check on an elderly resident of Blue Hill Drive. A family member had been trying to contact the resident for several hours. The resident was found at home and well; they had been out shopping.
9:03 p.m.: Police issued a stop sign violation at Pond Street near Clapboardtree Street.

Thursday, Dec. 31

6:50 a.m.: Police received a report of a Christmas tree that had fallen off a vehicle onto Dover Road.
10:32 a.m.: Police were called to the Gables on University Avenue on a report of a verbal dispute. The dispute focused on wearing face masks and social distancing. One of them left the building.
12:03 p.m.: A park ranger from Hale Reservation reported bonfires and drinking at Storrow Pond.
12:04 p.m.: Police were called to Wegmans on University Avenue on a report of a female who refused to leave. She wanted to purchase alcohol, but had an expired driver's license. The female, a resident of Canton, left the store without further incident.
3:48 p.m.: A couple were walking their dog on Wessex Street when their dog was attacked by another dog. The other dog's invisible fence had failed; the Animal Control officer cited the owners of the attacking dog for violating town bylaws.

Friday, Jan. 1, 2021

1:24 a.m.: A female Westwood officer was sent to Norwood Police to conduct a search of a female suspect.
10:22 a.m.: A wrist watch was found at the Sheehan School field and brought to the police station. The watch is worth about $15-$20.
1:20 p.m.: A resident of Olde Carriage Road found a bicycle in a wooded area behind their home. The bike, a blue Diamondback Insight, was brought to the station.
4:04 p.m.: A resident of Buckmaster Road reported a dog barking for more than three hours. A relative came a short time later to take care of the animals.
6:38 p.m.: Someone reported losing a key fob to a Toyota RAV4 near the Wegmans on University Avenue.
7:32 p.m.: The police department at Texarkana, Texas, reported that a person listed as missing in Westwood has been located. The person was removed from the missing persons list.
8:44 p.m.: Police were called to the Courtyard Marriott on a report of six people refusing to leave because they would not wear face masks. The people were ushered off the property.

Saturday, Jan. 2

8:27 a.m.: Police conducted a well-being check for a man reported struggling to walk on East Street. The man was gone by the time police arrived.
8:40 a.m.: Police received a report of a minivan in the parking lot of the Norfolk Golf Club. It turned out to be someone giving a driving lesson; the party was sent on its way.

LEGAL NOTICE

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199, intends to file an Application for Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial change in service and substantial capital expenditure for the (i) construction and development of a freestanding ambulatory surgery center ("ASC"), clinic space, and the acquisition of 1 magnetic resonance imaging ("MRI") unit and 1 computed tomography ("CT") unit at 1400 West Park Drive, Westborough, MA 01581; (ii) construction and development of an ASC and the acquisition of 2 MRI units and 2 CT units at 100 Brigham Way, Westwood, MA 02090; and (iii) construction and development of an ASC, clinic space, and the acquisition of 2 MRI units and 2 CT units at 2 Hill Street, Woburn, MA 01801. The total value of the Proposed Project based on the maximum capital expenditure is $223,724,658. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten taxpayers of Massachusetts may register in connection with the intended Application by no later than February 22, 2021, or 30 days from the filing date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 4th Floor, Boston, MA 02108 or dph .don@state.ma.us.

Represents Winchester and Woburn in US House

Statement from Rep. Clark on yesterday's insurrection attempt

WASHINGTON, D.C.—Statement from Assistant Speaker Katherine Clark (MA-5) on the violent insurrection at the U.S. Capitol:

"Despite the seditious attempt to overthrow our democracy, we in Congress will fulfill our duty to ensure the will of the people and the integrity of our democracy are upheld. But the next days and weeks remain dangerous.

"Donald Trump is a traitor to our country and our Constitution. He must be removed from office and prevented from further endangering our country and our people."

Return to Riverrun at Griffin Museum

WINCHESTER - Beginning on Jan. 9, 2021 through Feb. 14, 2021, Return to Riverrun opens at the Griffin Museum of Photography. The exhibition features a collection from the archive of New England photographer John Brook. The title of the exhibition is derived from the title of Brook's book A Long the Riverrun that was published in 1970 by the Scrimshaw Press. A selection of work from 1924-2016 will be displayed and placed in context to the world he saw around him.

A virtual reception will take place on Zoom on Jan. 14, 2021 at 7 p.m. Two panel discussions will be highlights of the exhibition during its run. The first panel on Sunday Jan. 31 at 4 p.m. EST highlights a conversation between Lou Jones, Gary Samson, Jessica Roscio and Thom Adams and a second conversation featuring a panel including Szari Bourque, Jean Gibran, Pat Nelson, David Herwaldt, Thom Adams and Jessica Roscio will take place on Sunday Feb. 14 at 4 p.m. EST.

Originally scheduled for April 2020, Return to Riverrun was cancelled at the Griffin Museum of Photography due to the COVID-19 pandemic.

John Brook was born in Woonsocket, Rhode Island. He graduated from Harvard. His photography career began in 1946 when he opened a portrait studio on Newbury St. in Boston where he resided for over 40 years.

- Burlington Election is April 10 ...

Town Election nomination papers are available; must be taken out by Feb. 17

BURLINGTON - Its election time again for the town of Burlington. Anyone interested in participating, here is the perfect opportunity. The Town Clerk's Office (Town Hall) is looking for residents who are interested in getting involved to get information and take out paper for the Town Election on April 10. Nomination papers must be taken out by Feb. 17 at 5 p.m.

There are a number of open seats for either town-wide or representative Town Meeting seats.

The seats that will be on the ballot this year include:

Town Wide Offices
Town Clerk (5 yr) (1 seat)
Moderator (1 yr) (1 seat)
Selectmen (3 yr) (2 seats)
Assessor (3 yr) (1 seat)
School Committee (3 yr) (1 seat)
Library Trustees (3 yr) (2 seats)
Planning Board (5 yr) (1 seat)
Board of Health (3 yr) (2 seat)
Housing Authority (5 yr) (1 seat)
Housing Authority (1 yr) (1 seat)
Recreation Commission (3 yr) (1 seat)
Recreation Commission (1 yr) (1 seat)
Shawsheen Tech. H.S. (3 yr) (1 seat)

Town Meeting Seats
Precinct 1 TMM (3 yr) (6 seats)
Precinct 1 TMM (2 yr) (1 seat)
Precinct 1 TMM (1 yr) (1 seat)
Precinct 2 TMM (3 yr) (6 seats)
Precinct 3 TMM (3 yr) (6 seats)
Precinct 4 TMM (3 yr) (6 seats)
Precinct 4 TMM (1 yr) (1 seat)
Precinct 5 TMM (3 yr) (6 seats)
Precinct 5 TMM (1 yr) (1 seat)
Precinct 6 TMM (3 yr) (6 seats)
Precinct 6 TMM (2 yr) (2 seats)
Precinct 7 TMM (3 yr) (6 seats)
Precinct 7 TMM (1 yr) (1 seat)

Here are the requirements for running for office:

1) Any registered voter living in Burlington who would like to participate in local government can take out papers to fill one of the seats;

2) You must contact the Town Clerk's office to register as an official candidate for the public office you want to run for;

3) You will need to get signatures from Burlington registered voters (50) who sign your candidate papers;

4) Return your papers by mail or the drop box to the Town Clerk's office for certifications, the deadline for returning you papers is February 19. Then you are ready to run for Office in the Town election on April 10.

All election are held at the Burlington High School Gym, 123 Cambridge Street, Burlington, MA 01803.

For further information or any questions you may have, please feel free to call the Town Clerk's office at 781-270-1660 or check out on the town website at *Burlington.org*.

PUBLIC NOTICE PUBLIC NOTICE

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199, intends to file an Application for Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial change in service and substantial capital expenditure for the (i) construction and development of a freestanding ambulatory surgery center ("ASC"), clinic space, and the acquisition of 1 magnetic resonance imaging ("MRI") unit and 1 computed tomography ("CT") unit at 1400 West Park Drive, Westborough, MA 01581; (ii) construction and development of an ASC and the acquisition of 2 MRI units and 2 CT units at 100 Brigham Way, Westwood, MA 02090; and (iii) construction and development of an ASC, clinic space, and the acquisition of 2 MRI units and 2 CT units at 2 Hill Street, Woburn, MA 01801. The total value of the Proposed Project based on the maximum capital expenditure is $223,724,658. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten taxpayers of Massachusetts may register in connection with the intended Application by no later than February 22, 2021, or 30 days from the filing date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 4th Floor, Boston, MA 02108 or dph.don@state.ma.us.

Virtual paint night is Jan. 26

BURLINGTON – What better way to de-stress than an evening being creative and playing with paint? Join Sherry Hoffman on a virtual paint night on Tuesday, Jan. 26 at 7 p.m.

All supplies will be included and available at curbside pickup. More information will be sent to participants about when to pick up materials.

Advanced registration is required for this Zoom event.

Register by inputting *https://bit.ly/3qqkfZ9* or call Shelley at 781-270-1691 to register over the phone,

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Postmaster - Send address changes to: Daily Times Chronicle
1 Arrow Drive, Woburn, MA 01801-2090

LEGAL NOTICES

LEGAL NOTICE

NOTICE OF MORTGAGEE'S SALE OF REAL ESTATE

Premises:
31 Chestnut Street,
Woburn, MA 01801

By virtue and in execution of the Power of Sale contained in a certain mortgage given by Craig L. Mahon and Jennifer E. Mahon to Mortgage Electronic Registration Systems, Inc., as Mortgagee, as nominee for Union Trust Mortgage Corporation, and now held by **1900 Capital Trust III, by U.S. Bank Trust National Association, not in its individual capacity but solely as Certificate Trustee**, said mortgage dated January 27, 2006 and recorded in the Middlesex County (Southern District) Registry of Deeds in Book 46887, Page 7, said mortgage was assigned from Mortgage Electronic Registration Systems as nominee for Union Trust Mortgage Corporation to HSBC Bank USA, N.A. by assignment dated March 22, 2012 and recorded with said Registry of Deeds in Book 58759, Page 300; said mortgage was assigned from HSBC Bank USA N.A. to Federal National Mortgage Association by assignment dated November 19, 2015 and recorded with said Registry of Deeds in Book 66465, Page 414; said mortgage was assigned from Federal National Mortgage Association to PROF-2013-S3 Legal Title Trust II, by U.S. Bank National Association, as Legal Title Trustee by assignment dated December 31, 2016 and recorded with said Registry of Deeds in Book 68699, Page 290; said mortgage was assigned from PROF-2013-S3 Legal Title Trust II, by U.S. Bank National Association, as Legal Title Trustee to Morgan Stanley Mortgage Capital Holdings LLC by assignment dated December 10, 2018 and recorded with said Registry of Deeds in Book 72104, Page 134; said mortgage was assigned from Morgan Stanley Mortgage Capital Holdings LLC to FV-I, Inc in Trust for Morgan Stanley Mortgage Capital Holdings LLC by assignment dated January 16, 2019 and recorded with said Registry of Deeds in Book 72138, Page 350; said mortgage was assigned from FV-I, Inc in Trust for Morgan Stanley Mortgage Capital Holdings LLC to 1900 Capital Trust III, by U.S. Bank Trust National Association, not in its individual capacity but solely as Certificate Trustee by assignment dated September 18, 2019 and recorded with said Registry of Deeds in Book 73691, Page 292; for breach of the conditions in said mortgage and for the purpose of foreclosing the same will be sold at **Public Auction on** February 4, 2021 at 12:00 PM Local Time upon the premises, all and singular the premises described in said mortgage, to wit:

The land, together with the buildings thereon, presently known and numbered 31 Chestnut Street, Woburn, Middlesex County, Massachusetts, containing 7,106 square feet situated on the Northerly side of Chestnut Street, bounded and described as follows:
SOUTHERLY by said Chestnut Street, fifty-nine and 45/100 (59.45) feet;
WESTERLY by land now or formerly of Margaret Walsh, one hundred thirty-six and 3/10 (136.3) feet; NORTHERLY by land now or formerly of heirs of Benjamin Parker and land now or formerly of John Winn and John W. Johnson, forty-eight and 5/10 (48.5) feet; and
EASTERLY by land now or formerly of John K. Kelley and Martin J. Kelley, one hundred twenty-seven (127) feet.
Meaning and intending to convey and hereby conveying the same premises conveyed to Craig L. Mahon and Jennifer E. Mahon by deed of Kristi M. Frazier and Laurent M. Jung to be recorded herewith.

The description of the property contained in the mortgage shall control in the event of a typographical error in this publication.

For Mortgagor's Title see deed dated January 18, 2006 and recorded in the Middlesex County (Southern District) Registry of Deeds in Book 46887, Page 5.

TERMS OF SALE: Said premises will be sold and conveyed subject to all liens, encumbrances, unpaid taxes, tax titles, municipal liens and assessments, if any, which take precedence over the said mortgage above described.

FIVE THOUSAND ($5,000.00) Dollars of the purchase price must be paid in cash, certified check, bank treasurer's or cashier's check at the time and place of the sale by the purchaser. The balance of the purchase price shall be paid in cash, certified check, bank treasurer's or cashier's check within thirty (30) days after the date of sale.

Other terms to be announced at the sale.

Brock & Scott, PLLC
1080 Main Street, Suite 200
Pawtucket, RI 02860
Attorney for 1900 Capital Trust III, by U.S. Bank Trust National Association, not in its individual capacity but solely as Certificate Trustee
Present Holder of the Mortgage
401-217-8701
210008 1/7,14,21/21

LEGAL NOTICE

CITY OF WOBURN
PUBLIC HEARING ON PROPOSED TRANSFER OF RCN CABLE LICENSE

The City of Woburn, by the Mayor as the statutory Cable License Issuing Authority, will hold a public hearing Pursuant to MGL c. 166A, s. 7 and 207 CMR 4.01 et seq and applicable federal law, on the application for transfer of control of the cable television license of RCN Telecom Services of Massachusetts ('RCN') to Stonespeak Infrastructure Partners on **Friday, January 22, 2021 at 11:00 a.m.** RCN's FCC Form 394 license transfer application and application materials are available for public inspection at City Hall. The Issuing Authority will consider the proposed change of control based on review of applicant's managerial, technical, financial and legal ability to operate the cable system pursuant to the existing RCN license.

Please Note: Due to the COVID-19 state of emergency, this public hearing will be virtual and can be attended by desktop, laptop, tablet or phone by visiting the following online video and/or audio link and/or telephone dial-in number as set forth below:

Log onto https://us02web.zoom.us/j/86376468508?pwd=VDBQdG9COVZUSGFCWktDUnNqaFA3UT09; at the prompt, enter Meeting ID: 863 7646 8508 and Passcode: 136035

By telephone, dial 1 929 205 6099 US (New York); at the prompt, enter Meeting ID: 863 7646 8508 and Passcode: 136035

Find your local number:
https://us02web.zoom.us/u/k6xWWBdep

If the State of Emergency is terminated or if the Governor's Order suspending certain provisions of the open meeting law is rescinded, this public hearing will be held in the City Council Chamber on the first Floor of City Hall, 10 Common Street, Woburn at the date and time specified above. Please call the City Clerk's office at (781) 897-5850 for more information. Public comment on the proposed transfer of RCN's Woburn cable license to Stonespeak Infrastructure is invited and shall be allowed as set forth above. Copies of City license transfer application materials may be made available for public inspection at the Office of the City Clerk by contacting City Solicitor Ellen Callahan Doucette c/o City Hall.

By order of the Mayor as statutory License Issuing Authority.
201240 1/7,14/21

LEGAL NOTICE

TOWN OF BURLINGTON CONSERVATION DEPARTMENT

NOTICE OF PUBLIC HEARING

Notice is hereby given that the Town of Burlington Conservation Commission will hold a virtual public hearing on Thursday, January 14, 2021 beginning at 8:10 PM via Cisco Webex.
To join meeting:

https://townofburlington.webex.com/townofburlington/j.php?MTID=m43cffa22874e8a20ab6be0195c34dec7
Meeting number (access code): 179 747 7321
Meeting password:
rrX3hS3KXR2
Join by phone:
+1-408-418-9388 United States Toll

The purpose of the public hearing is to take all information relating to a Notice of Intent filed by the Nordblom Development Company for the construction of a multi-family residential building with associated parking and utilities at 174 Middlesex Turnpike and 2 & 4 Fourth Avenue in Burlington. The proposed work would be within bordering land subject to flooding, riverfront area and the 100-foot buffer zone to bordering vegetated wetlands pursuant to MGL Chapter 131, Section 40 (The Wetlands Protection Act) and Burlington By-law Article 14. The Commission will review all information relative to this application and thereafter may issue an Order of Conditions/Burlington Wetland Permit. This application may be viewed at https://www.burlington.org/211/Conservation-Commission

TOWN OF BURLINGTON
CONSERVATION COMMISSION
Larry Cohen, Chair
210024 1/7/21

LEGAL NOTICE

MORTGAGEE'S SALE OF REAL ESTATE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by Joseph K. Jackowictz, Jr. and Joan L. Jackowictz to Countrywide Home Loans, Inc. dated June 19, 2003 and recorded with the Middlesex County (Southern District) Registry of Deeds, in Book 39782, Page 201, as assigned by Assignment of Mortgage dated October 10, 2014 and recorded with Middlesex County (Southern District) Registry of Deeds, Book 64367, Page 37, and as assigned by Assignment of Mortgage dated March 10, 2017 and recorded with Middlesex County (Southern District) Registry of Deeds, Book 69066, Page 155, and as assigned by Assignment of Mortgage dated May 7, 2019 and recorded with Middlesex County (Southern District) Registry of Deeds, Book 72784, Page 421, of which mortgage the undersigned is the present holder, for breach of the conditions of said mortgage and for the purpose of foreclosing the same will be sold at **Public Auction at 10:00 AM, on January 15, 2021,** on the premises known as **3 Robert Avenue, Woburn, Massachusetts,** the premises described in said mortgage, together with all the rights, easements, and appurtenances thereto, to wit:

The land with the buildings thereon, situated on Woburn, being shown as Lot 69 Robert Avenue, as shown on a Plan entitled "Sub-division of Land in Woburn, Mass.," dated Feb. 1953, Anthony Clericuzio, C.E., duly recorded with Middlesex South District Deeds, End of Book 8094, and bounded and described as follows:

Westerly by Robert Avenue, 121.05 feet;

Northerly by Lot 68, as shown on said plan, 162.96 feet;

Northeasterly by part of Lot #59, as shown on said Plan 21.39 feet; and

Southeasterly by Lots 71 and 70, as shown on said Plan, in 2 courses, 110 feet and 85.04 feet.

Containing 11,842 square feet of land, according to said plan.

Terms of Sale: These premises are being sold subject to any and all unpaid real estate taxes, water rates, municipal charges and assessments, condominium charges, expenses, costs, and assessments, if applicable, federal tax liens, partition wall rights, statutes, regulations, zoning, subdivision control, or other municipal ordinances or bylaws respecting land use, configuration, building or approval, or bylaws, statutes or ordinances regarding the presence of lead paint, asbestos or other toxic substances, sanitary codes, housing codes, tenancy, and , to the extent that they are recorded prior to the above mortgage, any easements, rights of way, restrictions, confirmation or other matters of record.

Purchaser shall also bear all state and county deeds excise tax. The deposit of $10,000.00 is to be paid in cash or bank or certified check at the time and place of the sale, with the balance of the purchase price to be paid by bank or certified check within forty-five (45) days after the date of the sale, to be deposited in escrow with Guaetta and Benson, LLC, at 73 Princeton Street, Suite 208, North Chelmsford, Massachusetts.

In the event that the successful bidder at the foreclosure sale shall default in purchasing the within described property according to the terms of this Notice of Sale and/or the terms of the Memorandum of Sale executed at the time of the foreclosure, the Mortgagee reserves the right to sell the property by foreclosure deed to the second highest bidder or, thereafter, to the next highest bidders, providing that said bidder shall deposit with said attorney, the amount of the required deposit as set forth herein within five (5) business days after written notice of the default of the previous highest bidder.

Other terms, if any, are to be announced at the sale.

Dated: December 16, 2020
Present holder of said mortgage

Wilmington Trust, National Association, not in its individual capacity, but solely as trustee of MFRA Trust 2014-2
by its Attorneys
Guaetta and Benson, LLC
Peter V. Guaetta, Esquire
P.O. Box 519
Chelmsford, MA 01824
December 24, 2020,
December 31, 2020,
January 7, 2021
201218 12/24,31/20, 1/7/21

LEGAL NOTICES ARCHIVE
All published legal notices are posted to the Massachusetts Public Notices website.
To search the archive of previously published legal notices go to: www.homenewshere.com or http://masspublicnotices.org/Search.aspx

LEGAL NOTICE

TOWN OF BURLINGTON CONSERVATION DEPARTMENT

NOTICE OF PUBLIC HEARING

Notice is hereby given that the Town of Burlington Conservation Commission will hold a virtual public hearing on Thursday, January 14, 2021 beginning at 7:25 PM via Cisco Webex.
To join meeting:

https://townofburlington.webex.com/townofburlington/j.php?MTID=m43cffa22874e8a20ab6be0195c34dec7
Meeting number (access code): 179 747 7321
Meeting password:
rrX3hS3KXR2
Join by phone:
+1-408-418-9388 United States Toll

The purpose of the public hearing is to take all information relating to a Notice of Intent filed by the Town of Burlington DPW for the construction of a sidewalk at Terrace Hall Avenue in Burlington. The proposed work would be within bordering land subject to flooding, riverfront area and the 100-foot buffer zone to bordering vegetated wetlands pursuant to MGL Chapter 131, Section 40 (The Wetlands Protection Act) and Burlington By-law Article 14. The Commission will review all information relative to this application and thereafter may issue an Order of Conditions/Burlington Wetland Permit. This application may be viewed at https://www.burlington.org/211/Conservation-Commission

TOWN OF BURLINGTON
CONSERVATION COMMISSION
Larry Cohen, Chair
210025 1/7/21

LEGAL NOTICE

TOWN OF BURLINGTON CONSERVATION DEPARTMENT

NOTICE OF PUBLIC MEETING

Notice is hereby given that the Town of Burlington Conservation Commission will hold a Webex virtual public meeting on Thursday, January 14, 2021 at 7:00 PM. Meeting link:

https://townofburlington.webex.com/townofburlington/j.php?MTID=m43cffa22874e8a20ab6be0195c34dec7

Join by phone: +1-408-418-9388 United States Toll
Meeting number: 179 747 7321
Password: rrX3hS3KXR2

At this meeting, the Conservation Commission will act upon a Request for Determination of Applicability filed by Rakesh Goel of 159 Mott Street LLC. The Commission will take all information relating to the proposed demolition of a house and construction of a new single-family house within the 100-foot buffer zone to bordering vegetated wetlands at 47 Cresthaven Drive in Burlington, MA, and will thereafter issue a Determination of Applicability. The application is being heard pursuant to MGL Chapter 131, Section 40 (The Wetlands Protection Act) and Burlington By-Law Article 14. To obtain a copy of this application email conservation@burlington.org.

TOWN OF BURLINGTON
CONSERVATION COMMISSION
Larry Cohen, Chair
210021 1/7/21

LEGAL NOTICE

CITY OF WOBURN
BOARD OF APPEALS

NOTICE OF PUBLIC HEARING

Notice is hereby given that the Board of Appeals will hold a **Public Hearing** on **Wednesday, January 20, 2021 at 6:00 p.m.**, on the petition **Alan Simpson and Janet Simpson, P.O. Box 4, Lexington, MA, 02420, Petitioners and Landowners,** seeking a Special Permit from Section 7.3 of the 1985 Woburn Zoning Ordinances, as amended**, to raze and replace a single-family home at 6 Foley Road, Woburn, MA, 01801.** A copy of the petition is on file at the Office of the City Clerk, City Hall, Woburn, Massachusetts. Any persons interested may review said petition and appear at the hearing. If special services, assistance or accommodations are required to participate in this meeting, please contact the City Clerk within sufficient time prior to the scheduled meeting time. 2021-3

NOTE: Meeting may be held as virtual meeting, check www.woburnma.gov or call (781) 897-5853 for updates

Gordon Vincent
Clerk of the
Board of Appeals
December 28, 2020
201252 12/31/20, 1/7/21

LEGAL NOTICE

TOWN OF BURLINGTON CONSERVATION DEPARTMENT

NOTICE OF PUBLIC MEETING

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Meeting number: 179 747 7321
Password: rrX3hS3KXR2

At this meeting, the Conservation Commission will act upon a Request for Determination of Applicability filed by Leigha Levesque. The Commission will take all information relating to the proposed cutting of trees within the 100-foot buffer zone to bordering vegetated wetlands and locally-regulated riverfront area at 23 Morrison Road in Burlington, MA, and will thereafter issue a Determination of Applicability. The application is being heard pursuant to MGL Chapter 131, Section 40 (The Wetlands Protection Act) and Burlington By-Law Article 14. To obtain a copy of this application email conservation@burlington.org.

TOWN OF BURLINGTON
CONSERVATION COMMISSION
Larry Cohen, Chair
210022 1/7/21

LEGAL NOTICE

WOBURN CONSERVATION COMMISSION

PUBLIC HEARING

Notice is hereby given that the City of Woburn Conservation Commission will hold a Public Hearing on Thursday, January 14, 2021, at 6:00 P.M., at which time an Abbreviated Notice of Resource Area Delineation filed by Richard Mede of Medford Engineering & Survey, on behalf of Courtney Green of The Begley Companies, under the Wetlands Protection Act, M.G.L. Chapter 131, sec. 40, and the Woburn Wetlands Ordinance, Title VII, will be heard. The application is seeking confirmation of the delineation of Bank and the absence of Bordering Vegetated Wetland at 87-89 Olympia Avenue, Woburn, Massachusetts (Woburn Assessors Map 25: Block 11, Lot 8). The purpose of the Hearing is to take in all information on the delineation to assist the Commission thereafter in the issuance of an Order of Resource Area Delineation. If special services, assistance or accommodations are required to participate in this meeting, please contact the Conservation Commission within sufficient time prior to the scheduled meeting time.

This Public Hearing will be held as a virtual meeting using the Zoom meeting platform. No in-person meeting will take place at City Hall. Check the Woburn Conservation Commission online agenda posting at www.woburnma.gov within 48 hours of the scheduled meeting time or call (781) 897-5933 prior to the meeting to obtain information on how to connect.

WOBURN
CONSERVATION
COMMISSION
Duane P. Cleak, Chairman
John J.Tancredi, Jr.,
Vice Chairman
Heather A. Barackman
Gerald T. Lohnes
Stephen M. Malone
Kevin C. Meaney
Pauline E. Scalley
210020 1/7/21

LEGAL NOTICE

TOWN OF BURLINGTON CONSERVATION DEPARTMENT

NOTICE OF PUBLIC HEARING

Notice is hereby given that the Town of Burlington Conservation Commission will hold a virtual public hearing on Thursday, January 14, 2021 beginning at 7:50 PM via Cisco Webex.
To join meeting:

https://townofburlington.webex.com/townofburlington/j.php?MTID=m43cffa22874e8a20ab6be0195c34dec7
Meeting number (access code): 179 747 7321
Meeting password:
rrX3hS3KXR2
Join by phone:
+1-408-418-9388 United States Toll

The purpose of the public hearing is to take all information relating to a Notice of Intent filed by the Nordblom Development Company for the reconstruction of a parking lot at 60 Blanchard Road in Burlington. The proposed work would be within riverfront area and the 100-foot buffer zone to bordering vegetated wetlands pursuant to MGL Chapter 131, Section 40 (The Wetlands Protection Act) and Burlington By-law Article 14. The Commission will review all information relative to this application and thereafter may issue an Order of Conditions/Burlington Wetland Permit. This application may be viewed at https://www.burlington.org/211/Conservation-Commission

TOWN OF BURLINGTON
CONSERVATION COMMISSION
Larry Cohen, Chair
210023 1/7/21

LEGAL NOTICE

WOBURN CONSERVATION COMMISSION

PUBLIC HEARING

Notice is hereby given that the City of Woburn Conservation Commission will hold a Public Hearing on Thursday, January 14, 2021, at 6:00 P.M., at which time a Notice of Intent filed by Richard Kirby of LEC Environmental Consultants, Inc., on behalf of Yogesh Patel, under the Wetlands Protection Act, M.G.L. Chapter 131, sec. 40, and the Woburn Wetlands Ordinance, Title VII, will be heard. The application is for work related to the construction of a single family dwelling at 12 Harold Avenue, Woburn, Massachusetts (Woburn Assessors Map 24: Block 1; Lot 5). Work is proposed within the buffer zone to a wetland resource area. The purpose of the Hearing is to take in all information on the proposal to assist the Commission thereafter in the issuance of an Order of Conditions. If special services, assistance or accommodations are required to participate in this meeting, please contact the Conservation Commission within sufficient time prior to the scheduled meeting time.

This Public Hearing will be held as a virtual meeting using the Zoom meeting platform. No in-person meeting will take place at City Hall. Check the Woburn Conservation Commission online agenda posting at www.woburnma.gov within 48 hours of the scheduled meeting time or call (781) 897-5933 prior to the meeting to obtain information on how to connect.

WOBURN
CONSERVATION
COMMISSION
Duane P. Cleak, Chairman
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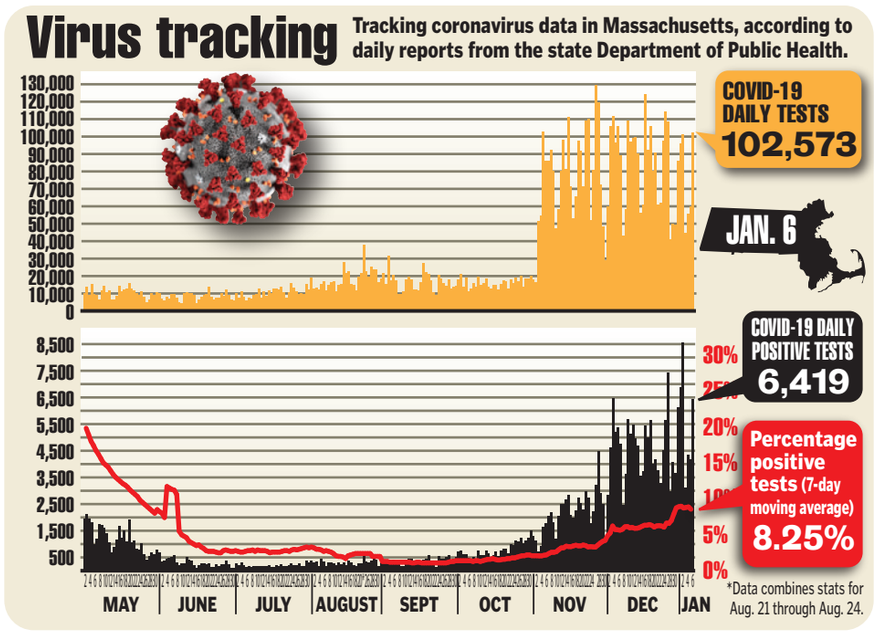
210018 1/7/21

ANOTHER LEGAL ON PAGE A5

PUBLIC NOTICE PUBLIC NOTICE

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199, intends to file an Application for Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial change in service and substantial capital expenditure for the (i) construction and development of a freestanding ambulatory surgery center ("ASC"), clinic space, and the acquisition of 1 magnetic resonance imaging ("MRI") unit and 1 computed tomography ("CT") unit at 1400 West Park Drive, Westborough, MA 01581; (ii) construction and development of an ASC and the acquisition of 2 MRI units and 2 CT units at 100 Brigham Way, Westwood, MA 02090; and (iii) construction and development of an ASC, clinic space, and the acquisition of 2 MRI units and 2 CT units at 2 Hill Street, Woburn, MA 01801. The total value of the Proposed Project based on the maximum capital expenditure is $223,724,658. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten taxpayers of Massachusetts may register in connection with the intended Application by no later than February 22, 2021, or 30 days from the filing date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 4th Floor, Boston, MA 02108 or dph.don@state.ma.us.



Virus cases surge 6,419 — one of the highest single-day counts ever

By RICK SOBEY

Massachusetts health officials on Wednesday reported 99 new coronavirus deaths and 6,419 new cases, one of the highest single-day counts ever as cases surge in the wake of Christmas.

Wednesday's count of 6,419 cases comes after Tuesday's 4,178 cases and Monday's 4,358 cases. Last Thursday — the final day of 2020 — was the state's single-day record high of 6,887 new cases.

Wednesday's 99 new virus deaths and three new probable virus deaths bring the state's total COVID-19 death toll to 12,836. The seven-day average of daily deaths is now 51, a significant jump from 13 daily deaths in early October. The death average peaked with 175 daily deaths in late April.

Of Massachusetts' 404,053 total recorded cases, at least 261,672 people have recovered. Health officials estimate there are 79,967 active cases across the state.

The seven-day weighted average of the state's positive test rate — removing higher education — has surged to 9.4%. The rate was 7.3% in the week before Christmas, and 1.7% at the start of September.

Statewide coronavirus hospitalizations on Wednesday went down by 12 patients, bringing the hospitalization total to 2,416.

The 2,416 patients is a significant increase from 436 patients at the start of November. The highest peak of Massachusetts' coronavirus hospitalizations was 3,965 on April 21.

Of the 12,836 total deaths in Massachusetts, 7,501 deaths have been reported in long-term care facilities.

The U.S. has recorded more than 359,000 coronavirus deaths and 21.2 million cases. The country's death toll and case count are the highest in the world.

CDC: Severe allergic reaction to vax is rare

By RICK SOBEY

Only 21 people out of the first 1.9 million recipients of the Pfizer coronavirus vaccine in the U.S. suffered a severe allergic reaction, the CDC reported Wednesday.

An anaphylaxis case after getting the Pfizer vax appears to be an extremely rare event, based on early safety monitoring, the Centers for Disease Control and Prevention said.

The majority of these severe allergic reactions (71%) happened within 15 minutes of receiving the shot.

Of the 21 anaphylaxis cases, 17 of the people have a documented history of allergies or allergic reactions, including to drugs or medical products, foods, and insect stings. Seven of the people had experienced an episode of anaphylaxis in the past, including one after getting a rabies vaccine and another after receiving an influenza (H1N1) vaccine.

Four of the patients were hospitalized, and 17 of the patients were treated in an emergency department. No deaths from anaphylaxis were reported after receiving the Pfizer COVID-19 vaccine.

The allergic reaction data from the CDC comes after officials recently noted that the reactions could be tied to a chemical called polyethylene glycol, which is found in both the Pfizer and Moderna vaccines.

A Boston oncology doctor with a shellfish allergy experienced a severe allergic reaction after he received Moderna's coronavirus vaccine at the end of December.

Because the FDA emergency use authorization for the Moderna COVID-19 vaccine was received one week later than the Pfizer vaccine, the CDC report on Wednesday focused on the Pfizer vaccine. An assessment of adverse events reported after receiving the Moderna COVID-19 vaccine will be forthcoming, the CDC said.

LEGAL NOTICES LEGAL NOTICES LEGAL NOTICES

NOTICE OF MORTGAGEE'S SALE OF REAL ESTATE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by Antonio Jarvis and Lucy Veiga to Mortgage Electronic Registration Systems, Inc., solely as nominee for American Mortgage, Inc., dated December 19, 2008, and recorded with the Suffolk County Registry of Deeds in Book 44347, Page 269, as affected by an assignment from Mortgage Electronic Registration Systems, Inc., to Bank of America, N.A., Successor by merger to BAC Home Loans Servicing, LP FKA Countrywide Home Loans Servicing, LP, dated January 31, 2012, and recorded with the Suffolk County Registry of Deeds in Book 49049, Page 279; assignment from Bank of America, N.A., Successor by merger to BAC Home Loans Servicing, LP FKA Countrywide Home Loans Servicing, LP, to Secretary of Housing and Urban Development, dated September 4, 2013, and recorded with the Suffolk County Registry of Deeds in Book 52864, Page 212; assignment from Secretary of Housing and Urban Development to Ventures Trust 2013-I-NH- by MCM Capital Partners, LLC, its Trustee, dated September 18, 2013, and recorded with the Suffolk County Registry of Deeds in Book 52864, Page 213; assignment from Ventures Trust 2013-I-NH by MCM Capital Partners, LLC, its Trustee to Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust, Not Individually but as Trustee for Ventures Trust 2013-I-NH, dated October 6, 2017, and recorded with the Suffolk County Registry of Deeds in Book 58698, Page 205; assignment from Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust, Not Individually but as Trustee for Ventures Trust 2013-I-NH to Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust, Not Individually but as Trustee for Hilldale Trust, dated October 16, 2017, and recorded with the Suffolk County Registry of Deed in Books 58698, Page 213; and Assignment from Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust, Not in its Individual Capacity but solely as Trustee for Hilldate Trust to Wilmington Savings Fund Society, FSB, as Owner Trustee of the Residential Credit Opportunities Trust V-D, dated September 11, 2019, and recorded with the Suffolk County Registry of Deeds in Book 61914, Page 60; of which mortgage the undersigned is the present holder by assignment, for breach of the conditions of said mortgage and for the purpose of foreclosing the same will be sold at Public Auction at 01:00 PM o'clock on January 21, 2021 at 77-79 Bloomfield Street, Dorchester, Suffolk County, Massachusetts, all and singular the premises described in said mortgage,

To wit:

The land with the buildings thereon, situated in that part of Boston, formerly Dorchester, being Lot 4 on a plan made by Morton & Quimby dated May 28, 1894, and recorded with the Suffolk Deeds Book 2203, end, bounded and described as follows:
SOUTHEASTERLY on Bloomfield Street, 50 feet;
SOUTHWESTERLY by Lot 3 on said plan, 92.13 feet;
NORTHWESTERLY by land of the heirs of Charles B. Pierce, 50 feet; and
NORTHEASTERLY by Lot 5 on said plan, 91.49 feet
Containing 4,590 square feet of land, more or less, according to said plan.
For title reference see Deed recorded with Suffolk District Registry of Deeds at Book 37938,
Page 242.

For mortgagor's title see deed recorded at the above-named Registry of Deeds in Book 44347, Page 267.

Premises to be sold and conveyed subject to and with the benefit of all rights, rights of way, restrictions, easements, covenants, liens or claims in the nature of liens, improvements, public assessments, any and all unpaid taxes, tax titles, tax liens, water and sewer liens and any other municipal assessments or liens or existing encumbrances of record which are in force and are applicable, having priority over said mortgage, whether or not reference to such restrictions, easements, improvements, liens or encumbrances is made in the deed.

Terms of sale: A deposit of five thousand dollars ($5,000) by certified or bank check will be required to be paid by the purchaser at the time and place of sale. The balance is to be paid by certified or bank check at the offices of WCG Law Group, PLLC, 21 High Street, Suite 208B, North Andover, MA 01845 within thirty (30) days from the date of sale. Deed will be provided to purchaser for recording upon receipt in full of the purchase price. In the event of an error in this publication, the description of the premises contained in said mortgage shall control.

Other terms, if any, to be announced at the sale.

Wilmington Savings Fund Society, FSB, as Owner
Trustee of the Residential Credit Opportunities Trust V-
D

Present Holder of said mortgage
By its attorneys,
WCG Law Group, PLLC
21 High Street, Suite 208B
North Andover, MA 01845
Jarvis, Antonio and Veiga, Lucy; 1412-FCI-1036;

Dec 31 Jan 7 14

LEGAL NOTICES LEGAL NOTICES LEGAL NOTICES

Public Announcement Concerning a Proposed Health Care Project

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199 intends to file a Notice of Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial capital expenditure and substantial change in service by Brigham and Women's Faulkner Hospital ("BWFH") located at 1153 Centre Street, Boston, MA 02130. This Application includes the following: (A) construction of a 5-story addition to BWFH's existing hospital facility that will contain the following: (1) 78 additional medical/surgical beds; (2) an 8-bed observation unit; (3) relocated and expanded endoscopy services, including one additional procedure room; (4) a magnetic resonance imaging ("MRI") unit and certain relocated radiology services; and (5) shell space for future build out to accommodate clinical services; and (B) other renovation projects to improve existing services and facilities at the BWFH main campus (collectively, the "Proposed Project"). The total value of the Proposed Project based on the maximum capital expenditure is $150,098,582. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten Taxpayers of Massachusetts may register in connection with the intended Application by no later than February 20, 2021 or 30 days from the Filing Date, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 6 th Floor, Boston, MA 02108.

Jan 7

LEGAL NOTICES LEGAL NOTICES LEGAL NOTICES

Public Announcement Concerning a Proposed Health Care Project

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199 intends to file a Notice of Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial capital expenditure and substantial change in service by The General Hospital Corporation d/b/a/ Massachusetts General Hospital ("MGH") located at 55 Fruit Street, Boston, MA 02114. This Application includes the following: (A) construction of a new building that will contain the following: (1) 482 new private medical/surgical and intensive care unit ("ICU") beds and with the corresponding closure of 388 existing semi-private beds, MGH will have a total of 94 additional licensed beds (54 additional medical/surgical; 40 additional ICU beds); (2) relocated and expanded outpatient oncology services; (3) 24 operating rooms; (4) two additional computed tomography ("CT") units; (5) two additional magnetic resonance imaging ("MRI") units; (6) two additional positron emission tomography-computed tomography ("PET/CT") units; (7) one additional positron emission tomography-magnetic resonance ("PET/MR") unit; and (B) other clinical services renovation projects at MGH's main campus and licensed satellites (collectively, the "Proposed Project"). The total value of the Proposed Project based on the maximum capital expenditure is $1,880,774,238. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten Taxpayers of Massachusetts may register in connection with the intended Application by no later than February 20, 2021 or 30 days from the Filing Date, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 6 th Floor, Boston, MA 02108.J

Jan 7

LEGAL NOTICES LEGAL NOTICES LEGAL NOTICES

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199, intends to file an Application for Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial change in service and substantial capital expenditure for the (i) construction and development of a freestanding ambulatory surgery center ("ASC"), clinic space, and the acquisition of 1 magnetic resonance imaging ("MRI") unit and 1 computed tomography ("CT") unit at 1400 West Park Drive, Westborough, MA 01581; (ii) construction and development of an ASC and the acquisition of 2 MRI units and 2 CT units at 100 Brigham Way, Westwood, MA 02090; and (iii) construction and development of an ASC, clinic space, and the acquisition of 2 MRI units and 2 CT units at 2 Hill Street, Woburn, MA 01801. The total value of the Proposed Project based on the maximum capital expenditure is $223,724,658. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten taxpayers of Massachusetts may register in connection with the intended Application by no later than February 22, 2021, or 30 days from the filing date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 4th Floor, Boston, MA 02108 or dph.don@state.ma.us.

Jan 7

PROBATE CITATIONS PROBATE CITATIONS

Commonwealth of
Massachusetts
The Trial Court Probate and Family Court
Suffolk Division
Docket No. SU20P2304EA
INFORMAL PROBATE PUBLICATION NOTICE
Estate of: Jeffrey T. Gauches
Date of Death: September 27, 2020 To all persons interested in the above captioned estate, by Petition of Petitioner Kathleen Gauches of South Glastonbury CT Kathleen Gauches of South Glastonbury CT has been informally appointed as the Personal Representative of the estate to serve without surety on the bond. The estate is being administered under informal procedure by the Personal Representative under the Massachusetts Uniform Probate Code without supervision by the Court. Inventory and accounts are not required to be filed with the Court, but interested parties are entitled to notice regarding the administration from the Personal Representative and can petition the Court in any matter relating to the estate, including distribution of assets and expenses of administration. Interested parties are entitled to petition the Court to institute formal proceedings and to obtain orders terminating or restricting the powers of Personal Representatives appointed under informal procedure. A copy of the Petition and Will, if any, can be obtained from the Petitioner.

Jan 7

STATE&REGION

LOTTERY

MASS. DAILY NUMBERS
EVENING DRAWING
Tuesday: 5-0-8-0
EXACT ORDER
All 4 digits $4,818
First or last 3: $675
Any 2 digits: $58
Any 1 digit: $6
ANY ORDER
All 4 digits 3 $401
First 3 $112
Last 3 $225
MIDDAY DRAWING
Tuesday: 3-6-1-4
EXACT ORDER
All 4 digits $4,130
First or last 3 $578
Any 2 digits $50
Any 1 digit $5
ANY ORDER
All 4 digits $172
First 3 $96
Last 3 $96
LUCKY FOR LIFE
Monday: 2-12-21-26-46
Lucky Ball: 7
MEGABUCKS DOUBLER
Saturday: 11-16-17-23-24-30
Estimated jackpot: $7 million
MEGA MILLIONS
Tuesday: 20-43-51-55-57
Megaball: 4
Megaplier: 2
Estimated jackpot: $490 million
POWERBALL
Saturday: 3-4-11-41-67
Powerball: 5
Power Play: 2
Estimated jackpot: $410 million
MASS CASH
Tuesday: 20-23-24-26-34
RHODE ISLAND DAILY NUMBERS
Tuesday
Midday: 2-6-1-5
Evening: 0-5-4-5

CORRECTION POLICY

The Daily News corrects errors of fact in stories, whether printed or published online. If you notice an error, please contact an editor at the news desk by calling 508-626-4412.

DA: Two Newton officers shot man who later died

By Julie M. Cohen
Wicked Local
USA TODAY NETWORK

NEWTON — Two Newton police officers shot a man who later died of his injuries Tuesday, after responding to a 911 call about a person armed with a knife at a Newton Highlands store, District Attorney Marian Ryan said during a press conference.

The DA said officers and a state trooper initially used "less-than-lethal" weapons to subdue the man, including a beanbag shotgun and a Taser, but neither worked.

The name of the 28-year-old white man who was killed will not be released until his family is notified, Ryan said, standing outside of the Newton Police Station. No officers were seriously injured, she said.

The incident began at 1:43 p.m. after the owner of Indulge!, a chocolate shop at 16 Lincoln St., called 911 to report a man with a knife was inside. Although the dispatcher "interpreted" the incident as an armed robbery, it is still under investigation, the DA said.

"The owner certainly kept a cool head in a difficult situation and was able to protect herself as well as to reach out and provide, by keeping the 911 line open, a fair amount of information to the police," said Ryan, who confirmed the owner was unharmed.

When two Newton police officers arrived at the store, the man with the knife ran upstairs and officers chased him to the third floor. Ryan said the man lived in an apartment above Indulge!, but did not specify which floor.

Police on Lincoln Street in Newton, following a police-involved shooting of a man following an armed robbery, Jan. 5, 2021. [WCVB]

A police officer, bundled against the cold, helping at the scene of a reported armed robbery in Newton Highlands, Jan. 5, 2021. [WICKED LOCAL STAFF PHOTO/JULIE COHEN]

After calling for backup, including a mental health clinician, more Newton officers and two state troopers arrived, said Ryan.

"The Newton police deployed less-than-lethal force" using a beanbag shotgun to try and stop the man, and at 2:01 a state trooper used a taser on him, but neither weapon "subdued" him, Ryan said. She added that the incident happened in a "common area."

"Two Newton police officers then fired their service weapon, striking the male carrying the knife," said the DA.

By 2:13 p.m., the man died of his injuries at Newton-Wellesley Hospital, she said.

After Mayor Ruthanne Fuller assured the public that the incident was over, Ryan said there was no further information and that the investigation was in the early phases.

A community rally was planned for 4 p.m. Wednesday near the Newton Police Department headquarters on Washington Street.

Baker: About 117K virus vaccines have been given

By Colin A. Young
State House News Service

BOSTON — More than 70,000 health care workers in Massachusetts who could encounter the coronavirus on the job have received at least the first dose of the COVID-19 vaccine.

Gov. Charlie Baker and Lt. Gov. Karyn Polito traveled to Baystate Medical Center in Springfield on Tuesday to highlight vaccine distribution efforts in the western part of the state and strategies the hospital system is taking to encourage its employees and, eventually, its patients to get vaccinated.

By the start of this week, about 287,000 doses of the Moderna and Pfizer vaccines had been distributed to providers in Massachusetts and 116,771 doses have been administered, Baker said. Seventy-four of 76 hospitals in the state have started vaccinating their workers (the two Shriners Hospitals for Children opted out of the first round of distribution) and at least 70,000 COVID-facing health care workers have gotten the shot, the governor said.

"It's great to see doctors and nurses and health care workers receive their first doses, and to highlight some of that on social media," Polito said Tuesday. "It not only gives others in terms of your colleagues in the medical profession some insight in terms of how that might feel, but it also was an inspiration to the public at large that these vaccinations are real, they're rolling out, and they will be near everyone in our commonwealth in a relatively short period of time."

Dr. Mark Keroack, president and CEO of Baystate Health, said his organization invited 12,252 people — all of its employees and some hospital-based private providers — to get the vaccine. About 7,600 people have opened their invitation and 6,162 have been given the first vaccine dose. Some of those people were scheduled for their second dose this week, he said. So far, 1,474 people have declined the vaccine, Keroack said.

"But over 60% of those are what I would call the softer variety. That is, people who are not adamantly opposed to vaccinations in general, but rather prefer to wait and see what happens with their friends and colleagues before they themselves step up," he said.

Keroack called the COVID-19 vaccines "a home run" because both the Moderna and Pfizer formulations have shown to be roughly 95% effective, compared to a flu shot that might be 70% effective in "a really good year."

Keroack said Baystate Health's vaccine center in Holyoke has been able to vaccinate about 850 people a day. He said mild sore arms have been a common side effect of the vaccine but that flu-like symptoms have been "surprisingly uncommon," having shown up in just 2% of people vaccinated.

Mega Millions jackpot soars to $490M for Friday's drawing

WCVB

BOSTON — The Mega Millions jackpot has soared to $490 million for Friday's drawing after no ticket matched all six numbers drawn Tuesday night.

While the jackpot rolls, there were plenty of other big winners Tuesday night, including four tickets that matched the five white balls to win the game's second prize of at least $1 million.

They were sold in California, Minnesota, New Jersey and New York. The New York ticket included the optional Megaplier (an extra $1 purchase available in most states) so it is worth $2 million after the 2X Megaplier was drawn.

Fifty-one tickets matched four white balls plus the Mega Ball to win $10,000; eight of those are actually worth $20,000 each because they also included the optional Megaplier. In total, there were 1,927,049 winning tickets at all prize levels in Tuesday's drawing.

Llama found wandering off highway

The Associated Press

NEWBURYPORT — A passerby spotted a wandering llama in a field off an interstate in Massachusetts and with the help of an animal control officer, brought it to a farm for safekeeping.

Patrick Boddy was driving in Newburyport when he spotted the male gray-and-white llama, stopped his truck and approached it on Monday, the Boston Globe reported.

The llama acted "very chill," as he walked up to him, Boddy told the newspaper.

"I had my arm around the thing, kind of calming him down. It was just really gentle and friendly. I knew it must've been some kind of pet or something," said Boddy.

Eventually, Kayla Provencher, the animal control officer for Newburyport and West Newbury, was alerted and joined Boddy in the field with the llama. They called around to local farms to see if any were missing a llama, the newspaper reported.

"I'm not sure where he came from or how he got there," Provencher told The Associated Press, but he was hungry and drank a lot of water, indicating he was in need of some care, she said. The state does have records of barn inspections, but she said none of the local farms are missing llamas.

Provencher does not have any leads on the wandering llama's owner, even after posting photos of him on the animal control's Facebook page.

For now, the llama is being housed just across the state line in New Hampshire with farm owner Carly LeSage. She owns other livestock but has never had a llama, the newspaper reported.

"I did a night check with him last night and had a glass of wine with him," LeSage told the newspaper. "I'm kind of a little attached to him at this point."

If no owner comes forward, LeSage told the newspaper she's considering keeping the llama herself.

Forecast for MetroWest

AccuWeather Plan your week | Get the NEW app

TODAY HIGH: 45° LOW: 20°
Plenty of sun
RealFeel: 43° / 16°

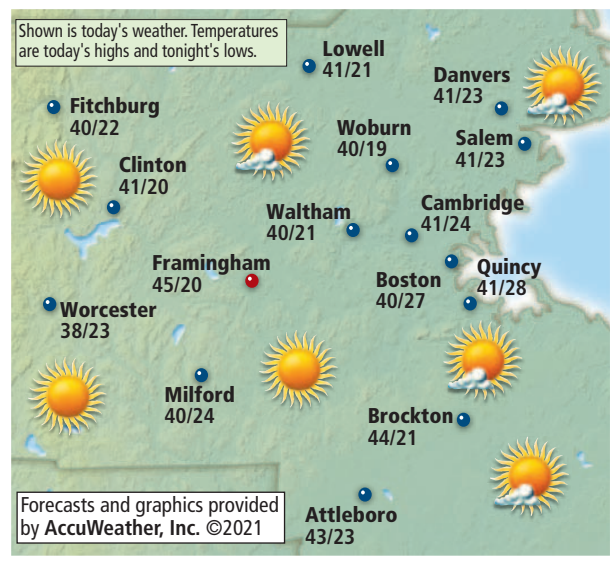
FRIDAY HIGH: 38° LOW: 17°
Plenty of sun
RealFeel: 39° / 13°

SATURDAY HIGH: 34° LOW: 20°
Partial sunshine
RealFeel: 34° / 17°

SUNDAY HIGH: 37° LOW: 20°
Partly sunny
RealFeel: 38° / 18°

MONDAY HIGH: 39° LOW: 20°
Sun and clouds
RealFeel: 39° / 13°

The patented **AccuWeather.com RealFeel Temperature®** is an exclusive index of effective temperature based on eight weather factors.



LOCAL ALMANAC

Statistics through 1 pm Wednesday

High / Low temperatures	43° / 31°
Precipitation 24 hrs. through 1 pm Wed.	Trace

SUN & MOON

	Today	Friday
Sunrise	7:14 am	7:14 am
Sunset	4:30 pm	4:31 pm
Moonrise	12:55 am	2:09 am
Moonset	12:15 pm	12:46 pm

MOON PHASES

New	First	Full	Last
Jan 12	Jan 20	Jan 28	Feb 4

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT

Mass General Brigham Incorporated ("Applicant") located at 800 Boylston Street, Suite 1150, Boston, MA 02199, intends to file an Application for Determination of Need ("Application") with the Massachusetts Department of Public Health for a substantial change in service and substantial capital expenditure for the (i) construction and development of a freestanding ambulatory surgery center ("ASC"), clinic space, and the acquisition of 1 magnetic resonance imaging ("MRI") unit and 1 computed tomography ("CT") unit at 1400 West Park Drive, Westborough, MA 01581; (ii) construction and development of an ASC and the acquisition of 2 MRI units and 2 CT units at100 Brigham Way, Westwood, MA 02090; and (iii) construction and development of an ASC, clinic space, and the acquisition of 2 MRI units and 2 CT units at2 Hill Street, Woburn, MA 01801. The total value of the Proposed Project based on the maximum capital expenditure is $223,724,658. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten taxpayers of Massachusetts may register in connection with the intended Application by no later than February 22, 2021, or 30 days from the filing date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 4thFloor, Boston, MA 02108 or dph.don@state.ma.us.

The METROWEST DAILY NEWS

1 Speen St., Framingham MA 01701

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Legal Notices Legal Notices

MASS GENERAL BRIGHAM INCORPORATED

LEGAL NOTICE

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AD#13934432
MWDN 1/7/21

FY22 WATER RATE HEARING
LEGAL NOTICE
NOTICE OF HEARING
TOWN OF HOLLISTON

Notice is hereby given that the Select Board will hold a public hearing on Monday January 25, 2021, at 7:00 p.m. in the Select Board's Meeting Room, Room 105 at Town Hall, 703 Washington Street, Holliston, MA to determine the water rate for fiscal year 2022. For remote participation instructions, see website at townofholliston.us.

Benjamin Sparrell
Clerk

AD#13934427
MWDN 1/7/21

FY 2022 BUDGET HEARING
LEGAL NOTICE
NOTICE OF PUBLIC HEARING
Assabet Valley Regional Vocational School District
215 Fitchburg Street
Marlborough, MA 01752-1288

On Tuesday, February 2nd, 2021, the Assabet Valley Regional Vocational School District Committee will hold a public hearing in accordance with MGL Chapter 71, Section 38N, on the FY 2022 Budget.

The hearing will be held at approximately 6:30pm in the School Committee Conference Room.

Any interested parties that would like to view the budget prior to the hearing may contact Kris Luoto, Director of Business Operations at (508) 263-9604.

AD#13934488
MWDN 1/7/21

LIC/7 POND STREET
LEGAL NOTICE
Public Hearing Notice

Notice is hereby given that the Select Board will conduct a public hearing for a request to change Sunday operating hours for Sunnyside Liquors. The current operating hours on Sunday are from 10:00 am to 8:00 pm and they are requesting to change to 10:00 am to 10:00 pm.

Sunnyside Liquors Store
7 Pond Street

The public hearing will be held on Wednesday January 20th, 2021 using Zoom. Meeting information will be posted on the agenda which can be found on the town website www.ashlandmass.com. The hearing will take place at 7:10 PM.

Persons wishing to be heard on this matter are invited to attend the public hearing by logging into the Zoom meeting. Interested parties who are unable to attend the hearing may submit written comments to the Select Board's Office, Town Hall 101 Main Street, Ashland, MA 01721 or by e-mailing Susan Robie at srobie@ashlandmass.com

Yolanda Greaves, Chair
Select Board

AD#13934575
MWDN 1/7/21

ZBA/4 MANZO WAY
LEGAL NOTICE
NOTICE OF PUBLIC HEARING
Petition #2020-13

Notice is hereby given of a Public Hearing to be held by the Hudson Zoning Board of Appeals on Thursday, January 14, 2021 at 7:00 p.m. in the Selectmen's Hearing Room, 2nd floor, Town Hall, 78 Main Street, or may be held fully remotely in accordance of the Governor of Massachusetts' March 12, 2020 Order Suspending Certain Provisions of the Open Meeting Law G.L. c. 30A, Section 20 on the following petition:

At this time the Board of Appeals will the request of Brian Lesniak and Samantha Pelosi for a special permit to construct a +/- 500 square foot Accessory Dwelling Unit at 4 Manzo Way pursuant to Section 5.2.6 of the Town of Hudson Zoning By-laws. The subject property is located in the SA-8 Zoning District, Assessors Map 12 Lot 149. The Board may consider any action deemed necessary relative to the subject petition.

All petition materials are available for review in the Town Clerk's Office during regular business hours, on the Town of Hudson website at https://www.townofhudson.org/zoning-board-appeals, and can be requested by calling (978) 562-2989 or by sending an email to kjohnson@townofhudson.org.

Jason Mauro, Clerk
Hudson Zoning Board of Appeals

AD#13933677
MWDN 12/31/20, 1/7/21

RFP - CONSULTANT SERVICES
LEGAL NOTICE
NOTICE TO PROPOSERS

Pursuant to Chapter 30B, Section 6 of the Massachusetts General Laws (M.G.L. c. 30B, §6), the Town of Natick, Natick Town Hall, 13 East Central Street, Natick, MA 01760 ("the Town"), acting through the Natick Select Board, invites the submission of sealed proposals for the procurement of consultant services for recruitment and selection of a Town Administrator in the Town of Natick. The Request for Proposals ("RFP") may be obtained from the Procurement Office, Natick Public Works, 75 West Street, Natick, MA 01760, by emailing bleblanc@natickma.org, beginning on January 11, 2021; note that emails are received by the Town of Natick Procurement Office between 8:00 A.M. and 4:00 P.M. local time, Monday through Thursday, and between 8:00 A.M. and 12:00 P.M. (noon) local time, Friday. Ten (10) copies of each sealed Proposal, contained in separately sealed envelopes marked, respectively, "RFP: Consultant Services for Recruitment and Selection of a Town Administrator in the Town of Natick – Price Proposal" and "RFP: Consultant Services for Recruitment and Selection of a Town Administrator in the Town of Natick – Non-Price Proposal" will be received until **11:00 A.M. local time, January 26, 2021**, at the Procurement Office, Natick Public Works, 75 West Street, Natick, MA 01760, at which time and place all Proposals will be opened. Proposers shall also include an electronic copy of their non-price proposal in the non-price proposal envelope. All Proposals shall comply with the RFP issued by the Town of Natick, including, without limitation, Section I. Introduction, and Section IV. Proposal Submission Requirements. The Town reserves the right to waive any informality in or to reject any, any part of, or all Proposals in the best interest of the Town. Any Proposal submitted will be binding for sixty (60) days subsequent to the deadline date for receipt of sealed Proposals. Award of a contract shall be subject to appropriation and shall be subject to vote by the Natick Select Board.

AD#13934383
MWDN 1/7/21

RFP 2021-01
LEGAL NOTICE
ASHLAND PUBLIC SCHOOLS
REQUEST FOR PROPOSALS
For Analysis and Report of District Wide Communication Strategies/Effectiveness

Contract # 2021-01

RFP is available after January 7, 2021 8:00 AM
Contact: Christopher Mathieu for a copy of the RFS
Cmathieu@ashland.k12.ma.us phone: 508 532 4006

Submission deadline: January 22, 2021 – 4:00 PM

Scope: February 2021-March 2021 the Successful bidder will conduct meetings with the Superintendent, School Committee and other stakeholders to ascertain the vision, strategic plan and political landscape facing the Ashland Public Schools. Two Community Forums will be conducted to gather information from residents and a final report with recommendations to be presented to the Ashland School Committee in April 2021.

Proposals shall be addressed to: Mr. Christopher Mathieu, Director of Finance and Operations, Ashland Public Schools, 87 West Union Street, Ashland, MA 01721

Awarding authority: Ashland Public Schools

The Ashland Public Schools reserves the right to reject any and all proposals, and to make awards deemed in the best interest of the District.

AD#13934585
MWDN 1/7/21

MORRELL
LEGAL NOTICE
Commonwealth of Massachusetts
The Trial Court
Probate and Family Court
Middlesex Division
Docket No. MI20P5796EA

INFORMAL PROBATE PUBLICATION NOTICE

Estate of: Eileen Morrell

Date of Death: September 09, 2020

To all persons interested in the above captioned estate, by Petition of

Petitioner **Nicholas P. Morrell** of **West Roxbury MA**

Nicholas P. Morrell of **West Roxbury MA** has been informally appointed as the Personal Representative of the estate to serve without surety on the bond.

The estate is being administered under informal procedure by the Personal Representative under the Massachusetts Uniform Probate Code without supervision by the Court. Inventory and accounts are not required to be filed with the Court, but interested parties are entitled to notice regarding the administration from the Personal Representative and can petition the Court in any matter relating to the estate, including distribution of assets and expenses of administration. Interested parties are entitled to petition the Court to institute formal proceedings and to obtain orders terminating or restricting the powers of Personal Representatives appointed under informal procedure. A copy of the Petition and Will, if any, can be obtained from the Petitioner.

AD#13934596
MWDN 1/7/21

SCANLON
LEGAL NOTICE
Commonwealth of Massachusetts
The Trial Court
Probate and Family Court
Middlesex Division
Docket No. MI20P5481EA

INFORMAL PROBATE PUBLICATION NOTICE

Estate of: Sandra Anne Scanlon

Also Known As: Sandra A. Scanlon

Date of Death: October 21, 2020

To all persons interested in the above captioned estate, by Petition of

Petitioners **Julie S. Curtis** of **Lithia FL** and **Timothy J. Scanlon** of **Orangevale CA**

a Will has been admitted to informal probate.

Julie S. Curtis of **Lithia FL** and **Timothy J. Scanlon** of **Orangevale CA** have been informally appointed as the Personal Representatives of the estate to serve without surety on the bond.

The estate is being administered under informal procedure by the Personal Representative under the Massachusetts Uniform Probate Code without supervision by the Court. Inventory and accounts are not required to be filed with the Court, but interested parties are entitled to notice regarding the administration from the Personal Representative and can petition the Court in any matter relating to the estate, including distribution of assets and expenses of administration. Interested parties are entitled to petition the Court to institute formal proceedings and to obtain orders terminating or restricting the powers of Personal Representatives appointed under informal procedure. A copy of the Petition and Will, if any, can be obtained from the Petitioner.

AD#13934446
MWDN 1/7/21

KORSMAN
LEGAL NOTICE
Commonwealth of Massachusetts
The Trial Court
Probate and Family Court
Middlesex Probate and Family Court
208 Cambridge Street
Cambridge, MA 02141
(617) 768-5800
Docket No. MI20P5737EA

CITATION ON PETITION FOR FORMAL ADJUDICATION

Estate of: Pamela Dianne Korsman
Also known as: Pamela Korsman, Pamela D. Korsman

Date of Death: 06/29/2020

To all interested persons:

A Petition for **Formal Adjudication of Intestacy and Appointment of Personal Representative** has been filed by **Gail G. Korsman** of **Pepperell MA** requesting that the Court enter a formal Decree and Order and for such other relief as requested in the Petition.

The Petitioner requests that: **Gail G. Korsman** of **Pepperell MA** be appointed as Personal Representative of said estate to serve **Without Surety** on the bond in **an unsupervised** administration.

IMPORTANT NOTICE

You have the right to obtain a copy of the Petition from the Petitioner or at the Court. You have a right to object to this proceeding. To do so, you or your attorney must file a written appearance and objection at this Court before: 10:00 a.m. on the return day of 01/21/2021.

This is NOT a hearing date, but a deadline by which you must file a written appearance and objection if you object to this proceeding. If you fail to file a timely written appearance and objection followed by an affidavit of objections within thirty (30) days of the return day, action may be taken without further notice to you.

UNSUPERVISED ADMINISTRATION UNDER THE MASSACHUSETTS UNIFORM PROBATE CODE (MUPC)

A Personal Representative appointed under the MUPC in an unsupervised administration is not required to file an inventory or annual accounts with the Court. Persons interested in the estate are entitled to notice regarding the administration directly from the Personal Representative and may petition the Court in any matter relating to the estate, including the distribution of assets and expenses of administration.

WITNESS, Hon. Maureen H Monks, First Justice of this Court.

Date: December 24, 2020

Tara E. DeCristofaro
Register of Probate

AD#13934592
MWDN 1/7/21

Ann McElhinney stands at the edge of her property at 12 Carriage House Way in Medway, which abuts a proposed 1.5 million-square-foot warehouse project at the end of Hopping Brook Road in Holliston. [KEN MCGAGH/DAILY NEWS STAFF]

Unkindest cut in Holliston

Tree work linked to warehouse project draws ire of Medway neighbors

By Lauren Young
The Milford Daily News
USA TODAY NETWORK

A cleared area at the end of Hopping Brook Road in Holliston, where a developer plans a 1.5 million-square-foot warehouse, Jan. 5, 2020. [KEN MCGAGH/DAILY NEWS STAFF]

MEDWAY — Five months ago, Ann McElhinney's backyard faced a wooded forest with thousands of trees. Now, she looks out to a barrier of clear-cut trees bordered by orange netting a few steps from her property line.

She estimates that hundreds, if not thousands, of trees were cut down along the Holliston line, which abuts her backyard, for a project being developed by CRG Integrated Real Estate Solutions at 555 Hopping Brook Road in Holliston. The tree-cutting started in late September and significant damage was done within two days, she said.

Up to 10,000 trees may be cut down, according to the original site plans for the project, which is estimated to cost $100 million.

The project features three warehouses, comprising a total of nearly 1.5 million square feet. The plan is for them to open later this year and be in operation 24/7. They're estimated to generate nearly 1,500 total truck trips each weekday.

But no permit was obtained to cut those trees in her backyard, said McElhinney, adding that it only stopped when the town of Holliston found out, and issued a cease-and-desist letter.

"They were clearing the trees like toothpicks — it happened so fast, and there was nothing the town of Holliston could do to stop them until two days worth of trees were cut down," she said.

According to the cease-and-desist letter, signed by Planning Board Chairman David Thorn and dated Sept. 28, Town Planner Karen Sherman and Conservation Agent Ryan Clapp visited the property and found that "substantial tree cutting" had been done. Sherman informed the project's civil engineer, Peter Bemis of Southborough-based Engineering Design Consultants Inc., that it was in violation of the town's Stormwater and Land Disturbance By-Law, which is in place to control the adverse impacts of increased post-development stormwater runoff.

Michael Milanoski, representing the landowner (New Hopping Brook Trust), confirmed to Holliston officials that trees were being cut, but told them it wasn't related to the development. Instead, he said, it was to cut, harvest and sell lumber.

When the Holliston town counsel spoke with the project's lawyer, Richard Nylen, his narrative conflicted with Milanoski's, wrote Thorn. Nylen said the tree work was part of the project — but that it didn't require a permit, wrote Thorn.

"His rationale was that clear-cutting the site but not removing the tree stumps was a loophole that does not invoke the permit," wrote Thorn in the cease-and-desist letter.

If what Milanoski said is true, provisions of the Massachusetts Forest Cutting Practices Act may still apply and no work may proceed until complying local and state approvals are received, wrote Thorn.

"While Attorney Nylen has claimed that removal of trees without removing the stumps serves as a loophole to exempt these activities, such a claim is clearly erroneous," wrote Thorn.

When tree-cutting resumed shortly afterward, the town issued an emergency restraining order to halt it. The fallen trees remain, as the developer seeks to earn a land-clearing permit for the project.

Another question remains: Who the tenant for these warehouses will be.

"They're saying, 'Well, it's definitely not Amazon,'" said McElhinney. "That's fine, but if it's someone like Amazon, then it's the same problem."

'All along the Medway line'

On Tuesday afternoon, McElhinney faced those fallen trees in the backyard of the Medway home she's owned with her husband since 2009. A few steps from her property line is a bright yellow sign nailed to a tree, warning of private property.

"They made a point of doing it all along the Medway line here," she said of the tree cutting and signs.

McElhinney and six of her neighbors have filed a lawsuit against the developer, whose initial site plan was approved last March.

She wouldn't say much about the lawsuit, other than it was filed shortly after she and other residents heard the project's height variance application for its two biggest buildings was approved in June, and wanted to appeal.

McElhinney said she received a letter about a meeting discussing that height variance in June. It was the first time she, and most other residents, had learned of the project, she said. Shortly after that meeting, the variance was approved.

"If we didn't (file the lawsuit), everything would've been in a nice little bow by December as they had hoped," she said. "I'm very thankful as a neighborhood we acted fast and came together to say, 'We need to get more information on this — we can't be railroaded."

A representative from CRG said Wednesday that the firm is declining to comment on the lawsuit and tree-cutting.

McElhinney said neighbors are also worried about environmental impacts, such as pollution stemming from the project and an increase in truck traffic.

During a Planning Board meeting in November, Bemis said no massive increase in traffic is expected from the project, and that traffic is not expected on South Street, a particularly narrow road. The developer would also cooperate in mitigating traffic, he said, and will discourage truckers from using that road in its lease.

The project will be discussed during the next Holliston Planning Board meeting at 7 p.m. Thursday via Zoom. The board is interested in seeing noise and traffic peer reviews for the project.

Lauren Young writes about politics, social issues and covers the town of Franklin. Reach her at 774-804-1499 or lyoung@wickedlocal.com. Follow her on Twitter @laurenwhy__.

A "No Trespassing" sign is posted off Carriage House Way in Medway at the edge of the proposed 1.5 million-square-foot warehouse project at 555 Hopping Brook Road in Holliston, Jan. 5, 2020. [KEN MCGAGH/DAILY NEWS STAFF]

Attachment 11

Massachusetts Department of Public Health
Determination of Need
Affidavit of Truthfulness and Compliance with Law and Disclosure Form 100.405(B)

Version: 7-6-17

Instructions: Complete Information below. When complete check the box "This document is ready to print:". This will date stamp and lock the form. Print Form. Each person must sign and date the form. When all signatures have been collected, scan the document and e-mail to: **dph.don@state.ma.us** Include all attachments as requested.

Application Number: 21012113-AS

Original Application Date: 1/21/2021

Applicant Name: Mass General Brigham Incorporated

Application Type: Ambulatory Surgery, Clinic Substantial Capital Expenditure, and DoN-Required Equipment

Applicant's Business Type: (•) Corporation ( ) Limited Partnership ( ) Partnership ( ) Trust ( ) LLC ( ) Other

Is the Applicant the sole member or sole shareholder of the Health Facility(ies) that are the subject of this Application? (•) Yes ( ) No

The undersigned certifies under the pains and penalties of perjury:

1. The Applicant is the sole corporate member or sole shareholder of the Health Facility[ies] that are the subject of this Application;
2. I have* ~~read~~ 105 CMR 100.000, the Massachusetts Determination of Need Regulation;
3. I understand and agree to the expected and appropriate conduct of the Applicant pursuant to 105 CMR 100.800;
4. I have* ~~read~~ this application for Determination of Need including all exhibits and attachments, and** ~~certify that~~ all of the information contained herein is accurate and true;
5. I have submitted the correct Filing Fee and understand it is nonrefundable pursuant to 105 CMR 100.405(B);
6. I have submitted the required copies of this application to the Determination of Need Program, and, as applicable, to all Parties of Record and other parties as required pursuant to 105 CMR 100.405(B);
7. I have caused, as required, notices of intent to be published and duplicate copies to be submitted to all Parties of Record, and all carriers or third-party administrators, public and commercial, for the payment of health care services with which the Applicant contracts, and with Medicare and Medicaid, as required by 105 CMR 100.405(C), et seq.;
8. I** ~~have caused~~ proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR 100.405(E) and 301 CMR 11.00; will be made if applicable.
9. If subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00, I have submitted such Notice of Material Change to the HPC - in accordance with 105 CMR 100.405(G);
10. Pursuant to 105 CMR 100.210(A)(3), I certify that both the Applicant and the Proposed Project are in material and substantial compliance and good standing with relevant federal, state, and local laws and regulations, as well as with all ~~previously issued~~ Notices of Determination of Need*** ~~and the terms and Conditions attached therein;~~
11. I have read and understand the limitations on solicitation of funding from the general public prior to receiving a Notice of Determination of Need as established in 105 CMR 100.415;
12. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions pursuant to 105 CMR 100.310, as well as any applicable Other Conditions as outlined within 105 CMR 100.000 or that otherwise become a part of the Final Action pursuant to 105 CMR 100.360;
13. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and
14. Pursuant to 105 CMR 100.705(A), I certify that the Proposed Project is authorized under applicable zoning by-laws or ordinances, whether or not a special permit is required; or,
    a. If the Proposed Project is not authorized under applicable zoning by-laws or ordinances, a variance has been received to permit such Proposed Project; or,
    b. The Proposed Project is exempt from zoning by-laws or ordinances.

Corporation:

Attach a copy of Articles of Organization/Incorporation, as amended

Anne Klibanski, M.D.		1/20/2021
President and CEO for Corporation Name:	Signature:	Date
Scott M. Sperling		
Board Chair for Corporation Name:	Signature:	Date

* been informed of the contents of

** have been informed that

***issued in compliance with 105 CMR 100.00, the Massachusetts Determination of Need Regulation effective January 27, 2017 and amended December 28, 2018

Massachusetts Department of Public Health
Determination of Need
Affidavit of Truthfulness and Compliance with Law and Disclosure Form 100.405(B)

Version: 7-6-17

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3. I understand and agree to the expected and appropriate conduct of the Applicant pursuant to 105 CMR 100.800;
4. I have* ~~read~~ this application for Determination of Need including all exhibits and attachments, and** ~~certify that~~ all of the information contained herein is accurate and true;
5. I have submitted the correct Filing Fee and understand it is nonrefundable pursuant to 105 CMR 100.405(B);
6. I have submitted the required copies of this application to the Determination of Need Program, and, as applicable, to all Parties of Record and other parties as required pursuant to 105 CMR 100.405(B);
7. I have caused, as required, notices of intent to be published and duplicate copies to be submitted to all Parties of Record, and all carriers or third-party administrators, public and commercial, for the payment of health care services with which the Applicant contracts, and with Medicare and Medicaid, as required by 105 CMR 100.405(C), et seq.;
8. I** ~~have caused~~ proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR 100.405(E) and 301 CMR 11.00; will be made if applicable.
9. If subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00, I have submitted such Notice of Material Change to the HPC - in accordance with 105 CMR 100.405(G);
10. Pursuant to 105 CMR 100.210(A)(3), I certify that both the Applicant and the Proposed Project are in material and substantial compliance and good standing with relevant federal, state, and local laws and regulations, as well as with all ~~previously issued~~ Notices of Determination of Need*** ~~and the terms and Conditions attached therein;~~
11. I have read and understand the limitations on solicitation of funding from the general public prior to receiving a Notice of Determination of Need as established in 105 CMR 100.415;
12. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions pursuant to 105 CMR 100.310, as well as any applicable Other Conditions as outlined within 105 CMR 100.000 or that otherwise become a part of the Final Action pursuant to 105 CMR 100.360;
13. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and
14. Pursuant to 105 CMR 100.705(A), I certify that the Proposed Project is authorized under applicable zoning by-laws or ordinances, whether or not a special permit is required; or,
    a. If the Proposed Project is not authorized under applicable zoning by-laws or ordinances, a variance has been received to permit such Proposed Project; or,
    b. The Proposed Project is exempt from zoning by-laws or ordinances.

Corporation:

Attach a copy of Articles of Organization/Incorporation, as amended

Anne Klibanski, M.D.		
President and CEO for Corporation Name:	Signature:	Date
Scott M. Sperling		1/20/2021
Board Chair for Corporation Name:	Signature:	Date

* been informed of the contents of

** have been informed that

***issued in compliance with 105 CMR 100.00, the Massachusetts Determination of Need Regulation effective January 27, 2017 and amended December 28, 2018

Attachment 12

Mass General Brigham

Real Estate and Facilities
399 Revolution Drive – 13E58
Somerville, MA 02145-1446
T 857 282 2331
M 617 861 5363
F 857 282 5949

Robert Seymour
Administration and Finance Director
Bureau of Health Professions Licensure
Bureau of Health Care Safety and Quality
MA Department of Public Health
67 Forest Street
Marlborough, MA 01752

21 January 2021

Dear Mr Seymour:

RE: DoN Filing Reference Number is: 21012113-AS

MGB filed DoN applications yesterday under the above reference number.
Enclosed is the DoN filing fee in the amount of $447,449.

Best regards,

John Messervy, AIA

Corporate Director, Design and Construction

Encl.: MGB Check #[redacted]

DATE						CHECK NO
01/08/2021						0006300136
VOUCHER	INVOICE NUMBER	INVOICE DATE	PO NUMBER	GROSS AMOUNT	DISCOUNT	NET AMOUNT
30878884	PERMIT-FEES-01072021	01/07/2021		447,449.00	0.00	447,449.00

MM Client Services (617) 726-2142	AP	0400	PA1001	782128	TOTAL AMOUNT		DISCOUNT	NET AMOUNT
					447,449.00		0.00	447,449.00

To Remove Document Fold and Tear Along This Perforation

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

PARTNERS HealthCare

Bank of America, N.A.
South Portland,ME

52-153
112 ME

DATE
01/08/2021

[redacted]

AMOUNT
$447,449.00

PAY **Four Hundred Forty-Seven Thousand Four Hundred Forty-Nine and 00/100 Dollars**

TO THE ORDER OF
COMMONWEALTH OF MASSACHUSETTS
250 WASHINGTON STREET, 4TH FLOOR
DEPARTMENT OF PUBLIC HEALTH
BOSTON MA

Peter K. Markell

AUTHORIZED SIGNATURE

VOID IF NOT CASHED WITHIN 90 DAYS

[redacted]

See Reverse Side For Easy Opening Instructions

PARTNERS P.O. Box 9127
Boston, MA 02129-9127

COMMONWEALTH OF MASSACHUSETTS
250 WASHINGTON STREET, 4TH FLOOR
DEPARTMENT OF PUBLIC HEALTH
BOSTON MA 02108