2024-2026

Community Health Needs Assessment

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INTENT STATEMENT

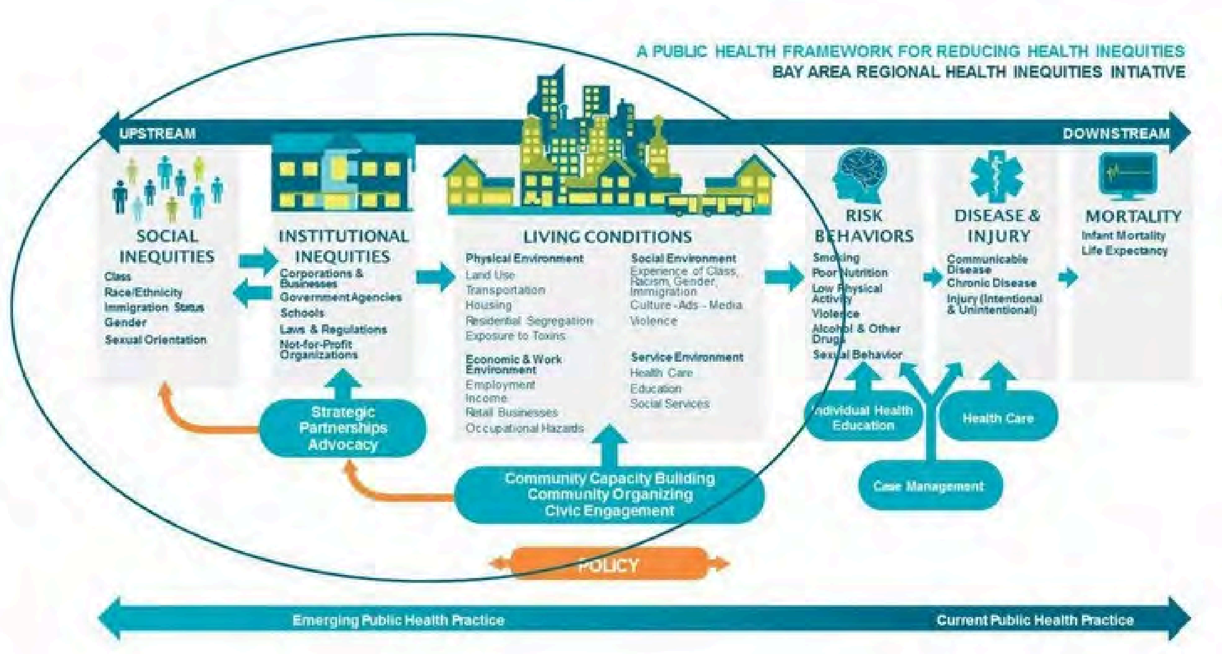
This 2024-2026 Community Health Needs Assessment (CHNA) is a collaborative effort between UMass Memorial Health - HealthAlliance-Clinton Hospital and Heywood Healthcare. Its aim is to gain a greater understanding of the unmet health and social services needs that residents of our Combined Service Area face as well as how those needs are currently being addressed and where there are gaps and opportunities to address those needs in the future.

The CHNA process synthesized statistics from secondary sources like the US Census Bureau, the Massachusetts Department of Public Health, and the participating hospital systems with qualitative information gathered through pre-existing surveys of local residents and Focus Groups of stakeholders from across the hospitals' service areas. This comprehensive, integrative process resulted in the identification of specific "areas of focus" and "priority populations" for the hospitals to address through their Community Benefits work.

Throughout the CHNA process and the writing of this report, special attention is paid to issues of ***Health-Related Social Needs*** (or Social Determinants of Health (SDOH)) and their impact on ***health disparities*** and ***health equity.***

Health-Related Social Needs are conditions in the places where people live, learn, work, and play that affect a wide range of health outcomes. According to the World Health Organization [1], research has shown up to half of all health outcomes are influenced by non-clinical factors like access to nutritious food, reliable transportation, quality housing, and financial stability. As a result, and in keeping with the Centers for Medicare & Medicaid Services' (CMS) new guidelines mandating that hospitals screen for SDOH, HealthAlliance-Clinton Hospital and Heywood Healthcare are increasingly recognizing the critical role of addressing Health-Related Social Needs in community health, particularly for members of traditionally marginalized communities.

While hospitals have always focused on caring for their communities both inside the hospital and through Community Benefits work, the new CMS requirements mandate that hospitals better connect patients with community-based resources and participate in "upstream" and "midstream" efforts to reduce negative health outcomes.



Source: May Area Regional Health Inequities Initiative. BARHII Framework. Accessed July 2024 at: https://barhii.org/framework

The Bay Area Regional Public Health Framework for Reducing Health Inequities (the BARHII Framework) [2] is a pathway for health that involves people and communities. The far right of the graphic represents the "*downstream"* part of the health pathway, where the traditional medical model of treating disease focuses. While interventions here are crucial, HealthAlliance-Clinton Hospital and Heywood Healthcare recognize the importance of involving our communities in health improvement efforts further upstream to prevent disease. Some strategies, often called "*midstream*" strategies, include prevention efforts focusing on individual risk and supporting behavior change. Other strategies move further "*upstream"* and address the policy, systems, and environments impacting health outcomes for entire populations exposed to them. All the way upstream, on the far left, are the structural drivers of health: institutional and social inequities like structural racism and the inequitable distribution of power, money, opportunity, and resources. The farthest left is the "*groundwater*," referring to the policies and interconnected systems perpetuating inequities.

An example of the BARHII Framework in action locally is the HEAL Collaborative (Hope, Empower, Access, and Love), a community movement spearheaded by Heywood Hospital aimed at impacting change at the groundwater-level to improve the health and quality of life for residents of Winchendon and Gardner. HEAL focuses on three pillars:

1. Social inclusion: Strengthening community bonds and ensuring everyone has a voice;
2. Healthy Food Access: Guaranteeing equitable access to nutritious food options; and
3. Economic Empowerment: Fostering economic growth and opportunities for all residents.

HEAL brings together community residents, youth leaders, municipalities, businesses, and organizations to make a change, connecting those who traditionally hold power with those who may have been excluded. By fostering social inclusion, redistributing power, and ensuring a lasting collective impact, HEAL is committed to holistically reshaping our communities, and creating hope for the future.

The HEAL Collaborative Steering Committee
The Steering Committee is the backbone of the HEAL Collaborative work, comprised of Youth and Resident leaders working in partnership with anchor institutions including Heywood Hospital, Growing Places, Gardner and Winchendon Public Schools, City of Gardner, Town of Winchendon, Gardner and Winchendon CAC's, CHNA9 and Three Pyramids. Here, the Steering Committe celebrates the newly established "Community Hub" in Winchendon.

Youth Changemakers
At the United Way Youth Venture Spring Showcase at Great Wolf Lodge, the Youth Changemakers present their initiatives to drive policy and systems change by establishing a Town Youth Advisory Council and launching the Sunshine Café and The Crib. These efforts aim to foster job skills, mental health, and belonging among youth in Winchendon and Gardner. They were honored with the "Changemaker of the Year" award by UWYV!

Another example of the BARHII Framework implemented locally is The North Central Mass Anchor Collaborative. This initiative, coordinated by the Health Equity Partnership of North Central MA engages institutions from multiple sectors to address systemic inequities and strengthen the local economic ecosystem by more intentionally aligning and leveraging their assets, purchases, and investments. With DoN funding from HealthAlliance Clinton Hospital, the two hospital systems have joined with the community health center, education institutions, and large social service organizations in the region along with partners in planning and workforce development to open up access to training and jobs through better supports like childcare and transportation. The Anchor Collaborative partners have also committed to purchasing more local produce for their cafeterias and services, which supports approximately 30 local farms and food businesses. As the institutions make small changes to hire, buy, and invest locally, the impact on the region's economy is multiplied. Small businesses succeed and expand, more people gain access to living wage jobs, and ultimately, more people will choose to live and work in our region.

HealthAlliance-Clinton Hospital and Heywood Healthcare have made great strides in partnering with local organizations to form robust networks that address SDOH comprehensively. However, to further enhance impact, it is essential to actively engage community leaders and other partners. By collaborating with a diverse array of stakeholders—including business leaders, educational institutions, and faith-based organizations—hospitals can develop more comprehensive strategies that address economic inequities and promote overall health.

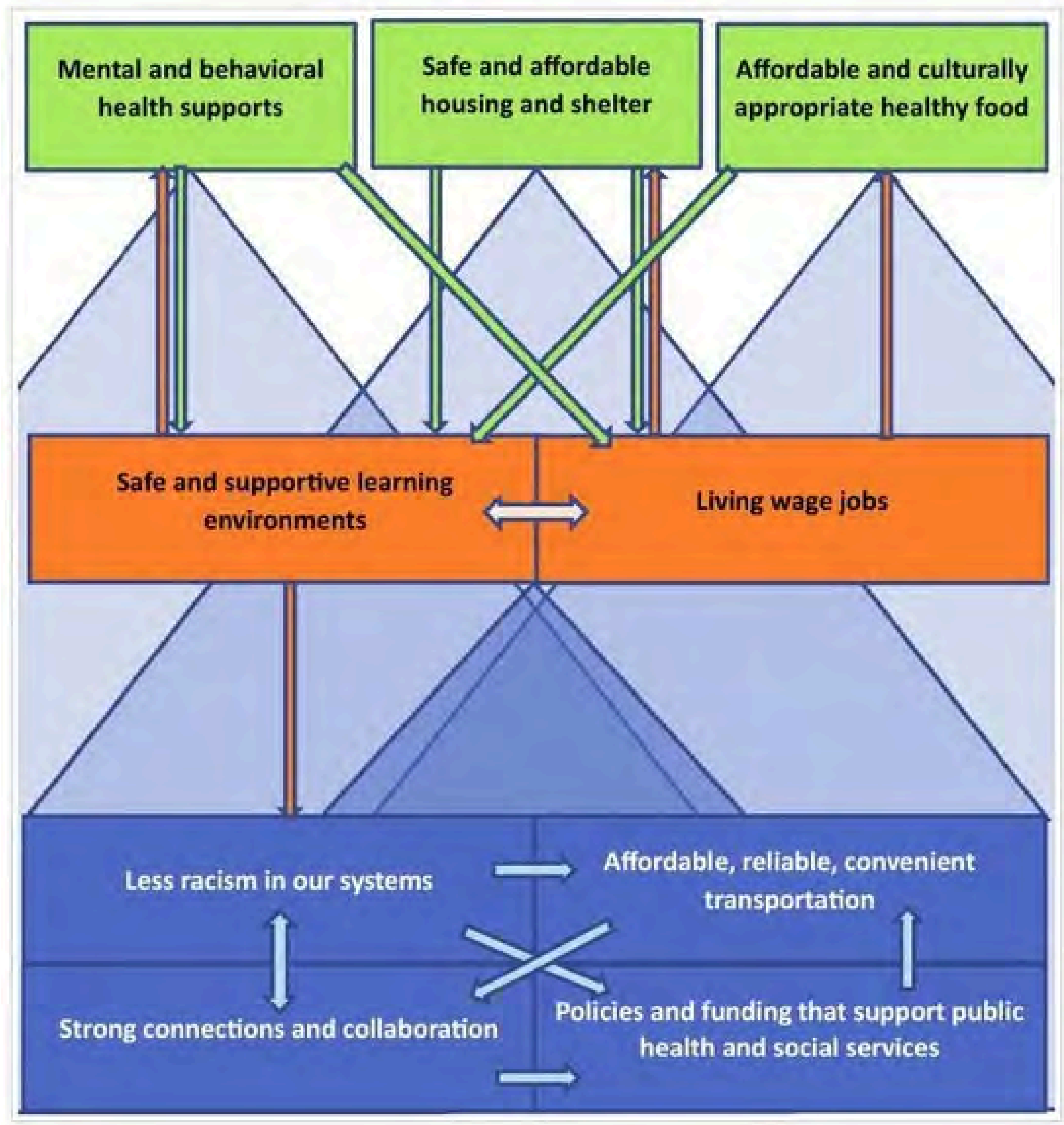
In advancing these efforts, it is crucial to prioritize intergenerational well-being and equity, using a lens of racial and economic justice. This approach ensures that the benefits of health initiatives are experienced by individuals of all ages and backgrounds, addressing long standing disparities that affect marginalized communities. By focusing on racial and economic justice, the partner hospitals can create a more inclusive healthcare system that acknowledges and works to rectify the systemic inequities that contribute to poor health outcomes.

Together, HealthAlliance-Clinton Hospital and Heywood Healthcare can drive significant improvements in community health by leveraging the strengths of various partners and creating a united front against the social determinants that negatively impact health. This collective effort not only enhances individual well-being but also fosters a more equitable and thriving community for all, ensuring a healthier future for generations to come.

Furthermore, it is the hope and commitment of HealthAlliance-Clinton Hospital and Heywood Healthcare that this Community Health Needs Assessment acts as a foundation for a larger conversation on how the partner hospitals can work with the community to improve the overall health and well-being of the region. In fact, this Community Health Needs Assessment report is intended to be a tool to inform local residents, government officials, businesses, community organizations, and other relevant stakeholders of the health status of their communities and to provide critical data to inform broad efforts around strategic planning, resource allocation, andpolicy-making with the ultimate goal of improving the health and well-being of all residents in the region (See Appendix A for a list of Regional Partners and Community Resources).

Health Equity Partnership of North Central Massachusetts' (CHNA9) North Central MA Community Health Improvement Plan (CHIP) is a primary example of how the hospitals' Community Health Needs Assessments inform regional efforts. The CHIP was first written in 2016-2017, utilizing data from the HealthAlliance-Clinton Hospital and Heywood Healthcare's Community Health Needs Assessments. At the time, CHNA9 brought together over 100 regional stakeholders to analyze the hospitals' data within a Social Determinants of Health framework. From the analysis, long-term priority areas were developed: Healthy Food Access, Healthy and Safe Relationships, Mental and Behavioral Health, Transportation, Housing, the Built Environment, and Racial and Social Justice. Further, multi-sector interdisciplinary working groups were established. These working groups include hospital leadership and staff and continue to this day to build capacity and collaboration at the systems level and to engage residents, organizations, and institutions in policy advocacy, awareness, and fundraising.

As needs have evolved over time, CHNA9 continues to convene partners and incubate collaborative solutions through the CHIP process. Most recently, the CHNA9 facilitated a causal analysis with over 160 participants in 15 small groups throughout the region. The results indicate that the conditions for wellbeing (i.e., mental and behavioral health supports, safe and affordable housing and shelter, and affordable and culturally appropriate healthy food) as well as the learning and working environments in which our residents spend the majority of their time, all function best when there is a strong foundation of anti-racist systems; affordable, reliable, and convenient transportation; policies and funding that support public health and social services; and strong connections and collaborations.



Source: The North Central MA Community Health Improvement Plan. Results of 2023 Community Charrettes. Accessed July 2024 at: https://www.chna9.org/31/Initiatives

Through initiatives like the North Central MA CHIP, the hospitals' Community Health Needs Assessment process is extended beyond the two healthcare systems, serving as a critical foundation for aligning regional efforts to improve the overall health and well-being of the residents of North Central MA.

OUR PARTNERS

UMass Memorial Health - HealthAlliance-Clinton Hospital is a full-service, not-for-profit, regional community hospital licensed for 138 beds. With campuses in Clinton, Fitchburg, and Leominster, HA-C's primary service area includes Ashburnham, Ashby, Bolton, Clinton, Fitchburg, Gardner, Harvard, Lancaster, Leominster, Lunenburg, Princeton, Sterling, Townsend, and Westminster.

HA-C has more than 550 physicians across nearly 50 health care specialties and offers a full complement of services, including two emergency departments and an urgent care, state-of-the- art diagnostic imaging, dialysis, laboratory, palliative care, surgery, and in-patient hospice care. In addition, HA-C operates the Simonds-Sinon Regional Cancer Center as well as the HealthAlliance Home Health and Hospice agency.

HA-C is part of the UMass Memorial Health system, the largest health and wellness partner of the people of Central Massachusetts. As the clinical partner of the UMass Chan Medical School, the UMMH system has access to the latest technology, research and clinical trials.

For more information, please visit our website:
https://www.ummhealth.org/healthalliance-clinton-hospital

Heywood Healthcare is an independent, community owned healthcare system dedicated to providing quality healthcare services to the residents of North Central Massachusetts. Heywood Healthcare is governed by a local community Board of Trustees and employs over 1400 residents of the region. The Medical Staff includes 200+ active, courtesy, and consulting physicians in primary care and a multitude of specialties. Heywood Healthcare is comprised of two hospitals: Athol Hospital and Heywood Hospital.

Athol Hospital is a 21-bed Critical Access, non-profit acute care hospital serving the nine communities of the North Quabbin Region. The hospital's service area includes the towns of Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, and Wendell.

The Athol Hospital campus features acute care treatment facilities, including: 24-hour emergency rooms, and a Swing Bed program, which transitions beds from acute care to sub-acute care to accommodate the rehabilitation needs of recovering patients.

Outpatient Services includes on-site cardiac specialists, high tech laboratory, radiology, cardiopulmonary testing, and a short-stay unit.

Heywood Hospital is a non-profit community-owned hospital licensed for 134 beds located in Gardner, Massachusetts. Heywood Hospital's primary service area includes the City of Gardner and the towns of Ashburnham, Hubbardston, Templeton, Westminster, and Winchendon.

Heywood offers medical surgery, specializing in bariatrics and orthopedics, and services including telemetry and intensive care, emergency care, maternity and pediatrics, geriatric and adult inpatient care, inpatient adult mental health, outpatient oncology and hematology, advanced imaging, special procedures, rehabilitation services and many others on an inpatient and outpatient basis.

Heywood Healthcare also includes Heywood Medical Group, Heywood Rehabilitation, Winchendon Health Center and the Murdock School-based Health Center in Winchendon, and Athol Community Elementary School-based Health Center and Tully Family Medicine and Walk-in in Athol. In addition, the organization includes the Heywood Healthcare Charitable Foundation.

For more information, please visit our websites:
Athol Hospital: http://www.atholhospital.org and Heywood Hospital: http://www.heywood.org

Health Equity Partnership of North Central Massachusetts (CHNA9) is one of 27 Community Health Network Areas delineated by the Department of Public Health in 1992 as an initiative to improve public health through local collaboration. These community coalitions play a critical role in civic engagement, organizing advocacy efforts, community-based health promotion, and convening multisector partners to design and implement strategies that address complex systemic disparities. CHNA9 serves 27 communities, from Winchendon in the northwest to Berlin in the southeast. The Partnership's mission is to bring together voices to promote health equity in all their communities.
For more information, please visit our website:
https://www.chna9.org

Three Pyramids/The Minority Coalition is a state-certified minority-led community and economic development corporation founded in 1971. It has a mission to promote equal opportunity, personal responsibility, and social justice by empowering people of color, women, children, and families through social, cultural, political, and economic means.

Founded in 1969 by Cape Verdeans, African Americans, and Native Americans in Duxbury on Cape Cod, Three Pyramids has operated community development projects in Massachusetts and Africa for over 51 years. The agency focuses on empowering individuals to take control of their lives.

Despite controversy, Three Pyramids has consistently taken public stands on social and racial justice issues. Its commitment to social, cultural, and economic justice has garnered support from education, government, business, and other community-based institutions. The agency is known for its collaborative approach, advocacy, and empowerment of its constituents through volunteerism.

ACKNOWLEDGEMENT

We extend our heartfelt gratitude to all those who contributed to the successful execution of this Community Health Needs Assessment (CHNA). This collaborative effort, spearheaded by UMass Memorial Health HealthAlliance-Clinton Hospital and Heywood Healthcare, was made possible through the dedicated contributions and invaluable support of numerous individuals and organizations.

We express our sincere appreciation to ***Health Equity Partnership of North Central Massachusetts (CHNA9)*** for their invaluable contributions and insights throughout the development process. Their expertise and partnership were instrumental in shaping the framework of our focus groups and ensuring the inclusivity and relevance of our approach as well as holding us accountable for a process and output that centers local voices. Additionally, we extend our gratitude to ***Three Pyramids/The Minority Coalition*** for their pivotal role in helping to center local voices and diverse perspectives. Their dedication to promoting inclusivity and social justice has been integral to the success of our community health needs assessment.

We also extend our thanks to ***Health Resources in Action (HRiA)*** for their guidance around inclusion and analysis of secondary data. Their commitment to health equity and to centering local community knowledge as well as their meticulous approach in structuring the secondary data provided a solid foundation for our assessment, enriching our understanding of the health landscape in North Central Massachusetts.

A key partner in the Community Health Needs Assessment process was ***Catherine Apostoleris.*** A Nationally Certified Results Oriented Management & Accountability (NCRI) professional with more than 15 years of experience in assessing community needs, Catherine played a crucial role in pulling together the various elements of the assessment and creating both the written document and the online living version hosted on ***mySidewalk***. Her extensive experience in developing needs-based strategic plans and monitoring progress through accountability measures ensured a comprehensive and actionable assessment, tailored to address the specific health needs of the Combined Service Area.

Furthermore, we express our gratitude to all the community-based organizations that actively participated in the gathering of lived experiences:

- YWCA of Central Massachusetts (Leominster)
- Health Equity Partnership of North Central Massachusetts (CHNA9) Youth Advisory Council
- Winchendon Council on Aging
- Winchendon Community Action Committee
- Townsend Public Library
- Nashoba Associated Boards of Health

- 19 Carter Community Center
- LUK, Inc.
- NewVue Communities
- Montachusett Veterans Outreach Council
- Making Opportunity Count, Inc.
- St. Joseph's House
- Beautiful Gate Church of God in Christ
- Three Pyramids/North Central Minority Coalition
- Ahmadiyya Muslim Community
- Pathways for Change
- Healthcare Access & Outreach Needs

Your dedication to amplifying the voices of our communities and addressing health-related social needs is commendable and deeply appreciated.

We also acknowledge the support of individuals within HealthAlliance-Clinton Hospital, Heywood Healthcare, and other partnering institutions who provided resources, guidance, and encouragement at every stage of this assessment. We particularly want to thank our community partners who willingly shared the results of their own community needs assessments. These provided valuable primary and secondary data as well as additional context about our communities' needs, strengths, and hopes for the future of the region.

- Making Opportunity Count, Inc.'s 2023 *Community Needs Assessment*
- Community Action Pioneer Valley's 2023 *Community Needs Assessment*
- Mount Wachusetts Community College's *2022/2023-2026/2027 Strategic Plan*
- North Central Massachusetts' Chamber of Commerce's *Engaging Hidden and Future Workers to Grow the Local Economy (2022)*
- *LifePath and Franklin Regional Council of Government's Age- and Dementia-Friendly Franklin County and North Quabbin Regional Action Plan 2024-2028*
- *North Central Workforce Board's Central Massachusetts Regional Workforce Blueprint (2023-2027)*
- *Health Equity Partnership of North Central Massachusetts' (CHNA9) Community Health Improvement Plan (2025), Planning for Sustainable Growth*
- *Health Equity Partnership of North Central Massachusetts' (CHNA9) Quabbin Regional Rural Transit Study Report (2023)*
- UMass Memorial HealthAlliance-Clinton Hospital's *Prenatal and Postnatal/Postpartum Community Need Assessment*
- Massachusetts Executive Office of Health and Human Services' *Review of Maternal Health Services*
- UMass Memorial HealthAlliance-Clinton Hospital's *Plan to Ensure Access to Health Resources*

- LifePath and Franklin Regional Council of Governments' *Age- and Dementia-Friendly Regional Plan 2023*
- Franklin County/North Quabbin Student Health Survey
- North Central MA Regional Youth and Community Survey 2023 Preliminary Data Report
- The Montachusett Suicide Prevention Task Force Data obtained by the Massachusetts State Police for DA Early and DA Sullivan's Offices

Lastly, we extend our heartfelt thanks to the residents of North Central Massachusetts who generously shared their experiences, insights, and perspectives. Your participation was integral to the success of this assessment, and your voices will continue to guide our efforts in fostering a healthier and more equitable community for all.

Together, through collaboration and shared commitment, we are better equipped to address the health challenges facing our communities and work towards meaningful and sustainable solutions. Thank you all for your invaluable contributions and dedication to improving the health and well-being of North Central Massachusetts.

OUR PROCESS

This section outlines the methodology UMass Memorial Health HealthAlliance-Clinton Hospital and Heywood Healthcare employed in conducting their joint 2024-2026 Community Health Needs Assessment (CHNA). The assessment integrates secondary data sourced from local, state, and federal sources with qualitative data obtained through a series of focus groups facilitated by CHNA9. The assessment also includes primary and secondary information gathered and reported by community partners through their own community needs assessment processes.

The overarching goals of this assessment are to comprehensively evaluate acute and chronic health conditions as well as health-related social needs in North Central Massachusetts, to assess findings within the framework of health equity, and to inform, not just the partners' efforts, but broad efforts around strategic planning, resource allocation, and policy-making with the ultimate goal of improving the health and well-being of all residents in the region.

- Data Sources
  - Secondary Data Collection:
    - Local, State, and Federal Sources: Relevant health data were gathered from various local, state, and federal agencies, including but not limited to:
      - Partner Hospital Data
      - Local Health Departments
      - Annie E. Casey Foundation
      - National Women's Law Center
      - US Department of Housing & Urban Development
      - The Donahue Institute Massachusetts
      - Department of Labor
      - Massachusetts Institute of Technology
      - Economic Policy Institute
      - Massachusetts Housing Partnership
      - Feeding America
      - US Centers for Disease Control
      - US Health and Human Services' Center for Medicare and Medicaid Services
      - Massachusetts Population Health Tool Massachusetts State Police
  - Qualitative Data Collection:
    - Focus Groups: Together CHNA9 and Three Pyramids conducted a series of (18) focus groups to gather qualitative insights from community members. Efforts were made to include a diverse group of participants geographically as well as socio-demographically. Specific stakeholder groups that were targeted include:

  - Latinx, Muslim, and Haitian residents
  - Immigrant and migrant residents
  - Youth, including youth of color, LGBTQ+, and low income youth
  - Women, including women of color and women of faith
  - Single mothers, including single mothers of color
  - Rural residents (North Middlesex region, Wachusett and Nashoba regions, Athol, and Winchendon)
  - Veterans
  - Older adults
  - Domestic violence survivors
  - Medical and social services providers

- Data Scope:
  - The assessment comprehensively addressed acute and chronic health conditions alongside health- related social needs. Health-related social needs include factors such as access to healthcare, socioeconomic status, housing conditions, food security, and transportation.
- Data Review Process:
  - Partners conducted a comprehensive review of existing reports and community assessments to gain an overarching understanding of the health and social service-related issues in the region, as recently reported by community partners and residents. This thorough examination served as a foundational step in informing the development of our community health needs assessment, allowing the partners to weave together a more comprehensive narrative and identify recurring themes, emerging trends, and priority areas for further exploration. By synthesizing insights from a diverse range of sources, including reports from local health departments, community organizations, and input from residents themselves, the partners ensured that the assessment process was informed by the lived experiences and perspectives of those directly impacted by health disparities and social inequities in the region.
  - Selection of Data: The data selection process was collaborative, with the hospital systems, CHNA9, and HRiA, each bringing to the table their own unique perspectives and expertise around the importance and representativeness of each proposed indicator. Only those indicators which reached consensus as descriptive of the region’s story and representative of all stakeholder groups were included.
  - Qualitative and Quantitative Data Integration: Quantitative data from secondary sources were synthesized and analyzed alongside qualitative data obtained from focus groups. This holistic approach allowed for a comprehensive understanding of community health needs that was driven by local community knowledge and that builds on community members’ own understanding of how they survive and thrive.

- Consideration of Health Equity:
    - The assessment was conducted with a focus on health equity, aiming to identify and address disparities in health outcomes across different demographic groups within our communities.
- Limitations:
    - Convenience Sample: The capacity of the study team limited qualitative data collection to a "convenience sample" rather than a statistically significant sample. Recognizing this limitation, efforts were intentionally made to target a diverse array of community members in focus groups and to incorporate data from multiple data sources to yield more accurate and applicable findings.
    - Selection Bias: Participants in the focus groups self-selected, potentially introducing bias into the qualitative data.
    - Data Availability: Not all quantitative statistics were available at the community level for all included communities, which may have impacted the comprehensiveness of the assessment.
- Ethical Considerations:
    - Confidentiality: Confidentiality and anonymity of participants in the focus groups were ensured to encourage open and honest discussion.
    - Informed Consent: Participants provided informed consent prior to participating in the focus groups, outlining the purpose of the assessment and their rights as participants.

This methodology described above ensured a comprehensive and inclusive approach to the community health needs assessment, incorporating both qualitative and quantitative data while prioritizing the consideration of health equity. By integrating insights from diverse sources, the assessment aimed to inform targeted interventions and initiatives to improve the overall health and well-being of the community served by HealthAlliance-Clinton Hospital and Heywood Healthcare.

A note about this Community Health Needs Assessment's use of ***mySidewalk***, a community data platform:

One of the key benefits of utilizing ***mySidewalk*** for a Community Health Needs Assessment (CHNA) is the platform's ability to automatically update data tables as the underlying sources are refreshed. This feature ensures that the partner hospitals, community-based organizations, and other stakeholders have continuous access to the most recent and relevant statistics, making the CHNA a dynamic and current tool for ongoing planning, decision-making, and grant writing. By minimizing outdated information, ***mySidewalk*** enhances the overall quality and reliability of the assessment, allowing users to base their strategies on the latest available data. However, it is important to note that users of the digital version of this CHNA may encounter discrepancies between the manually entered text and the automatically updated data tables. Careful attention to

these potential inconsistencies is necessary to ensure accurate interpretation and application of the information provided. HealthAlliance-Clinton Hospital and Heywood Healthcare are exploring the feasibility of a periodic update to the text to match the data tables.

Please see Data Sources in ***mySidewalk*** for an update schedule.

For further information or questions about this report, please contact:

HealthAlliance-Clinton Hospital at: HA_ContactUS@healthalliance.com or
Heywood Healthcare at: mary.giannetti@heywood.org

* The Central New England HealthAlliance Board of Trustees approved the CHNA on Friday, September 27th, 2024.

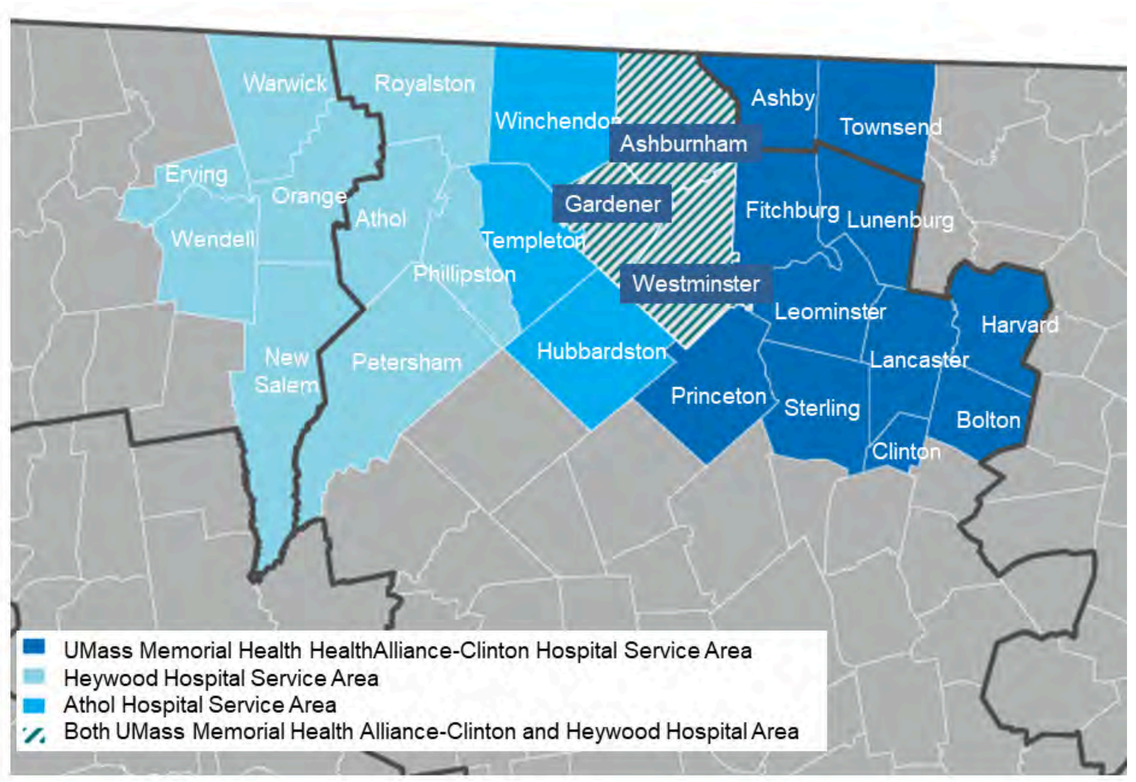
THE COMBINED SERVICE AREA

The combined service area of UMass Memorial Health - HealthAlliance-Clinton Hospital and Heywood Healthcare (Combined Service Area) lies approximately 50 miles west of Boston along the Route 2 corridor and extends from just north of the City of Worcester to the New Hampshire border. The region is largely rural. Its pastoral views, clean air, lakes, ponds, and hiking trails are treasured by residents and are a draw for tourists. Likewise, the small-town, neighborly vibe is considered by many residents to be a key asset of the region.

UMass Memorial Health - HealthAlliance-Clinton Hospital's Service Area includes: Ashburnham, Ashby, Bolton, Clinton, Fitchburg, Gardner, Harvard, Lancaster, Leominster, Lunenburg, Princeton, Sterling, Townsend, and Westminster.

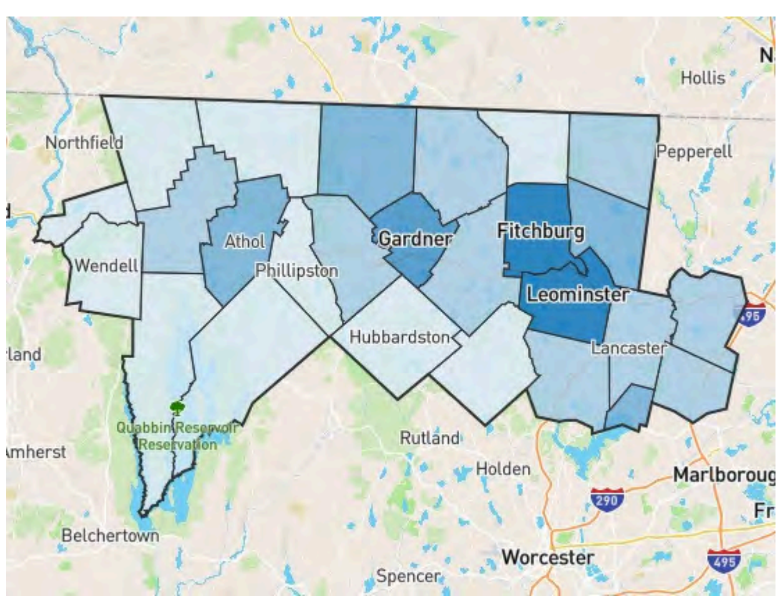
Heywood Hospital's Service Area includes: Ashburnham, Gardner, Hubbardston, Templeton, Westminster, and Winchendon.

Athol Hospital's Service Area includes: Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, and Wendell.



POPULATION & DEMOGRAPHICS

The Combined Service Area's 26 communities are home to 243,948 people. The region's six largest communities: Athol, Clinton, Fitchburg, Gardner, Leominster, and Winchendon comprise approximately half of the total population of the region.



Total Population

- 814 – <5,653
- 5,653 – <10,372
- 10,372 – <21,090
- 21,090 – <41,621
- 41,621 – 43,620

Source: US Census Bureau ACS 5-year 2018-2022

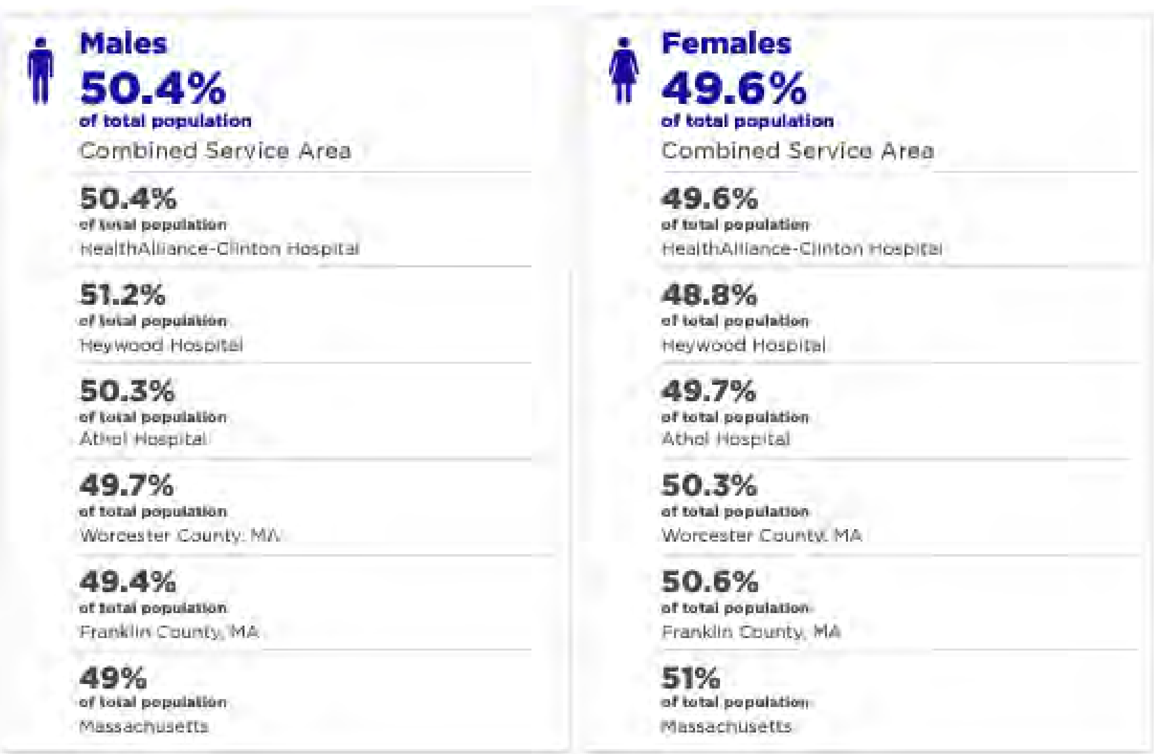
Access to a thriving community is a fundamental human need. Comparing total population across different Combined Service Area communities highlights variations in population density as well as in opportunities for social connections and resources. Examining differences in population density helps community leaders to understand strengths and areas for improvement in both providing essential services and fostering a sense of belonging for all residents. Additionally, understanding where people of different ages, races, and other demographics live is crucial for tailoring community resources effectively.

The following sections look more closely at where people from different demographic and socioeconomic groups live in the Combined Service Area to help highlight disparities across the region and to ensure that interventions and services provided address the specific needs of the diverse populations represented in the region.

Gender

The Combined Service Area population is approximately 50% male and 50% female as is typical across Worcester County, Franklin County, and the state of Massachusetts. However, the ratio of males to females in Heywood Hospital's service area slightly favors males which may be due to the presence of a correctional institution.

The North Central Correctional Institution in Gardner has an average daily population of 500-1,000 males who, due to the Census Bureau's Usual Residence Rule, are counted as residents of that community, even if they do not live there when they are not incarcerated. Given the relatively small total population of Heywood Hospital's service area, the additional 1,000 male residents of the North Central Correctional Institution may account for the slightly higher male to female ratio in that region.



Source: US Census Bureau ACS 5-year 2018-2022

Age

US Census Bureau data shows that the Median Age in the Combined Service Area as well as each individual hospital's service area is higher than the comparison areas of Worcester County and Massachusetts, but lower than Franklin County.

Understanding that the region's Median Age is relatively high can help hospitals and other service providers tailor healthcare and social services to meet the unique needs of the region's older population.

Median Age

43.2
Years Old
Combined Service Area

43
Years Old
HealthAlliance-Clinton Hospital

43.7
Years Old
Heywood Hospital

45.1
Years Old
Athol Hospital

40.2
Years Old
Worcester County, MA

47.1
Years Old
Franklin County, MA

39.8
Years Old
Massachusetts

Source: US Census Bureau ACS 5-year 2018-2022

To develop comprehensive support strategies, it is also essential to examine the distribution of children and older adults across the Combined Service Area. Identifying where these age groups are concentrated will provide further insights into the specific needs and resources required to support the health and well-being of all residents.

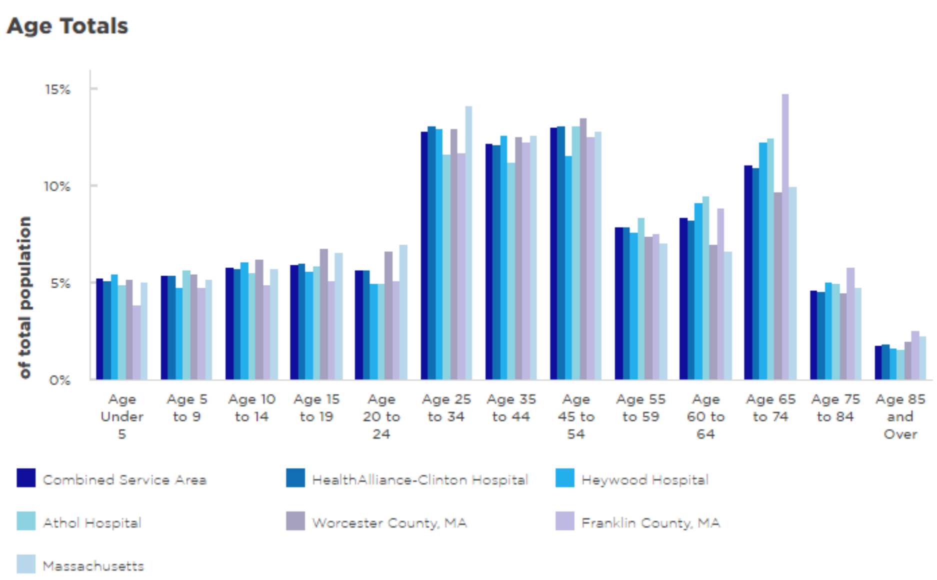
Approximately 20% of the total population is youth under 18 years of age and approximately 18% of the total population is adults 65 years and older. These numbers are similar to Worcester County and Massachusetts. However, the Combined Service Area has more children and fewer adults 65 years and older than Franklin County.

	Community	Under 18 years	18-44 years	45-64 years	65 years or older
Health Alliance-Clinton Hospital	Ashburnham	20.9%	42.0%	19.1%	18.0%
	Ashby	15.6%	34.8%	29.0%	20.6%
	Bolton	27.2%	34.3%	23.9%	14.6%
	Clinton	17.2%	48.7%	19.7%	14.3%
	Fitchburg	20.4%	46.0%	19.3%	14.3%
	Gardner	17.5%	42.9%	20.5%	19.2%
	Harvard	22.3%	37.4%	25.0%	15.3%
	Lancaster	17.7%	43.5%	20.7%	18.1%
	Leominster	19.0%	41.5%	20.9%	18.6%
	Lunenburg	22.3%	39.2%	21.3%	17.1%
	Princeton	20.6%	34.6%	24.0%	20.9%
	Sterling	19.6%	29.4%	29.3%	21.7%
	Townsend	20.7%	39.3%	24.5%	15.5%
	Westminster	19.6%	38.9%	14.6%	26.9%
	Area Total	19.7%	41.9%	21.0%	17.4%
Heywood Hospital	Ashburnham	20.9%	42.0%	19.1%	18.0%
	Gardner	17.5%	42.9%	20.5%	19.2%
	Hubbardston	20.1%	44.5%	17.6%	17.8%
	Templeton	22.4%	41.4%	20.0%	16.2%
	Westminster	19.6%	38.9%	14.6%	26.9%
	Winchendon	22.0%	41.8%	20.4%	15.8%
	Area Total	19.8%	41.9%	19.2%	19.0%
Athol Hospital	Athol	19.9%	41.2%	20.2%	18.7%
	Erving	20.2%	41.8%	18.9%	19.2%
	New Salem	13.7%	37.3%	30.0%	19.0%
	Orange	21.1%	40.2%	19.5%	19.2%
	Petersham	13.6%	35.2%	25.1%	26.1%
	Phillipston	18.7%	38.3%	28.6%	14.4%
	Royalston	23.0%	36.1%	22.5%	18.4%
	Warwick	13.5%	39.8%	27.6%	19.0%
	Wendell	13.7%	36.7%	23.5%	26.1%
	Area Total	19.5%	39.9%	21.5%	19.1%
	Combined Service Area	19.8%	41.7%	21.0%	17.5%
	Worcester County	20.8%	42.1%	20.9%	16.2%
	Franklin County	16.9%	39.8%	20.1%	23.2%
	Massachusetts	19.6%	43.4%	19.9%	17.1%

Source: US Census Bureau ACS 5-year 2018-2022

Per the more granular graph below, age distribution across the Combined Service Area is reasonably consistent with adults (ages 25-34 years) making up the largest proportion of residents in the Combined Service Area as well as across each individual hospital's service area. This pattern is consistent with the larger comparison areas of Worcester County and Massachusetts. To the west, however, in Heywood Hospital and Athol Hospital's service areas (i.e., Franklin County) there is a relatively larger population of older adults (ages 60 to 74).

Understanding these differences in age distribution can help hospital and community leaders plan for services and resources that meet the needs of different age groups, ensuring good access to healthcare and social services across the lifespan.



Source: US Census Bureau ACS 5-year 2018-2022

Race & Ethnicity

At the heart of every community is its people. Looking at the proportion of people of color in different regions can provide insight into diversity. When comparing smaller regions within the Combined Service Area like local hospital service areas to larger regions like Worcester County, Franklin County, and Massachusetts, it is apparent how communities vary in terms of representation. Understanding these differences can help foster a more equitable and united society for everyone.

The Combined Service Area is predominantly White and non-Hispanic. Seventy-nine percent (79.4%) of residents self-report their race as White and 88.4% self-report their ethnicity as non-Hispanic.

Race/Ethnicity Totals

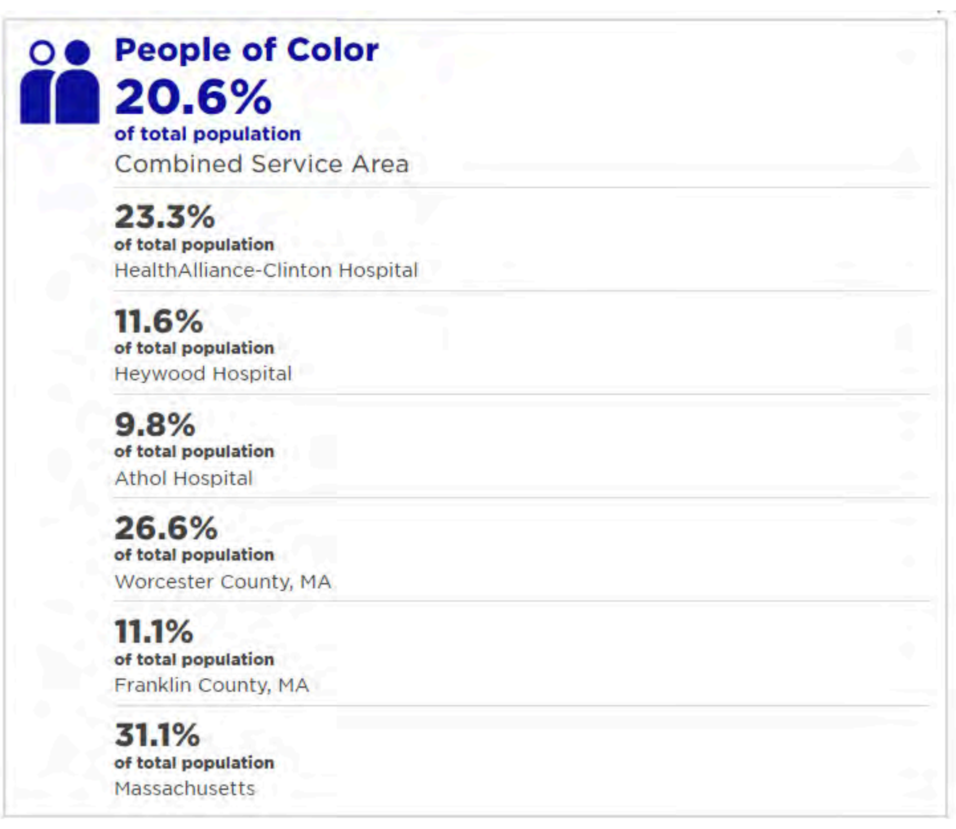
of total population: 0%, 25%, 50%, 75%

White (Not Hispanic or Latino) | Black (Not Hispanic or Latino) | Hispanic or Latino | American Indian (Not Hispanic or Latino) | Asian (Not Hispanic or Latino) | Hawaiian (Not Hispanic or Latino) | Single Race Other (Not Hispanic or Latino) | Two Or More Races Other (Not Hispanic or Latino)

Combined Service Area | HealthAlliance-Clinton Hospital | Heywood Hospital | Athol Hospital | Worcester County, MA | Franklin County, MA | Massachusetts

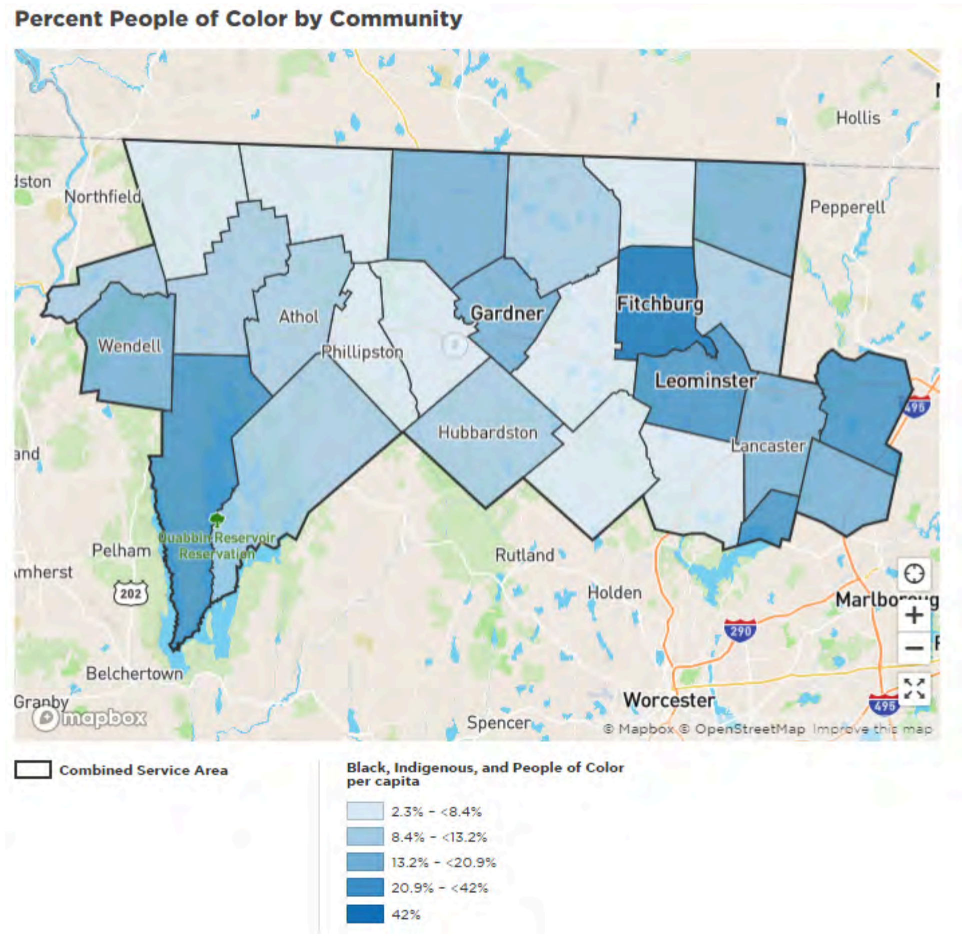
Source: US Census Bureau ACS 5-year 2018-2022

When considering race and ethnicity together in the Combined Service Area 20.6% of the population self- identifies as a person of color.



Source: US Census Bureau ACS 5-year 2018-2022

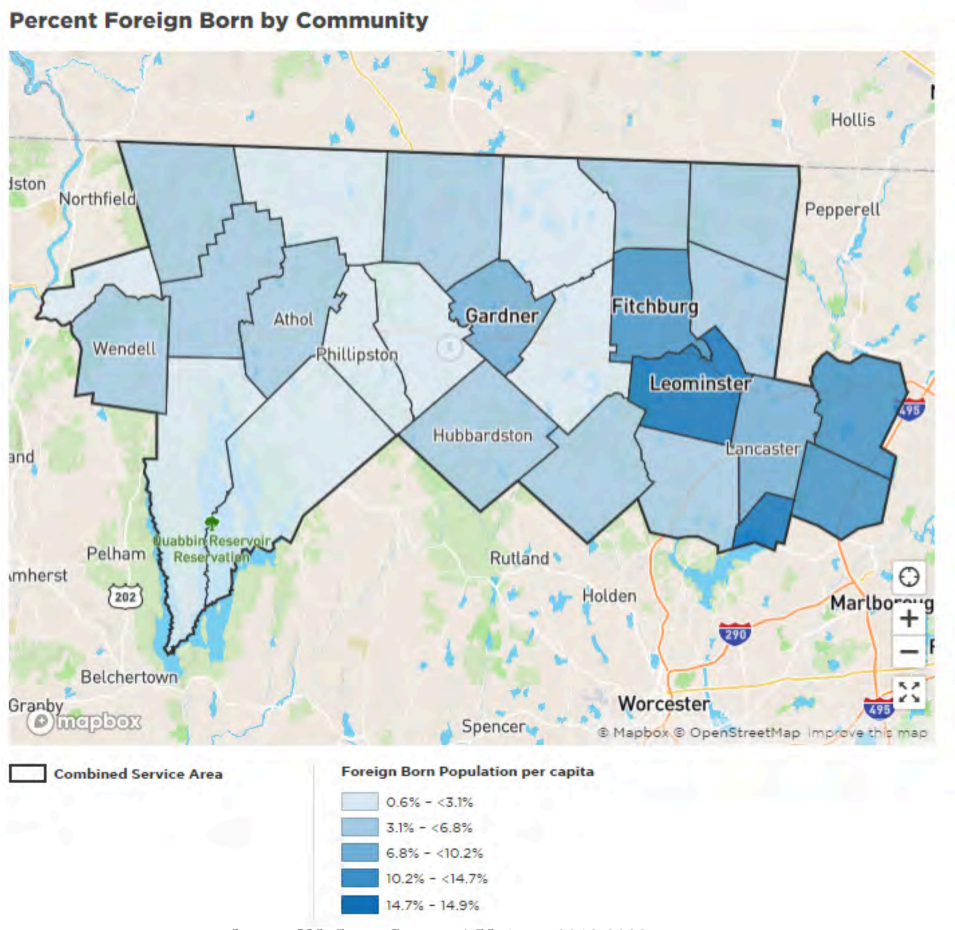
The map below shows that there are pockets of relative diversity across the region. The two largest urban areas, Fitchburg and Leominster, have percentages of residents of color over 25% (i.e., Fitchburg (42%) and Leominster (29%)). These communities are more similar to the comparison areas of Worcester County and Massachusetts with respect to racial and ethnic diversity.



Sources: US Census Bureau ACS 5-year 2018-2022

Foreign Born

According to the US Census Bureau, eight percent (8.3%) of the Combined Service Area's residents are Foreign Born. Forty percent (40%) of the Foreign Born residents are from Latin America, 20.9% from Asia, and 18.8% from Europe.



Sources: US Census Bureau ACS 5-year 2018-2022

Community members who participated in Focus Groups as part of this Community Health Needs Assessment process talked about a recent increase in the number of Foreign Born people living locally. Data from the Donahue Institute[3] confirms this perception. According to their analysis of 2023 US Census Bureau data, Massachusetts experienced an international migration rate of 7.2 per 1,000 residents (i.e., 50,647 people from other countries migrating into Massachusetts). This rate is more than twice the US average of 3.4. This influx of international migrants is reshaping the demographic landscape across the state, bringing new cultural diversity and contributing to the region's evolving social and economic fabric.

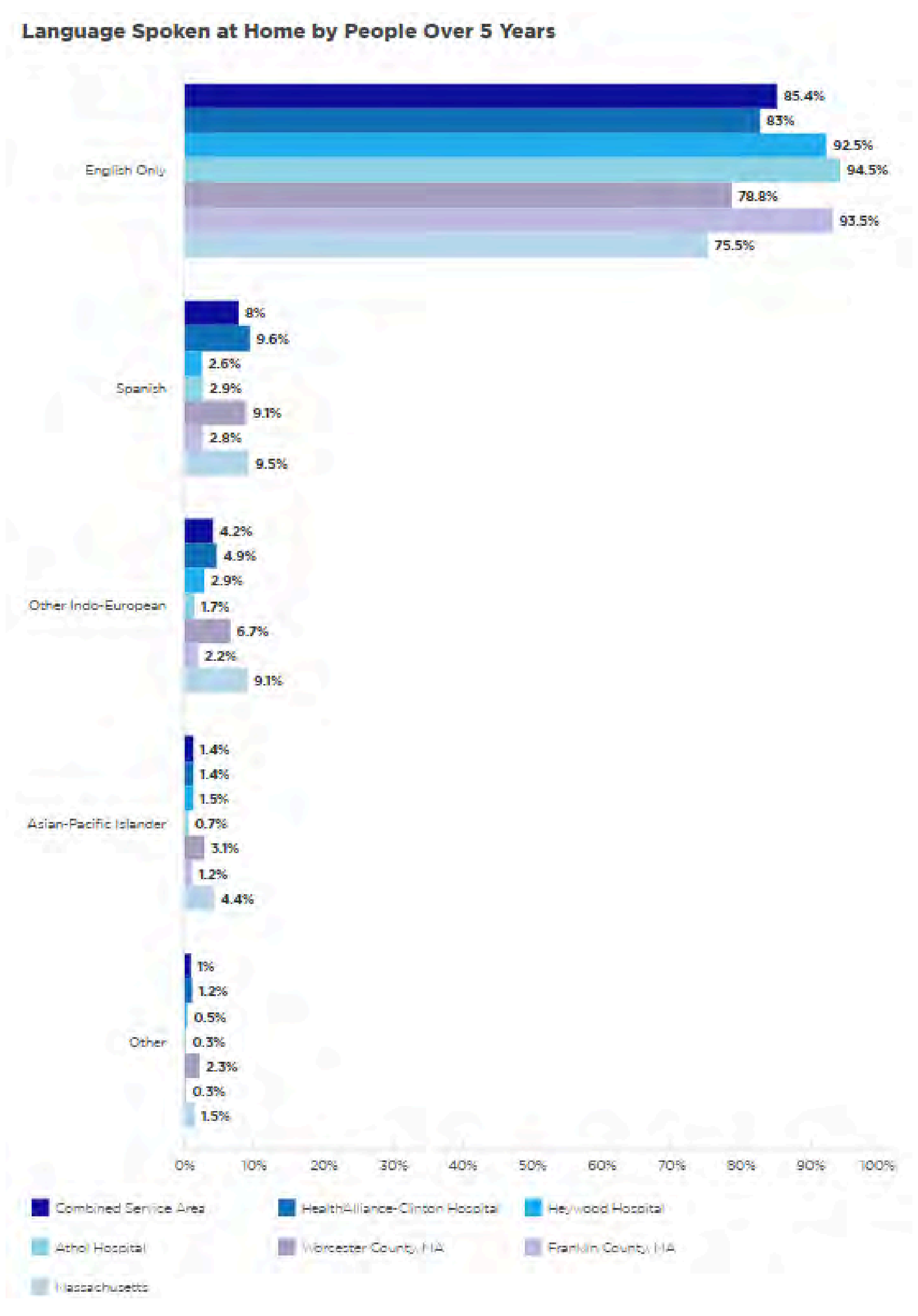
Locally, understanding the racial and ethnic breakdown, as well as the distribution and characteristics of the Foreign Born population in the region, provides critical insights into the diverse needs and cultural dynamics of the Combined Service Area. These demographic insights are essential for developing targeted health interventions and ensuring that all residents have access to equitable and culturally appropriate healthcare services.

Primary Languages

Also important to understand is language fluency. US Census Bureau data suggests that most people in the Combined Service Area speak only English (85.4% of the population

over 5 years). However, there is large variation between hospital service areas with 83.0% of residents in HealthAlliance-Clinton Hospital's service area speaking only English and 94.5% of Athol Hospital's service area residents speaking only English.

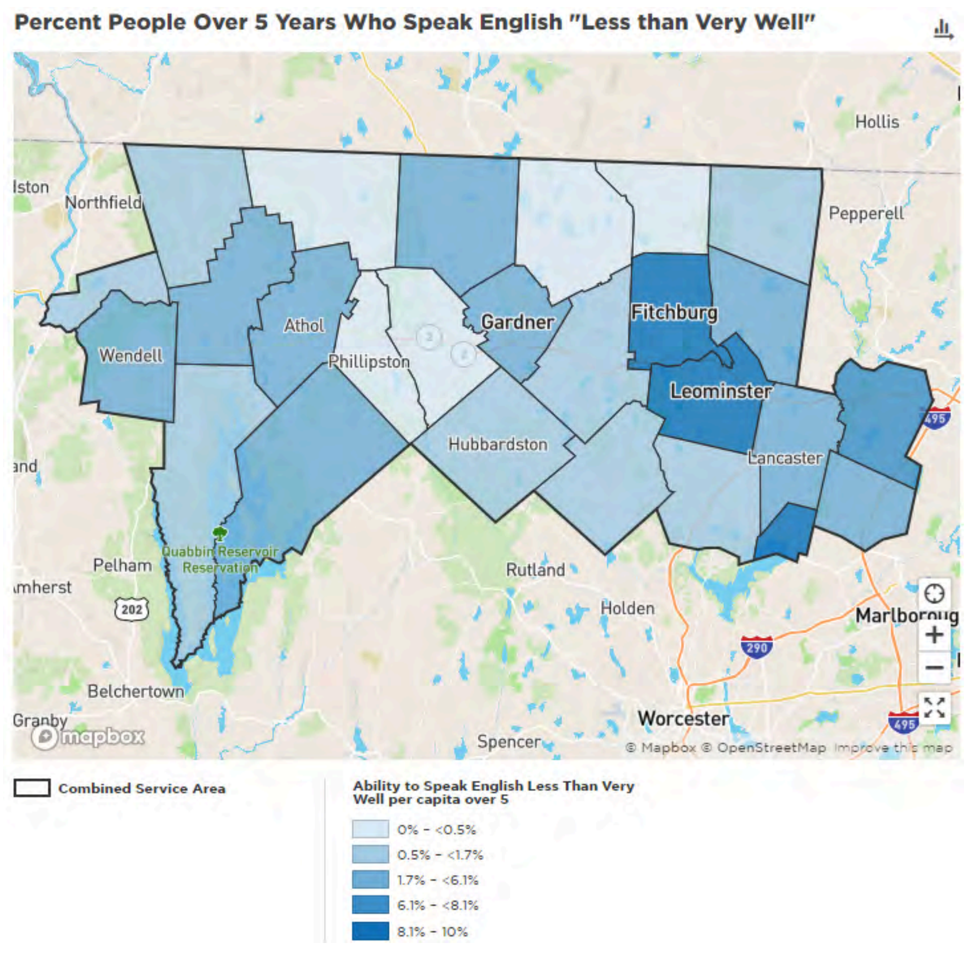
The most common non-English language spoken across the region is Spanish (i.e., 8.0% of the population over 5 years). This is true of each individual hospital's service area as well, with the exception of Heywood Hospital's service area where Other Indo-European languages are spoken more (2.9%) than Spanish (2.6%).



Sources: US Census Bureau ACS 5-year 2018-2022

Roughly one-third (33.4%) of all people who speak a language other than English across the Combined Service Area report speaking English "less than very well."

Individuals with Limited English Proficiency are not evenly distributed across the region. Rather, some communities in the Combined Service Area have relatively large concentrations of people who speak English "less than very well" while other communities have very few residents who speak English "less than very well". For example, in Fitchburg 10% of all people report speaking English "less than very well" whereas in Royalston, Ashburnham, Ashby, Phillipston, and Templeton no residents report speaking English "less than very well".



Sources: US Census Bureau ACS 5-year 2018-2022

Despite the relative English fluency of the population in the Combined Service Area, research has shown that "language concordant care" and efforts to address cultural aspects of care improve health outcomes. Conversely, a lack of these components of care is often emblematic of a lack of understanding of or appreciation for the disparate impact of social determinants of health on minority community members, including those with limited English proficiency. This lack of awareness of social determinants of health then contributes to further disenfranchisement of those most affected.

Data from both HealthAlliance-Clinton Hospital and Heywood Healthcare around Interpreter Services requests highlight the ongoing need for language support in healthcare settings. Interpreter requests at the hospital facilities, as well as in the Emergency Department, indicate a demand for language services.

Specifically, in Fiscal Year 2023, 17% of all patient encounters at HealthAlliance-Clinton Hospital included a request for Interpreter Services. The most common languages requested were Spanish, Portuguese-Brazilian, Haitian-Creole, Vietnamese, ASL, Arabic, and Chinese-Mandarin (all with more than 200 distinct requests). Forty-two percent (42%) of Interpreter Services requests were handled through face-to-face interpretation services by HealthAlliance-Clinton Hospital's Interpreter Services staff, 45% through remote video sessions, and 13% through telephonic services.

Included in the numbers above are Emergency Department requests for Interpreter Services. However, when looked at separately, it is notable that a higher percentage of ED visits have requests for Interpreter Services (22%) than all encounters together (17% across facilities).

In Fiscal Year 2023, Athol Hospital and Heywood Hospital had 3,180 requests for language support across facilities. Nearly three-quarters (74%) of the requests were for Spanish interpreter services. Other common languages requested were Arabic, Vietnamese, and American Sign Language. In the first half of Fiscal Year 2024, Heywood Healthcare has noted an increased need for Haitian Creole language services to support newly arrived migrant families.

These statistics underscore the importance of providing culturally and linguistically appropriate care to ensure that all community members, regardless of their primary language, receive equitable and effective healthcare. Addressing these needs is crucial for reducing health disparities and improving outcomes for minority populations in the Combined Service Area.

Beginning in late 2023, the Centers for Medicare & Medicaid Services (CMS) and EOHHS/State of Massachusetts required healthcare providers to collect key demographic information about each patient, including race, ethnicity, and language, sexual orientation and gender identity, social drivers of health, and disability status. Understanding each patient as an individual is essential for identifying potential disparities in care delivery and health outcomes, enabling healthcare providers to deliver consistent care to everyone. While this is both a state and federal requirement, both HealthAlliance-Clinton Hospital and Heywood Healthcare are committed not only to collecting this data but also to utilizing it to ensure their staff addresses every aspect of each patient's needs.

For example, HealthAlliance-Clinton Hospital, as part of the larger UMMH system, will use self-reported disability status data to help caregivers be aware of any assistance a patient may need to access care equitably —along with allowing hospital leadership and staff identify disparities in care and health outcomes related to disability status. In addition to questions about specific abilities, UMMH has also recently launched a system-wide initiative to ask patients about the types of accommodations they may need for their visit.

Though this CMS requirement is recent, Heywood Healthcare and HealthAlliance-Clinton Hospital have long recognized the disparities in access for people of non-dominant cultures. Heywood Healthcare's Diversity, Equity, and Inclusion (DEI) task force was established in 1999 and guides the system's health equity initiatives. It includes interdisciplinary staff, community-based organizations, and multi-racial, multi-cultural community members. The Health system, collaborating with the DEI task force, has developed a Health Quality and Equity Strategic Plan to guide the implementation of health quality and equity activities over the next four years. The plan aims to address health-related social needs and health disparities demonstrated by variations in quality performance. To accomplish this, the Health System will:

1) Review the alignment of Heywood Healthcare strategic plans with the Commonwealth's health care reform agenda with the participation of diverse stakeholders;
2) Identify the most prevalent chronic conditions affecting disadvantaged populations attending the hospital and the development of a key performance indicator dashboard within 2024;
3) Identify and track health disparities in patients seeking care in the Heywood Healthcare system; and
4) Collaborate with community-based organizations on an ongoing basis and conduct health promotion activities in vulnerable populations with yearly tracking of activities.

Like Heywood Healthcare, UMass Memorial Health (UMMH) has committed to advancing racial justice and ending systemic racism, which is central to its health care mission. The organization aims to eliminate racial disparities and racist behaviors and is proud of its ongoing anti-racism efforts. Moving forward, UMMH plans to further document and publicly share its commitment to health equity.

The health system has several teams and offices dedicated to health equity:

- Office of Diversity, Equity, Inclusion, and Belonging: Led by the Chief DEIB Officer, this office focuses on workforce inclusion, community partnerships, and belonging.
- Quality Office: Under the Chief Quality Officer and Associate Chief Quality Officer for Health Equity, this office handles health equity regulations and incentive programs.
- Population Health/Office of Clinical Integration: Implements value-based programs, social determinant of health screenings, and health equity incentive programs.
- Government and Community Relations: Oversees alignment with community and government partners.

UMMH has also established numerous working groups and committees to enhance health equity:

- MassHealth Steering Committee: Oversees the implementation of MassHealth Quality and Equity Incentives.
- Health Equity Measure Improvement Working Group: Focuses on reducing disparities through Health Equity True North Metric projects.
- Anchor Mission Steering Committee: Directs efforts to use institutional resources for equitable community development.
- MassHealth ACO Health Equity Committee: Monitors health equity efforts within the ACO.

- Health Equity Data Strategy Workgroup: Manages RELDSOGI data collection and analysis.
- SDOH Steering, Stakeholder, and Working Groups: Plans and manages social determinant of health screenings.
- Behavioral Health CQI Committee: Oversees behavioral health-related quality improvement measures.
- Disability Competent Care Committee: Manages disability components of health equity incentives.
- Health Equality Index Committee and SOGI Working Group: Supports inclusive practices for LGBTQIA+ caregivers and patients.

Additionally, at HealthAlliance-Clinton Hospital, the Community Benefits Advisory Committee, Patient Experience Committee, and Patient Family Advisory Council (PFAC) include community representatives and are led by leaders from Quality, Safety, Regulatory Affairs, and External Affairs.

UMMH's definition of health equity, as defined by the Robert Wood Johnson Foundation, emphasizes providing fair and just opportunities for health by addressing obstacles like poverty and discrimination. As such, UMMH, with HealthAlliance-Clinton Hospital, will continue to focus on three key areas:

1. Reducing Bias and Barriers: Increase training on implicit bias, enhance disability competent care, and improve language accessibility.
2. Addressing Structural Barriers: Identify patients' social needs, link them to community resources, and advocate for upstream social drivers of health.
3. Reducing Disparities: Improve demographic data quality, regularly review stratified data, and implement disparity reduction plans.

These goals will require enhanced alignment, communication, and structural support to achieve lasting impact.

Even with the hospital's proactive approach in the area of Diversity, Equity, Inclusion, and Belonging, data from previous community assessments conducted in the region as well as qualitative information gathered during the Focus Groups conducted as part of this Community Health Needs Assessment suggest that there remains a lack of language concordant and culturally competent healthcare and social services in the region. Specifically, a lack of diversity among providers and language barriers to care are cited in HealthAlliance-Clinton Hospital's Prenatal and Postnatal/Postpartum Community Needs Assessment: Findings and Priorities. Additionally, Focus Group participants extended these concerns to behavioral healthcare, social services, and public safety departments in the region.

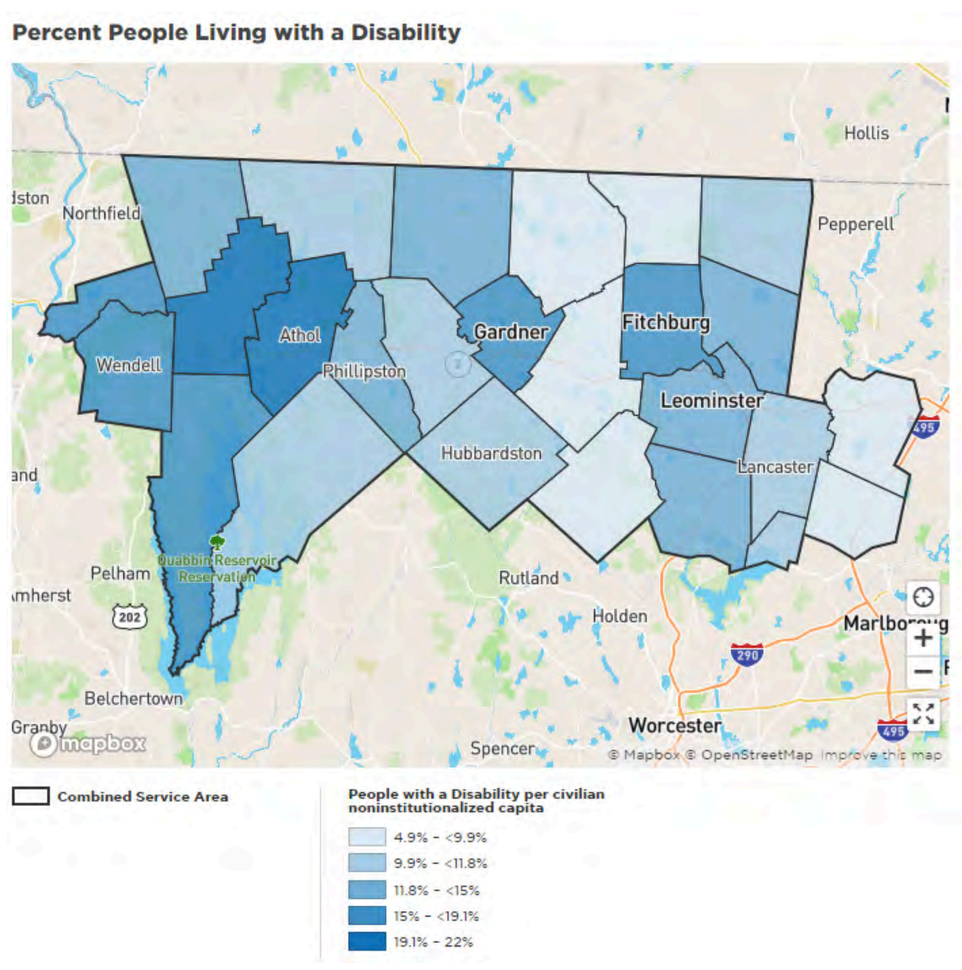
Other Special Populations

Understanding where people who make up special populations live is important when developing specialized health and social services and allocating resources to communities. The section below discusses the needs of Combined Service Area residents living with disabilities as well as Veterans.

People Living with Disabilities

People with disabilities often face barriers that impede their full participation in and access to community resources. Physical infrastructure lacking ramps or elevators, inadequate transportation options, and inaccessible public spaces restrict mobility. Additionally, discriminatory attitudes and misconceptions contribute to social isolation and exclusion from education and employment opportunities. Limited access to healthcare services due to transportation barriers or insufficient accommodations further exacerbates health disparities. Economic challenges stemming from lower employment rates and higher healthcare costs compound these obstacles, creating a complex web of barriers that hinder the well-being and integration of individuals with disabilities within communities.

Across the Combined Service Area 13% of residents are living with a disability. There are communities with higher concentrations of people living with disabilities. In Fitchburg (15.8%), Gardner (16%), and most of the Athol Hospital service area communities, for example, 15% or more of the population lives with a disability.



Sources: US Census Bureau ACS 5-year 2018-2022

Understanding the diverse range of disabilities within a community is crucial for effectively allocating resources to address specific needs. The table below shows the percentage of people living with different types of disability in the communities of the Combined Service Area. Ambulatory and Cognitive difficulties are the most common in the region.

	Community	Percent of Population with a Disability	Hearing Difficulty	Vision Difficulty	Cognitive Difficulty	Ambulatory difficulty	Self-care difficulty	Independent living difficulty
Health Alliance-Clinton Hospital	Ashburnham	7.4%	3.4%	0.3%	2.2%	2.4%	0.4%	2.2%
	Ashby	8.0%	1.4%	0.2%	1.2%	5.2%	2.4%	4.0%
	Bolton	4.9%	1.7%	1.1%	0.8%	1.8%	0.6%	2.0%
	Clinton	10.8%	4.2%	1.1%	4.2%	5.0%	1.3%	3.1%
	Fitchburg	15.8%	2.5%	2.2%	8.4%	7.5%	2.6%	7.7%
	Gardner	16.0%	4.4%	1.5%	7.6%	7.1%	3.5%	7.7%
	Harvard	5.6%	2.0%	1.3%	1.9%	2.7%	1.5%	2.9%
	Lancaster	10.7%	1.6%	1.9%	4.7%	5.0%	1.3%	3.2%
	Leominster	13.5%	2.9%	1.6%	6.7%	7.6%	3.2%	8.0%
	Lunenburg	11.8%	3.0%	2.1%	3.5%	5.4%	1.4%	4.5%
	Princeton	5.3%	0.6%	1.3%	2.1%	1.5%	0.7%	2.2%
	Sterling	12.0%	2.9%	1.1%	4.4%	5.3%	1.8%	4.6%
	Townsend	10.5%	3.0%	1.4%	4.2%	4.8%	1.4%	3.5%
	Westminster	7.3%	3.2%	1.1%	3.7%	2.4%	0.8%	3.1%
	Area Total	12.4%	2.9%	1.6%	5.4%	5.7%	2.1%	4.7%
Heywood Hospital	Ashburnham	7.4%	3.4%	0.3%	2.2%	2.4%	0.4%	2.2%
	Gardner	16.0%	4.4%	1.5%	7.6%	7.1%	3.5%	7.7%
	Hubbardston	10.9%	3.0%	0.9%	4.0%	3.6%	0.3%	5.3%
	Templeton	9.9%	3.8%	1.0%	3.7%	3.3%	1.2%	4.4%
	Westminster	7.3%	3.2%	1.1%	3.7%	2.4%	0.8%	3.1%
	Winchendon	13.0%	3.8%	2.0%	6.0%	5.9%	2.0%	4.8%
	Area Total	12.0%	3.8%	1.3%	5.1%	4.6%	1.9%	4.2%
Athol Hospital	Athol	19.1%	3.9%	2.9%	9.0%	9.8%	4.0%	8.3%
	Erving	15.9%	5.0%	2.1%	8.5%	8.5%	2.3%	6.5%
	New Salem	15.0%	8.0%	0.4%	4.5%	5.5%	2.4%	3.8%
	Orange	22.0%	4.9%	2.0%	9.3%	10.0%	4.4%	8.0%
	Petersham	10.8%	2.7%	2.0%	2.5%	5.8%	0.2%	4.7%
	Phillipston	12.9%	4.2%	0.7%	5.1%	4.9%	2.6%	6.7%
	Royalston	11.5%	4.1%	2.6%	4.6%	4.4%	0.4%	3.1%
	Warwick	12.7%	5.3%	4.7%	7.4%	6.3%	3.1%	5.4%
	Wendell	17.4%	6.5%	0.8%	3.3%	6.3%	3.7%	7.0%
	Area Total	18.2%	4.5%	2.3%	7.5%	8.2%	3.3%	5.8%
	Combined Servic	13.0%	3.2%	1.6%	5.6%	5.8%	2.2%	4.7%
	Worcester County	12.6%	3.4%	1.8%	5.6%	6.0%	2.5%	6.0%
	Franklin County	16.8%	5.4%	2.1%	7.4%	7.6%	3.2%	7.0%
	Massachusetts	11.9%	3.1%	1.9%	5.2%	5.7%	2.4%	5.5%

Sources: US Census Bureau ACS 5-year 2018-2022

By identifying the types of disabilities prevalent in the community, such as sensory, cognitive, or physical disabilities, policymakers and healthcare providers can tailor interventions and services to meet the unique challenges faced by individuals with different disabilities. This targeted approach ensures that resources are allocated where they are most needed, optimizing their impact and fostering inclusivity. Moreover, recognizing the intersectionality of disabilities with other factors such as age, ethnicity, socioeconomic status, and geographic location allows for a more comprehensive understanding of community health needs, enabling the development of holistic and equitable solutions.

Veterans

Assessing the size of the Veteran population as well as the geographic distribution of Veterans in a region is essential for developing tailored support systems and services that honor their service, address their unique health and social needs, and ensure equitable access to resources within the community. In the Combined Service Area, 6.5% of the population over 18 years is a Veteran.

Percent Veteran Population

6.5%
Combined Service Area

6%
HealthAlliance-Clinton Hospital

7.6%
Heywood Hospital

8.1%
Athol Hospital

5.7%
Worcester County, MA

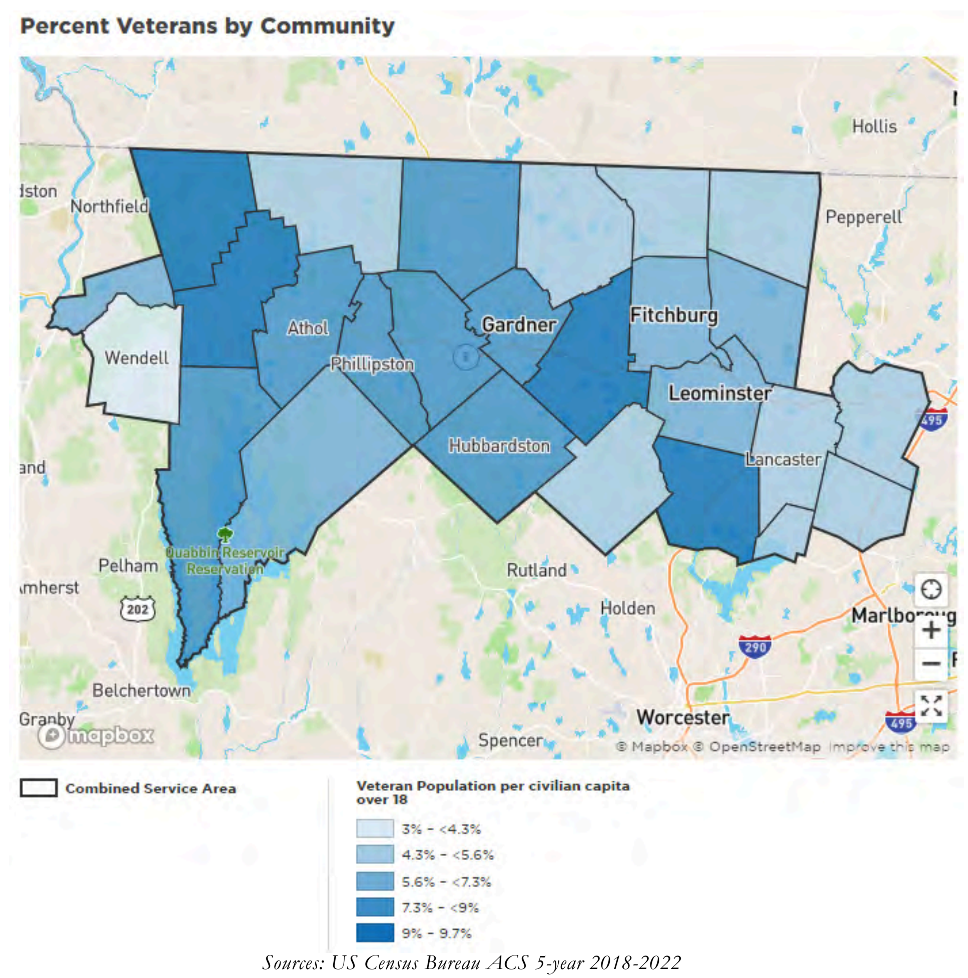
7.5%
Franklin County, MA

4.7%
Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

Per the table above, the communities in the Athol Hospital and Heywood Hospital service areas tend to have higher percentages of Veterans than the rest of the Combined Service Area.

Strategically locating Veterans services near where Veterans live is crucial for ensuring equitable access to essential resources. By aligning service provision with the geographic distribution of Veterans, barriers to accessing vital support systems are reduced, promoting improved health outcomes and well-being within the community.



Sources: US Census Bureau ACS 5-year 2018-2022

Using a localized approach to resource allocation fosters a sense of community and belonging among veterans, as they receive assistance within familiar surroundings. Additionally, it facilitates collaborative efforts between service providers and community stakeholders, promoting a comprehensive and responsive approach to addressing the health needs of Veterans within the community.

Participants in the Focus Groups conducted as part of this Community Health Needs Assessment process spoke to the need for active engagement with local Veterans around service and resource planning. Even though the overarching sentiment is that Veterans are supported much more in Massachusetts than in most other places...

"Veterans feel isolated, financially strained, and overlooked."

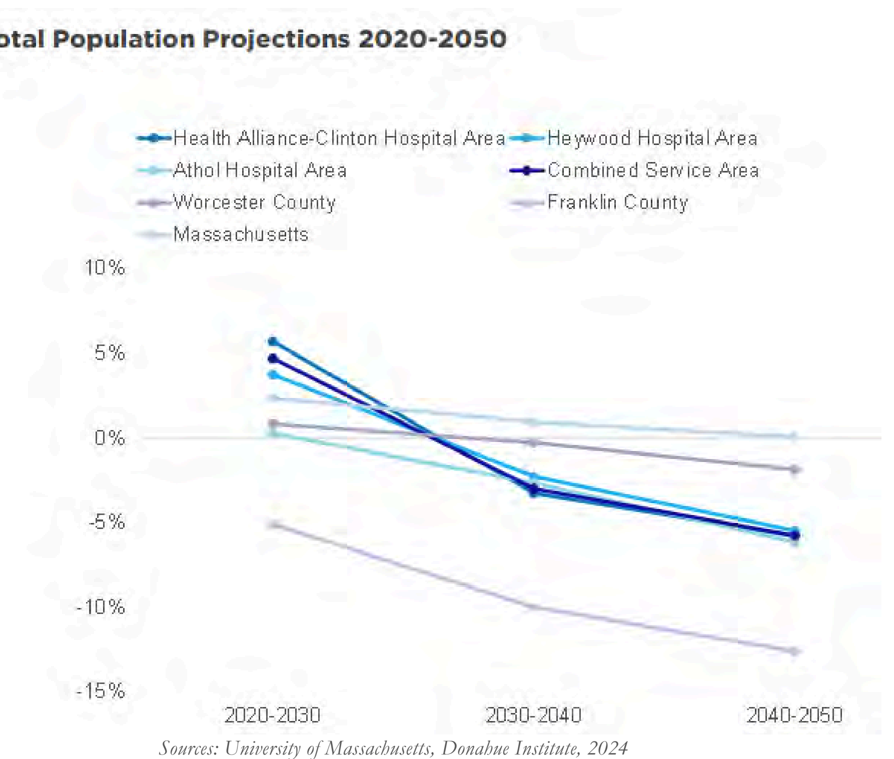
Engaging Veterans in planning services for themselves ensures that the support systems developed are rooted in their firsthand experiences, preferences, and needs, thus fostering a sense of ownership, empowerment, inclusion, and efficacy within their own communities.

TRENDS

Understanding the current demographic makeup of the Combined Service Area provides a vital snapshot of the region's characteristics, including age, race, ethnicity, and socioeconomic status. However, it is equally important to consider how these demographics are projected to change over the next 20 to 30 years. Anticipating demographic shifts can inform more sustainable and adaptable community planning. For instance, an aging population may require expanded healthcare services and senior housing, while an increase in younger families might necessitate more schools and childcare facilities. Building solutions based solely on the current demographic makeup can lead to short-term fixes that may not adequately address future needs. By considering pending demographic changes, community leaders and policymakers can develop long-term strategies that ensure resources and services remain relevant and effective, promoting a resilient and thriving community for decades to come.

Total Population

The Combined Service Area experienced growth of 5.3% from 2010 to 2022. While this rate is lower than Worcester County (7.6%) and the state of Massachusetts (6.7%), it is greater than the rate of Franklin County (-0.5%).



Sources: University of Massachusetts, Donahue Institute, 2024

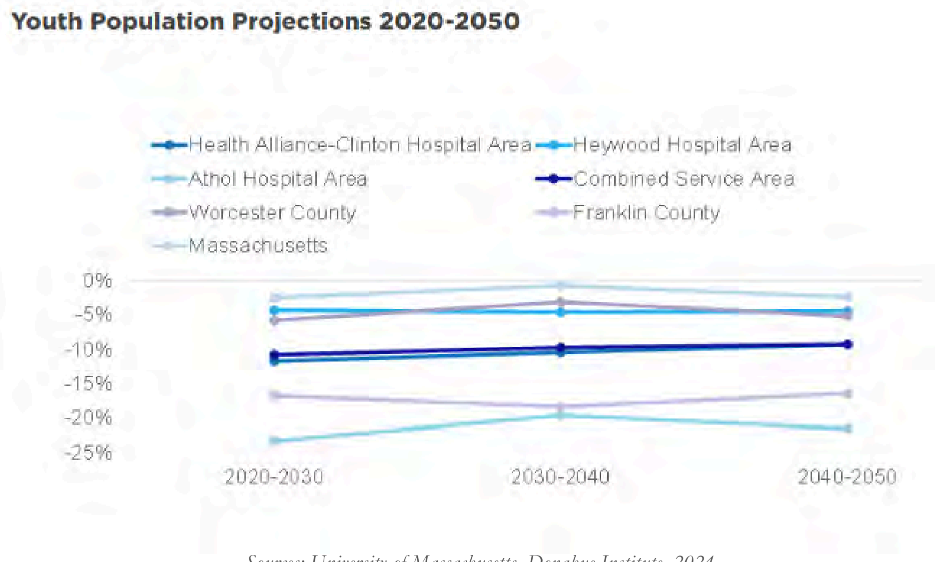
Despite its recent growth, the total population of the region is expected to begin shrinking within the next five to ten years. The projections above from the Donahue Institute suggest that by 2050, the total population of the Combined Service Area will have decreased roughly 5%.

Franklin County is a notable standout on the graph above, with population decreasing at the writing of this Community Health Needs Assessment and projected to decrease more than 10% by 2050.

Age

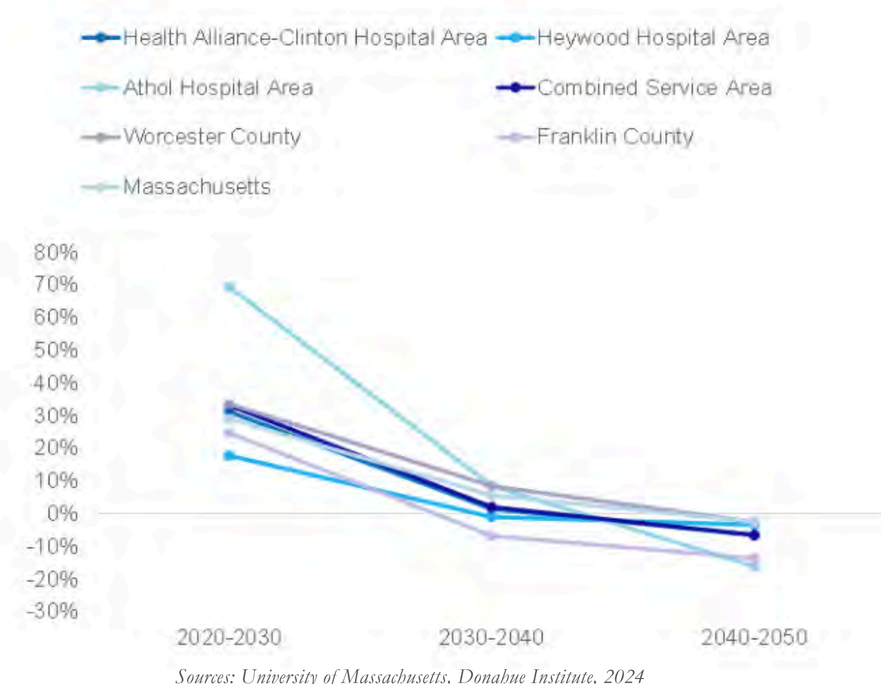
At the same time that total population growth is slowing it is also aging. From 2010 to 2022, the Combined Service Area's population aged 65+ years grew by 45.8%. This is in sharp contrast to an 7.0% decrease in the population under 19 years of age. It is also more extreme than in Worcester County and Massachusetts where the population of 65+ grew by 36.5% and 32.4%, respectively and the population 18 years and under decreased by 3.7% and 2.8%, respectively.

The projections below from the Donahue Institute show that population growth for youth (under 19 years) will continue to be negative for the foreseeable future.



Sources: University of Massachusetts, Donahue Institute, 2024

Whereas, the population growth for adults 65+ in the Combined Service Area will will continue to be positive for the next several years before beginning to decline with the overall population.



Sources: University of Massachusetts, Donahue Institute, 2024

According to the Donahue Institute's report *Engaging Hidden and Future Workers to Grow the Local Economy*, a slower-growing and aging population will lead to lower labor force participation rates at a time when demand for goods and services, including social services and healthcare delivery systems, is increasing. As a greater percentage of the population is comprised of older adults, services to care for this growing aged population will need to expand. However, growing the care network for older adults will be challenging as the youth population in the Combined Service Area is decreasing. Recognizing this need, Mount Wachusett Community College has highlighted, in their 2022/2023-2026/2027 strategic plan, the importance of expanding care by focusing on increasing degree and certificate production in fields associated with high-demand occupations like healthcare.

Additionally, utilizing strategies from the World Health Organization's model of "age-friendly environments" [4] can improve community life for the aging population. Communities can adopt this model by improving public transportation systems to be more accessible, creating more inclusive public spaces, ensuring that housing options are suitable for older adults, and offering in-home and community-based health and social services tailored to the needs of the elderly. These initiatives can help ensure that the region adapts to meet the evolving needs of its residents.

A local example of a community initiative to improve quality of life for older adults is the collaboration between LifePath and Franklin Regional Council of Governments (FRCOG). Working together, they are advocating for and the implementing policy and systems level change to make Franklin County and North Quabbin region more livable for people of all ages, with a special focus on older adults. LifePath and FRCOG developed the *Age- and Dementia-Friendly Franklin County and North Quabbin Regional Action Plan 2024-2028* based on community conversations and survey data. Their Age and Dementia -Friendly Project goals include:

- Raising awareness about dementia,
- Educating people about dementia,
- Helping people stay connected to important people,
- Helping people stay healthy and active, and
- Providing support to people who can no longer look after themselves.

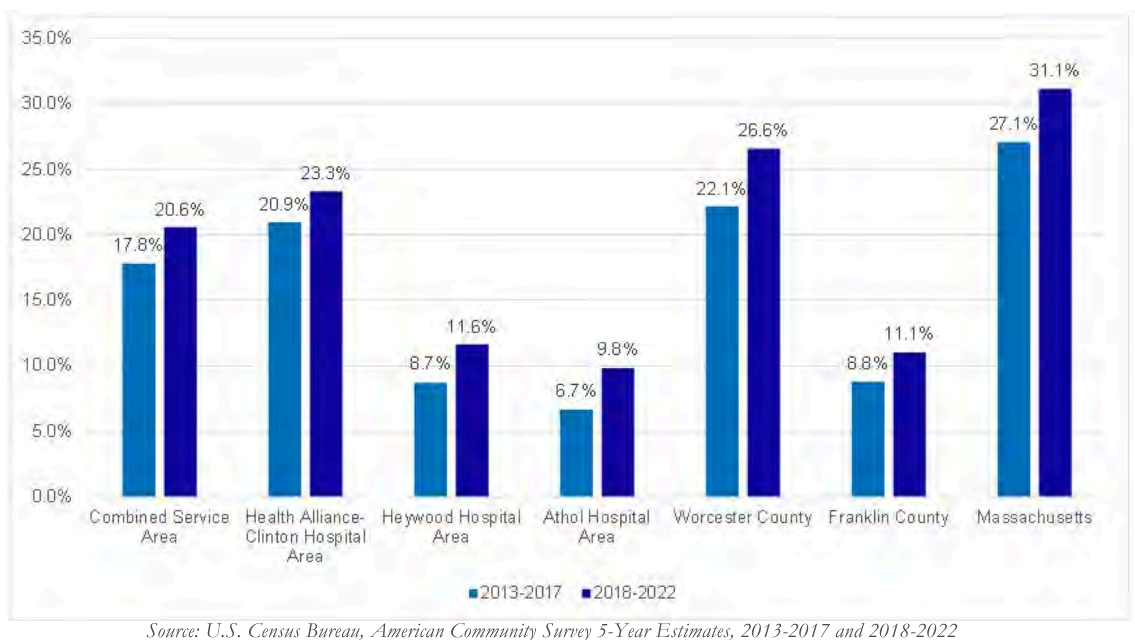
Life Path and FRCOG
A crowded age-friendly community meeting.

Participants in the Focus Groups conducted as part of this Community Health Needs Assessment process also offered strategies to improve the quality of life for older residents. Specifically, they called out the need for increased transportation options, more units and a wider variety of senior living options, in-home health and personal care services, and more opportunities for socialization, including intergenerational programming. Together, these initiatives will help foster a more connected and supportive community for all residents as demographics shift over time.

Race & Ethnicity

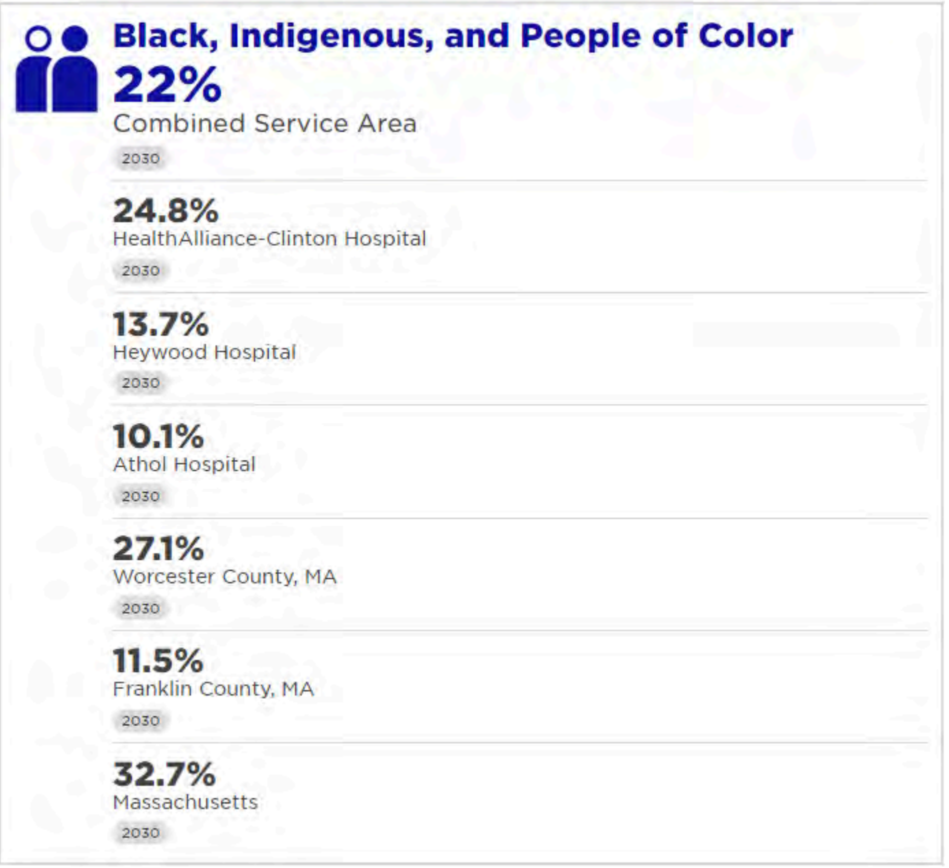
While the Combined Service Area's population is aging, it is also becoming more diverse. From 2017-2022, the percentage of the Combined Service Area population that self-identified as a person of color grew from 17.8% to 20.6% (i.e., 2.8% in 5 years).

Percentage Identifying as Person of Color, 2017 to 2022



Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017 and 2018-2022

Further, the US Census Bureau's 2030 projections show that percentage increasing more, to 22% for the Combined Service Area.



Sources: US Census Bureau 2030

Increasing diversity in the Combined Service Area was a common theme in the Focus Groups conducted as part of this Community Health Needs Assessment process. Many participants spoke about the need for more culturally and linguistically responsive health and social services as the region welcomes immigrants and migrants from around the globe. They also talked about engaging people of different racial and ethnic backgrounds in addressing...

"the issues that effect them."

Focus Group participants suggested using an "ask and listen" approach to developing solutions that work for all community members as well as leading with kindness and patience.

Conclusion

The Combined Service Area faces many of the same challenges as rural communities across the United States: an aging and declining population. However, in the face of this challenge, the Combined Service Area finds resilience through the injection of new energy via immigration and migration, promising continued vibrancy and cultural enrichment.

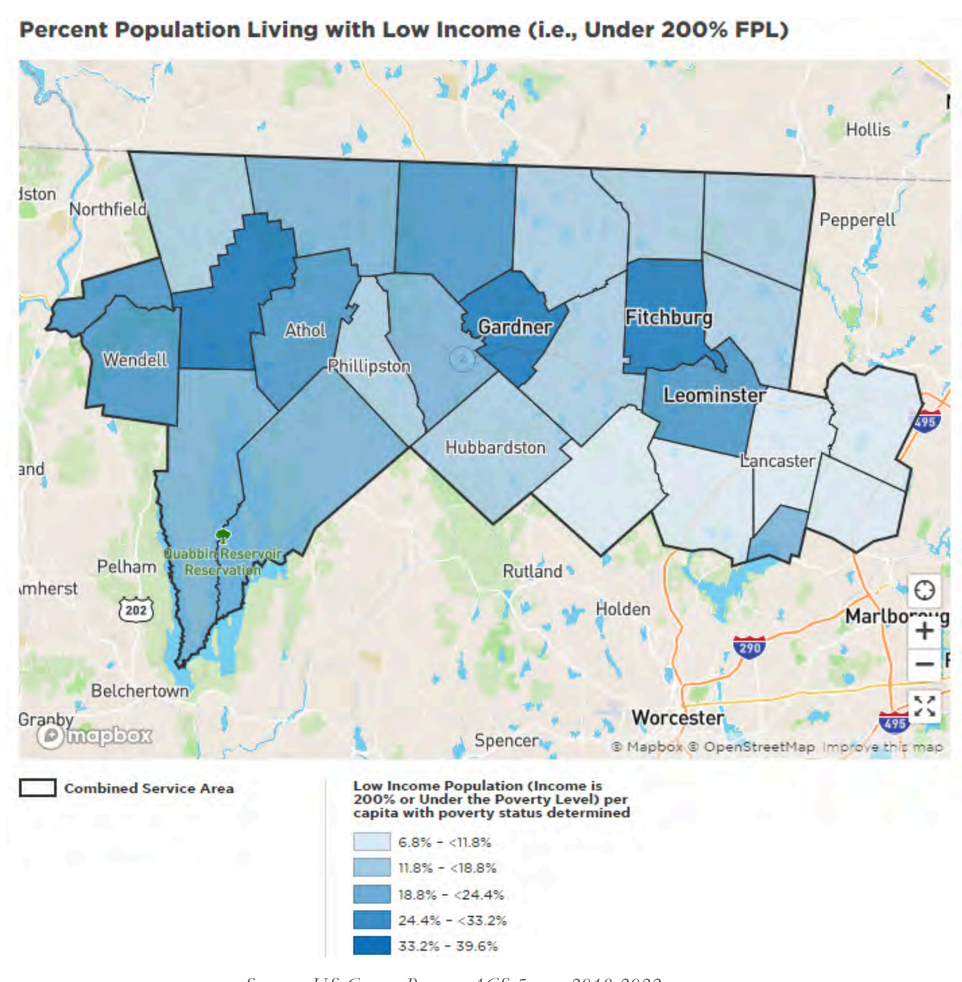
As younger individuals migrate to major urban centers in search of economic opportunities, rural communities face the dual challenges of population decline and aging demographics. This demographic shift not only strains local economies and social support systems but also presents opportunities for intergenerational exchange. Simultaneously, increasing immigration injects diversity into rural populations, offering potential solutions to labor shortages and revitalizing communities. Furthermore, embracing and harnessing the contributions of immigrants can foster resilience and innovation, enriching the social fabric of rural communities and contributing to their long-term sustainability. Balancing the needs of aging residents, newcomers, and existing communities is essential for fostering inclusive rural development and ensuring the vitality of rural areas in the face of demographic shifts.

POVERTY

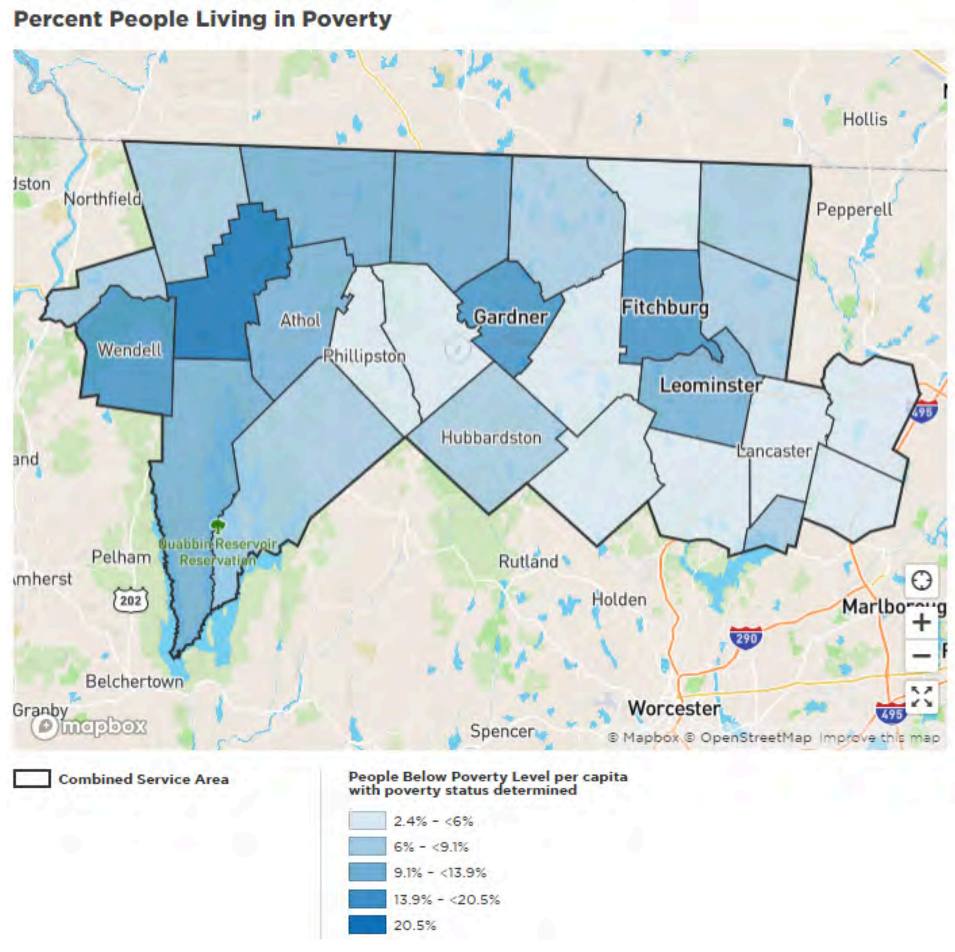
In the Combined Service Area, more than one in five (22.8%) people live with low income. Additionally, 9.3% of the total population lives below the Federal Poverty Level. While these numbers are similar to the comparison areas of Worcester County and Massachusetts, they are lower than that of Franklin County.

The aggregated data above masks significant pockets of poverty across the region. The maps below show the percentage of people, by community, living below 200% of the Federal Poverty Level (i.e., low income) and 100% of the Federal Poverty (i.e., living in poverty).

Generally, the more urban areas of the Combined Service Area have higher percentages of people living with low incomes and living in poverty. This is particularly true for Fitchburg, Gardner, Athol, and Winchendon. Additionally, the western most communities in the Combined Service Area (i.e., Athol Hospital's service area) tend to have higher percentages of residents living with low incomes and in poverty.

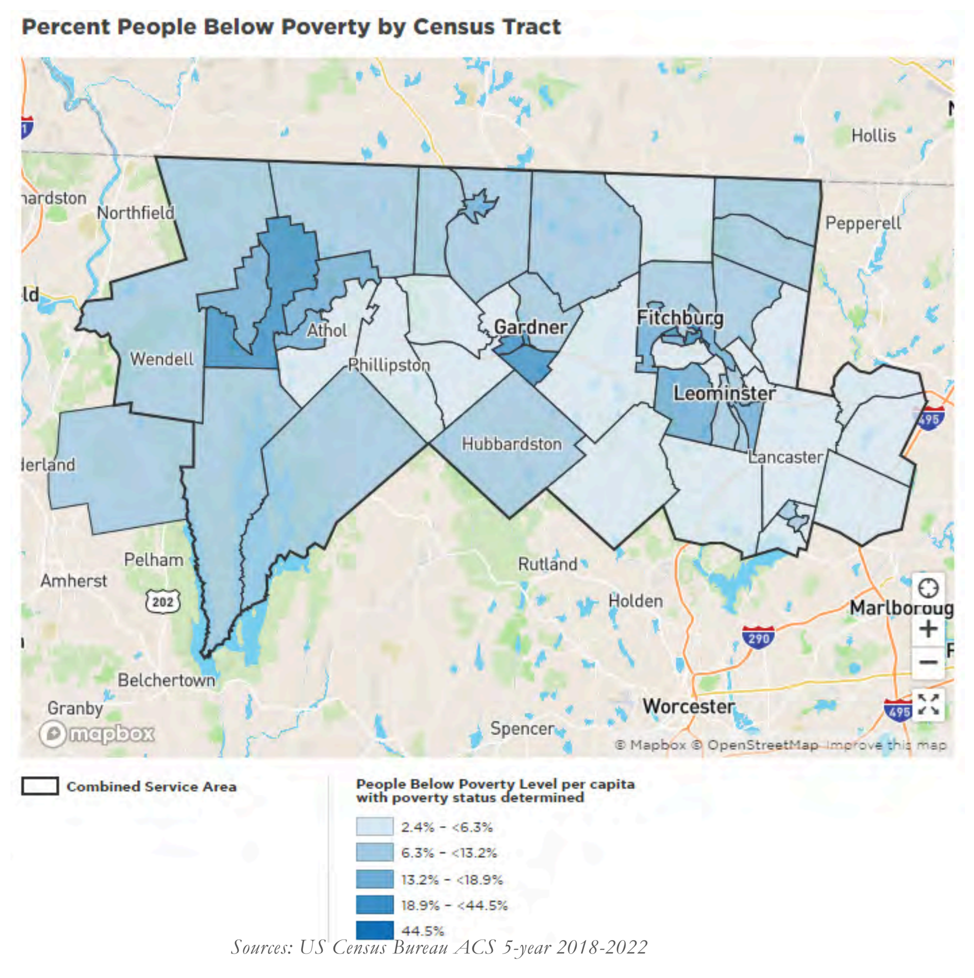


Sources: US Census Bureau ACS 5-year 2018-2022



Sources: US Census Bureau ACS 5-year 2018-2022

The map below shows the percentage of people living below the Federal Poverty Level by Census Tract. This more granular view allows for a closer look at where there are higher concentrations of people living in poverty across the Combined Service Area.



Sources: US Census Bureau ACS 5-year 2018-2022

Per the map above, there are pockets of extreme poverty in Orange, Gardner, Fitchburg, and Leominster where more than one in five people lives below the Federal Poverty Level.

Understanding the geographic distribution of poverty is crucial for targeting interventions and allocating resources effectively. By identifying where people in poverty live, community leaders and policymakers can tailor support services, such as affordable housing, healthcare access, and educational programs, to the areas most in need.

This detailed perspective enables the development of strategic initiatives that address the specific challenges faced by impoverished communities. For example, locally, Three Pyramids (based in Fitchburg) and HEAL Winchendon CAC (based in Winchendon) have adopted an Empowerment Economics approach to building community wealth and power. The approach includes a multigenerational strategy that engages communities, builds power to address policy and systems, and provides financial coaching and education centered on long-term wealth creation. These targeted initiatives promote economic stability and improve overall quality of life for residents in regions where high percentages of residents are living near or in poverty.

Income Inequality & Social Vulnerability

Another way to look at income inequality across the Combined Service Area is the Gini Index. The Gini Index is a statistical measure of inequality within a population. It is commonly used to measure income inequality, but it can be applied to any distribution of wealth or resources.

The index ranges from 0 to 1, where:

- 0 represents perfect ***equality***, where everyone has the same income or resource share.
- 1 represents perfect ***inequality***, where one person has all the income or resources and everyone else has none.

A Gini Index score of 0.5 or higher is often considered high inequality.

The table below shows the Gini Index scores for the Combined Service Area as well as the partner hospital service areas and the comparison areas.

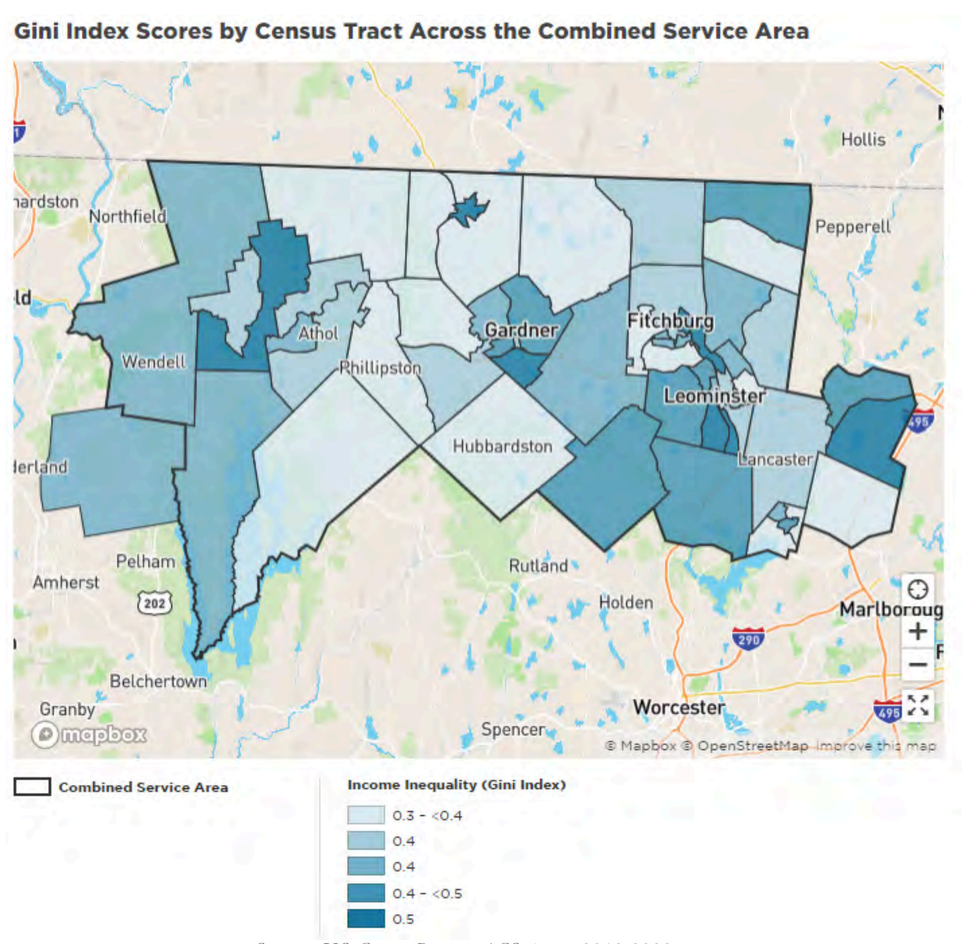
Income Inequality (Gini Index)	
Combined Service Area	0.4
HealthAlliance-Clinton Hospital	0.4
Heywood Hospital	0.4
Athol Hospital	0.4
Worcester County, MA	0.5
Franklin County, MA	0.4
Massachusetts	0.5

Sources: US Census Bureau ACS 5-year 2018-2022

Overall, inequality appears slightly lower across the Combined Service Area, the individual hospital service areas, and Franklin County than the comparison areas of Worcester County and Massachusetts (0.4 vs. 0.5).

When examined at a more granular level, though, income inequality across the region becomes more apparent. The map below shows the Combined Service Area divided into Census Tracts, allowing for a more discrete visualization of income inequality within the communities that comprise the region.

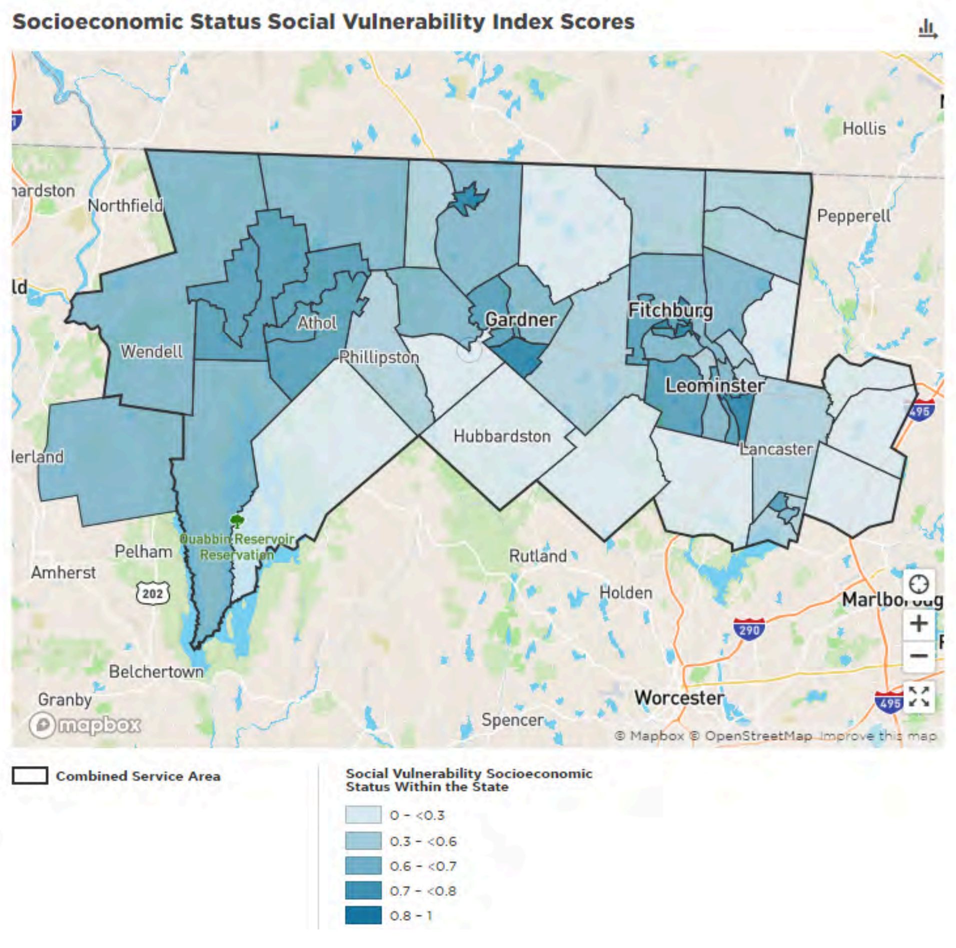
Areas with darker shading demonstrate greater income inequality and a more uneven distribution of resources among residents.



Sources: US Census Bureau ACS 5-year 2018-2022

Understanding community vulnerability is crucial in addressing inequalities. Much like the Gini Index measures income inequality, the Centers for Disease Control and Prevention's (CDC) Social Vulnerability Index (SVI) assesses social vulnerabilities. The SVI is a valuable tool used to identify communities that may need support before, during, and after hazardous events such as natural disasters, disease outbreaks, or human-made incidents. The SVI uses US Census data to rank each Census Tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing. These factors are grouped into four themes: Socioeconomic Status, Household Composition and Disability, Minority Status and Language, and Housing Type and Transportation. By assessing these variables, the SVI helps public health officials and emergency responders identify and prioritize areas that are most vulnerable to adverse health outcomes, allowing for more efficient and equitable allocation of resources and support services.

The map below shows the Socioeconomic Status SVI scores for Census Tracts within the Combined Service Area.



Source: CDC ASTDR SVI 2022

Generally, the SVI scores are higher in the more urban areas of Fitchburg, Leominster, Gardner, Winchendon, Clinton, Athol, and Orange.

Understanding where high Gini Index scores and high Social Vulnerability Index (SVI) scores overlap allows effective targeting of resources and interventions. High Gini Index scores indicate significant income inequality within a community, while high SVI scores highlight areas with heightened social vulnerability. When these two metrics intersect, they pinpoint regions where economic disparities and social vulnerabilities are most pronounced. Understanding these overlaps allows policymakers, public health officials, and community organizations to prioritize and allocate resources more effectively, addressing both economic and social challenges.

Examined together, the two maps above help to pinpoint specific areas of Fitchburg, Leominster, Gardner, and Orange as particularly vulnerable, with both high economic disparity and high social vulnerability. By targeting these high-need areas, efforts can be more precisely directed to reduce inequalities, enhance community resilience, and improve overall health and well-being.

Poverty & Special Populations

While understanding the geographical distribution of poverty is crucial, identifying the individuals and families affected by poverty is even more important. Knowing who (i.e., age, race/ethnicity, employment status, family composition, etc.) is living in poverty allows for a deeper analysis of the root causes like: systemic inequalities; lack of access to education, transportation, and childcare resources; and health disparities. This nuanced understanding is essential for developing targeted strategies that address the specific needs and circumstances of those in poverty, ultimately leading to more effective interventions and sustainable pathways out of poverty.

Age and Poverty

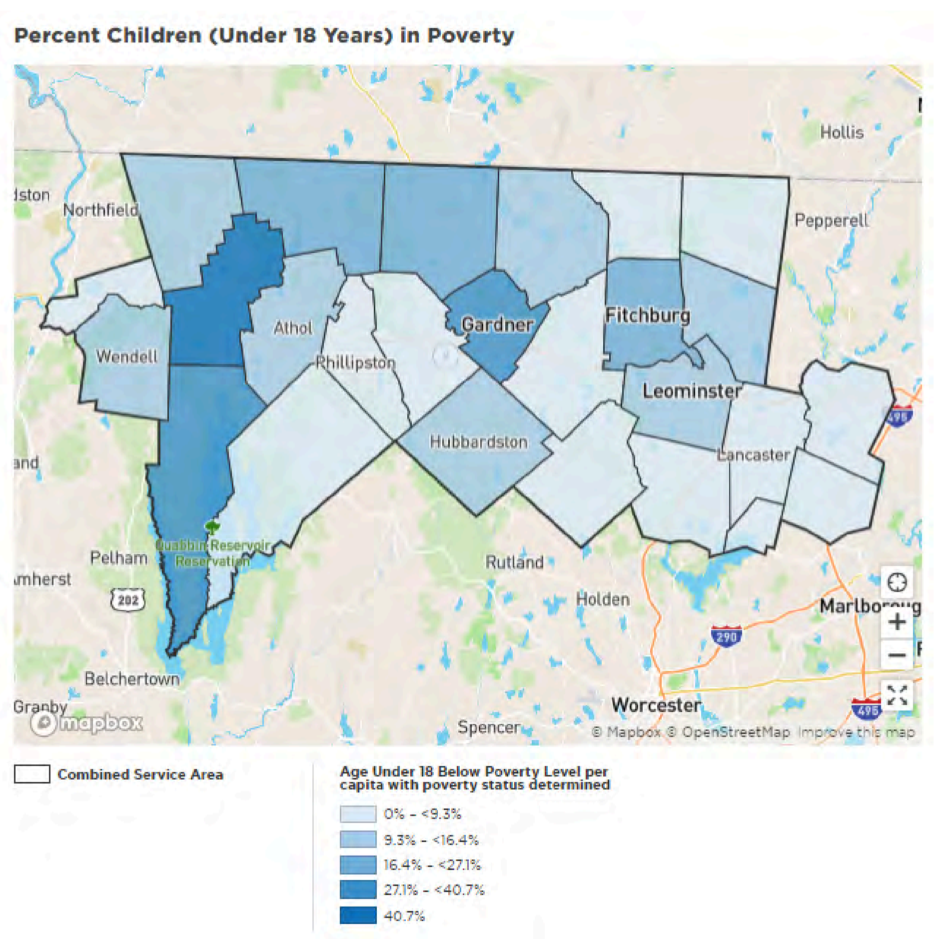
Poverty is a pervasive issue that affects individuals of all ages, but it disproportionately impacts the youngest and oldest members of our communities. In the Combined Service Area, as in many parts of the country, poverty rates among children are notably higher than those among older adults. This trend is particularly concerning, as childhood poverty can have long-lasting effects on physical and mental development, educational attainment, and future economic opportunities. At the same time, older adults living in poverty often face challenges related to fixed incomes, rising healthcare costs, and limited access to essential services.

The US Census Bureau data presented below show that, in the Combined Service Area 12.0% of children live in poverty as do 7.2% of older adults.

	Community	Under 18 years	65+ years
Health Alliance-Clinton Hospital	Ashburnham	12.8%	5.1%
	Ashby	3.0%	6.1%
	Bolton	0.0%	8.5%
	Clinton	5.4%	7.6%
	Fitchburg	16.4%	13.0%
	Gardner	27.1%	9.1%
	Harvard	2.0%	4.9%
	Lancaster	3.2%	7.1%
	Leominster	12.1%	4.9%
	Lunenburg	11.3%	5.5%
	Princeton	3.1%	3.1%
	Sterling	0.0%	1.6%
	Townsend	4.7%	7.0%
	Westminster	0.9%	6.0%
	Area Total Average	**11.1%**	**7.2%**
Heywood Hospital	Ashburnham	12.8%	5.1%
	Gardner	27.1%	9.1%
	Hubbardston	12.4%	7.2%
	Templeton	1.8%	2.3%
	Westminster	0.9%	6.0%
	Winchendon	19.6%	10.4%
	Area Total Average	**15.3%**	**7.3%**
Athol Hospital	Athol	9.3%	6.1%
	Erving	3.4%	5.1%
	New Salem	31.3%	7.8%
	Orange	40.7%	7.8%
	Petersham	2.1%	8.1%
	Phillipston	0.0%	16.7%
	Royalston	18.2%	6.3%
	Warwick	9.3%	3.2%
	Wendell	9.5%	14.0%
	Area Total Average	**18.3%**	**7.5%**
	Combined Service Are	**12.0%**	**7.2%**
	Worcester County	11.8%	9.2%
	Franklin County	17.5%	8.7%
	Massachusetts	11.8%	9.9%

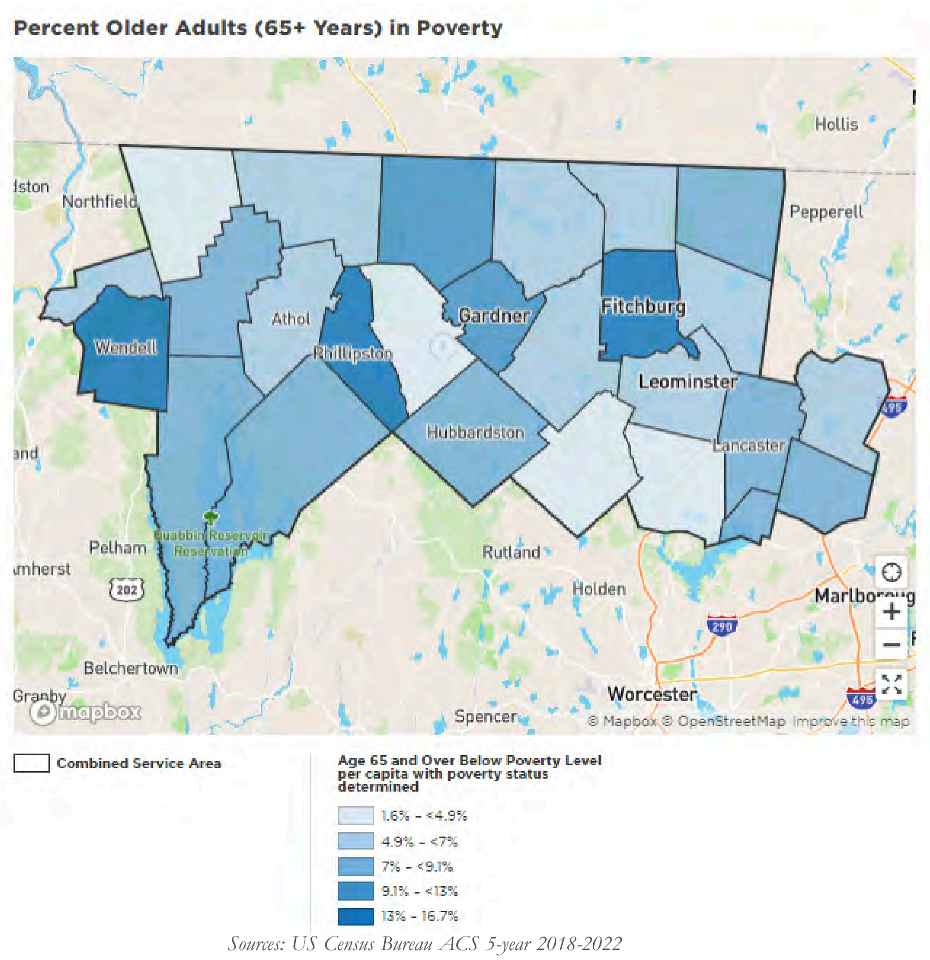
Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Rates of child poverty tend to be higher in the western portion of the Combined Service Area. Per the table above and the map below, Athol Hospital's service area has over 5% more children living in poverty than the Combined Service Area as a whole. Individual communities like Orange (40.7%) and New Salem (31.3%) stand out with more than three in ten children living in poverty.



Sources: US Census Bureau ACS 5-year 2018-2022

Geographic distribution of older adults living in poverty is more even across the Combined Service Area. Phillipston (16.7%), Wendell (14.0%), Fitchburg (13%), and Winchendon (10.4%) stand out with more than one in ten Older Adults living in poverty.



Sources: US Census Bureau ACS 5-year 2018-2022

Race & Ethnicity and Poverty

The economic disparities affecting people of color in the Combined Service Area are both stark and troubling, mirroring broader national trends [5]. The table on the next page shows that in every hospital service area within the region, as well as across all comparison areas, the percentage of people of color living in poverty exceeds that of White, Non-Hispanics. These disproportionate rates of poverty among communities of color are emblematic of the systemic inequities that persist throughout the United States, where racial and ethnic minorities are consistently more likely to face economic hardships.

Addressing and reducing racial and ethnic economic disparities is not just a matter of social justice but a critical component of improving the overall health and well-being of individuals and communities. The data above clearly demonstrate that people of color in the Combined Service Area face significantly higher rates of poverty than their White, Non-Hispanic counterparts. These economic disparities are closely linked to a range of negative health outcomes, including limited access to healthcare, increased stress, and higher rates of chronic conditions. Moreover, poverty can exacerbate social determinants of health, such as inadequate housing, food insecurity, and limited educational opportunities, further entrenching cycles of disadvantage. By prioritizing efforts to reduce these disparities, communities can foster greater equity, ensuring that all residents have the opportunity to thrive and contribute to a healthier, more resilient society.

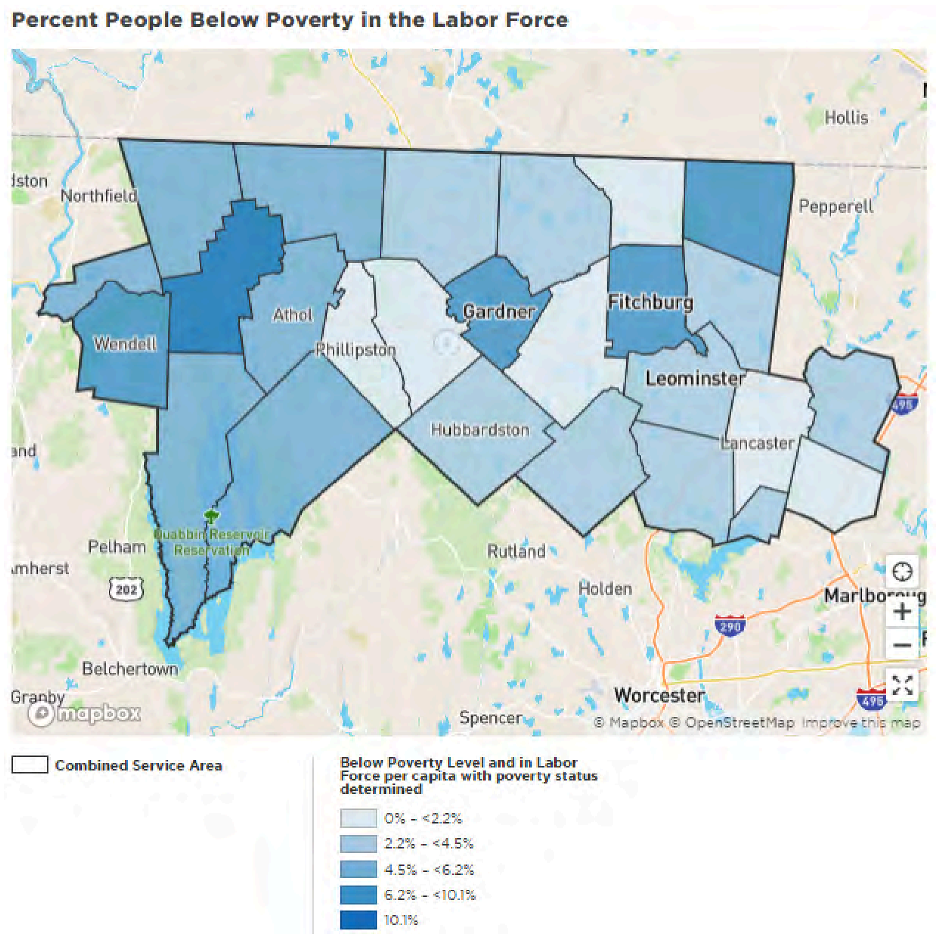
	Community	White alone, not Hispanic or Latino	POC in Poverty
Health Alliance-Clinton Hospital	Ashburnham	6.9%	16.9%
	Ashby	2.9%	2.6%
	Bolton	2.5%	1.5%
	Clinton	3.9%	13.6%
	Fitchburg	9.4%	20.1%
	Gardner	12.8%	25.9%
	Harvard	5.0%	0.8%
	Lancaster	1.9%	13.9%
	Leominster	8.7%	10.1%
	Lunenburg	7.8%	1.9%
	Princeton	1.8%	34.4%
	Sterling	1.7%	16.3%
	Townsend	8.2%	3.6%
	Westminster	3.5%	0.0%
	Area Total Average	**7.2%**	**14.9%**
Heywood Hospital	Ashburnham	6.9%	16.9%
	Gardner	12.8%	25.9%
	Hubbardston	4.3%	34.3%
	Templeton	5.1%	2.0%
	Westminster	3.5%	0.0%
	Winchendon	10.6%	13.8%
	Area Total Average	**8.5%**	**20.2%**
Athol Hospital	Athol	11.1%	11.4%
	Erving	7.1%	18.2%
	New Salem	3.4%	35.1%
	Orange	18.8%	37.4%
	Petersham	6.8%	2.9%
	Phillipston	4.8%	0.0%
	Royalston	10.2%	38.8%
	Warwick	6.9%	0.0%
	Wendell	16.3%	8.9%
	Area Total Average	**12.0%**	**20.0%**
	Combined Service Area	**7.8%**	**15.2%**
	Worcester County	7.8%	16.2%
	Franklin County	9.8%	29.8%
	Massachusetts	7.0%	16.4%

Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Labor Force & Poverty

Barriers to employment for residents in poverty are plentiful. According to the Bureau of Labor Statistics, factors like "job availability and pay; qualifications, education, and training; transportation; childcare and family issues; crime and substance misuse; housing instability; and disabilities and mental and physical health" [6] contribute to the difficulties those in poverty face in the job market. Furthermore, even when employed, people in poverty are often faced with incomes that are not sufficient to lift them and their families out of poverty and ensure decent living conditions. Providing the necessary resources and opportunities will give people in poverty and in the labor force the capabilities to find and maintain jobs with decent pay.

In certain Combined Service Area communities like Fitchburg, Leominster, and Gardner there are high percentages of people below the poverty level and in the labor force. This means many folks in these areas are working but still struggling financially. In Orange, for example, one in ten workers lives in poverty.



Sources: US Census Bureau ACS 5-year 2018-2022

This sentiment of working and still not being able to achieve economic stability was frequently cited in the Focus Groups conducted as part of this Community Health Needs Assessment process:

"It feels like it is no longer possible to make ends meet even if you are gainfully employed and working 40 hours per week."

Furthermore, Focus Group participants expressed concern about the lack of and loss of local, state, and federal benefits for people living just over the poverty level:

"If you fall slightly above the poverty line then you don't qualify for any assistance."

"As my SSI benefits go up, my SNAP benefits go down."

Communities with high numbers of employed people living below the poverty level may benefit from providing more support in areas like job training, affordable housing, childcare, transportation, and access to social services. Understanding where wages are not sufficient to provide economic security is crucial for the community to address economic challenges and work towards ensuring everyone

has access to stable employment and resources to thrive, including those who live at or just above the poverty level.

Single Householder Families and Poverty

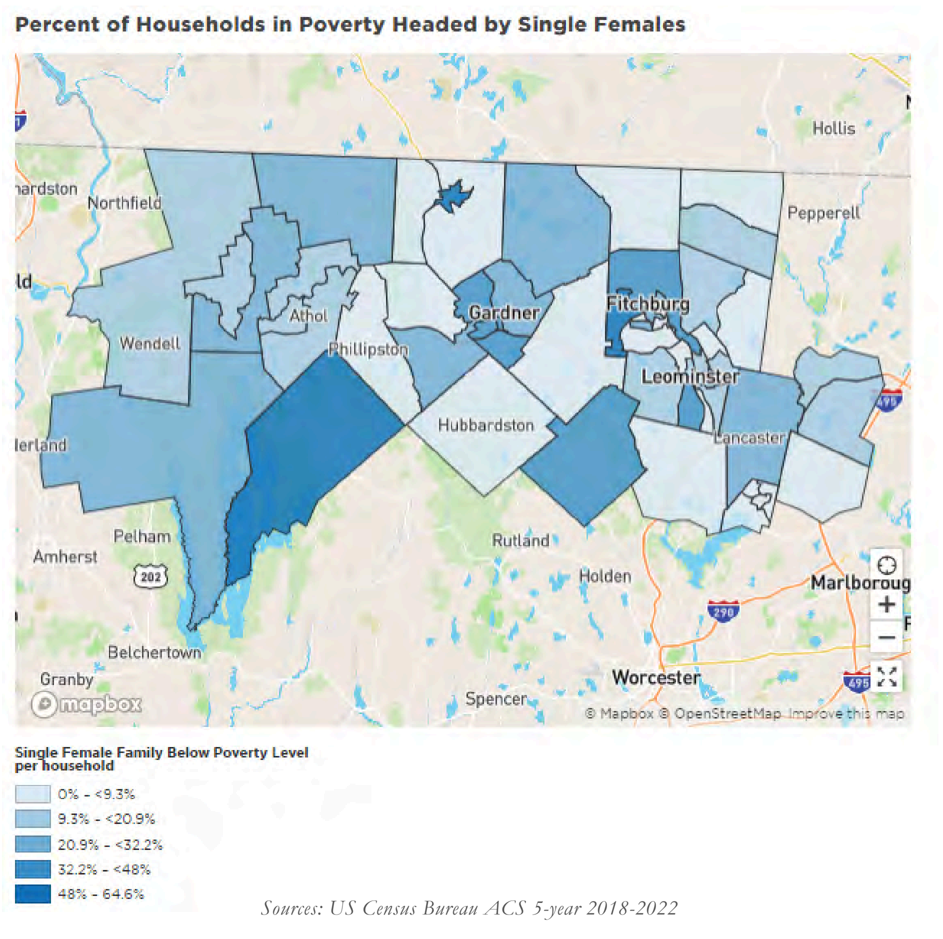
Being a single parent with children increases the risk of poverty. According to the table below, single parents across the Combined Service Area are more than twice as likely to live in poverty. That is, 13.6% of single parent families live in poverty versus 6.2% of all families.

% All Families Below Poverty Level	% Single Parent Families Below Poverty Level
6.2% Combined Service Area	**13.6%** Combined Service Area
6% HealthAlliance-Clinton Hospital	**12.7%** HealthAlliance-Clinton Hospital
6.4% Heywood Hospital	**17%** Heywood Hospital
9.3% Athol Hospital	**22%** Athol Hospital
6.6% Worcester County, MA	**15.8%** Worcester County, MA
7.1% Franklin County, MA	**17%** Franklin County, MA
6.5% Massachusetts	**16.6%** Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

Single-parent households often have only one income to support all family needs, which can strain financial resources and limit opportunities for economic mobility. Additionally, single parents may face higher childcare costs and reduced access to affordable housing, further exacerbating financial instability. According to the Annie E. Casey Foundation, single-mother families are particularly vulnerable [39]. Likewise, research from the National Women's Law Center highlights that single mothers are more likely to work in low-wage jobs without benefits, making it challenging to break the cycle of poverty [40]. Accordingly, addressing the specific needs of single householders, particularly women, with children is essential for reducing poverty rates and improving overall family well-being.

The map below shows the percentage of households living in poverty that are headed by single-mothers. Certain neighborhoods of Fitchburg, Petersham, Winchendon, Leominster, and Gardner have more than four in ten families living in poverty headed by single-mothers.



Sources: US Census Bureau ACS 5-year 2018-2022

Conclusion

People in poverty face significant barriers to self-sufficiency, healthcare, and other resources needed for economic prosperity. Breaking the cycle of poverty means removing barriers. Importantly, it means increasing access to nearby jobs with better pay to afford basic needs. It also means increasing quality, access, and affordability of food, housing, transportation, childcare, and medical care.

By delving into the specific poverty dynamics within special populations, policymakers and stakeholders can develop targeted approaches that address their distinct needs and circumstances. Moreover, comprehending the intersectionality of poverty with factors like age, race/ethnicity, employment status, and family composition is essential for promoting equity and social justice. By acknowledging and addressing the nuanced experiences of special populations within the broader context of poverty, communities can strive towards more inclusive and equitable outcomes, ensuring that no group is left behind in efforts to alleviate hardship and enhance well-being.

SOCIOECONOMICS

The economic landscape and labor market engagement of a region are critical determinants of community health and well-being. While labor market participation rates are relatively high in the Combined Service Area, the local economy is predominantly characterized by low-skilled, low-wage jobs. This economic structure significantly impacts residents' ability to achieve financial stability and secure a decent standard of living. Many individuals and families, despite being employed, struggle to make ends meet due to insufficient wages and limited opportunities for advancement. Understanding these economic dynamics is essential for identifying the underlying challenges faced locally and developing comprehensive strategies to enhance economic security and overall health outcomes.

Labor Market Engagement

The Labor Market Engagement Index (LMEI) measures how engaged residents are in the local labor market. The LMEI is calculated using a formula provided by US Department of Housing and Urban Development, and is based on the level of employment, labor force participation, and educational attainment (percent with a Bachelor's degree or higher) in a geography based on the US Census Bureau's American Community Survey. The value displayed is the national percentile ranking, higher scores are better.

The Labor Market Engagement Index score for the Combined Service Area is 51.7. This score is higher than Massachusetts as a whole, but lower than the other comparison areas of Worcester County and Franklin County.

Labor Market Engagement Index

51.7
Combined Service Area

54.7
HealthAlliance-Clinton Hospital

43.8
Heywood Hospital

35.4
Athol Hospital

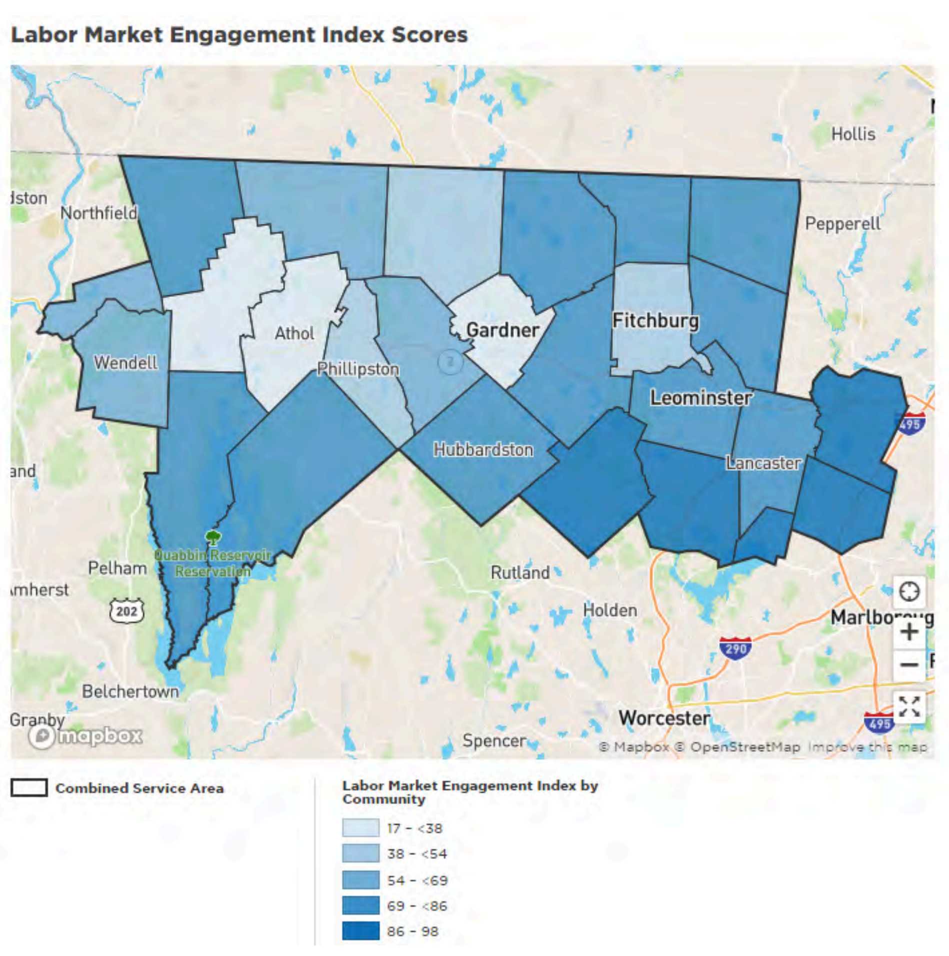
86
Worcester County, MA

81
Franklin County, MA

43
Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

Comparison of Labor Market Engagement Index data across different communities highlights disparities in opportunities for participation in the labor market. Some areas, particularly those in the southeastern portion of the Combined Service Area, have high levels of engagement, while others places like Orange, Gardner, Athol, Phillipston, and Fitchburg have lower levels of engagement (i.e., index scores under 50). Understanding these differences can help communities develop strategies to improve economic opportunities for all residents.



Sources: US Census Bureau ACS 5-year 2018-2022

Considered independently, the factors that comprise the Labor Market Engagement Index provide some insight into why there are variation across communities in scores.

Labor Force Participation

Economies benefit from skilled and mobile labor forces that respond quickly to changing business needs. The labor force is the number of people who are employed plus unemployed individuals who are looking for work. It does not include discouraged jobless workers who are not seeking employment nor does it include retired workers.

Across the Combined Service Area 65.1% of people are engaged in the Labor Force. This percentage is lower than the comparison areas of Worcester County and Massachusetts, but higher than Franklin County.

Labor Force Participation Rate

65.1%
Combined Service Area

65.7%
HealthAlliance-Clinton Hospital

61.6%
Heywood Hospital

61.2%
Athol Hospital

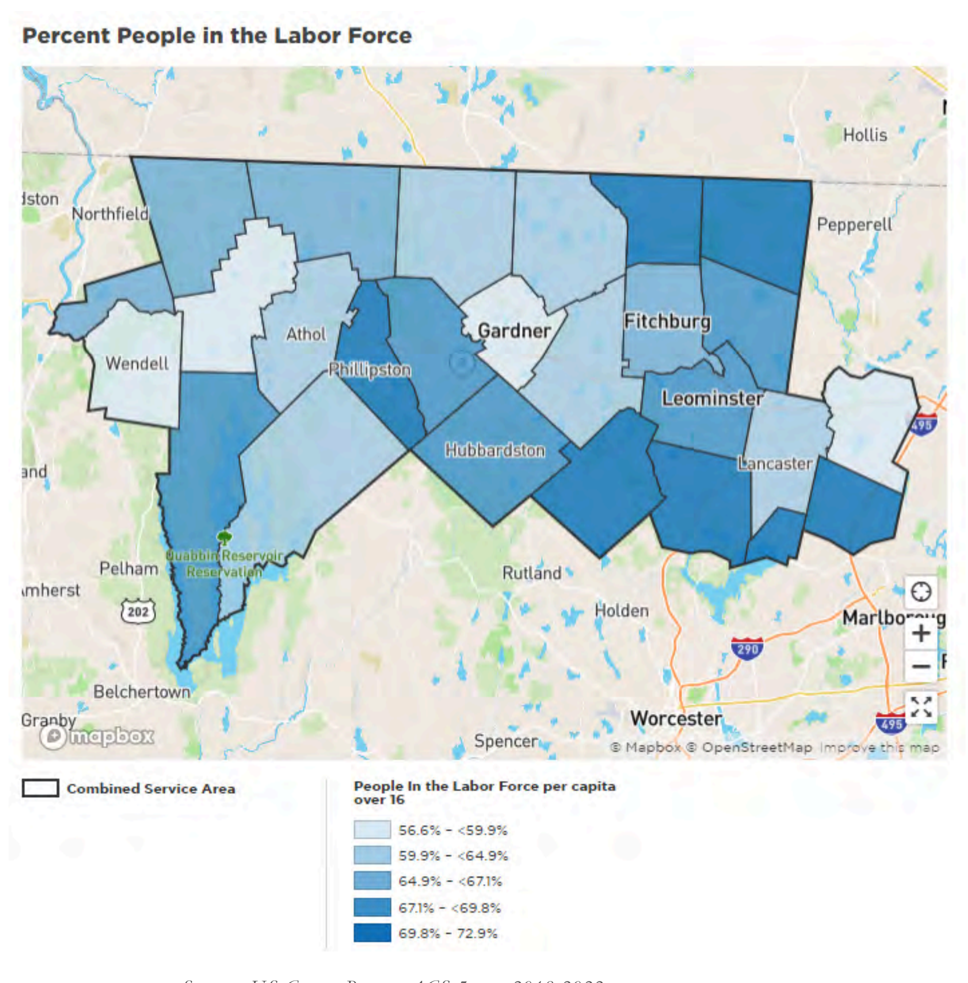
66.6%
Worcester County, MA

63.1%
Franklin County, MA

67.1%
Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

Labor force participation is a critical marker for the economic vitality of a community and the financial well- being of its residents. High participation rates indicate a robust economy where individuals have access to employment opportunities that can support themselves and their families. The eastern portion of the Combined Service Area tends to have higher Labor Force Participation. Given its proximity to MetroWest and Boston, this is not surprising - residents have better access to a wide range of employment opportunities.



Sources: US Census Bureau ACS 5-year 2018-2022

Various factors can contribute to low labor force participation in certain communities, including inadequate access to education and job training, health issues, childcare responsibilities, and systemic barriers such as discrimination and lack of transportation. These challenges hinder individuals from entering or remaining in the workforce, ultimately affecting the overall economic health and social cohesion of the community.

To begin to address the real barrier of childcare access to workforce participation, The Health Foundation of Central Massachusetts is funding two long-term Synergy Initiatives within the region.

The Family Services of Central MA's Family Childcare Success Project is a pioneering initiative that will foster economic growth and address the local childcare shortage. It will achieve this by empowering primarily bilingual families to establish their own high-quality, culturally sensitive Family Childcare Businesses in their communities. This unique approach to recruitment, training, education, and support is set to make a real difference in access to childcare as well as employment opportunity for local families.

North Central MA Employer-supported Childcare Coalition brings together the Community Foundation of North Central MA with the Chambers of Commerce, anchor institutions including the hospitals, the Federal Reserve Bank of Boston, and statewide groups to develop and implement a workable funding model that will break through the multiple barriers to affordable, accessible quality childcare for low- and moderate-income working families. The work also aims to offer a path to employment in a childcare sector that offers a livable wage. Both HealthAlliance-Clinton Hospital and Heywood Healthcare are participating members of the Coalition.

Employment

Employment indicators suggest that most people in the Combined Service Area who want to be employed are employed. With an unemployment rate of 3.6%, workforce participation across the region is similar to Worcester County and Massachusetts though higher than Franklin County where there is 2.9% unemployment. At the community level, unemployment rates range from a low of 2.7% in Townsend to a high of 4.8% in Fitchburg.

	Community	Unemployment Rate
Health Alliance-Clinton Hospital	Ashburnham	2.9%
	Ashby	2.8%
	Bolton	3.0%
	Clinton	3.5%
	Fitchburg	4.8%
	Gardner	4.0%
	Harvard	3.0%
	Lancaster	2.9%
	Leominster	3.8%
	Lunenburg	2.9%
	Princeton	2.8%
	Sterling	3.2%
	Townsend	2.7%
	Westminster	2.9%
	Area Total	**3.6%**
Heywood Hospital	Ashburnham	2.9%
	Gardner	4.0%
	Hubbardston	3.0%
	Templeton	3.6%
	Westminster	2.9%
	Winchendon	3.3%
	Area Total	**3.4%**
Athol Hospital	Athol	4.2%
	Erving	2.8%
	New Salem	2.7%
	Orange	4.1%
	Petersham	3.6%
	Phillipston	3.1%
	Royalston	3.0%
	Warwick	2.9%
	Wendell	3.0%
	Area Total	**3.8%**
	Combined Service Are	**3.6%**
	Worcester County	3.5%
	Franklin County	2.9%
	Massachusetts	3.4%

Source: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2023

While the employment numbers above appear quite favorable, the North Central Workforce Board in their *Central Massachusetts Regional Workforce Blueprint* (2023-2027) cautions that the actual unemployment rate across the region is likely higher than these statistics suggest. The official unemployment rate, the U-3 rate, only includes those actively looking for work within the past four weeks. That is, "discouraged workers" who have not searched for work recently are excluded from the rate. The North Central Workforce Board suggests that when including discouraged workers and those seeking full-time employment but only finding part-time work (i.e., the Bureau of Labor's U-6 measure), the unemployment rate in Central Massachusetts, where the Combined Service Area lies, rises to approximately 6.0%. This rate is consistent with the U-6 rate for Massachusetts, according to MassBenchmarks (May 2024).

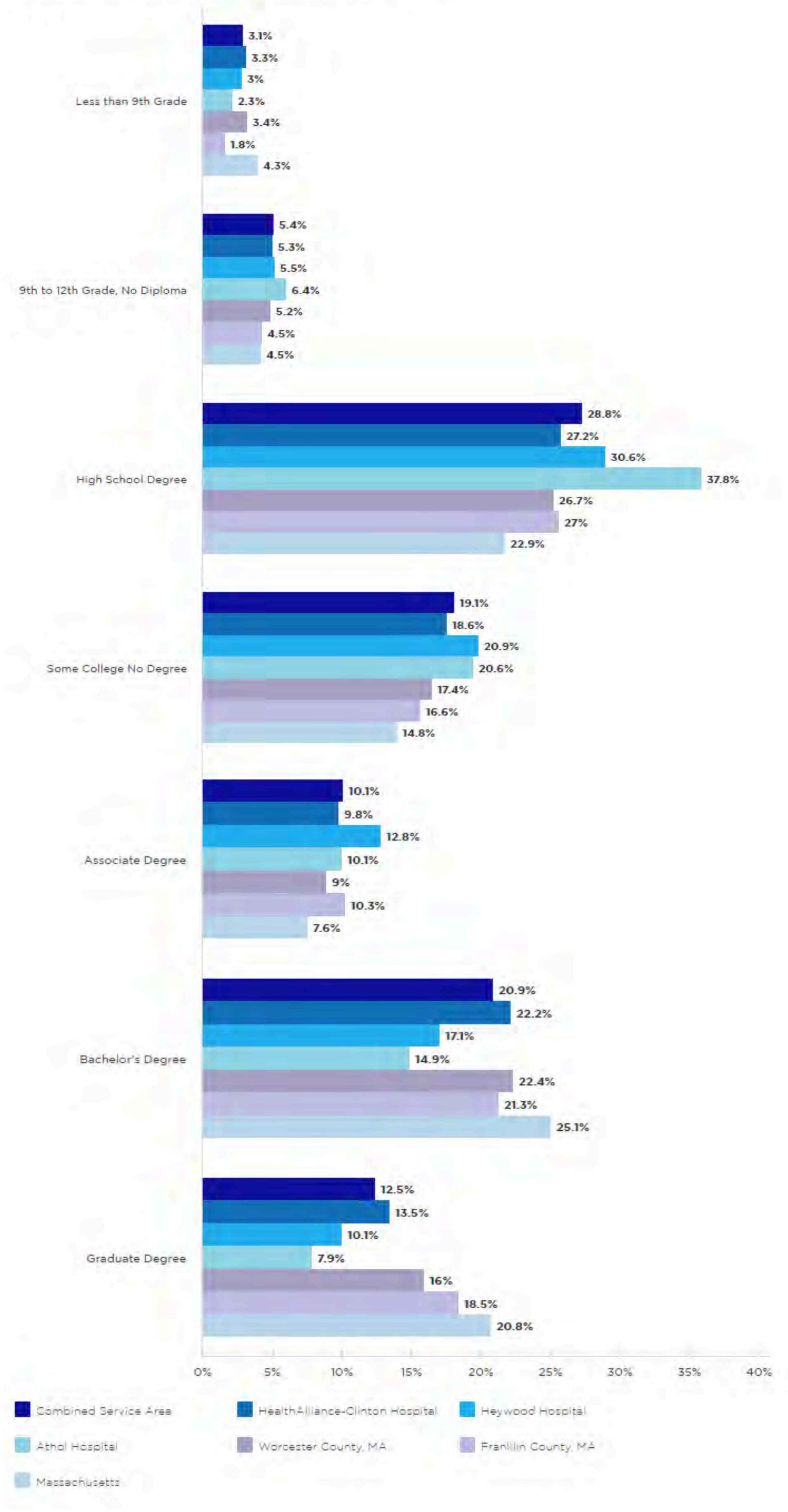
Even though traditional unemployment indicators suggest that unemployment rates are relatively low in the Combined Service Area, special populations, including people of color and Veterans, face disproportionately higher unemployment rates. According to the Economic Policy Institute [7], unemployment rates across the state for Black workers are nearly twice that of White workers,

and for Hispanic workers, they are roughly 1.5 times higher. Furthermore, according to the US Census Bureau, in some communities within the Combined Service Area, Veterans experience unemployment rates that are 5 to 10 times higher than the general workforce, highlighting disparities that require targeted interventions.

Educational Attainment

Educational attainment is also a component of the Labor Market Engagement Index score. It is a cornerstone of a robust economy, equipping individuals with the skills and knowledge necessary for high-productivity jobs, innovation, and competitiveness in the global market. A well-educated workforce attracts diverse industries, drives economic growth, and enhances overall quality of life. Conversely, an undereducated workforce can significantly hamper economic development. It limits the types of industries that can operate successfully in the region, perpetuates low-wage employment, and reduces the community's ability to adapt to technological advancements and evolving market demands. This educational gap can lead to higher unemployment rates, increased reliance on social services, and a cycle of poverty that is difficult to break, ultimately weakening the economic foundation of the community and contributing to worse health outcomes.

The educational attainment data presented below reveals a mixed landscape in the Combined Service Area. Compared to Worcester County, Franklin County, and Massachusetts, the Combined Service Area evidences a higher percentage of residents with high school diplomas, indicating a solid foundation of basic education. However, the proportion of individuals holding Bachelor's and Graduate degrees lags behind the comparison regions.



Sources: US Census Bureau ACS 5-year 2018-2022

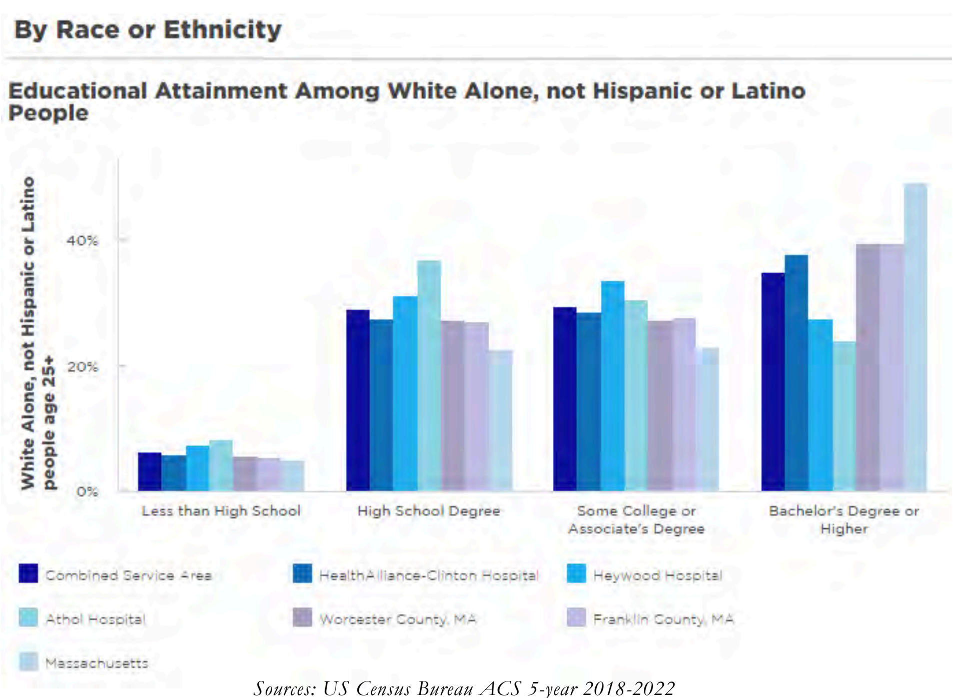
This disparity in higher education levels has implications for the local economy. While the strong high school completion rates provide a reliable workforce for entry-level and mid-skilled positions, the shortage of advanced degrees limits the region's ability to attract and sustain high-paying industries and specialized professions. This educational gap hinders economic diversification, reduces innovation, and restricts opportunities for economic advancement, ultimately affecting the region's long-term economic growth and competitiveness.

Racial and ethnic disparities in educational attainment across the Combined Service Area further exacerbate these challenges, particularly for members of specific communities of color. While national statistics reveal that individuals who self-identify as Black or Hispanic are less likely to obtain higher education degrees compared to their White and Asian neighbors [8], Black residents of the Combined Service Area are actually slightly more likely to have a Bachelor's Degree or Higher (36.5%) than their White counterparts (33.9%). However, Hispanic or Latino residents of the Combined Service Area are only half as likely (16.1%) to have a Bachelor's Degree or higher than their White neighbors. Asian residents of the Combined Service Area are the most likely to havehigher educational attainment (49.7%).

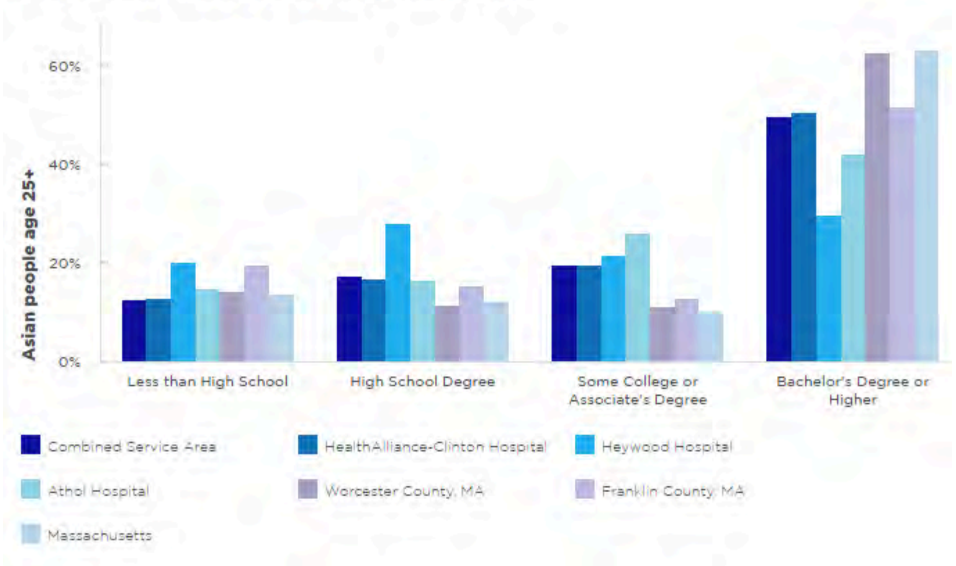
Combined Service Area	
Asian People with Bachelor's Degree or Higher Education per capita	49.7%
Black or African American People with Bachelor's Degree or Higher Education per capita	36.5%
White People with Bachelor's Degree or Higher Education per capita	33.9%
American Indian and Alaska Native People with Bachelor's Degree or Higher Education per capita	32.1%
Two or More Race People with Bachelor's Degree or Higher Education per capita	24.7%
Other Race People with Bachelor's Degree or Higher Education per capita	16.2%
Hispanic or Latino People with Bachelor's Degree or Higher Education per capita	16.1%

Sources: US Census Bureau ACS 5-year 2018-2022

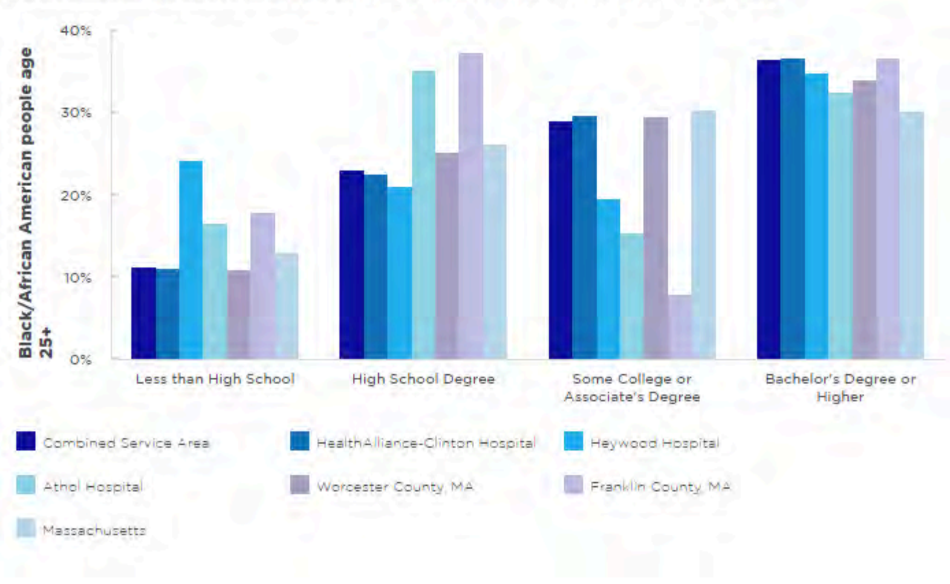
The graphs below provide a more detailed look at educational attainment by racial and ethnic group across the Combined Service Area and within the individual hospital service areas.



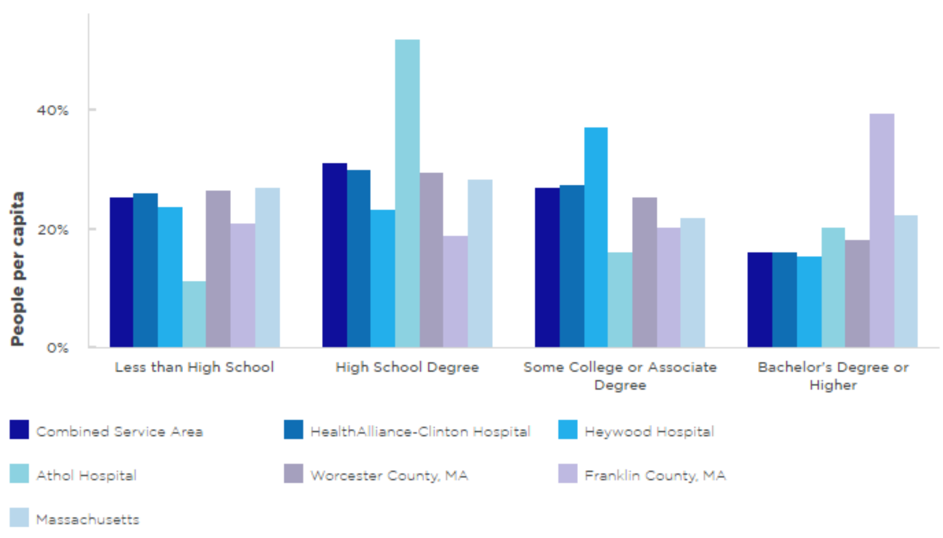
Sources: US Census Bureau ACS 5-year 2018-2022



Educational Attainment Among Black or African American People



Educational Attainment Among Hispanic or Latino People



Sources: US Census Bureau ACS 5-year 2018-2022

Racial and ethnic educational inequities not only limit access to well-paying jobs that require advanced skills but also contributes to higher rates of unemployment and underemployment within these communities. As a result, people of color are more likely to be confined to lower-wage positions with limited prospects for career advancement, perpetuating cycles of poverty and economic instability. The disparities in educational attainment thus have a cascading effect, influencing access to work, income levels, and ultimately, the overall economic health of the region. Addressing these disparities is critical for fostering a more inclusive and equitable economy that benefits all residents of the Combined Service Area.

The state of Massachusetts is actively working to address low educational attainment across the Commonwealth through MassReconnect and MassEducate. MassReconnect is a grant program aimed at encouraging adults aged 25 and older to attend community college and earn a postsecondary credential or degree. It provides "last dollar" financial assistance, covering remaining costs such as tuition, fees, books, and supplies after other financial aid has been applied. The program is designed to support adult learners in completing their education at public community colleges. MassEducate extends similar benefits to Massachusetts residents of all ages.

Locally, the Anchor Collaborative (i.e., the two partner hospital systems, the community health center, education institutions, and large social service organizations) have formed partnerships to improve pathways from secondary and post-secondary education to healthcare careers through classroom education and supervised practical experience. The healthcare partners have also worked with the North Central MA Workforce Investment Board and with certificate programs through Mount Wachusett Community College, Fitchburg State University, and Montachusett Regional Technical Vocational School to streamline and fast-track program participants into high-demand healthcare jobs. Some of these programs provide wraparound support for students such as English as a second language, career counseling, and linkages to community-based emergency assistance organizations.

Additionally, one of UMass Memorial Health's system-wide strategic goals for Fiscal Year 2024 was to design and implement three career pathway programs for 50 caregivers. These programs included:

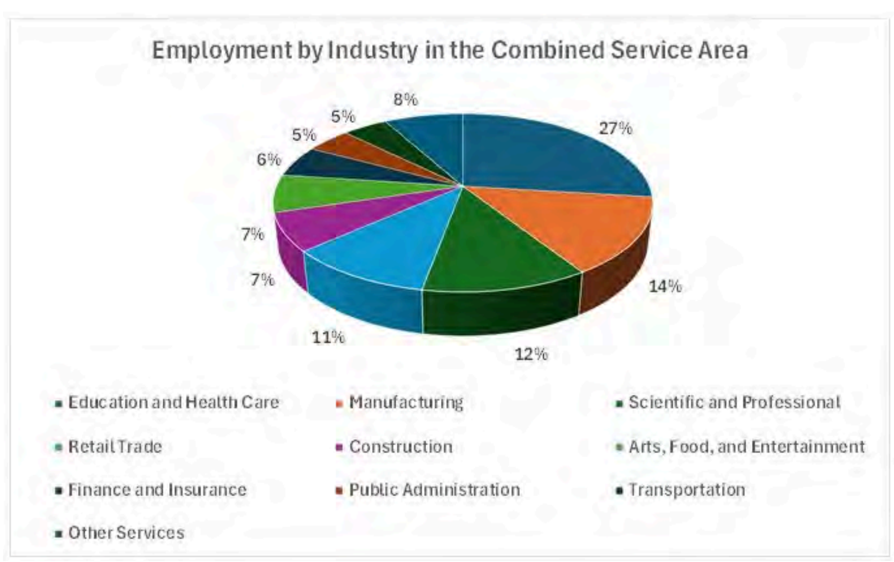
- Internal Career Pathway Programs: Medical Assistant Apprenticeship Program and Frontline Scholars for Surgical Technologists.
- External Career Pipeline Programs: PCA Pathway Program and youth cooperative education/work-based learning experiences.
- Foundational Support: Workplace English and Medical Terminology.

The system-wide goal was exceeded, with some participants being employees from HealthAlliance-Clinton Hospital.

Industry & Occupations

Individual factors such as labor force participation, educational attainment, and employment status impact a region's economic vitality. These elements determine the skill level of the workforce, which in turn influences the types of industries and jobs that can thrive in the area. That is, if industries perceive a lack of sufficiently skilled workers, they are less likely to establish themselves in the area, which hampers job creation and limits opportunities for residents to advance economically. This cycle can stymie economic growth and perpetuate a low-skill, low-wage job market, underscoring the need for targeted educational and workforce development initiatives to break this cycle and attract diverse, high-quality industries.

Once a thriving manufacturing community, the Combined Service Area has experienced significant declines in the industry over the past 60 years as factories and mills have moved south and overseas. Today, Education & Healthcare employs a larger percentage of residents of the Combined Service Area than Manufacturing. Of note is that Heywood Healthcare is the largest employer in the Gardner region.



Source: US Census Bureau ACS 5-year 2018-2022

Despite the vital roles these industries play in societal well-being and economic stability, the prevalence of low- skilled, low-paying positions within them leads workers to earn wages that barely cover basic necessities.

Wages & Income

Per the Massachusetts Department of Labor, none of the most common occupations across the Combined Service Area requires formal education at entry. Further, the Average Median Wage for these jobs in the North Central Workforce Development Area, which most closely aligns with the Combined Service Area, is $53,488 per year (or $25.72 per hour).

While this wage is higher than the state Minimum Wage ($15/hour), it is barely sufficient to support a single adult, let alone a family. Per the Massachusetts Institute of Technology's Living Wage Calculator [9], $25.72 per hour is roughly equivalent to the Average Living Wage for a Single Adult in Worcester County ($23.84) where most of the Combined Service Area lies. However, this wage quickly becomes out of step with the cost of living when additional adults and/or children are added to the household.

For example, the Economic Policy Institute's Family Budget Fact Sheet [10] shows that "for a two-parent, two-child family in the Fitchburg/Leominster metro area, it costs $9,812 per month ($117,742 per year) to secure a modest yet adequate standard of living."

Here's a breakdown of how much it costs for a two-parent, two-child family to get by in the Fitchburg/Leominster metro area:

Housing: $1,358 per month • $16,296/year

Food: $1,105 per month • $13,260/year

Child care: $2,255 per month • $27,060/year
Monthly costs range from $1,204 for a single-child family to $2,578 for a family with four kids.

Transportation: $1,515 per month • $18,180/year

Health care: $1,278 per month • $15,336/year

Other necessities: $872 per month • $10,464/year

Taxes: $1,428 per month • $17,136/year

Source: Economic Policy Institute. Family Budget Fact Sheet for the Fitchburg-Leominster Metro Area. Accessed June 2024 at: https://www.epi.org/resources/budget/budget-factsheets/#/3809

Based on the expenses outlined above, the two parents would both have to work more than full time in local jobs with Median Wages to support "a modest yet adequate standard of living". Of note is that, per the Economic Policy Institute's estimates, child care is the largest annual expense and accounts for nearly one quarter of the family's income.

The low wages residents earn from local jobs are a real barrier to economic stability for many. This theme was repeated time and time again in the Focus Groups conducted as part of this Community Health Needs Assessment process. Issues related to wages and their incompatibility with the cost of living were among the most frequently cited.

"People are living paycheck to paycheck."

"Single parents need to make at least $75K annually to support basic needs and that is often unattainable in this area."

"It's hard trying to find another job, especially when you are already working full time, the only options available are working at a supermarket, fast food, or gas station."

Like the Focus Group participants, community members who engaged in recent Community Needs Assessments by both Making Opportunity Count and Community Action Pioneer Valley, the federally-funded Community Action Agencies serving the Combined Service Area, reported that "jobs" were a top need in the region. Specifically, low wages and the incompatibility between wages and cost of living were highlighted.

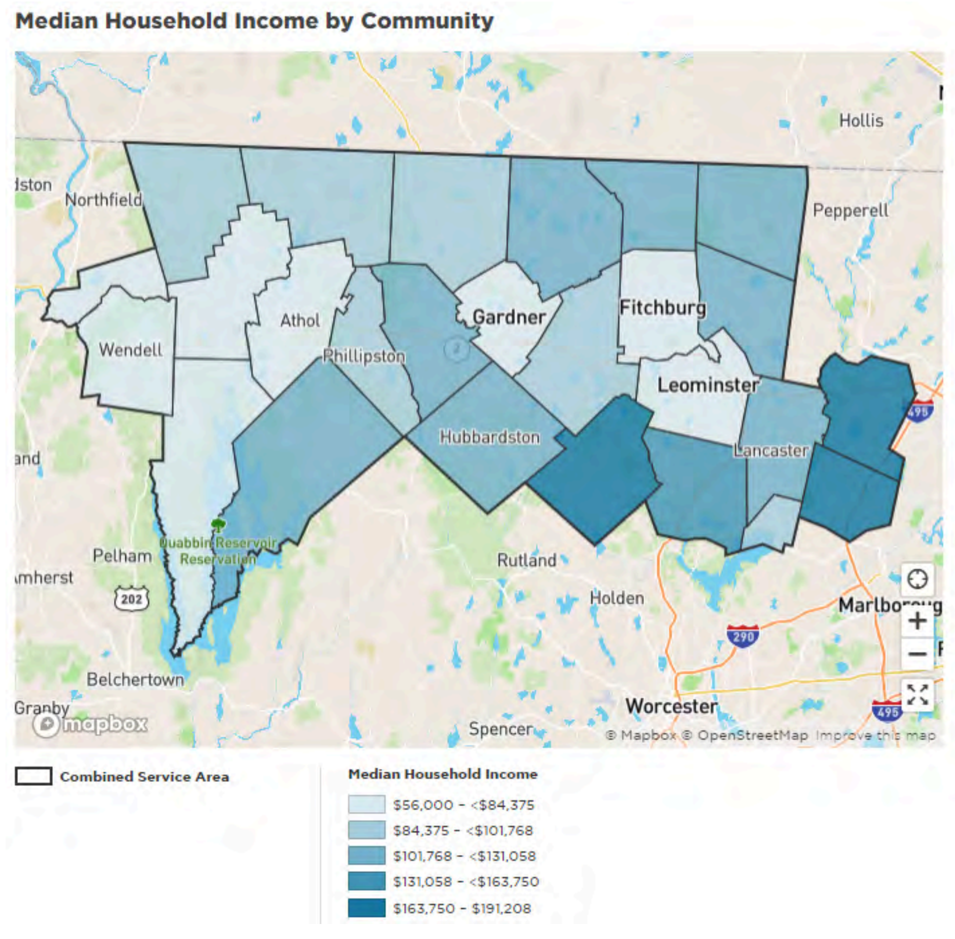
These concerns seem almost incompatible with the relatively strong Median Household Income in the region. At $90,630, Median Household Income in the Combined Service Area is roughly 94% of the Massachusetts' statewide Median Household Income.

Median Household Income	USD
Combined Service Area	**$90,630**
HealthAlliance-Clinton Hospital	**$93,327**
Heywood Hospital	**$86,464**
Athol Hospital	**$68,945**
Worcester County, MA	**$88,524**
Franklin County, MA	**$70,383**
Massachusetts	**$96,505**

Sources: US Census Bureau ACS 5-year 2018-2022

While the Median Household Income for the Combined Service Area is not far off the statewide Median Household Income, there are notable discrepancies between hospital service areas with regards to Median Household Income, ranging from $93,327 in the HealthAlliance-Clinton Hospital service area to $68,945 in the Athol Hospital service area.

Furthermore, there are notable discrepancies between individual communities' Median Household Income values across the Combined Service Area. The map below shows a range from $56,000 in Orange to $191,208 in Bolton. Additionally, many of the more urban areas (Leominster, Fitchburg, Gardner, and Athol) as well as communities in the western portion of the Combined Service Area have lower Median Household Incomes. In fact, per the map below, the very high Median Household Income values in the south eastern corner of the Combined Service Area may be inflating the overall value for the region.



Sources: US Census Bureau ACS 5-year 2018-2022

Conclusion

There are economic challenges within certain communities and regions of the Combined Service Area, where lower Labor Market Engagement scores are driven by lower workforce participation rates and lower educational attainment levels. The local economy, characterized by predominantly low-wage and low-skill jobs, exacerbates these issues. This economic structure creates a cycle of limited opportunities, where residents are often confined to low-paying positions, making it difficult to achieve financial stability and keep pace with the rising cost of living. These interconnected factors underscore the need for targeted interventions to enhance education, improve employment prospects, and ultimately break the cycle of poverty in these affected regions.

HOUSING

Finding and maintaining housing in a region dominated by low-skilled, low-wage jobs presents a significant challenge for many residents. When the majority of available employment opportunities offer limited pay, individuals and families often struggle to cover basic living expenses, let alone the escalating costs of housing.

The Combined Service Area has 103,201 housing units, 7.51% of which are considered "affordable". Per M.G.L. Chapter 40B, which was enacted in 1969 to help address the shortage of affordable housing units within the state, the standard is for cities and towns to provide a minimum of 10% of their housing inventory as affordable. Thus, the Combined Service Area is falling short of its duty to provide housing that is accessible to low and moderate income households.

Only three of the communities across the Combined Service Area: Bolton (15.15%), Gardner (14.38%), and Orange(11.97%) meet or exceed the goal of 10% affordable housing units.

The lack of affordable housing across the Combined Service Area is a barrier to attracting workers and it further impairs the region's ability to attract and retain strong employers. When businesses struggle to find employees due to housing shortages, they are less likely to establish or expand operations in the area. This, in turn, limits local job opportunities and economic growth, exacerbating unemployment and perpetuating the scarcity of affordable housing.

The North Central Massachusetts' Chamber of Commerce's recent report (prepared by the Donahue Institute), *Engaging Hidden and Future Workers to Grow the Local Economy*, cites the lack of affordable housing as a local housing issue in breaking the region's cycle of economic stagnation.

Homeownership

Over 71% of the Combined Service Area's housing units are owner occupied. This percentage is higher than the comparison areas of Worcester County, Franklin County, and Massachusetts.

Homeownership Rate	Renter Rate
71.1% Combined Service Area	**28.9%** Combined Service Area
69.2% HealthAlliance-Clinton Hospital	**30.8%** HealthAlliance-Clinton Hospital
74.2% Heywood Hospital	**25.8%** Heywood Hospital
76.4% Athol Hospital	**23.6%** Athol Hospital
65.9% Worcester County, MA	**34.1%** Worcester County, MA
69.6% Franklin County, MA	**30.4%** Franklin County, MA
62.4% Massachusetts	**37.6%** Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

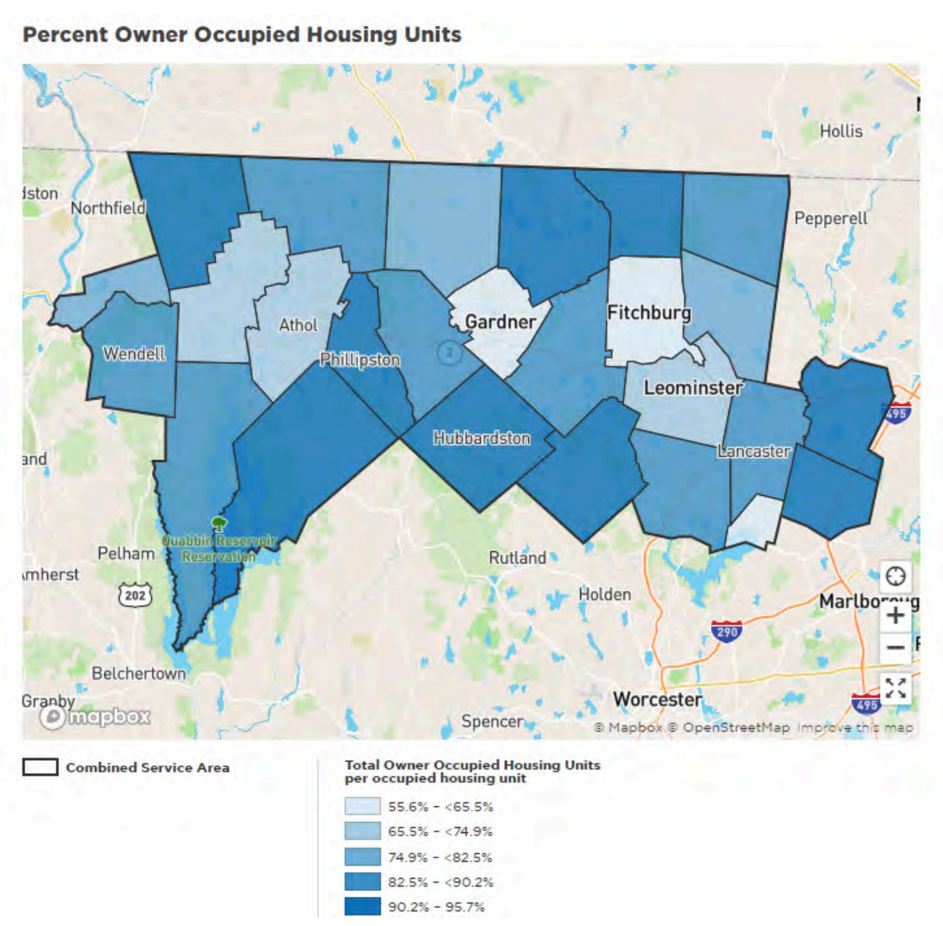
The relatively high homeowner occupancy rates in the Combined Service Area are likely due to several interrelated factors. First, per the table below, the area evidences relatively low Median Home Values as compared to Worcester County and Massachusetts. This relative affordability makes purchasing a home more accessible and financially appealing than renting for those who have the resources to cover purchase costs.

Median Home Value	
$322,214 USD	Combined Service Area
$339,648 USD	HealthAlliance-Clinton Hospital
$292,712 USD	Heywood Hospital
$238,025 USD	Athol Hospital
$363,200 USD	Worcester County, MA
$284,100 USD	Franklin County, MA
$483,900 USD	Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

Second, proximity to major economic centers (i.e., the City of Worcester, MetroWest, and Boston) makes the Combined Service Area an attractive bedroom community for individuals who work out of the region. The fact that the Combined Service Area is both relatively affordable and accessible to regions with larger job markets, makes it an ideal location for commuters.

The map below shows that owners generally occupy higher percentages of housing units in the more peripheral areas of the Combined Service Area. To the north and west, these communities have lower Median Home Values (per the table above). To the south and east, these communities lie within commuting distance of the City of Worcester, MetroWest, and Boston.



Sources: US Census Bureau ACS 5-year 2018-2022

Unfortunately, the region's attractiveness to commuters drives up housing demand and, consequently, property values as well as real estate taxes. While housing costs in the region may be affordable compared to surrounding areas, particularly those to the east, they are often out of reach for local workers who earn lower wages as well as older adults trying to stay in their own homes. This dynamic creates a disparity, where local residents struggle to afford homes in their own community.

Additionally, it is important to note that, at the writing of this Community Health Needs Assessment, home prices in the Combined Service Area have risen drastically from what the US Census Bureau reported in their American Community Survey for 2018-2022. A recent article from the Boston Globe [11] states that the "median home sale price in Fitchburg [rose] 80 percent from

2018 to 2023. Home prices in...Westminster, Gardner, Leominster, and Lunenburg all rose by more than 60 percent." This sudden and drastic increase in home prices exacerbates the challenge for people who work locally to live locally.

Utility Costs

Utility costs significantly contribute to overall housing expenses. Essential services such as electricity, water, heating, and cooling can constitute a substantial portion of monthly housing costs, particularly in regions with extreme weather conditions like the northeastern United States where winters, in particular, can be very cold. Additionally, utility costs tend to be higher for residents in older, less energy efficient housing stock.

For low income households, high utility bills can be especially challenging, as these households must allocate a larger percentage of their limited income to cover these necessities. As a result, managing utility expenses is a critical component of housing affordability, impacting the financial stability and quality of life for many households.

Locally, challenges with the affordability of utilities are highlighted in the results of HealthAlliance-Clinton Hospital's Social Determinants of Health (SDOH) risk and needs screening tool, which surveyed 8,364 patients, primarily from primary care settings, to assess their experiences and needs. The assessment revealed that 3% of respondents were at-risk of losing utility services in the past year, and 4% expressed needing assistance paying for utilities.

Recognizing that residents of color and those whose primary language is not English are often disproportionately affected by Social Determinants of Health, the hospital stratified the risk and need data by race/ethnicity and primary language. This analysis uncovered that 17% of respondents who identified as "Hispanic or Latino," 19% of respondents who identified as "Black," and 18% of respondents who identified as "Other" reported utility-related needs, compared to 6% of White respondents. Similarly, 25% of Spanish-speaking respondents, 23% of Portuguese-speaking respondents, and 17% of Haitian Creole-speaking respondents reported needing help with utilities, in contrast to 7% of English-speaking respondents. This stratified data underscores the deeper financial vulnerabilities faced by certain groups in the Combined Service Area.

High utility costs were also highlighted by participants in the Focus Groups conducted as part of this Community Health Needs Assessment process. Specifically, participants talked about recent increases in utility rates as well as the overall cost of heating.

"I worry about [heat] every year. It's stressful because I don't know if I can afford the heating bills. Every winter is different."

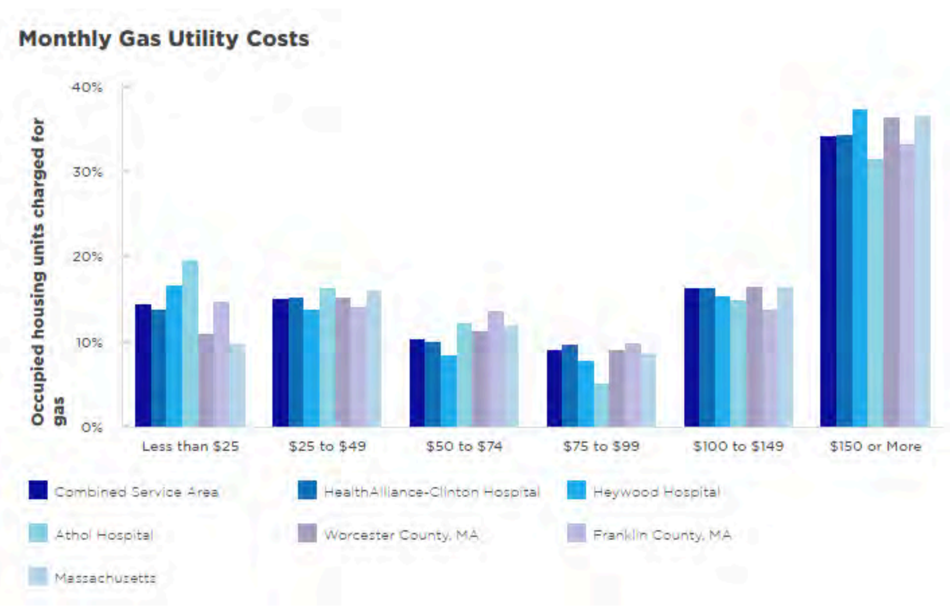
Similarly, in their recent Community Needs Assessments, both Making Opportunity Count and Community Action Pioneer Valley, the federally-funded Community Action Agencies serving the Combined Service Area, reported that residents who responded to their Community Needs Surveys selected "Ability to pay heating or utility bills" as the second biggest issue impacting people in their service areas.

Concerns about the cost of utilities are highly valid, as highlighted by the Council for Community and Economic Research's Cost of Living Index. The table below shows that utility costs in the region are 31.3 index points higher than the national average (though 1.7 index points lower than the Boston area). This significant disparity means that residents of the Fitchburg-Leominster area are paying substantially more for essential services such as electricity, water, heating, and cooling as compared to the average American household.

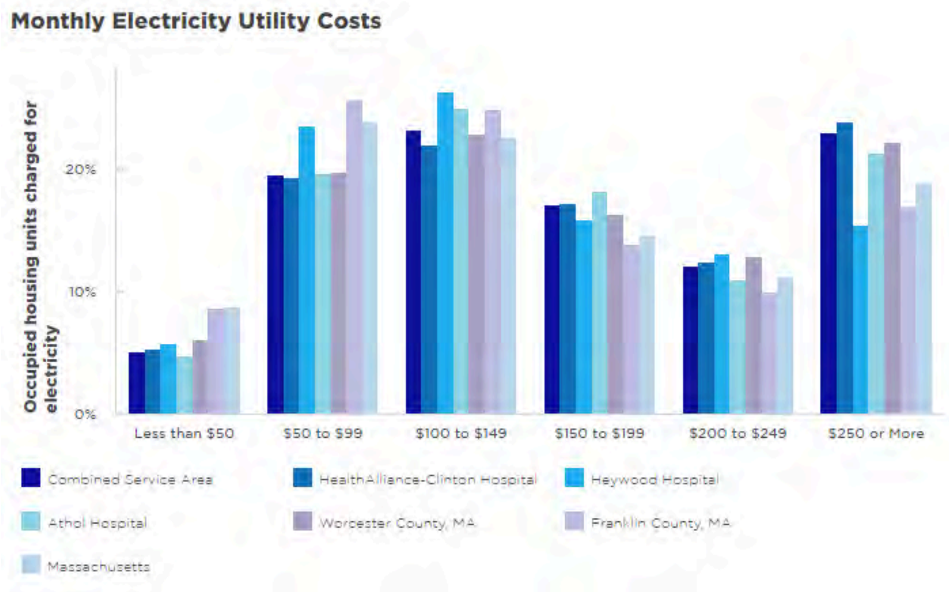
	Geography			Comparison of Fitchburg-Leominster MA	
Index	Fitchburg-Leominster MA	Boston MA	USA Average	To US	To Boston
Composite	113.9	147.1	100	13.9	-33.2
Grocery	98.3	105.2	100	-1.7	-6.9
Housing	117.8	220.6	100	17.8	-102.8
Utilities	131.3	133	100	31.3	-1.7
Transportation	96.5	117.8	100	-3.5	-21.3
Healthcare	118	113	100	18.0	5.0
Miscellaneous	118	122	100	18.0	-3.6

Source: The Council for Community and Economic Research. Cost of Living Index. Comparison between Fitchburg/Leominster, MA, Boston, MA, and Nation. Quarter 1-3, 2023.

US Census Bureau data echoes the Council for Community and Economic Research's finding. The graphs below show that over one-third of Combined Service Area residents are paying $150 or more per month for gas and nearly one-quarter of residents are paying $250 or more per month for electric.



Sources: US Census Bureau ACS 5-year 2018-2022



Sources: US Census Bureau ACS 5-year 2018-2022

These elevated utility costs place an additional financial burden on residents, particularly those with limited incomes, making it even more difficult to manage overall housing expenses. Addressing these high utility costs is crucial for alleviating the financial strain on local households and improving their economic stability and quality of life.

To help combat high utility costs, people who participated in Focus Groups as part of this Community Health Needs Assessment process suggested:

- reducing rates by encouraging competition among utility providers and
- advocating for expanding income eligibility for assistance programs like Fuel Assistance/HEAP because...

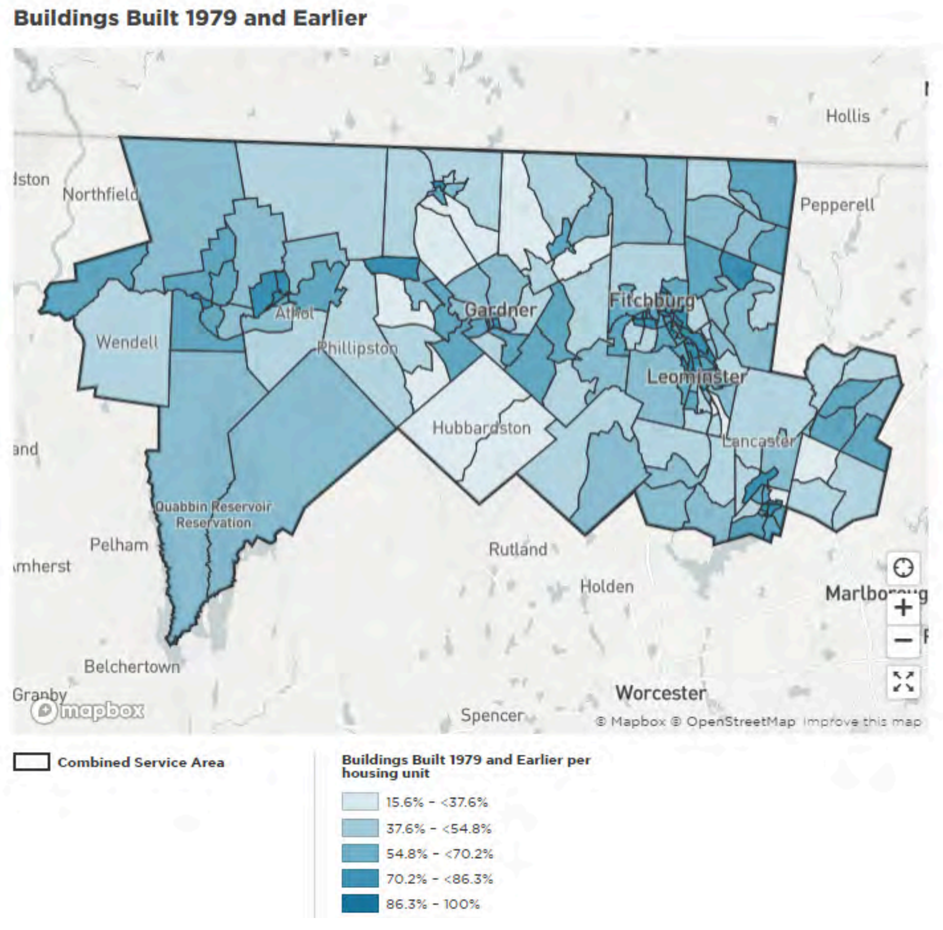
"Fuel assistance is not available to everyone. You have to [meet income eligibility] to qualify for any help."

Housing Stock

High utility costs are a significant burden for many residents, particularly in areas where older housing stock is prevalent. The inefficiencies and poor insulation common in older homes contribute to these elevated utility expenses, further impacting household budgets and financial stability.

The map below shows the Combined Service Area divided into Census Block Groups to highlight the specific neighborhoods in which older housing stock is more prevalent.

Buildings Built 1979 and Earlier



Sources: US Census Bureau ACS 5-year 2018-2022

The downtown areas of the larger more urban communities in the Combined Service Area tend to have the highest concentrations of older housing. These areas were the first developed in the region. At the turn of the 20th century, they housed the workers who tended the mills which were thriving along the Nashua River.

Though more than 500 housing units in the Combined Service Area are weatherized annually by Making Opportunity Count and Community Action Pioneer Valley, the local US Department of Energy Weatherization Assistance Providers in the region, there are still thousands of units which are likely less efficient than they could be and, therefore, placing an undo energy burden on their occupants. This burden on residents of older housing stock will likely increase as climate change impacts the frequency and intensity of extreme weather, further driving up the demand for heating and cooling.

The older housing stock not only leads to high energy costs due to poor insulation and inefficiencies but also poses a risk for lead exposure. Many of these older homes still contain lead-based paint and plumbing, creating serious health hazards for residents, particularly children.

For communities with older housing stock, like those highlighted in the map above, lead paint continues to be a threat to community health. Exposure to lead has been associated with

developmental and physical delay, learning disabilities, and even pregnancy complications. Children younger than 6 years are especially vulnerable to the effects of lead poisoning.

The cost of lead abatement in older homes can be prohibitively high, posing a significant financial challenge for homeowners and landlords. Lead abatement involves extensive procedures, including the removal or sealing of lead-based paint and the replacement of contaminated plumbing and fixtures. These processes require specialized contractors and adherence to strict safety regulations, driving up the costs. For many property owners, the financial burden of lead abatement is substantial, making it difficult to ensure safe living conditions without external support or funding assistance.

In the Combined Service Area, a great deal of work has been done over the past 15 years around lead abatement in the housing stock and ensuring families are testing their children's lead levels. As a result, lead levels in the communities that make up the region are no longer statistically significantly higher than Massachusetts. However, according to the Massachusetts Department of Public Health's Bureau of Environmental Health, there are elevated rates in some of the more urban communities where the housing stock tends to be older (e.g., Clinton, Fitchburg, Gardner, Athol, Winchendon) as well as the western most communities in the Combined Service Area (e.g., Athol and Orange).

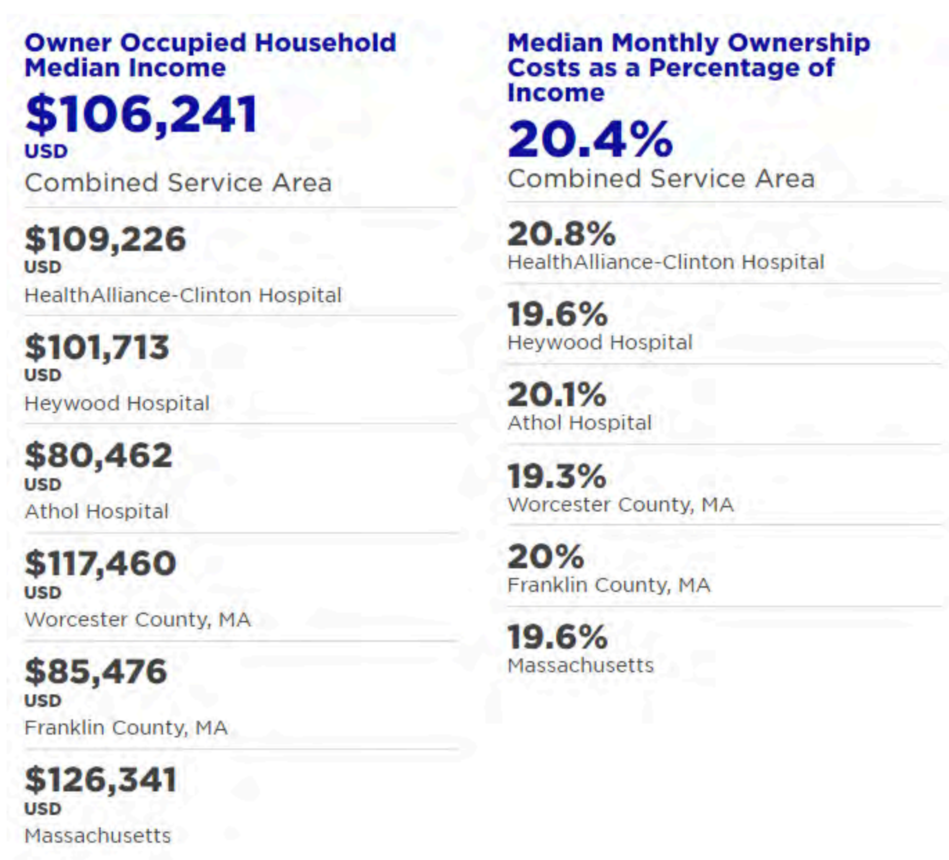
In addition to the risk of lead exposure, older housing stock poses a significant risk for asthma. Many of these aging homes are prone to issues such as mold growth and dust accumulation, which can aggravate respiratory conditions and lead to higher rates of asthma among residents. Poor insulation and ventilation in these homes can further exacerbate these problems, creating an environment that is detrimental to respiratory health.

In the Combined Service Area, 12% of adult residents have asthma as compared to 10.9% across Massachusetts. The prevalence of asthma among students enrolled in schools across the Combined Service Area is higher than the state (9.9 per 100 students) in Fitchburg, Gardner, Leominster, Lunenburg, Athol, and Warwick.

Homeownership Costs

As described above, homeownership is a significant financial investment that extends beyond the initial down payment. Each month, homeowners must manage mortgage payments, which often represent a substantial portion of their income. In addition to the mortgage, there are ongoing maintenance costs to ensure the property remains in good condition, ranging from routine repairs, to lead abatement, to unexpected issues like plumbing or roofing problems. Utility costs, including electricity, water, and heating, also add to the monthly expenses. Together, these costs represent a considerable financial commitment.

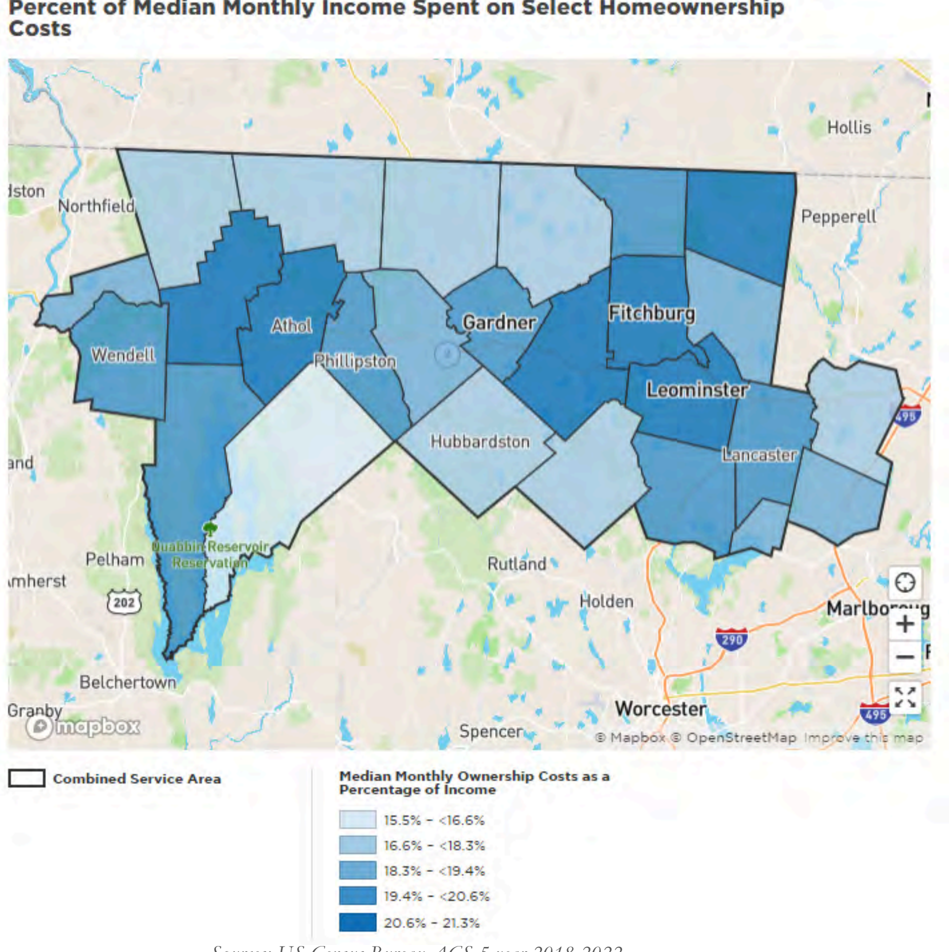
Per the table below, homeowner households across the Combined Service Area make roughly $106,000 annually and spend just over 20% of that income on their housing. In a region where the Median Household Income for all households is less than $91,000, the cost of homeownership is out of reach for many.



Area	Owner Occupied Household Median Income	Median Monthly Ownership Costs as a Percentage of Income
Combined Service Area	$106,241 USD	20.4%
HealthAlliance-Clinton Hospital	$109,226 USD	20.8%
Heywood Hospital	$101,713 USD	19.6%
Athol Hospital	$80,462 USD	20.1%
Worcester County, MA	$117,460 USD	19.3%
Franklin County, MA	$85,476 USD	20%
Massachusetts	$126,341 USD	19.6%

Sources: US Census Bureau ACS 5-year 2018-2022

As the map below shows, the percent of Median Monthly Income spent on select homeownership costs is generally higher in more urban communities of the Combined Service Area (i.e., Leominster, Fitchburg, Gardner, and Athol) as well as the communities that lie along the Route 2 corridor.



Sources: US Census Bureau ACS 5-year 2018-2022

Property in urban settings with good accessibility to major highways tend to be more expensive. Proximity to major highways offers residents convenient commuting options, reducing travel time to work, shopping centers, and other essential services. Ease of access attracts both individuals and businesses, driving up demand for housing and commercial properties. Additionally, areas with better highway access often see more infrastructure development and increased economic activity, further boosting property values. The combination of high demand, superior connectivity, and robust economic opportunities likely contributes to the elevated cost of living in these well-connected urban communities.

The relatively high cost of homeownership across the region, particularly for local workers, was a common theme in the Focus Groups conducted as part of this Community Health Needs Assessment process. Comments like those below are emblematic of the issue.

"Housing prices are extremely high. People with good jobs and good credit are unable to afford housing."

"What's available is not attainable."

"Jobs don't pay enough to cover housing."

The concerns expressed by Focus Group participants regarding housing costs are echoed in recent reports published by the two federally-funded Community Action Agencies serving the Combined Service Area. In their recent Community Needs Surveys, both Making Opportunity Count and Community Action Pioneer Valley reported that the top issue impacting people in their communities was "Affordable housing". This significant alignment underscores the widespread recognition of housing affordability as a critical issue impacting the community. The shared concerns highlight the urgent need for targeted interventions and comprehensive strategies to address housing affordability, ensuring that all residents have access to stable and reasonably priced housing options.

Cost Burden

Given that the Average Median Wage for jobs available in the Combined Service Area is $53,488, it is not surprising that homeownership costs are burdensome for many local workers. According to the Department of Housing and Urban Development (HUD), spending more than 30% of income on housing costs constitutes a cost burden. For residents earning the median wage, the expenses associated with owning a home—such as mortgage payments, property taxes, insurance, and maintenance—often exceed this threshold, making it difficult to achieve financial stability.

Across the Combined Service Area, 27.9% of homeowners with a mortgage and 20.2% of homeowners without a mortgage are "cost burdened."

	Community	Mortage: 30% or More	No Mortage: 30% or more
Health Alliance-Clinton Hospital	Ashbumham	26.2%	10.8%
	Ashby	29.9%	8.9%
	Bolton	23.4%	4.4%
	Clinton	22.9%	27.4%
	Fitchburg	32.6%	28.6%
	Gardner	31.2%	14.8%
	Harvard	21.2%	13.0%
	Lancaster	27.6%	21.0%
	Leominster	26.4%	23.4%
	Lunenburg	29.6%	24.6%
	Princeton	22.0%	7.6%
	Sterling	24.0%	16.6%
	Townsend	28.4%	23.1%
	Westminster	37.8%	18.6%
	Area Total	**28.2%**	**20.8%**
Heywood Hospital	Ashbumham	26.2%	10.8%
	Gardner	31.2%	14.8%
	Hubbardston	15.0%	18.5%
	Templeton	23.9%	26.6%
	Westminster	37.8%	18.6%
	Winchendon	21.9%	10.6%
	Area Total Average	**27.3%**	**18.4%**
Athol Hospital	Athol	34.3%	14.8%
	Erving	24.0%	13.7%
	New Salem	37.4%	25.0%
	Orange	31.3%	22.8%
	Petersham	23.8%	26.0%
	Phillipston	24.0%	14.2%
	Royalston	25.4%	11.5%
	Warwick	40.0%	12.8%
	Wendell	36.1%	23.1%
	Area Total Average	**31.6%**	**18.1%**
	Combined Service Are	**27.9%**	**20.2%**
	Worcester County	26.6%	18.9%
	Franklin County	32.6%	16.1%
	Massachusetts	29.8%	19.1%

Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

The table above shows that there are pockets of high "cost burden" in both the western and eastern portions of the Combined Service Area. Not surprisingly, the darker shading in this map (i.e., higher percentage of cost burdened homeowners) aligns reasonably well with the map above of the communities that spend a higher percentage of income on homeownership costs.

Understanding the geographic distribution of cost-burdened homeowners is crucial for effective policy-making and resource allocation. By identifying areas where a high percentage of residents spend more than 30% of their income on housing, local governments and organizations can target interventions and support services more precisely. This geographic insight helps in developing tailored housing programs, improving infrastructure, and allocating financial assistance where it is most needed, ultimately aiming to reduce economic disparities and enhance community well-being.

While HUD defines a cost burden as spending more than 30% of income on housing, individuals' perceptions of this burden can vary widely. Many residents feel financially strained even if their

housing costs fall within this threshold, as other essential expenses like healthcare, education, childcare, and transportation also impact their overall economic well-being. Focus Group participants expressed this concern, questioning how they can be expected to pay 30% of income toward housing when...

"everything else costs so much!"

Housing cost burden can lead to significant stress and anxiety. This financial strain often leaves little room for other essential expenses, causing ongoing worry about meeting basic needs. Such chronic stress can contribute to mental health issues like anxiety and depression and can increase the risk of substance use disorders as individuals seek ways to cope. Additionally, the overall physical and mental well-being of residents is compromised, as the pressure to meet housing costs can lead to poor health outcomes and a lower quality of life. Addressing housing cost burdens is therefore essential for improving the holistic health and stability of communities.

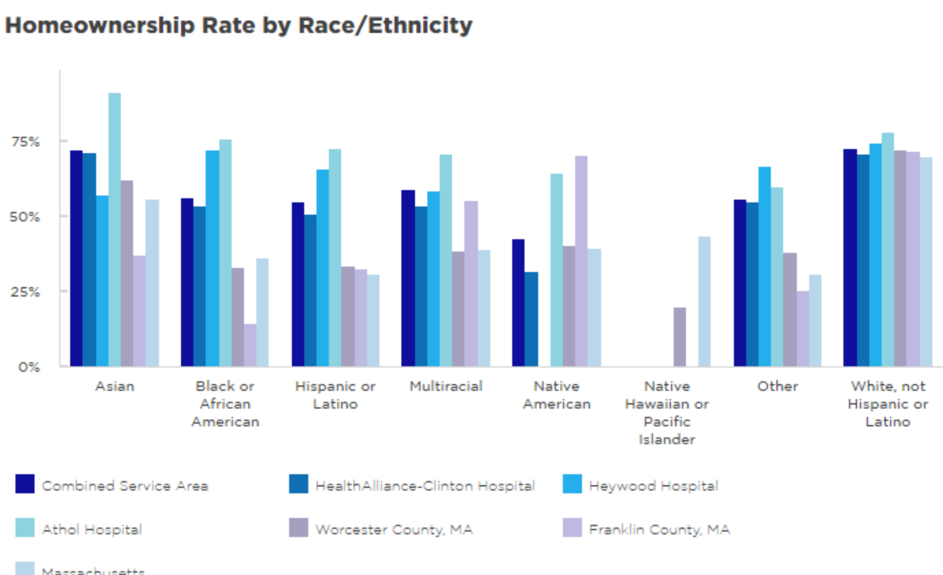
Habitat for Humanity
In 2022, Habitat for Humanity received $10,000 from HA-C's Determination of Needs funding to support low-incomed, economically distressed homeowners who are struggling to maintain the integrity of their homes.

Disparities in Homeownership

The history of racism in housing has had a profound impact on homeownership rates, particularly among Black families. Discriminatory practices such as redlining [12],where banks and insurance companies refused to offer loans or services to Black neighborhoods, systematically excluded Black families from homeownership opportunities and the wealth-building benefits that come with it. Additionally, racially restrictive covenants and discriminatory lending practices further entrenched segregation and economic disparity [13]. Even after the Civil Rights Movement led to legislative changes, the long-term effects of these practices have persisted, contributing to lower homeownership rates among Black families today.

The graph below shows the homeownership rate of people by race across the Combined Service Area.

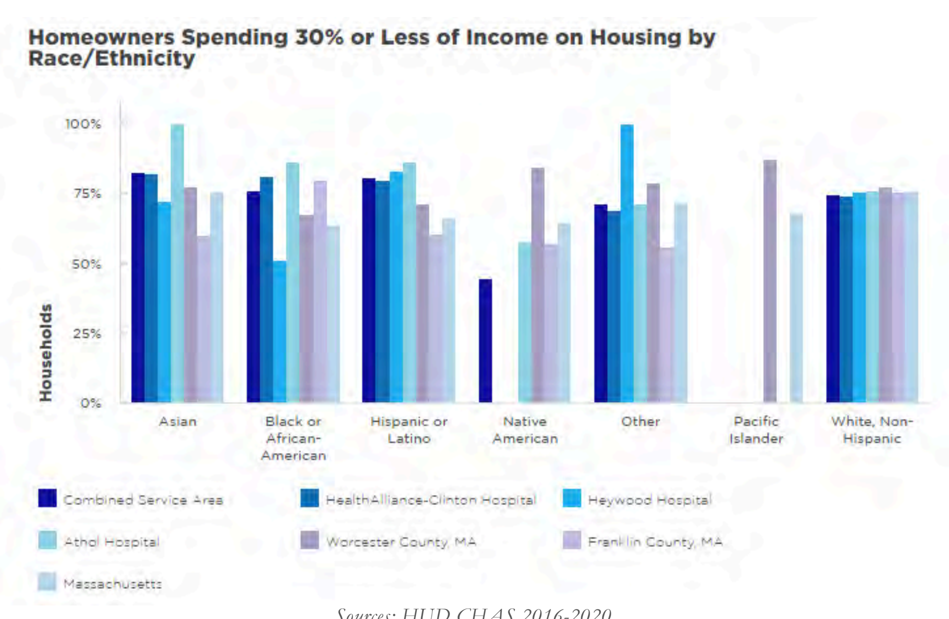
By Race/Ethnicity



Sources: US Census Bureau ACS 5-year 2018-2022

Per the graph above, 72.8% of White, non-Hispanic residents own homes across the Combined Service Area whereas only 56.4% of Black or African American residents and 54.9% of Hispanic residents own homes. Asian residents, at 72.4%, are the only racial group to have homeownership rates similar to White, non-Hispanics.

Interestingly, the percentage of homeowners of color who are cost burdened by their housing in the Combined Service Area is generally lower than that of their White counterparts. Per the series of graphs below, a higher percentage of Asians (82.5%), Black or African Americans (76.3%), and Hispanic or Latino (80.8%) residents spend less than 30% of their income on homeownership costs than their White (74.8%) neighbors.



Sources: HUD CHAS 2016-2020

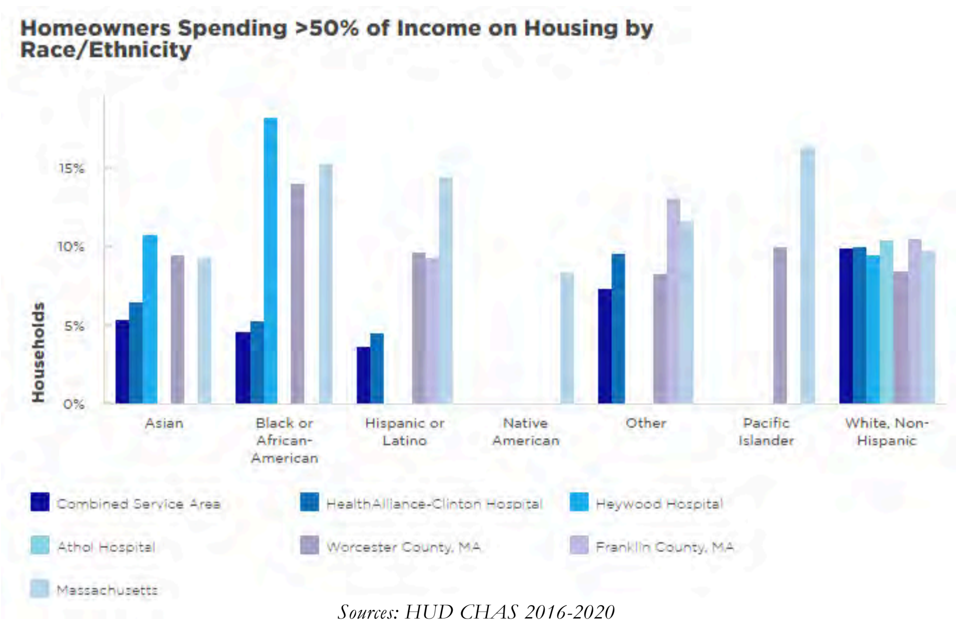
*Spending more than 30% of income on housing is also known as excessive cost burden. This data represents homeowners who are not experiencing excessive costs.

Homeowners Spending Between >30% and 50% of Income on Housing by Race/Ethnicity

Sources: HUD CHAS 2016-2020

*Spending more than 30% of income on housing is also known as excessive cost burden. This data represents homeowners who are experiencing excessive costs.

Similarly, a lower percentage of homeowners identifying as Asian (5.4%), Black or African American (4.6%), Hispanic or Latino (3.7%), and Other (7.3%) pay more than 50% of their income on housing than their White (9.9%) counterparts.

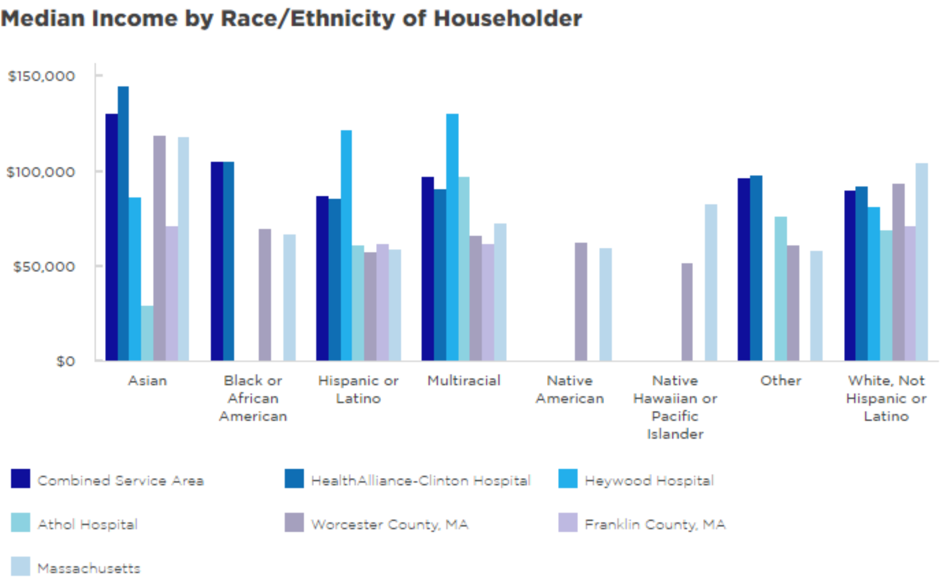


Sources: HUD CHAS 2016-2020

*Spending more than 30% of income on housing is also known as excessive cost burden. This data represents homeowners who are experiencing excessive costs.

This finding—a lower housing cost burden among homeowners of color—may, in part, be due to the systemic barriers these households face in purchasing housing. Achieving homeownership often requires a greater level of financial security for People of Color compared to their White neighbors. And, in fact, across the Combined Service Area we see a higher Median Household Income for households of color versus White households. Per the graph below, Median Household Incomes for residents in the Combined Service Area who self-identify as Asian, Black or African American, Multiracial, or Other are higher than their White neighbors.

By Race/Ethnicity



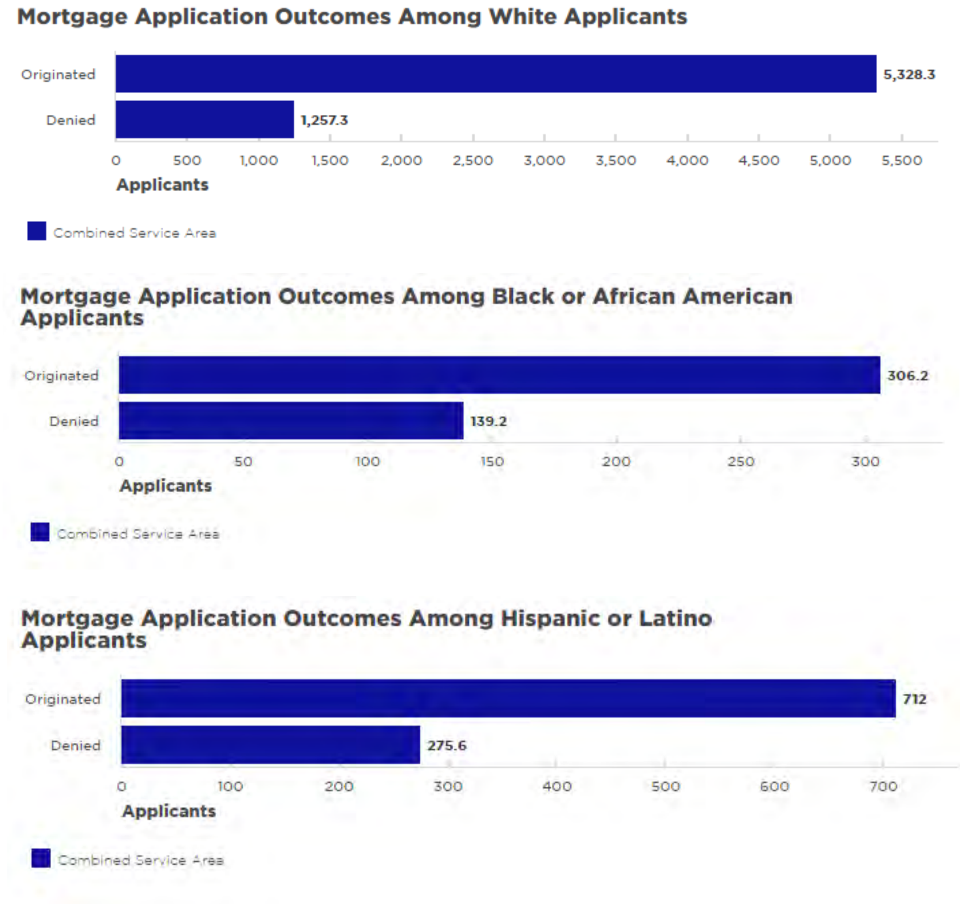
Sources: US Census Bureau ACS 5-year 2018-2022

These higher incomes may enable households of color to better manage their housing costs, resulting in a lower rate of cost burden.

Renting

The transaction costs associated with buying a home, including down payments, closing costs, and fees, can be significant barriers to homeownership for many local workers in the Combined Service Area. For residents whose wages are already stretched thin by the high cost of living, these upfront expenses make homeownership an unattainable goal. As a result, many rent their housing.

Additionally, systemic barriers to homeownership - like higher rates of mortgage application denials - play a role in people of color becoming renters versus homeowners. Per the graphs below, 24% of White applicants in the Combined Services Area are denied mortgages whereas 45% of Black or African American applicants and 39% of Hispanic or Latino applicants are denied.

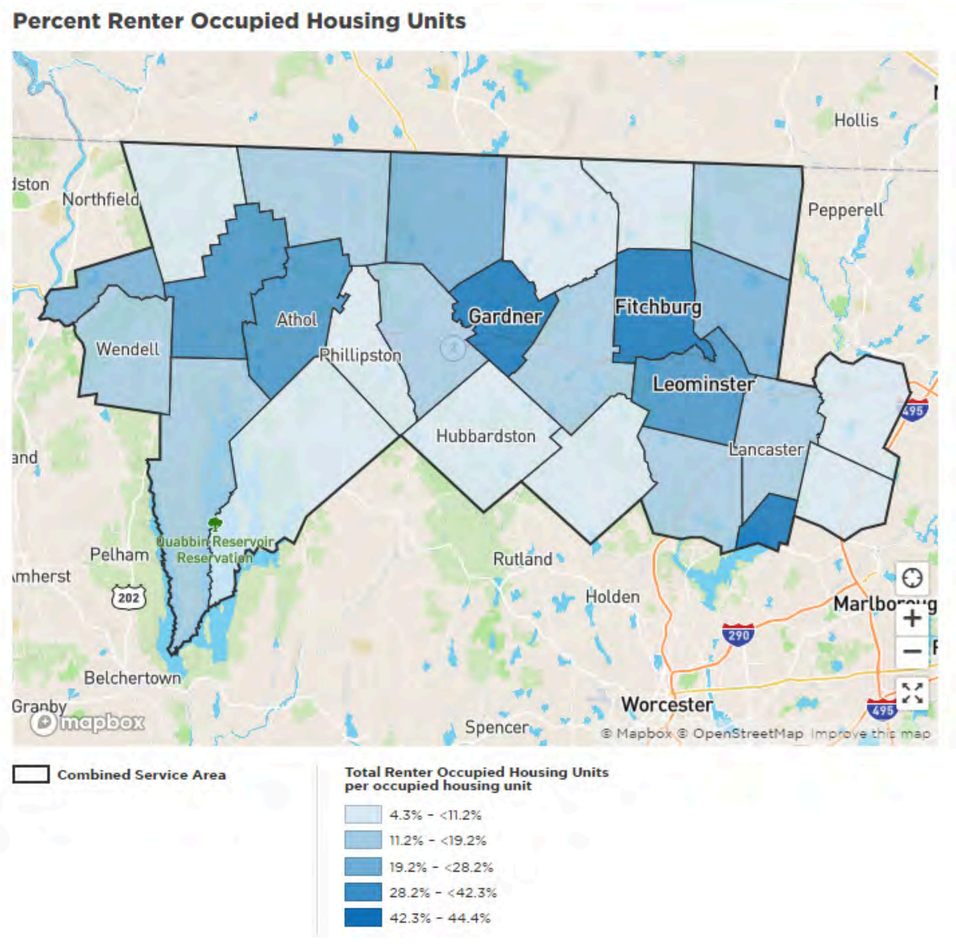


Sources: FFIEC HMDA 2022

These disparities in mortgage application denials have profound implications for people of color. When higher denial rates prevent them from becoming homeowners, it undermines their ability to build credit and accumulate wealth over time. Homeownership is a critical means of financial stability and wealth generation [14]; it allows individuals to build equity, access lower interest rates, and benefit from property value appreciation. Without these advantages, people of color face significant obstacles in establishing and growing long-term wealth. This systemic inequity perpetuates economic disparities [15], limiting opportunities for financial advancement and intergenerational wealth transfer and reinforcing existing inequalities. These inequalities extend beyond access to economic resources - to education and employment opportunities, access to quality healthcare, and exposure to environmental stressors and hazards, creating a cycle of disadvantage that affects multiple aspects of life for people of color.

Renting in the Combined Service Area

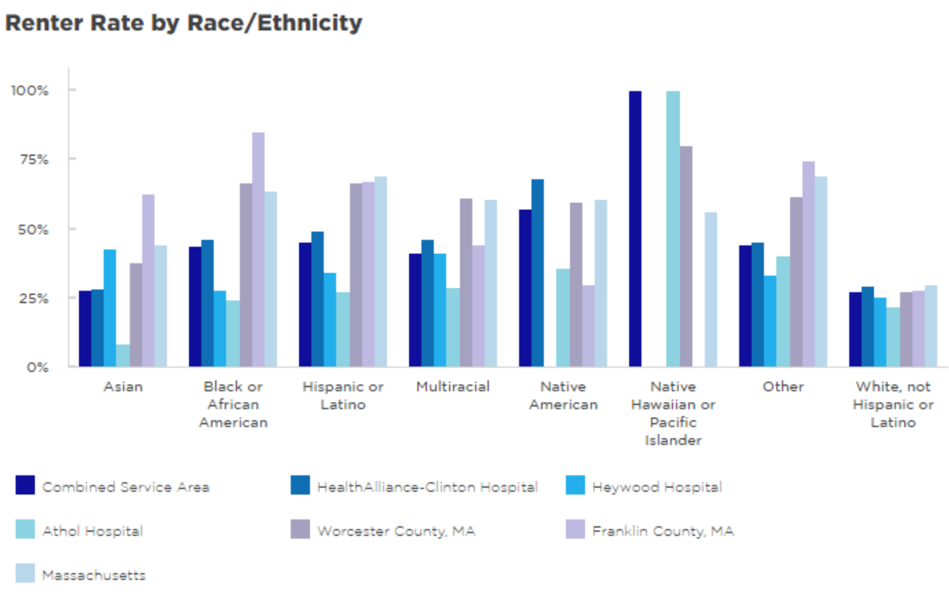
In the Combined Service Area, rental rates are higher in the more urban communities. Per the map below, Fitchburg, Leominster, Gardner, Athol, Orange, and Winchendon have the highest percentages of renter occupied housing units. This finding is in contrast to homeownership rates which are higher in the more rural areas of the Combined Service Area.



Sources: US Census Bureau ACS 5-year 2018-2022

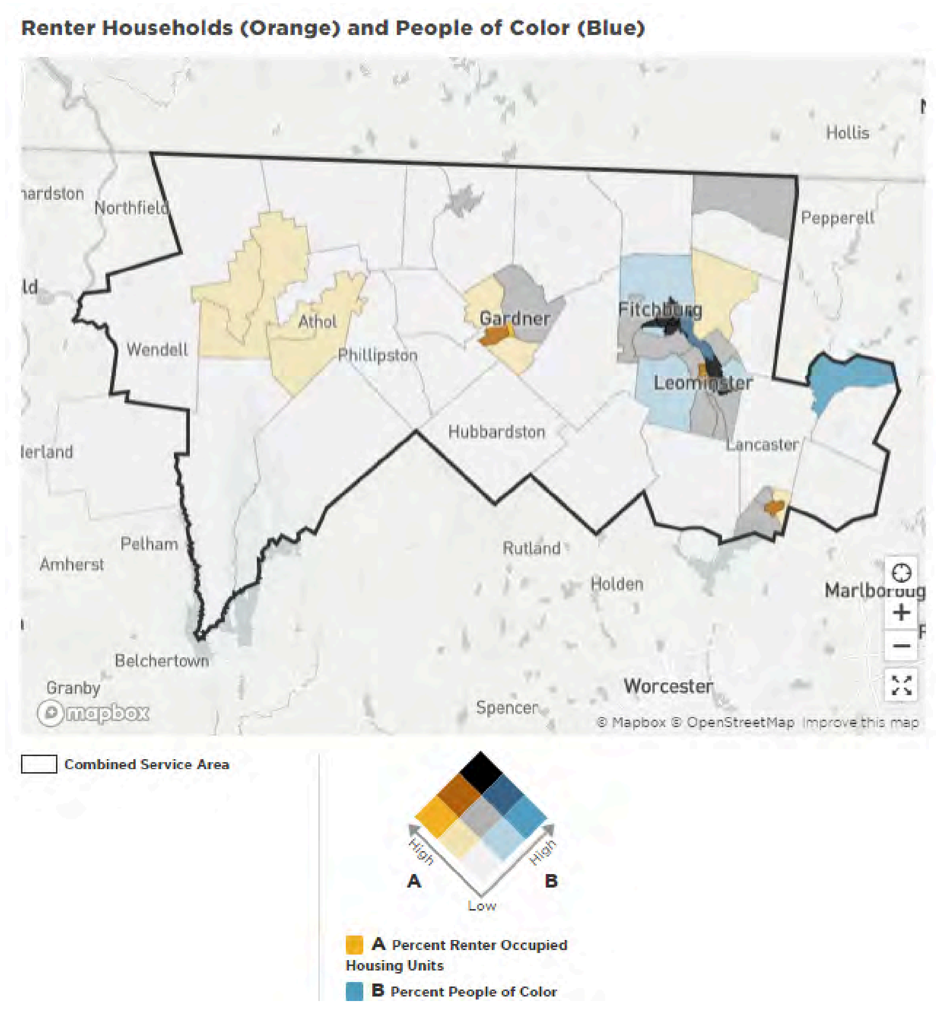
In the Combined Service Area, renters are disproportionately people of color, highlighting significant racial and ethnic disparities in housing. While only 21% of the overall population consists of people of color, a striking 72.8% of renter households are people of color. This discrepancy points to the systemic inequities in housing access and economic opportunities discussed in previous sections, where people of color are more likely to face barriers to homeownership and are thus overrepresented in the rental market.

By Race/Ethnicity



Sources: US Census Bureau ACS 5-year 2018-2022

The map below illustrates the geographic overlap between renters and people of color in the Combined Service Area. Areas in black represent places where there are a high concentration of renters and people of color.



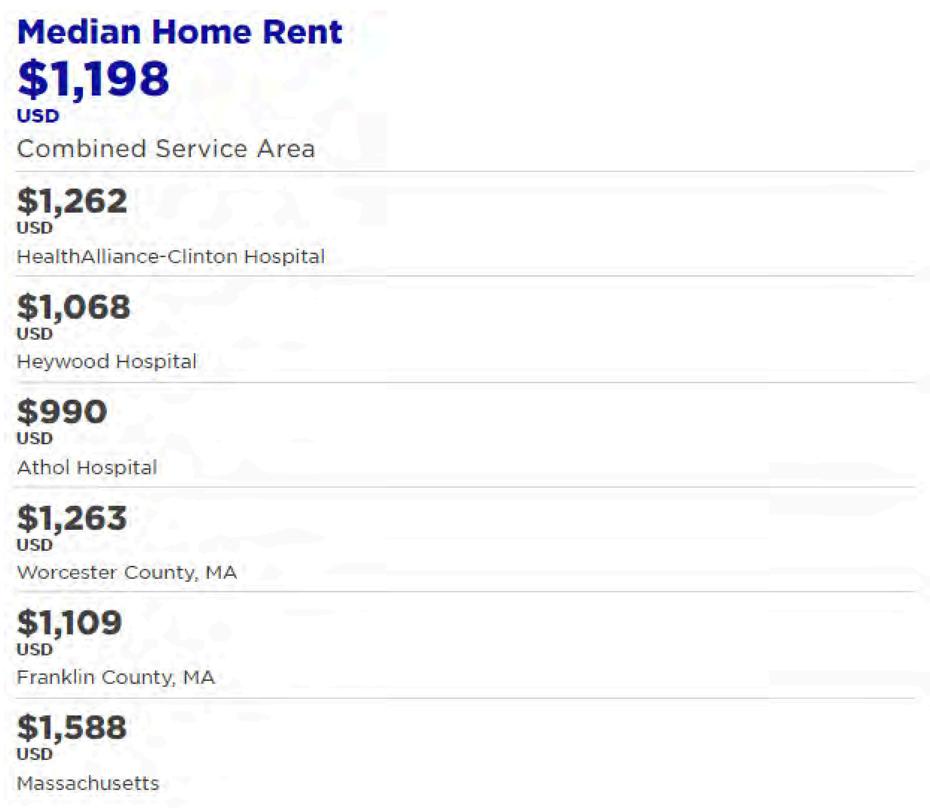
Sources: US Census Bureau ACS 5-year 2018-2022

Note: This is a bivariate map showing 2 variables on top of each other. Areas with high concentrations of renter occupied housing units are shown in orange while areas with high concentrations of people of color are shown in blue. Areas in black display high concentrations of both variables while areas in white display low concentrations of both variables.

The above visual representation is crucial for understanding the spatial dynamics of housing inequality, highlighting areas where people of color are disproportionately represented in the rental market. By identifying these neighborhoods, policymakers and community organizations can better target resources and interventions to address housing affordability and stability issues. Understanding where people of color are renting helps in developing strategies to combat systemic inequities, promote fair housing practices, and ensure that all residents have access to safe and affordable housing options.

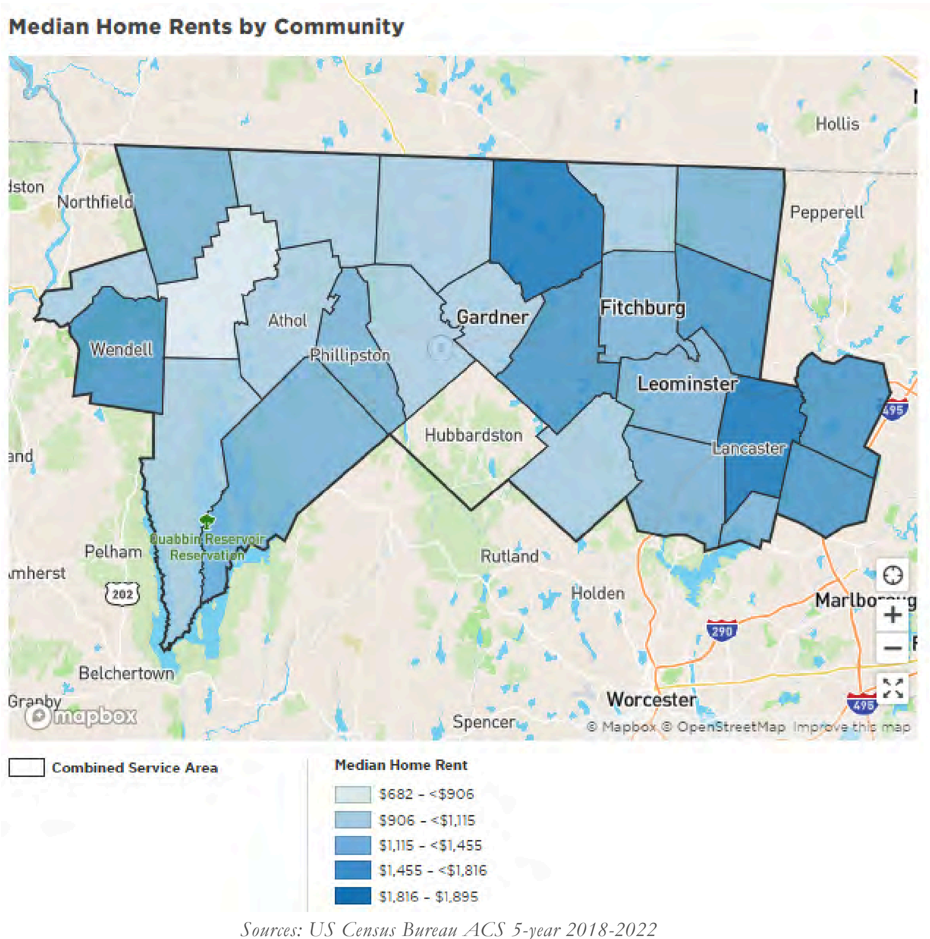
Rental Costs

The Median Home Rent across the Combined Service Area is $1,198. This figure is lower than the comparison areas of Worcester County and Massachusetts, but higher than Franklin County.



Sources: US Census Bureau ACS 5-year 2018-2022

With the exception of Wendell, on the the very western boundary of the Combined Service Area, Median Home Rents tend to be higher in the eastern portion of the region. As with homeownership costs, rental costs in the eastern portion of the Combined Service Area are likely driven up by the units' relative proximity to strong economic markets like the City of Worcester, MetroWest, and Boston.



Sources: US Census Bureau ACS 5-year 2018-2022

This same pattern of higher rental costs to the east is evident in the Department of Housing and Urban Development's (HUD) Fair Market Rents. The image on the next page shows the HUD-determined Fair Market Rents for the Metro Areas covered by the Combined Service Area, from west to east.

Fair Market Rents for a two-bedroom apartment in the Combined Service Area range from $1,454 in the western portion of the region to $1,889 in the east. As with home values, rents tend to be higher to the east where housing is accessible to commuters who work in the major economic centers of the City of Worcester, MetroWest, and Boston.

Even at their least expensive, Fair Market Rents for a two-bedroom apartment in the Combined Service Area outpace the Average Median Wages of people who live and work in the region. As mentioned in the Socioeconomics section, data from the Massachusetts Department of Labor estimates the Average Median Wage for jobs in the region to be $53,488 annually. Fair Market Rent for a two-bedroom apartment in the Franklin County, MA HUD Metro Area (i.e., the least expensive HUD Metro Area in the region) is 33% of that wage. Fair Market Rent for a two-bedroom apartment in Eastern Worcester County, MA HUD Metro Area (i.e., the most expensive HUD Metro Area in the region) is 42% of that wage.

Franklin County, MA HUD Metro Area

Final FY 2024 & Final FY 2023 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2024 FMR	$986	$1,107	$1,454	$1,766	$2,052
FY 2023 FMR	$856	$988	$1,280	$1,586	$1,831

Fitchburg-Leominster, MA HUD Metro Area

Final FY 2024 & Final FY 2023 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2024 FMR	$1,072	$1,238	$1,582	$2,055	$2,373
FY 2023 FMR	$989	$1,047	$1,358	$1,748	$2,040

Worcester County, MA HUD Metro Area

Final FY 2024 & Final FY 2023 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2024 FMR	$1,282	$1,292	$1,661	$2,008	$2,212
FY 2023 FMR	$1,231	$1,272	$1,635	$1,990	$2,196

Eastern Worcester County, MA HUD Metro FMR Area

Final FY 2024 & Final FY 2023 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2024 FMR	$1,280	$1,438	$1,889	$2,662	$2,935
FY 2023 FMR	$1,112	$1,263	$1,663	$2,254	$2,681

Across the Combined Service Area, renters have a Median Household Income of $47,614, which is just 45% of the Median Household Income for homeowners ($106,000).

The challenge of housing affordability is further compounded when considering the wage disparity among renters. While Fair Market Rents exceeding 30% of the region's Average Median Wages already indicates a significant cost burden, the situation is even more dire for renters, whose wages are typically lower than the Average Median.

Renter Occupied Household Median Income	Median Gross Rent as a Percentage of Income
$47,614 USD Combined Service Area	29.2% of income Combined Service Area
$50,227 USD HealthAlliance-Clinton Hospital	28.5% of income HealthAlliance-Clinton Hospital
$44,049 USD Heywood Hospital	29.6% of income Heywood Hospital
$35,213 USD Athol Hospital	32.8% of income Athol Hospital
$47,669 USD Worcester County, MA	29.5% of income Worcester County, MA
$37,368 USD Franklin County, MA	32.6% of income Franklin County, MA
$56,051 USD Massachusetts	30.1% of income Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

This disparity in income for renters suggests that renting is the only housing option available to many people in a region dominated by low-paying jobs. Despite the lower costs of renting, renters spend a greater percentage of their income on housing costs—nearly 30% compared to the 20% spent by homeowners. This highlights the financial strain renters face, even with seemingly more affordable housing options.

In the Combined Service Area, nearly 50% (47.7%) of renters experience this strain as "cost burden." That is, nearly half of renters are paying 30% or more of their income toward housing expenses.

	Community	Rent: 30% or more
Health Alliance-Clinton Hospital	Ashburnham	57.8%
	Ashby	22.0%
	Bolton	13.2%
	Clinton	36.5%
	Fitchburg	50.2%
	Gardner	48.8%
	Harvard	69.1%
	Lancaster	62.3%
	Leominster	47.4%
	Lunenburg	44.8%
	Princeton	59.6%
	Sterling	37.4%
	Townsend	37.2%
	Westminster	67.1%
	Area Total	47.3%
Heywood Hospital	Ashburnham	57.8%
	Gardner	48.8%
	Hubbardston	52.3%
	Templeton	34.6%
	Westminster	67.1%
	Winchendon	50.6%
	Area Total Average	**49.8%**
Athol Hospital	Athol	52.6%
	Erving	58.7%
	New Salem	77.0%
	Orange	48.2%
	Petersham	29.0%
	Phillipston	42.8%
	Royalston	82.5%
	Warwick	26.3%
	Wendell	73.6%
	Area Total Average	**52.3%**
	Combined Service Are	**47.7%**
	Worcester County	48.8%
	Franklin County	55.5%
	Massachusetts	50.2%

Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

In some communities in the Combined Service Area, two-thirds or more of renters are cost burdened. This is the case in Royalston (82.5%), New Salem (77.0%), Wendell (73.6%), Harvard (69.1%), and Westminster (67.1%).

The data above paints a difficult picture for renters (i.e., the average renter in the Combined Service Area makes just $47,614 per year and spends nearly 30% of that on rental costs with nearly 50% of renters across the region being "cost burdened"). To some extent, though, this data is already out of date at the writing of this Community Health Needs Assessment as the data is from 2018-2022. More recent information suggests that the rental housing market in Massachusetts and the Combined Service Area has gotten even tighter in the last two to three years.

In their North Central MA Community Health Improvement Plan for 2025, *Planning for Sustainable Growth*, the Health Equity Partnership of North Central Mass (CHNA9) cites that Massachusetts is now the fifth most expensive state in which to rent a home, with Boston now the second most expensive rental market in the country. Furthermore, they note that across the Commonwealth, housing costs are increasing at unsustainable rates and people and communities are being pushed out.

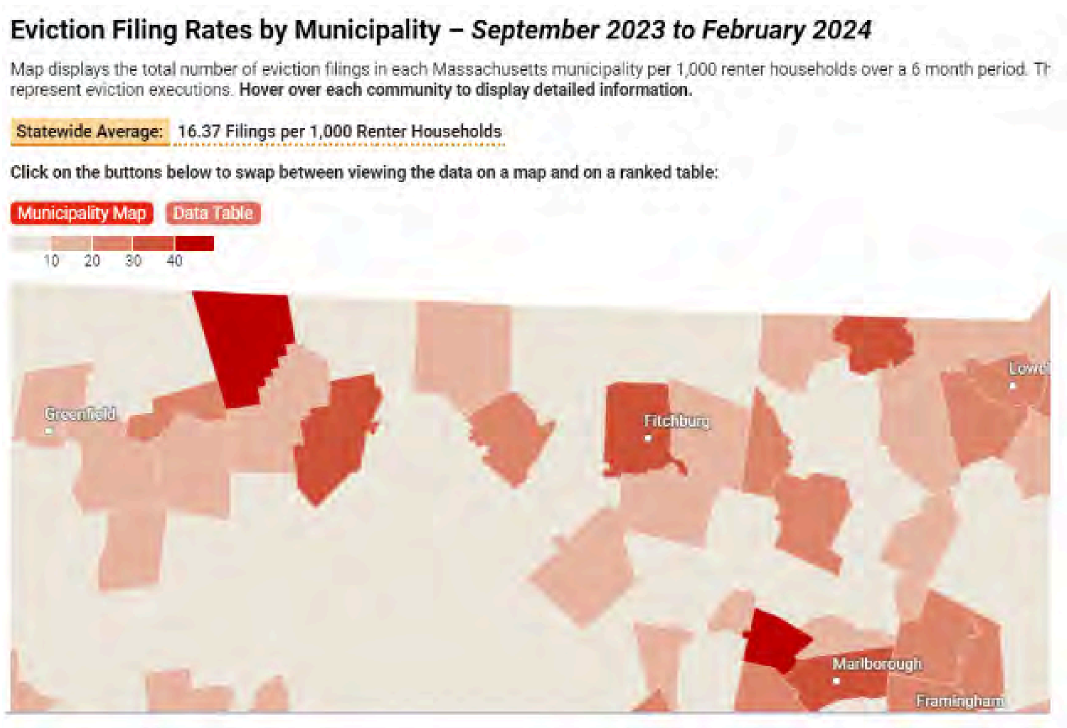
In addition, a recent Boston Globe article (Sweeney, E. April 25, 2024) stated that the Worcester metro area, which includes parts of the Combined Service Area, ranked the third most competitive rental market in the country. High mortgage rates, elevated home prices, and low vacancy rates have led to the third highest rental price increases over the last year (2023). As a result, median rental prices in the Worcester metro area are nearly $200 higher than the median price of all the communities looked at in the study.

The Cost of High Rental Costs

The high cost of rental housing in the Combined Service Area places a significant financial burden on many residents, often consuming a substantial portion of their income. This economic strain not only makes it difficult for renters to afford other essential needs but also increases their vulnerability to housing instability. As rental costs continue to rise, so do the risks of eviction and homelessness.

According to the Massachusetts Housing Partnership, the high cost of rental housing has lead to nearly two years of elevated eviction filings as compared to pre-pandemic [17]. This period also coincides with several changes in the housing assistance programming put in place to help families weather the significant financial effects of the COVID pandemic, specifically: the end of Emergency Rental Assistance Program and the new "Notice to Quit" requirement for Residential Assistance for Families in Transition (RAFT) eligibility.

Together, increasing rental costs and reductions in rental support have led to increased eviction filing rates across the state as well as in the Combined Service Area. The map below from the Massachusetts Housing Partnership shows Eviction Rates by Municipality from September 2023 to February 2024. Warwick (43.48), Athol (33.87), Fitchburg (32.64), Erving (25.42), Gardner (24.58), Harvard (22.47), Leominster (19.84), and Princeton (17.86) have higher rates than the state (16.37 per 1,000 renter households).



Per the Massachusetts Housing Partnership, these persistently elevated levels of eviction filings result in high need for access to emergency housing resources.

In Massachusetts, the only state in the nation to retain a "right-to-shelter law" (at the writing of this Community Health Needs Assessment), temporary emergency shelter is one such resource for families experiencing homelessness. Unfortunately, for the first time in the forty years since the law was enacted, the state has reached its 7,500 household cap [18] and is now placing families requesting shelter placement on a waiting list.

As demonstrated here, the demand for homelessness-related services for families is significant and growing. At the same time, there is a large population of individuals experiencing homelessness in and around the Combined Service Area. According to the Department of Housing & Urban Development's (HUD) 2023 Point-in-Time Homelessness Survey, there were 641 homeless individuals counted in the Worcester City & Worcester County CoC on January 25, 2023 [19]. These individuals were Unsheltered (21%) or in state-funded Emergency Shelter (51%) and Transitional Housing (28%) programs on the night of the count.

Between new arrivals from other countries and local people facing post-pandemic housing crises, the demand for temporary housing and shelter services has increased as of late. This heightened demand is leading to longer waiting times for housing assistance and increased competition for affordable housing units, which are limited in the area. The pressure on shelter resources makes it even more challenging to provide adequate support for both new arrivals and long-term residents in need. Addressing this issue requires comprehensive strategies that include expanding shelter capacities, increasing the availability of affordable housing, and providing targeted support services to help migrants integrate and stabilize in their new communities.

Locally, challenges with housing affordability are further highlighted by the results of HealthAlliance-Clinton Hospital's Social Determinants of Health (SDOH) risk and needs screening tool, which surveyed 8,364 patients, primarily from primary care settings, to assess their experiences and needs. The assessment revealed that 7% of respondents were not living in a stable situation and that 4% needed housing resources.

Recognizing that residents of color and those whose primary language is not English are often disproportionately affected by Social Determinants of Health, the hospital stratified the data by race, ethnicity, and primary language. This analysis uncovered that 17% of respondents who identified as "Hispanic or Latino," 13% of respondents who identified as "Black," and 12% of respondents who identified as "Other" reported housing-related needs, compared to 3% of White respondents. Similarly, 16% of Spanish-speaking respondents, 15% of Portuguese-speaking respondents, and 17% of Haitian Creole-speaking respondents reported needing help with housing resources, in contrast to 3% of English-speaking respondents. This stratified data underscores the heightened vulnerabilities faced by certain groups in the Combined Service Area.

High and escalating housing costs and competition for limited affordable housing were all issues on the minds of people who participated in the Focus Groups conducted as part of this Community Health Needs Assessment. Common sentiments included:

"Rent prices are out of control."

"Rents have doubled in the last 4 years, but salaradjustments have not come close to that."

"There's not enough affordable housing for everyone. "

Moreover, Focus Group participants seemed to understand the close connection between housing stability and well-being. Many made statements about how high housing costs...

"are creating anxiety and depression."

"lead to more isolation because there's no money left to be social."

"cause stress which leads to substance use disorders, domestic violence, and mental health issues."

Despite being frustrated with the lack of affordable housing locally, Focus Group participants did

provide constructive upstream suggestions for improving the housing situation, such as::

- re-purpose abandoned buildings for affordable housing;
- advocate for "rent cap" policies; and
- advocate for the expansion of housing voucher programs (i.e., more vouchers and less restrictive income eligibility).

Initiatives are already underway across the Combined Service Area. For example, The Fitchburg Arts Community project, located in the heart of downtown Fitchburg, will create 68 mixed-income apartments for artists and art enthusiasts in three historic buildings: the former BF Brown Middle School, City Stables, and High School Annex. Located near the Fitchburg Art Museum, the development will offer affordable housing and artist amenities, and will foster a creative community with support from the Museum for professional development and programming. Through their Anchor Mission, UMass Memorial Health (UMMH), the parent hospital system of HealthAlliance-Clinton Hospital, granted NewVue Communities, the local Community Development Corporation spearheading the project, with pre-development financing, helping them to leverage additional funds for this $45 million project.

Fitchburg Arts Community
NewVue Communities received $150,000 in pre-development supports from UMass Memorial Health for the Fitchburg Arts Community Project, a $45-million, 68-unit housing project that gives artists preferential access. This new complex, scheduled to be completed in early 2025, is critical to the City's downtown revitalization effort aimed at bolstering the local creative economy.

Additionally, partners from across the Combined Service Area meet monthly under the facilitation of the Central Mass Housing Alliance and the United Way of North Central Massachusetts to hear from local legislators and to share resources, challenges, and strategies related to increasing housing and shelter options in the area. The group began during the de-congregation of shelters during the pandemic and has since supported the conversion of the Days Inn in Leominster to a shelter and the development of a new mixed use, including transitional housing, building for WHEAT Community Services in Clinton. They have also provided advocacy and technical assistance on a number of tenant, shelter, and housing-related issues.

WHEAT on High Street in Clinton, MA
UMass Memorial Health's Anchor Mission Investment funds provided low-interest loan funds to assist with the overall financial package that will allow the development of a mixed-use housing, food pantry, and office space for WHEAT on High Street in Clinton, Massachusetts. The official groundbreaking took place in September 2024.

Conclusion

The Combined Service Area faces significant housing challenges that are deeply rooted in the region's economics as well as historical and systemic issues. Relatively high home values and homeownership costs that outpace local wages, have made purchasing and maintaining housing particularly difficult for residents who work in the area. Historical discrimination in housing, such as redlining and racially restrictive covenants, has had lasting effects and further contributes to lower homeownership rates among people of color.

High and escalating rental costs in the Combined Service Area make even this relatively more affordable housing option difficult for local workers who earn limited wages. In a region where utility cost are high and rental prices continue to rise, many low-wage earners find it increasingly challenging to secure and maintain stable housing. This financial strain likely disproportionately affects people of color, who are overrepresented in the rental market. Consequently, people of color suffer higher rates of evictions and homelessness in a region already grappling with a limited supply of affordable housing and significant competition for emergency housing services.

Addressing housing affordability is crucial for fostering economic stability and social equity in the Combined Service Area. Ensuring that residents can afford to purchase and maintain homes within their means is essential for reducing financial strain and enhancing quality of life. By tackling the root causes of housing challenges, including the mismatch between local wages and housing costs and historical discrimination, stakeholders can work towards creating a more inclusive and resilient community. Improving housing affordability will not only support individual well-being but also stimulate local economic growth and promote a more equitable distribution of resources and opportunities across the region.

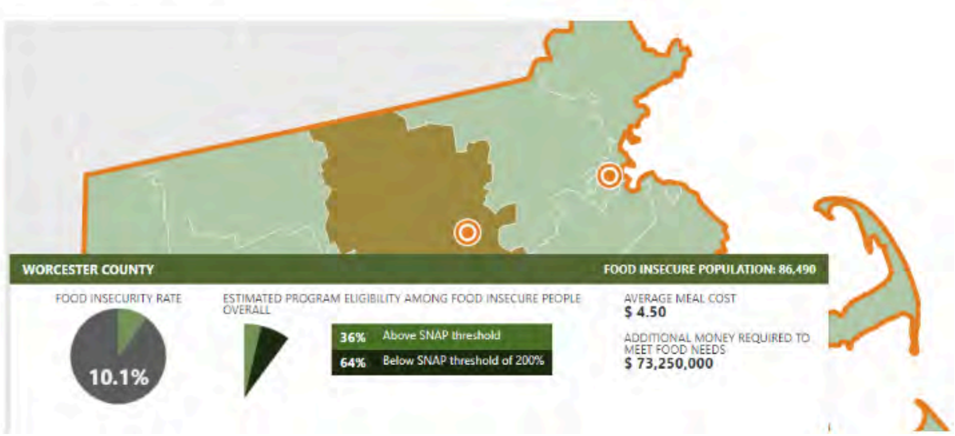
FOOD SECURITY

Access to affordable, healthy food is a fundamental aspect of community health and well-being. In a region like the Combined Service Area where a significant portion of income is devoted to maintaining housing, residents may struggle to afford healthy food options, leading to food insecurity and poor nutrition. This lack of access to affordable, healthy food impacts physical health and also contributes to broader socioeconomic disparities. Understanding and addressing these challenges is crucial for improving overall community health, reducing healthcare costs, and promoting a higher quality of life for all residents.

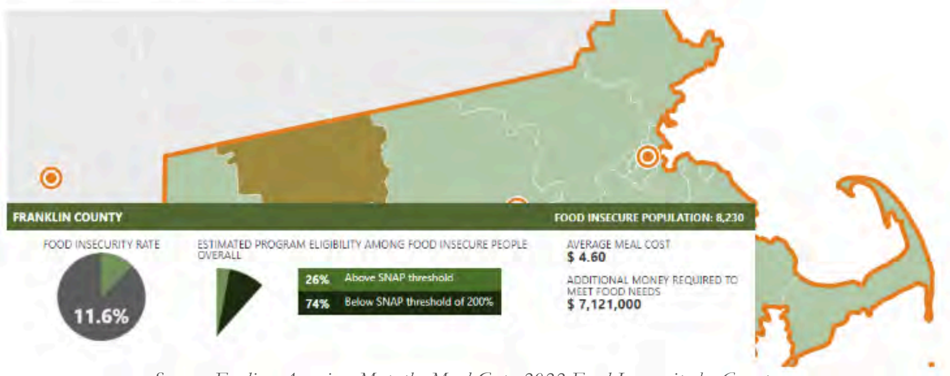
1 in 10 residents of the Combined Service Area is estimated to be food insecure, according to Feeding America.

County-level data available from Feeding America estimates that roughly one in ten residents in the Combined Service Area is food insecure. Data from Worcester County and Franklin County, where the majority of Combined Service Area communities lie, shows that food insecurity is higher in the western portion of the region, with 11.6% of Franklin County residents experiencing food insecurity and 10.1% of Worcester County residents experiencing food insecurity.

Food Insecurity Worcester County



Food Insecurity Franklin County



Source: Feeding America. Map the Meal Gap. 2022 Food Insecurity by County.

This pattern aligns with findings elsewhere in this report: residents of communities in the western portion of the Combined Service Area tend to fare worse on socioeconomic, social, and health indicators as compared to their peers in the east.

Food Access

Food accessibility is often framed around the popular term "food desert". Food deserts are geographic areas with limited access to affordable and nutritious foods. Neighborhood conditions, including rural versus urban, and socioeconomic status, affect physical access to food.

For example, access to full-service grocery stores is generally more limited in rural communities and in low income neighborhoods. Furthermore, low income neighborhoods may have an abundance of convenience stores and dollar stores. These types of stores often have lower quality and less variety of foods available.

That said, food access is more complicated than simply the availability of food outlets. Factors such as the incomes of residents and their access to transportation to purchase food also play a crucial role in determining food security and overall well-being.

Across the Combined Service Area, 45.6% of residents have low access to healthy food. This means that in urban areas residents live more than 0.5 miles from a food outlet and in rural areas residents live more than 10 miles from a food outlet.

People with Low Access to Healthy Food

45.6%
Combined Service Area

49.7%
HealthAlliance-Clinton Hospital

36.1%
Heywood Hospital

54.9%
Athol Hospital

56.1%
Worcester County, MA

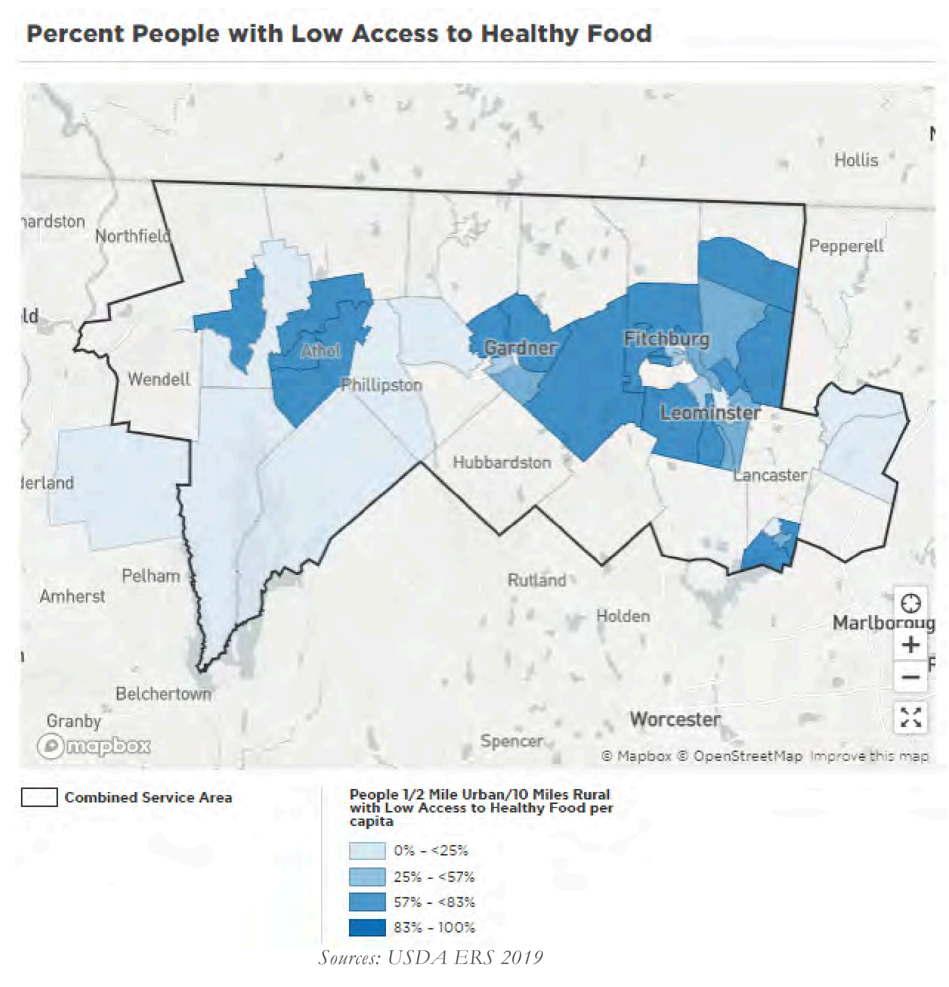
29.6%
Franklin County, MA

53.6%
Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022; USDA ERS 2019

Geographic disparities in access to healthy food are evident in the table above. For example, over half of residents of the Athol Hospital service area (54.9%) face low access while just over a third (36.1%) of residents of the Heywood Hospital service area do.

The map below highlights specific Census Tracts within the Combined Service Area where food access is particularly low.



Sources: USDA ERS 2019

Generally, food access is lowest in the urban communities of the Combined Service Area. Census Tracts in Fitchburg, Gardner, Leominster, Athol, Orange, and Clinton have the highest percentages of people with low access.

Together, the data presented above suggests a complex relationship between food insecurity and food access. That is, they are not necessarily directly related. For example, according to the Feeding America data, Franklin County has the highest percentage of residents residents experiencing food insecurity (11.6%). Yet, it also has the lowest percentage of people with low food access (29.6%). This finding suggests that proximity to grocery stores and food outlets does not ensure food security.

Rather, food security is also heavily influenced by socioeconomic and logistical factors. For example, lower incomes in Franklin County (see Socioeconomics Section) mean that even with food available, many residents cannot afford to purchase it consistently. Additionally, a high housing cost burden (see Housing Section) leaves less disposable income for food expenses. Finally, transportation also plays a crucial role: while food might be physically accessible, individuals without reliable transportation may struggle to reach these resources (see Transportation Section). Thus, despite having better food access, residents of Franklin County face significant food insecurity challenges due to these interconnected socio-demographic and logistical factors.

Locally, challenges with food security are further highlighted by the results of HealthAlliance-Clinton Hospital's Social Determinants of Health (SDOH) risk and needs screening tool, which surveyed 8,364 patients, primarily from primary care settings, to assess their experiences and needs. The assessment revealed that, in the last year, 7% of respondents were enrolled in WIC or SNAP, did not have the funds to purchase enough food, and/or were worried their food would run out. Additionally, 5% indicated needing food resources.

Recognizing that residents of color and those whose primary language is not English are often disproportionately affected by Social Determinants of Health, the hospital stratified the data by race, ethnicity, and primary language. This analysis uncovered that 13% of respondents who identified as "Hispanic or Latino," 10% of respondents who identified as "Black," and 15% of respondents who identified as "Other" reported food-related needs, compared to 3% of White respondents. Similarly, 29% of Spanish-speaking respondents, 15% of Portuguese-speaking respondents, and 33% of Haitian Creole-speaking respondents reported needing help with food-related resources, in contrast to 3% of English-speaking respondents. This stratified data underscores the heightened vulnerabilities faced by certain groups in the Combined Service Area.

The importance of good nutrition and a lack of access to healthy food in the Combined Service Area was a topic of concern among the people who participated in the Focus Groups conducted as part of this Community Health Needs Assessment process. Specifically, residents of Winchendon discussed the fact that there is no grocery store in their community. As one of the larger yet more remote towns in the area, where food delivery options are limited, the lack of a grocery store is felt deeply. Other groups discussed the relationship between income and food access, stating that:

"limited income leads to poor nutrition which impacts health."

In addition to physical and financial access to healthy foods, Focus Group participants also talked about a need for nutrition education to help people understand the importance of organic produce and the pitfalls of processed foods.

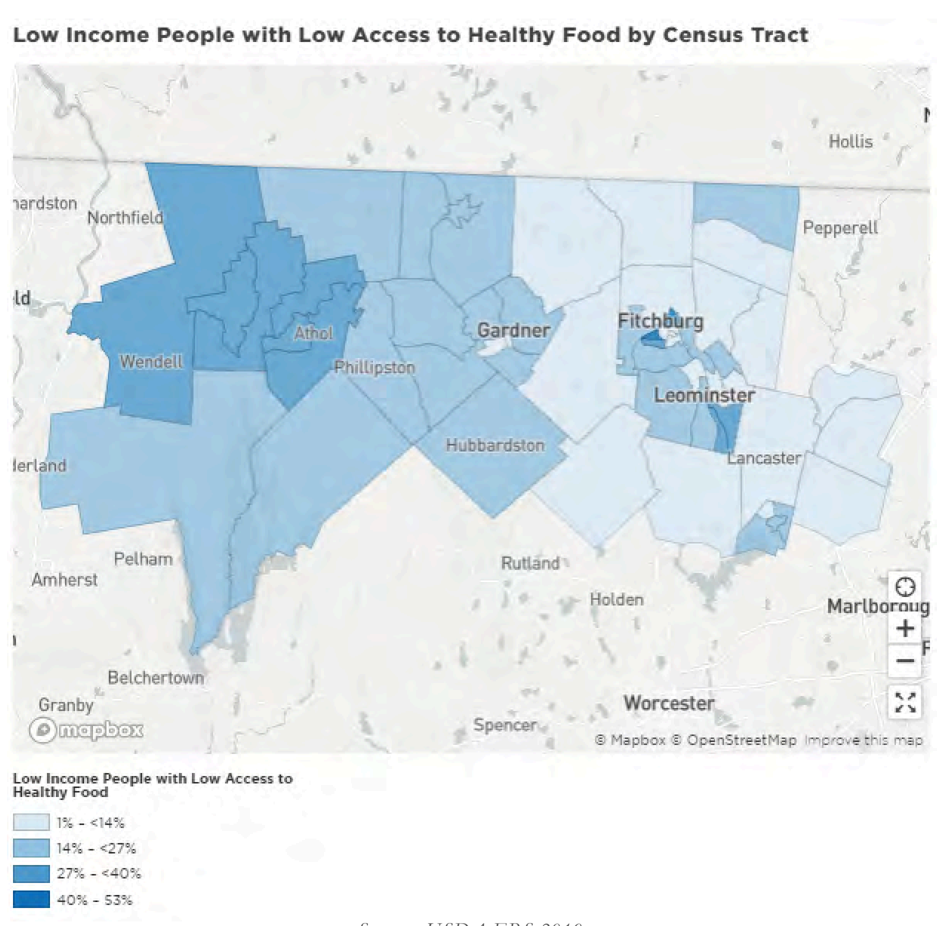
These themes around food access: the high cost of healthy foods, a lack of access to retail locations, and a need for nutrition education echoed finings from a recent Community Assessment conducted by Making Opportunity Count, one of the two Community Action Agencies serving the Combined Service Area. As a result of their assessment, which included community, stakeholder, and customer satisfaction surveys as well as focus groups, Making Opportunity Count highlighted "access to food" and nutrition education, as a priority in their strategic plan for 2024-2026.

Disparities in Food Access

While geographic location plays a clear role in determining food availability and accessibility, various socioeconomic and demographic factors further compound these issues and, ultimately, contribute to health inequities. The following section delves into how income levels, disability status, and racial and ethnic backgrounds influence access to food across the Combined Service Area, highlighting the need for comprehensive strategies to address these overlapping challenges.

Income

A large body of research documents that the primary cause of food insecurity is low income and poverty. According to the USDA [20], in 2022, 36.7% of low income households were food insecure, compared to 12.8% of all households. The map below shows the Census Tracts in the Combined Service Area where high concentrations of people with low incomes also have low access to healthy foods.



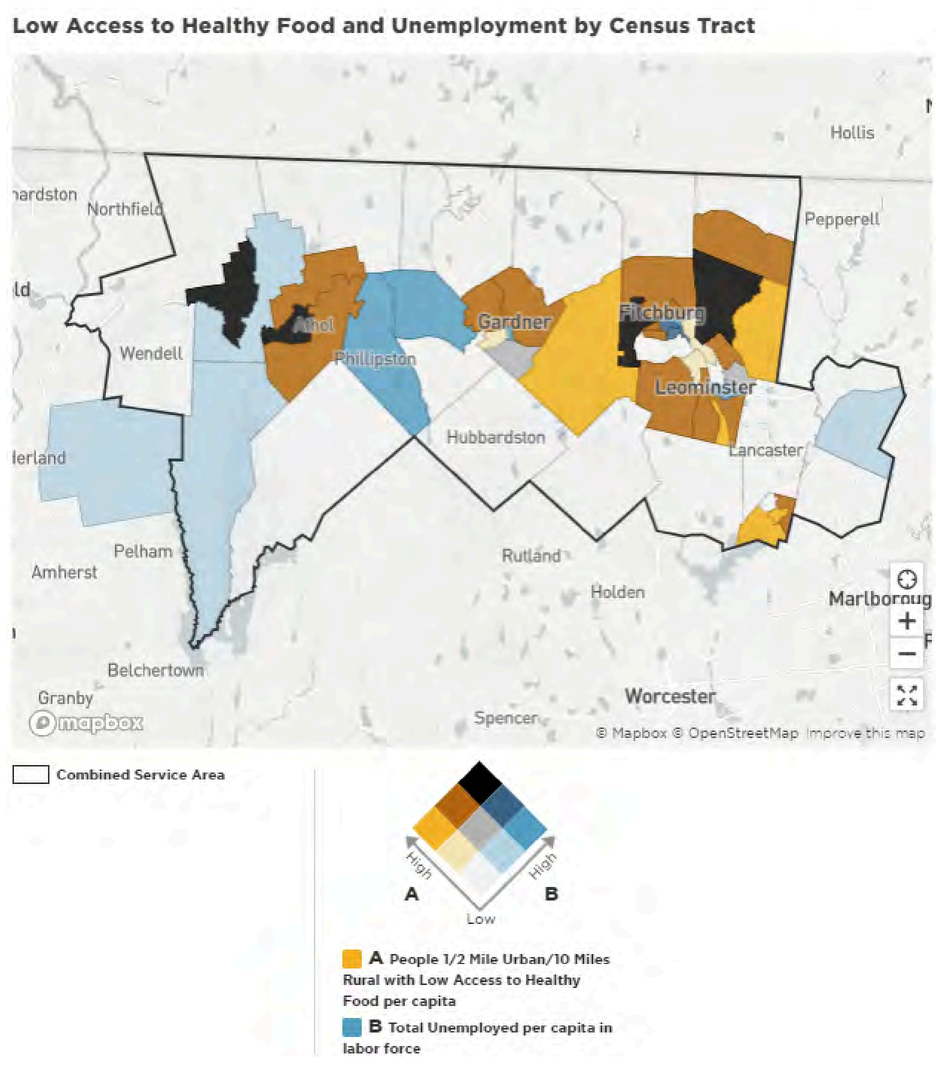
Sources: USDA ERS 2019

Targeting food access programming to where people in poverty live is crucial for addressing food insecurity and improving overall community health. By focusing food access initiatives in these areas, including upstream and midstream interventions like establishing affordable grocery stores, farmers' markets, and community gardens, organizations can directly alleviate some of the obstacles that residents living with limited income face. Additionally, programs that provide food assistance, nutrition education, and support for local food systems can empower these communities to achieve better health outcomes and economic stability. Ensuring that food access programming is strategically placed in areas with high poverty rates helps create a more equitable food system and promotes the well-being of the most vulnerable populations.

Employment

Unemployment can negatively affect a household's food security status as unemployment is typically associated with limited income. In addition, according to the Annie E. Casey Foundation [21], children with unemployed parents have higher rates of food insecurity than children with employed parents.

The map below overlays low access to healthy food (yellow) and unemployment (blue). Areas in black are key places to note. They represent areas in the Combined Service Area that experience the highest rates of unemployment and the lowest access to healthy food.



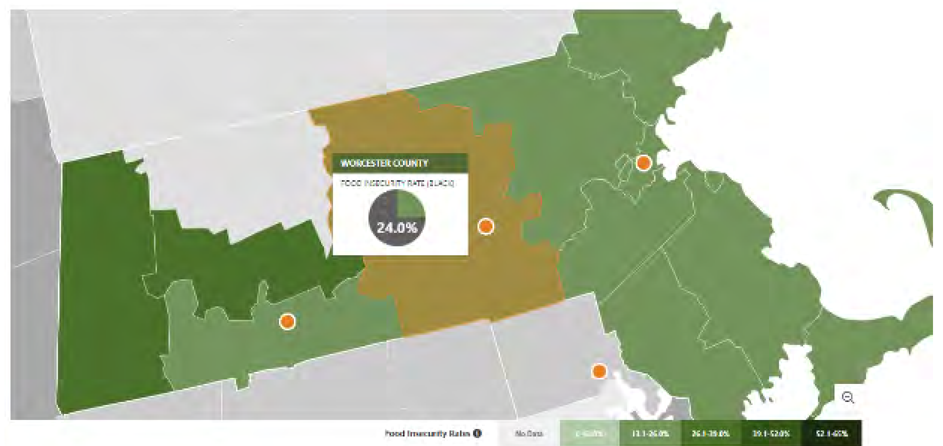
Sources: US Census Bureau ACS 5-year 2018-2022; USDA ERS 2019

The areas of highest unemployment overlap closely with areas of high poverty (see Poverty section), underscoring the importance of implementing food access programming in regions with elevated unemployment rates. In these communities, the dual challenges of limited financial resources and inadequate employment opportunities exacerbate food insecurity. By focusing food access initiatives in these areas, organizations can address the barriers that residents face due to both unemployment and poverty.

Race

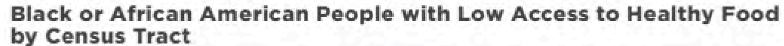
The burden of household food insecurity is disproportionately high among racial/ethnic minority groups, particularly among Black, non-Hispanics. According to the USDA, in 2022, Black, non-Hispanic households were nearly 2 times more likely to be food insecure (22.4%) than the national average (12.8%) [20].

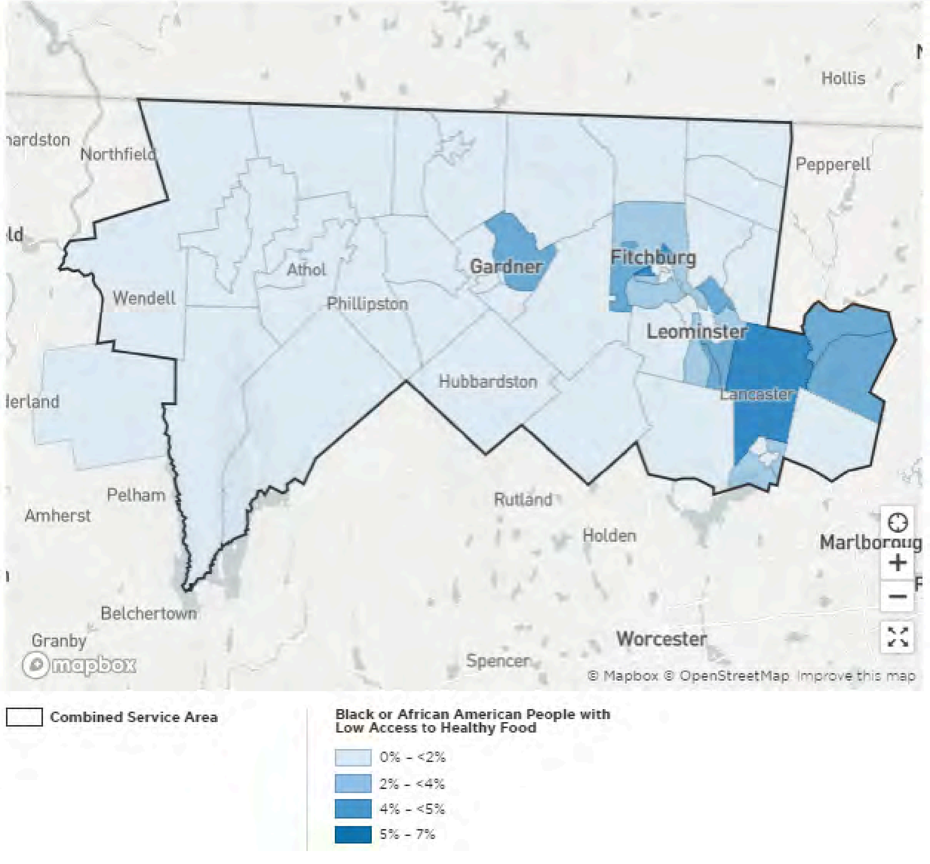
According to Feeding America, this finding holds true for the Combined Service Area as well. In 2022, 24.0% of Black residents of Worcester County, where the majority of the Combined Service Area communities lie, reported food insecurity. This number is more than twice the percentage (10.6%) of all residents of Worcester County reporting food insecurity.



Source: Feeding America. Map the Meal Gap. 2022 Food Insecurity by County and Race.

The map below shows Census Tracts within the Combined Service Area where low access to healthy food is likely a factor in the high rates of food insecurity, particularly among Black residents. Darker shading indicates higher concentrations of Black residents with low access to healthy food.





Sources: USDA ERS 2019

Targeting food access programming to Black, non-Hispanic residents is vital for addressing food insecurity and promoting health equity within the Combined Service Area. With food insecurity numbers nearly twice as high as among the general population, Black, non-Hispanic individuals face disproportionate barriers to accessing nutritious food. These barriers include systemic inequalities that contribute to disproportionate rates of poverty, unemployment, and other economic challenges which result in food insecurity as well as associated health disparities.

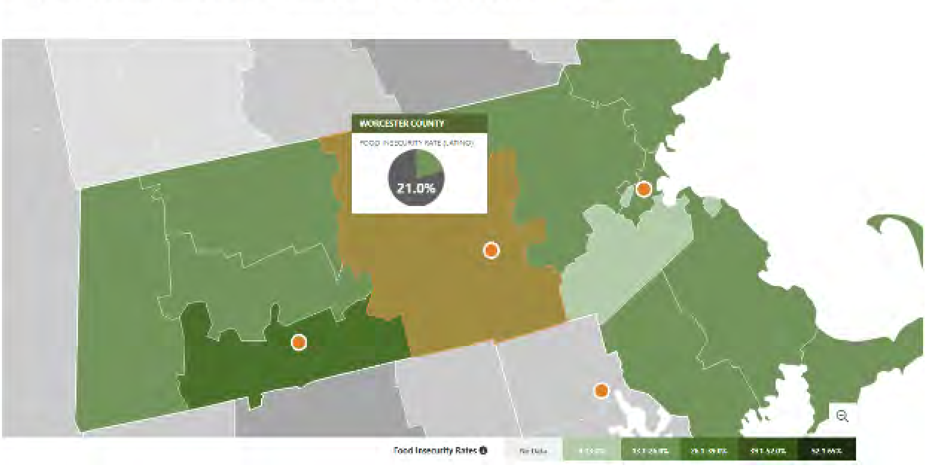
By focusing food access initiatives in areas predominantly inhabited by Black, non-Hispanic residents, organizations can help mitigate these disparities. Additionally, providing midstream interventions like culturally appropriate nutrition education and food assistance programs can empower these communities to make healthier food choices and improve overall well-being. Ensuring that food access programming is specifically tailored to meet the needs of Black, non-Hispanic residents is essential for fostering a more equitable food system and enhancing the health and quality of life for this historically marginalized group.

Ethnicity

As it is crucial to address the food access needs of Black, non-Hispanic residents, it is equally important to recognize and target the unique challenges faced by Hispanic communities. Hispanic residents often experience barriers to accessing nutritious food, including economic hardship, language barriers, and a higher likelihood of living in food deserts. These challenges contribute to significant disparities in food access and food insecurity within Hispanic populations.

According to the USDA, in 2022, 20.8% of Hispanic households across the United States were food insecure [20]. In Worcester County, where most of the Combined Service Area communities lie, 21.0% of Hispanic households reported food insecurity.

Hispanic Resident Food Insecurity in Worcester County



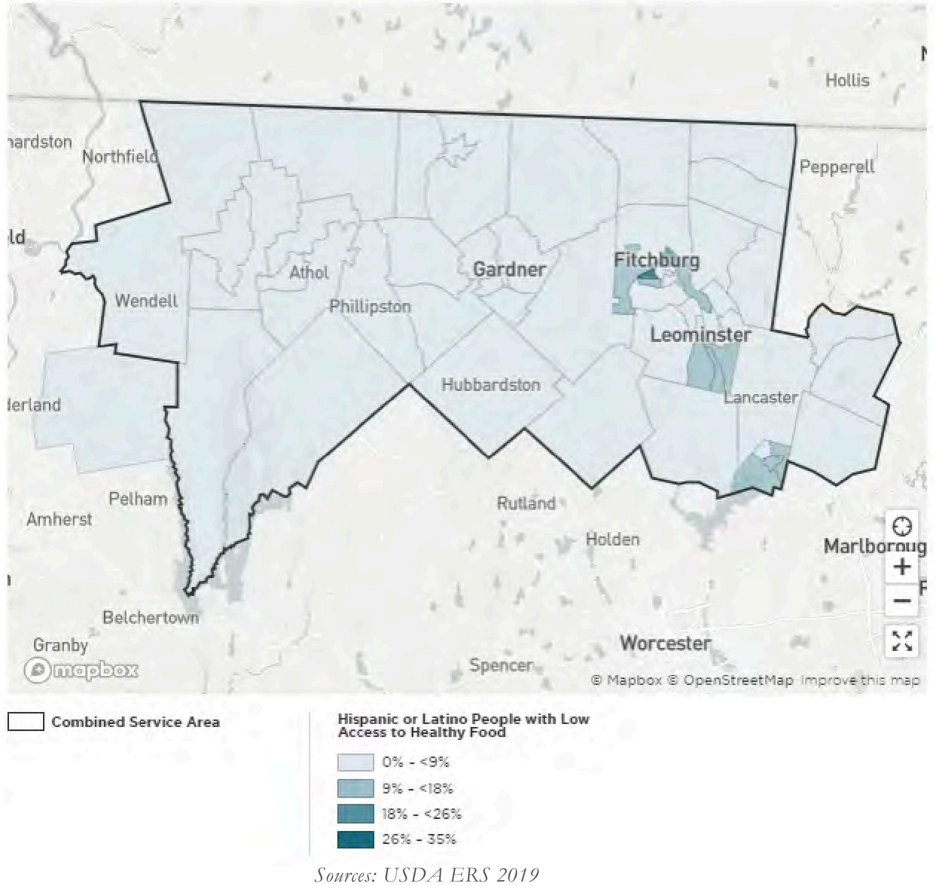
Source: Feeding America. Map the Meal Gap. 2022 Food Insecurity by County and Ethnicity.

The percentages are similar, but slightly lower in Franklin County on the western edge of the Combined Service Area. Here, 20.0% of Hispanic residents reported food insecurity.

Hispanic Resident Food Insecurity in Franklin County

Source: Feeding America. Map the Meal Gap. 2022 Food Insecurity by County and Ethnicity.

The map below highlights Census Tracts with high food insecurity among Hispanic residents, providing a visual representation of the areas most in need of targeted food access interventions.



Sources: USDA ERS 2019

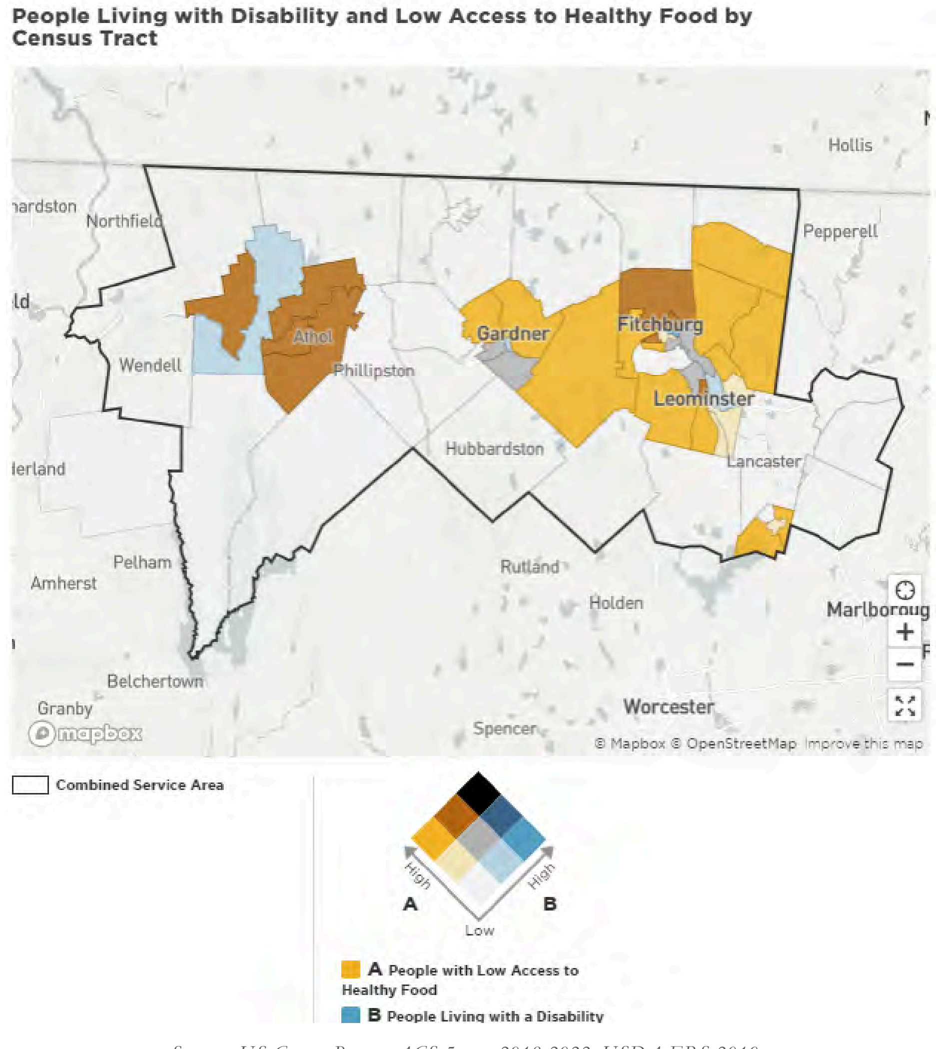
This geographic analysis is essential for understanding the specific neighborhoods where Hispanic communities are facing the greatest challenges in accessing nutritious food. By identifying these hotspots, community organizations, policymakers, and public health officials can better allocate resources and develop programs that address the unique barriers faced by Hispanic residents. Targeted upstream and midstream efforts, such as establishing bilingual food assistance services, creating community gardens, and increasing the availability of affordable grocery stores, can help mitigate food insecurity and promote healthier, more equitable communities.

In their *Improving Community Health - North Central MA Community Health Improvement Plan 2025: Planning for Sustainable Growth*, Health Equity Partnership of North Central Massachusetts (CHNA9) emphasizes the need for increasing access to culturally appropriate healthy food, calling it a "basic need for health". They also elevate the fact that increasing access is not necessarily straightforward. It relies on multiple other drivers like: transportation, good jobs, policies and funding, reducing racism, and creating strong connections and collaborations.

Disability

Like people of color, people living with disabilities often face additional barriers to accessing nutritious food. Limited mobility, transportation challenges, and higher medical expenses, for example, can compound food access and security issues for people living with a disability.

The map below overlays people living with a disability (blue) and low access to healthy food (yellow). While the Combined Service Area does not have any areas shaded black (i.e., high concentration of people living with a disability and people with low access to healthy food), there are gray areas (i.e., moderately sized populations of people living with a disability and low access to food).



Sources: US Census Bureau ACS 5-year 2018-2022; USDA ERS 2019

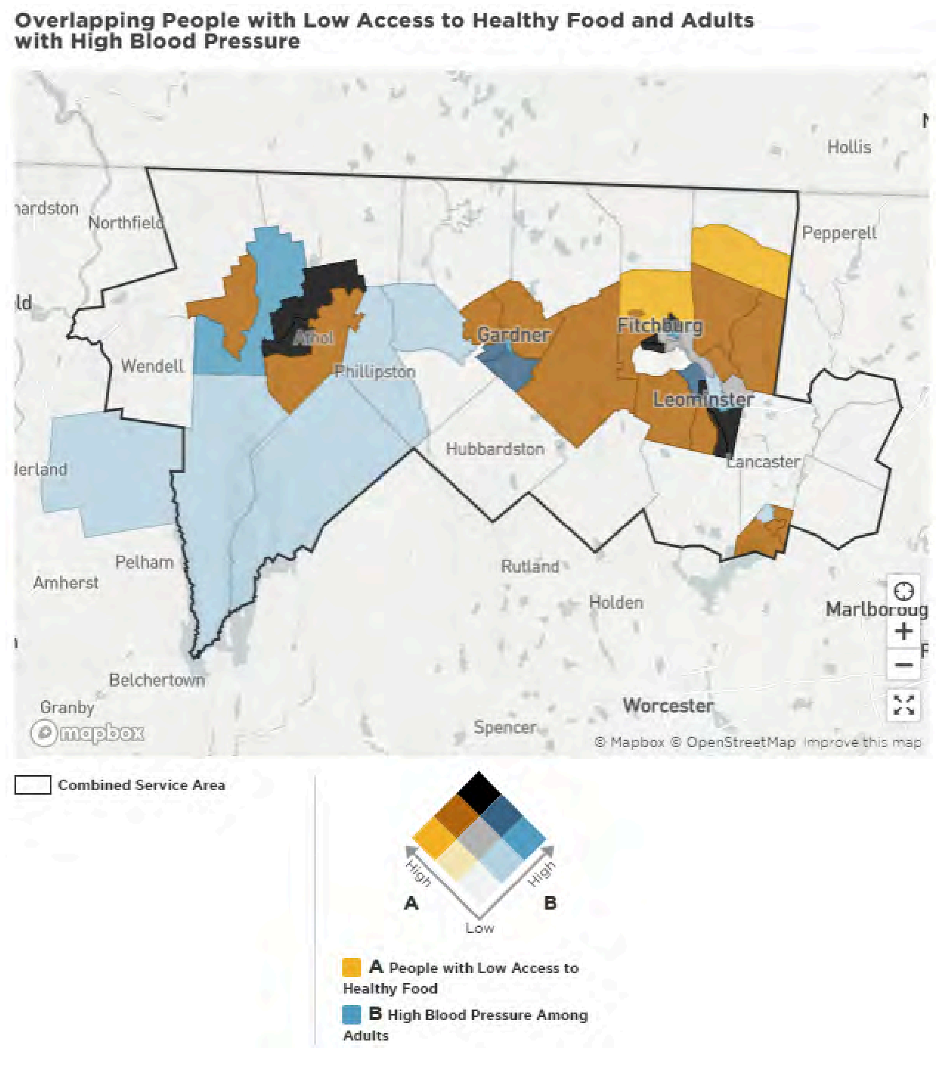
By identifying specific areas where people living with a disability experience low food access, policymakers and community organizations can develop tailored strategies to address their unique needs. Upstream and midstream interventions might include improving public transportation routes to grocery stores, offering home delivery services for groceries, and increasing the availability of affordable, healthy food options in nearby stores. Targeting these interventions appropriately ensures that resources are utilized efficiently and that people living with disabilities receive the support they need to achieve better food security and overall well-being.

Health Outcomes Associated with Food Access & Security

Overtime, poor nutrition can put individuals at risk of serious health outcomes. Common conditions associated with low food access include coronary heart disease and diabetes - the first and eighth leading causes of death in the United States, per the Centers for Disease Control. Long-term diet and consumption patterns are determinants of health outcomes.

High Blood Pressure

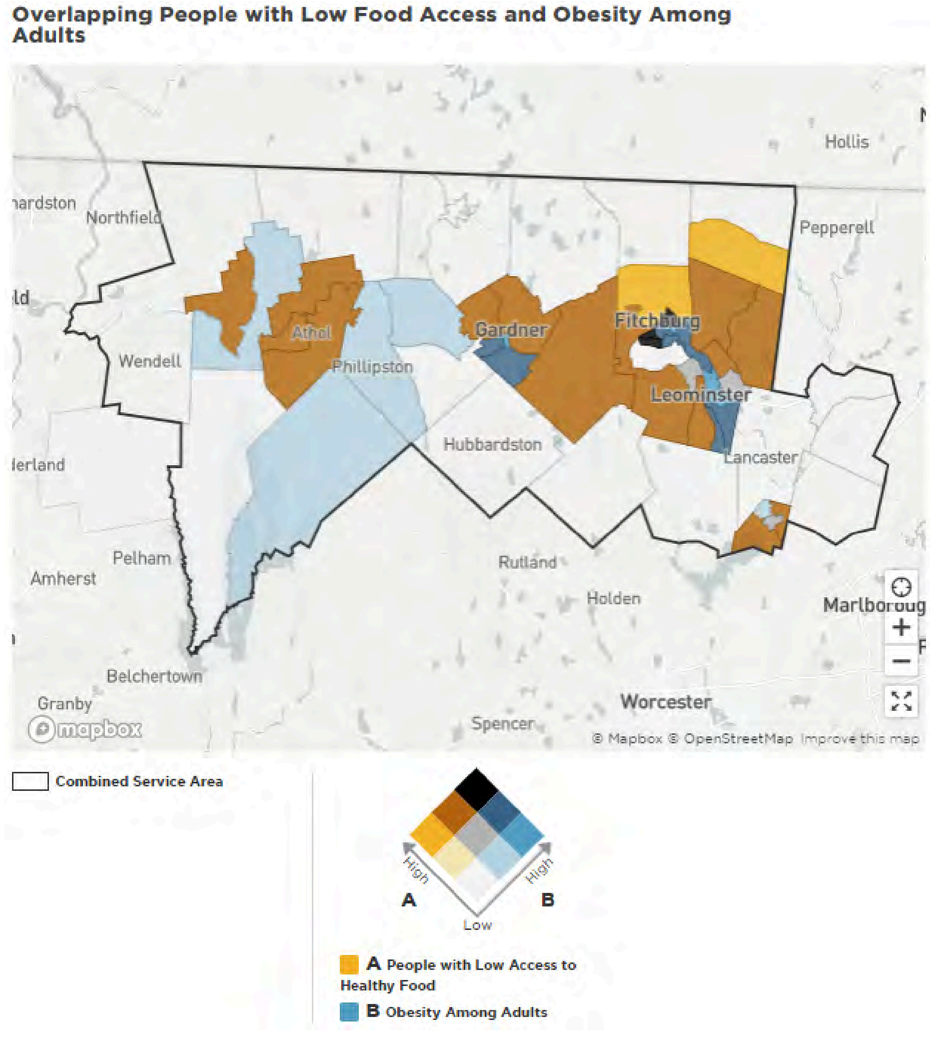
The map below overlays low access to healthy food (yellow) and adults with high blood pressure (blue). Areas in black are key places to note. They represent areas that experience the lowest access to healthy food and the highest rates of adults with high blood pressure.



Sources: CDC BRFSS PLACES 2019; USDA ERS 2019

Diabetes

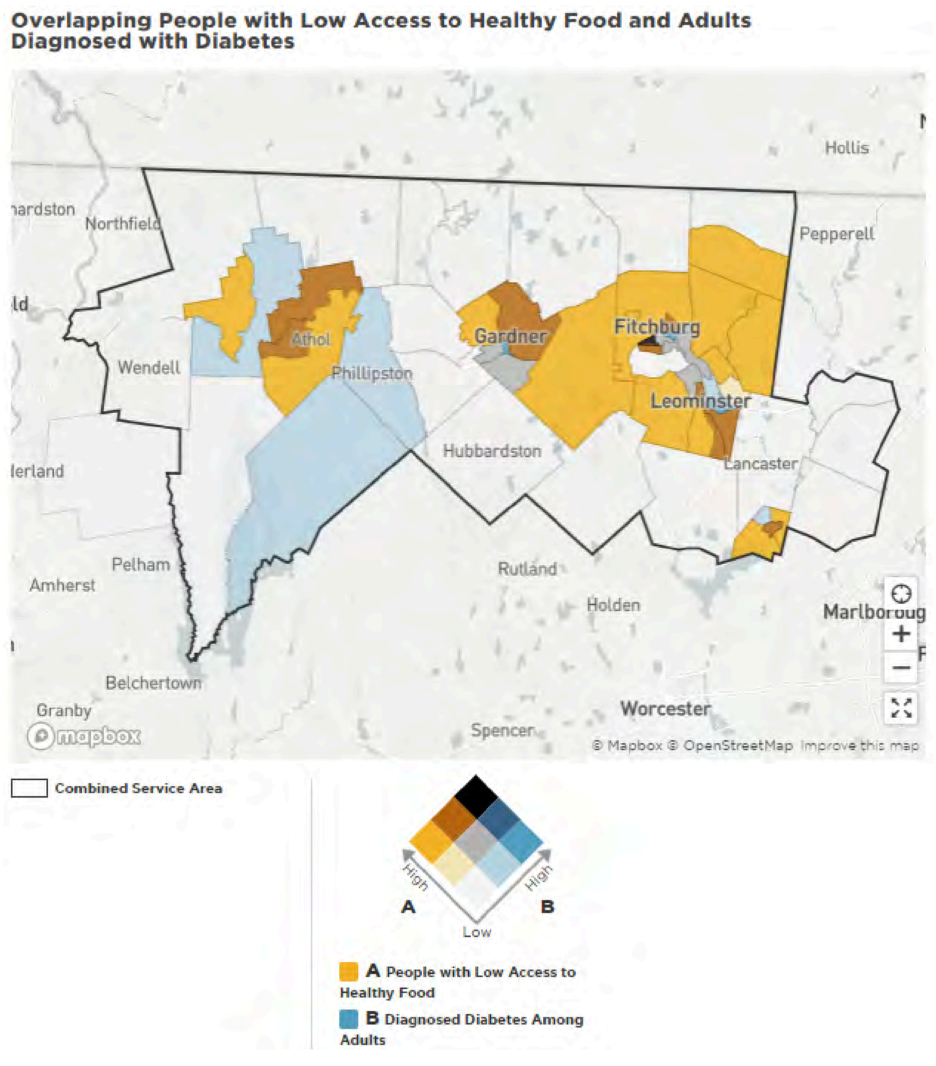
The map below overlays low access to healthy food (yellow) and adults diagnosed with diabetes (blue). Areas in black are key places to note. They represent areas that experience the lowest access to healthy food and the highest rates of adults diagnosed with diabetes.



Sources: CDC BRFSS PLACES 2019; USDA ERS 2019

Obesity

The map below overlays low access to healthy food (yellow) and obesity among adults (blue). Areas in black are key places to note. They represent areas that experience the lowest access to healthy food and the highest rates of obesity among adults.



Sources: CDC BRFSS PLACES 2019; USDA ERS 2019

Understanding where areas of low food access overlap with areas of high rates of chronic conditions among adults is essential for developing effective public health interventions. Limited access to nutritious food can exacerbate chronic health issues such as heart disease, diabetes, and obesity, creating a cycle of poor health and food insecurity. By identifying these overlapping areas, policymakers and community organizations can prioritize resources and design programs that address both food access and health care needs.

The Aspen Institute's Food Is Medicine Research Action Plan [22] emphasizes the importance of integrating food access and health care to improve health outcomes. Upstream and midstream initiatives such as establishing nutritional education and counseling programs, improving transportation to grocery stores, and providing affordable, healthy food options at grocery stores and farmers' markets can help break this cycle.

Targeting these efforts in high-need areas ensures a more holistic approach to improving health outcomes and fostering healthier communities, in line with the comprehensive strategies advocated by the Food Is Medicine Research Action Plan.

Addressing Food Insecurity

Addressing food access issues is critical to reducing food insecurity. Both local initiatives, such as programs designed to bring healthy food to isolated residents, and federally funded nutrition programs play crucial roles in ensuring that all community members have reliable access to nutritious food.

In the Combined Service Area, Local Food Works is working to create an equitable, sustainable, and accessible food system in North Central Massachusetts by leveraging the region's local food and farm assets. Emerging from previous Community Health Needs Assessments and the food access assessment conducted by Health Equity Partnership of North Central Massachusetts (CHNA9), as well as in response to the closure of the last Winchendon-based grocery store, Local Food Works has engaged over 150 local food system stakeholders. They aim to establish a values-based food system through a Regional Food Center extending from Athol to Pepperell to Clinton. Their efforts include closing gaps in residents' access to healthy food through home delivery and mobile markets, providing resources to local farmers to scale their businesses, lightly processing local food to make it accessible for both consumers and large food buyers at a regional processing center in Gardner, supporting local food makers, and connecting locally grown foods to institutional buyers via a turnkey online ordering platform.

In addition, both hospitals are partnering with Growing Places to increase access to healthy foods for patients. Heywood Hospital's Food is Medicine project targets patients with food related chronic conditions and patients who screen positively for food insecurity. Similarly, HealthAlliance-Clinton Hospital's Rx Food-FARMacy initiative at the Simonds-Sinon Regional Cancer Center and Fitchburg Family Practice enhances access to fresh, healthy food for patients by addressing food insecurity and economic stability. The Rx Food-FARMacy program focuses on reducing barriers through Supplemental Nutrition Assistance Program (SNAP) and Health Incentives Program (HIP) education, offering home delivery services, and increasing fresh food consumption. Likewise, Heywood Hospital is also partnering with Growing Places on a Food is Medicine project for patients with food related chronic conditions and patients that screen positively for food insecurity.

Patients of identified as food insecure via a social determinant of health assessment tool are referred to Growing Places for support with SNAP, HIP education, and access to a weekly produce program. Enrolled patients can receive up to six months of home delivery services. Growing Places reports positive impacts from the program: 96% of participants find it easier to access fresh produce, 87% experience improved mood and health, and 73% increase their fruit and vegetable intake.

HealthAlliance-Clinton Hospital's Rx Food-FARMacy initiative at the Simonds-Sinon Regional Cancer Center and Fitchburg Family Practice is a collaboration with Growing Places and its Local Food Works Initiative aimed at improving fresh food access to patients and the community at large.

Relatedly, UMass Memorial Health (UMMH), committed to impactful community support, recently formed an internal Community Health Equity Team to develop strategic goals for health equity. The team has chosen to focus on food access and food insecurity, aiming to align resources and create a significant impact through a strategic plan with both short-term and long-term goals. This plan includes addressing immediate needs and tackling the root causes of hunger. To effect meaningful change, HealthAlliance-Clinton Hospital and UMMH will collaborate with community partners, residents, and policymakers to build a just regional food system, complementing ongoing efforts such as the Rx Food-FARMacy Food as Medicine pilot projects and support for charitable food organizations.

Additionally, the United Way of North Central Massachusetts [23] addresses critical needs in the region, including food insecurity, housing, and other basic necessities, through funding, convening stakeholders, and collaborating with partners. Their approach involves year-round food collection efforts, including a major holiday food drive. The organization is also leading a group of emergency food access points/pantries to more efficiently transport food from the Worcester County Food Bank to access points in the region. Education programming is another focus area, with an initial plan to educate local food pantries and other organizations on the benefits of utilizing SNAP benefits to enhance services for their clients and support the pantries themselves.

Leominster Farmers' Market
A day at the Leominster Farmers' Market with Growing Places mobile market accepting SNAP and the MA Healthy Incentive Program (HIP) for 30+ farmers from North Central MA.

Local Food Baskets
Local food baskets representing the rainbow of food that North Central's MA's 180+ farmers have to offer the community.

While local food access initiatives are vital for reaching isolated residents and addressing immediate needs, federally funded nutrition programs provide the necessary support to ensure long-term food security and broader reach across diverse populations.

Optimal nutrition starting in the first 1,000 days of life [24] (from pregnancy to age 2) is crucial to support childhood development and adult health in the long term. Food assistance programs help relieve the impact of food insecurity for many households, particularly those with children. Government nutrition programs that exist today range from breakfast and lunch assistance for schoolchildren to nutrition programs for women, infants and children. The largest program is the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps. The central goal of SNAP is to alleviate hunger and malnutrition by increasing resources for the purchase of food for a nutritious diet.

Across the Combined Service Area, 14.0% of households receive SNAP.

	Community	Percent Households Recieving SNAP
Health Alliance-Clinton Hospital	Ashburnham	4.9%
	Ashby	1.7%
	Bolton	3.9%
	Clinton	9.7%
	Fitchburg	24.2%
	Gardner	18.1%
	Harvard	1.5%
	Lancaster	10.1%
	Leominster	14.3%
	Lunenburg	6.4%
	Princeton	2.8%
	Sterling	5.7%
	Townsend	5.2%
	Westminster	5.0%
	Area Total	**13.4%**
Heywood Hospital	Ashburnham	4.9%
	Gardner	18.1%
	Hubbardston	10.0%
	Templeton	11.4%
	Westminster	5.0%
	Winchendon	16.8%
	Area Total	**13.2%**
Athol Hospital	Athol	22.8%
	Erving	15.2%
	New Salem	4.4%
	Orange	19.6%
	Petersham	6.3%
	Philipston	5.1%
	Royalston	9.5%
	Warwick	9.8%
	Wendell	21.9%
	Area Total	**17.9%**
	Combined Service Area	**14.0%**
	Worcester County	14.1%
	Franklin County	15.1%
	Massachusetts	12.9%

Source: US Census, American Community Survey, 5-Year Estimates, 2018-2022

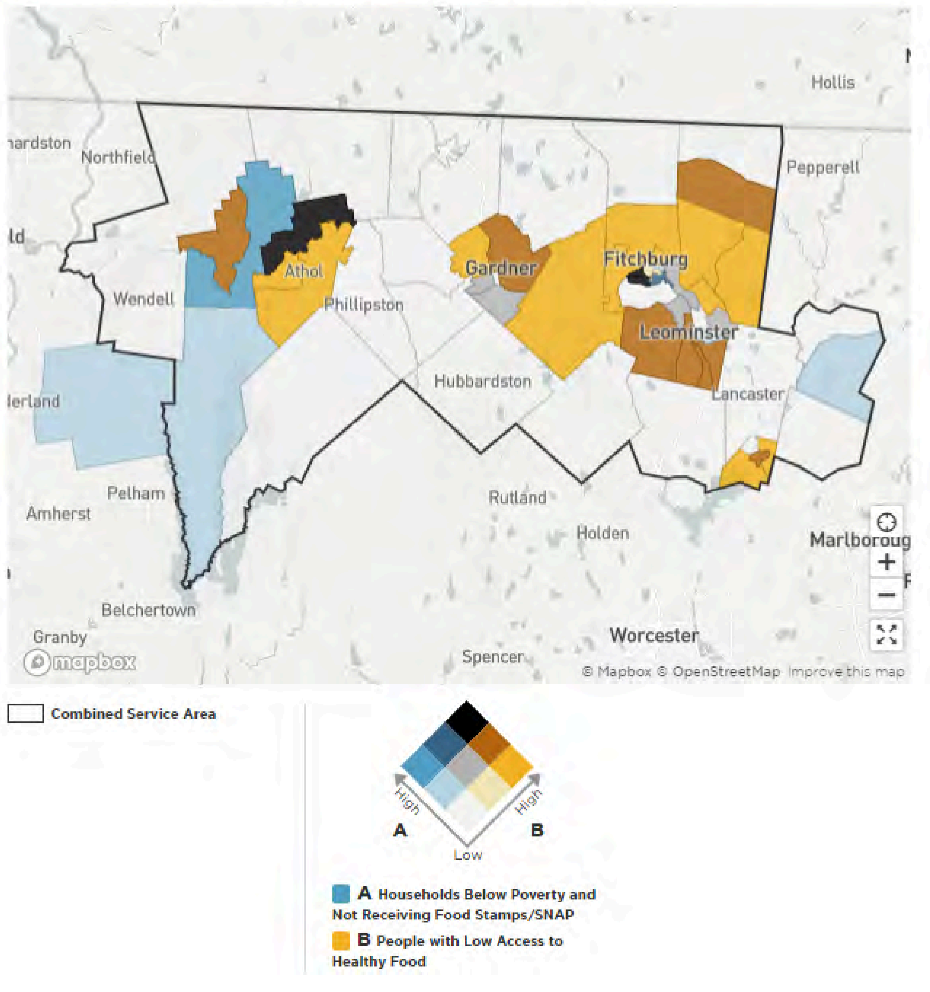
Eligibility for SNAP is largely based on income. Generally, people living at or below 200% of the Federal Poverty Level are eligible for SNAP, meaning that nearly everyone living in poverty is eligible. Yet, in the Combined Service Area nearly half of people living in poverty do not receive this critical nutrition benefit.

Households Below Poverty That Do Not Receive SNAP/Food Stamps

Percentage	Area
47.4%	Combined Service Area
47.9%	HealthAlliance-Clinton Hospital
43%	Heywood Hospital
47.6%	Athol Hospital
50.4%	Worcester County, MA
52.7%	Franklin County, MA
52.5%	Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

The map below overlays low access to healthy food (yellow) and households below poverty that are not receiving food stamps (blue). Areas in black are key places to note. They represent areas in the Combined Service Area that experience the lowest access to healthy food and the highest rates of households below poverty that are not receiving food stamps.



Sources: US Census Bureau ACS 5-year 2018-2022; USDA ERS 2019

In Massachusetts, the SNAP program is augmented by Healthy Incentives Program (HIP). HIP provides extra benefits to spend on farm fresh, locally grown vegetables and fruits at any registered HIP vendor. In the Combined Service Area there are roughly 50 HIP vendor sites including farmers' markets, farm stands, mobile market stops, and CSA programs [25].

Targeting food access interventions to geographic areas with the greatest need is crucial for effectively combating food insecurity. Tailored upstream and midstream interventions, such as establishing affordable grocery stores, community gardens, and nutrition education programs, can directly address the unique challenges faced by these communities. This strategic approach not only helps to alleviate food insecurity but also promotes equity and improves the overall health and well-being of the most vulnerable populations.

Conclusions

Food insecurity is a concern in the Combined Service Area, affecting one in ten residents. This issue disproportionately impacts Black and Hispanic communities, where the rate of food insecurity is roughly double that of the general population, and is even more severe among low-income households, where the rate is three times higher. Limited access to nutritious food not only challenges daily well-being but also exacerbates chronic health conditions such as heart disease, diabetes, and obesity, creating a detrimental cycle where poor health further entrenches food insecurity. Addressing food insecurity is crucial to improving overall community health and breaking this cycle.

Addressing food insecurity in the Combined Service Area requires a comprehensive approach that considers both geographic areas with low access to healthy food and the specific populations most affected, including low income residents, unemployed individuals, people of color, and people with disabilities. Local initiatives aimed at increasing food access are critical, as they can be tailored to meet the unique needs and values of the communities they serve. These upstream and midstream initiatives can include the establishment of community gardens, farmers' markets, and mobile food pantries that directly reach underserved neighborhoods. Additionally, maximizing enrollment in federal benefit programs like SNAP and state programs like the Health Incentives Program is essential to ensuring that all individuals, regardless of their socioeconomic status, have access to a basic level of good nutrition. By combining local efforts with robust participation in state and federal programs, the community can create a more equitable food system and improve the overall health and well-being of its residents.

TRANSPORTATION

Transportation plays a critical role in accessing essential services that contribute to overall community health and well-being. Reliable transportation is fundamental for individuals to reach employment opportunities, ensuring economic stability and growth. It also enables residents to access healthy food options, which are often located outside immediate residential areas. Furthermore, transportation is vital for obtaining healthcare services, from routine check-ups to emergency medical care. Without adequate transportation options, many residents face significant barriers that hinder their ability to achieve and maintain good health, economic security, and a high quality of life. The following section will explore the impact of transportation on these crucial areas and highlight the importance of addressing transportation barriers to promote equitable access for all community members.

Public Transit

According to the *2023 Quabbin Regional Rural Transit Study Report*, the Combined Service Area has several public transportation resources including those offered by:

- Montachusett Regional Transit Authority (MART)
- Worcester Regional Transit Authority (WRTA), and
- Pioneer Valley Transit Authority (PVTA).

Montachusett Regional Transit Authority
MART serves as the regional transportation provider, providing fixed route and paratransit services as well as brokering human service transportation. This service provides MassHealth members with access to non-emergency transportation to medical appointments.

Despite the existence of these publicly-funded resources, there are limitations in their scope and coverage.

For example, in their recent community needs assessment, Community Action Pioneer Valley, the federally- qualified Community Action Agency serving the western portion of the Combined Service Area stated (pg. 109):

"Financing public transit in rural areas always poses a difficulty; the geographic area is large, and the ridership per mile traveled is small. State policy has not prioritized adequate public transit funding for western Massachusetts. As a result, public transit here is inadequate, especially in the more rural areas outside of the operating hubs."

Furthermore, the towns of North Quabbin are divided between two counties, and residents must navigate two transportation systems. The residents of the rural North Quabbin areas have higher transportation costs and more limited accessibility than those of the more densely populated areas as the fixed bus routes do not reach the smaller towns.

Similarly, UMass Memorial HealthAlliance-Clinton Hospital's *Prenatal and Postnatal/Postpartum Community Need Assessment* found that public transit stops and hours are limited across the region and that taxis and on- demand ride-hailing services are not adequate to supplement the public transit services.

Additionally, the North Central Massachusetts Chamber of Commerce's *Engaging Hidden and Future Workers to Grow the Local Economy* cites such limitations in the local transportation system, labeling them as a top barrier to local residents entering the workforce.

Challenges with the transportation are further highlighted by the results of HealthAlliance-Clinton Hospital's Social Determinants of Health (SDOH) risk and needs screening tool, which surveyed 8,364 patients, primarily from primary care settings, to assess their experiences and needs. The assessment revealed that 5% of respondents lacked adequate transportation in the past year, and 3% needed transportation assistance.

Recognizing that residents of color and those whose primary language is not English are often disproportionately affected by Social Determinants of Health, the hospital stratified the data by race, ethnicity, and primary language. This analysis uncovered that 7% of respondents who identified as "Hispanic or Latino," 5% of respondents who identified as "Black," and 8% of respondents who identified as "Other" reported transportation-related needs, compared to 2%of White respondents. Similarly, 13% of Spanish-speaking respondents, 8% of Portuguese-speaking respondents, and 17% of Haitian Creole-speaking respondents reported needing help with transportation, in contrast to 3% of English-speaking respondents. This stratified data underscores the deeper vulnerabilities faced by certain groups in the Combined Service Area.

Qualitative feedback about transportation in the region from residents who participated in the Focus Groups conducted as part of this Community Health Needs Assessment process, was generally negative.

Common criticisms included:

- routes that fail to adequately cover the region, particularly in the more rural communities:

"There is nowhere near enough public transportation in this region."

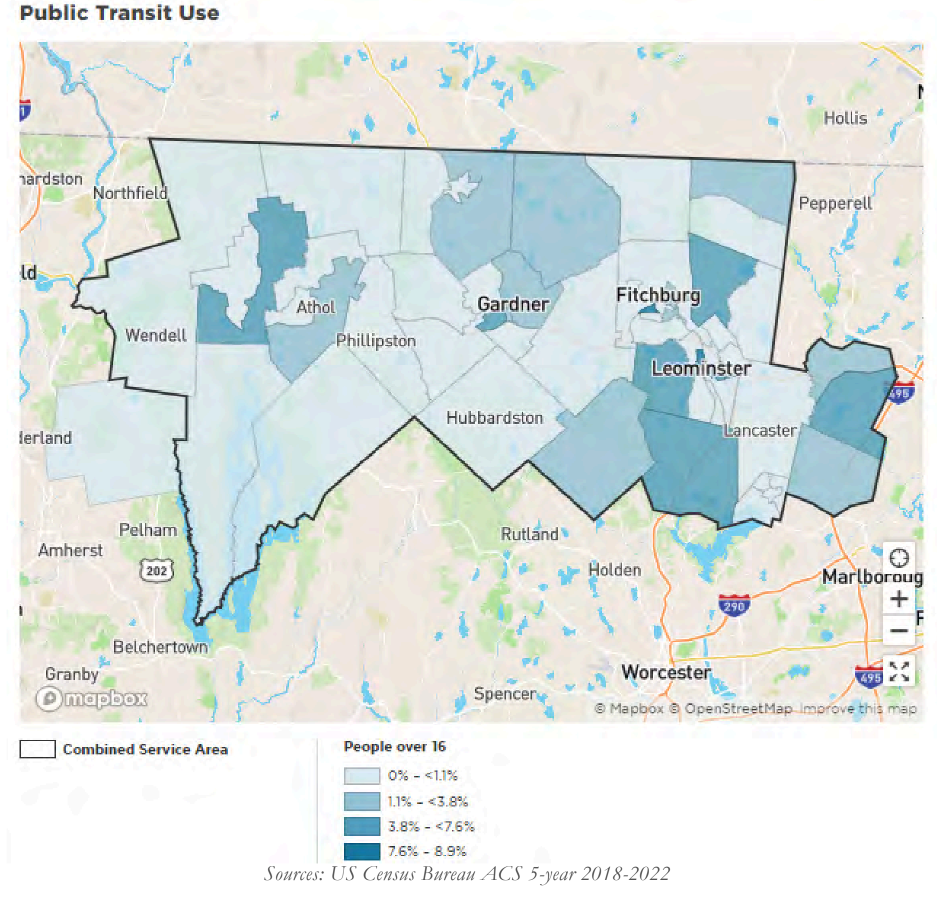
- schedules that do not meet the needs of residents around work, entertainment, and errands:

"Public transportation to get to work is limited, especially for those who work middle shifts. We need longer hours."

"A trip to Walmart takes half your day."

Additional barriers to public transportation cited in recent studies and assessments include: a lack of communication about and marketing of transportation resources; complicated eligibility requirements for free and reduced cost services; and a lack of adherence to posted routes and schedules.

Due to these limitations, public transit use across the Combined Service Area is low. For example, the map below shows utilization of public transportation for commuting to work by residents over 16 years of age. With the exception of isolated Census Tracts in Fitchburg and Leominster, public transportation as a means of commuting to work is much lower in the Combined Service Area than Massachusetts (7.6%), but similar to Worcester (1.5%) and Franklin (1.0%) Counties.



Sources: US Census Bureau ACS 5-year 2018-2022

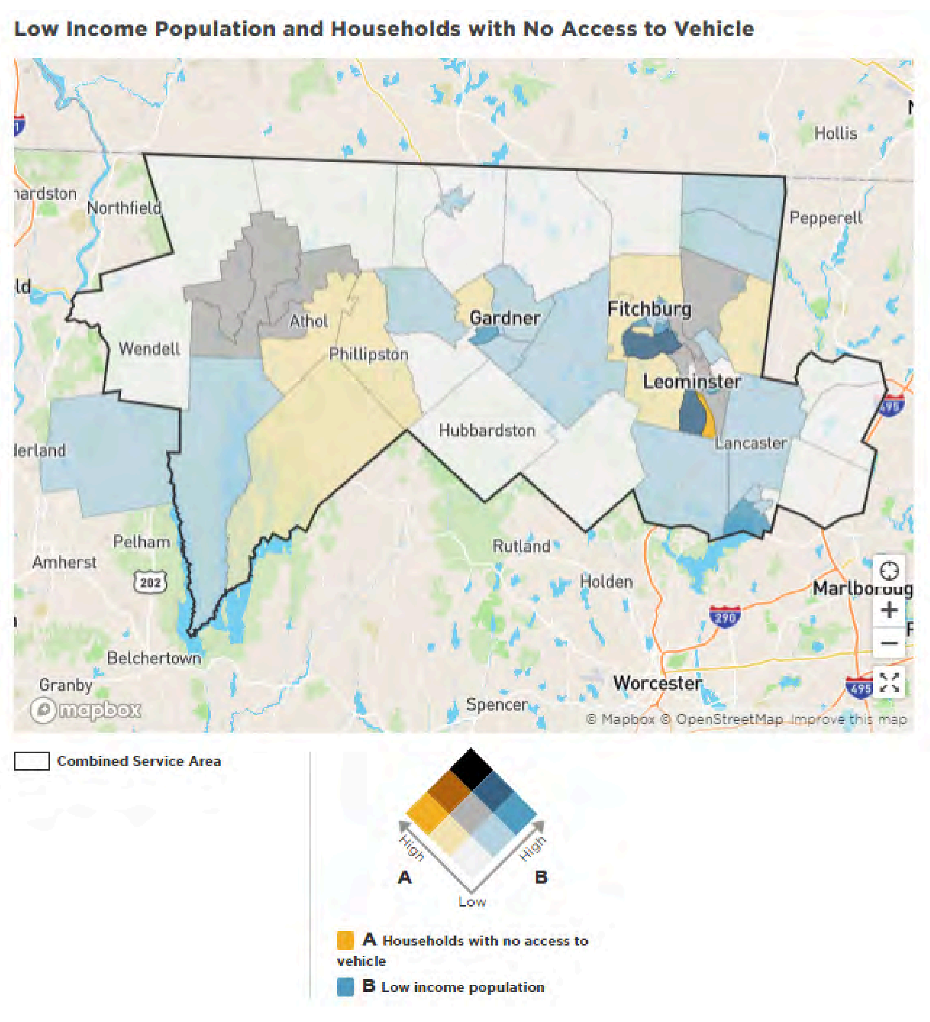
Personal Vehicles

Per the *Quabbin Regional Rural Transit Study*, underutilization of public transit in the region has created an over-reliance on personal vehicles.

Within the Combined Service Area, the vast majority of households have access to a personal vehicle. Among homeowners, 97.3% of households have access to a personal vehicle while 81.6% of renter households have access to a personal vehicle.

This difference in vehicle availability between homeowners and renters suggests an income disparity in transportation access as the Median Income of renters across the Combined Service Area is lower than that of homeowners (see Housing Sections).

The map below shows an overlay of low income households (blue) with households with no vehicle access (yellow). While there are no black hotspots indicating strong overlap between the two indicators, there are gray areas where overlap is notable.



Sources: HUD Low-Mod (LMISD) 2016-2020; US Census Bureau ACS 5-year 2018-2022

Note: The darkest color at the top of the diamond represents areas with the greatest overlap between the two indicators (Indicator A and Indicator B).

Maintaining a personal vehicle imposes an extra financial burden on low income individuals, as they must contend with ongoing costs such as gasoline, regular maintenance, and unexpected repairs. These expenses can strain already limited budgets, making it even more challenging for low income households to achieve financial stability and meet other essential needs. As a result, the areas in gray above, which represent moderate overlap between households with no access to vehicles and households with low income, may be appropriate geographical targets for transportation access interventions.

Walkability

Vehicle ownership is critical for accessing employment opportunities, especially in areas where public transportation options are limited. However, enhancing walkability in communities can also significantly impact access to employment and promote a healthy lifestyle.

Walkability is a measure used to indicate the ease of pedestrian travel in an area. Communities with greater walkability make it easier to get around on foot and to live a more active lifestyle. The EPA Walkability Index is a nationwide geographic data resource that ranks Census Block Groups according to their relative walkability. Scores range from 1 to 20, with scores closer to 1 indicating lower walkability and scores closer to 20 indicating higher walkability. Understanding which areas of the Combined Service Area are walkable and which are not enables stakeholders to make informed decisions about what kind of improvements are needed and where.

According to the Index scores presented below, the Combined Service Area is more walkable than the comparison area of Franklin County, but less walkable than Worcester County and Massachusetts.

Walkability Index

8.7
Combined Service Area

9.1
HealthAlliance-Clinton Hospital

8.1
Heywood Hospital

7.5
Athol Hospital

9.8
Worcester County, MA

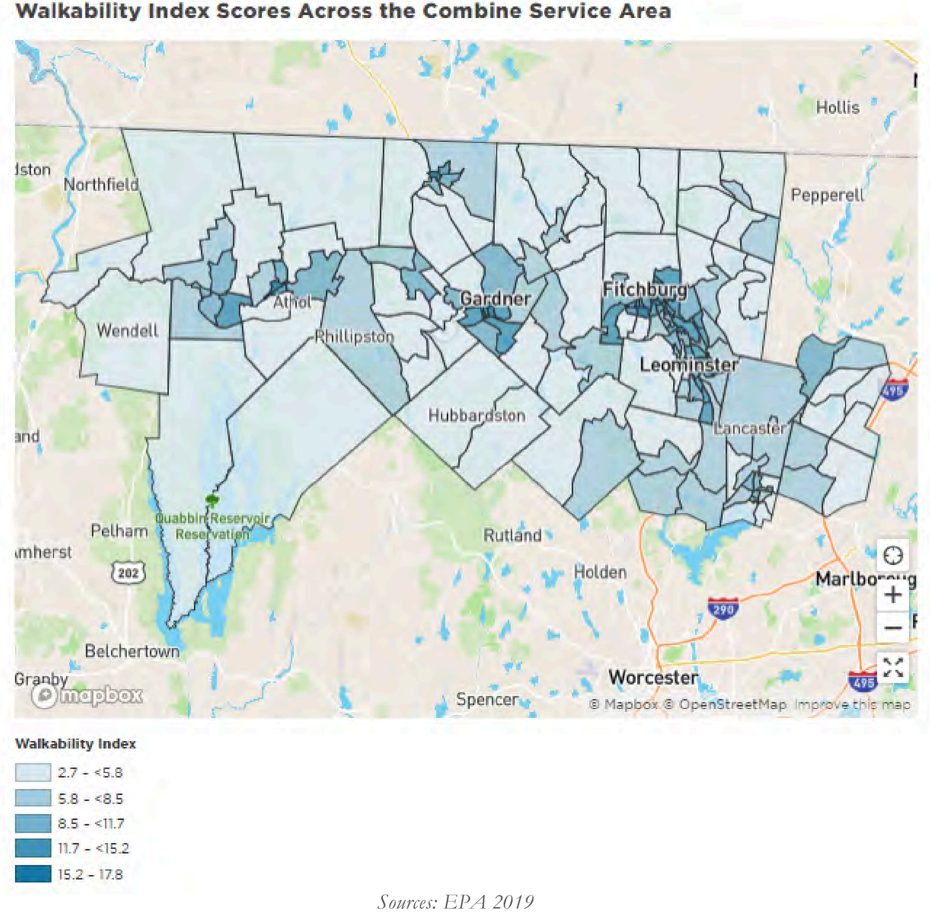
8
Franklin County, MA

11.6
Massachusetts

Sources: EPA 2019

The map below divides the Combined Service Area into Census Block Groups, identifying which neighborhoods are more and less walkable.

Walkability Index Scores Across the Combine Service Area



Sources: EPA 2019

Access to walkable communities can greatly impact residents' quality of life. The level of walkability in different areas can affect how easily individuals can walk to essential places like employment, schools, parks, and food access points. The above Walkability Index map highlights how some parts of the Combined Service Area are more conducive to walking than others. This information is important as stakeholders work to create pedestrian-friendly environments within communities, which can enhance overall well-being and reduce reliance on transportation.

Fitchburg-Leominster Rail Trail
The Fitchburg-Leominster Rail Trail is used for recreation and connection to goods and services.

The Cost of Transportation Barriers

Limited public transportation options, high vehicle ownership costs, and limited walkability have impacts on residents beyond their ability to simply get places. Recent community assessment reports as well as the Focus Groups conducted as part of this Community Health Needs Assessment process highlight transportation barriers as impacting residents' access to necessary healthcare services, including maternal health services, emergency services, specialty healthcare services, and behavioral health services.

HealthAlliance-Clinton Hospital's *2023 Prenatal and Postnatal/Postpartum Community Needs Assessment*, for example, identified "limited transportation, generally and for prenatal/postpartum services and support" as the top need of women and birthing people in the hospital's service area.

Additionally, the *2023 Quabbin Region Rural Transit Study Report* states that there is a "pressing need for efficient, accessible, and reliable transit solutions to bolster community health...and improve overall well-being." According to the study, while there are public transportation services specifically designated for accessing healthcare, these services are often limited to specific populations (e.g., older adults, people living with disabilities, etc.) and types of transport (e.g., non-emergent). Furthermore, they often require pre-approval processes. During the Community Health Needs Assessment process, local medical providers noted that transportation barriers can "result in delayed or missed appointments".

The issue of missed medical appointments due to transportation challenges was also raised by participants in the Focus Groups conducted as part of this Community Health Needs Assessment process. They reported that transportation to medical appointments can put an undo burden on family and friends who are asked to provide rides. Focus Group participants stated that, in some cases, they would choose to forgo needed care to avoid having to ask for help.

In response to such concerns, Heywood Healthcare has partnered with Woods Ambulance, Inc. to provide their patients with reduced rates to non-emergency medical appointments. For patients who have financial hardship, the hospital has supported their rides through community benefit funds. Additionally, the Woods Plus Rideshare Services provides visitors and residents of Gardner riding within the city limits with on-demand, same day non-medical transportation for a flat rate of $10/ride.

HealthAlliance-Clinton Hospital has also committed to address transportation barriers since the closing of their Maternity Center. Their *Plan to Ensure Access to Health Resources* calls for hospital supported, around the clock, non-emergency transportation through GoGo, a service that works with Uber, Lyft, and other taxi/livery companies to provide reliable transportation throughout the day and night. Opportunities to utilize this service for other patients, including cancer patients traveling to and from the Fitchburg campus, are being explored. HealthAlliance-Clinton Hospital is also working with the Montachusett Regional Transit Authority to examine how PT1 services could be enhanced

to their patient populations through physician office education and training.

In addition to impacting access to needed healthcare services, Focus Group participants shared that limited local transportation resources impede their ability to connect with friends and family members, contributing to social isolation and reduced well-being.

"I don't go to family functions unless I have a ride for sure before I go."

"I'm worried [gas prices are] going to stay like this during the summer so it's going to limit how much we decide to drive out with the kids. Now I have to figure out what I'm going to do with them when they are out of school. I don't like to keep them stuck in the house."

Social isolation is dangerous for everyone, but it presents additional challenges for older adults and youth. For older adults who are aging in place, staying connected with their communities is crucial for maintaining mental and emotional well-being, yet limited mobility and transportation options can exacerbate feelings of loneliness and isolation. In their *Age- and Dementia-Friendly Regional Plan*, LifePath and Franklin Regional Council of Governments report that a significant number of older adults across the region report feeling lonely, unsafe, unsupported, socially isolated, and often left out of their communities. These older adults (and people who care for them) report both and a lack of services and a lack of information about ways to get engaged in existing social support networks, civic, or volunteer activities. Additionally, activities that are available can be difficult to access due to disability, cost, and transportation issues.

At the same time that older adults are struggling with social isolation, youth who have experienced prolonged periods of remote learning and social distancing face difficulties in rebuilding their social networks and engaging in peer interactions.

Both groups are at heightened risk of the negative health effects associated with isolation, such as depression, anxiety, and cognitive decline, underscoring the need for targeted interventions to enhance social connectivity and support within these vulnerable populations.

Addressing Transportation Barriers

Several suggestions for improving transportation challenges across the Combined Service Area have been proposed in local community assessment reports and by those who

participated in the Focus Groups conducted as part of this Community Health Needs Assessment process.

For example, to address general challenges with limited public transportation routes and schedules, the *Quabbin Regional Rural Transit Study Report* calls for upstream and midstream approaches like the creation of micro-transit services. Micro-transit is a flexible, on-demand transportation service that operates within a defined area, often using smaller vehicles like vans or shuttles. Unlike traditional public transit with fixed routes and schedules, micro-transit adapts to real-time passenger demand, providing more efficient and personalized service. It aims to bridge the gaps in public transportation networks, offering a convenient and cost-effective alternative for underserved areas.

To address transportation challenges around healthcare access, in particular, the *Quabbin Regional Rural Transit Study Report* calls for volunteer transport services for long-distance trips and better collaboration between anchor institutions like local governments, transit authorities, healthcare providers, educational institutions, and community-based organizations with shared interests in transportation services.

HealthAlliance-Clinton Hospital's *Prenatal and Postnatal/Postpartum Community Needs Assessment* calls for in- home care for pregnant women and birthing people and expanding transportation services for parents and families with children in the NICU. It also goes beyond transportation-based solutions to suggest temporary housing near birthing centers for pregnant women and birthing people.

Participants in the Focus Groups conducted as part of this Community Health Needs Assessment process also shared their ideas for upstream and midstream approaches improving the local public transportation infrastructure:

- expanding existing bus routes and hours,
- late night discounts for workers who need to use Uber or Lyft to get to and/or from work, and
- extending "Fare-Free MART" so that residents can continue to ride all MART buses for free.

They also talked about the need to improve sidewalks for pedestrians, to fix the potholes that plague the region's roadways, and to offer drivers' education in schools to support young drivers.

Examples of efforts to address transportation barriers already under way across the Combined Service Area include Lifepath's Rides for Health and Groton Neighbors Helping Neighbors, two volunteer transportation models that make a big difference in the lives of people who otherwise may not be able to get to the doctor or other health-related appointments.

Additionally, since December 2023, Health Equity Partnership of North Central MA (CHNA9) has been leading an effort called the *Future of Mobility* to develop a regional master plan and an aligned and actionable strategic plan to address the limited mobility options in its 27-member town region. The vision for the *Future of Mobility* Plan is for "All people who live in, work in, and visit the North Central MA region can easily and safely move to, from, and between places they wish to go." Promising initiatives recently funded by the Department of Transportation to address the region's transportation issues are:

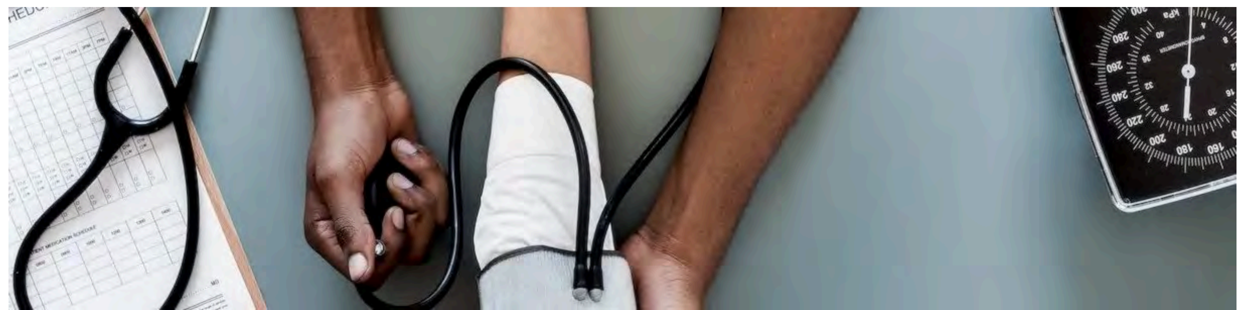
1. MART's Regional Rural Connector-Intercity Loop Northwest which will create a new van service, as well as use taxi and livery companies to transport riders from Ashburnham, Templeton, and Winchendon to an intercity loop route in Gardner;
2. A MART shuttle service to connect unserved areas of Gardner and Westminster to essential services; and
3. Winchendon Community Connection & Access Project (WCCAP) which will expand the existing service hours within the town of Winchendon and contiguous communities to support access to healthy food, economic empowerment, social inclusion, and wellness.

Future of Mobility
North Central MA Future of Mobility planning group member, Jane LaPointe, leading a visioning activity.

Conclusion

Limited public transportation, high transportation costs, and limited walkability pose significant challenges for accessing essential goods and services within the Combined Service Area. These transportation barriers hinder individuals' ability to reach employment opportunities, reducing economic stability and growth. Additionally, they restrict access to healthy food options, impacting nutritional outcomes. Difficulties reaching healthcare services impedes timely medical care and further exacerbates health disparities. Beyond these practical impacts, inadequate transportation contributes to social isolation, as people are unable to maintain connections with their communities and support networks. Addressing transportation issues is crucial for enhancing access to employment, food, and healthcare, and for fostering a more connected and healthy community.

HEALTHCARE ACCESS & HEALTH BEHAVIORS



Understanding clinical aspects of health, including access to healthcare and individuals' health behaviors, often provides the most direct understanding of community and individual health. By examining these clinical aspects, such as the number of healthcare providers in the region, their geographical distribution, insurance coverage rates, and the choices that people make around their health, we can evaluate how effectively upstream interventions, such as policy changes and environmental improvements, and midstream interventions, like lifestyle modifications and health education, translate into tangible health benefits at the individual and community levels. This comprehensive understanding helps us to determine the impact of these interventions on downstream health outcomes, such as reduced disease prevalence, improved management of chronic conditions, and overall enhancements in health and well-being.

Until this point, this Community Health Needs Assessment has focused on the groundwater, upstream, and midstream Social Determinants of Health that impact health outcomes. The next section will shift its focus to the local health care delivery system and individual's health behaviors. These aspects of health and well-being are intimately connected to the broader context of Social Determinants of Health, as they directly influence how upstream factors are addressed and how health behaviors are managed within the community. By exploring these elements, we aim to bridge the gap between broader Social Determinants and their practical implications for health care and individual health practices.

Healthcare Access

Access to healthcare can be particularly limited in rural areas, like the Combined Service Area, due to several factors. These regions often face shortages of healthcare providers, including primary care physicians and specialists, making it difficult for residents to receive timely and comprehensive care. Additionally, rural areas may lack healthcare facilities such as hospitals, clinics, and pharmacies, forcing residents to travel long distances to obtain medical services. Transportation challenges and lower rates of insurance coverage further exacerbate these issues, leading to delayed treatment and poorer health outcomes. Addressing these barriers is crucial for ensuring that rural populations have equitable access to necessary healthcare services.

Per the tables below, the Combined Service Area has lower provider-to-patient ratios for Primary Care Physicians, Specialist Physicians, OB-GYNs, Mental Health Providers, and Dentists than the comparison areas for nearly all of the provider types, except Dentists in Franklin County.

Local Health Care Providers

Primary Care Physicians per 100,000	
Combined Service Area	93.5
HealthAlliance-Clinton Hospital	107.9
Heywood Hospital	72
Athol Hospital	51.2
Worcester County, MA	151.7
Franklin County, MA	99.9
Massachusetts	159.4

Specialist Physicians per 100,000	
Combined Service Area	1,412.5
HealthAlliance-Clinton Hospital	1,567.3
Heywood Hospital	1,223
Athol Hospital	1,078
Worcester County, MA	2,492.6
Franklin County, MA	2,117.8
Massachusetts	2,548.8

OB-GYNs per 100,000	
Combined Service Area	4.8
HealthAlliance-Clinton Hospital	6.1
Heywood Hospital	5
Athol Hospital	0
Worcester County, MA	15.3
Franklin County, MA	5.5
Massachusetts	16.5

Mental Health Providers per 100,000	
Combined Service Area	242.6
HealthAlliance-Clinton Hospital	253.9
Heywood Hospital	291.5
Athol Hospital	266.1
Worcester County, MA	294.1
Franklin County, MA	451.8
Massachusetts	345.4

Number of Dentists per 100,000	
Combined Service Area	59.6
HealthAlliance-Clinton Hospital	70.4
Heywood Hospital	35.2
Athol Hospital	27.3
Worcester County, MA	62.9
Franklin County, MA	56.1
Massachusetts	84.2

Sources: NPPES NPI 2022, 2023; US Census Bureau 2024

Provider-to-patient ratios in the Combined Service Area tend to be 60-70% of those across Massachusetts, reflecting a general shortage of healthcare providers in the region. This discrepancy is particularly stark for OB-GYNs, where the provider-to-patient ratio is alarmingly low, just 30% of Massachusetts.

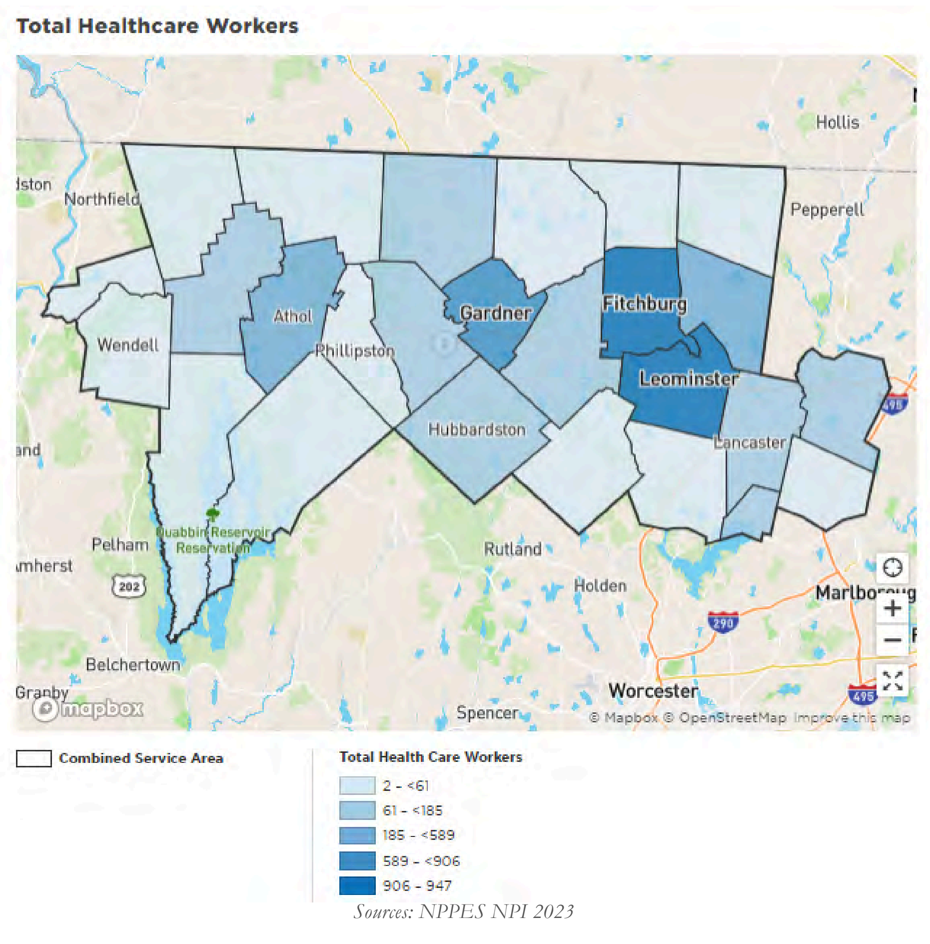
Also of note in the provider-to-patient tables above is that across the individual hospital service areas, the provider-to-patient ratios tend to decrease from east to west. In fact, Athol Hospital is a federally designated Critical Access Hospital with a Geographic Health Provider Shortage Area (HPSA) because of a shortage of providers in the region and distance from other healthcare facilities.

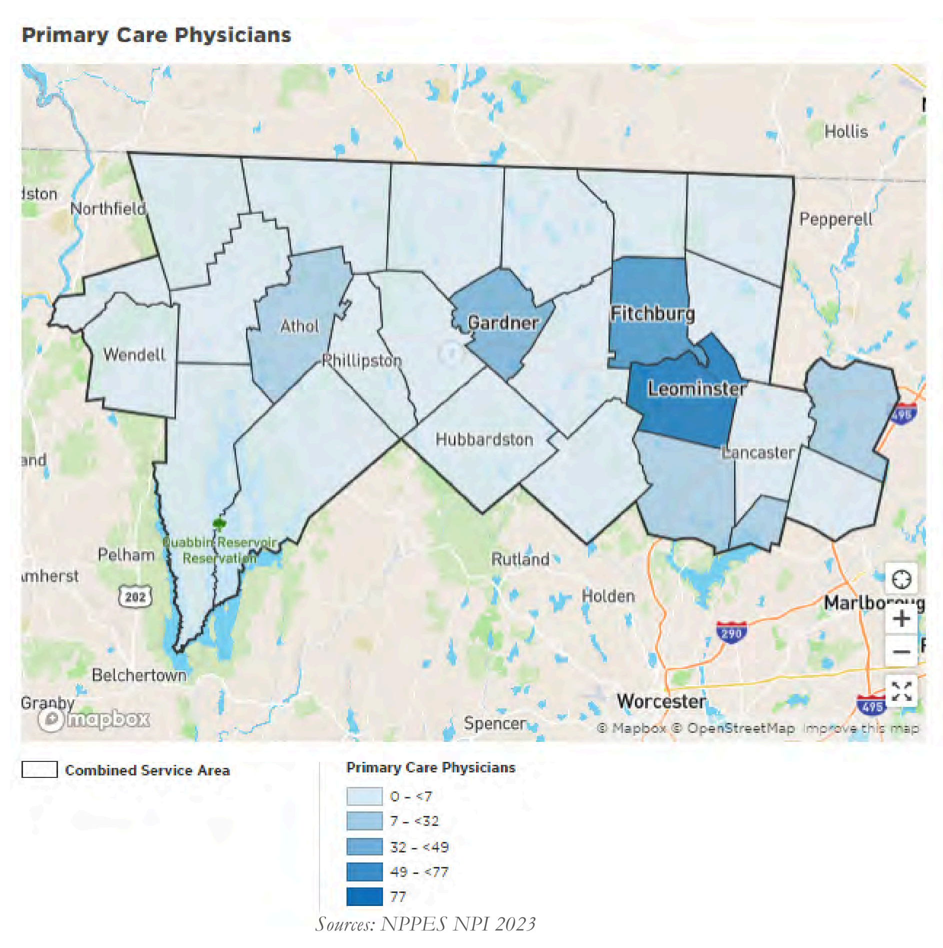
This pattern of worsening indicators in the western portion of the Combined Service Area has been noted elsewhere in the Community Health Needs Assessment and may reflect the transition from more urban, well- resourced communities to more rural, less well-resourced communities. This pattern is not unique to the Combined Service Area. The United States is experiencing a "misallocation" of healthcare resources with provider-to-patient ratios increasing in larger metro areas while dropping in rural areas [26].

The root causes of physician and caregiver shortages are complex and multifaceted, including factors such as inadequate funding for medical education in rural areas, lower financial incentives for healthcare professionals to work in underserved regions, and broader systemic issues in healthcare policy and resource distribution. These shortages are part of a national trend rather than local decisions about pay or service investment. However, the impacts of these shortages are evident in the Combined Service Area: reduced access to care, longer wait times, and decreased availability of specialized services. Understanding broader trends is essential for addressing the service delivery gaps locally and improving healthcare access across all regions, including in the Combined Service Area.

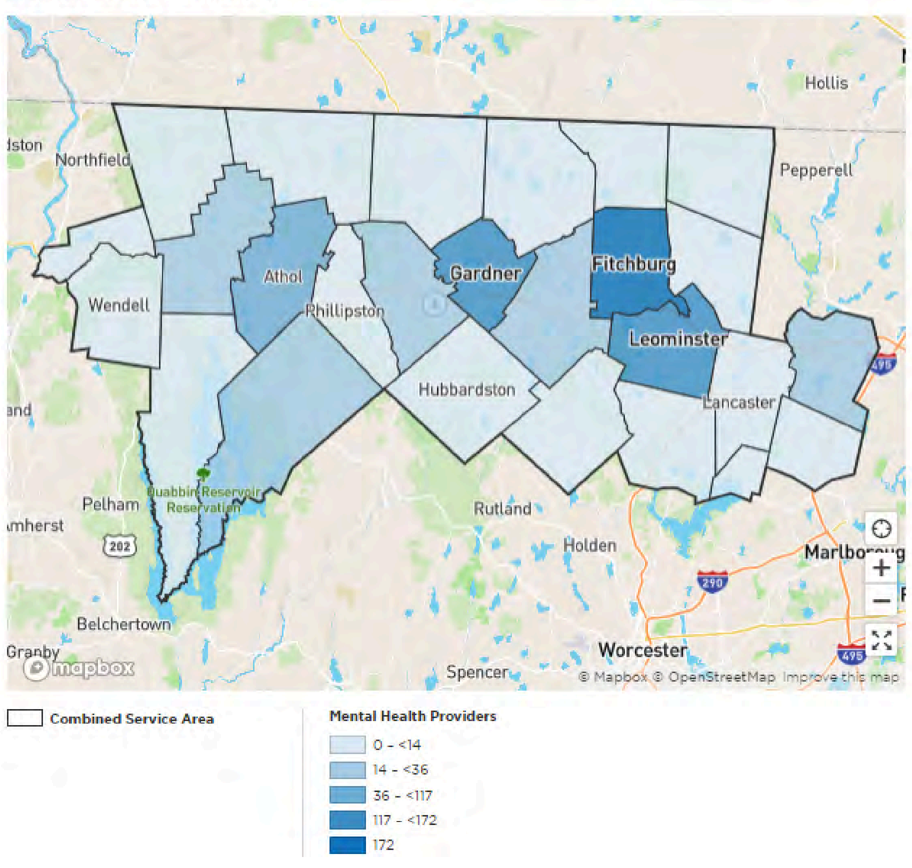
The low provider-to-patient ratios in the Combined Service Area will become particularly problematic as the population continues to age and boomer-generation doctors reach retirement age. The American Association of Medical Colleges projects long-term workforce shortages [27], which will further strain the already limited healthcare resources in the Combined Service Area. Addressing these disparities is crucial to ensuring equitable healthcare access for all residents, especially as demand for medical services grows with an aging population.

In addition to having low provider-to-patient ratios, the Combined Service Area also has unequal geographic distribution of providers. The set of maps below shows the number of different types of providers in the communities across the Combined Service Area. Communities with darker shading have more workers.


Total Healthcare Workers
Hollis
Northfield
Pepperell
Athol
Gardner
Fitchburg
Wendell
Phillipston
Leominster
Hubbardston
Lancaster
Pelham
Quabbin Reservoir Reservation
Rutland
Holden
Belchertown
Granby
Worcester
Spencer
© Mapbox © OpenStreetMap Improve this map
Combined Service Area
Total Health Care Workers
2 - <61
61 - <185
185 - <589
589 - <906
906 - 947
Sources: NPPES NPI 2023

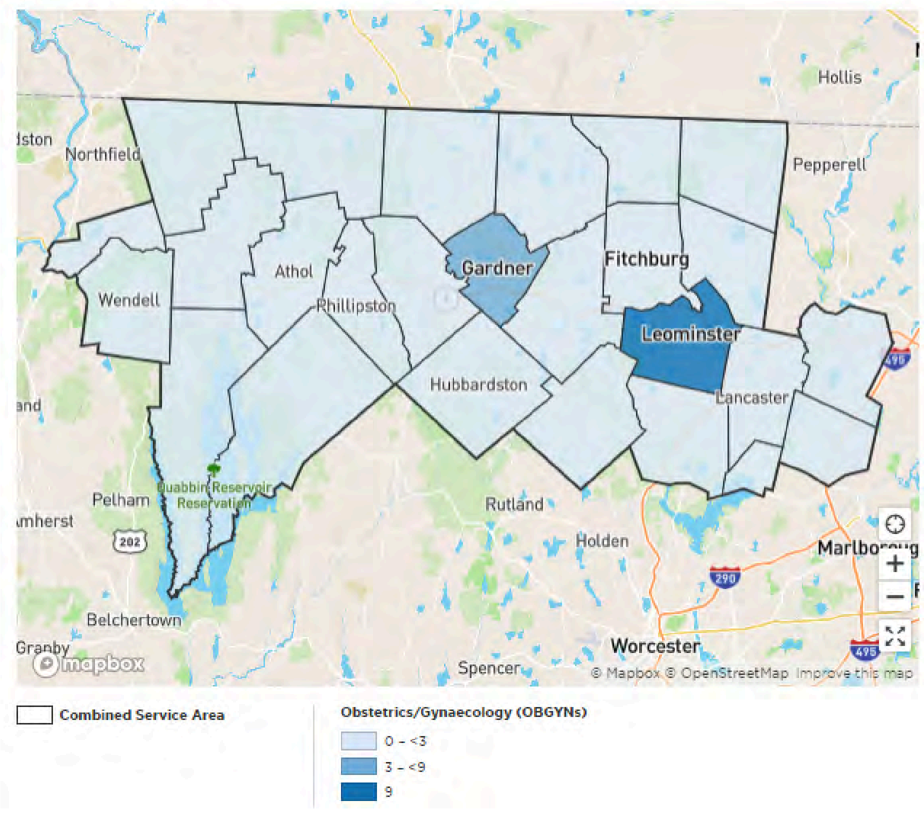

Primary Care Physicians
Hollis
Northfield
Pepperell
Athol
Gardner
Fitchburg
Wendell
Phillipston
Leominster
Hubbardston
Lancaster
Pelham
Quabbin Reservoir Reservation
Rutland
Holden
Belchertown
Granby
Worcester
Spencer
© Mapbox © OpenStreetMap Improve this map
Combined Service Area
Primary Care Physicians
0 - <7
7 - <32
32 - <49
49 - <77
77
Sources: NPPES NPI 2023

Mental Health Providers

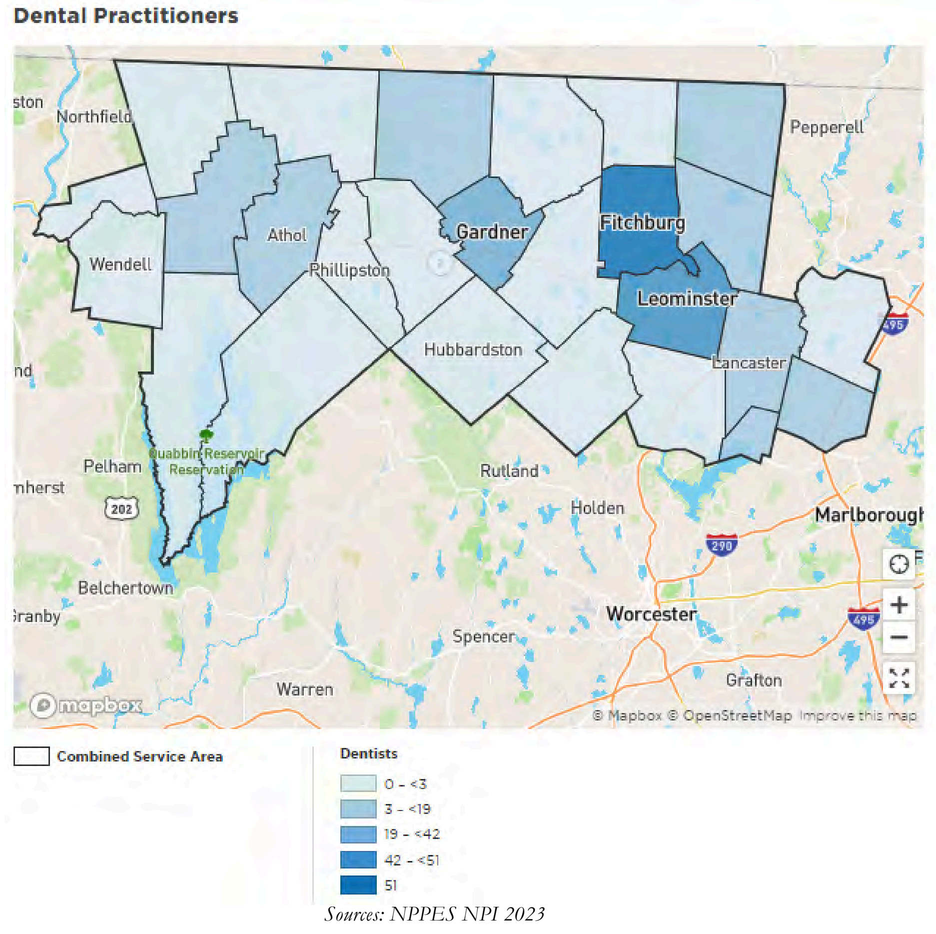


Sources: NPPES NPI 2023

OB-GYN Providers



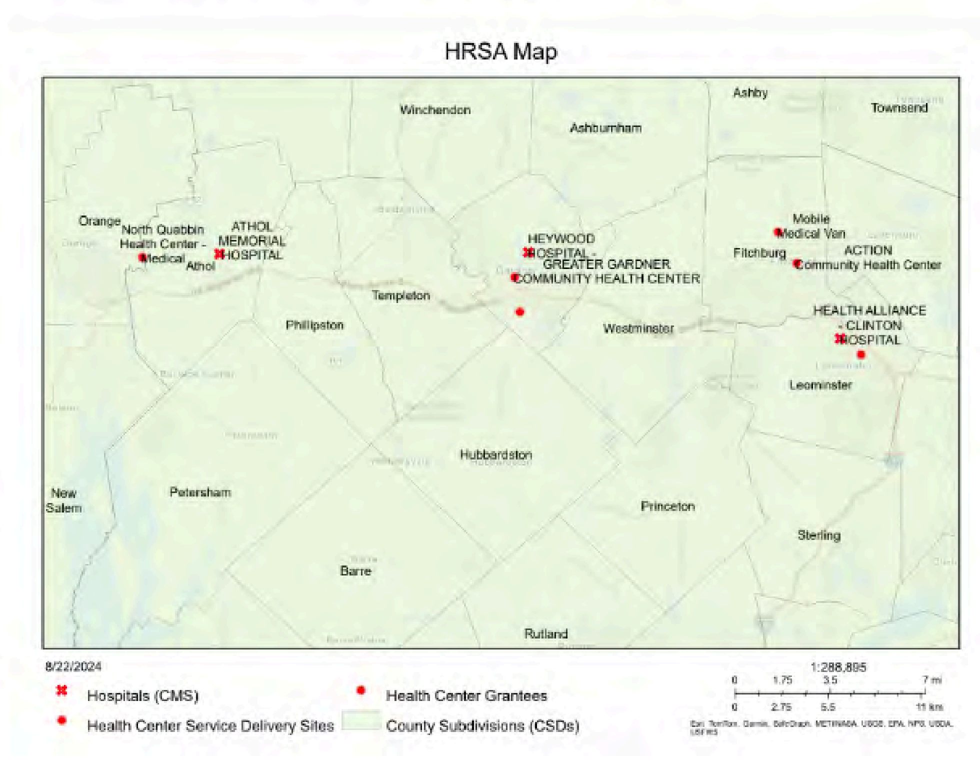
Sources: NPPES NPI 2023



Sources: NPPES NPI 2023

Generally, Fitchburg, Leominster, Gardner, and Athol have the most practitioners available. This finding aligns with the distribution of healthcare facilities in the region. Per the map below, the hospitals and health center sites, tend to be in those four communities.

Local Hospitals and Federally-Funded Health Centers



Source: US Health Resources & Services Administration. Map Tool. Accessed June 2025 at: data.HRSA.gov

Low provider-to-patient ratios and unequal distribution of healthcare resources across the region are frequently cited criticisms of the healthcare landscape in the Combined Service Area as is a lack of diversity and cultural competence among the providers who do work in the region.

According to the Massachusetts Executive Office of Health and Human Services (MA EOHHS) *Review of Maternal Health Services* conducted in 2023, North Worcester County, where much of the Combined Service Area lies, is facing a (pg. 30) "significant health care staffing shortage." Additionally, the report states that the region lacks:

- healthcare services, including Mental Health and Substance Abuse Services, pharmacy, and other specialty services like dialysis care, outside of the MA Route 2 corridor,
- transportation options resulting in reliance on 911 for non-emergent transport or deferment of care, and
- lack of ambulance services resulting in longer transportation times to care and a reliance on EMS for medical care during the transport.

Community members who participated in Focus Groups and healthcare providers from HealthAlliance-Clinton Hospital and Heywood Healthcare who were engaged as part of this Community Health Needs Assessment process echoed MA EOHHS's report findings. They expressed concerns about the decreasing availability of services locally leading to long wait times for patients as well as long distances to travel for services. Providers emphasized how difficult it is to recruit and retain primary care physicians and other specialty providers like behavioral health clinicians.

They also expressed concerns about a lack of diversity among local providers. They noted that there is a limited number of providers speaking languages other than English and a lack of translation and interpretation services locally.

Additionally, Focus Group participants expressed concern about differential treatment of patients of color in healthcare settings:

"No matter what your status is wealthy or poor – you can be wealthy and still not get the same treatment, or treatment you should receive, based on the color of your skin."

They also expressed concern that there is a lack of understanding or expertise in the local healthcare community about how to treat co-occurring medical, neurodevelopmental, and/or behavioral health disorders. And, they talked about the fragmented nature of the local healthcare delivery system.

"Everything is siloed."

Additionally, at the writing of this Community Health Needs Assessment, Nashoba Valley Medical Center, immediately to the east of the Combined Service Area in Ayer, announced its imminent closure. This community hospital has served 16 towns in North Central Massachusetts since 1964 with emergency medicine, diagnostic imaging, cardiology, gastroenterology, ophthalmology, oncology, orthopedics, physical therapy, and general surgery. Also, located on Nashoba's campus is a comprehensive Diabetes and Endocrine Center, the Garvin Center for Geriatric Psychiatry, a Travel Clinic and Occupational Health Services.

Closure of this neighboring institution will doubtless impact access to healthcare services in the region. HealthAlliance-Clinton Hospital and Heywood Healthcare are wholly committed to supporting all patients seeking care across the region and are working directly with the Massachusetts Department of Public Health and Nashoba Valley's leadership team to ensure their patients have access to high-quality, affordable healthcare services and that their employees and physicians have access to job opportunities within the Combined Service Area.

In spite of the challenges facing local healthcare landscape, the region does have assets on which to build. The Massachusetts Executive Office of Health and Human Services *Review of Maternal Health Services* notes that:

- Athol Hospital has a 5-star rating from the Centers for Medicare & Medicaid Services;
- Dialysis care in the Combined Service Area receives high quality ratings from the Centers for Medicare & Medicaid Services; and
- The Massachusetts Bureau of Substance Addiction Services has successfully integrated Substance Use Disorder treatment into all local houses of correction.

Additionally:

- HealthAlliance-Clinton Hospital's home health and hospice organization has a 5-star rating from the Centers for Medicare & Medicaid Services;
- UMass Memorial Medical Center's Neonatal Intensive Care Unit (NICU) is internationally recognized for quality care and is the region's only Level III NICU for high-risk obstetrical and neonatal care;
- HealthAlliance-Clinton Hospital's Leominster Campus recently opened a Diabetes Center of Excellence with providers in: cardiology, endocrinology, infectious disease, oncology, pain/anesthesia, rheumatology, thoracic surgery, and behavioral health; and
- HealthAlliance-Clinton Hospital's Cancer Center, which also uses a multidisciplinary approach to care, was accredited by the Commission on Cancer of the American College of Surgeons in March of 2024.

Furthermore, recognizing that "a person's zip code is more predictive of one's life expectancy than one's own genetic code", the Massachusetts Executive Office of Health and Human Services has designated six of the communities in the Combined Service Area (i.e., Athol, Ayer, Fitchburg, Gardner, Orange, and Winchendon) as Place-Based Investment Zones [28]. This designation means

that the MA EOHHS has committed to focusing, in a granular way, their improvement efforts on these communities which evidence the largest health disparities across a broad range of measures.

Such improvement efforts might center around upstream and midstream approaches like those called for in the Review of Maternal Health Services or ideas generated locally and shared by physicians and Focus Group participants engaged through this Community Health Needs Assessment process:

- healthcare workforce recruitment and retention, including of diverse providers, through financial incentives as well as initiatives around affordable housing and childcare for new providers;
- region-based approaches to delivering essential services; and
- inclusive home health, mobile health, and telehealth programs.

Ronald McDonald Care Mobile
The UMass Memorial Health Ronald McDonald Care Mobile delivers an innovative, community-based model of medical services and preventive dental care to the vulnerable, socioeconomically disadvantaged, uninsured and undocumented children and their families living in Worcester County.

Special Focus: Maternity Care

Barriers do exist for patients seeking maternity care services in the Combined Service Area. Focus Group participants expressed concerns about potential disparities in birth outcomes, particularly for people of color across the region. While local providers are prepared to meet the needs of birthing patients, the provider-to-patient ratio for OB-GYNs in the Combined Service Area is particularly concerning.

Hospitals across the state are evaluating their services and resources given unprecedented workforce shortages. Maternity care is especially challenging due to the highly specialized nature of these services. There is anticipated shortage of 22,000 OB-GYNs by 2050 per the American College of Obstetricians and Gynecologists' (ACOG) projections [29] and 1,119 counties across the US being deemed maternity care deserts per March of Dimes. Given the specialized nature of maternity, volume is necessary to maintain quality. Since 2014, 11 hospitals have closed or filed to close their maternity service according to a *Review of Maternal Health Services in Massachusetts*, including HealthAlliance-Clinton Hospital's inpatient maternity unit.

Maternity care requires continuous and consistent round the clock coverage, which exacerbates industry-wide staffing concerns. Community hospitals across the state are struggling to attract and retain staff in critical positions despite significant investments. Providers are increasingly seeking employment opportunities in larger centers with call groups with which to share 24/7 coverage, greater clinical resources to support care of higher acuity patients, and innovative research. Before the closure of HealthAlliance-Clinton Hospital's inpatient maternity unit, there was a documented decline of obstetricians, nurses, and other clinical professionals –which would have resulted in insufficient staffing of the maternity unit in the long term.

Specifically, the MA HHS *Review of Maternal Health Services* found that, in 2022, before the closure of the HealthAlliance-Clinton Hospital Maternity Unit, only three towns in the Leominster area had greater than 90% of births with adequate prenatal care. Two of those towns were adjacent to Heywood Hospital and Emerson Hospital (in Concord, MA), respectively, and therefore likely had better physical access to prenatal care. Additionally, the *Review of Maternal Health Services* highlighted that the North Quabbin region, which includes Athol Hospital's service area, is a US Health Resources & Services Administration designated Maternity Care and Health Professional Target Area [30].

HealthAlliance-Clinton Hospital's prenatal and postpartum community needs assessment further highlighted access concerns and extended them from prenatal period to after birth for birthing person and offspring. The report points to disparities in neonatal/infant outcomes, with disproportionately high infant mortality rates for Black/African Americans and high rates of neonatal abstinence syndrome for births in the region as well as a lack of support services for new parents. Focus Group participants spoke about disparities in birth outcomes, expressing concern for Black women and their infants. They also highlighted the differential treatment of Black and White women during the prenatal to postnatal period.

Despite these challenges, Massachusetts is cited as having full access to maternity care by the March of Dimes [31]. Several local facilities continue to serve birthing patients within 30 minutes of HealthAlliance-Clinton Hospital. This includes UMass Memorial Medical Center, Heywood Hospital, Saint Vincent Hospital's Center for Women and Infants, and Emerson Hospital's Clough Birthing Center. Even before plans to close HealthAlliance-Clinton's birthing center, roughly one-third of patients in the community chose to deliver at UMass Memorial Medical Center. With the closure, these adjacent hospitals have seen an increase number of births. While Heywood Healthcare welcomes additional births and patients, they are also experiencing workforce and financial challenges that result in a strain on the hospitals.

As the obstetric care clinicians who historically delivered their patients at HealthAlliance-Clinton Hospital predominantly moved their deliveries to UMass Memorial Medical Center in Worcester, the Medical Center expanded the number of labor and delivery staff, expanded their

OB-GYN resident coverage, added a dedicated Maternal Fetal Medicine subspecialist to the care team, and implemented a structured platform for communication and shared decision-making between birthing patients and providers. In addition, the Medical Center has made a commitment to further addressing experiences of obstetric racism and patient-focused maternal complications in Black patients through initiatives such as anti-racism workforce training and increased utilization of birth doulas. The Medical Center is also nearing the final stage of a policy revision that will sanction midwives supervising resident trainees delivering obstetric care and thus will enhance opportunities to develop a midwifery service.

UMass Memorial Health's (UMMH) commitment to pregnant and birthing people beyond the inpatient obstetric environment is evidenced by a PCORI grant. This grant, in its second year, is focused on improving postpartum outcomes for those marginalized by racism and socioeconomic disadvantage. For eligible and consented participants, the focus is on improving care related to hypertensive diseases, perinatal mental health, and social drivers of health through remote medical monitoring initially and in the final phase through the addition of community health workers or postpartum doulas. It is also important to note that the UMMH's Neonatal Intensive Care Unit (NICU) is the region's only Level III NICU for high-risk obstetrical and neonatal care and is internationally recognized for its quality care.

Local residents who participated in Focus Groups as part of this Community Health Needs Assessment process mentioned the closure of the Birthing Center at HealthAlliance-Clinton Hospital as problematic for the region, particularly around transportation to services during times of high stress:

"The closing of the maternity ward in Leominster is causing problems. People have to find transportation to get to the hospital, but then can be sent home due to false labor - this is expensive."

HealthAlliance-Clinton Hospital has committed approximately $600,000 in investments towards organizations and programs that support access to this care in the region. HealthAlliance-Clinton Hospital has also committed to address transportation barriers since the closing of their Maternity Center. Specifically, the hospital has a three-year plan to ensure access to hospital-supported, around the clock, non-emergency transportation through GoGo, a service that works with Uber, Lyft, and other taxi/livery companies to provide reliable transportation throughout the day and night.

In the future, partnerships between providers and local stakeholders can further address challenges faced by patients in the Combined Service Area. These community-based investments could include upstream and midstream approaches like:

- Mental health, substance abuse, and social supports, particularly for new parents,
- Expanded childcare resources,
- Programs to support basic needs for new parents, such as food and diapers
- Expanded doula and midwifery services, and Innovation through telehealth and remote monitoring.

Additionally, Heywood Hospital was recently notified of a funding award through the MA Department of Public Health's "Grants to Increase Maternal Care Access and Expand Delivery Models." This grant will allow Heywood Hospital to invest in strategies that improve maternal health outcomes and reduce racial disparities in North Central MA. While Heywood Healthcare has welcomed additional births and patients since the closing of HealthAlliance-Clinton Hospital's maternity center, the hospital is experiencing related workforce and financial challenges. Heywood Hospital has seen a 30% increase in births (i.e., from 309 births in 2022 to 400 births in 2024), involving an increasingly diverse group of birthing patients. These changing demographics are reflective of the migrant families living in local shelters and the increase in birthing patients coming from the more eastern communities in the Combined Service Area, including Fitchburg and Leominster.

Funding through Heywood Hospital's new DPH grant will enable the hospital and community partners to increase access, improve infrastructure, and build workforce capacity to provide prenatal and perinatal services, especially for parenting people of color and individuals impacted by mental health or substance use disorder. Strategies to increase access include expanding culturally competent doula services and integrating culturally relevant education to improve health literacy and family well-being. The infrastructure strategies include updating equipment and space to support the increased number of births and preferences of the growing diversity of birthing persons and investing in technology and processes to undertake maternal health equity outcome quality improvement work. The workforce development strategies include employing robust recruitment efforts to grow and diversify staff and training hospital care teams (e.g., explicit and implicit bias impacting clinical decisions and neonatal resuscitation) and training hospital/community partners on trauma-informed practices and recovery-oriented systems of care.

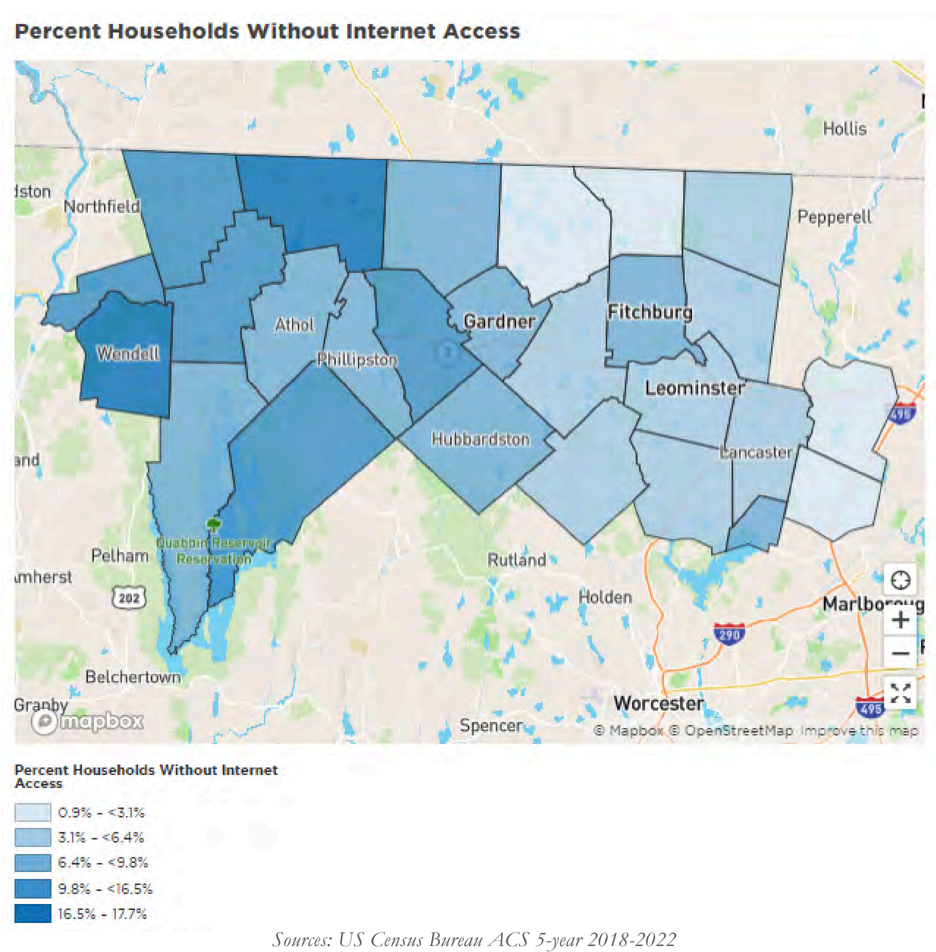
Synergistically, HealthAlliance-Clinton Hospital has recently announced their own grant funding opportunity through which they will invest in maternal health strategies across the area.

Heywood Healthcare's Doulas
Heywood Healthcare is a Doula-friendly organization and welcomes the services of Doulas. Currently, there are approximately 10 Doulas in Labor & Delivery who may be available to help birthing patients.

Special Focus: Telehealth

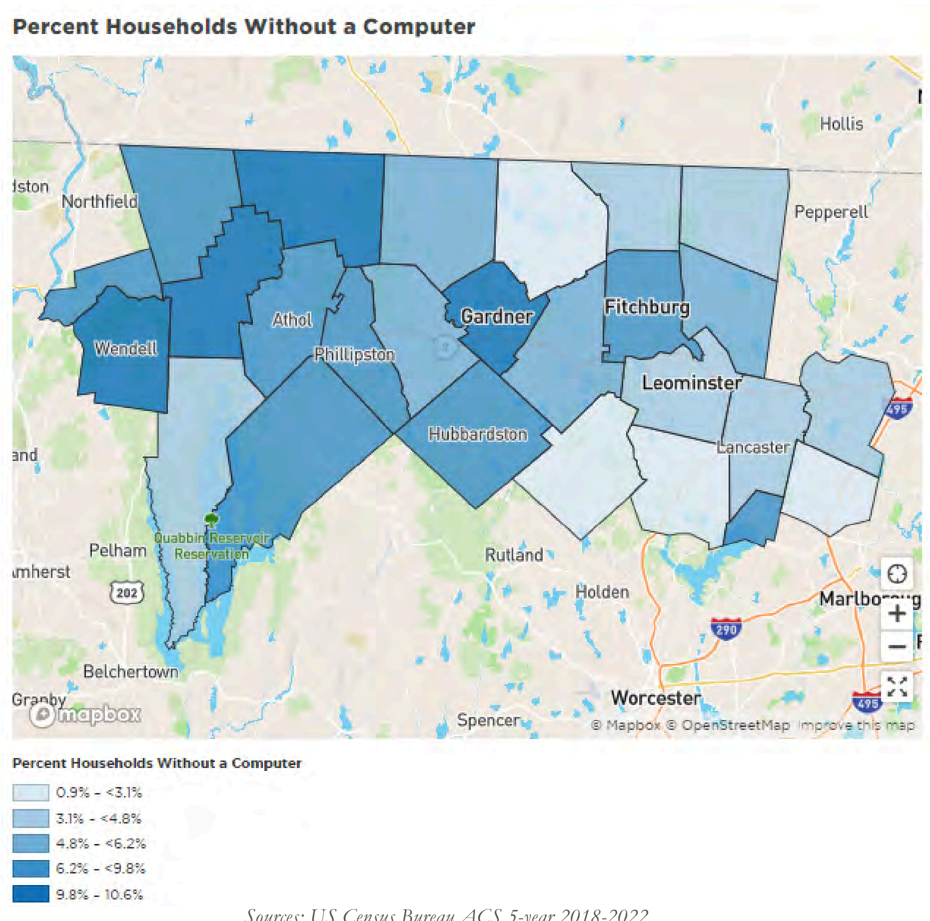
Addressing healthcare workforce challenges requires innovative solutions to ensure that all residents receive the care they need. One effective approach is the use of telehealth, which can extend healthcare services across the Combined Service Area's broad geographic expanse. Telehealth leverages technology to connect patients with providers, reducing barriers such as distance and travel time. However, the success of telehealth initiatives is heavily dependent on reliable access to broadband, cellular networks, digital devices, and digital literacy. The next section explores the current state of broadband and cellular infrastructure in the Combined Service Area, as well as the availability of devices, to better understand how these factors influence the feasibility and effectiveness of telehealth solutions locally.

Residents of the communities across the Combined Service Area have their choice of five to eight internet providers. And, per the maps below, most Combined Service Area residents have both internet access and at least one computer to access the internet. However, more than one in ten households in most of the Athol Hospital service area communities do not have internet access: Wendell (17.7%), Royalston (16.5%), Petersham (12.6%), Orange (12.2%), Erving (10.9%), and Warwick (10.6%).



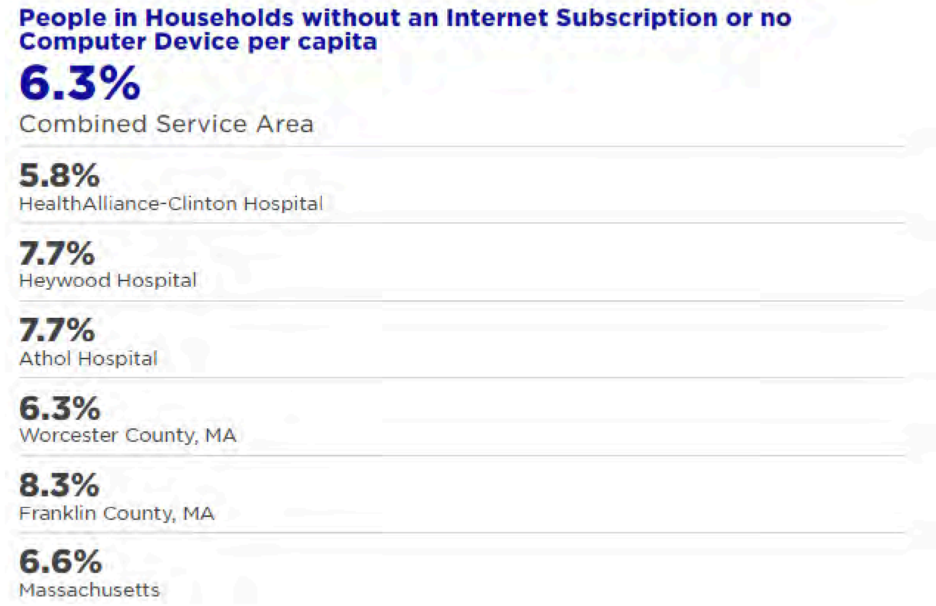
Sources: US Census Bureau ACS 5-year 2018-2022

Additionally, one in ten households in Royalston (10.6%), Orange (10.2%), and Wendell (10.0%) does not have a computer.



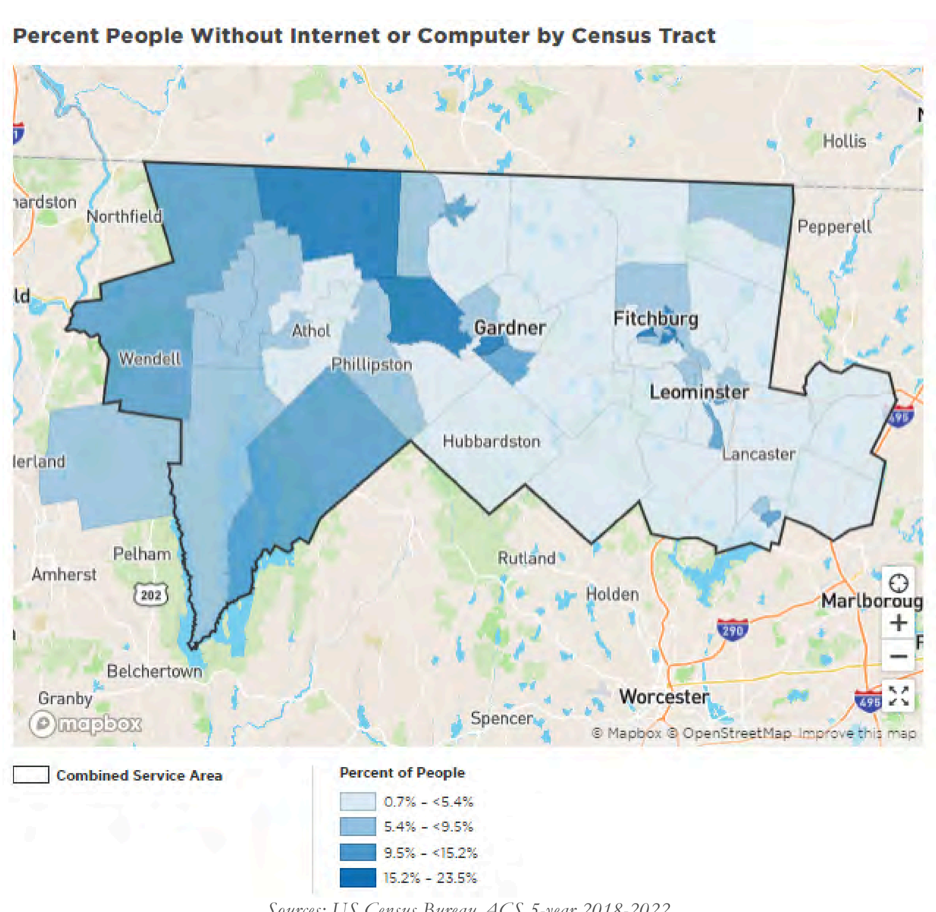
Sources: US Census Bureau ACS 5-year 2018-2022

Together, 6.3% of people in households across the Combined Service Area have neither internet access nor a computer.



Sources: US Census Bureau ACS 5-year 2018-2022

The map below shows the geographic distribution of people without internet and computer access. Concentrations of people with limited connectivity are highest in the western portion of the Combined Service area as well as the downtown areas of Fitchburg, Gardner, and Leominster where poverty rates tend to be higher (see Poverty section).



Sources: US Census Bureau ACS 5-year 2018-2022

The digital divide evidenced in the map above poses a substantial barrier to implementing telehealth as a comprehensive solution for healthcare access issues. Limited connectivity restricts residents' ability to participate in virtual medical appointments, access online health resources, and engage with digital health management tools. As a result, it is essential to consider alternative strategies alongside telehealth to ensure equitable healthcare access for all residents. This may include upstream and midstream approaches like expanding mobile health clinics, increasing in-person healthcare services in underserved areas, and enhancing community-based health programs. Addressing these connectivity gaps is crucial for creating a more inclusive healthcare system that meets the needs of every community member.

Heywood Healthcare's TeleMed Service
Heywood's School-Based Services TeleMed program offers telemedicine appointments to students by connecting them with a Nurse Practitioner through a telehealth cart located in their school.

Health Insurance Coverage

In addition to access to providers, residents need health insurance in order to secure the healthcare services they need. Across the Combined Service Area 97.9% of people have health insurance. This percentage is consistent with the comparison areas of Worcester County, Franklin County, and Massachusetts.

People with Health Insurance

97.9%
Combined Service Area

98%
HealthAlliance-Clinton Hospital

97.9%
Heywood Hospital

97.4%
Athol Hospital

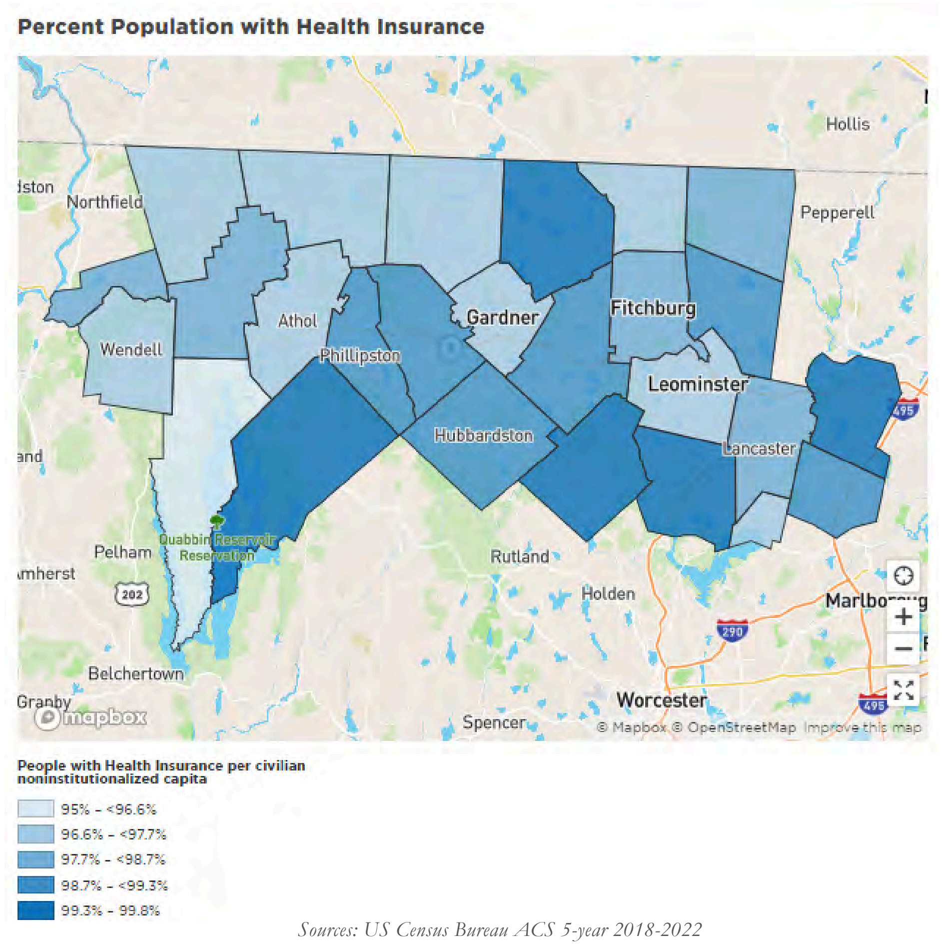
97.5%
Worcester County, MA

97.8%
Franklin County, MA

97.3%
Massachusetts

Sources: US Census Bureau ACS 5-year 2018-2022

The map below shows some disparities in health insurance coverage between Combined Service Area towns with New Salem (95%), Royalston (96.6%), Gardner (96.7%), and Athol, (96.9%) having the lowest rates, all below 97%.



Sources: US Census Bureau ACS 5-year 2018-2022

While health insurance coverage tends to be robust across the Combined Service Area, Focus Group participants did talk about the high cost of insurance and the fact that not all insurances are equal or accepted universally.

"Discrimination is not only race. In healthcare [discrimination happens] with insurances. If a patient has a lower insurance, they are being given less care based on what they can afford."

Although health insurance coverage is generally strong across the Combined Service Area the region faces significant challenges in healthcare access due to low provider-to-patient ratios, the concentration of healthcare facilities in just a few communities, and a lack of culturally responsive care. These limitations can result in residents experiencing long waits for services, deferring needed medical care, or traveling considerable distances to receive care.

Health Behaviors

While personal health behaviors such as diet, physical activity, smoking, alcohol consumption, and adherence to medical advice are crucial determinants of health, these behaviors are significantly influenced by external factors such as community resources, social environment, and the built environment. Access to healthcare resources is just one example of how external factors shape health behaviors. For instance, individuals in areas with limited access to healthcare providers may face obstacles in receiving preventive care, health education, and necessary medical interventions. Similarly, socioeconomic status and educational opportunities impact the ability to engage in healthy behaviors, as these factors often determine the availability of resources and knowledge needed to maintain a healthy lifestyle.

Environmental factors also play a critical role in shaping health behaviors. The built environment, including the availability of parks, safe walking areas, and access to affordable, nutritious food, can either facilitate or hinder physical activity and healthy eating. In regions where these resources are scarce or unevenly distributed, residents may struggle to adopt and maintain positive health behaviors. Consequently, addressing these external factors through community health initiatives is essential for promoting healthier lifestyles and improving overall health outcomes, as they create the necessary conditions for individuals to make informed and health-supportive choices.

The data below from the US Center for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS) estimate the annual prevalence rate of adults who report specific health-related behaviors.

Three-quarters of adults in the Combined Service Area reported having received a doctor checkup in the past year. This percentage is similar to the comparison areas of Worcester County, Franklin County, and Massachusetts.

Doctor Checkup in Past Year Among Adults

75%
Combined Service Area

75.1%
HealthAlliance-Clinton Hospital

75.3%
Heywood Hospital

74.6%
Athol Hospital

76.2%
Worcester County, MA

75.6%
Franklin County, MA

73.5%
Massachusetts

Sources: CDC BRFSS PLACES 2021

Regular checkups are a foundational component of preventative medicine, serving as the gateway to a broader array of recommended screenings and assessments. These screenings are crucial for the early detection of various conditions, such as cancer, cardiovascular diseases, and diabetes, and can significantly impact long-term health outcomes. Analyzing both the overall rates of checkups and the percentages of adults receiving specific screenings provides a more comprehensive understanding of how well preventative measures are being implemented and their effectiveness in contributing to the overall health of the community. This dual perspective helps identify gaps in preventative care and highlights opportunities for improving health interventions and education.

Data from UMass Memorial Health for primary care patients living in the Combined Service Area service area show a wide variation between adherence to recommended screenings.

Measure Name	White	Asian	Black or African American	Hispanic (All races)	Other Race or Multi-racial	Unknown or Declined to Answer	Total
Breast Cancer Screening	78%	72%	68%	77%	72%	66%	78%
Colorectal Cancer Screening (45 to 75)	69%	65%	57%	63%	57%	60%	68%
Cervical Cancer Screening	69%	68%	67%	71%	66%	48%	69%
Diabetes A1c Screening	85%	87%	84%	81%	86%	74%	84%
Hypertension Blood Pressure Control	66%	65%	52%	65%	65%	56%	65%
Well Child Visit (All Ages)	77%	71%	66%	67%	62%	61%	73%
Childhood Immunization Status	70%	100%	50%	64%	83%	67%	68%
Adolescent Immunization Status	48%	63%	22%	41%	33%	0%	45%
Depression Screening and Follow Up	36%	32%	29%	29%	30%	24%	34%

Source: Epic EMR data updated for UMMH Primary Care Patients that reside in the Combined Service Area (as of 5/31/2024).

Per the table above, rates of adherence to recommended health screenings are notably lower among some racial and ethnic groups, reflecting disparities in access to and utilization of healthcare services. Research indicates that minority groups, including Black and Hispanic populations, often experience lower rates of screening for conditions such as breast cancer, colorectal cancer, and diabetes compared to their White counterparts. The data above echoes these findings.

Several factors contribute to these disparities. Socioeconomic barriers, such as lack of health insurance and limited access to healthcare facilities, can impede timely screening. Cultural factors and mistrust of the medical system also play a role, as does the absence of culturally tailored health education and outreach programs. Additionally, systemic issues such as provider biases and inadequate translation services can further limit access and adherence to screening recommendations. Addressing these barriers is essential for reducing health disparities and improving outcomes for all racial and ethnic groups.

Skin Cancer Awareness Month
HealthAlliance-Clinton Hospital partnered with the Fitchburg Department of Health for a Free Skin Cancer Screening Clinic at Simonds-Sinon Regional Cancer Center. Individuals received screenings and education about the importance of skin care and screening.

While preventive health screenings are crucial for early detection and long-term health management, it is also important to consider other health behaviors that significantly impact overall wellness. These behaviors, including tobacco use, alcohol consumption, sleep patterns, and physical activity, play a vital role in shaping health outcomes. The next section will delve into these health behaviors, examining their prevalence and implications for public health, and identifying areas for potential intervention and support.

In the Combined Service Area, per the tables below, slightly higher percentages of adults smoke tobacco, binge drink, and report no leisure time activity as compared to their peers across Massachusetts. Social and environmental factors may significantly influence these behaviors. For example, local norms may contribute to higher binge drinking and smoking rates in the Combined Service Area. Similarly, socioeconomic conditions, low walkability, and availability of green space for recreational opportunities may contribute to less than optimal engagement in physical activity.

	Community	Percentage of Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Percentage of Adults that are Current Smokers	% of Adults 20+ Years Reporting Lack of Leisure Time Physical Activity
Health Alliance-Clinton Hospital	Ashburnham	18.7%	12.2%	18.5%
	Ashby	19.6%	12.9%	15.5%
	Bolton	17.8%	9.1%	17.6%
	Clinton	16.9%	15.3%	19.1%
	Fitchburg	16.5%	16.5%	18.4%
	Gardner	16.7%	17.1%	19.3%
	Harvard	19.0%	9.5%	19.4%
	Lancaster	19.0%	13.0%	19.4%
	Leominster	16.1%	15.4%	19.0%
	Lunenburg	17.0%	13.2%	18.6%
	Princeton	16.8%	10.2%	19.3%
	Sterling	17.2%	10.7%	19.2%
	Townsend	19.9%	12.1%	15.4%
	Westminster	17.7%	12.8%	18.7%
	Area Total	**17.1%**	**14.6%**	**19.4%**
Heywood Hospital	Ashburnham	18.7%	12.2%	18.5%
	Gardner	16.7%	17.1%	19.3%
	Hubbardston	18.3%	13.6%	19.5%
	Templeton	17.5%	15.5%	18.8%
	Westminster	17.7%	12.8%	18.7%
	Winchendon	17.5%	15.9%	18.8%
	Area Total	**17.4%**	**15.3%**	**19.8%**
Athol Hospital	Athol	16.4%	17.1%	18.8%
	Erving	17.5%	16.8%	15.8%
	New Salem	17.5%	11.4%	16.4%
	Orange	17.5%	18.1%	15.6%
	Petersham	17.0%	15.4%	19.6%
	Phillipston	17.0%	15.4%	19.2%
	Royalston	17.8%	16.8%	19.6%
	Warwick	17.5%	16.8%	16.7%
	Wendell	17.5%	16.8%	16.2%
	Area Total	**17.0%**	**17.0%**	**18.7%**
	Combined Service Area	**17.1%**	**14.9%**	**19.4%**
	Worcester County	16.0%	13.2%	18.8%
	Franklin County	16.1%	13.8%	16.1%
	Massachusetts	16.8%	12.1%	18.2%

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2021. As Cited by MA PHIT

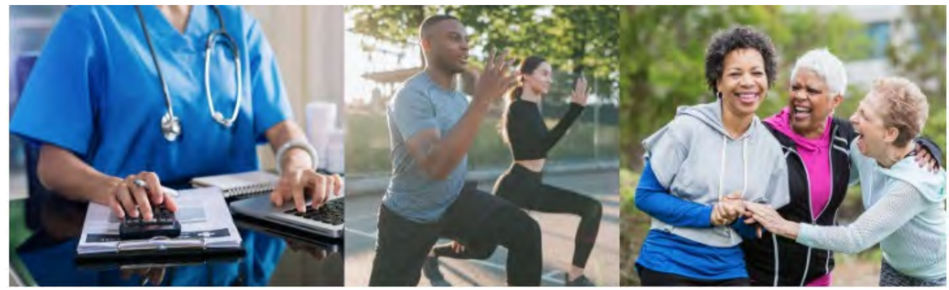
The elevated prevalence of certain unhealthy behaviors in the Combined Service Area underscores the need for targeted public health interventions and community programs aimed at promoting healthier lifestyles. Addressing these issues is critical for improving the overall health and well-being of residents in the Combined Service Area. However, these interventions and community programs should not only focus on individual-level changes but also address the broader social and environmental factors that contribute to these unhealthy behaviors. By tackling issues such as socioeconomic disparities, environmental stressors, and limited access to resources, public health strategies can more effectively foster healthier communities and create sustainable improvements in health outcomes.

Conclusion

The Combined Service Area faces significant challenges with a low provider-to-patient ratio, healthcare facilities concentrated in a few communities within a broad geographic area, a lacking transportation system, and a shortage of culturally diverse providers. These issues are compounded by environmental factors that do not promote healthy lifestyles.

The region also has notable strengths on which to build. The designation as a Place-Based Investment Zone by the Massachusetts Executive Office of Health and Human Services brings opportunities for targeted funding and development. Additionally, certain healthcare facilities and services in the area have received high quality ratings from the Centers for Medicare and Medicaid Services, demonstrating excellence in care provision. The strong collaborative spirit among community stakeholders further enhances the region's capacity to address these healthcare challenges. By leveraging these strengths, the Combined Service Area can develop comprehensive strategies to improve healthcare access and outcomes for all its residents.

HEALTH OUTCOMES



This section on Health Outcomes follows a comprehensive report on Social Determinants of Health, including the socioeconomics of the region as well as the status of housing, the food landscape, the transportation system, and available health services across the Combined Service Area. These factors are inextricably tied to the health outcomes presented below. By examining metrics such as disease prevalence and mortality rates, a comprehensive understanding of the health status of residents can be gained. Through this examination, key health priorities can be identified, and strategies can be developed to enhance the health and well-being of all individuals in the Combined Service Area.

General Health

The data provided below are collected by the US Center for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS) and published in the 500 Cities: Local Data for Better Health Project. Poor Health Indicators show the estimated annual prevalence rate of adults who report 14 or more days during the past 30 days during which their physical health was not good.

In the Combined Service Area, roughly one in ten adults reported poor physical health in the last 30 days.

Poor Physical Health Among Adults

10.6%
Combined Service Area

10.5%
HealthAlliance-Clinton Hospital

10.6%
Heywood Hospital

11.8%
Athol Hospital

10.1%
Worcester County, MA

11.2%
Franklin County, MA

9.8%
Massachusetts

Sources: CDC BRFSS PLACES 2021

As reported elsewhere in this Community Health Needs Assessment, this indicator worsens from east to west across the Combined Service Area, with Athol Hospital having the highest percentage of adults reporting poor physical health (11.8%). This pattern suggests that the worse social determinants of health in the western portion of the Combined Service Area are contributing to the poorer general health reported by residents in that region.

This overarching look at poor physical health sets the stage for a deeper examination of specific chronic conditions affecting residents of the Combined Service Area.

Chronic Conditions

The tables below show the percentage of adults who have a history of being told by a healthcare professional that they have a specific chronic condition.

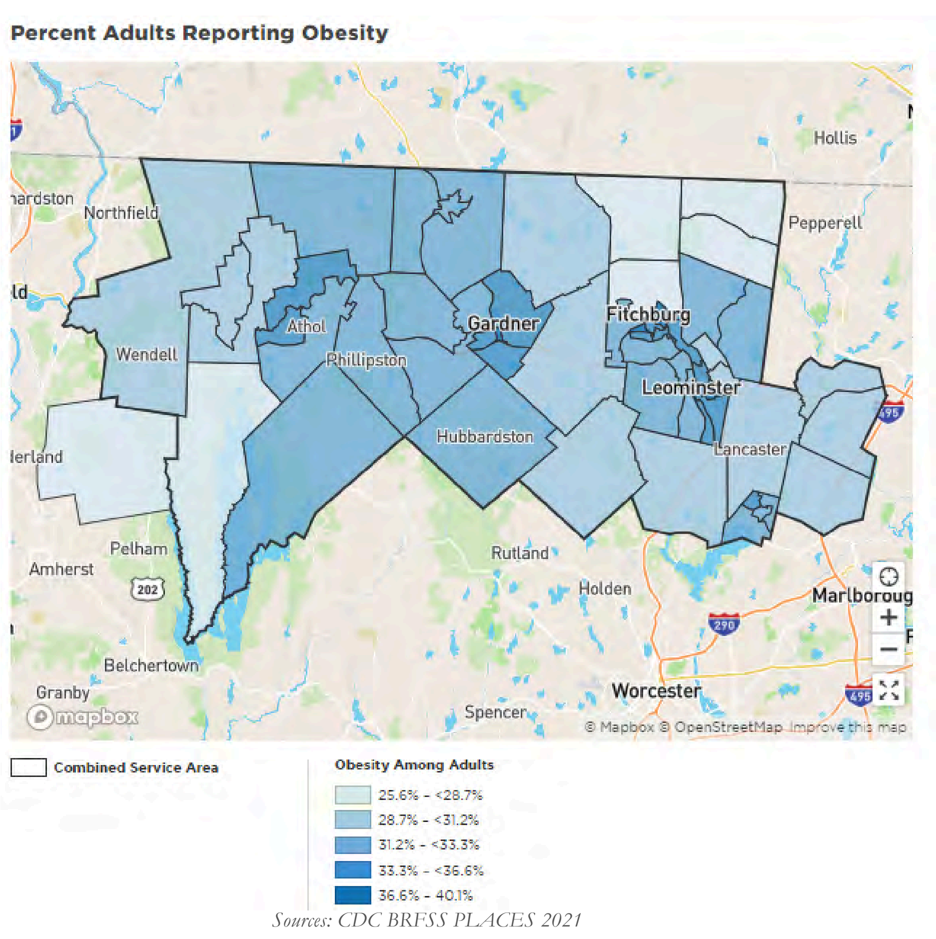
	Community	% Adults with Asthma	% Adults Self Reported Obese (Crude)	% Adults Age 18+ Ever Diagnosed with Diabetes (Crude)	% Adults Ever Eiagnosed with Coronary Heart Disease	Cancer Incidence Rate (Per 100,000 Population)
Health Alliance-Clinton Hospital	Ashburnham	11.4%	30.2%	7.2%	4.4%	467.5
	Ashby	10.7%	26.8%	7.5%	4.9%	428.7
	Bolton	10.8%	28.7%	6.9%	4.0%	476.2
	Clinton	12.2%	32.9%	9.1%	5.4%	470.3
	Fitchburg	12.6%	33.3%	9.7%	5.6%	470.5
	Gardner	12.3%	33.6%	9.9%	6.3%	471.5
	Harvard	10.3%	28.9%	7.0%	4.1%	467.9
	Lancaster	11.3%	30.2%	7.3%	4.5%	470.1
	Leominster	12.3%	33.0%	9.8%	5.8%	470.0
	Lunenburg	11.6%	31.2%	8.6%	5.4%	472.4
	Princeton	11.2%	29.9%	8.1%	4.9%	458.9
	Sterling	11.1%	29.5%	7.6%	4.8%	475.2
	Townsend	10.8%	26.5%	7.1%	4.5%	431.2
	Westminster	11.5%	30.9%	8.0%	4.9%	472.2
	Area Total Average	**11.9%**	**31.8%**	**8.9%**	**5.4%**	**464.5**
Heywood Hospital	Ashburnham	11.4%	30.2%	7.2%	4.4%	467.5
	Gardner	12.3%	33.6%	9.9%	6.3%	471.5
	Hubbardston	11.8%	31.7%	7.8%	4.7%	467.6
	Templeton	12.0%	32.2%	8.8%	5.7%	465.7
	Westminster	11.5%	30.9%	8.0%	4.9%	472.2
	Winchendon	12.1%	32.5%	8.7%	5.4%	471.8
	Area Total Average	**12.0%**	**32.3%**	**8.8%**	**5.5%**	**469.4**
Athol Hospital	Athol	12.4%	33.4%	9.9%	6.4%	473.0
	Erving	11.7%	29.8%	9.6%	6.2%	429.6
	New Salem	10.9%	27.0%	8.3%	5.2%	396.9
	Orange	12.0%	30.0%	9.7%	6.4%	412.4
	Petersham	11.9%	32.9%	9.2%	5.7%	494.5
	Phillipston	11.9%	32.9%	9.2%	5.7%	488.9
	Royalston	12.3%	33.1%	8.5%	5.2%	473.3
	Warwick	11.7%	29.8%	9.6%	6.2%	417.0
	Wendell	11.7%	29.8%	9.6%	6.2%	422.3
	Area Total Average	**12.1%**	**31.7%**	**9.3%**	**6.2%**	**445.3**
	Combined Service Area	12.0%	31.9%	9.0%	5.5%	464.4
	Worcester County	11.6%	31.3%	9.6%	5.7%	470.1
	Franklin County	11.2%	28.1%	10.2%	6.9%	413.8
	Massachusetts	10.9%	27.6%	9.2%	5.5%	449.4

Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via MA PHIT 2021; Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2021. As cited by MA PHIT; and State Cancer Profiles. 2016-20 via MA PHIT.

The data above generally follows the same pattern as the poor health data at the top of this section: the Athol Hospital service area tends to have the highest rates in the region, with the exception of Cancer.

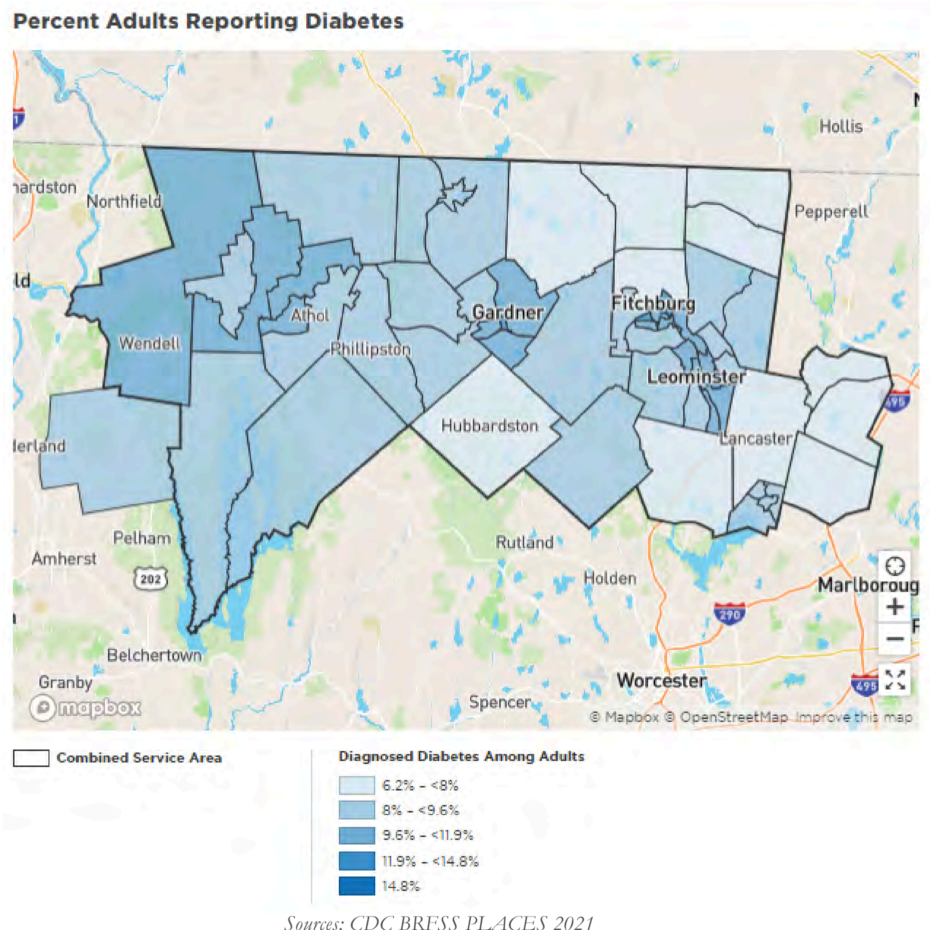
The series of maps below presents Census Tract level details of the prevalence data discussed above. This granular depiction of the geographic distribution of chronic illnesses can help healthcare providers, community leaders, and other stakeholders pinpoint locations with the highest need for targeted interventions.

Note that the communities in the western portion of the Combined Service Area tend to have darker shading, indicating more illness, as do the more urban neighborhoods of Fitchburg, Leominster, Gardner, Clinton, Athol, and Orange (with the last two communities falling in the western portion of the Combined Service Area).



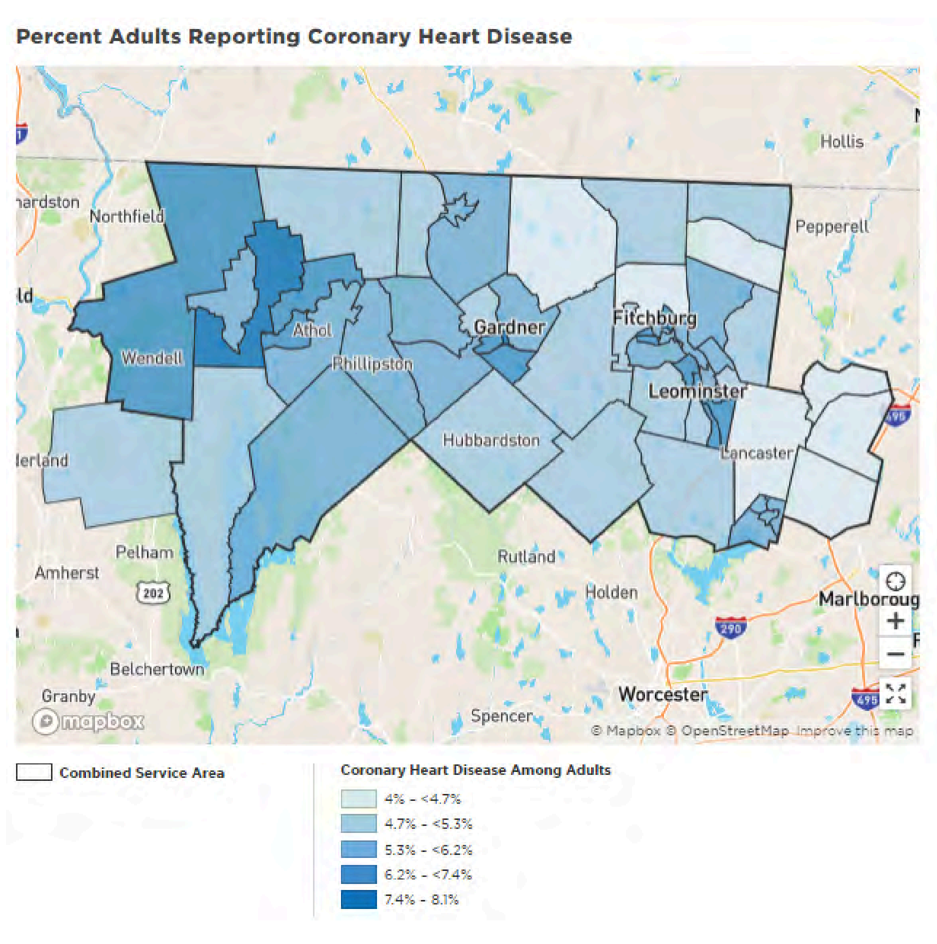
Sources: CDC BRFSS PLACES 2021

Percent Adults Reporting Diabetes



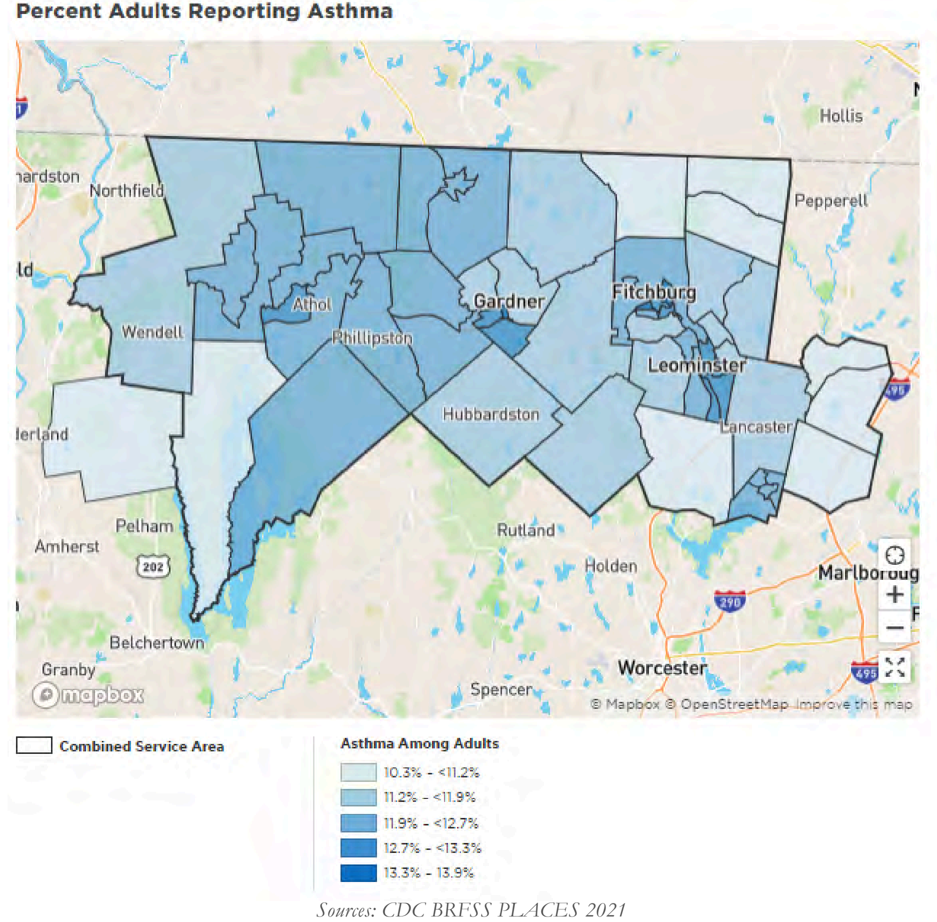
Sources: CDC BRFSS PLACES 2021

Percent Adults Reporting Coronary Heart Disease



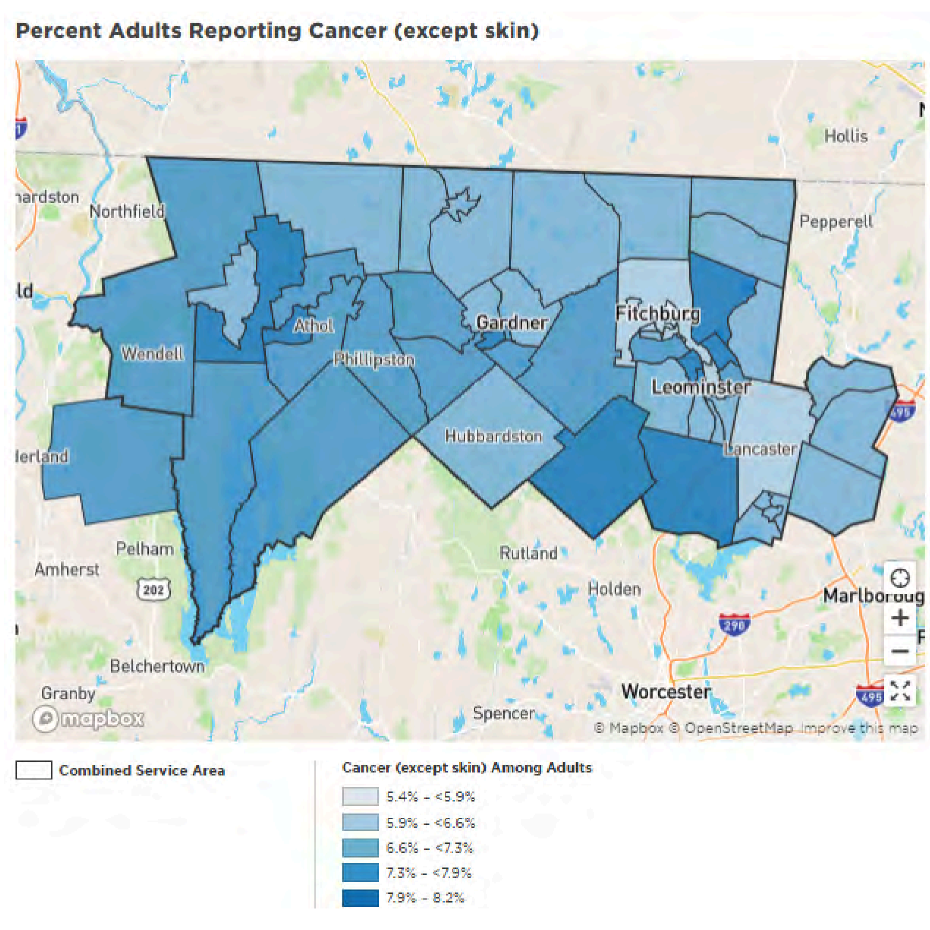
Sources: CDC BRFSS PLACES 2021

Percent Adults Reporting Asthma



Sources: CDC BRFSS PLACES 2021

Percent Adults Reporting Cancer (except skin)



Sources: CDC BRFSS PLACES 2021

The maps reveal that higher percentages of people reporting specific chronic conditions are concentrated toward the west and in similar neighborhoods of Fitchburg, Leominster, Gardner, Clinton, Athol, and Orange. These areas exhibit a greater burden of chronic illness, indicating a critical need for targeted healthcare services. Establishing specialized healthcare services in these neighborhoods could significantly improve management and outcomes for residents with chronic conditions.

An example of such a specialized healthcare service located in the Combined Service Area is the Diabetes and Nutrition Clinic. A satellite of the Diabetes Center of Excellence at UMass Memorial Health in Worcester, the clinic is located at HealthAlliance-Clinton Leominster's Campus. The staff of the diabetes center work closely with the endocrinologists at the hospital to provide coordinated diabetes care. Dietitians and diabetes educators provide information on practical lifestyle modifications including diet and exercise recommendations. Additionally, they utilize the (Conversation Maps) Diabetes Care Coach program to provide comprehensive education for those newly diagnosed with diabetes.

To best serve the local community, clinic educators remain up to date on the latest technologies including continuous glucose monitoring and insulin pump therapies. They also engage and refer to many community resources when clients have need that extend beyond clinic services. Most notably, the clinic assists patients with applications for Growing Places CSA program, a non-profit that provides fresh, local produce utilizing the Supplemental Nutrition Assistant Program (SNAP) and Healthy Incentives Program (HIP) benefits for those with food insecurity. In the near future, the clinic plans to restart group education classes to further help the community build a network of resources for ongoing diabetes management.

In addition to providing specialized healthcare services like the Diabetes and Nutrition Clinic, implementing groundwater and upstream policy, systems, and environmental changes that address the root causes of diabetes and other chronic conditions is essential in reducing their prevalence. These strategies could include increasing access to nutritious food (see Food Security section), promoting physical activity, enhancing healthcare accessibility and affordability, and increasing affordable housing (see Housing sections). Examples of community initiatives to improve social determinants of health have already been made in other sections of this Community Health Needs Assessment report.

Communicable Disease

Understanding the prevalence and distribution of chronic health conditions in the Combined Service Area provides critical insights into the long-term health challenges faced by the

community. Chronic illnesses, such as diabetes, heart disease, and respiratory conditions, require ongoing management and contribute significantly to the overall health burden. However, addressing the community's health needs also necessitates a focus on communicable illnesses, which can arise suddenly and have immediate, severe impacts. The next section will examine the prevalence and impact of communicable illnesses in the region, highlighting how these conditions further strain healthcare resources and affect the well-being of residents. Considering both chronic and communicable disease burden ensures a holistic understanding of the community's health landscape and enabling more effective interventions and support systems.

Per the table below, rates of COVID-19, Chlamydia, Gonorrhea, Syphilis, and HIV/AIDS tend to be lower in the Combined Service Area than across the state. Additionally, and *unlike* most other indicators presented here, rates of Chlamydia, Gonorrhea, Syphilis, and HIV/AIDS are lower in the communities that make up the western portion of the Combined Service area (i.e., Athol Hospital's service area and the most rural area of the region).

	Community	Covid-19 Rate Per 100,000	Chlamydia Infections, Rate per 100,000 Pop.	Primary and Secondary Syphilis Infections, Rate per 100,000 Pop.	Gonorrhea Infections, Rate per 100,000 Pop.	Population with HIV / AIDS, Rate per 100,000 Pop.
Health Alliance-Clinton Hospital	Ashburnham	744.3	307.8	7.5	79.5	280.7
	Ashby	720.3	307.5	10.4	99.4	291.7
	Bolton	1,041.5	307.8	7.5	79.5	280.7
	Clinton	1,231.5	307.8	7.5	79.5	280.7
	Fitchburg	1,316.0	307.8	7.5	79.5	280.7
	Gardner	1,136.8	307.8	7.5	79.5	280.7
	Harvard	1,065.5	307.8	7.5	79.5	280.7
	Lancaster	710.8	307.8	7.5	79.5	280.7
	Leominster	1,327.0	307.8	7.5	79.5	280.7
	Lunenburg	687.5	307.8	7.5	79.5	280.7
	Princeton	1,373.4	307.8	7.5	79.5	280.7
	Sterling	989.4	307.8	7.5	79.5	280.7
	Townsend	887.5	307.5	10.4	99.4	291.7
	Westminster	901.0	307.8	7.5	79.5	280.7
	Area Estimate	--	**307.8**	**7.71**	**80.8**	**281.4**
Heywood Hospital	Ashburnham	744.3	307.8	7.5	79.5	280.7
	Gardner	1,136.8	307.8	7.5	79.5	280.7
	Hubbardston	854.9	307.8	7.5	79.5	280.7
	Templeton	1,325.3	307.8	7.5	79.5	280.7
	Westminster	901.0	307.8	7.5	79.5	280.7
	Winchendon	1,032.4	307.8	7.5	79.5	280.7
	Area Estimate	--	**307.8**	**7.53**	**79.5**	**280.7**
Athol Hospital	Athol	1,582.3	307.8	7.5	79.5	280.7
	Erving	1,982.0	156.6	9.9	33.9	155.5
	New Salem	610.4	156.6	9.9	33.9	155.5
	Orange	1,744.0	156.6	9.9	33.9	155.5
	Petersham	1,842.5	307.8	7.5	79.5	280.7
	Phillipston	1,100.8	307.8	7.5	79.5	280.7
	Royalston	880.0	307.8	7.5	79.5	280.7
	Warwick	0.0	156.6	9.9	33.9	155.5
	Wendell	865.8	156.6	9.9	33.9	155.5
	Area Estimate	--	**243.6**	**8.53**	**60.12**	**226.5**
	Combined Service Area	--	300.4	7.8	78.3	247.9
	Worcester County	1,238.8	307.8	7.5	82.6	280.7
	Franklin County	1,255.8	156.6	9.9	47.9	155.5
	Massachusetts	1,320.0	406.4	11.8	131.9	352.7

Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022 via Massachusetts PHIT

NOTE: The HIV/AIDS indicator reports the prevalence of HIV in the report area as a rate per 100,000 population over age 13. The data reflect persons living with diagnosed HIV infection at the end of the latest reporting year, or persons living with infection ever classified as stage 3 (AIDS) at the end of the latest report year.

Rates of sexually transmitted diseases (STDs) might be lower in more rural areas for several reasons. Rural populations tend experience less population mobility so fewer new diseases are introduced. Additionally, social networks in rural areas are often tighter-knit, potentially leading to greater social scrutiny and more conservative attitudes towards sexual behavior, which can contribute to lower rates of STD transmission. Moreover, the availability of anonymous sexual health services may be limited in rural areas, possibly resulting in lower reported rates.

It is important to note that lower reported rates do not necessarily equate to lower actual rates, as underreporting and limited access to testing and healthcare services in rural areas can mask the true prevalence of STDs.

Regardless of the lower reported rates, it is still crucial to treat these conditions quickly and confidentially to prevent complications and further spread. The new Massachusetts Department of Public Health-funded Title X Sexual & Reproductive Health Clinic at Making Opportunity Count serves as a valuable local asset in combating STDs in the region, providing accessible and confidential care to those in need.

Behavioral Health

Behavioral health, encompassing both mental health and substance use-related issues, is a critical aspect of overall well-being. In the Combined Service Area, statistics around behavioral health outcomes reveal challenges that require urgent attention. Behavioral health issues, such as depression, suicide, and substance use disorders, affect a substantial portion of the population, with many residents reporting poor mental health and struggles with addiction. This section of the Community Health Needs Assessment presents detailed statistics on the prevalence of these conditions, highlighting the geographic and demographic variations across the region. Understanding the scope and distribution of behavioral health outcomes is essential for developing targeted interventions and support services to improve the mental and emotional health of the community.

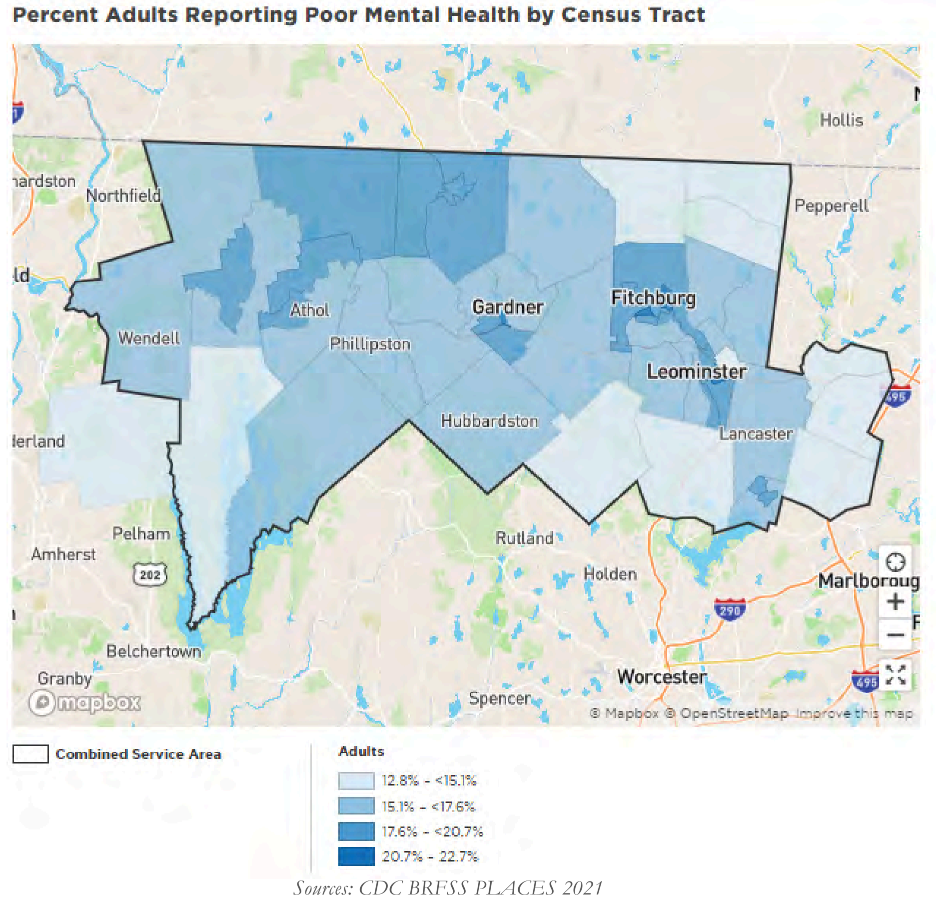
Per the table below, 16.9% of adults across the Combined Service Area report poor mental health for 14 of the last 30 days. Additionally, 23.1% of adult residents report having been diagnosed by a health professional with depression.

	Community	Adults Age 18+ with Poor Mental Health (Crude)	% Adults with Diagnosed Depression (Crude)
Health Alliance-Clinton Hospital	Ashburnham	15.3%	22.2%
	Ashby	14.5%	22.2%
	Bolton	12.8%	20.4%
	Clinton	17.4%	23.5%
	Fitchburg	19.0%	23.9%
	Gardner	18.1%	23.9%
	Harvard	12.9%	19.3%
	Lancaster	15.5%	21.2%
	Leominster	17.3%	23.0%
	Lunenburg	15.4%	22.4%
	Princeton	13.4%	21.1%
	Sterling	13.8%	21.2%
	Townsend	14.6%	22.5%
	Westminster	15.3%	22.3%
	Area Total Average	**16.8%**	**22.8%**
Heywood Hospital	Ashburnham	15.3%	22.2%
	Gardner	18.1%	23.9%
	Hubbardston	16.2%	23.2%
	Templeton	16.8%	23.5%
	Westminster	15.3%	22.3%
	Winchendon	17.6%	23.9%
	Area Total Average	**17.0%**	**23.4%**
Athol Hospital	Athol	18.2%	24.3%
	Erving	16.5%	24.6%
	New Salem	13.5%	22.3%
	Orange	17.5%	25.2%
	Petersham	16.4%	23.1%
	Phillipston	16.4%	23.1%
	Royalston	17.8%	24.2%
	Warwick	16.5%	24.6%
	Wendell	16.5%	24.6%
	Area Total Average	**17.4%**	**24.4%**
	Combined Service Area	**16.9%**	**23.1%**
	Worcester County	15.9%	21.7%
	Franklin County	14.8%	22.8%
	Massachusetts	14.7%	20.9%

Source: PLACES Data Portal, as cited by MA Population Health Information Tool (PHIT), 2021

The table above shows that, again, indictors for the western portion of the Combined Service Area (i.e., Athol Hospital's service area) are worse than those to the east. Orange stands out in the table below as having one in four adult diagnosed with depression.

The map below shows that there are also pockets of poor mental health in the same neighborhoods of Fitchburg, Leominster, Gardner, Clinton, Athol, and Orange where there were pockets of high incidence of chronic illness.



Sources: CDC BRFSS PLACES 2021

Per national prevalence statistics [32], depression is a relatively common mental health condition that affects a significant portion of the population, manifesting in persistent feelings of sadness, hopelessness, and a lack of interest in daily activities. While many individuals with depression manage their symptoms through therapy, medication, and support systems, the condition can sometimes escalate to a critical level, leading to isolation, anger, and even violence.

Emergency Department (ED) data from Heywood Healthcare demonstrates the prevalence of behavioral health issues in the Combined Service Area. Primary and secondary diagnosis codes for ED visits were analyzed for calendar years 2022 and 2023. Data showed Mental Health and Substance Abuse were the most prevalent diagnoses in the sample. Overall, 11.77% of patients seen in the Heywood ED and 13.86% of patients seen in the Athol ED had a mental health or substance abuse-related diagnosis.

Community members who participated in Focus Groups and healthcare providers from HealthAlliance-Clinton Hospital and Heywood Healthcare who were engaged as part of this Community Health Needs Assessment process talked about this cycle of negative emotions, isolation, and violence. They reported a:

> ***"...lack of neighborhood....Now people want to be left alone. People live in fear...[They] feel isolated."***

"People seem more angry and stressed."

When negative emotions become overwhelming or mental illness, like depression, goes untreated suicidal thoughts and behaviors can emerge. Suicide is a tragic outcome that occurs when individuals feel that their situation is dire and see no other way to escape their suffering. It underscores the urgent need for accessible mental health resources, early intervention, and comprehensive support for those struggling with severe depression. Addressing these needs is crucial to prevent such devastating consequences and to promote mental well-being within the community.

In the Combined Service Area there were ***23 deaths by suicide*** in 2021.

Since 2012, Heywood Healthcare has been spearheading The Montachusett Suicide Prevention Task Force (MSPTF) in response to several youth suicides in Gardner. Since this time, the MSPTF has tracked suicide death data from the Worcester County and Franklin County District Attorney's offices and data supplied by the Massachusetts Department of Public Health (MA DPH) on suicide trends.

Per that data, White men are the highest risk population in the Combined Service Area, accounting for 77.8% of suicide deaths in 2023 (through November). Data provided by MA DPH indicates that the Hispanic/Latino population reported the greatest increase in average monthly Emergency Department (ED) visits due to suicidal ideation and attempts (January 2019-February 2020 vs. June 2021-May 2023).

Young people ages 15-24 years had the highest number of ED visits related to suicidal ideation/attempts. More recent data shows that youth ages 11-14 had the highest percent increase in ED visits from 2021 to 2023. Suicide rates among Black, Asian, and Hispanic/Latino youth increased at least one year between 2016 and 2020, and LGBTQIA+ youth consistently report higher rates of suicidal ideation, making a plan, and attempts, compared to other groups of youth.

Having this data aggregated for the region enhances the hospital system and partner organizations' efforts to offer targeted, effective suicide prevention resources to the public. For example, the MSPTF, itself, provides evidence-based training (i.e., Question Persuade and Refer and Mental Health First Aid) for the general public, medical professionals, first responders, and community-based and faith-based organizations. They also offer support groups reaching those most impacted by suicide such as:

- MENders peer support groups promote healthy living and offer coping skills for managing symptoms associated with mental illness and substance use. The MENders groups provide a safe, stigma-free space for people who identify as male to share, care, learn, grow, and connect.
- Vet to Vet Café offers education, resources, and an opportunity for veterans to share their stories/experiences of serving to promote healthy living and socialization. LGBTQIA+
- support group led by and for LGBTQIA+ individuals. The group shares experiences and targeted discussion on challenges facing the community. The group works on outreach and community events as well.
- Moving Forward support group led by and for survivors of suicide loss provides a safe and comforting space where individuals with a common experience can connect and find comfort.

Additionally, UMass Memorial Health, HealthAlliance-Clinton Hospital's parent organization, also operates Community Healthlink (CHL), the largest mental health and substance use services agency in Central Massachusetts. Offering more than 60 programs, CHL treats more then 22,000 people annually across all age groups and demographics, including over 4,600 residents of North Worcester County in the past six months. CHL's wide spectrum of services include adult, child, and family outpatient counseling services, mobile crisis intervention services, inpatient and outpatient substance use services, and several community-based and school-based services. CHL also manages group living environments throughout Worcester County.

In 2022, the Massachusetts Executive Office of Health and Human Services selected CHL to operate two of the commonwealth's twenty-five Community Behavioral Health Centers (CBHC). The CBHC initiative was a key component to the EOHHS "Roadmap to Behavioral Healthcare Reform" and established protocols to expand behavioral health services, increase access to care, and provide services in a timely manner. CHL operates the CBHC in Leominster and the CBHC in Worcester.

The CHL Mobile Crisis Intervention (MCI) team works closely with the Health Alliance-Clinton Hospital's Emergency Department teams at both Leominster and Clinton campuses. Staff meet daily to discuss current mental health patients and have developed a seamless workflow of sending referrals to CHL when a client has become medically cleared and in need of a mental health evaluation. They collaborate and determine which team – CHL or ED – can take the appropriate action to move patients forward. There are also instances when the CHL team works with hospital social workers to help patients enroll/re-enroll with insurance providers to help clients become eligible for various community-based services. The working relationship between the two entities helps patients to receive services faster than if working separately.

The MCI team also is in contact with Heywood Hospital and sends patients to its Partial Hospitalization Program and its Geriatrics Inpatient unit.

Overdose Awareness Vigil
UMMH's Pharmacy Manager and two MCPHS pharmacy student attended the city of Fitchburg's Overdose Awareness Vigil.

According to the National Institutes of Health and the Substance Abuse and Mental Health Services Administration, depression and suicidal ideation are often interlinked with substance abuse [33] and trauma [34] as individuals struggling with severe emotional pain may turn to drugs or alcohol as a means of coping. Substance abuse can exacerbate mental health issues, creating a vicious cycle that increases the risk of both depression and suicidal behavior. The data below estimate the prevalence of substance use across the region including binge drinking, smoking, and opioid use.

	Community	Percentage of Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Percentage of Adults that are Current Smokers	Opiod Related Overdose Deaths (per 100,000)
Health Alliance-Clinton Hospital	Ashburnham	18.7%	12.2%	63.12
	Ashby	19.6%	12.9%	0.00
	Bolton	17.8%	9.1%	0.00
	Clinton	16.9%	15.3%	32.58
	Fitchburg	16.5%	16.5%	48.05
	Gardner	16.7%	17.1%	71.12
	Harvard	19.0%	9.5%	14.63
	Lancaster	19.0%	13.0%	0.00
	Leominster	16.1%	15.4%	32.10
	Lunenburg	17.0%	13.2%	8.52
	Princeton	16.8%	10.2%	28.60
	Sterling	17.2%	10.7%	62.09
	Townsend	19.9%	12.1%	22.05
	Westminster	17.7%	12.8%	12.17
	Area Total	**17.1%**	**14.6%**	**35.81**
Heywood Hospital	Ashburnham	18.7%	12.2%	63.12
	Gardner	16.7%	17.1%	71.12
	Hubbardston	18.3%	13.6%	0.00
	Templeton	17.5%	15.5%	49.04
	Westminster	17.7%	12.8%	12.17
	Winchendon	17.5%	15.9%	38.57
	Area Total	**17.4%**	**15.3%**	**47.85**
Athol Hospital	Athol	16.4%	17.1%	75.50
	Erving	17.5%	16.8%	0.00
	New Salem	17.5%	11.4%	0.00
	Orange	17.5%	18.1%	52.74
	Petersham	17.0%	15.4%	84.96
	Phillipston	17.0%	15.4%	104.28
	Royalston	17.8%	16.8%	0.00
	Warwick	17.5%	16.8%	0.00
	Wendell	17.5%	16.8%	0.00
	Area Total	**17.0%**	**17.0%**	**56.30**
	Combined Service Area	**17.1%**	**14.9%**	**38.12**
	Worcester County	16.0%	13.2%	303.41
	Franklin County	16.1%	13.8%	38.04
	Massachusetts	16.8%	12.1%	291.27

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2021. As Cited by MA PHIT and MA Executive Office of Health and Human Services, Number of Opioid-Related Overdose Deaths, All Intents by City/Town 2015-2022.

As discussed previously (see Healthcare Access & Health Behaviors), residents of the Combined Service Area report more binge drinking and smoking than their counterparts across the state and in the comparison areas of Worcester and Franklin Counties. That trend does not appear to hold true for opioid use. The rate of opioid-related deaths in the Combined Service Area is lower than that in Worcester County and Massachusetts and similar to that in Franklin County.

Predicting opioid usage within the Combined Service Area based solely on opioid death data is, for several reasons, not reliable. Firstly, opioid death data only captures the most severe outcomes and does not reflect the broader spectrum of opioid use and misuse within the community. Many individuals who use opioids may not experience fatal overdoses but still suffer from addiction and its associated health and social consequences. Secondly, opioid death data may be influenced by various factors such as the availability of naloxone (an opioid overdose reversal drug), the presence of harm reduction programs, and access to emergency medical care, which can mitigate the fatality rates without necessarily reducing overall usage. Thirdly, stigma and reporting discrepancies can lead to underreporting of opioid deaths, skewing the data. Therefore, a more comprehensive approach, including surveys, treatment admissions, and prescription data, is necessary to accurately gauge opioid usage and devise effective intervention strategies. That level of inquiry is beyond the scope of this Community Health Needs Assessment, though, some additional information on admissions is presented below.

While local admission data related to opioid use is limited, county level data for Worcester and Franklin Counties, where the majority of Combined Service Area Communities lie, show that over one third of admissions (37%) to Bureau of Substance Addiction Services (BSAS)-funded treatment facilities are related to heroin/fentanyl or other opioid use. This percentage is lower than Massachusetts where 40% of admissions are related to heroin/fentanyl or other opioid use. Paired with opioid-related death data presented above, this finding further suggests that opioid use may be lower locally than across the state.

Alcohol admissions constitute the highest percentage of admissions into BSAS-funded treatment facilities in Worcester County (42%) and they fall just under opioid-related admissions in Franklin County (35%). Marijuana- related admissions stand at 3% for Worcester and Franklin Counties as well as Massachusetts. Notable is the crack/cocaine admission percentage in Franklin County. At 12% it is 1.5 times as high as Worcester County and 1.3 times as high as Massachusetts.

The statistics above present a clearer pattern of substance use in the region with alcohol being the most common substance abused. Untreated misuse of alcohol, as well as nicotine, marijuana, prescription and over- the-counter medications, has been linked to elevated risk of opioid misuse later in life, as has untreated mental illness. The community needs to remain vigilant in actively

preventing the use of "gateway drugs" and invest in prevention efforts [35]. Additionally, the community needs to work to identify at-risk populations, assess the effectiveness of current interventions, and plan future strategies to reduce substance use and its associated harms. Through targeted efforts around substance use, the community can work towards improving the overall health and well-being of its residents.

One such targeted effort underway in the Combined Service Area is HealthAlliance-Clinton Hospitals' Road to Care program. The Road to Care program is a mobile unit for addiction services designed to reach out to those experiencing homelessness and substance use disorder to reduce morbidity and mortality while also mitigating barriers such as lack of transportation or mistrust in health care. The Road to Care program also supports the distribution of naloxone discharge kits with fentanyl testing strips at HealthAlliance-Clinton Hospital's Clinton and Leominster Emergency Departments.

HealthAlliance-Clinton Hospital's Pharmacy Department staff also attend community events and health fairs and provide information to the community on substance use intervention. Other interventions include Naloxane training for all caregivers in the Pharmacy Department and the department spearheaded the installation and maintenance of medication safe drug disposal boxes at the Fitchburg Cancer Center and outside both Emergency Departments.

Special Focus: Youth Mental Health

Understanding issues related to adult behavioral health provides crucial insights into the mental health challenges and substance use issues faced by the community. However, addressing behavioral health requires a comprehensive approach that also considers the unique needs and experiences of younger populations. Youth behavioral health is a critical area of focus, encompassing a range of issues including mental health, bullying, substance use, and teen pregnancy.

The following section delves into these behaviors using data from the Youth Risk Behavior Survey (YRBS). The YRBS data presented here offers a snapshot of the prevalence and impact of these challenges on youth in the region. The data presented covers four of the 15 school districts that comprise the Combined Service Area. Data for the North Quabbin region includes responses from over 425 9th through 12 graders. Data for the North Central MA Region includes data for over 750 9th and 10th graders. It is important to note that the total sample included here (i.e., approximately 1,200 students) represents a small percentage of the youth population living in the Combined Service area. It is also important to note that the North Central MA Region sample contains data from only 9th and 10th graders whereas the North Quabbin

and Massachusetts samples contain data from 9th, 10th, 11th, and 12th graders. Differences in prevalence rates between the North Central MA Region and the North Quabbin Region and/or the Massachusetts data may be due to a younger sample versus a real difference in behaviors across regions.

Bearing these limitations in mind, the YRBS data presented below do reveal patterns and trends in youth behavior that are vital for understanding how mental health and substance abuse issues manifest at a younger age and how they can influence long-term health outcomes.

Measure Name	North Quabbin	North Central MA Region	Massachusetts
Interpersonal Interactions			
Bullied at school 12 months	25%	22%	
Forced to have unwanted sexual intercourse	9%	6%	
Recent Substance Use (last 30 days)			
Any smoking (cigarettes)	5%	1%	
Any vaping	14%	7%	16%
Any drinking	11%	10%	22%
Binge drinking	5%	3%	
Cannabis	15%	9%	17%
Lifetime Substance Use			
Cigarettes	20%	4%	12%
Vaping	30%	17%	30%
Alcohol	35%	25%	41%
Cannabis	31%	17%	30%
Mental Health			
Too sad/hopeless for usual activities for 2+ weeks in past 12 months	46%	32%	34%
Purposely hurt yourself without wanting to die (i.e., self harm) in past 12 months	27%	23%	19%
Seriously considered attempting suicide in past 12 months	20%	15%	13%
Planned how you would attempt suicide in past 12 months	17%	12%	
Attempted suicide in past 12 months	11%	7%	

Sources: Results of Massachusetts Youth Health Survey 2024 from Massachusetts Department of Public Health's Health Survey Program. Data Science, Research, and Epidemiology Division, Office of Population Health. 2023 Franklin County/North Quabbin Student Health Survey. North Central MA Regional Youth and Community Survey 2023 Preliminary Data Report.
NOTE: Blacked out cells represent items for which no state comparison data was available.

Per the data table above, more than one in five local respondents reported being bullied at school in the last 12 months. Alcohol is the most commonly tried substance (lifetime) across the Combined Service Area with recent use (last 30 days) of cannabis and vaping being almost as common as (North Central MA Region) or more common than (North Quabbin) alcohol. Additionally, roughly one-third or more of local respondents reported feeling sad or hopeless for 2+ weeks in the past year with approximately one-quarter reporting self harm.

When the data above are stratified by gender identity and sexual orientation striking trends emerge. The table below shows that females and people identifying as LGBTQIA+ generally report higher rates of risk behaviors.

Measure Name	Region	Gender Identity		Sexual Orientation	
		Male	Female	Hetero	LGBTQIA+
Depression	Massachusetts	23.0%	46.0%	26.0%	62.2%
	North Quabbin	32.0%	57.0%	35.0%	71.0%
Self Harm	Massachusetts	23.0%	46.0%	26.0%	62.2%
	North Quabbin	32.0%	57.0%	35.0%	71.0%
Active Suicidal Ideation	Massachusetts	7.6%	17.8%	7.5%	30.4%
	North Quabbin	10.0%	18.0%	11.0%	33.0%
Marijuana Use (recent use)	Massachusetts	14.6%	19.0%	14.7%	24.9%
	North Quabbin	10.0%	21.0%	11.0%	22.0%
Alcohol Use (recent use)	Massachusetts	17.9%	26.5%	20.9%	26.9%
	North Quabbin	9.0%	15.0%	11.0%	13.0%
Vape Use (recent use)	Massachusetts	12.9%	19.0%	15.0%	19.9%
	North Quabbin	11.0%	22.0%	13.0%	17.0%

Sources: Results of Massachusetts Youth Health Survey 2024 from Massachusetts Department of Public Health's Health Survey Program. Data Science, Research, and Epidemiology Division, Office of Population Health. 2023 Franklin County/North Quabbin Student Health Survey.

The data presented above highlights a concerning trend: high school-aged females are more likely than their male counterparts to engage in risky behaviors and those identifying as LGBTQIA+ exhibit the highest likelihood of such behaviors. This pattern underscores the importance of recognizing the distinct challenges faced by these groups. For females, societal pressures, gender norms, and possibly higher rates of mental health issues such as anxiety and depression [36] may contribute to this increased vulnerability. For LGBTQIA+ youth, the intersection of stigmatization, discrimination, and identity-related stressors can exacerbate feelings of isolation and lead to higher rates of risky behaviors, including substance use, self-harm, and unsafe sexual practices [37]. These findings highlight the urgent need for targeted interventions that address the specific needs of high-risk groups within the youth population, fostering a more inclusive environment that promotes mental well-being and reduces the inclination towards harmful behaviors.

The heightened vulnerability of high school-aged youth to risky behaviors, calls for tailored and accessible support systems. For example, Community Action Teams (CATs) in the region help to coordinate connections between schools and local organizations to provide in-school and after-school youth prevention and intervention programs and services. Some of these local organizations are LUK, Inc., Making Opportunity Count, the YWCA, Pathways for Change, the Gardner Community Action Team, and CHNA9. Topics covered by these programs include resilience, active bystandership, substance use prevention, healthy relationships, and more. Programs are administered by trained professionals, and are typically grant-funded and provided to schools free of charge.

Heywood Healthcare's School-based tele-behavioral health counseling program is a critical resource in addressing these complex needs, offering convenient and confidential mental health and substance abuse counseling directly within the school environment. Students are often referred to this program for various reasons, reflecting the diverse challenges they face in both academic and personal spheres. Among the most common issues prompting referrals are anxiety and depression, which can

significantly impact a student's emotional well-being and academic performance. Substance use, often a manifestation of deeper struggles, is another prevalent concern, as students grapple with addiction. The presence of suicidal ideation and self-injurious behavior underscores the urgent need for prompt mental health support. Additionally, students with attention-deficit/hyperactivity disorder (ADHD) are frequently referred, as they may struggle to focus and engage in academic tasks. Issues related to gender and sexual identity are also common, with students seeking guidance in navigating their unique experiences and fostering a positive sense of self. By addressing this wide range of mental health and behavioral issues, Heywood's program not only mitigates the risks associated with these behaviors but also promotes a supportive, inclusive school climate where all students can thrive emotionally and academically.

High Ridge Harmony Farm
Heywood Hospital's school-based services program has partnered with High Ridge Harmony Farm, an Animal-Assisted Healing and Wellness Center. The equine therapy program offers a unique blend of equine-assisted activities and therapeutic techniques to promote emotional well-being, self-awareness, and personal growth.

Recently, Community Health Connections, the region's Federally Qualified Community Health Center recently launched a new Children's Behavioral Health Center in Fitchburg. Their child-focused services include: Individual & Group Therapy, Psychiatry, Play Therapy, Expressive Therapy, and Behavioral Health Mentors. Services are also provided to family members and individuals of all ages by their team of therapists and psychiatric providers at locations in Gardner, Fitchburg, and Leominster both via in-office services and telehealth.

The data above on mental health issues and bullying among youth highlight significant challenges that can impact their overall well-being and development. These issues often intersect with other behavioral health concerns, creating a complex web of factors that influence adolescents' lives. One such related concern is teen pregnancy, which can have profound implications for the health and future prospects of young mothers and their children.

The table below detailing the percentage of births to teen mothers reveals that the Combined Service Area has a slightly elevated rate compared to Worcester County, Franklin County, and Massachusetts. This overall higher percentage appears to be driven by a few communities within the region that exhibit much higher rates of births to teen mothers: 5.8% births to teen mothers in Orange, 5.4% in Athol, and 4.3% in Bolton and Fitchburg.

	Community	% Teen Births (Ages 15-19)
Health Alliance-Clinton Hospital	Ashburnham	0.0%
	Ashby	0.0%
	Bolton	4.3%
	Clinton	1.7%
	Fitchburg	4.3%
	Gardner	2.9%
	Harvard	0.0%
	Lancaster	3.8%
	Leominster	1.5%
	Lunenburg	0.0%
	Princeton	0.0%
	Sterling	0.0%
	Townsend	0.0%
	Westminster	0.0%
	Area Total Average	**2.2%**
Heywood Hospital	Ashburnham	0.0%
	Gardner	2.9%
	Hubbardston	0.0%
	Templeton	3.7%
	Westminster	0.0%
	Winchendon	3.1%
	Area Total Average	**2.1%**
Athol Hospital	Athol	5.4%
	Erving	0.0%
	New Salem	0.0%
	Orange	5.8%
	Petersham	0.0%
	Phillipston	0.0%
	Royalston	0.0%
	Warwick	0.0%
	Wendell	0.0%
	Area Total Average	**0.4%**
	Combined Service Area	**2.4%**
	Worcester County	2.0%
	Franklin County	2.0%
	Massachusetts	2.0%

Source: MA DPH Vital Records and Statistics, 2021 and National Vital Statistics Reports Vol.72 No.1, Births: Final Data, 2021

These localized spikes suggest that targeted interventions and support programs in these specific geographic areas could be effective in addressing and reducing the incidence of teen pregnancies, thereby aligning the region more closely with broader state and county trends.

The data on teen pregnancy above provides crucial insights into the reproductive health challenges faced by youth in the Combined Service Area and is intimately connected to overall teen mental health and well-being. Building on this, it is essential to consider the qualitative information gathered from local residents about youth mental health issues. These personal accounts shed light on the broader context of adolescent well-being, highlighting the intersection between mental health struggles and other risk factors, such as teen pregnancy.

Youth and adults who participated in Focus Groups as part of this Community Health Needs Assessment process spoke about a mental health crisis among youth in the area. They referenced the pandemic and its prolonged effect on youth and their academic and social lives. They talked about a lack of organized, free/low-cost activities for youth to relieve boredom and channel energy in positive directions. They also spoke about recent spikes in youth violence, substance abuse, and suicidal ideation.

The Communities That Care Risk and Protective Factor Framework [38] emphasizes that various community, school, family, and peer factors can positively influence youth towards better behavioral health outcomes. This framework highlights the importance of leveraging existing resources within the community to support and enhance these protective factors. Community-based programs such as Three Pyramids Community Leadership Empowerment Institute and Making Opportunity Count's Youth Innovation Center are valuable assets that already contribute to improving youth behavioral health.

In addition, Heywood Healthcare has implemented several school-based services in collaboration with the five school districts within Heywood and Athol Hospitals' service areas. These programs aim to address students' physical, social, and emotional well-being. During the 2023/2024 school year, the Heywood Murdock and Athol Community Elementary School-based Health Centers provided 2,859 student visits. Additionally, Heywood's Youth Tele Behavioral Health Program conducted 5,014 tele-behavioral health sessions, 157 youth received A-CRA evidence-based substance use treatment services, and 128 students participated in the Heywood Project AMP Mentorship program. Furthermore, Heywood's Handle With Care (HWC) initiative offers a school-community response to support children exposed to trauma at home, school, or in the community, ensuring they receive appropriate assistance to achieve emotional and academic success. In the 2023/2024 school year, Law Enforcement made 366 referrals to the Handle With Care program.

Building upon these community- and hospital-based resources and integrating them into a broader intervention strategy can create a more supportive environment for youth, addressing the multifaceted nature of their behavioral health challenges and fostering resilience and well-being.

Heywood Youth Mentor Program
This program provides year-round support for students in 5 school districts. Pictured is School Based Services Youth Mentors and Community Health Workers hosting a junk journaling class in collaboration with the Athol Public Library.

Conclusion

Health outcomes related to chronic and communicable diseases, as well as behavioral health for both adults and youth, reveal significant challenges within the Combined Service Area. There are notable pockets of high disease burden, particularly in the western portion of the region and in specific neighborhoods of the larger, more urban communities. These disparities highlight the urgent need for targeted interventions to address the unique health needs of these areas. The region is also home to numerous assets, including community-and hospital-based resources, that have the potential to make a substantial impact. By supporting and expanding these existing resources, the community can work towards reducing health disparities and improving overall health outcomes for all residents.

SUMMARY OF FINDINGS

The Combined Service Area, which includes the 26 cities and towns of North Central Massachusetts served by HealthAlliance-Clinton Hospital, Heywood Hospital, and Athol Hospital, is navigating a complex landscape of challenges and opportunities. This predominantly rural region has historically been mostly White but has recently seen a significant increase in diversity, driven in part by international migration. As the population ages and declines, the area finds new strength in the cultural enrichment and economic revitalization brought by newcomers and youth. Addressing the needs of an aging population while embracing and integrating new residents and a new generation necessitates targeted policies and investments in healthcare and infrastructure. This approach aims to foster inclusive growth and leverage the benefits of increased diversity for long-term community resilience.

The Combined Service Area's economic structure is characterized by low-wage, low-skill jobs. As such, the region's economy contributes to financial insecurity among residents and makes it challenging for people who live and work in the area to keep pace with the escalating cost of living. The result is a cycle of poverty that severely impacts access to essential resources such as employment, housing, and healthcare. Disparate rates of educational attainment, employment, and poverty are evident geographically and among special populations, including individuals of different racial and ethnic backgrounds, those with disabilities, veterans, and single parents. These groups often face compounded difficulties, highlighting the need for targeted, equity-focused wealth generation strategies to break the cycle of poverty and enhance economic opportunities for all.

Housing challenges are pronounced in the Combined Service Area, with most communities falling far short of the required 10% affordable housing units. Rising home values and escalating rental costs, coupled with historical discrimination and systemic issues, contribute to affordability problems. Additionally, high utility costs and the region's older housing stock exacerbate the issue of energy burden. The extreme cold of the Northeast and changing weather patterns due to climate change further increase heating and cooling costs, adding to the financial strain faced by residents. Addressing housing affordability is essential for promoting economic stability and social equity. Local efforts to increase housing efficiency have helped hundreds of families reduce energy costs and redevelopment efforts, like the Fitchburg Arts Community, are adding affordable units to communities where the need is high. Nonetheless, the region must continue to seek innovative ways to address housing affordability to support long-term economic stability and inclusivity.

Food insecurity is a concern in the Combined Service Area, affecting one in ten residents. This issue disproportionately impacts Black and Hispanic communities, where the rate of food insecurity is roughly double that of the general population, and is even more severe among low-income households, where the rate is three times higher. Limited access to nutritious food not only challenges daily well-being but also exacerbates chronic health conditions such as heart disease, diabetes, and obesity, creating a detrimental cycle where poor health further entrenches food insecurity. Addressing food insecurity is crucial to improving overall community health and breaking this cycle and requires a comprehensive approach that combines local initiatives with robust participation in benefit programs. Local efforts, such as community gardens, farmers' markets, and mobile food pantries, are vital for improving food access as are efforts spearheaded by Local Food Works and the United Way of North Central Massachusetts to better coordinate regional food resources. Additionally, benefit programs like the federal Supplemental Nutrition Assistance Program and the Massachusetts Healthy Incentives Program, which provides extra benefits for purchasing farm-fresh, locally grown produce, play an important role in ensuring that all individuals can access and afford healthy food options. This dual approach to food insecurity aims to improve both access and nutritional quality for underserved populations.

Transportation barriers in the Combined Service Area further complicate access to essential services, including employment, healthcare, and healthy food options, particularly for the more remote communities of the region. Limited public transportation and high costs or personal transportation restrict mobility and contribute to social isolation. However, efforts to improve healthcare-related transportation are underway, with HealthAlliance-Clinton Hospital providing 24-hour non-emergency transportation through a collaboration with GoGo and advocating for the expansion of PT1 services to better support patients with transportation needs. Additionally, HeywoodHealthcarehaspartneredwithWoodsAmbulance,Inc.toprovidepatientswith reduced rates to non-emergency medical appointments and residents of Gardner with on-demand, same day, flat-rate transportation anywhere within city limits. Furthermore, CHNA9 is leading a Future of Mobility collaborative that is working to develop a Regional Mobility Master Plan as well as establish a Transportation Management Association to address workforce transportation gaps. Ongoing efforts to address transportation issues are crucial for enhancing access to essential services and fostering a more connected and healthy community.

The Combined Service Area faces significant challenges related to healthcare access, exacerbated by a low provider-to-patient ratio, particularly outside of the Leominster/Fitchburg/Gardner corridor, and a shortage of culturally diverse providers. These issues are part of a national trend rather than local decisions about pay or service investment and they are compounded by complex, systemic factors such as inadequate funding for medical education in rural areas, lower financial incentives for healthcare professionals to work in

underserved regions, and broader healthcare policy and resource distribution issues. As the Combined Service Area's population continues to age and the baby boomer generation of doctors reaches retirement age, the American Association of Medical Colleges projects long-term workforce shortages that will further strain the already limited healthcare resources in the region.

Addressing these disparities is crucial for equitable healthcare access, especially given the growing demand for medical services driven by an aging population in the Combined Service Area, relatively high rates of chronic diseases such as cancer and asthma, and notable prevalence of behavioral health concerns across the region. Fortunately, the Combined Service Area benefits from its designation as a Massachusetts Executive Office of Health and Human Services Place-Based Investment Zone, which brings opportunities for targeted funding and development. Additionally, strong community collaboration and high-quality services, including multiple Centers for Medicare & Medicaid Services 5-star rated facilities and others that are nationally and internationally recognized for excellence, can be leveraged to improve healthcare access and outcomes for all residents.

IDENTIFICATION OF PRIORITIES

HealthAlliance-Clinton Hospital, Heywood Healthcare, and community partners increasingly recognize the need to address health disparities through integrated approaches that prioritize prevention, enhance access, improve care coordination, and tackle social determinants of health. There is a growing national emphasis on addressing upstream factors and systemic issues, particularly those related to systemic racism.

This regional assessment identified several key health challenges and social drivers of health, including the impact of social and economic factors like affordable housing and food insecurity, the burden of mental health and substance abuse, challenges in equitable access to care, and the management of risk factors for chronic and complex conditions.

Between July and September 2024, the CHNA planning committee, along with hospital leaders, their Community Benefits Advisory and Patient and Family Advisory Committees, reviewed the quantitative data from the assessment as well as the strength of existing community health efforts. Each hospital also considered its strategic priorities and health equity plans to ensure alignment of resources. The goal of the review was to elevate a list of priority areas on which to focus community health investments, leverage existing resources, and maximize regional impact.

The review revealed three priority areas for the hospitals to guide their efforts around health improvement and equity (in alphabetical order):

1. Equitable Access to Care, with a focus on complex and chronic conditions, including:
    - Cancer
    - Diabetes
    - Cardiovascular disease
    - Respiratory illness
2. Mental Health and Substance Abuse
3. Social Determinants of Health (SDOH), with emphasis on:
    - Financial stability
    - Housing
    - Food security
    - Transportation

As Heywood Healthcare has an inpatient maternal health unit, they will also prioritize infant and maternal health. Similarly, HealthAlliance-Clinton Hospital will address the community-based needs of birthing people and infants as part of their community benefits strategic implementation plan.

Both hospitals aim to focus community efforts on addressing the needs of underserved populations, including black, indigenous, people of color; low income individuals and families; birthing people; infants, children and adolescents; adults aged 75 years and older; veterans; people with disabilities; individuals and families who are homeless; individuals who identify as LGBTQIA+; recent immigrants; and non-English speakers. In addition, both hospitals are committed to enhancing community health, addressing health disparities, and achieving health equity through the lens of structural racism and systemic inequities.

The HealthAlliance-Clinton Hospital governing board, Central New England HealthAlliance Board of Trustees, approved the CHNA by unanimous vote on Friday, September 27, 2024. This assessment will be publicly available on the hospitals' websites and through partner organizations. This assessment report may be used to inform other community health improvement initiatives or plans. The hospitals may be invited to be engaged in such future planning processes and may choose to align their community benefit efforts with those of other external partners.

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APPENDIX A

UMass HealthAlliance-Clinton Hospital and Heywood Healthcare
Community Health Needs Assessment 2024-2027
Inventory of Regional Partners and Community Resources

2Gether We Eat, Inc
Able To Serve
Abolitionist Park of Fitchburg
Active Life Adult Day Health Care
Aging Services of North Central Massachusetts (ASNCM)
AIDS Project Worcester
Alyssa's Place Peer Recovery and Resource Center
At Home and Afar
Athol Board of Health
Athol Police Department
Athol Primary Care
Athol Royalston School District
Ashburnham and Westminster School District
Ashburnham Board of Health
Ashburnham Police Department
Ashburnham Senior Center
Behavioral Health Integrated Resources for Children Project (BIRCh Project)
Boys & Girls Club of Fitchburg, Gardner and Leominster
Care Central VNA & Hospice, Inc.
Catholic Charities of Worcester County
Central Massachusetts Housing Alliance, Inc.
Central Massachusetts Planning Commission
Central Massachusetts Tobacco Free Community Partnership
Children's Aid & Family Service An Affiliate of Seven Hills Foundation
City of Fitchburg Economic Dev. Office
City of Fitchburg Health Department
City of Fitchburg - Fitchburg Senior Center
Clean Slate
Clear Path for Veterans New England, Inc
Clinton Adult Learning Center

Clinton Community Partnership
Clinton Housing Authority
Clinton Public Schools
Community Foundation North Central Massachusetts on behalf of the North Central Faith-Based Coalition
Community Foundation of Central Massachusetts
Community Health Connections Inc
Community Health Network of Central Massachusetts (CHNA 9)
Community Healthlink, Inc.
Community Legal Aid, Inc. (CLA)
Cooperative Elder Services, Inc.
Councils on Aging
Ellie Fund
Erving Board of Health
Regional Behavioral Health Collaborative
Regional EMS
First Baptist Church of Leominster
Fitchburg Art Museum
Fitchburg Board of Health
Fitchburg Comprehensive Treatment Center
Fitchburg Housing Authority
Fitchburg Public Library
Fitchburg Public Schools
Fitchburg State University
Franklin County Sheriff Office
Franklin Hampshire System of Care Task Force (SOC)
Framingham State University
Friendly House, Inc.
Friends of Sterling Seniors Senior Centers
GAAMHA, Inc.
Gardner Board of Health
Gardner Community Action Committee
Gardner Police Department
Gardner Public Schools
Ginny's Helping Hand, Inc.
Growing Places Garden Project, Inc.
Habitat for Humanity of Central Massachusetts
HealthAlliance Home Health and Hospice
Health Equity Partnership CHNA 9
HEAL Winchendon

Heart to Home Meals
Heywood Hospital
Highland Baptist Church
House of Peace and Education (HOPE)
Hubbardston Board of Health
Hubbardston Senior Center
Interfaith Hospitality Network of 14 Churches
JUMP, Inc.
JUST UNDERSTAND MY POTENTIAL, Inc.
Leominster Board of Health
Leominster Housing Authority
Leominster Police Substance Abuse Outreach Program
Leominster Public Schools
Loaves and Fishes
Local Boards of Health and Public Health
Local Fire Departments
Local Police Departments
LUK Crisis Center, Inc.
Mahar Regional District
Making Opportunity Count (MOC) - CARE AIDS
Making Opportunity Count (MOC)
Mass Audubon
Mass College of Pharmacology and Health science
Massachusetts Department of Transitional Assistance
MassHire of North Central MA
Monty Tech Vocational High School
Montachusett Public Health Network
Montachusett Recovery Center
Montachusett Recovery Foundation Corp
Montachusett Regional Planning Commission
Montachusett Regional Transit Authority (MART)
Montachusett Regional Vocational Technical School
Montachusett Suicide Prevention Taskforce -
Montachusett Veterans Outreach Center
Mount Wachusett Community College (MWCC)
Mount Wachusett Community College Foundation, Inc
Nashoba Valley Chamber of Commerce

Narragansett Regional School District
National Alliance on Mental Health (NAMI)
New Salem Board of Health
New Vue Communities
North Central Correctional Institution (NCCI)
North Central Mass Faith Based Community Coalition
North Central Massachusetts Chamber of Commerce
NorthWestern County District Attorney, David Sullivans Office
North Quabbin Children's Health and Wellness System of Care Task Force (CHWTF)
North Quabbin Community Coalition
North Star Family Services, Inc.
Open Sky Community Services
Opportunities for Hope
Orange Board of Health
Orange Police Department
Orange Senior Center
Orange School District
Other Local Public Schools
Our Father's Table
Oxford Housing Authority
P.A.R.T. (Prevention, Addiction, Recovery, Treatment)
Parent Professional Advocacy League
Petersham Board of Health
Petersham Police Department
Phillipston Board of Health
Phillipston Police Department
Quinnsigamond Community College
QuittersWin
Quabbin Food Harvest
Quabbin Retreat
Ralph C Mahar School District
RCAP Solutions
Recovery Centers of America
Recovery Resource Center
Revive of the USA
Right Choice Health Group

Rise Above Foundation
Robert F. Kennedy Community Alliance (RFK)
Royalston Board of Health
Salvation Army
Salvation Army of North Central
Seeds of Solidarity
Seven Hills as fiscal sponsor for the Leaders for Equitable Local Economies Fitchburg initiative
Seven Hills/Fitchburg Aid and Family Services
Simmons College
South Middlesex Opportunity Council SMOC
Spanish American Center
Sprout Change/Germinemos
Sterling First Church
St. Paul Consortium
Templeton Board of Health
Templeton Food Pantry
Templeton Police Department
The Clinton Early Childhood Resource Center
The Gardner Are interagency Team (GAIT)
The Health Foundation of Central Massachusetts
The North Central Massachusetts Minority Coalition
The SHINE Initiative
The Winchendon School
Three Pyramids
Town of Winchendon
Transition House
Twin Cities Rail Trail Association
United Way of North Central Massachusetts, Inc.
United Way of Tri-County - WHEAT Community Connections
University of New Hampshire
Valley Medical Group
Warwick Board of Health
Wendell Board of Health
Westminster Board of Health
Westminster Police Department
Westminster Senior Center
WHEAT Community Connections

Winchendon Board of Health
Winchendon Community Action Center
Winchendon Health Center
Winchendon Police Department
Winchendon Public Schools
Winchendon Senior Center
Woods Ambulance and Medivan Services
Worcester Community Action Council, Inc. (WCAC)
Worcester County District Attorney Joseph Early Office
Worcester County Food Bank
YOU, Inc.
YWCA Central Massachusetts

*This report recognizes that this is not a complete list of all resources in the combined service area. Both hospitals are committed to partnering with all local organizations that support addressing health outcomes for all residents.

APPENDIX B

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Population and Demographics

Table 1. Total Population, 2010 and 2018-2022

	Community	Total Population, 2010	Total Population, 2018-2022	% change
Health Alliance-Clinton Hospital	Ashburnham	6,081	6,337	4.2%
	Ashby	3,074	3,187	3.7%
	Bolton	4,897	5,653	15.4%
	Clinton	13,606	15,347	12.8%
	Fitchburg	40,318	41,621	3.2%
	Gardner	20,228	21,090	4.3%
	Harvard	6,520	6,835	4.8%
	Lancaster	8,055	8,395	4.2%
	Leominster	40,759	43,620	7.0%
	Lunenburg	10,086	11,735	16.3%
	Princeton	3,413	3,497	2.5%
	Sterling	7,808	8,053	3.1%
	Townsend	8,926	9,070	1.6%
	Westminster	7,277	8,220	13.0%
	Area Estimate	**181,048**	**192,660**	6.4%
Heywood Hospital	Ashburnham	6,081	6,337	4.2%
	Gardner	20,228	21,090	4.3%
	Hubbardston	4,382	4,338	-1.0%
	Templeton	8,013	8,157	1.8%
	Westminster	7,277	8,220	13.0%
	Winchendon	10,300	10,372	0.7%
	Area Estimate	**56,281**	**58,514**	4.0%
Athol Hospital	Athol	11,584	11,921	2.9%
	Erving	1,800	1,631	-9.4%
	New Salem	990	1,074	8.5%
	Orange	7,839	7,584	-3.3%
	Petersham	1,234	1,177	-4.6%
	Phillipston	1,682	1,918	14.0%
	Royalston	1,258	1,455	15.7%
	Warwick	780	814	4.4%
	Wendell	848	847	-0.1%
	Area Estimate	**28,015**	**28,421**	1.4%
Additional Geographies	**Combined Service Area**	**231,758**	**243,948**	5.3%
	Worcester County	798,552	858,898	7.6%
	Franklin County	71,372	70,980	-0.5%
	Massachusetts	6,547,629	6,984,205	6.7%
	United States	308,745,538	331,097,593	7.2%

Sources: U.S. Census Bureau, Decennial Census (2010) and American Community Survey 5-Year Estimates (2018-2022)

Table 2. Sex, 2018-2022

	Community	Male	Female
Health Alliance-Clinton Hospital	Ashburnham	52.5%	47.5%
	Ashby	50.7%	49.3%
	Bolton	49.7%	50.3%
	Clinton	49.4%	50.6%
	Fitchburg	48.2%	51.8%
	Gardner	52.6%	47.4%
	Harvard	56.2%	43.8%
	Lancaster	53.7%	46.3%
	Leominster	50.9%	49.1%
	Lunenburg	50.5%	49.5%
	Princeton	50.6%	49.4%
	Sterling	49.4%	50.6%
	Townsend	49.7%	50.3%
	Westminster	47.1%	52.9%
	Area Estimate	**50.4%**	**49.6%**
Heywood Hospital	Ashburnham	52.5%	47.5%
	Gardner	52.6%	47.4%
	Hubbardston	50.1%	49.9%
	Templeton	53.7%	46.3%
	Westminster	47.1%	52.9%
	Winchendon	49.1%	50.9%
	Area Estimate	**51.2%**	**48.8%**
Athol Hospital	Athol	50.7%	49.3%
	Erving	48.0%	52.0%
	New Salem	55.4%	44.6%
	Orange	47.5%	52.5%
	Petersham	55.1%	44.9%
	Phillipston	49.1%	50.9%
	Royalston	58.7%	41.3%
	Warwick	49.8%	50.2%
	Wendell	51.1%	48.9%
	Area Estimate	**50.3%**	**49.7%**
Additional Geographies	**Combined Service Area**	**50.4%**	**49.6%**
	Worcester County	49.7%	50.3%
	Franklin County	49.4%	50.6%
	Massachusetts	49.0%	51.0%
	United States	49.6%	50.4%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 3. Age Distribution, 2018-2022

	Community	Under 18 years	18-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65 years or older
Health Alliance-Clinton Hospital	Ashburnham	20.9%	9.9%	11.3%	20.8%	11.6%	7.5%	18.0%
	Ashby	15.6%	5.8%	8.5%	20.5%	14.9%	14.1%	20.6%
	Bolton	27.2%	5.5%	9.0%	19.7%	13.8%	10.2%	14.6%
	Clinton	17.2%	10.6%	18.1%	20.0%	12.3%	7.3%	14.3%
	Fitchburg	20.4%	12.4%	13.8%	19.8%	13.0%	6.3%	14.3%
	Gardner	17.5%	5.9%	15.5%	21.5%	12.0%	8.5%	19.2%
	Harvard	22.3%	6.4%	8.4%	22.6%	18.1%	6.9%	15.3%
	Lancaster	17.7%	8.5%	15.0%	20.0%	12.3%	8.4%	18.1%
	Leominster	19.0%	8.1%	13.5%	19.9%	13.8%	7.0%	18.6%
	Lunenburg	22.3%	6.7%	10.3%	22.2%	13.6%	7.7%	17.1%
	Princeton	20.6%	6.1%	9.2%	19.3%	13.3%	10.7%	20.9%
	Sterling	19.6%	2.1%	10.7%	16.6%	14.8%	14.5%	21.7%
	Townsend	20.7%	8.3%	11.0%	20.1%	13.8%	10.6%	15.5%
	Westminster	19.6%	4.6%	10.3%	23.9%	7.8%	6.8%	26.9%
	Area Estimate	**19.7%**	**8.4%**	**13.1%**	**20.4%**	**13.1%**	**7.9%**	**17.4%**
Heywood Hospital	Ashburnham	20.9%	9.9%	11.3%	20.8%	11.6%	7.5%	18.0%
	Gardner	17.5%	5.9%	15.5%	21.5%	12.0%	8.5%	19.2%
	Hubbardston	20.1%	9.5%	8.9%	26.1%	11.2%	6.4%	17.8%
	Templeton	22.4%	6.7%	13.1%	21.6%	12.1%	7.9%	16.2%
	Westminster	19.6%	4.6%	10.3%	23.9%	7.8%	6.8%	26.9%
	Winchendon	22.0%	9.6%	12.5%	19.7%	13.4%	7.1%	15.8%
	Area Estimate	**19.8%**	**7.2%**	**13.0%**	**21.8%**	**11.6%**	**7.6%**	**19.0%**
Athol Hospital	Athol	19.9%	8.3%	12.8%	20.1%	13.1%	7.1%	18.7%
	Erving	20.2%	8.1%	11.2%	22.5%	12.4%	6.5%	19.2%
	New Salem	13.7%	6.1%	6.3%	24.9%	10.2%	19.7%	19.0%
	Orange	21.1%	7.2%	12.4%	20.7%	12.1%	7.4%	19.2%
	Petersham	13.6%	7.7%	7.7%	19.7%	15.1%	10.0%	26.1%
	Phillipston	18.7%	9.6%	9.8%	18.8%	15.2%	13.5%	14.4%
	Royalston	23.0%	5.8%	10.3%	20.0%	13.5%	9.0%	18.4%
	Warwick	13.5%	3.8%	12.0%	24.0%	14.4%	13.3%	19.0%
	Wendell	13.7%	2.0%	7.3%	27.4%	18.2%	5.3%	26.1%
	Area Estimate	**19.5%**	**7.5%**	**11.6%**	**20.8%**	**13.1%**	**8.4%**	**19.1%**
Additional Geographies	**Combined Service Area**	**19.8%**	**8.3%**	**12.8%**	**20.5%**	**13.1%**	**7.9%**	**17.5%**
	Worcester County	20.8%	9.6%	12.9%	19.5%	13.5%	7.4%	16.2%
	Franklin County	16.9%	6.9%	11.7%	21.2%	12.6%	7.6%	23.2%
	Massachusetts	19.6%	10.0%	14.1%	19.3%	12.8%	7.1%	17.1%
	United States	22.1%	9.4%	13.7%	19.3%	12.4%	6.5%	16.5%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 4. Racial/Ethnic Distribution, 2018-2022

	Community	Asian	Black	Hispanic/Latino	White	Additional categories
Health Alliance-Clinton Hospital	Ashburnham	0.9%	0.8%	3.9%	90.2%	4.3%
	Ashby	0.5%	0.0%	2.6%	95.2%	1.7%
	Bolton	6.2%	0.0%	3.9%	84.8%	5.0%
	Clinton	1.8%	0.4%	15.7%	78.0%	4.0%
	Fitchburg	1.7%	5.8%	30.6%	58.0%	3.9%
	Gardner	3.2%	1.8%	8.3%	83.6%	3.0%
	Harvard	5.3%	6.0%	9.8%	78.1%	0.8%
	Lancaster	0.7%	3.8%	8.6%	84.2%	2.8%
	Leominster	3.0%	5.9%	13.9%	70.8%	6.4%
	Lunenburg	1.0%	1.8%	3.9%	89.0%	4.3%
	Princeton	0.0%	0.2%	2.4%	93.5%	3.8%
	Sterling	0.3%	0.7%	3.4%	94.6%	1.0%
	Townsend	3.3%	3.1%	4.1%	86.8%	2.7%
	Westminster	0.6%	0.0%	1.5%	97.0%	0.9%
	Area Estimate	**2.2%**	**3.5%**	**13.6%**	**76.7%**	**4.0%**
Heywood Hospital	Ashburnham	0.9%	0.8%	3.9%	90.2%	4.3%
	Gardner	3.2%	1.8%	8.3%	83.6%	3.0%
	Hubbardston	2.5%	2.8%	2.8%	89.2%	2.6%
	Templeton	0.9%	0.2%	1.9%	95.6%	1.4%
	Westminster	0.6%	0.0%	1.5%	97.0%	0.9%
	Winchendon	4.2%	1.3%	3.9%	84.2%	6.4%
	Area Estimate	**2.4%**	**1.2%**	**4.8%**	**88.4%**	**3.2%**
Athol Hospital	Athol	0.7%	0.5%	6.4%	88.6%	3.8%
	Erving	0.0%	1.2%	3.4%	91.6%	3.8%
	New Salem	0.9%	0.0%	1.8%	79.1%	18.2%
	Orange	0.7%	1.0%	5.0%	90.7%	2.6%
	Petersham	1.0%	0.0%	3.5%	90.1%	5.4%
	Phillipston	0.0%	0.3%	0.8%	97.7%	1.3%
	Royalston	0.1%	0.0%	0.0%	96.6%	3.2%
	Warwick	1.1%	0.0%	1.0%	95.8%	2.1%
	Wendell	2.1%	5.7%	4.3%	84.1%	3.9%
	Area Estimate	**0.7%**	**0.7%**	**4.6%**	**90.2%**	**3.8%**
Additional Geographies	**Combined Service Area**	**2.1%**	**3.0%**	**11.6%**	**79.4%**	**3.9%**
	Worcester County	5.1%	4.7%	12.5%	73.4%	4.2%
	Franklin County	1.8%	1.1%	4.6%	88.9%	3.5%
	Massachusetts	6.9%	6.6%	12.6%	68.9%	5.0%
	United States	5.7%	12.1%	18.7%	58.9%	4.7%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 5. Percent People of Color, 2018-2022

	Community	People of Color
Health Alliance-Clinton Hospital	Ashburnham	9.8%
	Ashby	4.8%
	Bolton	15.2%
	Clinton	22.0%
	Fitchburg	42.0%
	Gardner	16.4%
	Harvard	21.9%
	Lancaster	15.8%
	Leominster	29.2%
	Lunenburg	11.0%
	Princeton	6.5%
	Sterling	5.4%
	Townsend	13.2%
	Westminster	3.0%
	Area Estimate	**23.3%**
Heywood Hospital	Ashburnham	9.8%
	Gardner	16.4%
	Hubbardston	10.8%
	Templeton	4.4%
	Westminster	3.0%
	Winchendon	15.8%
	Area Estimate	**11.6%**
Athol Hospital	Athol	11.4%
	Erving	8.4%
	New Salem	20.9%
	Orange	9.3%
	Petersham	9.9%
	Phillipston	2.3%
	Royalston	3.4%
	Warwick	4.2%
	Wendell	15.9%
	Area Estimate	**9.8%**
Additional Geographies	**Combined Service Area**	**20.6%**
	Worcester County	26.6%
	Franklin County	11.1%
	Massachusetts	31.1%
	United States	41.1%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 6. Percent Foreign Born, 2018-2022

	Community	Foreign Born
Health Alliance-Clinton Hospital	Ashburnham	2.9%
	Ashby	3.9%
	Bolton	11.7%
	Clinton	14.9%
	Fitchburg	10.2%
	Gardner	8.6%
	Harvard	10.9%
	Lancaster	6.8%
	Leominster	14.7%
	Lunenburg	4.7%
	Princeton	3.6%
	Sterling	3.9%
	Townsend	4.6%
	Westminster	2.0%
	Area Estimate	**9.7%**
Heywood Hospital	Ashburnham	2.9%
	Gardner	8.6%
	Hubbardston	5.0%
	Templeton	1.0%
	Westminster	2.0%
	Winchendon	4.5%
	Area Estimate	**5.0%**
Athol Hospital	Athol	4.0%
	Erving	2.3%
	New Salem	2.7%
	Orange	4.2%
	Petersham	2.4%
	Phillipston	0.6%
	Royalston	1.2%
	Warwick	3.1%
	Wendell	3.3%
	Area Estimate	**3.4%**
Additional Geographies	**Combined Service Area**	**8.3%**
	Worcester County	13.4%
	Franklin County	5.0%
	Massachusetts	17.6%
	United States	13.7%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 7. Top Countries of Origin (of Foreign Born), 2018-2022

Health Alliance-Clinton Hospital		
Total Foreign Born	18,631	-
Brazil	2,151	11.5%
Canada	2,003	10.8%
Uruguay	1,382	7.4%
Dominican Republic	1,176	6.3%
India	589	3.2%
Heywood Hospital		
Total Foreign Born	2,935	-
Canada	930	31.7%
Laos	313	10.7%
India	176	6.0%
Egypt	96	3.3%
Dominican Republic	81	2.8%
Athol Hospital		
Total Foreign Born	973	-
Canada	187	19.2%
Argentina	148	15.2%
Germany	68	7.0%
Colombia	67	6.9%
United Kingdom	53	5.4%
Combined Service Area		
Total Foreign Born	22,539	-
Canada	3,120	13.8%
Brazil	2,191	9.7%
Uruguay	1,539	6.8%
Dominican Republic	1,257	5.6%
India	806	3.6%
Massachusetts		
Total Foreign Born	1,227,846	-
China	120,039	9.8%
Dominican Republic	101,767	8.3%
Brazil	92,959	7.6%
India	82,934	6.8%
Haiti	60,432	4.9%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 8. Percent Population That Speaks Only English and Percent Population That Speaks Language Other Than English, 2018-2022

	Community	Only English	Language Other than English
Health Alliance-Clinton Hospital	Ashburnham	95.9%	4.1%
	Ashby	96.5%	3.5%
	Bolton	87.6%	12.4%
	Clinton	78.7%	21.3%
	Fitchburg	71.3%	28.7%
	Gardner	88.2%	11.8%
	Harvard	81.1%	18.9%
	Lancaster	87.6%	12.4%
	Leominster	78.3%	21.7%
	Lunenburg	92.0%	8.0%
	Princeton	95.9%	4.1%
	Sterling	96.3%	3.7%
	Townsend	93.5%	6.5%
	Westminster	96.4%	3.6%
	Area Estimate	**83.0%**	**17.0%**
Heywood Hospital	Ashburnham	95.9%	4.1%
	Gardner	88.2%	11.8%
	Hubbardston	95.0%	5.0%
	Templeton	97.7%	2.3%
	Westminster	96.4%	3.6%
	Winchendon	91.0%	9.0%
	Area Estimate	**92.5%**	**7.5%**
Athol Hospital	Athol	92.1%	7.9%
	Erving	96.4%	3.6%
	New Salem	96.6%	3.4%
	Orange	94.8%	5.2%
	Petersham	97.0%	3.0%
	Phillipston	99.0%	1.0%
	Royalston	99.0%	1.0%
	Warwick	96.2%	3.8%
	Wendell	96.3%	3.7%
	Area Estimate	**94.5%**	**5.5%**
Additional Geographies	**Combined Service Area**	**85.4%**	**14.6%**
	Worcester County	78.8%	21.2%
	Franklin County	93.5%	6.5%
	Massachusetts	75.5%	24.5%
	United States	78.3%	21.7%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 9. Languages Spoken, 2018-2022 (table continued below)

	Community	Spanish	French, Haitian, or Cajun	German or other West Germanic languages	Russian, Polish, or other Slavic languages	Other Indo-European languages	Korean
Health Alliance-Clinton Hospital	Ashburnham	0.6%	0.9%	0.3%	0.0%	2.2%	0.0%
	Ashby	0.0%	0.4%	1.4%	0.0%	0.8%	0.0%
	Bolton	1.2%	0.0%	0.3%	0.3%	5.8%	0.2%
	Clinton	11.1%	0.2%	0.4%	0.2%	7.0%	0.4%
	Fitchburg	22.3%	2.2%	0.4%	0.0%	1.0%	0.1%
	Gardner	4.9%	3.6%	0.1%	0.1%	0.7%	0.4%
	Harvard	10.4%	2.6%	0.4%	0.4%	2.2%	0.0%
	Lancaster	6.6%	0.2%	0.0%	0.0%	4.0%	0.0%
	Leominster	10.3%	1.2%	0.2%	0.7%	4.8%	0.2%
	Lunenburg	2.4%	0.7%	0.0%	0.6%	3.2%	0.2%
	Princeton	1.3%	1.2%	0.6%	0.0%	0.7%	0.0%
	Sterling	0.0%	0.2%	0.0%	0.0%	3.5%	0.0%
	Townsend	1.1%	0.3%	0.0%	0.0%	2.3%	0.0%
	Westminster	1.6%	0.4%	0.0%	0.0%	1.3%	0.0%
	Area Estimate	**9.6%**	**1.4%**	**0.2%**	**0.2%**	**3.0%**	**0.2%**
Heywood Hospital	Ashburnham	0.6%	0.9%	0.3%	0.0%	2.2%	0.0%
	Gardner	4.9%	3.6%	0.1%	0.1%	0.7%	0.4%
	Hubbardston	0.8%	1.8%	0.2%	0.2%	1.7%	0.0%
	Templeton	0.4%	0.9%	0.0%	0.0%	0.6%	0.0%
	Westminster	1.6%	0.4%	0.0%	0.0%	1.3%	0.0%
	Winchendon	2.2%	0.6%	0.1%	0.4%	0.2%	0.0%
	Area Estimate	**2.6%**	**1.8%**	**0.1%**	**0.1%**	**0.9%**	**0.1%**
Athol Hospital	Athol	4.1%	1.5%	0.5%	0.0%	0.4%	0.0%
	Erving	0.5%	1.0%	0.0%	0.2%	0.8%	0.0%
	New Salem	1.6%	0.3%	0.0%	0.6%	0.0%	0.9%
	Orange	3.6%	0.6%	0.0%	0.3%	0.0%	0.0%
	Petersham	0.4%	0.5%	0.6%	0.0%	0.3%	0.0%
	Phillipston	0.3%	0.7%	0.0%	0.0%	0.0%	0.0%
	Royalston	0.3%	0.4%	0.0%	0.0%	0.3%	0.0%
	Warwick	0.6%	0.4%	0.0%	0.6%	1.8%	0.0%
	Wendell	0.5%	0.2%	0.0%	0.0%	0.0%	0.0%
	Area Estimate	**2.9%**	**1.0%**	**0.2%**	**0.1%**	**0.3%**	**0.0%**
Additional Geographies	**Combined Service Area**	**8.0%**	**1.3%**	**0.2%**	**0.2%**	**2.4%**	**0.1%**
	Worcester County	9.1%	1.1%	0.3%	0.9%	4.5%	0.1%
	Franklin County	2.8%	0.4%	0.3%	0.4%	1.2%	0.1%
	Massachusetts	9.5%	2.0%	0.3%	1.0%	5.8%	0.3%
	United States	13.3%	0.7%	0.5%	0.7%	1.9%	0.3%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 10. Languages Spoken, 2018-2022 (continued from table above)

	Community	Korean	Chinese	Vietnamese	Tagalog	Other Asian and Pacific Island languages	Arabic	Other and unspecified languages
Health Alliance-Clinton Hospital	Ashburnham	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Ashby	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.8%
	Bolton	0.2%	3.6%	0.0%	0.2%	0.2%	0.0%	0.5%
	Clinton	0.4%	0.9%	0.2%	0.0%	0.0%	0.0%	0.9%
	Fitchburg	0.1%	0.1%	0.2%	0.1%	1.0%	0.2%	1.2%
	Gardner	0.4%	0.0%	0.2%	0.1%	1.2%	0.4%	0.2%
	Harvard	0.0%	1.6%	0.0%	0.9%	0.2%	0.2%	0.1%
	Lancaster	0.0%	0.2%	0.0%	0.2%	0.3%	0.2%	0.6%
	Leominster	0.2%	0.5%	0.2%	0.2%	0.7%	0.2%	2.3%
	Lunenburg	0.2%	0.0%	0.0%	0.0%	0.2%	0.5%	0.2%
	Princeton	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
	Sterling	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Townsend	0.0%	0.5%	1.8%	0.0%	0.1%	0.0%	0.4%
	Westminster	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%
	Area Estimate	**0.2%**	**0.4%**	**0.2%**	**0.1%**	**0.5%**	**0.2%**	**1.0%**
Heywood Hospital	Ashburnham	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Gardner	0.4%	0.0%	0.2%	0.1%	1.2%	0.4%	0.2%
	Hubbardston	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
	Templeton	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%
	Westminster	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%
	Winchendon	0.0%	0.5%	0.0%	0.1%	3.7%	1.1%	0.1%
	Area Estimate	**0.1%**	**0.1%**	**0.1%**	**0.0%**	**1.1%**	**0.3%**	**0.2%**
Athol Hospital	Athol	0.0%	0.2%	0.1%	0.0%	0.5%	0.0%	0.5%
	Erving	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.5%
	New Salem	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Orange	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.2%
	Petersham	0.0%	0.0%	0.6%	0.3%	0.3%	0.0%	0.0%
	Phillipston	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Royalston	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Warwick	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%
	Wendell	0.0%	0.0%	0.0%	2.1%	1.0%	0.0%	0.0%
	Area Estimate	**0.0%**	**0.1%**	**0.1%**	**0.1%**	**0.4%**	**0.0%**	**0.3%**
Additional Geographies	**Combined Service Area**	**0.1%**	**0.3%**	**0.2%**	**0.1%**	**0.6%**	**0.2%**	**0.8%**
	Worcester County	0.1%	0.9%	0.8%	0.1%	1.2%	0.7%	1.6%
	Franklin County	0.1%	0.6%	0.1%	0.1%	0.4%	0.0%	0.3%
	Massachusetts	0.3%	2.1%	0.7%	0.1%	1.2%	0.6%	0.9%
	United States	0.3%	1.1%	0.5%	0.6%	1.0%	0.4%	0.8%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 11. Percent Population Lacking Proficiency in English (Of People Who Speak A Language other than English), 2018-2022

	Community	Lacking Proficiency in English (Of People Who Speak A Language other than English)
Health Alliance-Clinton Hospital	Ashburnham	0.4%
	Ashby	0.0%
	Bolton	17.6%
	Clinton	38.8%
	Fitchburg	34.8%
	Gardner	29.3%
	Harvard	32.5%
	Lancaster	23.7%
	Leominster	37.3%
	Lunenburg	37.2%
	Princeton	16.9%
	Sterling	29.8%
	Townsend	17.6%
	Westminster	24.0%
	Area Estimate	**34.2%**
Heywood Hospital	Ashburnham	0.4%
	Gardner	29.3%
	Hubbardston	10.9%
	Templeton	0.0%
	Westminster	24.0%
	Winchendon	20.2%
	Area Estimate	**23.2%**
Athol Hospital	Athol	28.8%
	Erving	26.8%
	New Salem	19.4%
	Orange	33.2%
	Petersham	68.6%
	Phillipston	0.0%
	Royalston	0.0%
	Warwick	26.7%
	Wendell	58.1%
	Area Estimate	**30.5%**
Additional Geographies	**Combined Service Area**	**33.4%**
	Worcester County	36.8%
	Franklin County	37.7%
	Massachusetts	39.2%
	United States	37.9%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 12. Percent Population with a Disability, by Age, 2018-2022

	Community	Under 5 years	5 to 17 years	18 to 34 years	35 to 64 years	65 to 74 years	75 years and over
Health Alliance-Clinton Hospital	Ashburnham	0.0%	4.3%	6.1%	4.7%	11.7%	39.0%
	Ashby	0.0%	0.0%	2.9%	7.0%	19.1%	21.8%
	Bolton	0.0%	1.7%	0.9%	4.9%	6.8%	37.6%
	Clinton	0.0%	6.9%	3.7%	14.4%	9.5%	56.5%
	Fitchburg	0.9%	9.2%	11.1%	16.5%	21.8%	56.5%
	Gardner	0.0%	11.2%	13.0%	15.4%	19.6%	39.9%
	Harvard	0.4%	1.3%	0.2%	4.7%	10.7%	43.9%
	Lancaster	0.0%	10.4%	6.4%	7.0%	20.8%	31.8%
	Leominster	4.5%	3.1%	6.9%	13.4%	17.7%	55.6%
	Lunenburg	0.0%	6.7%	4.1%	10.7%	22.3%	45.0%
	Princeton	0.0%	0.9%	2.6%	5.0%	13.5%	9.7%
	Sterling	0.0%	15.4%	5.0%	7.7%	14.3%	55.2%
	Townsend	0.0%	4.3%	6.6%	10.8%	19.5%	35.4%
	Westminster	9.3%	3.3%	5.5%	3.6%	7.5%	39.8%
Heywood Hospital	Ashburnham	0.0%	4.3%	6.1%	4.7%	11.7%	39.0%
	Gardner	0.0%	11.2%	13.0%	15.4%	19.6%	39.9%
	Hubbardston	2.8%	9.8%	6.3%	9.8%	18.0%	31.2%
	Templeton	0.0%	2.4%	5.3%	9.4%	28.3%	30.9%
	Westminster	9.3%	3.3%	5.5%	3.6%	7.5%	39.8%
	Winchendon	0.0%	7.2%	13.8%	12.3%	15.2%	41.0%
Athol Hospital	Athol	3.3%	6.8%	18.1%	18.6%	31.7%	43.8%
	Erving	0.0%	7.0%	9.9%	16.3%	20.3%	56.6%
	New Salem	0.0%	10.1%	4.5%	13.2%	14.0%	53.3%
	Orange	3.6%	20.5%	18.5%	19.2%	34.1%	47.9%
	Petersham	0.0%	8.1%	1.1%	10.2%	11.8%	31.4%
	Phillipston	14.8%	0.0%	5.9%	12.1%	36.9%	38.4%
	Royalston	12.1%	3.4%	2.6%	11.5%	22.7%	41.7%
	Warwick	0.0%	10.1%	10.9%	7.1%	29.2%	37.9%
	Wendell	0.0%	0.0%	2.5%	13.7%	21.4%	62.1%
Additional Geographies	Worcester County	1.0%	5.7%	8.3%	11.8%	21.0%	47.6%
	Franklin County	0.9%	10.9%	10.4%	14.2%	23.4%	50.6%
	Massachusetts	0.8%	6.3%	6.8%	10.5%	20.1%	45.8%
	United States	0.7%	5.9%	7.2%	12.4%	24.1%	46.9%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 13. Veteran Population, 2018-2022

	Community	Number of Veterans	Percent Veterans
Health Alliance-Clinton Hospital	Ashburnham	252	5.0%
	Ashby	124	4.6%
	Bolton	197	4.8%
	Clinton	551	4.3%
	Fitchburg	1,838	5.6%
	Gardner	1,262	7.3%
	Harvard	259	4.9%
	Lancaster	331	4.8%
	Leominster	2,318	6.6%
	Lunenburg	533	5.9%
	Princeton	138	5.0%
	Sterling	585	9.0%
	Townsend	364	5.1%
	Westminster	599	9.1%
	Area Estimate	**9,351**	**6.0%**
Heywood Hospital	Ashburnham	252	5.0%
	Gardner	1,262	7.3%
	Hubbardston	293	8.5%
	Templeton	515	8.1%
	Westminster	599	9.1%
	Winchendon	653	8.1%
	Area Estimate	**3,574**	**7.6%**
Athol Hospital	Athol	793	8.3%
	Erving	80	6.1%
	New Salem	72	7.8%
	Orange	582	9.7%
	Petersham	67	6.6%
	Phillipston	115	7.4%
	Royalston	51	4.6%
	Warwick	67	9.5%
	Wendell	22	3.0%
	Area Estimate	**1,849**	**8.1%**
Additional Geographies	**Combined Service Area**	**12,661**	**6.5%**
	Worcester County	38,883	5.7%
	Franklin County	4,433	7.5%
	Massachusetts	266,304	4.7%
	United States	17,038,807	6.6%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 14. Percent Veterans in Poverty and Percent Veterans with Disability, 2018-2022

	Community	Veterans in Poverty (Income in the past 12 months below Poverty Level)	Veterans With Any Disability
Health Alliance-Clinton Hospital	Ashburnham	23.0%	5.2%
	Ashby	0.0%	9.7%
	Bolton	0.0%	17.8%
	Clinton	2.9%	34.5%
	Fitchburg	4.4%	30.6%
	Gardner	6.9%	28.3%
	Harvard	7.0%	11.0%
	Lancaster	0.0%	19.8%
	Leominster	5.4%	36.4%
	Lunenburg	0.0%	29.8%
	Princeton	6.5%	0.0%
	Sterling	9.4%	24.8%
	Townsend	3.8%	16.2%
	Westminster	0.0%	8.7%
	Area Estimate	**4.9%**	**27.1%**
Heywood Hospital	Ashburnham	23.0%	5.2%
	Gardner	6.9%	28.3%
	Hubbardston	3.1%	16.4%
	Templeton	0.0%	32.4%
	Westminster	0.0%	8.7%
	Winchendon	12.4%	27.3%
	Area Estimate	**6.6%**	**22.7%**
Athol Hospital	Athol	6.0%	45.9%
	Erving	5.0%	28.8%
	New Salem	8.3%	34.7%
	Orange	4.0%	38.8%
	Petersham	3.0%	41.8%
	Phillipston	0.0%	27.8%
	Royalston	0.0%	17.6%
	Warwick	6.0%	20.9%
	Wendell	13.6%	81.8%
	Area Estimate	**4.8%**	**39.9%**
Additional Geographies	**Combined Service Area**	**5.1%**	**29.0%**
	Worcester County	6.1%	27.7%
	Franklin County	5.8%	39.7%
	Massachusetts	6.2%	29.1%
	United States	7.0%	29.8%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 15. Veteran Median Income and Veteran Unemployment Rate, 2018-2022

	Community	Veterans Median Income ($)	Veterans Unemployment Rate
Health Alliance-Clinton Hospital	Ashburnham	-	0.0%
	Ashby	75,238	0.0%
	Bolton	78,333	7.6%
	Clinton	58,033	0.0%
	Fitchburg	51,331	1.3%
	Gardner	41,906	2.4%
	Harvard	-	0.0%
	Lancaster	75,043	0.0%
	Leominster	51,938	0.1%
	Lunenburg	61,806	0.0%
	Princeton	117,917	0.0%
	Sterling	26,753	41.4%
	Townsend	77,750	3.1%
	Westminster	38,948	0.0%
Heywood Hospital	Ashburnham	-	0.0%
	Gardner	41,906	2.4%
	Hubbardston	60,536	0.0%
	Templeton	65,625	8.7%
	Westminster	38,948	0.0%
	Winchendon	34,875	3.3%
Athol Hospital	Athol	35,039	0.0%
	Erving	35,000	23.1%
	New Salem	31,875	0.0%
	Orange	48,922	0.0%
	Petersham	-	0.0%
	Phillipston	71,944	5.5%
	Royalston	70,208	17.4%
	Warwick	-	3.1%
	Wendell	76,250	-
Additional Geographies	Worcester County	49,885	4.5%
	Franklin County	40,576	3.7%
	Massachusetts	54,357	3.8%
	United States	50,397	4.2%

Trends

Table 16. Population Projections, 2020-2050

Community	2020	2025	2030	2035	2040	2045	2050
Health Alliance-Clinton Hospital Area	171,198	183,855	180,959	178,481	175,074	170,447	164,948
Heywood Hospital Area	53,529	56,044	55,530	55,122	54,264	52,909	51,290
Athol Hospital Area	27,203	27,312	27,277	27,087	26,553	25,797	24,918
Combined Service Area	251,930	267,211	263,766	260,690	255,891	249,153	241,156
Worcester County	862,123	865,117	869,335	870,289	866,858	859,669	850,686
Franklin County	71,032	69,559	67,382	64,317	60,666	56,794	52,999
Massachusetts	7,029,933	7,106,597	7,195,346	7,242,935	7,263,082	7,271,709	7,267,961

Sources: University of Massachusetts, Donahue Institute, 2024

Table 17. Projected Change in Population, 2020-2050

Community	Change in 10 year increments			% Change in ten year increments		
	2020-2030	2030-2040	2040-2050	2020-2030	2030-2040	2040-2050
Health Alliance-Clinton Hospital Area	9,761	-5,885	-10,126	5.7%	-3.3%	-5.8%
Heywood Hospital Area	74	-724	-1,635	0.3%	-2.7%	-6.2%
Athol Hospital Area	2,001	-1,266	-2,974	3.7%	-2.3%	-5.5%
Combined Service Area	11,836	-7,875	-14,735	4.7%	-3.0%	-5.8%
Worcester County	7,212	-2,477	-16,172	0.8%	-0.3%	-1.9%
Franklin County	-3,650	-6,716	-7,667	-5.1%	-10.0%	-12.6%
Massachusetts	165,413	67,736	4,879	2.4%	0.9%	0.1%

Sources: University of Massachusetts, Donahue Institute, 2024

Table 18. 0-19 Population Projections, 2020-2050

Community	2020	2025	2030	2035	2040	2045	2050
Health Alliance-Clinton Hospital Area	44,668	41,387	39,428	37,472	35,304	33,474	32,009
Heywood Hospital Area	13,284	12,278	11,869	11,388	10,789	10,216	9,723
Athol Hospital Area	6,079	5,720	5,504	5,224	4,955	4,689	4,475
Combined Service Area	56,022	52,080	49,949	47,671	45,075	42,756	40,893
Worcester County	202,366	192,370	190,599	188,172	184,632	179,106	175,016
Franklin County	13,504	12,360	11,240	10,096	9,173	8,389	7,665
Massachusetts	1,583,501	1,540,008	1,543,469	1,537,556	1,532,573	1,510,960	1,495,617

Sources: University of Massachusetts, Donahue Institute, 2024

Table 19. 0-19 Projected Change in Population, 2020-2050

Community	Change in 10 year increments			% Change in ten year increments		
	2020-2030	2030-2040	2040-2050	2020-2030	2030-2040	2040-2050
Health Alliance-Clinton Hospital Area	-5,240	-4,124	-3,295	-11.7%	-10.5%	-9.3%
Heywood Hospital Area	-575	-549	-480	-4.3%	-4.6%	-4.4%
Athol Hospital Area	-1,415	-1,080	-1,066	-23.3%	-19.6%	-21.5%
Combined Service Area	-6,073	-4,874	-4,182	-10.8%	-9.8%	-9.3%
Worcester County	-11,767	-5,967	-9,616	-5.8%	-3.1%	-5.2%
Franklin County	-2,264	-2,067	-1,508	-16.8%	-18.4%	-16.4%
Massachusetts	-40,032	-10,896	-36,956	-2.5%	-0.7%	-2.4%

Sources: University of Massachusetts, Donahue Institute, 2024

Table 20. 65+ Population Projections, 2020-2050

Community	2020	2025	2030	2035	2040	2045	2050
Health Alliance-Clinton Hospital Area	32,287	37,732	42,354	43,763	42,956	41,270	40,175
Heywood Hospital Area	10,013	11,991	13,790	14,495	14,401	13,795	13,259
Athol Hospital Area	5,439	6,442	7,216	7,333	7,079	6,733	6,588
Combined Service Area	41,554	48,943	55,323	57,379	56,449	54,194	52,723
Worcester County	139,432	163,851	186,225	198,429	201,898	198,477	196,653
Franklin County	16,412	18,988	20,462	20,261	19,070	17,484	16,467
Massachusetts	1,195,205	1,382,209	1,542,433	1,621,989	1,628,882	1,597,112	1,588,056

Sources: University of Massachusetts, Donahue Institute, 2024

Table 21. 65+ Projected Change in Population, 2020-2050

Community	Change in 10 year increments			% Change in ten year increments		
	2020-2030	2030-2040	2040-2050	2020-2030	2030-2040	2040-2050
Health Alliance-Clinton Hospital Area	10,067	602	-2,781	31.2%	1.4%	-6.5%
Heywood Hospital Area	1,777	-137	-491	17.7%	-1.0%	-3.4%
Athol Hospital Area	3,777	611	-1,142	69.4%	8.5%	-16.1%
Combined Service Area	13,769	1,126	-3,726	33.1%	2.0%	-6.6%
Worcester County	46,793	15,673	-5,245	33.6%	8.4%	-2.6%
Franklin County	4,050	-1,392	-2,603	24.7%	-6.8%	-13.6%
Massachusetts	347,228	86,449	-40,826	29.1%	5.6%	-2.5%

Sources: University of Massachusetts, Donahue Institute, 2024

Table 22. Percent of People of Color, 2013-2017 and 2018-2022

	Community	2013-2017	2018-2022
Health Alliance-Clinton Hospital	Ashburnham	5.0%	9.8%
	Ashby	5.1%	4.8%
	Bolton	9.8%	15.2%
	Clinton	21.5%	22.0%
	Fitchburg	35.7%	42.0%
	Gardner	14.7%	16.4%
	Harvard	16.9%	21.9%
	Lancaster	14.8%	15.8%
	Leominster	28.4%	29.2%
	Lunenburg	12.5%	11.0%
	Princeton	7.5%	6.5%
	Sterling	8.4%	5.4%
	Townsend	6.3%	13.2%
	Westminster	4.1%	3.0%
	Area Estimate	**20.9%**	**23.3%**
Heywood Hospital	Ashburnham	5.0%	9.8%
	Gardner	14.7%	16.4%
	Hubbardston	6.1%	10.8%
	Templeton	3.8%	4.4%
	Westminster	4.1%	3.0%
	Winchendon	7.7%	15.8%
	Area Estimate	**8.7%**	**11.6%**
Athol Hospital	Athol	9.4%	11.4%
	Erving	5.0%	8.4%
	New Salem	4.0%	20.9%
	Orange	4.5%	9.3%
	Petersham	4.2%	9.9%
	Phillipston	6.5%	2.3%
	Royalston	3.0%	3.4%
	Warwick	4.3%	4.2%
	Wendell	7.9%	15.9%
	Area Estimate	**6.7%**	**9.8%**
Additional Geographies	**Combined Service Area**	**17.8%**	**20.6%**
	Worcester County	22.1%	26.6%
	Franklin County	8.8%	11.1%
	Massachusetts	27.1%	31.1%
	United States	38.5%	41.1%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Poverty

Table 23. Percent Individuals in Poverty, 2018-2022

	Community	100% Federal Poverty Level	200% Federal Poverty Level
Health Alliance-Clinton Hospital	Ashburnham	7.9%	11.8%
	Ashby	2.9%	13.4%
	Bolton	2.4%	6.8%
	Clinton	6.0%	19.1%
	Fitchburg	13.9%	33.2%
	Gardner	14.8%	34.0%
	Harvard	4.3%	7.3%
	Lancaster	3.1%	8.8%
	Leominster	9.1%	24.4%
	Lunenburg	7.2%	14.4%
	Princeton	3.9%	8.9%
	Sterling	2.5%	9.7%
	Townsend	7.6%	15.1%
	Westminster	3.4%	13.3%
	Area Estimate	**8.9%**	22.1%
Heywood Hospital	Ashburnham	7.9%	11.8%
	Gardner	14.8%	34.0%
	Hubbardston	7.5%	13.5%
	Templeton	4.9%	20.9%
	Westminster	3.4%	13.3%
	Winchendon	11.1%	24.4%
	Area Estimate	**9.8%**	**23.5%**
Athol Hospital	Athol	11.1%	28.6%
	Erving	8.1%	25.5%
	New Salem	10.1%	20.7%
	Orange	20.5%	39.6%
	Petersham	6.5%	19.3%
	Phillipston	4.6%	15.1%
	Royalston	11.2%	18.8%
	Warwick	6.7%	15.7%
	Wendell	15.1%	26.4%
	Area Estimate	**12.8%**	**28.8%**
Additional Geographies	**Combined Service Area**	**9.3%**	**22.8%**
	Worcester County	10.0%	22.3%
	Franklin County	12.0%	27.5%
	Massachusetts	9.9%	21.4%
	United States	12.5%	28.8%

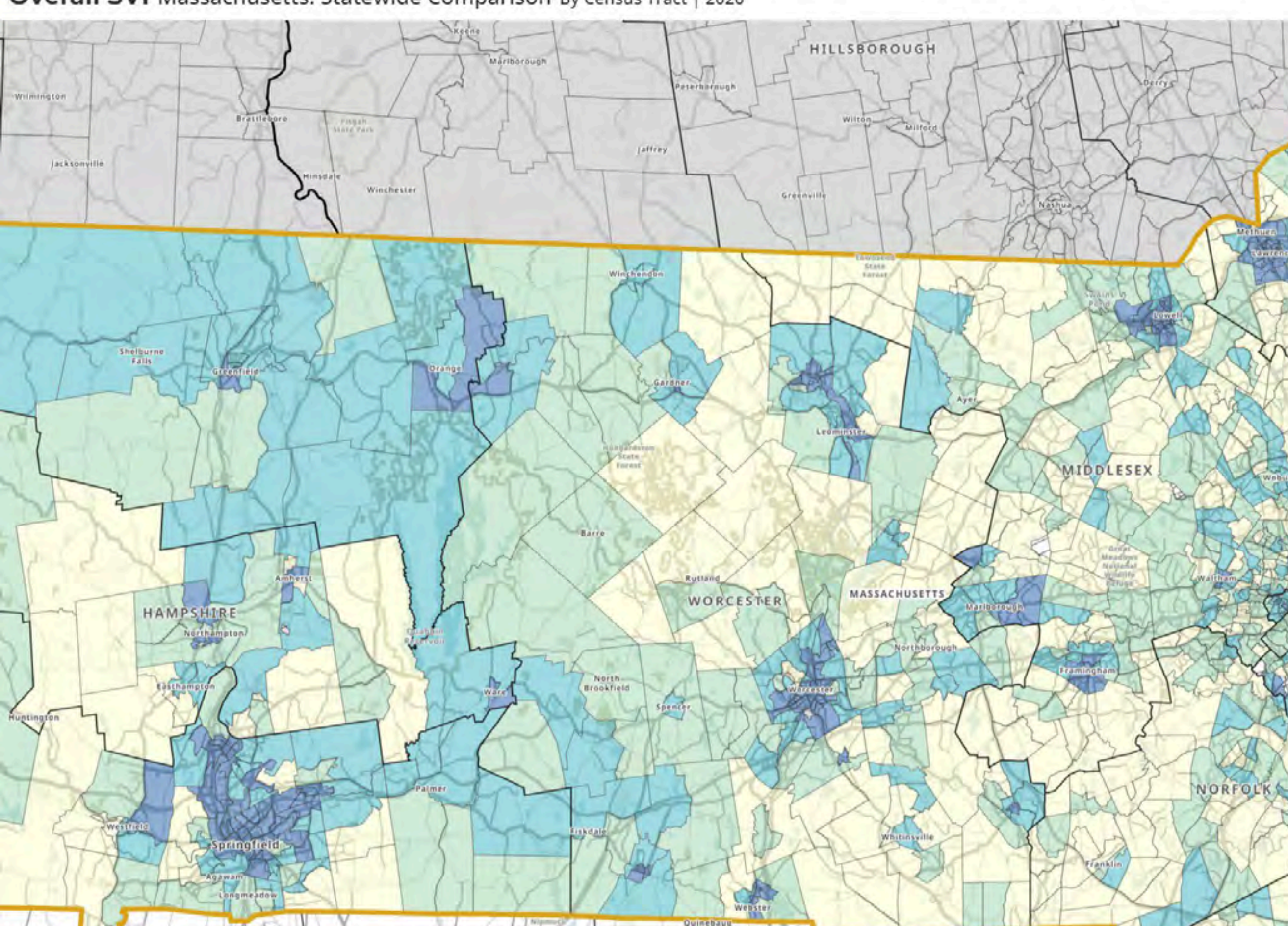
Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 24. Gini Index, 2018-2022

	Community	Gini Index
Health Alliance-Clinton Hospital	Ashburnham	0.35
	Ashby	0.38
	Bolton	0.36
	Clinton	0.38
	Fitchburg	0.43
	Gardner	0.44
	Harvard	0.49
	Lancaster	0.37
	Leominster	0.44
	Lunenburg	0.40
	Princeton	0.43
	Sterling	0.45
	Townsend	0.39
	Westminster	0.41
	Area Estimate	**0.41**
Heywood Hospital	Ashburnham	0.35
	Gardner	0.44
	Hubbardston	0.36
	Templeton	0.37
	Westminster	0.41
	Winchendon	0.41
	Area Estimate	**0.39**
Athol Hospital	Athol	0.39
	Erving	0.44
	New Salem	0.40
	Orange	0.42
	Petersham	0.37
	Phillipston	0.34
	Royalston	0.34
	Warwick	0.36
	Wendell	0.41
	Area Estimate	**0.39**
Additional Geographies	Combined Service Area	**0.40**
	Worcester County	0.46
	Franklin County	0.44
	Massachusetts	0.49
	United States	0.48

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Figure 1. Social Vulnerability Index



Sources: Center for Disease Control, Agency for Toxic Substances and Disease Registry, Social Vulnerability Index, 2020

Table 25. Percent Population Under 18 in Poverty, 2018-2022

	Community	Under 18 years in Poverty
Health Alliance-Clinton Hospital	Ashburnham	12.8%
	Ashby	3.0%
	Bolton	0.0%
	Clinton	5.4%
	Fitchburg	16.4%
	Gardner	27.1%
	Harvard	2.0%
	Lancaster	3.2%
	Leominster	12.1%
	Lunenburg	11.3%
	Princeton	3.1%
	Sterling	0.0%
	Townsend	4.7%
	Westminster	0.9%
	Area Estimate	**11.1%**
Heywood Hospital	Ashburnham	12.8%
	Gardner	27.1%
	Hubbardston	12.4%
	Templeton	1.8%
	Westminster	0.9%
	Winchendon	19.6%
	Area Estimate	**15.3%**
Athol Hospital	Athol	9.3%
	Erving	3.4%
	New Salem	31.3%
	Orange	40.7%
	Petersham	2.1%
	Phillipston	0.0%
	Royalston	18.2%
	Warwick	9.3%
	Wendell	9.5%
	Area Estimate	**18.3%**
Additional Geographies	**Combined Service Area**	**12.0%**
	Worcester County	11.8%
	Franklin County	17.5%
	Massachusetts	11.8%
	United States	16.7%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 26. Percent Population 65 and Over in Poverty, 2018-2022

	Community	65+ in Poverty
Health Alliance-Clinton Hospital	Ashburnham	5.1%
	Ashby	6.1%
	Bolton	8.5%
	Clinton	7.6%
	Fitchburg	13.0%
	Gardner	9.1%
	Harvard	4.9%
	Lancaster	7.1%
	Leominster	4.9%
	Lunenburg	5.5%
	Princeton	3.1%
	Sterling	1.6%
	Townsend	7.0%
	Westminster	6.0%
	Area Estimate	**7.2%**
Heywood Hospital	Ashburnham	5.1%
	Gardner	9.1%
	Hubbardston	7.2%
	Templeton	2.3%
	Westminster	6.0%
	Winchendon	10.4%
	Area Estimate	**7.3%**
Athol Hospital	Athol	6.1%
	Erving	5.1%
	New Salem	7.8%
	Orange	7.8%
	Petersham	8.1%
	Phillipston	16.7%
	Royalston	6.3%
	Warwick	3.2%
	Wendell	14.0%
	Area Estimate	**7.5%**
Additional Geographies	**Combined Service Area**	**7.2%**
	Worcester County	9.2%
	Franklin County	8.7%
	Massachusetts	9.9%
	United States	10.0%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 27. Percent People in Poverty, by Racial/Ethnic Categories, 2018-2022

	Community	White alone, not Hispanic or Latino in Poverty	People of Color (POC) in Poverty
Health Alliance-Clinton Hospital	Ashburnham	6.9%	16.9%
	Ashby	2.9%	2.6%
	Bolton	2.5%	1.5%
	Clinton	3.9%	13.6%
	Fitchburg	9.4%	20.1%
	Gardner	12.8%	25.9%
	Harvard	5.0%	0.8%
	Lancaster	1.9%	13.9%
	Leominster	8.7%	10.1%
	Lunenburg	7.8%	1.9%
	Princeton	1.8%	34.4%
	Sterling	1.7%	16.3%
	Townsend	8.2%	3.6%
	Westminster	3.5%	0.0%
	Area Estimate	**7.2%**	**14.9%**
Heywood Hospital	Ashburnham	6.9%	16.9%
	Gardner	12.8%	25.9%
	Hubbardston	4.3%	34.3%
	Templeton	5.1%	2.0%
	Westminster	3.5%	0.0%
	Winchendon	10.6%	13.8%
	Area Estimate	**8.5%**	**20.2%**
Athol Hospital	Athol	11.1%	11.4%
	Erving	7.1%	18.2%
	New Salem	3.4%	35.1%
	Orange	18.8%	37.4%
	Petersham	6.8%	2.9%
	Phillipston	4.8%	0.0%
	Royalston	10.2%	38.8%
	Warwick	6.9%	0.0%
	Wendell	16.3%	8.9%
	Area Estimate	**12.0%**	**20.0%**
Additional Geographies	**Combined Service Area**	**7.8%**	**15.2%**
	Worcester County	7.8%	16.2%
	Franklin County	9.8%	29.8%
	Massachusetts	7.0%	16.4%
	United States	9.2%	17.2%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Socioeconomics

Table 28. Total Labor Force, 2023

	Community	Total Labor Force
Health Alliance-Clinton Hospital	Ashburnham	3,685
	Ashby	1,910
	Bolton	3,182
	Clinton	8,297
	Fitchburg	19,441
	Gardner	9,693
	Harvard	2,810
	Lancaster	3,868
	Leominster	22,251
	Lunenburg	6,722
	Princeton	1,966
	Sterling	4,453
	Townsend	5,542
	Westminster	4,785
	Area Estimate	**98,605**
Heywood Hospital	Ashburnham	3,685
	Gardner	9,693
	Hubbardston	2,688
	Templeton	4,357
	Westminster	4,785
	Winchendon	5,627
	Area Estimate	**30,835**
Athol Hospital	Athol	5,847
	Erving	957
	New Salem	626
	Orange	3,562
	Petersham	685
	Phillipston	965
	Royalston	724
	Warwick	523
	Wendell	463
	Area Estimate	**14,352**
Additional Geographies	Combined Service Area	125,629
	Worcester County	440,698
	Franklin County	39,803
	Massachusetts	3,751,662
	United States	167,116,000

Sources: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2023

Table 29. Educational Attainment, 2018-2022

	Community	Less than 9th grade	9th to 12th grade, no diploma	High school graduate	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
Health Alliance-Clinton Hospital	Ashburnham	2.0%	2.5%	20.1%	21.4%	14.8%	25.0%	14.1%
	Ashby	2.1%	4.5%	28.7%	13.6%	9.7%	21.8%	19.7%
	Bolton	0.3%	0.5%	9.4%	7.8%	4.9%	36.1%	41.0%
	Clinton	1.9%	5.5%	25.8%	18.8%	11.0%	22.5%	14.5%
	Fitchburg	6.1%	7.6%	31.6%	21.9%	9.1%	16.2%	7.5%
	Gardner	4.0%	7.8%	34.2%	22.1%	12.6%	13.1%	6.3%
	Harvard	1.3%	3.8%	12.7%	12.8%	4.9%	36.0%	28.6%
	Lancaster	1.7%	4.6%	21.8%	15.3%	5.4%	33.4%	17.7%
	Leominster	4.2%	5.6%	28.3%	18.7%	10.1%	21.2%	11.9%
	Lunenburg	1.6%	3.3%	27.5%	16.0%	9.7%	25.8%	16.0%
	Princeton	0.3%	1.4%	11.2%	15.2%	8.3%	37.5%	26.2%
	Sterling	0.3%	2.8%	23.3%	16.9%	7.0%	31.2%	18.5%
	Townsend	1.7%	3.1%	27.1%	19.0%	11.4%	26.1%	11.7%
	Westminster	2.7%	3.6%	27.4%	14.5%	11.7%	21.3%	18.9%
	Area Estimate	**3.3%**	**5.3%**	**27.2%**	**18.6%**	**9.8%**	**22.2%**	**13.5%**
Heywood Hospital	Ashburnham	2.0%	2.5%	20.1%	21.4%	14.8%	25.0%	14.1%
	Gardner	4.0%	7.8%	34.2%	22.1%	12.6%	13.1%	6.3%
	Hubbardston	1.0%	3.7%	29.4%	21.5%	13.7%	20.0%	10.7%
	Templeton	4.3%	4.4%	26.8%	21.9%	13.6%	19.1%	9.9%
	Westminster	2.7%	3.6%	27.4%	14.5%	11.7%	21.3%	18.9%
	Winchendon	1.6%	5.3%	35.0%	22.6%	12.2%	14.9%	8.4%
	Area Estimate	**3.0%**	**5.5%**	**30.6%**	**20.9%**	**12.8%**	**17.1%**	**10.1%**
Athol Hospital	Athol	3.1%	7.2%	39.6%	20.6%	10.0%	13.9%	5.6%
	Erving	2.7%	4.7%	39.7%	20.3%	8.1%	16.6%	7.9%
	New Salem	2.3%	2.1%	28.1%	25.4%	12.4%	18.8%	10.8%
	Orange	2.4%	6.6%	42.6%	21.4%	10.0%	11.5%	5.5%
	Petersham	0.0%	3.3%	22.8%	23.8%	6.6%	20.3%	23.2%
	Phillipston	0.7%	7.3%	33.6%	19.7%	14.0%	17.2%	7.6%
	Royalston	1.2%	10.2%	34.9%	16.4%	12.5%	15.1%	9.7%
	Warwick	0.9%	2.5%	34.2%	16.6%	6.1%	26.3%	13.4%
	Wendell	0.3%	3.5%	23.9%	16.2%	8.1%	24.6%	23.2%
	Area Estimate	**2.3%**	**6.4%**	**37.8%**	**20.6%**	**10.1%**	**14.9%**	**7.9%**
Additional Geographies	**Combined Service Area**	**3.1%**	**5.4%**	**28.8%**	**19.1%**	**10.1%**	**20.9%**	**12.5%**
	Worcester County	3.4%	5.2%	26.7%	17.4%	9.0%	22.4%	16.0%
	Franklin County	1.8%	4.5%	27.0%	16.6%	10.3%	21.3%	18.5%
	Massachusetts	4.3%	4.5%	22.9%	14.8%	7.6%	25.1%	20.8%
	United States	4.7%	6.1%	26.4%	19.7%	8.7%	20.9%	13.4%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 30. Median Income, 2018-2022

	Community	Median Income ($)
Health Alliance-Clinton Hospital	Ashburnham	112,133
	Ashby	105,750
	Bolton	191,208
	Clinton	89,888
	Fitchburg	65,963
	Gardner	56,974
	Harvard	189,647
	Lancaster	111,506
	Leominster	75,620
	Lunenburg	106,138
	Princeton	163,750
	Sterling	131,058
	Townsend	105,662
	Westminster	95,674
	Area Estimate	**93,327**
Heywood Hospital	Ashburnham	112,133
	Gardner	56,974
	Hubbardston	114,922
	Templeton	101,768
	Westminster	95,674
	Winchendon	84,375
	Area Estimate	**86,464**
Athol Hospital	Athol	63,809
	Erving	70,560
	New Salem	75,951
	Orange	56,000
	Petersham	104,205
	Phillipston	90,625
	Royalston	98,542
	Warwick	89,643
	Wendell	66,815
	Area Estimate	**68,945**
Additional Geographies	**Combined Service Area**	**90,630**
	Worcester County	88,524
	Franklin County	70,383
	Massachusetts	96,505
	United States	75,149

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Housing

Table 31. Total Occupied Housing Units and Percent Households Occupied by Owners and Renters, 2018-2022

	Community	Total Occupied Housing Units	Owner-occupied Housing Units	% Owner-occupied Housing Units	Renter-occupied Housing Units	% Renter-occupied Housing Units
Health Alliance-Clinton Hospital	Ashburnham	2,288	2,142	93.6%	146	6.4%
	Ashby	1,241	1,185	95.5%	56	4.5%
	Bolton	1,882	1,781	94.6%	101	5.4%
	Clinton	6,732	3,743	55.6%	2,989	44.4%
	Fitchburg	16,645	9,270	55.7%	7,375	44.3%
	Gardner	8,872	5,116	57.7%	3,756	42.3%
	Harvard	1,965	1,813	92.3%	152	7.7%
	Lancaster	2,981	2,458	82.5%	523	17.5%
	Leominster	18,474	12,109	65.5%	6,365	34.5%
	Lunenburg	4,589	3,710	80.8%	879	19.2%
	Princeton	1,316	1,259	95.7%	57	4.3%
	Sterling	3,461	3,075	88.8%	386	11.2%
	Townsend	3,504	2,943	84.0%	561	16.0%
	Westminster	3,248	2,788	85.8%	460	14.2%
	Area Estimate	**77,198**	**53,392**	**69.2%**	**23,806**	**30.8%**
Heywood Hospital	Ashburnham	2,288	1,185	93.6%	56	6.4%
	Gardner	8,872	5,116	57.7%	3,756	42.3%
	Hubbardston	1,553	1,431	92.1%	122	7.9%
	Templeton	3,125	2,655	85.0%	470	15.0%
	Westminster	3,248	2,788	85.8%	460	14.2%
	Winchendon	3,627	2,718	74.9%	909	25.1%
	Area Estimate	**22,713**	**15,893**	**74.2%**	**5,773**	**25.8%**
Athol Hospital	Athol	4,706	3,381	71.8%	1,325	28.2%
	Erving	677	528	78.0%	149	22.0%
	New Salem	453	390	86.1%	63	13.9%
	Orange	3,006	2,135	71.0%	871	29.0%
	Petersham	461	416	90.2%	45	9.8%
	Phillipston	703	641	91.2%	62	8.8%
	Royalston	538	477	88.7%	61	11.3%
	Warwick	348	323	92.8%	25	7.2%
	Wendell	389	330	84.8%	59	15.2%
	Area Estimate	**11,281**	**8,621**	**76.4%**	**2,660**	**23.6%**
Additional Geographies	**Combined Service Area**	**96,784**	**68,817**	**71.1%**	**27,967**	**28.9%**
	Worcester County	330,319	217,813	65.9%	112,506	34.1%
	Franklin County	31,234	21,737	69.6%	9,497	30.4%
	Massachusetts	2,740,995	1,711,341	62.4%	1,029,654	37.6%
	United States	125,736,353	81,497,760	64.8%	44,238,593	35.2%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 32. Median Housing Costs, by Housing Tenure, 2018-2022

	Community	Median For Units with a Mortgage ($)	Median For Units w/o Mortgage ($)	Median for Units Paying Rent ($)
Health Alliance-Clinton Hospital	Ashburnham	2,146	977	1,895
	Ashby	2,186	820	987
	Bolton	3,659	1,419	1,545
	Clinton	2,036	771	1,289
	Fitchburg	1,886	816	1,115
	Gardner	1,747	704	1,041
	Harvard	3,504	1,335	1,455
	Lancaster	2,512	1,095	1,816
	Leominster	2,051	866	1,171
	Lunenburg	2,282	935	1,602
	Princeton	2,694	1,059	906
	Sterling	2,319	884	1,223
	Townsend	2,375	880	1,256
	Westminster	2,125	910	1,597
	Area Estimate	**-**	**-**	**1,262**
Heywood Hospital	Ashburnham	2,146	977	1,895
	Gardner	1,747	704	1,041
	Hubbardston	1,940	867	-
	Templeton	1,827	670	1,098
	Westminster	2,125	910	1,597
	Winchendon	1,900	711	1,004
	Area Estimate	**-**	**-**	**1,068**
Athol Hospital	Athol	1,528	675	1,004
	Erving	1,468	475	945
	New Salem	2,032	676	1,045
	Orange	1,636	738	682
	Petersham	1,797	773	1,223
	Phillipston	1,943	689	1,143
	Royalston	1,668	614	1,066
	Warwick	1,949	648	1,188
	Wendell	1,625	608	1,614
	Area Estimate	**-**	**-**	**990**
Additional Geographies	**Combined Service Area**	**-**	**-**	**1,198**
	Worcester County	2,230	867	1,263
	Franklin County	1,824	755	1,109
	Massachusetts	2,553	957	1,588
	United States	1,828	584	1,268

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Transportation

Table 33. Means of Transportation, 2018-2022

	Community	Car, truck, or van, drove alone	Car, truck, or van, carpooled	Public transportation (excluding taxicab)	Walked	Other means	Worked from home
Health Alliance-Clinton Hospital	Ashburnham	76.4%	2.7%	1.5%	1.9%	1.6%	16.0%
	Ashby	76.7%	7.2%	0.2%	1.7%	0.0%	14.2%
	Bolton	67.8%	0.6%	1.3%	0.2%	0.4%	29.7%
	Clinton	73.3%	9.9%	0.1%	2.3%	1.2%	13.2%
	Fitchburg	73.0%	10.4%	1.5%	4.3%	2.0%	8.7%
	Gardner	72.6%	11.1%	1.4%	2.6%	2.7%	9.6%
	Harvard	57.5%	2.5%	3.8%	1.1%	1.0%	34.2%
	Lancaster	56.8%	2.3%	1.0%	1.4%	5.5%	32.9%
	Leominster	79.6%	7.6%	1.5%	0.3%	0.7%	10.2%
	Lunenburg	79.3%	5.6%	3.0%	0.4%	0.0%	11.7%
	Princeton	68.1%	3.3%	1.8%	2.1%	1.6%	23.1%
	Sterling	80.0%	4.6%	4.9%	0.0%	0.5%	10.0%
	Townsend	84.4%	3.9%	1.6%	1.4%	0.8%	7.8%
	Westminster	83.7%	2.1%	0.4%	1.3%	0.5%	12.0%
	Area Estimate	**75.0%**	**7.3%**	**1.6%**	**1.8%**	**1.4%**	**12.9%**
Heywood Hospital	Ashburnham	76.4%	2.7%	1.5%	1.9%	1.6%	16.0%
	Gardner	72.6%	11.1%	1.4%	2.6%	2.7%	9.6%
	Hubbardston	80.2%	3.7%	0.0%	1.7%	0.8%	13.6%
	Templeton	79.3%	3.6%	0.0%	2.6%	2.4%	12.1%
	Westminster	83.7%	2.1%	0.4%	1.3%	0.5%	12.0%
	Winchendon	77.4%	10.2%	0.8%	2.1%	0.6%	8.9%
	Area Estimate	**77.1%**	**7.0%**	**0.9%**	**2.2%**	**1.7%**	**11.3%**
Athol Hospital	Athol	76.0%	10.4%	0.6%	5.0%	0.9%	7.1%
	Erving	80.7%	11.8%	1.5%	1.8%	0.5%	3.7%
	New Salem	66.9%	13.3%	0.0%	2.7%	1.1%	16.0%
	Orange	80.5%	9.5%	1.8%	1.7%	0.5%	6.0%
	Petersham	77.3%	8.6%	0.0%	4.6%	0.0%	9.5%
	Phillipston	79.9%	9.6%	0.0%	0.7%	0.7%	9.1%
	Royalston	78.5%	10.0%	0.0%	0.6%	3.2%	7.8%
	Warwick	82.4%	4.2%	0.0%	1.9%	0.0%	11.6%
	Wendell	70.6%	14.2%	0.0%	0.8%	3.0%	11.4%
	Area Estimate	**77.5%**	**10.1%**	**0.8%**	**3.1%**	**0.9%**	**7.6%**
Additional Geographies	**Combined Service Area**	**75.6%**	**7.5%**	**1.4%**	**2.0%**	**1.3%**	**12.1%**
	Worcester County	73.5%	7.7%	1.5%	2.5%	2.1%	12.7%
	Franklin County	72.2%	8.0%	1.0%	4.0%	1.1%	13.7%
	Massachusetts	64.2%	7.0%	7.6%	4.3%	2.3%	14.6%
	United States	71.7%	8.5%	3.8%	2.4%	1.9%	11.7%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 34. Percent Households with No Vehicles Available, by Housing Tenure, 2018-2022

	Community	Owner Occupied No vehicle available	Renter Occupied No vehicle available
Health Alliance-Clinton	Ashburnham	1.6%	0.0%
	Ashby	0.0%	0.0%
	Bolton	0.0%	8.9%
	Clinton	0.6%	9.3%
	Fitchburg	4.2%	22.3%
	Gardner	2.1%	21.0%
	Harvard	0.0%	34.9%
	Lancaster	1.5%	16.8%
	Leominster	5.4%	18.2%
	Lunenburg	2.8%	9.2%
	Princeton	0.6%	15.8%
	Sterling	1.6%	11.9%
	Townsend	1.5%	10.0%
	Westminster	1.7%	0.0%
	Area Estimate	**2.8%**	**17.7%**
Heywood Hospital	Ashburnham	1.6%	0.0%
	Gardner	2.1%	21.0%
	Hubbardston	0.0%	32.8%
	Templeton	0.4%	2.6%
	Westminster	1.7%	0.0%
	Winchendon	1.4%	16.2%
	Area Estimate	**1.4%**	**16.8%**
Athol Hospital	Athol	4.1%	33.4%
	Erving	3.2%	16.8%
	New Salem	0.0%	0.0%
	Orange	4.4%	25.5%
	Petersham	6.7%	0.0%
	Phillipston	2.7%	0.0%
	Royalston	0.6%	24.6%
	Warwick	1.9%	0.0%
	Wendell	0.9%	5.1%
	Area Estimate	**3.6%**	**26.6%**
Additional Geographies	**Combined Service Area**	**2.7%**	**18.3%**
	Worcester County	2.8%	20.1%
	Franklin County	2.5%	18.4%
	Massachusetts	3.6%	25.8%
	United States	3.1%	17.9%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Health Access & Health Behaviors

Table 35. Percent Population Overall and Under 18 Insurance Status, 2018-2022

	Community	Uninsured	Uninsured Under 18	Insured	Insured Under 18
Health Alliance-Clinton Hospital	Ashburnham	0.5%	0.0%	99.5%	100.0%
	Ashby	2.8%	1.7%	97.2%	98.3%
	Bolton	1.0%	0.0%	99.0%	100.0%
	Clinton	2.8%	0.9%	97.2%	99.1%
	Fitchburg	1.8%	0.0%	98.2%	100.0%
	Gardner	3.3%	1.1%	96.7%	98.9%
	Harvard	0.7%	0.7%	99.3%	99.3%
	Lancaster	2.0%	0.0%	98.0%	100.0%
	Leominster	2.7%	1.8%	97.3%	98.2%
	Lunenburg	1.3%	0.5%	98.7%	99.5%
	Princeton	0.2%	0.0%	99.8%	100.0%
	Sterling	0.2%	0.0%	99.8%	100.0%
	Townsend	1.7%	0.0%	98.3%	100.0%
	Westminster	1.1%	0.0%	98.9%	100.0%
	Area Estimate	**2.0%**	**0.7%**	98.0%	99.3%
Heywood Hospital	Ashburnham	0.5%	0.0%	99.5%	100.0%
	Gardner	3.3%	1.1%	96.7%	98.9%
	Hubbardston	1.2%	0.0%	98.8%	100.0%
	Templeton	0.9%	0.0%	99.1%	100.0%
	Westminster	1.1%	0.0%	98.9%	100.0%
	Winchendon	2.8%	0.2%	97.2%	99.8%
	Area Estimate	**2.1%**	**0.7%**	**97.9%**	**99.3%**
Athol Hospital	Athol	3.1%	1.6%	96.9%	98.4%
	Erving	2.3%	0.0%	97.7%	100.0%
	New Salem	5.0%	0.9%	95.0%	99.1%
	Orange	2.0%	0.0%	98.0%	100.0%
	Petersham	0.7%	0.0%	99.3%	100.0%
	Phillipston	1.0%	2.1%	99.0%	97.9%
	Royalston	3.4%	0.0%	96.6%	100.0%
	Warwick	2.7%	0.0%	97.3%	100.0%
	Wendell	2.6%	3.0%	97.4%	97.0%
	Area Estimate	**2.6%**	**1.2%**	**97.4%**	**98.8%**
Additional Geographies	**Combined Service Area**	**2.1%**	**0.7%**	97.9%	99.3%
	Worcester County	2.5%	1.3%	97.5%	98.7%
	Franklin County	2.2%	1.4%	97.8%	98.6%
	Massachusetts	2.7%	1.5%	97.3%	98.5%
	United States	8.7%	5.3%	91.3%	94.7%

Sources: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018-2022

Table 36. Percent Adults Self-Reporting Obesity, 2021

	Community	% Adults Self-Reporting Obese (Crude)
Health Alliance-Clinton Hospital	Ashburnham	30.2%
	Ashby	26.8%
	Bolton	28.7%
	Clinton	32.9%
	Fitchburg	33.3%
	Gardner	33.6%
	Harvard	28.9%
	Lancaster	30.2%
	Leominster	33.0%
	Lunenburg	31.2%
	Princeton	29.9%
	Sterling	29.5%
	Townsend	26.5%
	Westminster	30.9%
	Area Estimate	**31.8%**
Heywood Hospital	Ashburnham	30.2%
	Gardner	33.6%
	Hubbardston	31.7%
	Templeton	32.2%
	Westminster	30.9%
	Winchendon	32.5%
	Area Estimate	**32.3%**
Athol Hospital	Athol	33.4%
	Erving	29.8%
	New Salem	27.0%
	Orange	30.0%
	Petersham	32.9%
	Phillipston	32.9%
	Royalston	33.1%
	Warwick	29.8%
	Wendell	29.8%
	Area Estimate	**31.7%**
Additional Geographies	**Combined Service Area**	**31.9%**
	Worcester County	31.3%
	Franklin County	28.1%
	Massachusetts	27.6%
	United States	33.0%

Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, accessed via MA Population Health Information Tool (PHIT), 2021

Table 37. Percent Adults Ever Diagnosed with Diabetes, 2021

	Community	Adults Age 18+ Ever Diagnosed with Diabetes (Crude)
Health Alliance-Clinton Hospital	Ashburnham	7.2%
	Ashby	7.5%
	Bolton	6.9%
	Clinton	9.1%
	Fitchburg	9.7%
	Gardner	9.9%
	Harvard	7.0%
	Lancaster	7.3%
	Leominster	9.8%
	Lunenburg	8.6%
	Princeton	8.1%
	Sterling	7.6%
	Townsend	7.1%
	Westminster	8.0%
	Area Estimate	**8.9%**
Heywood Hospital	Ashburnham	7.2%
	Gardner	9.9%
	Hubbardston	7.8%
	Templeton	8.8%
	Westminster	8.0%
	Winchendon	8.7%
	Area Estimate	**8.8%**
Athol Hospital	Athol	9.9%
	Erving	9.6%
	New Salem	8.3%
	Orange	9.7%
	Petersham	9.2%
	Phillipston	9.2%
	Royalston	8.5%
	Warwick	9.6%
	Wendell	9.6%
	Area Estimate	**9.3%**
Additional Geographies	**Combined Service Area**	**9.0%**
	Worcester County	9.6%
	Franklin County	10.2%
	Massachusetts	9.2%
	United States	11.3%

Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, accessed via MA Population Health Information Tool (PHIT), 2021

Table 38. Deaths of Despair: Deaths Due to Intentional Self-harm (suicide), Alcohol-related Disease, and Drug Overdose, 2016-2020

	Community	Five Year Total Count (2016-2020)	Crude Death Rate Per 100,000 Population	Age Adjusted Death Rate Per 100,000 population
Health Alliance-Clinton Hospital	Ashburnham	17.0	56.1	54.9
	Ashby	No data	No data	No data
	Bolton	15.0	56.1	54.9
	Clinton	42.0	56.1	54.9
	Fitchburg	113.0	56.1	54.9
	Gardner	57.0	56.1	54.9
	Harvard	18.0	56.1	54.9
	Lancaster	23.0	56.1	54.9
	Leominster	118.0	56.1	54.9
	Lunenburg	32.0	56.1	54.9
	Princeton	No data	No data	No data
	Sterling	22.0	56.1	54.9
	Townsend	18.0	39.5	36.9
	Westminster	22.0	56.1	54.9
Heywood Hospital	Ashburnham	17.0	56.1	54.9
	Gardner	57.0	56.1	54.9
	Hubbardston	12.0	56.1	54.9
	Templeton	22.0	56.1	54.9
	Westminster	22.0	56.1	54.9
	Winchendon	28.0	56.1	54.9
Athol Hospital	Athol	32.0	56.1	54.9
	Erving	No data	No data	No data
	New Salem	No data	No data	No data
	Orange	20.0	51.9	47.0
	Petersham	No data	No data	No data
	Phillipston	No data	No data	No data
	Royalston	No data	No data	No data
	Warwick	No data	No data	No data
	Wendell	No data	No data	No data
Additional Geographies	**Combined Service Area**	647.0	55.0	53.5
	Franklin County	183.0	51.9	47.0
	Worcester County	2321.0	56.1	54.9
	Massachusetts	18225.0	53.0	50.7
	United States	806246.0	49.4	47.0

DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, accessed via MA Population Health Information Tool (PHIT), 2016-2020

Table 39. Percent Adults Ever Diagnosed with Asthma, 2021

	Community	% Adults with Asthma
Health Alliance-Clinton Hospital	Ashburnham	11.4%
	Ashby	10.7%
	Bolton	10.8%
	Clinton	12.2%
	Fitchburg	12.6%
	Gardner	12.3%
	Harvard	10.3%
	Lancaster	11.3%
	Leominster	12.3%
	Lunenburg	11.6%
	Princeton	11.2%
	Sterling	11.1%
	Townsend	10.8%
	Westminster	11.5%
	Area Estimate	**11.9%**
Heywood Hospital	Ashburnham	11.4%
	Gardner	12.3%
	Hubbardston	11.8%
	Templeton	12.0%
	Westminster	11.5%
	Winchendon	12.1%
	Area Estimate	**12.0%**
Athol Hospital	Athol	12.4%
	Erving	11.7%
	New Salem	10.9%
	Orange	12.0%
	Petersham	11.9%
	Phillipston	11.9%
	Royalston	12.3%
	Warwick	11.7%
	Wendell	11.7%
	Area Estimate	**12.1%**
Additional Geographies	**Combined Service Area**	**12.0%**
	Worcester County	11.6%
	Franklin County	11.2%
	Massachusetts	10.9%

Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, accessed via MA Population Health Information Tool (PHIT), 2021

Table 40. Percent Adults Ever Diagnosed with Coronary Heart Disease, 2021

	Community	% Adults with Coronary Heart Disease
Health Alliance-Clinton Hospital	Ashburnham	4.4%
	Ashby	4.9%
	Bolton	4.0%
	Clinton	5.4%
	Fitchburg	5.6%
	Gardner	6.3%
	Harvard	4.1%
	Lancaster	4.5%
	Leominster	5.8%
	Lunenburg	5.4%
	Princeton	4.9%
	Sterling	4.8%
	Townsend	4.5%
	Westminster	4.9%
	Area Estimate	**5.4%**
Heywood Hospital	Ashburnham	4.4%
	Gardner	6.3%
	Hubbardston	4.7%
	Templeton	5.7%
	Westminster	4.9%
	Winchendon	5.4%
	Area Estimate	**5.5%**
Athol Hospital	Athol	6.4%
	Erving	6.2%
	New Salem	5.2%
	Orange	6.4%
	Petersham	5.7%
	Phillipston	5.7%
	Royalston	5.2%
	Warwick	6.2%
	Wendell	6.2%
	Area Estimate	**6.2%**
Additional Geographies	**Combined Service Area**	**5.5%**
	Worcester County	5.7%
	Franklin County	6.9%
	Massachusetts	5.5%
	United States	6.1%

Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, accessed via MA Population Health Information Tool (PHIT), 2021

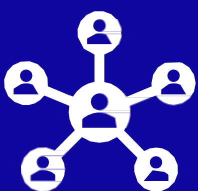
APPENDIX C

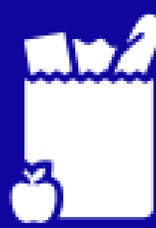
UMass HealthAlliance-Clinton Hospital and Heywood Healthcare
Community Health Needs Assessment 2024-2027
Strategic Implementation Plan Evaluation of Impact 2022-2024

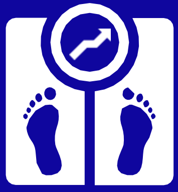
UMass Memorial Health
HEALTHALLIANCE-CLINTON HOSPITAL

Community Benefits

Strategic Implementation Plan
Evaluation of Impact
2022-2024







Evaluation of Impact, 2022-2024

UMass Memorial Health – HealthAlliance-Clinton Hospital developed and approved an Implementation Strategy to address significant health needs identified in the 2022-2024 Community Health Needs Assessment (CHA). These programs support the Community Health Improvement Plan (CHIP) which was developed collaboratively with CHNA9, Heywood Healthcare, Montachusett Regional Planning Commission, North Central stakeholders, residents, grassroots minority lead organizations, and the Montachusett Public Health Network. The Implementation Strategy closely aligns the CHIP and addresses the following health needs through a commitment of Community Benefit programs and resources.

HealthAlliance-Clinton Hospital's Community Benefits Program strives to meet and exceed the Schedule H/Form 990 IRS mandate to "promote health for a class of persons sufficiently large so the community as a whole benefits." Our programs mirror the five core principles outlined by the Public Health Institute in terms of the "emphasis on communities with disproportionate unmet health-related needs; emphasis on primary prevention; building a seamless continuum of care; building community capacity; and collaborative governance."

UMass Memorial Health is committed to improving the health status of all those it serves and to addressing the health problems of the poor and other medically underserved populations. In addition, nonmedical conditions that negatively impact the health and wellness of our community are addressed.

The Mission incorporates the World Health Organization's broad definition of health defined as "a state of complete physical, mental and social well-being and not merely the absence of disease." The UMass Memorial Health Care (UMMHC) Community Benefits Mission was developed and recommended by the Community Benefits Advisory Committee and approved by the UMass Memorial Health Care Board of Trustees.

PRIORITY AREAS AND GOALS:

Focusing on the social determinants of health and health indictors in the priority framework, UMass Memorial HealthAlliance-Clinton Hospital identified the following priority areas and overarching goals.

Priority Areas	Goal
Priority Area A1: **Health Care Access and Quality**	**Goal:** Increase access to comprehensive, high-quality, *equitable* health care services
Priority Area A2: **Social and Community Context**	**Goal:** Increase social and community support *for our target populations.*
Priority Area A3: **Housing, Neighborhood and Built Environment**	**Goal:** *Support efforts to improve housing stock,* neighborhoods and environments that promote *affordability*, health, and safety.
Priority Area A4: **Economic Stability**	**Goal:** Support efforts that lead to economic wellbeing for target populations.
Priority Area A5: **Healthy Food and Nutrition**	**Goal:** Reduce household food insecurity and hunger *through the promotion of equitable food access.*
Priority Area B1: **Behavioral Health and Substance Use**	**Goals:** *1) External*: Support social determinants of health (SDOH) efforts that lead to better mental health outcomes, including prevention of mental illness *2) Internal:* Expand and develop systems that support the continuum of mental health care to improve health outcomes.
Priority Area C1: **Chronic Disease**	**Goals:** 1) *External:* Support community-based prevention efforts for chronic diseases, particularly heart disease, diabetes, and cancer 2)*Internal*: Address access to diagnosis and self-management resources.

Note: *This Plan was intended to be a fluid document that will be updated annually according to new opportunities, programming, and partnerships and to coincide with the latest version of the North Central Massachusetts Community Health Improvement Plan (CHIP). UMass Memorial HealthAlliance-Clinton Hospital recognizes that through the CHNA process, many needs have been identified. However, due to limited resources it is not possible to address all identified community health needs. As such, we focus on priorities identified through the community engagement process in which we can partner and leverage resources to achieve the greatest impact.*

In addition, the target populations identified included:

Racial & Ethnic Minorities	Recent Immigrants & Non-English Speakers	Low Income Individuals and Families	Older Adults	Veterans	Homeless	Children & Adolescents	LGBTQIA+

The following list provides additional detail on the eight populations that the assessment identified as needing or deserving special attention: **Figure 4: Target Populations**

(1) Racial & Ethnic Minorities

- Black, indigenous, and other people of color, people of historically marginalized ethnic groups, including in our area: Hispanic/Latinos; Portuguese/Brazilians; Arabic; Haitian-Creole; Hmong; ASL; West and East Africans
- Unique Issues around language and cultural competency, systemic racism, and access to wealth; mental health (stress and trauma)

(2) Recent Immigrants & Non-English Speakers

- Undocumented persons, migrants, immigrants, and refugees
- People whose primary language is not English, speaks another foreign language(s)

(3) Low-Income Individuals and Families

- People with low socio-economic status who struggle to afford basic household items (healthy food, utilities, weather appropriate clothing)

(4) Older Adults

- The aging population (62+) whose concerns center around transportation, isolation, mental health, and substance use

(5) Veterans

- Persons who served in the active military, naval, or air service, and who were discharged or released therefrom under conditions other than dishonorable.

(6) Homeless

- Both individuals and families who lack a fixed, regular, and adequate night-time residence.

(7) Children and Adolescents

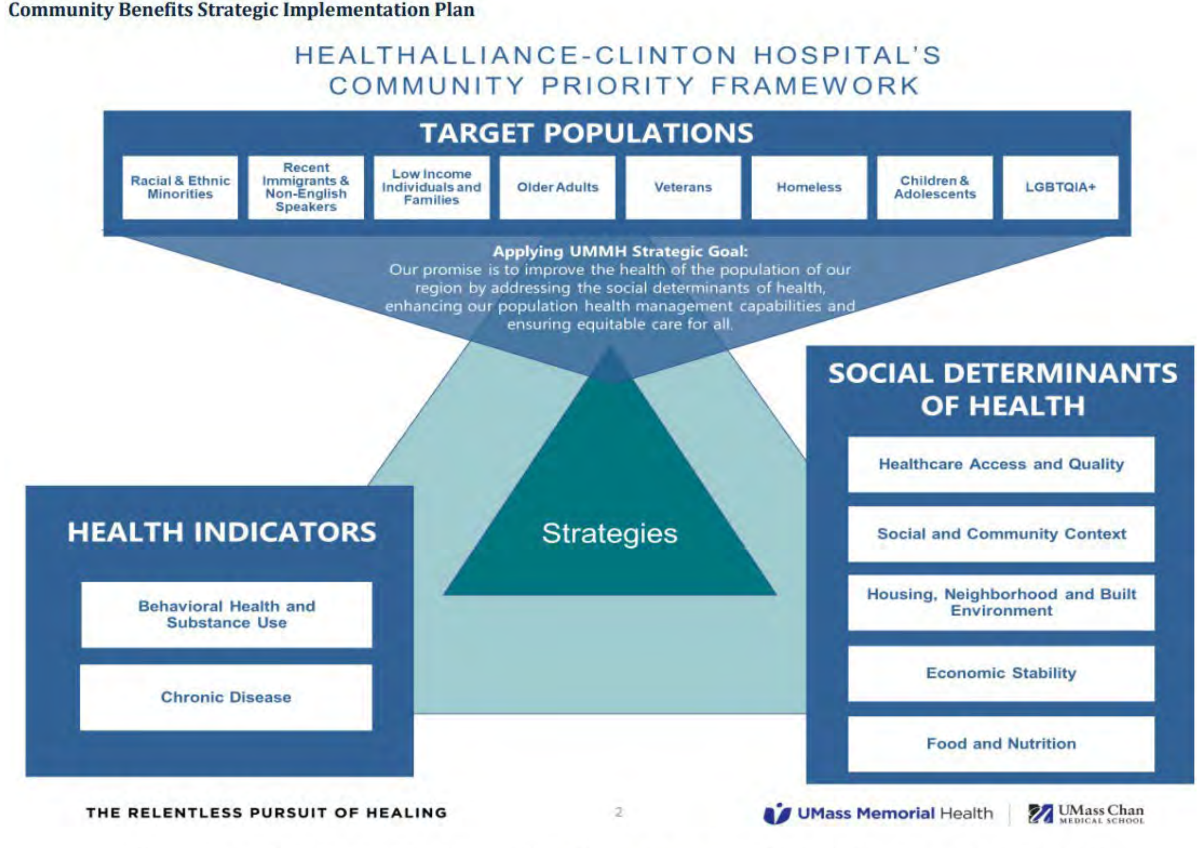
- People under 21 years of age, whose developing bodies and minds require special attention and care.

(8) LGBTQIA+

- Persons who express a spectrum of gender identities and sexual orientations that are counter to the mainstream.

Building off the findings of the CHNA and the CHIP described above, the staff and leadership at HealthAlliance-Clinton Hospital, along with input from some community representatives developed a framework for prioritizing and selecting strategies and activities over the next three years that HealthAlliance-Clinton Hospital could put into action. The goal was to select a framework that would provide enough focus to be

useful while leaving flexibility for updates and changes as the context and needs of the community shift over time.
The framework selected allows for the focus on strategies that have some intersectionality across a set of target populations and a set of health indicators and social determinants of health.



Approved and adopted by the UMass Memorial HealthAlliance-Clinton Hospital's Board of Trustees on December 3, 2021.

Strategies to address the priority health needs/Domains were identified and impact measures tracked. The following tables outline the impact made on the selected significant health needs since the completion of the 2022 Community Health Needs Assessment and Implementation Plan. UMass Memorial has a dedicated Community Benefits Department that works closely with community organizations and reports activities to the UMass Memorial Health – HealthAlliance-Clinton Hospital.

ENABLING STRUCTURES FOR ADDRESSING PRIORITY AREAS:

In alignment with the UMass Memorial Health system-wide goal to "improve the health of the population of our region by addressing the social determinants of health, enhancing our population health management capabilities and ensuring equitable care for all", HealthAlliance-Clinton Hospital is working to explore a wider network of enabling structures and leverage points throughout the entire organization to support our community priorities. This moves us toward a more efficient and integrated approach to community health engagement.

In particular, we've identified the following UMass Memorial Health and HealthAlliance-Clinton Hospital structures through which we will implement the strategies in our above identified priority areas:

Community Benefits Program:
Community Benefits are programs, activities, or services that improve the health of the community by providing treatment or promoting health as a response to an identified community need, and meet at least one of the following criteria:

- Improve access to health care to the medically underserved
- Enhance the public health of the community; or respond to the need of underserved populations
- Advance medical or health care knowledge through education or research
- Reduce or relieve the financial burden of government; or by supporting programs that would otherwise be discontinued because they operate at a financial loss
- Are done in collaboration with the community

The Determination of Need Process:
The Determination of Need (DoN) law and regulations governs how healthcare facilities implement Substantial Capital Expenditure, Substantial Change in Services and Original Licensure as well as many Transfers of Ownership and Changes. The purpose and objective of the DoN program is to encourage competition with a public health focus; to promote population health; to support the development of innovative health delivery methods and population health strategies within the health care delivery system; and to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost. In this way the Department hopes to advance the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation. (DPH definition)

Diversity, Equity, Inclusion, and Belonging: Working across the UMass Memorial Health system, the newly formed Office of Equity, Inclusion, and Belonging is focused on nurturing and empowering a diverse and engaged workforce at UMass Memorial Health. Some of the office's key focal activities include recruiting top diverse talent; building awareness understanding and respect, strengthening belonging to improve talent retention, connecting with community, and ensuring equity across our system's policies and initiatives.

Anchor Mission: In 2018, UMass Memorial Health enacted an Anchor Mission—a commitment to **consciously use** the **business and economic power** of UMass Memorial Health, in combination with our **human and intellectual resources,** to better the long-term welfare, equity, and resiliency of central Massachusetts communities. The work of the Anchor Mission traditionally falls into four pillars—investment (moving 1% of UMass Memorial's long term investments out of the stock market and into local investments that address the social determinants of health), purchasing (increasing the amount of business we do with local and/or minority and women owned businesses), hiring (creating quality employment and growth opportunities from the most vulnerable neighborhoods in Central Massachusetts), and volunteering (leveraging our workforce to get engaged in local efforts to address social determinants of health). UMass Memorial's Anchor Mission aligns with similar commitments with more than 60 other healthcare organizations across the country organized as the Healthcare Anchor Network.

Advocacy: As the largest employer in central Massachusetts, a major contributor to the local economy, and the safety healthcare provider for all of central MA, UMass Memorial Health wields a powerful voice in local, state, and national political decision making. In addition, many of HealthAlliance- Clinton Hospital and UMass Memorial Health leadership sit on national organizations who set policy and goals for healthcare organizations broadly. We see the immense value of focusing our advocacy attention on social determinants of health and the overall health and vitality of our community and local residents.

Clinical Integration: Historically, clinical integration efforts have focused on coordinating patient care across providers, settings, and time, making it easier for patients to get the care that they need in a safe, efficient, and timely way. We're moving beyond just thinking about clinical integration as a way to manage clinical care but to also address issues and environmental challenges that patients face—e.g. the social determinants of health. The UMass Memorial Population Health/Office of Clinical Integration was established to provide data and analytics, and health policy quality improvement, and coordination for clinical integration efforts across the system. Efforts in clinical integration don't have to be limited to efforts lead by this office—since the real opportunities for change can most often be identified and put into place by clinical teams themselves.

Priority Area A1: Health Care Access and Quality Goal: Increase access to comprehensive, high-quality, *equitable* health care services **Objective:** Support priority populations gain access to resources such as affordable medical, dental, and mental health care services; insurance (Medicare or Medicaid enrollment); translation and transportation services; or housing, food, and education			
Programs/Strategies to Address Need	**Fiscal Years**	**Enabling Structure**	**Outcomes**
Provide health insurance outreach and support to assist individuals whose employers do not offer affordable coverage, who are self-employed, or who are unemployed	2021-current	CB	Over 5,300 patients and community members were enrolled in health insurance from our service area: • FY21: 2,000 individuals • FY22: 2,000 individuals • FY23: 1,298 individuals
Explore community health worker (CHW) initiative to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes	2021; 2023	CB, Clinical Integration	FY'21: HA-C provided $25,000 in DoN funds to the Spanish American Center to support a Promotores de Salud (Community Health Worker) model to help improve the delivery of healthcare to underserved Latinos by using trained community-based peers and trusted neighbors (Promotores) to bridge the gap between Latinos and healthcare providers. FY'23 HA-C provided $50,000 in DoN funds to support NewVue Communities and their Healthcare Connections Project to support health outreach workers to directly reach out to residents, identify barriers, assets and resources, and foster connections that improve healthcare access and social and community supports.
Increase referral outcomes as a result of SDOH screening tools in inpatient/outpatient setting utilizing medical electronic record, Community Help (an on-line resource inventory linking people to community resources) and warm handoffs to community partners	2021-current	CB, Clinical Integration	FY'21: Claimed organizations grew to 875; approx. 23,437 searches (in 2021 calendar year); SDOH screening options extended in the EHR; Routine SDOH screening minimum 1x/year expanded to 34 clinics/offices (a 75% increase) FY'22: Claimed organizations grew to 2,190 (a 19% increase); Approx. 20,258 searches; Routine SDOH screening minimum 1x/year expanded to 43 primary care practices in UMMH system, including Fitchburg Family Practice and Simonds-Sinon Regional Cancer Center. FFP and Cancer Center launched RX Food Farmacy program; FY'23: Expanded screening efforts and increased quality of resource listings to facilitate warm handoffs to community organizations
Provide funding to address healthcare access/reduce barriers through HA-C's DoN grantmaking resources.	2021-current	DoN	Since 2020, the Hospital has sought to provide $2.35 million in community benefits through Determination of Needs (DoN) funding from our emergency department capital project by the end of FY'24. Over $1.8 million has been awarded to support 63 community grants.

			FY'21: $781,720 FY'22: $511,996 FY'23: $526,353 UMass Memorial Health has also established Anchor Mission Task Forces to collaborate with community groups on workforce development, neighborhood revitalization, and local investment. In HA-C's service area, funds were provided to support the pre-development costs of the Fitchburg Arts Community.
Conduct health equity/diversity trainings with clinical and non-clinical partners to improve cultural competency and patient experience	2021-2023	DEIB, Anchor Mission	FY'21: HealthAlliance-Clinton Committee on Equal Opportunity and DEI is an active committee of only diverse community members, stakeholders, and hospital personnel who meet monthly to develop ideas and implement strategies on how to combat institutional racism, identify issues that affect disadvantaged, underserved populations in our communities, offering solutions to improve social determinants of health and health care experience. FY'22 and FY'23, ongoing: HealthAlliance-Clinton Hospital participates in UMMH's DEI efforts aimed to 1) Increase awareness of health and racial inequities and impacts of social determinants 2) Reduce barriers to health care services and disparities in health outcomes and 3) Promote cultural sensitivity at the Hospital, the community, and among other clinical and non-clinical partners. FY'23: HA-C provided $10,000 in DoN funds to support Spanish American Center (SAC) of Leominster to help implement staff development trainings on an array of topics to provide Diversity, Equity and Inclusion. These trainings helped to enhance the staff's knowledge, understanding and practice of critical topics and trends in the community to ensure that SAC offers the highest quality with all their services. FY'21, FY'22 and FY'23: HA-C provided $150,000 in DoN funds to Clinton Public Schools over three years to support the Welcome Center's Family Outreach Coordinator position that supported families for whom English is not their primary language. Support students with vaccines and required medical documentation. Additional support was provided to low-income families with housing, food and utilities
Support clinical and non-clinical partners in their efforts to improve health literacy and advance National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care	2022-2024	DEIB, Anchor Mission	HA-C provided $150,000 in DoN funds to Mount Wachusett Community College to train 50 individuals who speak English as a second language for EMT, CMAA, and CNA roles. MWCC has also worked to sustain this pathway beyond DoN funding, potentially leveraging other sources of workforce funding in the state. In FY'23 HA-C provided $10,000 to the Ellie Fund's Equitable Pathways to Breast Cancer Care for Patients in North Central Massachusetts (MA) project. Expected outcomes are:

			(1) increased number of area breast cancer patients served; (2) patients better represent the region's racial and ethnic diversity; (3) patients experience relief from the financial and emotional stressors of breast cancer diagnosis and treatment; (4) more patients adhere to and complete their treatment plan. These impacts will move us closer to revolutionizing how and when vulnerable patients access non-medical support in local healthcare.
In coordination with UMMH, execute an equity seed program to promote inclusion, expand innovation and collaboration to promote equitable care and support caregivers of color.	2021-present	DEIB, Anchor Mission	In FY'21 HealthAlliance-Clinton formed a committee to address equal opportunity and implement DEI framework. In FY'22 HealthAlliance-Clinton continued the committee to address equal opportunity and implement DEI framework. In FY'23 this program was continued.
Provide training regarding MassHealth's transportation benefits for hospital staff and other community providers. (Use of PT1 form)	2023	CB, Clinical Integration	System committee developed in Fall of FY'23 aimed at improving transportation access and utilization of MassHealth PT-1 Program. CB Staff participated in Health Equity Partnership's Transportation/Access charrettes with our lens of health access.

Priority Area A2: Social and Community Context

Goal: Increase social and community support *for our target populations.*

Objective: Reduce barriers to accessing education, employment, and health care opportunities by increasing access to technology (high-speed broadband internet, hardware) and transit resources.

Objective: Reduce social isolation among target population

Programs/Strategies to Address Need	Fiscal Years	Enabling Structure	Outcomes
Advocate for policy changes to address the digital divide as a SDOH in order to strengthen healthcare access and allow for more patient and community-centered approaches	N/A	Advocacy, Anchor mission, Clinical Integration, CB	*Delayed until FY'24- regional efforts underway to address digital divide. HA-C involved in community and workforce approaches*
Support public, private, and community training programs that promote digital literacy, including health access	2022-2023	CB, Anchor Mission	**FY'22 and 23: United Way of North Central Massachusetts, Working Families Initiative (WFI)** received funding for their comprehensive approach to helping individuals and families increase their income, build savings, gain assets, and develop the capability to fully participate in the economy. WFI provided community residents with tools, programs, and resources to help families improve financial capability, including how to utilize online tools with an approach to support digital literacy. The tools provided included employment and financial coaching, credit building, debt reduction and access to financial products to help build income and wealth. **FY'23: HA-C provided $10,000 in DoN funds to the Spanish Amercian Center's** STEM Success for kids Crossroads Program to provide access to a personal laptop, thereby enabling them to fully benefit from the STEM training.
Leverage public, private, nonprofit, and community collaborations to provide funding and in-kind support for digital inclusion. Work collaboratively to identify barriers to Internet, broadband technology access locally and develop solutions to overcome them.	N/A	CB, Anchor Mission, Advocacy, DoN	*Delayed until FY'24- regional efforts underway to address digital divide. HA-C involved in community and workforce approaches*

Collaborate with community partners to raise awareness about LGBTQ issues and reduce health disparities for LGBTQ populations	2022-2023	Clinical Integration, CB, DEIB, DoN	**FY' 22: Fitchburg Family Practice (FFP)** participated in the Fitchburg NoWoCo Pride event to engage with LGBTQIA+ community members to provide health and medical access information while building trust with the community; **FY'23**: FFP continued to support this annual event.
Support youth programs and services that seek to empower youth, build resiliency and address social isolation.	2022-2023	CB, DON	**FY'22: HealthAlliance Guild Book Drive for the Fitchburg Family Practice**: In response to Fitchburg Family Practice's need for books for their pediatric patients to read while waiting for their appointments, the HealthAlliance Guild held a book drive during the month of December. The book drive collected 105 books for patients ages 6 months to 5 years of age. **FY'23:** HA-C provided $10,000 in DoN funds to the Spanish American Center's STEM Success for Kids Program, serving 25 Leominster 7th and 8th graders. The program focused on STEAM education and provided laptops to enhance the training.
Provide patient referrals to community-based resources that seek to address social isolation including support groups or counseling, telephone or web- based support, social skills training or activities for social interaction. Support these community resources**.**	2022-current	CB, DON, Anchor, Clinical Integration	FY'22-23, ongoing: Efforts are underway to increase referral outcomes as a result of SDOH screening tools in inpatient/outpatient settings utilizing medical electronic records, CommunityHelp (an online resource inventory linking people to community resources), and warm handoffs utilizing social workers and CHWs to community partners to increase access to services. Specifically, the Fitchburg Family Practice and Simonds-Sinon Regional Cancer Center are engaged in this effort.
Link people to community resources using on-line and phone resource inventory utilizing Community Help	2022-current	CB, Clinical Integration, DON	See above

Priority Area A3: Housing, Neighborhood and Built Environment

Goal: Support efforts to improve housing stock, neighborhoods and environments that promote affordability, health, and safety.

Objective: Promote health and safety in the places where people live, work, learn, and play.

Programs/Strategies to Address Need	Fiscal Years	Enabling Structure	Outcomes
Enhance local public-private engagement to improve community identity, stimulate an improved quality of life for local residents, and spur increased investment and economic activity in Fitchburg, MA	2021-2023	CB, Anchor Mission, DON	FY'21 - FY'23: North County Anchor Collaborative's DoN funds supported the Health Equity Partnership (CHNA9) to convene 6 local institutions, including Community Health Connections, Fitchburg State University, Gardner Public Schools, Heywood Healthcare, and LUK to form the North Central Massachusetts Anchor Collaborative. Anchor institutions are large place-based employers that play a vital role investing in their local communities and economies. The goal of this effort is to develop a cohesive collaborative of local anchor organizations that can systematically have direct impacts on growing and sustaining local economic and social wealth as well as healthy communities.
Engage in cross-sector collaboration and advocacy efforts with the MA North Regional Housing network aiming to reduce homelessness and increase housing affordability	2021-2023	CB, Anchor Mission, DON	FY'21-current: Hospital Community Benefits staff engaged in cross-sector collaboration and advocacy efforts with the MA North Regional Housing network aiming to reduce homelessness and increase housing affordability. FY'22-FY'23: Through the Housing Network, worked to support SMOC's efforts to purchase and expand homeless shelter housing at the former Day's Inn Hotel in Leominster by strengthening community and healthcare partnerships. In FY'23 HA-C provided $5,000 to Catholic Charities of Worcester County to support Leominster's Emergency Stabilization & Homeless Prevention Programs
Support placemaking efforts that reflect the priorities of the community and foster a sense of belonging and improve residents' quality of life, with a focus on increasing access to recreational assets near HA-C Campuses (Flat Rock- Fitchburg; Twin Cities Rail Trail- Leominster and Clinton's Complete Street initiatives (designed and operated to enable safe use	2023	CB, DON, Anchor Mission, Advocacy	In FY'23 HA-C provided $9,153 in DoN funds which enabled Mass Audubon's education team to collaborate with North County Land Trust to design accessibility programs in Fitchburg and Princeton. They served 84 people with mobility challenges, tested accessibility at 5 sites, and trialed equipment like rollators and freedom chairs on trails.

and support mobility for all users).			
Provide support, including funding, for local community development activities such as affordable housing, anti-poverty programs, and infrastructure development	2022	CB, Anchor Mission, DON	In FY'22 HA-C provided $10,000 in DoN funds to help support Habitat for Humanity North Central Massachusetts' (NCM) Home Ownership and Critical Repair programs address one of the leading social determinants of health – safe and affordable housing for families under 60% of the area median income. In our state, one in seven households spend more than half of their income on housing, leaving them unable to afford decent shelter and with little to spend on food and health. Habitat for Humanity's building and home repair programs provide a "hand up" to these families in need.
As a pilot project, provide vulnerable patients with transportation services to and from the Simonds-Sinon Cancer Center located on the Fitchburg campus.	N/A	CB, Clinical Integration	*Delayed pilot program until FY'24. (Cancer Center did secure financial supports to provide eligible patients with Lyft transportation when necessary)*
In coordination with Montachusett Regional Transit Authority and WRTA, analyze current bus route utilization for all three campuses and seek opportunities to improve access (location of stops, schedules, bus shelters, etc.)	2021-current	Advocacy, CB	FY'21: Community Health Equity Partnership, in coordination with the North County Anchor Network, identified transportation as a priority focus area. FY'22-FY'23: Efforts continued to identify needs and assets to address transportation in region leading to the development of a Transportation Management Association, in collaboration with MART for future planning in FY'24 and beyond. FY'23 Transportation: To address transportation needs of area birthing people, HA-C committed to the development and implementation of an urgent, on demand (non-emergency) transportation resource for birthing people that need to access the UMass Memorial Medical Center maternity center in Worcester. We implemented free 24/7/365, curb-to-curb transportation to the Memorial Campus of UMass Memorial Medical Center for birthing people with transportation barriers who are also patients of participating providers in North Central Massachusetts. Visitor transit for maternity patients is also provided.
In coordination with UMMH, HA-C will support investments into local projects to improve the welfare of Our community, including projects that address homelessness and affordable housing.	2021-2023	CB, Anchor Mission, DON	FY'21-23: Pre-development financing provided to New Vue Communities for the Fitchburg Arts Community to build 68 units of mixed income apartments that will be preferentially available to local artists. FY'21: HA-C partnered with YWCA (Daybreak) displaying "Empty Plate" display at each hospital campus: an art exhibition which features dinner place settings representing real victims of domestic violence missing from their family's lives, educational materials and a public comment/feedback box.

			FY'21; FY'22; FY'23- ongoing Pathways for Change: HA-C provides in-kind support through the provision of discounted office space at the Fitchburg Campus location to Pathways for Change, a non-profit organization that provides support services to any person impacted by Sexual Violence, as well as education that helps End Sexual Violence. FY'21: HA-C partnered with YWCA (Daybreak) displaying "Empty Plate" display at each hospital campus: an art exhibition which features dinner place settings representing real victims of domestic violence missing from their family's lives, educational materials and a public comment/feedback box. FY'21; FY'22; FY'23-ongoing Pathways for Change: HA-C provides in-kind support through the provision of discounted office space at the Fitchburg Campus location to Pathways for Change, a non-profit organization that provides support services to any person impacted by Sexual Violence, as well as education that helps End Sexual Violence.

Priority Area A4: Economic Stability

Goal: Support efforts that lead to economic wellbeing for target populations.

Objective: Promote hiring, retention, and workforce development of local racially and ethnically diverse residents; workplace culture that values diversity and inclusion; mentorship and support opportunities to advance to higher skilled positions.

Programs/Strategies to Address Need	Fiscal Years	Enabling Structure	Outcomes
Develop hiring policies and resources that support local hiring and workforce pipeline development	2023	DEIB, Anchor Mission	**FY'23: Education Pathways:** Participating as employer-partner with Mount Wachusett Community College on PCA-II Bridge Training Program and supported over 18 CNA's meet their clinical hours to achieve graduation.
Provide scholarships and internships to priority population youth and providing bridge to at-risk youth to improve wellness and learn about careers in health care	2021-2023	CB, Anchor Mission	**FY'21; FY'22 and FY'23: Support youth education**: Provide scholarships to high school graduating seniors living in the service area who are pursuing a college education in a health-related field: FY'21: 4 scholarships: FY'22: 3 scholarships and FY'23: 3 scholarships.
Support community based financial empowerment assets that seek to "bank the unbanked" by strengthening low-income people's financial inclusion, knowledge and access.	2022-2023	CB, DEIB, Anchor Mission	**FY'22 and 23: United Way of North Central Massachusetts, Working Families Initiative (WFI)** received funding for their comprehensive approach to helping individuals and families increase their income, build savings, gain assets, and develop the capability to fully participate in the economy. WFI provided community residents with tools, programs, and resources to help families improve financial capability, including how to utilize online tools with an approach to support digital literacy. The tools provided included employment and financial coaching, credit building, debt reduction and access to financial products to help build income and wealth.
Build capacity, design and implement regional workforce blueprints that address the healthcare workforce crisis and identify which areas of the workforce, training and education systems will need to be built out to address workforce crisis	2021-2023	CB, DEIB, Anchor Mission	**FY21-FY23: Community Collaboration to address workforce needs:** HA-C's senior leader, Senior Director of External Affairs, participates on the North County MassHire Board of Directors.

Priority Area A5: Healthy Food and Nutrition

Goal: Reduce household food insecurity and hunger *through the promotion of equitable food access.*

Objective: Support community efforts to increase the number of healthy food assets in the region while addressing barriers to accessing the resources.

Programs/Strategies to Address Need	Fiscal Years	Enabling Structure	Outcomes
Expand access to affordable and nutritious food (eg, community gardens, Farmers Market Nutrition Program; Veggie Rx, a fruit and vegetable prescription program to alleviate food insecurity among patients with diabetes)	2021-2023	CB, DON, Anchor Mission	**FY'21, FY'22 and FY'23:** HA-C provided $191,000 in DoN Tier 3 funds to **Germinemos and SproutChange Academy**, through the supports of fiscal agents, to offer a Train-the-Trainer program in Fitchburg, MA to help empower, train, and develop a new workforce in North Central MA with the knowledge, tools, and resources they need to teach a philosophy and methodology on using food as medicine, natural remedies, and herbs as well as growing their own organic healing foods sustainably. Workshop Overview: • 58% of workshops covered mental health topics • 53% covered chronic health conditions or illnesses • 43% covered healthy aging • 46% covered social determinants of health • 76% had provided childcare **FY'22, FY'23: Rx Food FARMacy Initiative**: **Food as Medicine** In August of 2022, HealthAlliance-Clinton Hospital launched the **Rx Food FARMacy** initiative at the Simonds-Sinon Regional Cancer Center and the Fitchburg Family Practice in collaboration with Growing Places and its Local Food Works. FY'22: • Social Determinants of Health Assessment Tool utilized to identify food insecurity among cancer center patients **–** conducted 298 SDOH screenings (August 1-December 25, 2022) • Identify Needs of Patients and make appropriate Food as Medicine Referrals- of those screened, 10% (36) of patients indicated food insecurities; 100% referred to nutritionist and Growing Places • Fresh Food resources and SNAP/HIP screenings: 26 patients were provided tokens to receive monthly fresh food. 100% of those patients were screened and/or enrolled for SNAP and HIP benefits. Once enrolled, patients can sign up for monthly fresh food CSA delivery utilizing their EBT cards.

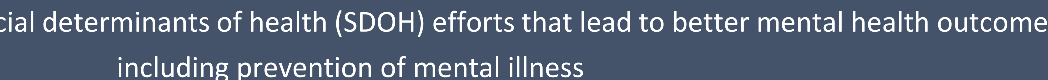
			• Fresh Food Market Access for Patients: 7 monthly Mobile Markets were held at the Cancer Center with locally grown fresh food between 8/1/22-11/7/22. FY'23: • SDOH screenings conducted: 457 screened • Of those screened, 12% of patients indicated food insecurities; 100% referred to nutritionist and Growing Places • 61% successful contact by Growing Places • Of those, 30% enrolled into CSA home delivery program • 61% contacted were currently receiving SNAP benefits and were all educated about SNAP enrollment **FY'21, FY'22, FY'23** and ongoing: Hospital staff works with **CHNA 9's Healthy Eating and Active Living Workgroup** to expand access to healthy foods and recreational opportunities in partnership with area food banks, farmers markets, community garden organizations, recreational facilities, and other community organizations. **FY'21; FY'22; FY'23**- **WHEAT Café:** Increase access to healthy and affordable foods: HA-C supports a feeding program at the WHEAT Community Café for populations living in poverty once a month through the provision of nutritional meals to help address food insecurities for over 700 families annually. Organize food security and food access projects targeted at vulnerable populations: FY'21 and FY'22: during COVID, food was prepacked. FY'23: meal program restored to café style. **FY'23: HA-C provided** $**50,000 in DoN Funds to support the Boys and Girls Club of Fitchburg, Leominster and Gardner's Leominster** campus by investing in the capital costs to build a new kitchen at the site to address food security for youth and their families (project completed in FY'24). F**Y'23: HA-C provided $25,000 in DoN funds to support Montachusett Veterans Outreach Center** to update outdated equipment and expand upon the variety of foods in their food pantry to support the food insecurity needs of local veterans and their families. **FY'21-FY'23: HA-C provided $120,000 in DoN funds to support the Salvation Army's Comprehensive Basic Needs Program** in the region to help struggling individuals and families by providing basic and emergency services that address their immediate needs

			and identify ways in which they can be supported to improve their economic situation and overall wellbeing through other services, referrals, and additional resources. **FY'23: HA-C provided $10,000 in DoN funds to support Ginny's Helping Hand, Inc**. to increase access to fresh and nutritious food, provide healthy educational recipes, and identify clients eligible for SNAP/HIP benefits while reducing the reliance on emergency food service programs. The program served 257 people, providing healthy recipes, identifying SNAP/HIP eligibility, and reducing reliance on emergency food services. 20 monthly Mobile Markets were held at the Cancer Center and Fitchburg Family Practice with locally grown fresh food between 10/01/2022-09/30/2023. **FY-23: HA-C provided $5,000 in DoN funds to the Community Foundation of North Central Massachusetts on behalf of the North Central Faith Based Coalition** to continue their ability to diminish food insecurity for our most vulnerable populations. Feeding good nutritious food helps these individuals healthier and more able to recover from the multitude of issues they face. We hire staff that have experienced these problems and are able to provide service respecting their dignity.
Support local food banks and other community-based organizations to promote access to healthy foods and addressing obesity (e.g., Local food banks, Farmers Markets, community gardens and faith-based organizations)	2021-2023	CB, DON, Anchor Mission	**FY'21, FY'22 and FY'23:** HA-C provided $191,000 in DoN Tier 3 funds to **Germinemos and SproutChange Academy**, through the supports of fiscal agents, to offer a Train-the-Trainer program in Fitchburg, MA to help empower, train, and develop a new workforce in North Central MA with the knowledge, tools, and resources they need to teach a philosophy and methodology on using food as medicine, natural remedies, and herbs as well as growing their own organic healing foods sustainably. Workshop Overview: • 58% of workshops covered mental health topics • 53% covered chronic health conditions or illnesses • 43% covered healthy aging • 46% covered social determinants of health • 76% had provided childcare **FY' 22, FY'23: Rx Food FARMacy Initiative**: **Food as Medicine** In August of 2022, HealthAlliance-Clinton Hospital launched the **Rx Food FARMacy** initiative at the Simonds-Sinon Regional Cancer Center and the Fitchburg Family Practice in collaboration with Growing Places and its Local Food Works. FY'22:

			• Social Determinants of Health Assessment Tool utilized to identify food insecurity among cancer center patients – conducted 298 SDOH screenings (August 1-December 25, 2022) • Identify Needs of Patients and make appropriate Food as Medicine Referrals- of those screened, 10% (36) of patients indicated food insecurities; 100% referred to nutritionist and Growing Places • Fresh Food resources and SNAP/HIP screenings: 26 patients were provided tokens to receive monthly fresh food. 100% of those patients were screened and/or enrolled for SNAP and HIP benefits. Once enrolled, patients can sign up for monthly fresh food CSA delivery utilizing their EBT cards. • Fresh Food Market Access for Patients: 7 monthly Mobile Markets were held at the Cancer Center with locally grown fresh food between 8/1/22-11/7/22. FY'23: • SDOH screenings conducted: 457 screened • Of those screened, 12% of patients indicated food insecurities; 100% referred to nutritionist and Growing Places • 61% successful contact by Growing Places • Of those, 30% enrolled into CSA home delivery program • 61% contacted were currently receiving SNAP benefits and were all educated about SNAP enrollment **FY'21, FY'22, FY'23** and ongoing: Hospital staff works with **CHNA 9's Healthy Eating and Active Living Workgroup** to expand access to healthy foods and recreational opportunities in partnership with area food banks, farmers markets, community garden organizations, recreational facilities, and other community organizations. **FY'21; FY'22; FY'23- WHEAT Café:** Increase access to healthy and affordable foods: HA-C supports a feeding program at the WHEAT Community Café for populations living in poverty once a month through the provision of nutritional meals to help address food insecurities for over 700 families annually. Organize food security and food access projects targeted at vulnerable populations: FY'21 and FY'22: during COVID, food was prepacked. FY'23: meal program restored to café style. **FY'23: HA-C provided $50,000 in DoN Funds to support the Boys and Girls Club of Fitchburg, Leominster and Gardner's Leominster** campus by investing in the capital costs

			to build a new kitchen at the site to address food security for youth and their families (project completed in FY'24) **FY'23: HA-C provided $25,000 in DoN funds to support Montachusett Veterans Outreach Center** to update outdated equipment and expand upon the variety of foods in their food pantry to support the food insecurity needs of local veterans and their families. They served 763 individual veterans with 1,542 visits to the food pantry and an average of 20 food boxes delivered per month. Catholic Charities with funds received allowed the programs to serve 17,386 people with a focus in enhanced emergency/immediate financial assistance and food pantry services. **FY'21-FY'23: HA-C provided $120,000 in DoN funds to support the Salvation Army's Comprehensive Basic Needs Program** in the region to help struggling individuals and families by providing basic and emergency services that address their immediate needs and identify ways in which they can be supported to improve their economic situation and overall wellbeing through other services, referrals, and additional resources. **FY'23: HA-C provided $10,000 in DoN funds to support Ginny's Helping Hand, Inc**. to increase access to fresh and nutritious food, provide healthy educational recipes, and identify clients eligible for SNAP/HIP benefits while reducing the reliance on emergency food service programs.The program served 257 people, providing healthy recipes, identifying SNAP/HIP eligibility, and reducing reliance on emergency food services. 20 monthly Mobile Markets were held at the Cancer Center and Fitchburg Family Practice with locally grown fresh food between 10/01/2022-09/30/2023.
Work with CHNA 9's Healthy Eating and Active Living Workgroup to expand access to healthy foods and recreational opportunities in partnership with area food banks, farmers markets, community garden organizations, recreational facilities, and other community organizations	2021-2023	CB, DON, Anchor Mission	Work with CHNA 9's Healthy Eating and Active Living Workgroup to expand access to healthy foods and recreational opportunities in partnership with area food banks, farmers markets, community garden organizations, recreational facilities, and other community organizations

Priority Area B1: Behavioral Health and Substance Use



Goal 1 (*External*): Support social determinants of health (SDOH) efforts that lead to better mental health outcomes including prevention of mental illness

Objective: Address social determinants of health by supporting equitable, sustainable and collaborative strategies that reduce behavioral health disparities.

Programs/Strategies to Address Need	Fiscal Years	Enabling Structure	Outcomes
Continue and expand HA-C's Opioid Task Force, made up of healthcare providers, community leaders, patient advocates and many others to tackle the problem of heroin and prescription drug abuse in the area by reducing opioid and heroin addiction, preventing overdose deaths, and improving the well- being of our community.	2021-2023	CB, Clinical Integration, DON	• FY'21 Opioid Task Force: HealthAlliance-Clinton Hospital formed an Opioid Task Force in response to the growing problem of opioids/substance use in the North Central MA region (Leominster, Fitchburg, Clinton, and surrounding towns). The Task Force aims to bring together healthcare providers, community leaders, patient advocates and community stakeholders to tackle the problem of substance and prescription drug abuse in the area by reducing opioid and addiction, preventing overdose deaths, and improving the well-being of our community.
Work to ensure access of NARCAN in the community	2021-2023	CB, Clinical Integration, DON	• 2021- ongong: NARCAN kits provided in the ED
Increase recovery support navigation in Eds in coordination with CHL, GAAMHA and other providers	2021-2023	CB, Clinical Integration, DON	• FY'22-ongoing: Community Health Link providing onsite recovery navigation to support Emergency Departments
Identify community resources for patients in need of BH services and seek to improve coordination	2021-2023	CB, Clinical Integration, DON	FY'21
Organize support groups with mental health organizations in the community to support those suffering from behavioral issues and their families and caregivers	2021	CB, Clinical Integration	• DoN funds supported Aids Project Worcester Transportation to Recovery program: to address the number-one barrier for people from North County who are living with a substance use disorder and who want to enter detox: transportation and the inability to get to a detox or treatment facility. Providing transportation to clients to detox/treatment -20 per month total. DoN funds supported Restoration Recovery Center Inc. providing 76 individuals with recovery assistance and transportation to access health care and other human services. • DoN funds supported GAAMHA Family Recovery Coaching program providing 60 individuals in a community setting as well as individual services for families who are in need of support due to a loved one's substance use disorder.

			FY'23 • HA-C provided $50,000 in DoN funds to support LUK's Equity & Access Project (LEAP) Designed to increase access to quality behavioral health care for populations that have been historically underserved, marginalized, and/or adversely affected by inequality. This will be accomplished by increasing access to appointments during nontraditional times and by providing sessions in languages other than English. • HA-C provided $4,200 in DoN funds to LUK's Community Training Academy, to train two additional trainers in Youth Mental Health First Aid that provided the course to 50 registered participants to better meet the training needs of the community. • HA-C provided $50,0000 in DoN funds to St. Paul Consortium's Mental and Behavioral Health Equity Initiative to address the mental and behavioral health needs to a population of over 500 students. • HA-C provided $50,000 in DoN funds to Montachusett Recovery Foundation for its Continued Transportation Initiative which provided 500 instances of transportation to individuals affected by substance use disorder (SUD) both to and from local services at Montachusett Recovery Center (MRC) in Leominster as well as to treatment and other providers in the area. • Medication take-back bins installed at the Leominster campus, with plans to expand to other campus.
Goal 2(Internal): Expand and develop systems that support the continuum of mental health care to improve health outcomes.			
Objective: Identify, assess, and implement strategies, when appropriate, that seek to improve healthcare delivery through integrated physical and behavioral health services.			
Programs/Strategies to Address Need	Fiscal Years	Enabling Structure	Outcomes

Provide Behavioral Health First Aid Training to caregivers	N/A	CB, Clinical Integration	While this particular training was not provided, as part of the system strategies to address the mental health crisis, HA-C continues to support caregivers through training and other resources to improve health outcomes of our patients. In addition, CHL provides trainings and resources as part of their on-site efforts.

Priority Area C1:

Goal 1 (*External*): Support community-based chronic disease prevention efforts, particularly focused on heart disease, diabetes, and cancer.

Objective: Increase patients' health-related knowledge via efforts to simplify health education materials, improve patient-provider communication, and increase overall literacy

Programs/Strategies to Address Need	Fiscal Year	Enabling Structure	Outcome
Continue to work with the region's board of health offices on community outreach, education, testing and vaccination efforts to address COVID-19 with an emphasis on addressing disparities and reaching vulnerable groups and populations including ethnic and linguistic populations.	2021	CB, Clinical Integration	FY'21: COVID Response: In partnership with the cities of Fitchburg and Leominster, secured resources from the MA Department of Public Health for the installation of two COVID-19 (PCR) Nasopharyngeal Swab Community Testing Sites that served over 8700 community members. In addition, Hospital staff supported community vaccine sites in both Fitchburg and Leominster.
Support Community Health Worker (Promotoras de Salud) and recovery coaches' models	2021-2023	CB, Clinical Integration, DON	FY'21: DoN funds supported the Spanish American Center to support a Promotores de Salud (Community Health worker) model to help improve the delivery of healthcare to underserved Latinos by using trained community-based peers and trusted neighbors (Promotores) to bridge the gap between Latinos and healthcare providers. FY'23 HA-C provided $50,000 in DoN funds to support NewVue Communities and their Healthcare Connections Project to support health outreach workers to directly reach out to residents, identify barriers, assets and resources, and foster connections that improve healthcare access and social and community supports.
Organize educational opportunities and events for internal collaboration and external engagement around equity	2021-2023	CB, Clinical Integration	HA-C staff attended annual community events, including Clinton Olde Home Day (2021-2023); Johnny Appleseed Festival (2021&2022), NoWoCo event (2022 & 2023) and other community events to provide education regarding tobacco use, lung cancer, breast cancer screening and other health resources targeting at risk populations.
Engage marginalized patients in the design and validation of health innovation solutions	2021-2023	CB, Clinical Integration	Patient, Family Advisory Committee engaged in improving patient experience and substance abuse/behavioral health efforts in the emergency department.

			FY'23: Women and Infants: HA-C committed more than $600,000 in Women's Health Investment Initiative funding beginning in FY'23-26 to help address residents' prenatal, postnatal and infants needs. To help identify priorities for these investments, HealthAlliance-Clinton Hospital contracted with Health Resources in Action (HRiA) in the summer to conduct a community needs assessment focused on understanding the needs of women and birthing people, including prenatal and postnatal needs, and infants in HealthAlliance-Clinton Hospital's service area. Assessment findings were scheduled to be presented in the Fall of 2023.
Goal 2 (*Internal)*: address access to diagnosis and self-management resources.			
Objective: Reduce disparities in screening rates and health outcomes for priority populations segment			
Programs/Strategies to Address Need	**Fiscal Year**	**Enabling Structure**	**Outcome**
Continue to conduct SDOH Screening in hospital and community settings. Implement strategy to connect needs of patients identified in screening tool with community-based resources.	2023	Clinical Integration, CB, Population Health	FY'23 the Simonds-Sinon Regional Cancer Center and Fitchburg Family Practice conducted 950 SDOH screenings. They identified 163 patients with food insecurities, all of whom were referred to a nutritionist.
Organize breast and lung cancer education, screening, and referral programs for priority populations	2023	Clinical Integration, CB,	FY'23 the Simonds-Sinon Regional Cancer Center and Fitchburg Family Practice provided information on breast cancer screening and prevention, including self-breast exam models, scheduled mammograms on-site, and displayed models of healthy and diseased lungs.