Beth Israel Lahey Health
New England Baptist Hospital

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for New England Baptist Hospital (NEBH) is the culmination of a collaborative process that began in June 2024. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key stakeholders from throughout NEBH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging historically underserved populations.

NEBH appreciates all who invested time, effort, and expertise to develop this report and the Implementation Strategy. This report summarizes the assessment and planning activities and presents key findings, community health priorities, and strategic initiatives that are the results of this work.

NEBH thanks the New England Baptist Hospital Community Benefits Advisory Committee and the residents who contributed to this process. Hundreds of residents throughout NEBH's Community Benefits Service Area shared their needs, experiences, and expertise through interviews, focus groups, surveys, and a community listening session. This assessment and planning process would not have been possible or as successful had it not been for the time and effort of the residents who engaged in this work.

NEBH also thanks the Steering Committee of the Boston Community Health Collaborative (BCHC) for their collaboration in this assessment process. The BCHC, comprised of Boston area teaching hospitals and medical centers, community health centers, the Boston Public Health Commission, community-based organizations and residents, hired Health Resources in Action to support their effort. The Boston Public Health Commission (BPHC) serves as the backbone organization to the BCHC and their Community Health Needs Assessment effort. Per federal and Commonwealth requirements, local health departments must be involved in CHNA activities, and the Boston Public Health Commission fulfilled this requirement.

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Introduction

Background

New England Baptist Hospital (NEBH) is the premier regional provider for orthopedic surgery and the treatment of musculoskeletal diseases and disorders. NEBH is the site of one of the first artificial hip replacements in the country and continues to lead the way in developing new methods to diagnose and treat musculoskeletal disease and promote musculoskeletal health. NEBH is consistently ranked as one of America's top hospitals for orthopedics by U.S. News and World Report and is nationally recognized for high patient satisfaction and leadership in quality and clinical outcomes. For the past 15 consecutive years, the Hospital has received the Press Ganey Guardian of Excellence Award. This prestigious national award is granted only to hospitals ranking in the 95th percentile or higher in patient satisfaction. NEBH is an affiliate of Tufts University School of Medicine, conducts teaching programs in collaboration with Harvard Medical School, and has been the official hospital of the Boston Celtics for over 39 years. The hospital prides itself on its ability to blend exceptional patient care and advanced medical knowledge in ways that allow it to achieve the best outcomes for its patients.

NEBH is committed to being an active partner and collaborator with the communities it serves. In 2019, as part of a merger of two health systems in the greater Boston region, NEBH became part of Beth Israel Lahey Health (BILH) - a system of academic medical centers, teaching hospitals, community hospitals and specialty hospitals with more than 35,000 caregivers and staff are collaborating in new ways across professional roles, sites of care and regions to make a difference for our patients, our communities and one another. NEBH, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA).

This 2025 Community Health Needs Assessment (CHNA) report is an integral part of NEBH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that NEBH provides are appropriately focused, delivered in ways that are responsive to those in its CBSA and address unmet community needs. This assessment, along with the associated prioritization and planning processes, also provides a critical opportunity for NEBH to engage the community and strengthen the community partnerships that are essential to its success now and in the future. The assessment engaged hundreds of individuals from across the CBSA, including local public health officials, clinical and social service providers,

community-based organizations, faith leaders, other government officials and community residents.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of NEBH's mission. Finally, this report allows NEBH to meet its federal and Commonwealth community benefits requirements per the federal Internal Revenue Service, as part of the Affordable Care Act, and the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

Purpose

The CHNA is at the heart of NEBH's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care, as well as the injustices that underlie existing disparities. Throughout the assessment process, efforts are made to understand the needs of the communities that NEBH serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

Prior to this current CHNA, NEBH completed its last assessment in 2022 and the report, along with the associated 2023-2025 IS, was approved by NEBH's Board of Trustees on September 14, 2022. The 2022 CHNA report was posted on NEBH's website before September 30, 2022 and, per federal compliance requirements, made available in paper copy, without charge, upon request. The assessment and planning work for this current report was conducted between June 2024 and September 2025, and NEBH's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 10, 2025.

Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within the hospital's designated CBSA. Understanding the geographic and demographic characteristics of NEBH's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

Description of Community Benefits Service Area

NEBH's primary facility is in the Mission Hill neighborhood of Boston, where it provides a broad range of medical, surgical, and rehabilitation services that promote wellness, restore function, lessen disability, alleviate pain, and advance knowledge of musculoskeletal diseases and related disorders. In addition, NEBH operates a multi-specialty clinic in Dedham, a physical therapy clinic and a radiology clinic in Chestnut Hill, and a surgery center in Brookline.

NEBH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, spoken language,

national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. NEBH is equally committed to serving all patients, even those who are medically underserved, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

NEBH's CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns where NEBH operates licensed facilities. NEBH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within this CBSA. In recognition of the considerable health disparities that exist in some communities in its CBSA, NEBH focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in the Boston neighborhood of Mission Hill.

While there are segments of the populations in Brookline, Chestnut Hill, and Dedham who face significant disparities in access, underlying social determinants, and health outcomes, the greatest disparities exist for those who live in Mission Hill. By prioritizing these cohorts, NEBH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources. Further, while NEBH operates a licensed facility in Dedham, this service location is in Beth Israel Deaconess Hospital-Needham's (BID Needham) CBSA. BID Needham is part of the BILH system and as a result, the community benefits activities for Dedham have been delegated to BID Needham. This helps to ensure that activities are properly coordinated and address the identified needs.

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Assessment Approach & Methods

Approach

It would be difficult to overstate NEBH's commitment to community engagement and a comprehensive, data-driven, collaborative and transparent assessment and planning process. NEBH's Community Benefits staff, along with its CBAC, dedicated hours of their time and resources to participate in and gather information from three concurrent assessments.

The first of these assessments was for NEBH's own CBSA assessment, which engaged local public health officials, clinical and social service providers, community-based organizations, other government officials, and community residents. This CBSA assessment gathered quantitative and qualitative information from all of the neighborhoods and municipalities that are part of NEBH's CBSA. These activities are detailed below.

In addition to this assessment, NEBH's Community Benefits staff collaborated with the Boston Community Health Collaborative (BCHC)'s Community Health Needs Assessment. The BCHC, consisting of Boston's hospitals, The Boston Public Health Commission, community-based organizations and community residents, conducted a robust and collaborative community health needs assessment for the City of Boston as a whole. The BCHC's Community Health Needs Assessment serves as a foundational resource for policymakers and community leaders, and informs community health improvement planning, priority setting, program and policy development, and collaboration. This is the third city-wide coordinated Community Health Needs Assessment and builds upon previous coordinated efforts in 2019 and 2022. The overall approach was participatory and collaborative, engaging community residents and collaborators throughout the CHNA process. Nancy Kasen, Beth Israel Lahey Health's Vice President of Community Benefits and Community Relations, served on the BCHC Community Health Needs Assessment Steering Committee. NEBH and the BCHC shared information with each other to support each other's assessment efforts.

Finally, NEBH participated in the Beth Israel Lahey Health (BILH) CHNA and collaborated with Beth Israel Deaconess Needham Hospital (BID Needham) and Beth Israel Deaconess Medical Center (BIDMC). With respect to BID Needham, NEBH and BID Needham both include Dedham in their CBSAs and, as a result, both gathered and shared information on this municipality as part of their assessment processes. With respect to BIDMC, NEBH and BIDMC both include the Roxbury and Mission Hill neighborhoods of Boston in their CBSAs. Similarly, both NEBH and BIDMC shared the information gathered on these neighborhoods as part of their processes.

It should be noted that all of the collaborative activities referenced above were bi-directional, meaning that each institution shared quantitative and qualitative findings that they gathered on the overlapping neighborhoods and municipalities with the other institutions. Involvement in these concurrent efforts allowed NEBH and the other hospitals involved to fully leverage the breadth of resources being invested across their CBSA to understand community need and system capacity, while not unduly burdening the community. This involvement also facilitated important and valuable collaboration between NEBH and the other health service organizations outside of the CHNA process.

Altogether, this approach involved extensive data collection activities, substantial efforts to engage NEBH's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been historically underserved, such as those are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

The CHNA and IS development process was guided by the following principles: equity, accountability, community engagement, and impact.

Equity:

Apply an equity lens to achieve fair and just treatment so that all communities and people can achieve their full health and overall potential.

Accountability:

Hold each other to efficient, effective and accurate processes to achieve our system, department and communities' collective goals.

Community Engagement:

Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

Impact:

Employ evidence-based and evidence-informed strategies that align with system and community priorities to drive measurable change in health outcomes.

The assessment and planning process was conducted between June 2024 and September 2025 in three phases, which are detailed in the table below.

Phase I: Preliminary Assessment & Engagement	Phase II: Focused Engagement	Phase III: Strategic Planning & Reporting
Engagement of existing CBAC	Additional interviews	Presentation of findings and prioritization with CBAC and hospital leadership
Collection and analysis of quantitative data	Facilitation of focus groups with community residents and community-based organizations	Draft and finalize CHNA report and IS document
Interviews with key collaborators	Dissemination of community health survey, focusing on resident engagement	Presentation of final report to CBAC and hospital leadership
Evaluation of community benefits activities	Facilitation of a community listening session to present and prioritize findings	Presentation to hospital's Board of Trustees
Preliminary analysis of key themes	Compilation of resource inventory	Distribution of results via hospital website

In April of 2024, BILH hired JSI Research & Training Institute, Inc. (JSI), a public health consulting firm based in Boston, to integrate the information gathered across these concurrent assessments and augment the information gathered, where appropriate. NEBH worked with JSI to ensure that the final NEBH CHNA engaged the necessary community constituents, incorporated comprehensive quantitative information for all communities in its CBSA, and fulfilled federal and Commonwealth community benefits requirements.

Methods

Oversight and Advisory Structures

The CBAC greatly informs NEBH's assessment and planning activities. NEBH's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and members of the hospital's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Education
- Housing (such as community development corporations, local public housing authority, etc.)
- Social services
- Private sectors
- Community-based organizations

These institutions are committed to serving everyone throughout the region and are particularly focused on serving the medically underserved, those experiencing poverty and those who face inequities due to their race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, age, disability status, or other personal characteristics.

The involvement of NEBH's staff in the CBAC promotes transparency and communication and ensures that there is a direct link between NEBH and many of the community's leading health and social service community-based organizations. The CBAC meets quarterly to support NEBH's community benefits work and met five times during the assessment and planning process. During these meetings, the CBAC provided invaluable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities.

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, NEBH collected a wide range of quantitative data to characterize the communities served across NEBH's CBSA. NEBH also gathered data to help identify leading health-related issues, barriers to accessing care and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments and other sources. A databook that includes all the quantitative data gathered for this assessment including the Community Health Survey for NEBH is included in Appendix B.

Whenever possible data has been reported for the Mission Hill neighborhood, which is defined by data as the 02120 zip code tabulation area (ZCTA). The Mission Hill neighborhood is part of the larger Boston neighborhood of Roxbury. As such, when data was not available for the Mission Hill neighborhood and was available for the Roxbury neighborhood, data is reported for Roxbury. When data was not available for either Mission Hill or Roxbury, data is reported for the City of Boston overall.

It should also be noted that NEBH's CBSA includes Chestnut Hill – a village west of Boston – which is located partially within Brookline and partially within Newton. Data for both municipalities were included in this report.

Demographic, SES* & SDOH** Data	Commonwealth/National Health Status Data	Hospital Utilization Data	Municipal Data Sources
Age, SOGI***, race, ethnicity	Vital statistics	Inpatient discharges	Public school districts
Poverty, employment, education	Behavioral risk factors	Emergency department discharges	Local assessments and reports
Crime/violence	Disease registries		
Food access	Substance use data		
Housing/transportation	MDPH Community Health Equity Survey		

*Socioeconomic status **Social determinants of health ***Sexual orientation and gender identity

Every effort was made to leverage any data that could be brought to bear on NEBH's CBSA. However, this methodology highlights the limitations that the assessment faced due to gaps in the availability of data for Mission Hill at the neighborhood-level.

Community Engagement and Qualitative Data Collection

Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk and crafting a collaborative, evidence-informed IS. Accordingly, NEBH applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, NEBH employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Between June 2024 and February 2025, NEBH's assessment included 43 (30 by NEBH/BIDMC), one-on-one interviews with key collaborators in the community, 23 focus groups (10 by NEBH/BIDMC) with segments of the population facing the greatest health-related disparities, and one community listening session that engaged 26 participants. In addition, both BILH and BCHC conducted Community Health Surveys to collect information from community residents. The surveys gathered over 300 responses from individuals in NEBH's CBSA.

Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Appendix A includes copies of the interview, focus group, and listening session guides and summaries of findings. It also includes a copy of BILH's Community Health Survey, and a link to the BCHC Community Health Needs Assessment report.

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across the broad continuum of services, including:

- Domestic violence
- Food assistance
- Housing
- Mental health and substance use
- Senior services
- Transportation

The resource inventory was compiled using information from existing resource inventories and partner lists from NEBH. Community Benefits staff reviewed NEBH's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which included a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify available community resources in the CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

The NEBH CBAC was engaged at the outset of the strategic planning and reporting phase of the project. The CBAC was updated on assessment progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in a prioritization process using a set of anonymous polls, which allowed them to identify a set of community health priorities and population cohorts that they believed should be considered for prioritization as NEBH developed its IS.

After prioritization with the CBAC, a community listening session was organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA. Using the same set of anonymous polls, community listening session participants were asked to prioritize the issues that they believed were most important. The session also allowed participants to share their ideas on existing community strengths and assets, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the prioritization process, a CHNA report was developed and the hospital's existing IS was augmented, revised and tailored. In developing the IS, NEBH's Community Benefits staff took care to retain the community health initiatives that worked well and that aligned with the identified priorities from the 2025

assessment but also pose new strategies to address the newly identified priorities.

The BCHC also conducted an extensive series of prioritization and planning meetings to facilitate the development of a city-wide Community Health Improvement Plan (CHIP). The BCHC developed a summary and full report of findings, which was extensively referenced to develop this report. The link to the final BCHC Community Health Needs Assessment report is included in Appendix A.

After drafts of the CHNA report and IS were developed, they were shared with NEBH's senior leadership team for input and comment. NEBH Community Benefits staff then reviewed this input and incorporated elements, as appropriate, before the final 2025 CHNA report and 2026-2028 IS were submitted to NEBH Board of Trustees for approval.

After the Board of Trustees formally approved the 2025 CHNA report and adopted the 2026-2028 IS, these documents were posted on NEBH's website, alongside the 2022 CHNA report and 2023-2025 IS, for easy viewing and download. As with all NEBH CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that NEBH Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

Questions regarding the 2025 assessment and planning process or past assessment processes should be directed to:

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Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community-based organizations, faith leaders, other government officials and community residents engaged in supporting the health and well-being of residents throughout NEBH's CBSA. Findings are organized into the following areas:

- **Community Characteristics**
- **Social Determinants of Health**
- **Systemic Factors**
- **Behavioral Factors**
- **Health Conditions**

Each section begins with a highlight of key findings. This introduction is followed by graphs and other data visuals. It is important to note that these five sections do not review all of the findings collected during the assessment, rather they draw out the most significant drivers of health status and health disparities. A databook that includes all the quantitative data gathered for this assessment, along with a summary of interviews, focus groups, and a listening session, are included in Appendices A and B.

Please note:

Data has been reported for the Mission Hill neighborhood, defined as the 02120 ZCTA, whenever possible. The Mission Hill neighborhood is part of the larger Boston neighborhood of Roxbury. As such, when data was not available for Mission Hill and was available for Roxbury, data was reported for Roxbury. When data was not available for either Mission Hill or Roxbury, then data was reported for the City of Boston overall. City of Boston data was also included in each graph as a comparison point.

NEBH's CBSA includes Chestnut Hill – a village west of Boston – which is located partially within Brookline and partially within Newton. Data for both Brookline and Newton are included in this report.

Community Characteristics

A description of the population's demographic characteristics and trends lays the foundation for understanding community needs and health status. This information is critical to recognizing health inequities and identifying communities and population segments that are disproportionately impacted by health issues and other social, economic, and systemic factors. This information is also critical to NEBH's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status, and other characteristics.

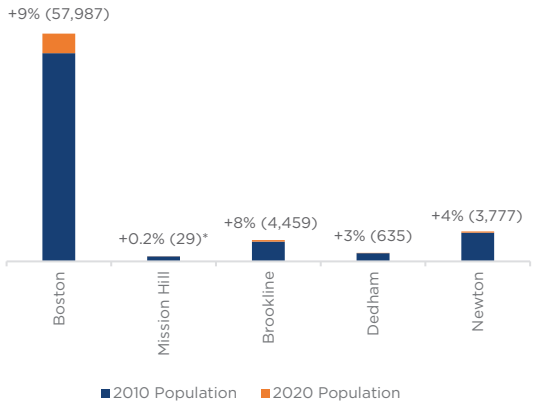
Based on the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the NEBH CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, as well as focus group and community listening session participants that older adults, individuals living with disabilities, individuals who speak a language other than English, and those who are economically insecure were most likely to have poor health status and face systemic challenges accessing care and services. Quantitative data compiled from the US Census Bureau, highlights the diversity that existed in the Mission Hill neighborhood, particularly with respect to age and race/ethnicity. Census Bureau data also highlighted issues of economic security that dominated the assessment findings.

One issue to be noted was the lack of data available by gender identity and sexual orientation at the community or municipal level. Research shows that those who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning experience health disparities and challenges accessing services.[2]

Population Growth

Between 2010 and 2020, Mission Hill saw a very slight increase in population size (+0.2%). The greatest increase in population size was in Brookline (+8%).

Population Changes by, Municipality, 2010 to 2020



Source: US Census Bureau Decennial Census 2010 and 2020

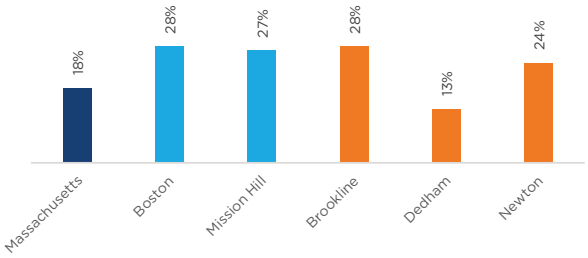
*Note that Mission Hill data point compares 2010 decennial census to 2016-2020 5-year estimate due to availability of data

Nation of Origin

Immigration status is linked to health in many ways; individuals who are foreign-born are less likely to have access to health care and are more likely to forgo needed care due to fear of interacting with public agencies.[3]

The percentage of the population that is foreign-born was higher than the Commonwealth overall (18%) in Mission Hill (27%) and all NEBH CBSA municipalities, with the exception of Dedham (13%)

Percent of the Population that is Foreign Born, 2019-2023



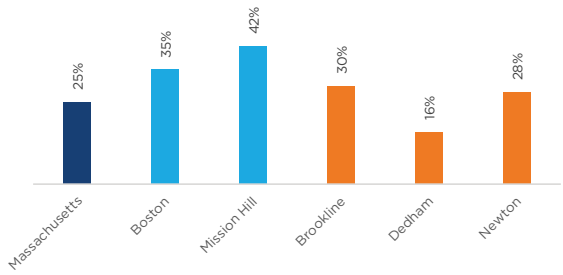
Source: US Census Bureau American Community Survey 2019-2023

Language

Language barriers pose significant challenges to receiving and providing effective and high-quality health and social services. Studies show that health outcomes improve when patients and providers speak the same language.[4]

The percentage of the population 5 years of age and older that speaks a language other than English in their home was higher than the Commonwealth overall (25%) in Mission Hill (42%) and all NEBH CBSA municipalities, with the exception of Dedham (16%).

Percent of the Population 5 Years of Age and Older That Speak a Language Other Than English in the Home, 2019-2023



Source: US Census Bureau American Community Survey 2019-2023

Age

Age is a fundamental factor to consider when assessing individual and community health status. Older adults are at a higher risk of experiencing physical and mental health challenges and are more likely to rely on immediate and community resources for support compared to young people.[5]

The percentage of residents in the NEBH CBSA who were 65 years of age and older was significantly* higher than the Commonwealth overall (18%) in Newton (19%) and Dedham (20%). The percentage was significantly lower* in Brookline (15%), Boston (13%), and Mission Hill (7%).

The percentage of residents who were under 18 years of age in the NEBH CBSA was significantly* higher than the Commonwealth overall (20%) in Newton (21%) and significantly* lower in Boston (15%) and Mission Hill (10%). Percentages were similar to the Commonwealth in Brookline (19%) and Dedham (19%).

Though Mission Hill had a lower percentage of individuals under 18 years of age, it did have a lower median age (24.5) compared to the City of Boston (33.2) and the Commonwealth overall (40.0). This was largely driven by the high proportion of college-aged adults that reside in the neighborhood. Given the transient nature of the college-aged, younger adult population, this population segment's concerns were largely not reflected in the assessment's qualitative findings. Qualitative findings were dominated by the concerns expressed by adults, older adults, and families with children who make up Mission Hill's more permanent residents.

Source: US Census Bureau American Community Survey 2019-2023
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Gender Identity and Sexual Orientation

Massachusetts has the tenth largest lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQIA+) population of any state in the nation (7%). LGBTQIA+ individuals face issues of disproportionate violence and discrimination, socioeconomic inequality, and health disparities.[6]

7%
of adults in Massachusetts identify as LGBTQIA+.
Source: Gallup/Williams, 2023

21% of LGBTQIA+ adults in Massachusetts are raising children
Source: Gallup/Williams, 2019

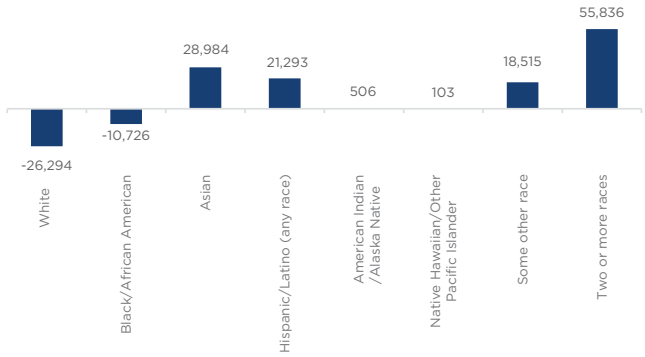
Community Characteristics

Race and Ethnicity

In the CBSA† overall, the number of residents who identified as white or Black/African American has decreased since 2010, while there was an increase in other census categories. Interviewees reported that they felt the CBSA was increasingly diverse, though the NEBH CBSA was predominantly white.

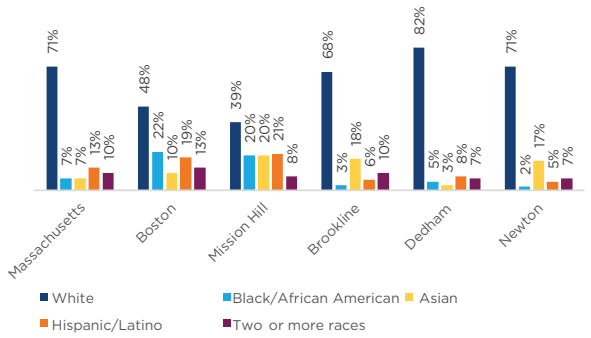
Data for Boston, Brookline, Dedham, and Newton are included in this statistic

CBSA Population Changes by Race/Ethnicity, 2010 to 2020



Source: US Census Bureau Decennial Census, 2010 and 2020

Race/Ethnicity by Municipality, 2019-2023



Source: US Census Bureau American Community Survey 2019-2023

The percentage of the population who identify as Black/African American was higher in Mission Hill (20%) than the Commonwealth overall (7%). The percentage of residents who identify as Asian was higher than the Commonwealth (7%) overall in all municipalities except Dedham (3%). The percentage who identify as Hispanic/Latino (of any race) was higher than the Commonwealth (13%) in Mission Hill (21%).

Note: The US Census Bureau reports that the 2020 Decennial Census significantly undercounts Black/African American, American Indian or Alaska Native, Some Other Race alone and Hispanic or Latino populations. The Census significantly overcounts the White, Non-Hispanic white and Asian populations.

Household Composition

Household composition and family arrangements may have significant impacts on health and well-being, particularly as family members act as sources of emotional, social, financial, and material support.[7]

The percentage of NEBH CBSA households with one or more people 18 years of age or younger was significantly* lower than the Commonwealth overall (28%) in Brookline (25%), Boston (20%), and Mission Hill (17%). The percentage was significantly* higher than the Commonwealth in Newton (33%).

The percentage of NEBH CBSA households with one or more people 65 years of age or older was significantly* lower than the Commonwealth overall (32%) in Brookline (27%), Boston (23%), and Mission Hill (14%). The percentage was significantly* higher than the Commonwealth in Newton (36%) and Dedham (36%).

Source: US Census Bureau American Community Survey 2019-2023
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.[8]

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, and a listening session reinforced that these issues have the greatest impact on health status and access to care in the region.

Interviewees, focus groups, and listening session participants shared that access to affordable housing was a significant challenge for many residents throughout the NEBH CBSA. This is particularly true for older adults, individuals living in poverty and/or on inadequate fixed incomes, and those with mental health and/or substance use disorders.

Transportation is a critical factor to maintaining one's health and accessing care. Transportation is particularly challenging for residents of Mission Hill, given its steep terrain. It is also difficult for individuals without a personal vehicle, and those without caregivers, family, and social support networks.

Food insecurity, food scarcity, and hunger were also identified as a significant challenge, particularly in Mission Hill, where a greater percentage of the population was experiencing economic insecurity. These issues were largely driven by issues related to job loss, the inability to find employment that paid a livable wage, or living on an inadequate, fixed income, which impacted the ability of individuals and families to eat a healthy diet.

Interviewees, focus group, and listening session participants from Mission Hill expressed concerns about public safety and violence, and reflected on the need to enhance security measures, expand access to out-of-school activities for youth, and address drug use in community spaces. This was not identified as an issue in other NEBH CBSA municipalities.

Economic Stability

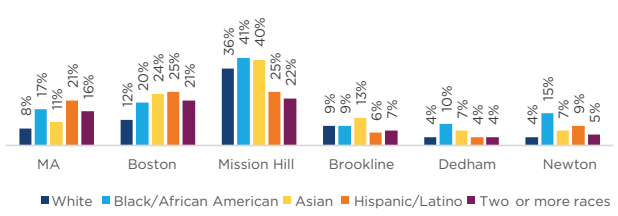
Economic stability is affected by income/poverty, financial resources, employment, and work environment, which allow people the ability to access the resources needed to lead a healthy life.[9] Lower-than-average life expectancy is highly correlated with low-income status.[10] Those who experience economic instability are also more likely to be uninsured or have health insurance plans with very limited benefits. Research has shown that those who are uninsured or have limited health insurance benefits are substantially less likely to access health care services.[11]

COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability.

Across the NEBH CBSA, the percentage of individuals living below the poverty level tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of cumulative disadvantage over time.[12]

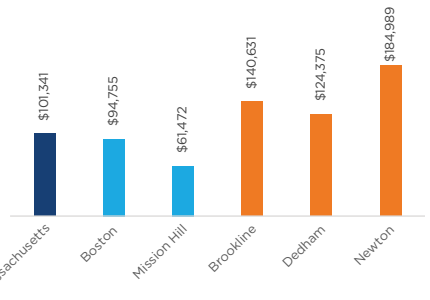
Median household income was higher than the Commonwealth in all NEBH CBSA communities, with the exception of the Mission Hill neighborhood, which was lower by nearly $40,000. Median household income is the total gross income before taxes, received within a one-year period by all members of a household.

Percentage of Residents Living Below the Poverty Level by Race/Ethnicity, 2019-2023



Source: US Census Bureau American Community Survey, 2019-2023

Median Household Income, 2019-2023



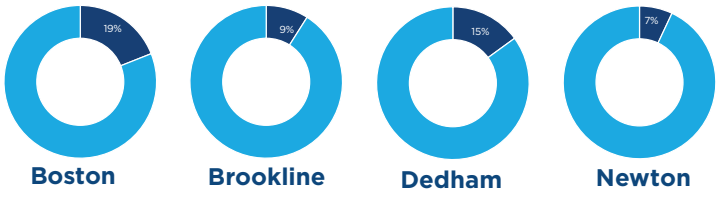
Source: US Census Bureau American Community Survey, 2019-2023

Social Determinants of Health

Economic Stability

The Massachusetts Department of Public Health (MDPH) conducted the 2023 Community Health Equity Survey in the summer and fall of 2023 to better understand the most pressing needs facing Massachusetts residents. Results of the survey indicated that community residents were struggling with economic insecurity. Residents in all NEBH CBSA municipalities reported that, by the end of the month, they did not have enough money to pay for needed items. Note that data was not available for Boston neighborhoods.

Percentage Without Enough Money to Pay for Needed Things at the End of the Month, 2023



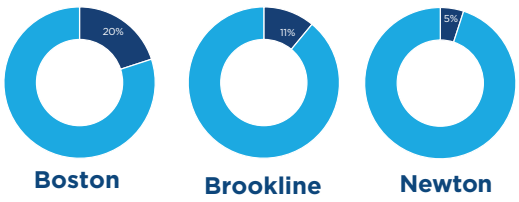
Source: MDPH Community Health Equity Survey, 2023

Food Insecurity and Nutrition

Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

The percentage of NEBH CBSA households that received Supplemental Nutrition Assistance Program (SNAP) benefits within the past year was significantly* lower compared to the Commonwealth overall (14%) in all NEBH CBSA communities, with the exception of Mission Hill (28%), where the percentage was significantly* higher. SNAP provides benefits to low-income families to help purchase healthy foods.

Percentage Who Had Trouble Paying for Food or Groceries (Including Formula or Baby Food) Sometime in the Past Year, 2023



Data unavailable for Mission Hill and Dedham

Source: MDPH Community Health Equity Survey, 2023

*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Education

Research shows that those with more education live longer, healthier lives. Patients with a higher level of educational attainment are able to better understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers.[13]

The percentage of NEBH CBSA residents 25 years of age and older with a high school degree or higher was significantly* higher compared to the Commonwealth (91%) in all NEBH CBSA communities except Mission Hill, where the percentage was significantly lower (78%).

The percentage of NEBH CBSA residents 25 years of age and older with a bachelor's degree or higher was significantly* higher compared to the Commonwealth (47%) in all NEBH CBSA communities except Mission Hill, where the percentage was similar (44%).

Source: US Census Bureau American Community Survey 2019-2023
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Neighborhood and Built Environment

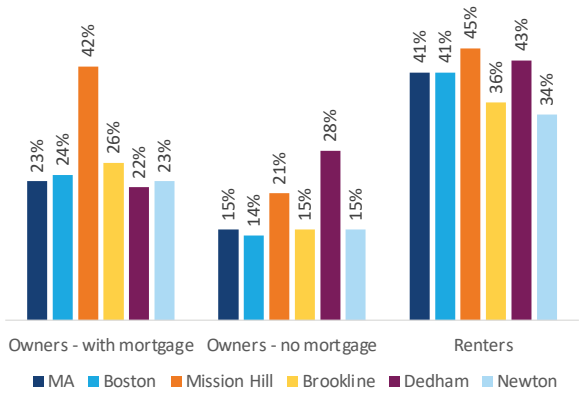
The conditions and environment in which one lives have significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks, and bike lanes improve health and quality of life.[14]

Housing

Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases, and poor mental health. At the extreme are those without housing, including those who are unhoused or living in unstable or transient housing situations who are more likely to delay medical care and have mortality rates up to four times higher than those who have secure housing.[15]

Interviewees, focus group participants, and listening session participants expressed concern over the limited options for affordable housing throughout the NEBH CBSA, especially in Mission Hill. The high-proportion of college-aged, young adults, who are often subsidized by their families and/or by student loans, has driven up rental and housing values, which over the years has led to the displacement of many long-standing community residents.

Percentage of Housing Units with Monthly Owner/Renter Costs Over 35% of Household Income, 2019-2023



Source: US Census Bureau American Community Survey, 2019-2023

The percentage of housing units in the CBSA with owner costs in excess of 35% of household income was lower than the Commonwealth in all NEBH CBSA communities, with the exception of Mission Hill and Dedham among owners with no mortgage. Among renters, the percentage spending in excess of 35% of household income was higher than the Commonwealth in Mission Hill (45%) and Dedham (43%), and lower in Brookline (36%) and Newton (34%).

Transportation

Lack of transportation has an impact on access to health care services and is a determinant of whether an individual or family can access basic resources. Access to affordable and reliable transportation widens opportunity and is essential to addressing poverty and unemployment; it allows access to work, school, healthy foods, recreational facilities, and other community resources.

Transportation was identified as a significant concern for older adults and individuals living with disabilities in Mission Hill; the landscape and physical terrain in the neighborhood makes it difficult for individuals to navigate the community. Transportation was also identified as a barrier to care and services for older adults in Dedham.

"When people need to take groceries home, it is really hard because bus stops are not accessible." – NEBH focus group participant

20% of adults in Mission Hill said better access to reliable public transportation is a factor that would improve the quality of life and health in the community.

Source: 2025 Boston Community Health Needs Assessment, Boston Community Health Collaborative

Roads/Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety and increased mobility. Sidewalks allow more space for people to walk or bike, which increases physical activity and reduces the need for vehicles on the road. Several interviewees in Mission Hill noted a need for better maintenance of roads and sidewalks to ensure individuals have safe routes for walking and exercise.

13% of adults in Mission Hill said improving the accessibility of sidewalks is one of the top five factors that would improve the quality of life and health in their community.

Source: 2025 Boston Community Health Needs Assessment, Boston Community Health Collaborative

Systemic Factors

In the context of the health care system, systemic factors include a broad range of considerations that influence a person's ability to access timely, equitable, and high-quality services. There is a growing appreciation for the importance of these factors as they are critical to ensuring that people are able to find, access, and engage in the services they need, communicate with clinical and social service providers, and transition seamlessly from one service setting to another. The assessment gathered information related to perceptions of service gaps, barriers to access, care coordination, and information sharing.

Systemic barriers affect all segments of the population but have particularly significant impacts on people of color, persons whose first language is not English, foreign-born individuals, individuals living with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+.

Findings from the assessment highlighted the challenges that residents throughout the NEBH CBSA face with respect to long wait times, provider/workforce shortages, and service gaps, which impact people's ability to access services in a timely manner. This was particularly true with respect to primary care, behavioral health, and medical specialty care. As discussed earlier in this report, participants reflected on linguistic and cultural barriers to care. The assessment findings also reflected on how difficult it is for many residents to schedule appointments, coordinate care, and find the services they need. In this regard, interviewees, focus groups, and listening session participants discussed the need for tools to support these efforts, such as resource inventories, case managers, recovery coaches and healthcare navigators.

Finally, individuals participating in interviews, focus groups, and listening session reflected on the high cost of care, including prescription medications, particularly for those who are uninsured or who have limited health insurance benefits.

Accessing and Navigating the Health Care System

Interviewees, focus group participants, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, and stem from the way in which the system does or does not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.[16] Finally, transportation was also identified as a significant barrier, particularly for those without a personal vehicle or those with mobility issues who may have challenges accessing public transportation.

Populations facing barriers and disparities

- Low-resourced individuals
- Racially, ethnically, and linguistically diverse populations
- Individuals living with disabilities
- Older adults
- Youth
- LGBTQIA+

Community Connections and Information Sharing

A great strength of NEBH's CBSA is the strong community collaboratives, advocates, and task forces that convene to share information and resources. Many individuals described a strong sense of partnership and camaraderie among community-based organizations and clinical and social service providers, especially in Mission Hill, borne out of a shared mission to ensure that community members have access to the services and care that they need. This was especially true in the realms of housing and older adult health and wellness.

"There are not as many community-based organizations in Mission Hill as there used to be, but the ones we do have work closely together. Organizations are collaborative and there is a recognition that we don't want to duplicate efforts."
-Interviewee

Behavioral Factors

The nation, including the residents of Massachusetts and NEBH's CBSA, face a health crisis due to the increasing burden of chronic medical conditions. Underlying these health conditions are a series of behavioral risk factors that are known to help prevent illness and are the early signs or contributors of the leading causes of death (e.g., heart disease, cancer, stroke, and diabetes). The leading behavioral risk factors include an unhealthy diet, physical inactivity, and tobacco, alcohol, and marijuana use. Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being, and reduces the risk of illness and death due to the chronic conditions.[17]

When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use and alcohol use. Those who participated in the assessment's community engagement activities were also asked to identify the health issues that they felt were most important. Historically, NEBH focused activities on addressing common risk factors, such as access to healthy affordable foods, and finding solutions for individuals with mobility issues.

Nutrition

Adults who eat a healthy diet have increased life expectancy and decreased risk of chronic diseases and obesity; children require a healthy diet to grow and develop properly.[18] Access to affordable healthy foods is essential to a healthy diet. Individuals who participated in interviews, focus groups, and listening session expressed concern about people's ability to afford healthy, culturally appropriate foods, especially in Mission Hill.

40% of adults in Mission Hill said improving access to low-cost healthy foods is one of the top five factors that would improve the quality of life and health in their community.

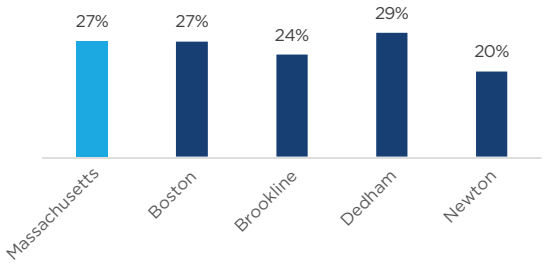
Source: 2025 Boston Community Health Needs Assessment, Boston Community Health Collaborative

Physical Activity

Individuals engaged in the assessment acknowledged that lack of physical fitness is a leading risk factor for obesity and a number of chronic health conditions. Interviewees and focus group and listening session participants reported that physical activity is a challenge for many older adults in Mission Hill, especially in the context of COVID-19, which kept people inside.

The percentage of adults who are obese (with a body mass index over 30) was lower than the Commonwealth in Brookline and Newton. Note that data was not available for Boston neighborhoods.

Percentage of Adults Who are Obese, 2022



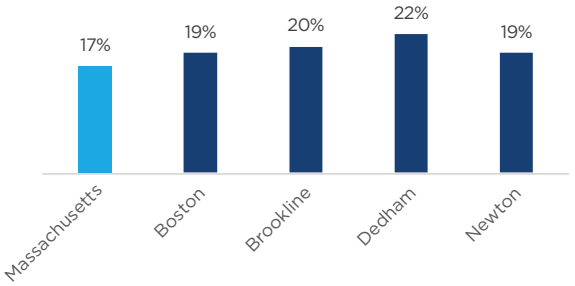
Source: CDC Places, 2022

Alcohol, Marijuana, and Tobacco Use

Though legal in the Commonwealth for those aged 21 and older, long-term and excessive use of alcohol, marijuana, and tobacco can lead to the development and exacerbation of chronic and complex conditions, including high blood pressure, cardiovascular disease, and cancer.

Clinical service providers reported linkages between substance use and mental health concerns, noting that individuals may use substances such as alcohol or marijuana as a way to cope with stress. Interviewees and focus group participants also identified vaping as a concern particularly affecting youth.

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC Places, 2022

Health Conditions

The assessment gathered information related to the conditions that are known to be the leading causes of death and illness. These conditions include chronic and communicable medical conditions as well as mental health and substance use disorders. As discussed in the introductory sections of this report, the assessment gathered quantitative data to assess the extent that these issues were a concern in NEBH's CBSA.

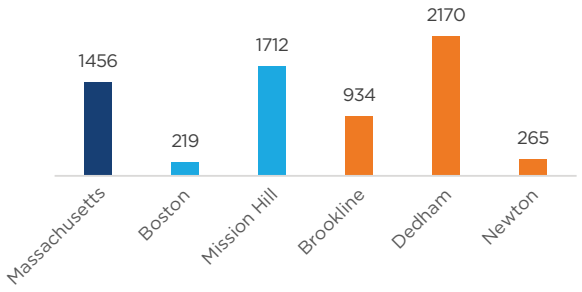
To augment and clarify this information, the assessment efforts included community engagement activities and specifically asked participants to reflect on the issues that they felt had the greatest impact on community health. Efforts were made to ensure that participants reflected on a broad range of issues, including chronic and communicable medical conditions and behavioral health disorders. Given the limitations of the quantitative data, specifically that it was often out of date and was not stratified by age, race and ethnicity, the qualitative information from interviews, focus groups and listening session was of critical importance.

Mental Health

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults, and social isolation among older adults.

In addition to the overall burden and prevalence of mental health issues residents also identified a need for more behavioral health providers and treatment options, including inpatient and outpatient services and specialty care. Interviewees, focus groups, and listening session participants also reflected on the need to support individuals in navigating care options within the behavioral health system.

Inpatient Discharges (per 100,000) for Mental Health Conditions Among Those Over 65 Years of Age, 2019



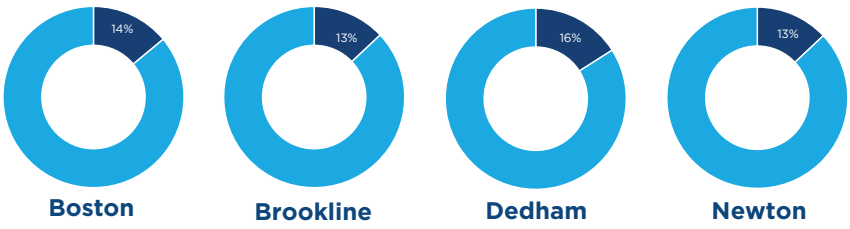
Source: Behavioral Risk Factor Surveillance System, 2024

"Social isolation is a major issue. Depression and substance use are also top concerns. We don't have perfect answers for any of these issues, but we are trying different things in our community. We are trying to take a community approach."

-interviewee

In every NEBH CBSA community, more than 10% of respondents reported more than 15 poor mental health days in the past month. Note that data was not available for Boston neighborhoods.

Percent of Adults Who Experienced Frequent Mental Distress Within the Past 30 Days, 2022



Source: CDC Places, 2022

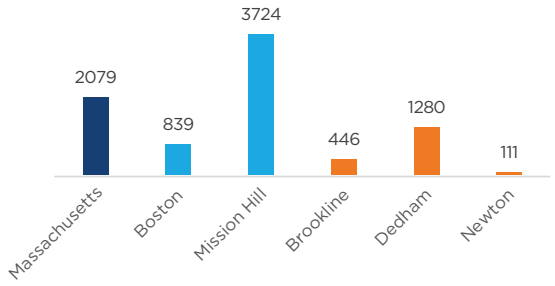
Health Conditions

Substance Use

Substance use continued to have a major impact on the CBSA; the opioid epidemic was an area of focus and concern, and there is recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified a need to address drug use in community spaces, and the need to address mental health and substance use as co-occurring issues.

Inpatient discharges for individuals 18-44 years of age and older for substance use disorders were higher than the Commonwealth in Mission Hill.

Inpatient Discharges for Substance Use Disorder Among Those 18-44 Years of Age, 2024



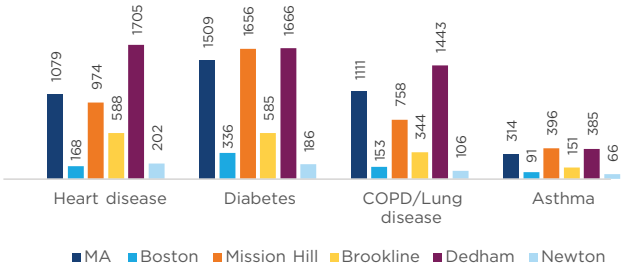
Source: Center for Health Information and Analysis, 2024

Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.[19]

Looking across chronic and complex conditions, inpatient discharge rates were consistently higher than the Commonwealth overall in Boston and Brookline. Note that data was not available for Boston neighborhoods.

Inpatient Discharge Rates (per 100,000) for Chronic/Complex Conditions Among Individuals 65 Years of Age, 2024



Source: Center for Health Information and Analysis, 2024

Roxbury had the second highest percentage of adult residents with asthma (14%) among all Boston neighborhoods; this percentage was higher than the City of Boston overall (11%). As seen in the graph above, the inpatient discharge rate for asthma among residents of Mission Hill (396 per 100,000) was higher than the Commonwealth overall (314 per 100,000).

Source: Boston Behavioral Risk Factor Survey (2017, 2019, 2021); Boston Public Health Commission

Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability, and even death - as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees or participants of focus groups and listening session, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

Priorities

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, NEBH's CBAC and community residents, through the community listening session, formally prioritized the community health issues and cohorts that they believed should be the focus of NEBH's IS. This prioritization process helps to ensure that NEBH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

Massachusetts Attorney General's Office	Massachusetts Department of Public Health
• Chronic disease - cancer, heart disease, and diabetes • Housing stability/homelessness • Mental illness and mental health • Substance use disorder • Maternal health equity	• Built environment • Social environment • Housing • Violence • Education • Employment
Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy	*Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)*

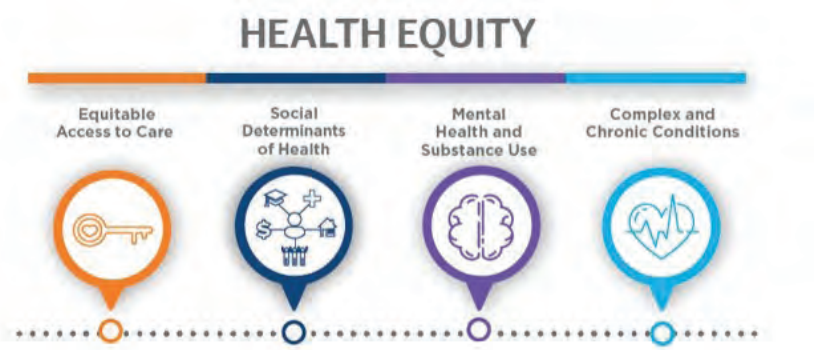
Community Health Priorities and Priority Cohorts

NEBH is committed to promoting health, enhancing access and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.

NEBH Community Health Needs Assessment: Priority Cohorts

- **Youth**
- **Older Adults**
- **Low-Resourced Populations**
- **Racially, Ethnically, and Linguistically Diverse Populations**
- **Individuals Living with Disabilities**

NEBH Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by NEBH

It is important to note that there are community health needs that were identified by NEBH's assessment that were not prioritized for investment or included in NEBH's IS. Specifically, addressing issues in the built environment (e.g., improving roads and sidewalks). While these issues are important, NEBH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, NEBH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. NEBH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in NEBH's IS

The issues that were identified in the NEBH CHNA and are addressed in some way in the hospital IS are housing issues, food insecurity, transportation, economic insecurity, community safety, long wait times for care, navigating a complex health care system, health insurance and cost barriers, language and cultural barriers, social isolation among older adults, depression/anxiety/stress, youth mental health, navigating the behavioral health system, supportive services for individuals with substance use disorder, community-based education and screenings, conditions associated with aging, support for caregivers, and care navigation support.

Implementation Strategy

NEBH's current 2023-2025 IS was developed in 2022 and addressed the priority areas identified by the 2022 CHNA. The 2025 CHNA provides new guidance and invaluable insight on the characteristics of NEBH's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed NEBH to develop its 2026-2028 IS.

Included below, organized by priority area, are the core elements of NEBH's 2026-2028 IS. The content of the strategy is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

Below is a brief discussion of the resources that NEBH will invest to address the priorities identified by the CBAC and NEBH's senior leadership team. Following the discussion of resources are summaries of each of the selected priority areas and a listing of goals that were established for each priority area.

Community Benefits Resources

NEBH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by NEBH and/or its partners to improve the health of those living in its CBSA. Additionally, NEBH works on its own or with its partners to leverage funds through public or private grants and other funding sources. NEBH supports residents in its CBSA by providing financial assistance to individuals who are low-resourced and are unable to pay for care and services. Moving forward, NEBH will continue to provide free or discounted health services to persons who meet the organization's eligibility criteria.

Recognizing that community benefits planning is ongoing and will change with continued community input, NEBH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. NEBH is committed to assessing information and updating the plan as needed.

Following are brief descriptions of each priority area, along with the goals established by NEBH to respond to the CHNA findings and the prioritization and planning processes. Please refer to the full IS in Appendix E for more details.

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

Strategies to address the priority:

- Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.
- Advocate for and support policies and systems that improve access to care.

SOCIAL DETERMINANTS OF HEALTH

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

Strategies to address the priority:

- Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable nutritious food.

- Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.
- Support programs and activities that increase employment, earnings, and financial security.
- Support community/regional programs and partnerships to enhance access to affordable and safe transportation.
- Support programs and activities that foster social connections, strengthen community cohesion and resilience, and address causes and impacts of violence.
- Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.
- Advocate for and support policies and systems that address social determinants of health.

MENTAL HEALTH AND SUBSTANCE USE

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

Strategies to address the priority:

- Support mental health and substance use education, awareness, and stigma reduction initiatives.
- Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality culturally and linguistically appropriate services.
- Advocate for and support policies and programs that address mental health and substance use.

CHRONIC AND COMPLEX CONDITIONS

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

Strategies to address the priority:

- Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with chronic and complex conditions and/or their caregivers.
- Advocate for and support policies and systems that address those with chronic and complex conditions.

Evaluation of Impact of 2023-2025 Implementation Strategy

As part of the assessment, NEBH evaluated its current IS. This process allowed the hospital to better understand the effectiveness of their community benefits programming and to identify which programs should or should not continue. Moving forward with the 2026-2028 IS, NEBH and all BILH hospitals will review community benefits programs through an objective, consistent process.

For the 2023-2025 IS process, NEBH planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2022 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and financial assistance. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Years 2023 and 2024. NEBH will continue to monitor efforts through FY 2025 to determine its impact in improving the health of the community and inform the next IS. A more detailed evaluation is included in Appendix D.

Priority Area	Summary of Accomplishments and Outcomes
Social Determinants of Health	NEBH invested in addressing social determinants of health through food access, housing support, workforce development, and environmental improvements. The hospital supported multiple food pantries, distributed grocery gift cards and fresh produce, and collaborated with Stop & Shop to provide food during the holidays—reaching hundreds of residents annually. It also maintained McLaughlin Field and participated in neighborhood beautification to create safer and cleaner spaces. Housing efforts included providing school supplies, clothing, and household essentials to over 350 families each year, along with financial and social support through a Resident Services Coordinator. NEBH's workforce development investments included internships, ESOL classes, career advising, and job placement efforts—supporting young adults, individuals living with disabilities, and community members pursuing careers in health care.
Equitable Access to Care	NEBH advanced equitable access to care by supporting transportation, interpretation services, financial counseling, and inclusive policy efforts. The hospital continued its major financial support for the Mission Link bus, which provided over 7,000 rides annually to Mission Hill residents for errands, appointments, and social events. Interpreter services expanded from 1,644 to 2,222 encounters across multiple languages. The hospital also provided resource directories and financial counseling, while BILH Government Affairs, with NEBH's participation, supported a growing number of statewide policy initiatives to improve access to care, including 23 in FY24 alone.
Mental Health and Substance Use	NEBH promoted mental health and social connection by supporting youth development, senior engagement, and stigma-reduction efforts. It funded youth programs such as the Tobin Community Center's summer and after-school offerings, the Police Athletic League, and the Mission Grammar School basketball team. Seniors participated in birthday celebrations, BBQs, and a prom event, with over 140 attending each year. NEBH maintained McLaughlin Field to support outdoor activity and collaborated with local organizations and police on violence prevention programs. The hospital sponsored two Mental Health First Aid trainings and contributed to broader behavioral health advocacy, supporting eight state-level bills in FY24 through BILH Government Affairs.
Complex and Chronic Conditions	NEBH supported chronic disease prevention and management through fitness and wellness programming, particularly for older adults in Mission Hill. The hospital collaborated with the Boston Celtics to host three Sr. Celtics events annually, each drawing over 140 seniors for physical activity and social engagement. NEBH also funded Mindful Movement, a weekly yoga class attended by over 30–35 older adults each year, with participants reporting improved flexibility, reduced stress, and reduced isolation. The hospital maintained McLaughlin Park and its walking paths throughout the year, encouraging outdoor activity for all residents. These efforts aimed to improve health outcomes by fostering physical activity, mental well-being, and community connection for individuals living with or at risk for chronic conditions.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: 2026-2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Community Partner Assessment

Boston Community Health Collaborative Community Health Needs Assessment

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

Introduction:
Thank you for agreeing to participate in this interview. As you may know, Beth Israel Lahey Health, including [name of Hospital] are conducting a Community Health Needs Assessment to better understand community health priorities in their region. The results of this needs assessment are used to create and Implement Strategy that the hospital will use to address the needs that are identified.

During this interview, we will be asking you about the assets, strengths, and challenges in the community you work in. We will also ask about the populations that you work with, to understand whether there are particular segments that face significant barriers to getting the care and services that they need. We want to know about the social factors and community health issues that your community faces, and get your perspective on opportunities for the hospital to collaborate with partners to address these issues.

The data we collect during this interview will be analyzed along with the other information we're collecting during this assessment. We are gathering and analyzing quantitative data on demographics, social determinants of health, and health behaviors/outcomes, conducting focus groups with historically marginalized populations, and we conducted a robust Community Health Survey that you may have seen and/or helped us to distribute.

Before we begin, I want you to know that we will keep your individual contributions anonymous. That means no one outside of our Project Team will know exactly what you have said. When we report the results of this assessment, we will not attribute information to anyone directly. We will be taking notes during the interview, but if you'd like to share something "off the record", please let me know and I will remove it from our notes.

Are there any questions before we begin?

1. **Please tell me a bit about yourself. What is your role at your organization, how long have you been in that position, and do you participate in any community or regional collaboratives or task forces? Do you also live in the community?**

2. **In [name of Hospital's] last assessment, we identified [4-5] community health priority areas [list them]. When you think about the large categories of issues that people struggle with the most in your community, do these seem like the right priorities to you?**

    a. Would you add any additional priority areas?
    b. I'd like to ask you about the specific issues within each of these areas that are most relevant to your community. For example, in the area of Social Determinants of Health, which issues do people struggle with the most (e.g., housing, transportation, access to job training)?

i. In the area of [Social Determinants of Health] – what specific issues are most relevant to your community?
ii. In the area of [Access to Care] – what specific issues are most relevant to your community?
iii. In the area of [Mental Health and Substance Use] – what specific issues are most relevant to your community?
iv. In the area of [Chronic and Complex Conditions] – what specific issues are most relevant to your community?
v.

3. **In the last assessment, [name of Hospital] identified priority cohorts – or populations that face significant barriers to getting the care and services they need. The priority cohorts that were identified are [list them]. When you think about the specific segments of the population in your community that face barriers, do these populations resonate with you?**
    a. Are there specific segments that I did not list that you would add for your community?
    b. What specific barriers do these populations face that make it challenging to get the services they need?

LHMC, MAH, Winchester: Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/Linguistically Diverse Populations, LGBTQIA+

BIDMC: Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/Linguistically Diverse Populations, LGBTQIA+, Families Impacted by Violence and Incarceration

BH/AGH, Needham, : Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/Linguistically Diverse Populations

AJH, NEBH, Milton, Plymouth: Youth, Older Adults, Low Resourced Populations, Racially/Ethnically/ Linguistically Diverse Populations, Individuals Living with Disabilities

Exeter: Older adults, Individuals living with disabilities, LGBTQIA+, Low resource populations

4. **I want to ask you about community assets and partnerships.**
    a. What is the partnership environment in your community? Are organizations, collaboratives/task forces, municipal leadership, and individuals open to working with one another to address community issues?
        i. Are there specific multi-sector collaboratives that are particularly strong?
    b. Are there specific organizations that you think of as the "backbone" of your community – who work to get individuals the services and support that they need?

5. **Thank you so much for your time, and sharing your perspectives. Before we hang up, is there anything I didn't ask you about that you'd like us to know?**

New England Baptist Hospital
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Representative Samantha Montano, State Representative, 15th Suffolk District
- Patricia Flaherty, Executive Director, Mission Hill Neighborhood Housing Services
- Courtney Wright, Executive Director, Mission Hill Main Streets
- Karen Gately, Executive Director, Roxbury Tenants of Harvard
- Emily Shea, Commissioner, Boston Age Strong
- Matilda Drayton, President, Alice Taylor Task Force
- John Jackson, Director, Tobin Community Center
- Aliece Dutson, President, Mission Grammar School
- Alexandra Oliver-Davila, Executive Director, Sociedad Latina
- Pauline Lin, Community Resident
- Brian Miller, Special Education Teacher, Madison Park High School
- Kylee Foley, Health Director, Town of Dedham
- Councilor Henry Santana, City Councilor At-Large, City of Boston
- Terry Parson, Resident Services Coordinator, Clinical Social Worker, Roxbury Tenants of Harvard

Community Health Priority Areas

Social Determinants of Health

- Economic insecurity
    - Need better access to jobs for youth
    - Need job training for community residents so they can stay and work in our neighborhood, especially at our local health care institutions and universities
    - Since COVID, most agencies are understaffed. Works are doing more than their job and are over-burdened, and many still aren't making a livable wage
- Housing
    - Expansion of institutions like colleges and hospitals have had impacts on neighborhoods, primarily Mission Hill and Fenway. Families and individuals have been displaced
        - Lots of new developments in recent years
    - Becoming increasingly more challenging for people to find affordable housing in Mission Hill. This also has affects on organizations' ability to recruit staff into their organization – you can't hire someone to work for you if they aren't able to afford to live within travel distance.
        - People are facing eviction and have no funds for moving costs
    - Concerns around asbestos, rodent, and trash issues
- Food insecurity
    - There used to be a robust farmers market in the community, but it doesn't seem to be as active
    - People in the neighborhood want access to food that is healthy and affordable
    - It's hard for some older adults and people with disabilities to independently access the resources that may be available
- Transportation

    - See many families struggling to get their children to school
    - Once young people leave the Boston Public School system, they no longer have free access to the T, which is problematic for many
    - There are mental and physical barriers to transportation use (e.g., lack of lights, bus shelters)
    - Services like the RIDE may be available but they're not always reliable
    - Mission Hill is a difficult community for some to navigate, especially people who are older, or who have disabilities
- Language and cultural barriers to services
    - Most places have some sort of interpreter services, but not all. Language is a barrier to some of our community resources
- Community safety
    - Community residents are concerned about safety. Would like to see more police presence in our streets

Access to Care

- Connecting older adults to navigation support
- Navigation – you need patience and navigation to navigate the healthcare system, which not all people have the social capital to do.
    - Not everyone has family members or friends who can help them navigate care decisions, get to appointments, etc.
- People have trouble getting appointments and keeping them. Transportation barriers create cancellations and delays
- Cost and insurance barriers – it's difficult for people to find the right healthcare plans
    - Some people skip medications because they can't afford it
- There are long wait lists, even for primary care providers. Wait times for specialists can be up to 6 months. Anecdotally, people have said they were not experiencing such long wait times before COVID
- Care continues to offered in a virtual format, which can be particularly challenging for older adults. "Technology can be a boon and a burden – not everyone has a Smartphone to join appointments that way."

Mental Health and Substance Use

- Depression, anxiety, stress
    - "We continue to see a high number of people who are really depressed and anxious. We need to be thinking about mental health for parents and how to better support them."
    - "Mental health should be a priority for all, but it's hard to prioritize when you're struggling with food and housing insecurity."
- Older adult isolation
    - Would like to see more programs that connect older adults with young people
    - Loneliness is an issue, especially for those in our public housing communities
- Youth mental health
    - Need to expand resources for youth, including after school programs that provide support and activities (e.g., music, arts, mindfulness, community service opportunities)
    - Cyber-bullying and addiction to technology

    - Difficult to find culturally sensitive care for youth that is covered by insurance
    - Would like to see more youth mentorship programs
- Immigrant/refugee trauma
    - It is a very scary time for people that are undocumented, and they may shy away from accessing services.
- Lack of providers
    - Have seen significant challenges hiring enough mental health clinicians, despite being so close to world class institutions
- Substance use
    - There is active drug use in the community. Would like to see a larger police presence
    - Need more support for individuals with substance use to get into treatment and supportive services. There have been instances of people passing away in public places in the neighborhood
    - Services need to made available at the right time, when a client is ready to engage in services
- Navigation – there are gaps in knowledge about what services are available

Chronic and Complex Conditions

- Concerns about asthma in Mission Hill – have heard that rates are high compared to other neighborhoods.
- Aging
    - Concerns are plentiful – dementia, mobility, isolation, high blood pressure, diabetes
- Navigation – you need patience and navigation to navigate the healthcare system, which many people aren't adequately prepared for.
- Would like to see more education around nutrition
- Chronic conditions can persist between generations
- Would like to see programs brought into community spaces – for example, doing vaccinations in community centers. Getting appointments at CVS and primary care places is sometimes challenging
    - There used to be programs in the community that focused on door-to-door education and community events to share resources around health issues.
- Diabetes
- Would like to see more specialists who are focused on the needs of older adults
- Language barriers – whenever there is a program that offers services or education in languages other than English, they're well attended. Additionally, need for paperwork and forms to be translated into other languages

Priority Populations

- Agreement across interviewees that the following populations should continue to be the priority, as they face the most significant barriers to care and services:
    - Older adults
    - Racially/ethnically/linguistically diverse (including immigrants and refugees – primarily those that have newly arrived)
        - An interviewee highlighted disparities specifically among the Latino community – health outcomes, economic disparities.

        - Immigrants and refugees – we are going to continue to see more new residents come to our communities.
    - Low-resourced/low-income populations
    - LGBTQIA+
    - Individuals living with disabilities
        - Not as represented as they should be, and needs have increased since the pandemic. There are needs for both youth and adults.
    - Youth
        - Need more support for early childhood growth and development
- Families need more support

Community Resources, Partnership, and Collaboration

- In Mission Hill, there aren't as many community organizations, partnerships, or non-profits as there used to be.
    - Organizations are fighting for resources, which can create strain and negativity
    - People are good at coming together in a crisis, but the neighborhood needs organizations to come together in more thoughtful and proactive ways.
- Many large institutions have a footprint in Mission Hill – healthcare, schools – and they could be doing more in our community. They take up a lot of space, and it should be required that they do more in service of Mission Hill.
    - Would like to see the City involve the neighborhood in planning efforts in a more thoughtful way
- Schools are very collaborative
- There are lots of public spaces in Mission Hill that can be utilized by other organizations (e.g., Tobin Community Center, public library)
- Specific organizations identified as key community resources: Mission Hill Neighborhood Housing Services, Tobin Community Center, Sociedad Latina, NEBH, schools, Ethos, AgeStrong, housing communities, Fresh Truck, BAGLY, Fenway Health, City of Boston services

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

Name of group:
Hospital:
Date/time and location:
Facilitator(s):
Note taker(s):
Language(s):

Instructions for Facilitators/Note Takers (Review before focus group)

- This focus group guide is specifically designed for focus group facilitators and note-takers, and should not be distributed to participants. It is a comprehensive tool that will equip you with the necessary knowledge and skills to effectively carry out your roles in the focus group process.
- As a **facilitator**, your role is to guide the conversation so that everyone can share their opinions. This requires you to manage time carefully, create an environment where people feel safe to share, and manage group dynamics.
    - Participants are not required to share their names. If participants want to introduce themselves, they can.
    - Use pauses and prompts to encourage participants to reflect on their experiences. For example: "Can you more about that?" "Can you give me an example?" "Why do you think that happened?"
    - While all participants are not required to answer each question, you may want to prompt quieter individuals to provide their opinions. If they have not yet shared, you may ask specific people – "Is there anything you'd like to share about this?"
    - You may have individuals that dominate the conversation. It is appropriate to thank them for their contributions but encourage them to give time for others to share. For example, you may say, "Thank you for sharing your experiences. Since we have limited time together, I want to make sure we allow other people to share their thoughts."
- As a **notetaker**, your role is to document the discussion. This requires you to listen carefully, to document key themes from the discussion, and to summarize appropriately.
    - Do not associate people's names with their comments. You can say, "One participant shared X. Two other participants agreed."
    - Responses such as "I don't know" are still important to document.
    - At the end of the focus group, notetakers should take the time to review and edit their notes. The notetaker should share the notes with the facilitator to review them and ensure accuracy.
    - After focus group notes have been reviewed and finalized, notes should be emailed to Madison_Maclean@jsi.com

Opening Script

- Thank you for participating in this discussion about community health. We are grateful to [Focus group host] for helping to pull people together and for allowing the use of this space. Before we get started, I am going to tell you a bit more about the purpose of this meeting, and then we'll discuss some ground rules.
- My name is [Facilitator name] and I will be leading the discussion today. I am also joined by [any co-facilitators] who will be helping me, and [notetaker] who will be taking notes as we talk.
- Every three years, [name of Hospital] conducts a community health needs assessment to understand the factors that affect health in the community. The information we collect today will be used by the Hospital and their partners to create a report about community health. We will share the final report back with the community in the Fall of 2025.
- We will not be sharing your name – you can introduce yourself if you'd like, but it is not necessary. When we share notes back with the Hospital, we will keep your identity and the specific things you share private. We ask that you all keep today's talk confidential as well. We hope you'll feel comfortable to discuss your honest opinions and experiences. After the session, we would like to share notes with you so that you can be sure that our notes accurately captured your thoughts. After your review, if there is something you want removed from the notes, or if you'd like us to change something you contributed, we are happy to do so.
- Let's talk about some ground rules.
    - **We encourage everyone to listen and share in equal measure.** We want to be sure everyone here has a chance to share. The discussion today will last about an hour. Because we have a short amount of time together, I may steer the group to specific topics. We want to hear from everyone, so if you're contributing a lot, I may ask that you pause so that we can hear from others. If you haven't had the chance to talk, I may call on you to ask if you have anything to contribute.
    - **It's important that we respect other people's thoughts and experiences.** Someone may share an experience that does not match your own, and that's ok.
    - **Since we have a short amount of time together, it's important that we keep the conversation focused on the topic at hand.** Please do not have side conversations, and please also try to stay off your phone, unless it is an emergency.
    - **Are there any other ground rules people would like to establish before we get started?**
- Are there any questions before we begin?

Question 1

We want to start by talking about <u>physical health</u>. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
b. **What stops you from being as physically healthy as you'd like to be?**

Summarize: Based on what you shared, it sounds like [list to 3-4 themes] have the biggest impact on your physical health. Is that correct, or do we want to add some more?

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?
b. What stops you from being as mentally healthy as you'd like to be?

Summarize: Based on what you shared, it sounds like [list to 3-4 themes] have the biggest impact on your mental health. Is that correct, or do we want to add some more?

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health." What social factors are most problematic in your community?

a. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others?
    a. What sorts of barriers do they face in getting the resources they need?

Summarize:

- It sounds like people struggle with [list top social factors/social determinants]. Is this a good summary, or are there other factors you'd like to add to this list?
- It sounds like [list segments of the population identified] may struggle to get their needs met, due to things like [list reasons why]. Are there other populations or barriers you'd like to add to this list?

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?
b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

Summarize: It sounds like some of the key community resources include [list top responses]. I also heard that you'd like to see more [list resource needs]. Did I miss anything?

Question 5

- Is there anything we did not ask you about, that you were hoping to discuss today?
- Are there community health issues in your community that we didn't identify?
- Are there any other types of resources or supports you'd like to see available in your community?

Thank you

Thank you so much for participating in our discussion today. This information will be used to help ensure that Hospitals are using their resources to help residents get the services they need.

After we leave today, we will clean up notes from the discussion and would like to share them back with you, so that you can be sure that we captured your thoughts accurately. If you'd like to receive a copy of the notes, please be sure you wrote your email address on the sign-in sheet.

We also have $25 gift cards for you, as a small token of our appreciation for the time you took to participate. [*If emailing, let them know they will receive it via email. If giving in person, be sure you check off each person who received a gift card, for our records*].

New England Baptist Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Youth in Mission Hill
Location: Tobin Community Center
Date, time: 10/9/2024
Facilitator: JSI
Approximate number of participants: 10

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself and other people your age. What sort of things do people your age do to stay physically healthy?**
    i. Workout/play sports (+2).
        1. One participant specifically mentioned going for a run.
    ii. Eating healthy (+2)
    iii. Walking a lot
    iv. Taking care of your body
    v. Doing skin care
b. **What prevents people your age from being physically healthy?**
    i. Difficulty managing mental health – like depression
    ii. Laziness
    iii. Junk food
    iv. Playing games too much (video games)
    v. Lacking resources nearby
        1. Participants mentioned that if you live far from gyms it will be hard to workout
c. **What are some support to help you with your health?**
    i. Families
    ii. Have more discipline and confidence
    iii. Start a winter "ARC" (motivation season)
    iv. What you eat and what you do in your routine – build positive habits

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. **Think about yourself and others your age. What sort of things do you and the people you know do to stay mentally healthy?**
    a. Isolation can lead to problems with mental health
    b. Listen to music
    c. Therapy – Therapy should be more available for teenagers, especially nowadays.
    d. Talk to friends and family members – some participants feel comfortable talking to family members, other participants do not
        i. Another participant also mentioned that they feel comfortable talking to parents and friends
    e. Participant noted what makes them feel uncomfortable talking about their mental health
        i. Stigma – "feel like we will be laughed out and [people will] make jokes, not take you seriously."
    f. Participants felt like there were not trusted adults at school settings or the Tobin center
b. **What stops you and others your age from being as mentally healthy as you'd like to be?**
    a. Bad habits – too much screen time, being addicted to junk food
    b. Social media – get bullied online. Can be bad for you because you compare yourself to other people and compare yourself to influencers. This is a common experience for people their age.
    c. Social media can influence you in bad ways – doing stuff just because people do it online.
c. **What are some supports to help you with your mental health?**
    a. Participants would like to have a trusted adult.
        i. Characteristics that they look for in a trusted adult
            1. "Keep it between you and me.". Confidentiality
            2. Someone who makes time for you and speaks with you. Someone who gives you advice.
        ii. Participants would like mentors.
            1. Mentor – someone to teach you how to deal with certain situations and how to get out of them (specific situation mentioned – i.e., if you're in trouble or thinking through consequences)
            2. One participant noted: Their brother had a mentor who helped him mature a lot. The mentor told him about different careers that he could pursue.
                a. Before the mentor his brother got expelled from all his schools, the Big Brother program also helped a lot. He got a mentor who came every Friday and took him out to Dunkin Donuts.
    b. In a school environment – students should be able to take breaks. 2 or 3 minute breaks if you are having a mental breakdown. The counselors' office is shared with five other people, so there isn't privacy.
    c. Take a break from social media and focus on your goals

d. Take a break from other people and focus on yourself. If you have a bad relationship with someone, you might have to isolate yourself and get in the right mindset
e. Resources in the community they use:
    i. Programs at the Tobin or other community are also supports
    ii. Roslindale Community Center
    iii. Archdale Community Center
    iv. YMCA – play basketball

d. What are some programs that could help with your mental health if they were available?

a. Boxing – would prevent street fights.
    i. One participant engaged in boxing: "Felt better because I could express anger and get anger out." Outlet for emotions.
b. Program where you work on yourself.
c. Programs that give you jobs – careers.
    i. Both for jobs for right now and in the future
    ii. Job training – electricity and mechanics training for youth
d. Yoga

Question 3

I want to ask about resources – the people and places in your community that help you to stay physically and mentally healthy. This could include a whole range of places and people – like parents, teachers, coaches, doctor's offices, BCNC, etc.

a. What are the key places or people that help support people your age to stay healthy? What do they do to show that they support you?

a. Friends – can relate to a lot of things
b. Somewhere you feel comfortable
c. Coach and teachers for help with homework
d. Arnold Arboretum – The participant doesn't go there often because they live by Mission Hill, but it is a nice place to walk around. They feel refreshed during nature walks.
e. Generally feel nature is helpful with mental and physical health
f. Home – family, your room

b. Are there types of places or resources that you wish were available to you, but aren't?

a. More after school activities
    i. Mostly relating to sports

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?
Are there community health issues in your community that we didn't identify?
Are there any other types of resources or supports you'd like to see available in your community?

- Afterschool Jobs
    - Medical jobs

    - Entrepreneurship – business in general. Opportunities if someone is interested in law or engineering
    - Pre medicine, pre-law.
    - “I go to the Mission, there is a business path and an engineering path, so I could go down those paths if I wanted.”
    - EMK (Edward M. Kennedy Academy) – for 4 years they give you nursing training, in 11th grade you can go to the hospital and see patients. There is a new program with Harvard Medical School. (Mission Hill School)
- “Tell teenagers not to do bad stuff and to influence them – have someone who is closer to your age that you can relate to” (general agreement on this statement)
- One participant shared that they ran away from home one day. Having a therapist was helpful because they had ADHD and OCD.

New England Baptist Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Older adults
Location: Tobin Community Center
Date, time: 10/12/2024
Facilitator: JSI
Approximate number of participants: 17

Question 1

We want to start by talking about <u>physical health</u>. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **What sort of things do you do to stay physically healthy? What stops you?**
    i. Taking Care of kids, sitting on floor and small chairs and getting up impacts sciatica
        1. Concern maybe happens while you're at work, but afterwards they do not care about your health
        2. It [the pain] gets worse after you stop the activity
        3. When the pain comes it is overwhelming, stuck in place
        4. Causes loss in muscle, you need to exercise to supplement [the loss]
    ii. Zumba at the Tobin Community Center, Softball at the Tobin Field (not as often anymore because of knee pain)
    iii. Need to work on eating veggies
    iv. Gotta keep appointments with your doctor, walking and other forms of exercise are important to stay healthy
    v. You need someone to keep you accountable to being healthy so that you want to stay healthy
        1. As someone who lives alone and is older, there isn't incentive to stay healthy
        2. Need to force oneself to stay healthy, others need to tell her to do it.
    vi. Taking care of grandkids, being around kids
    vii. Walk group (Mission Main Walking Group - Every Thursday started 6 weeks ago 12-1PM)
    viii. Zumba
    ix. Keeping Appointments
    x. Sometimes it's hard, losing your mind is easy
    xi. Pinched nerve but the doctors don't know where it is, she doesn't want to take more pills
        1. Physical Therapy is important, the physical therapist does massage therapy and exercises

2. Sense that when you get old, “they don’t want to diagnose you anymore”
3. Care team is important to maintaining care (nurse practitioners and physical therapists)

xii. Working for Classic Citizens keeps her healthy; being able to hold others accountable in a way keeps yourself accountable.
1. Caring for other people, advocating for others helps you keep busy
2. Mind and brain practices as a form of physical health!
3. Engaging with others

xiii. “Too active”
1. If I don’t do anything then you get stiff and it’s hard to get out of the stiffness
2. “People say you do too much”
3. Cleaning, routines, help keep busy and keep mind off of any pain/discomfort
4. If you don’t stay active - it affects your mind!

xiv. Keep the mind going, if you don’t do anything the mind goes “Zoom Zoom Zoom Zoom”

Question 2

Now let’s talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. What do you do to stay mentally healthy? What stops you?

a. Keep your blood pressure down
   i. “Everytime I go to the doctor, my blood pressure is high”
   ii. Sense that blood pressure rises as a result of blood pressure rather than a day-to-day concern
b. Change in care team increases stress
   i. Referrals are complicated, one has to go and find the practitioners oneself
c. Medicare
   i. Wait time is two months for help via phone
   ii. A lot of doctors are not taking new patients
d. Navigating healthcare is a big stressor and impacts mental health
e. Having a care team that acknowledges Mental Health makes one feel more validated
   i. Often nurse practitioners are better at this than doctors
f. Working with Seniors and family members some people stigmatize mental health
   i. Isolation from COVID, could be mistaken as dementia
   ii. Stigmatization around seeking healthcare services but this is IMPORTANT

g. Taking care of family members affects personal mental health
    i. Experiences PTSD after death of their son (sirens)
h. Being around community, need an increase in community services/activities improved mental health and promoted mental health
i. Access to mental health (understanding it, services)
    i. Medicaid
        1. If yes, you have extra help
        2. If no, access is difficult
    ii. Only way to access mental health services are through falling into government systems (i.e. criminal system)
    iii. Would love to see increase in mental health services through community centers
    iv. With regular insurance it is hard to navigate the system
    v. 18 month wait for three separate seniors for local providers to get services
j. You have to recognize mental health first to know that you need services
    i. "Maneuvering the system just to keep mental health is an issue"
    ii. Some people might be ashamed to acknowledge mental health

b. What are the top three concerns?

a. Loneliness, living to paycheck-to-paycheck (income disparity), physical pain and mental health, not being heard (voice is not acknowledged, being talked at, patronized in the doctor's office)
b. Bodily autonomy and being able to communicate this to doctors
c. No particular focus on seniors for programming (healthcare specific)
    i. Talk but no action
    ii. "Medicine has to realize that we are living longer, and not only that we are living longer, the faculties in our bodies are living longer too"
    iii. "They haven't had anyone to study, they don't really know senior needs"
d. They say that exercise is better than medicine but they still give you the pill first

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. What are the parts of the community that struggles to get resources? What are the barriers?

a. A lot of activities at Mission Park, This person experienced a heart attack a year ago
    i. Access is good
    ii. Bus takes residents to the mall and other places based on interest
    iii. Bingo at Mission Park (Spanish Language)

1. Those who don't live in Mission Park are able to come because there is interest

b. Mission Main has a lot of resources for LatinX residents
    i. Access to resources is good
    ii. Only for Mission Main residents
    iii. Have to be creative with resources because they are minimal even though there are a lot of people with need.
    iv. "I wish I could say' here's a box' to everyone" but it's not feasible
c. Seniors who don't live in a community are alone
    i. Even in buildings with small community rooms, resources are small
d. Transportation
    i. Need more Bus stops
        1. "You can walk faster than the bus"
        2. When people need to take groceries home it is really hard because bus stops are not accessible
    ii. Mission Link Bus
        1. Stops at Alice Taylor, Mission Main,
        2. Need them to stop at 650 Huntington
    iii. Mission Park has their own bus
    iv. 650 Huntington is not accessible to groceries + the hill
        1. Things feel political

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. Tell me about the resources in your community? What organizations are active? What is not available?
    a. Whittier Street
        i. Has just about everything
        ii. Wait Time to create an appointment is long
        iii. Shuttle bus/ resource bus (screenings and other resources come to Mission Hill spots)
        iv. "They don't turn no one down"
        v. Financial support if you need it for services
    b. Boston Medical
        i. Tufts Medical
        ii. Provides a lot of information for people
        iii. They will call for a ride if you do not have access to one
        iv. Good programs
    c. Mission Park
        i. A mobile vaccine clinic stops at Mission Park
    d. Tobin Community Center (John Jackson)
        i. Even having a focus group, is a feat of its own

    ii. “It does my heart good to see seniors engaging”
    iii. To see people socialize, helps
e. Age Strong
    i. Physical activities for seniors
    ii. Senior to senior program
    iii. Networking amongst the community is important
f. Information Sharing
    i. “ Each one can teach one”
g. Activities and Programming are available but physical spaces are lacking
    i. And some people don’t want to leave their buildings
h. Adult day care and companion programs could make people healthier, happier, stronger
i. Judy at 650 Huntington
    i. Leads Social programming
    ii. Diverse population shows up (including Men)
    iii. Providing gift cards if available
j. Co-ops versus housing communities (650 Huntington)
    i. Residents are the leaders of change but they don’t own their buildings
    ii. Need to empower people to communicate, advocate
k. Events like Fun Day at Mission Main are open to the community
    i. Good and fun for residents
l. Need more resource sharing; need a one-stop hub for all the information
    i. Word of mouth to community leaders is the current way to send info out
m. Mission Hill housing communities are independent from one another
    i. Some people are not invited to events because they are for residents only

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?
Are there community health issues in your community that we didn’t identify?
Are there any other types of resources or supports you’d like to see available in your community?

- Noise is a concern
- BCYF Johnson just opened (at Alice Taylor)
    - Has a basketball court
    - Is available to all
- More money
    - Invest in the Tobin, and modernize facilities

New England Baptist Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Odults living in affordable housing
Location: Maria Sanchez House, Mission Hill
Date, time: 10/11/2024
Facilitator: JSI and Mission Hill Neighborhood Housing Services
Approximate number of participants: 10

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. I try walking (several participants agreed)
    ii. "I try to walk around here. I go to Dunkin Donuts and come back"
    iii. I go to the gym
    iv. I have friends who go out to lunch, and one of my girlfriends came over yesterday and said 'let's go for a walk.' She's a senior and lives down in Back Bay. I don't go every day. A week might come where I've been in the house for 2-3 days and I'll walk to the market.
    v. Connecting with other people to keep physically active
    vi. One of the things that my family does – if they don't hear from me, they'll call me to make sure I'm alright and getting around. I have a lot of outlets and friends who keep me active. I was more active when I wasn't incapacitated, like I am now.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. My ailments. I'm not able to do things like I used to. Mobility. I'm slower. I have to be careful when I'm walking around my apartment, and even when I'm getting dressed. I have to be careful in the bathroom. I have a container in the bathroom that I have to hold on to when I'm getting dressed.
    ii. My asthma
    iii. I need a hip replacement
    iv. Pain. If I took the medication that they gave me, I'd probably be in less pain. The medicine they give me makes me feel loopy and dizzy and sets my balance off. That's why I don't take it during the day, I only take it sometimes.
    v. It's hard around here. Even accessing the Tobin sometimes. I pay to use the gym over there when the door is open. Getting into the building can sometimes be a challenge for me. There is no way to get in from the front. You have to get someone to help you up the stairs.

1. This area – the sidewalks are horrible. I have to be very careful because of stones and things like that. Sidewalks are elevated because trees are growing into the sidewalks. Like today, I couldn't get off the train station because people double park by Brigham Circle. I told the bus driver – I have to go in front of you, because I can't use the sidewalk.
2. There is AgeStrong at the Tobin, but you can't get to AgeStrong! It's not accessible. I'm a little offended by the fact that there is a sign that says I need to go upstairs. They have a little elevator or lift, but it never works. But even getting into that – the door has to be open. It's only accessible if you can actually get into the building. It says to call, but there's no number on the door to call.
3. ABCD used to have an elevator. There are a lot of resources offered in the community, but you can't get to them.

vi. I suffer from chronic low back pain. If I'm doing dishes or cooking – whatever I'm doing – I have to stop and go lie down on the heating pad. When I feel better, I can get back up and do what I have to do.

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?

a. Stick to myself. If you're by yourself, people can't stress you out
b. I read, do word searches, and play solitaire on my phone
c. Watching TV
d. Mentally, I'm fine. I don't worry. Why worry? If you can't fix it, why worry about it?
e. Resting
f. Talking to my family every day. Staying in contact with them.
g. Getting involved in things beyond my home and this neighborhood.
h. NEBH and Wentworth students come in to some places and do activities – like Bingo games – I'd love that.
i. Try to keep myself busy. Bingo, crochet.
j. Volunteer at a Food Pantry
k. I used to be a hockey player. I used to play volleyball. I don't think I'll be doing that anymore. They're doing wheelchair soccer, which I don't do because I'd probably get injured. But I work with the organization. I try to be involved in different things.
l. Church. I have a friend that picks me up on Sunday morning and brings me back.
m. When I need help, I have no problem asking for it

b. What prevents you from being mentally well?

a. My apartment is a mess and I don't have someone to help me.
b. I have three children and they are in England. I used to visit my daughter once a week before she left. I haven't been able to talk to her. I talk to my grandson in Texas, and every week he calls and Facetimes me and we talk – that gives me a lot of joy and pride.
    i. When they were little, I wasn't there for them. They needed me and I wasn't there. And now I need them. It's hard.
c. I have a family by birth and a family by choice. It doesn't really affect my mental health. I have a family of people that I wasn't born to, but they're there for me. I had to accept my situation and I can do that most of the time. There are days where I want to go back to my old job and life. The obstacles are things that I have to reframe.
d. In the past I was always working. It was a major part of who I was. I was traveling full time. Now I have to pay for my own travel. I've accepted that most days. Other times, it's hard. It's more like… I don't have that disposable income.
e. You don't want to put too much on one person. They'll get tired because you're always asking for rides.
f. Financial stress

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. What social factors are most problematic in your community?
    a. Language barriers in the community. Most of the people who live in this building speak Spanish, and assume I speak the language. I feel bad. It prevents people from coming together. For example, when we had the fire… all of the Spanish speakers were out and they were all communicating what was happening, and I didn't understand. But there was a disconnect.
    b. Food – when we have events, the food has lots of sugar.
    c. Transportation is a barrier
        i. Especially for seniors and those with mobility issues
    d. Lack of compassion for community members
        i. Participants gave examples of people on buses not giving up their seats. Bus drivers do not open the ramp for people in wheelchairs.
    e. Having to plan in advance for things – like when there will be kids on the buses and sidewalks. I have to plan around that so I can get around.
    f. It's hard to figure out what's available in this community. I spend a lot of time helping my neighbors figure out what they can use.

b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. What are the resources available in the community that help people to stay healthy ?

a. Brigham van. They come and take my blood pressure and talk about my medications. It keeps me on top of what I'm doing. If the weather is bad, at least you know they're there. Trying to get to a clinic when the weather is bad is difficult
    i. One participant shared a story about the van. They were able to use the van for her asthma appointment instead of going to the hospital
b. Senior Elder Services from Central Boston sends a nurse out once a year
c. Food from ABCD
d. The church drops off lunch every week.
e. Farmers market
f. AgeStrong office has coupons for food, but you have to be able to get into the building

b. What resources are missing in the community?

a. Food resources and food access. It would be nice if they had stuff in the building to help, especially when you can't get out of the house, and in the winter.
b. There is stigma and shame about asking for food.
c. There is a Farmers Market but it's very expensive.
d. Pharmacies – they're taking away all the pharmacies.

New England Baptist Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals Living in Affordable Housing
Location: 1 Gurney Street
Date, time: 11/13/2024
Facilitator: JSI
Approximate number of participants: 6

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Eat healthy, work out, take kids on a walk to a park, and do home workouts with kids
    ii. Taking the stairs instead of the elevator
    iii. Walking to get groceries
    iv. Local stores, parks, and events make it easier to get around

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Hard to fit in going to the gym, so finding small ways to exercise is important
    ii. Lack of discipline and lack of motivation
    iii. Having kids can take over your personal life, being a parent is physical and emotional labor
    iv. Being a new mother or getting custody of a child can be a lot of pressure
    v. Depression and mental health can prevent physical healthiness
        1. Trauma and depression
        2. Trauma can be hard even to pin down or process; it can take years
    vi. Time is a huge factor
    vii. Accessing places that take insurance, waitlists for resources, and wanting a choice in where your child goes to daycare
    viii. Feeling unheard and unseen by human services workers who are meant to connect them to resources
    ix. Having people you trust to help you can be hard
    x. Sacrificing pay for flexible hours as a mother

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?

- a. Silent screams
- b. Alone time
  - i. Spending time in the car to be away from children
- c. Prayer
  - i. Praying five times a day as a Muslim
- d. Venting, talking to someone who isn't giving advice, but is just listening
- e. Access to a psychiatrist; the ability to get diagnoses for mental illness for themselves

b. What stops you from being as mentally healthy as you'd like to be?

- a. Cultural stigma
  - i. Hard to lean on others when it is so stigmatized in your community
  - ii. Family within the community, hard to talk to others outside of family when it could come back
- b. Access to medication
  - i. Finding the correct medication
  - ii. For some people, medicine is not effective
  - iii. Adverse effects of some medication
  - iv. Stigma around medication
- c. Finding a doctor who will work with you to get the care that is best for your child, not just what treatment is 'supposed' to happen
- d. Insurance
  - i. Insurance not covering certain medications, treatments, etc
- e. Access is an issue - Waitlists that can last for over a year,

c. What could help?

- a. Stronger community around women - support groups within the community
  - i. Lots of women need support, regardless of mental health issues
- b. Some people are worried about privacy or lack of professional presence

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. What social factors are most problematic in your community?

- a. Housing as a determinant of health

b. Sound in the buildings is an issue
c. Congestion and foot traffic
d. People doing drugs, going to the bathroom outside, selling drugs
e. Transportation, parking
    i. Street parking being taken up by people who don't live here; people who commute to work but live in the suburbs
    ii. Snow plowing blocks peoples' cars; hardest for moms with children trying to dig out their cars in the morning
    iii. The Ride (T for disabled people) is NOT free
f. Language
    i. Lack of access to translation services, community having to help
g. Insurance covering healthcare
h. What resources are currently available? What aren't?
i. There are some homeless shelters
j. Portal for formal complaints with management
k. MetroHousing
    i. Issues with RAFT
    ii. Feel talked down to by employees
    iii. Does not feel like a safe resource
    iv. Denial for rental assistance
    v. Lack of respect by employees for their home
    vi. Difficult to communicate with them
    vii. Understaffed and high demand for RAFT
    viii. Just a disconnect between staff and the community served
    ix. Lack of mutual respect

b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?

a. Seniors as a vulnerable population
b. People who are scared of insurance
    i. It is complicated, it's scary, many people think they don't qualify, don't know about resources that can help them renew their insurance, unaware of any resources
    ii. It is particularly confusing for older people

New England Baptist Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals living in affordable housing
Location: Roxbury Tenants of Harvard
Date, time: 11/18/2024
Facilitator: JSI and RTH
Approximate number of participants: 10

Question 1

We want to start by talking about physical health. Physical health is about how well your body works. It includes being free from illnesses or injuries, having enough energy for daily activities, and feeling strong and healthy overall.

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Walking/exercising
    ii. Eating healthy
    iii. Crocheting
    iv. Doing things that you enjoy
    v. Social activities
    vi. Self care like going to Zumba
    vii. Dancing and Zumba

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Mental health and anxiety (+2)
    ii. High cost of living
    iii. Other responsibilities
    iv. People are struggling—paycheck to paycheck
        1. Financial burden
    v. Current events—things that are going on externally
    vi. Future
    vii. Technology—everything is online/geared towards technology. I would like a program about how to use technology. Technology limits socializing. Addiction to technology and phones.
    viii. Disabilities
    ix. Education

Question 2

Now let's talk about mental health. Mental health is about how you think and feel. It includes your emotions, mood, and how you handle stress, as well as your overall sense of well-being and happiness.

a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?

a. Exercise
b. Prayer and faith
c. Meditation
d. Yoga
e. Doing something that you enjoy
f. Music
g. Talking with friends
h. Engaging with mental health professionals; but it can be difficult with copays, losing access to care due, and long waitlists
i. People need community

b. What stops you from being as mentally healthy as you'd like to be?

a. Affordability, especially the price of Asthma care
    i. People are in survival mode
b. It is difficult to find a therapist that is a good fit
c. Peer support could be a helpful model, depending on a person's situation and needs. People need to be open.
d. Isolation. Community is really important because you get out and you're not around strangers.
e. Judgement. People are scared to seek help.
f. Cultural barriers. People don't feel comfortable talking about certain things.
g. Stigma is still alive despite marketing and ads.
    i. The stigma is still there, but there is education around mental health. Continuing to educate future generations and children; we need to talk about it in homes.
h. There is a concern about DCF involvement if kids disclose something and there is a fear of being taken away. Fear of a 51A, so you don't feel comfortable sharing.
i. Injuries
j. Weather is a barrier, as it gets colder
k. Don't feel secure in the apartment. Inspectors walk-in to the apartment and there are concerns about privacy.

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

a. **What social factors are most problematic in your community?**
    a. Feeling safe. I would like to see older security guards.
    b. Transportation; cars are getting towed
    c. Accessibility to food. We need more variety in the types of food for kids and more access to foods
    d. More programs for the 18-25 year olds; more programming needs to happen. One participant started a program for autistic children/children on the spectrum. The program ran for almost a year and only had 3 families to show up.
    e. Staff aren't trained for dealing with kids with ADHD. You have to send your children [somewhere else].
    f. Creativity and flexibility is limited
    g. Need for more community
b. **Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?**
    a. Parents and families
    b. Kids with special needs or disabilities

Question 4

I want to ask about community health resources – the services and places in the community that help people to stay healthy. This includes a whole range of places and organizations – like doctor's offices and clinics, schools, senior centers, parks, multi-service centers, etc.

a. **Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
        a. Brigham & Women's; they provide flu shots and COVID vaccines
        b. Community partnerships
        c. Mass Eye & Ear
        d. RTH; they provide a lot for residents. They provide events, celebrations, child care, and food trucks. May not be across the board. There were lots of resources provided during COVID. They provided funding to get additional personal protective equipment.
            i. Senior activities
            ii. Food pantry in resident services
            iii. Environmental supports e.g., bed bugs etc.
b. **What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
        a. Families with kids programming
        b. Information about supports
            i. For example, information around rental assistance and other social factors
        c. In-depth services, geared towards physical and mental health.
            i. More mental health supports for families
        d. Support for diabetes and chronic issues

Community Listening Sessions

- Presentation from FacilitationTraining for Community Facilitators
- Facilitation guide for listening session
- Presentation and voting results from February 2025 Listening Session

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

- What is a Community Listening Session?
- Event Agenda
- Role of the Community Facilitator
- Review Breakout Discussion Guide
- Q&A
- Characteristics of a good facilitator (if time permits!)

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

- Closed captioning is available at all sessions
- Interpretation available based on requests made during registration

Goals:

- Interactive, inclusive, participatory sessions that reflect populations served by each Hospital
- Present community health needs assessment data
- Prioritize community health issues
- Identify opportunities for community-driven/led solutions and collaboration

BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

Each group will have 1 Community Facilitator, 1 JSI Notetaker, and up to 8 participants

Participants will be asked to:

- Prioritize community health issues based on their personal and professional experiences
- Share reaction to key themes from data
- Share ideas on community-based solutions

ROLE OF COMMUNITY FACILITATOR

Establish ground rules

Initiate and guide discussion

Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

JSI will email your event-specific guide 2 days prior to event date

Provides a "script" for the questions you'll ask in the Breakout Sessions

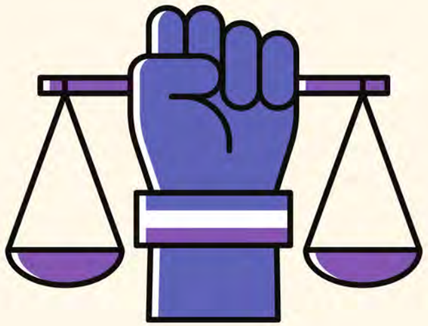
Will include a list of Community Facilitator/Notetaker pairings and contact info for all event staff

LET'S REVIEW.

REMEMBER: YOU HAVE SUPPORT.

CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic

Patient

Enthusiastic

INCLUSIVE FACILITATION

inclusive means including everyone

Provide space and identify ways participants can engage at the start of the meeting

Ask participants to share their name, where they're from, and if they're from a particular community organization. Make sure they know that this is optional and if its ok if they'd rather not share

Dedicate time for personal reflection

Normalize silence. It's okay if folks are quiet, don't interpret it as non-participation. Encourage people to take the time to reflect on the information presented to them.

Establish group agreements

Create common ground. This helps with addressing power dynamics that may be present in the space.

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

Maintain eye contact; Pay attention to non-verbal cues that someone may want to share (or doesn't); Thank them for their input

Consider accessibility

Be aware that some folks may be using the dial-in number to join the meeting (if via Zoom). Consider asking for their thoughts directly. Be sure to ask if they're able to see the Mentimeter poll (if not, the notetaker can log their votes for them)

THANK YOU!

Feel free to send in any questions to Madison

madison_maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

Session name, date, time: [filled in before session]
Community Facilitator: [filled in before session]
Notetaker: [filled in before session]
Mentimeter link: [filled in before session]
Miro board: [filled in before session]

Ground rules and introductions (5 minutes)

Facilitator: "Thank you for joining the Community Listening Session today. We will be in this small breakout group for about 50 minutes. Before we begin, I want to make sure that everybody was able to access the Mentimeter poll. Did anyone run into issues?" *If participants are having trouble logging in, the JSI Notetaker can help get them to the right screen.*

"Let's start with brief introductions and some ground rules for our time together. I will call on each of you. If you're comfortable, please share your name, what community you're from, and if you're part of any local community organizations. I'll start. I'm [name], from [community name], and I also work at [organization]." *(Facilitator calls on each participant)*

"Thanks for sharing. I'd like to start with some ground rules to be sure we get the most out of our discussion today:

- Make space and take space. We ask that you try to speak and listen in equal measure
- Be open to learning about experiences that don't match with your own
- What is said here stays here; what is learned here leaves here. [Notetaker's name] will be taking notes during our conversation today, but will not be marking down who says what. None of the information you share will be linked back to you specifically.

"Are there other ground rules people would like to add to our discussion today?"

Priority Area 1: Social Determinants of Health (12 minutes)

Facilitator: "We're going to have a chance to prioritize the issues that were presented during the earlier part of our meeting. First, we will start with the Social Determinants of Health. The priorities in this category are listed here on the screen. Using Mentimeter, **we want you to prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community.** Go ahead and vote now. If you run into issues, let us know and we can help make sure your vote is logged." *[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" [*Notetaker reports to Madison when all votes are logged, and polling results are shared back to all groups]*

Facilitator: "Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- Possible probes (if needed): Are there any issues in the area of social determinants that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 2: Access to Care (12 minutes)

Facilitator: "We're now going to go through the same exercise for our second priority area – Access to Care. Priorities in this category are listed here on the screen. Again, using Mentimeter, please prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community. Go ahead and vote now."*[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" *[Notetaker reports to Madison when all votes are logged. Polling results are then shared back to all groups].*

"Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- **Possible probes (if needed):** Are there any issues in the area of Access to Care that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues than others?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 3: Mental Health and Substance Use (12 minutes)

Facilitator: "We're now going to go through the same exercise for our third priority area – Mental Health and Substance Use. Priorities in this category are listed here on the screen. Again, using Mentimeter, please prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community. Go ahead and vote now."*[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" *[Notetaker reports to Madison when all votes are logged. Polling results are then shared back to all groups].*

"Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- **Possible probes (if needed):** Are there any issues in the area of social determinants that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 4: Chronic and Complex Conditions (12 minutes)

Facilitator: "We're now going to go through the same exercise for our fourth and final priority area – Chronic and Complex Conditions. Priorities in this category are listed here on the screen. Again, using Mentimeter, please prioritize these issues in order of what you feel should be the highest priority, based on what you know about needs in your community. Go ahead and vote now."*[Pause and allow people to vote]*

Facilitator, after 1-2 minutes: "Has everyone been able to log their vote?" *[Notetaker reports to Madison when all votes are logged. Polling results are then shared back to all groups].*

"Based on the poll, it looks like [Priority 1], [Priority 2], and [Priority 3] came out on top."

Facilitator asks Question 1: Did anything about the list of sub-priorities or the voting results surprise you?

- **Possible probes (if needed):** Are there any issues in the area of Chronic and Complex Conditions that you know to be a priority, that you didn't see on the list? Are there certain segments of the population that are more affected by these issues?

Facilitator asks Question 2: What would you like to see happen in your community to address the priorities in this area?

- **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.
Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Wrap up (1 minute)

"I want to thank you all for sharing your experiences, perspectives, and knowledge. In a minute we're going to be moved back into the Main Zoom room to hear the next steps in the Needs Assessment process."

New England Baptist Hospital

Community Listening Session

February 19, 2025 | 2:00-3:30pm

Beth Israel Lahey Health

New England Baptist Hospital Community Listening Session

New England Baptist Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
2:00-2:05	Welcome	JSI
2:05-2:10	Overview of assessment purpose, process, and guiding principles	Chris Dwyer, Community Benefits & Community Relations Manager, NEBH
2:10-2:25	Presentation of preliminary themes and data findings	JSI
2:25-2:30	Transition to Breakout Groups	JSI
2:30-3:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
3:25-3:30	Wrap up and Next Steps	Chris Dwyer

Assessment Purpose and Process

Assessment Purpose and Process

Purpose

Identify and prioritize the community health needs of those living in the service area, with an emphasis on diverse populations and those experiencing inequities.

- A **Community Health Needs Assessment (CHNA)** identifies key health needs and issues through data collection and analysis.
- An **Implementation Strategy** is a plan to address public health problems collaboratively with municipalities, organizations, and residents.

All non-profit hospitals are required to conduct a CHNA and develop an Implementation Strategy every 3 years

Beth Israel Lahey Health
New England Baptist Hospital

Community Benefits Service Area

- H New England Baptist Hospital
- 1 New England Baptist Outpatient Care Center at Chestnut Hill
- 2 New England Baptist Outpatient Care Center at Brookline
- 3 New England Baptist Outpatient Care Center at Dedham

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

Accountability: Hold each other to efficient, effective and accurate processes to achieve our system, department and communities' collective goals.

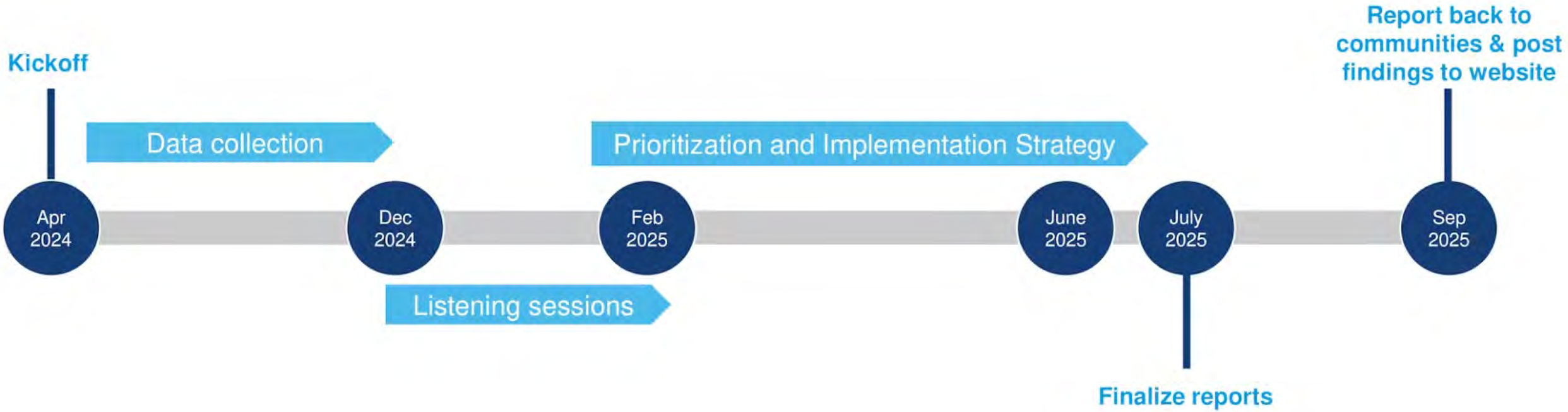
Community Engagement: Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

Equity: Apply an equity lens to achieve fair and just treatment so that ***all*** communities and people can achieve their full health and overall potential.

Impact: Employ evidence-based and evidence-informed strategies that align with system and community priorities to drive measurable change in health outcomes.

Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process

Meeting goals

Goals:

- Conduct listening sessions that are ***interactive, inclusive, participatory and reflective of the populations*** served by NEBH
- Present data for prioritization
- Identify opportunities for ***community-driven/led solutions and collaboration***

We want to hear from you.
Please share when we get to Breakout Sessions

Key Themes & Data Findings

New England Baptist Hospital

Community Listening Session

February 19, 2025 | 2:00-3:30pm

Beth Israel Lahey Health

New England Baptist Hospital Community Listening Session

New England Baptist Hospital Community Listening Session

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Assessment Purpose and Process

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Beth Israel Lahey Health
New England Baptist Hospital

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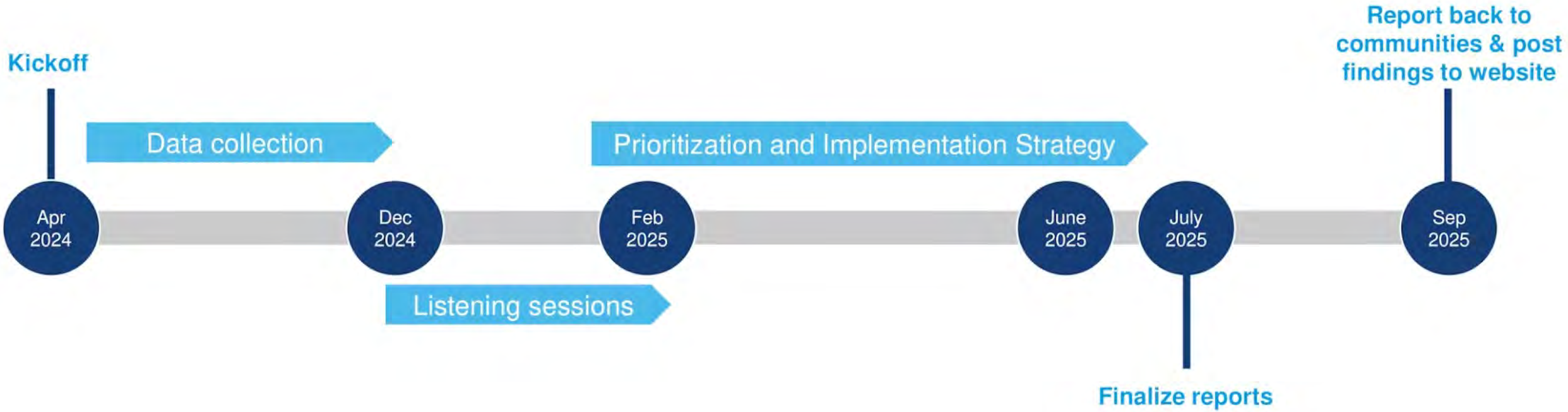
Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process

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Goals:

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- Identify opportunities for ***community-driven/led solutions and collaboration***

We want to hear from you.
Please share when we get to Breakout Sessions

Key Themes & Data Findings

FY25 CHNA Progress
Activities to date

Collection of secondary data, e.g.:

- US Census Bureau
- Center for Health Information and Analytics (CHIA)
- County Health Rankings
- Behavioral Risk Factor Surveillance Survey
- Youth Risk Behavior Surveys
- CDC and National Vital Statistics
- MA Community Health Equity Survey
- Data from partner hospitals and assessment efforts
- Other local sources of data

15 Interviews

312 FY25 NEBH Community Health Survey Respondents ***(also includes survey data from BPHC)***

5 Focus Groups

- Youth (*Tobin Community Center*)
- Older adults (*Tobin Community Center*)
- Families (*Halleck/One Gurney St.*)
- Spanish speaking older adults (*Maria Sanchez House*)
- Families (*Roxbury Tenants of Harvard*)

FY25 CHNA Progress

NEBH Community Health Survey Responses

312 responses

(Includes responses from BILH Community Health Survey and BPHC CHNA Survey)

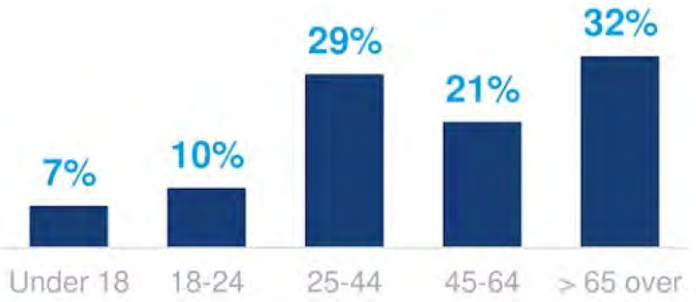
13% of respondents report a language other than English as the primary language spoken in their home **(same as FY22)**

68% of the respondents are women **(down from 75% in FY22)**

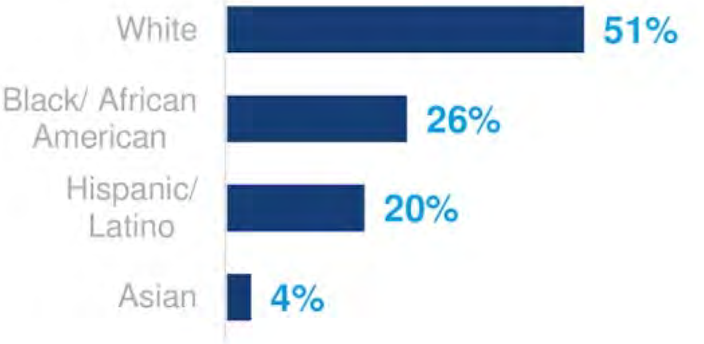
20% of the respondents identify as having a disability **(up from 12% in FY22)**

10% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(down from 13% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 22 in FY25 compared to 7 in FY22
- **Black/African American respondents:** 26% in FY25 compared to 5% in FY22
- **Hispanic respondents:** 20% in FY25 compared to 9% in FY22
- **Asian respondents:** 4% in FY25 compared to 9% in FY22

FY25 CHNA Progress
Community Benefits Service Area Strengths

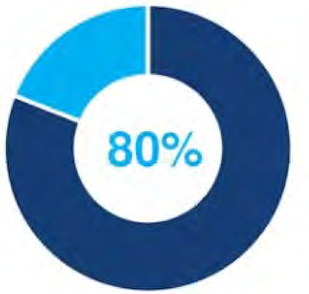
FROM INTERVIEWS & FOCUS GROUPS:

- Active, resident-minded civic groups
- Many of the key organizations in Mission Hill have been there for many years, and have developed deep roots in the neighborhood
- Many major institutions with a footprint in Mission Hill mean ample financial resources

FROM FY25 NEBH COMMUNITY HEALTH SURVEY:

said they **feel like they belong** in their community **(compared to 84% in FY22)**

said the community is **a good place to grow old (compared to 78% in FY22)**



said they are satisfied with their quality of life **(compared to 91% in FY22)**

FY25 CHNA Progress

Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

Interviews and survey results show that community health concerns remained remarkably consistent between FY22 and FY25, with the same 5 categories emerging as the preliminary priority areas. Information from focus groups reinforced findings from interviews and survey results.

FY25 CHNA Progress
Social Determinants of Health

Primary concerns:

- Housing issues (displacement, affordability, homelessness)
- Transportation and navigating the community
- High cost of living/economic insecurity
- Access to healthy food
- Safety

"When people need to take groceries home, it is really hard because bus stops are not accessible."

– Focus group participant

When asked what they'd like to improve in their community, **46%** of FY25 Community Health Survey respondents reported **more affordable housing** (#1 response) **[down from 49% in FY22]**

When asked what they'd like to improve in their community, **26%** of FY25 NEBH Community Health Survey respondents reported **better access to public transportation** **[down from 34% in FY22]**

29% of FY25 NEBH Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

Data source: 2018-2022 US Census Bureau 5-year Estimates

FY25 CHNA Progress

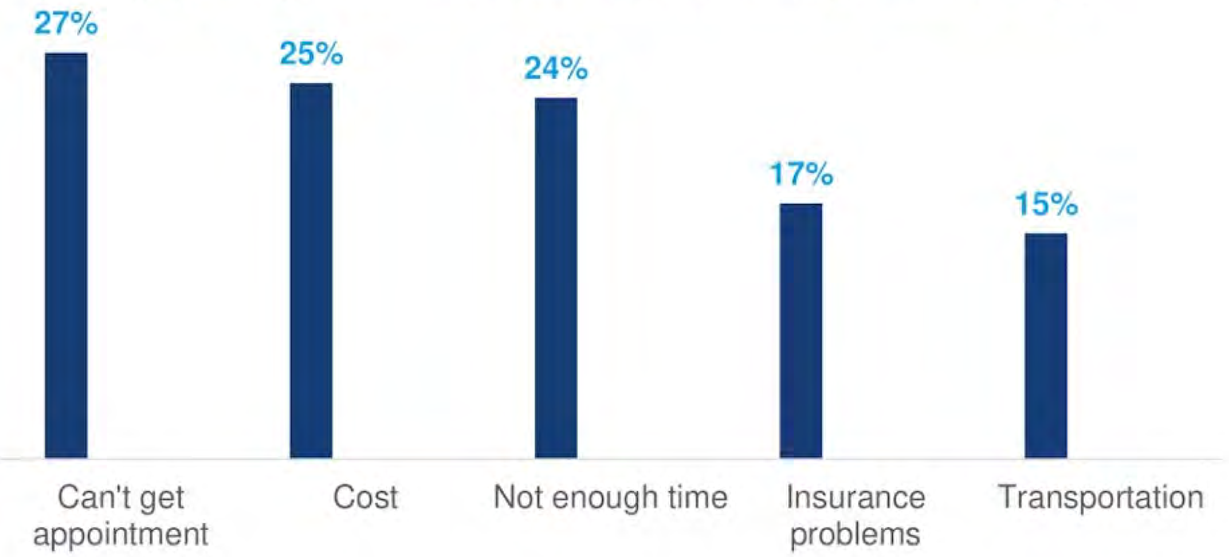
Preliminary Themes: Equitable Access to Care

Primary concerns:

- Long wait times for care
- Navigating a complex health care system
- Health insurance and cost barriers
- Language and cultural barriers to care

What barriers keep you from getting needed health care?

(Top 5 responses from FY25 NEBH Community Health Survey)



"Access to information is really lacking. How do people hear information? It's especially complex for older adults – for some it's just word of mouth. Then you have to think about language accessibility. Then, there's transportation issues, and digital access. More and more, there's only certain things you can do online." - ***Interviewee***

FY25 CHNA Progress

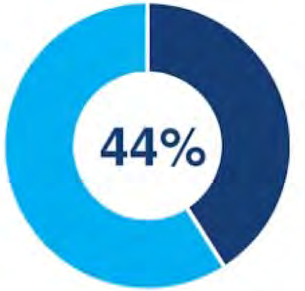
Preliminary Themes: Mental Health and Substance Use

Primary Concerns:

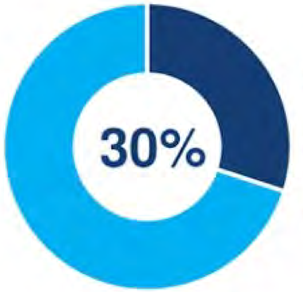
- Social isolation among older adults
- Depression, anxiety, and stress
- Youth mental health
- Navigating the behavioral health system
- Supportive services for individuals with substance use disorder

*"Social isolation is a major issue. Depression and substance use are also top concerns. We don't have perfect answers for any of these issues, but we are trying different things in our community. We are trying to take a community approach."– **Interviewee***

AMONG FY25 NEBH COMMUNITY HEALTH SURVEY RESPONDENTS:



44% identified mental health (anxiety, depression, etc.) as a heath issue that matters most in their community (#1 response)



30% said health care in the community does not meet people's mental health needs

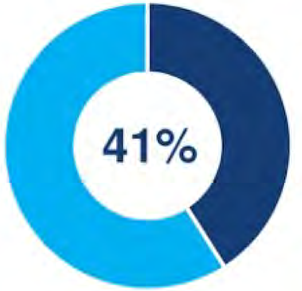
FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

Primary Concerns:

- Desire for more community-based education and screenings, in places where people already gather (e.g., housing complexes, councils on aging, libraries, schools)
- Need more support for conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Need more support and respite services for caregivers
- Need for more care navigation support

AMONG FY25 NEBH COMMUNITY HEALTH SURVEY RESPONDENTS:



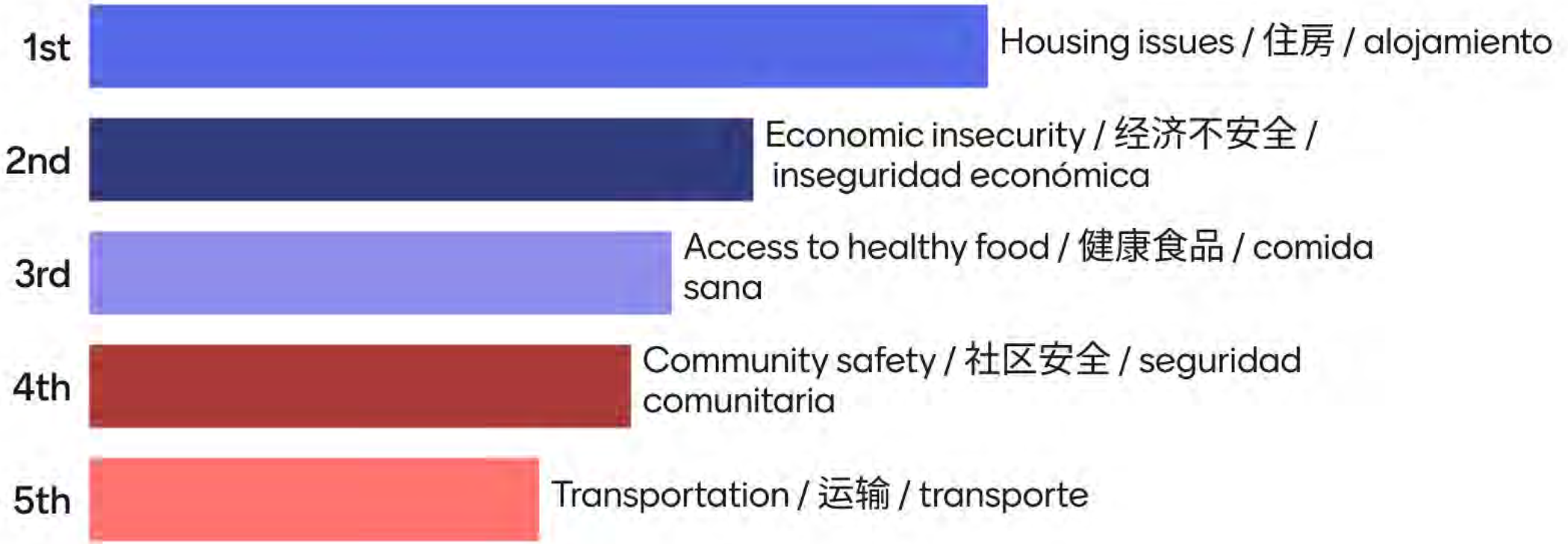
41% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community

"These conditions are threats to our most vulnerable populations. There is not enough outreach to our most vulnerable populations – those with English as a second language, people with disabilities, people who are unhoused, youth, and seniors." ***-Interviewee***

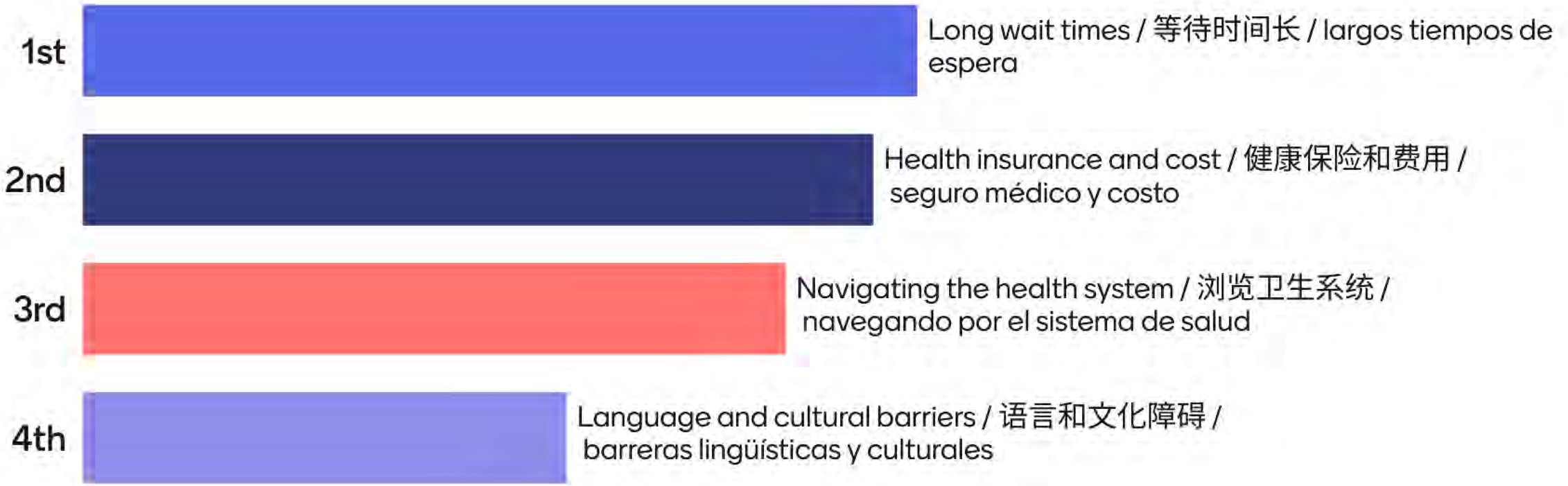
Instructions

Breakout Sessions

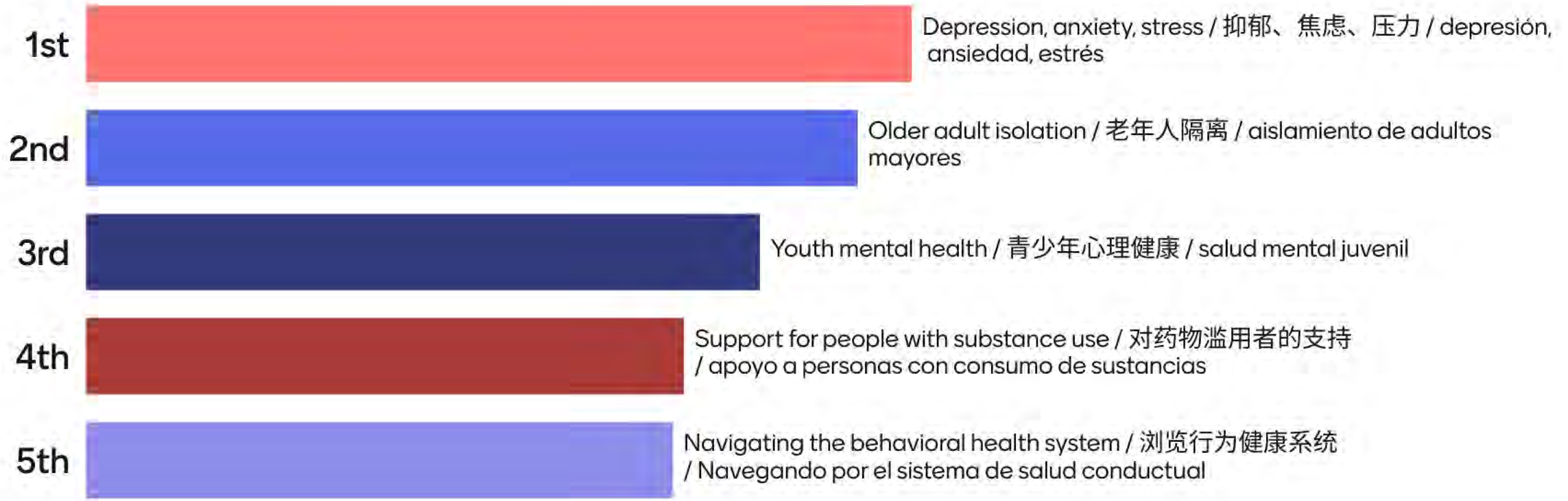
Social Determinants: Rank the following in order of what you feel should be the highest priority, based on needs in your community



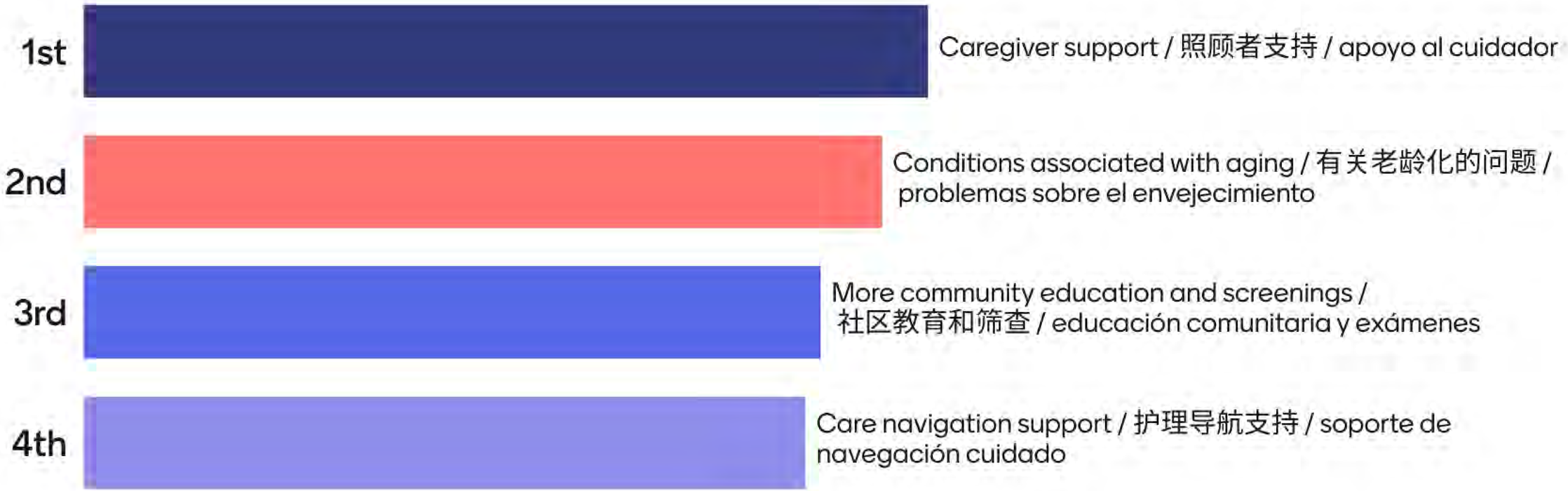
Access to Care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



Mental Health and Substance Use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



Chronic and Complex Conditions: Rank the following in order of what you feel should be the highest priority, based on needs in your community



Reconvene

Next Steps

Christine Dwyer

Manager, Community Benefits & Community Relations || NEBH

cdwyer1@nebh.org

Community Health and Community Benefits Information on Website:

https://www.nebh.org/who-we-are/giving-back

Community Benefits Annual Meeting in September

Appendix B:
Data Book

Secondary Data

Demographics

Demographics
Data Source: US Census Bureau, American Community Survey 2019 - 2023
Key
Significantly low compared to Massachusetts based on margin of error
Significantly high compared to Massachusetts overall based on margin of error

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Population								
Total population	6992395	1622896	724540	782172	663972	62822	25109	88504
Male	48.9%	49.4%	48.5%	48.3%	48.1%	46.0%	48.1%	48.6%
Female	51.1%	50.6%	51.5%	51.7%	51.9%	54.0%	51.9%	51.4%
Age Distribution								
Under 5 years (%)	5.0%	5.1%	5.2%	4.9%	4.6%	5.3%	5.1%	4.1%
5 to 9 years	5.2%	5.4%	5.5%	4.1%	3.8%	4.9%	5.0%	5.6%
10 to 14 years	5.7%	5.6%	6.1%	4.6%	4.4%	6.0%	5.3%	6.6%
15 to 19 years	6.5%	6.3%	6.4%	6.9%	7.1%	4.6%	4.6%	9.6%
20 to 24 years	6.8%	6.8%	6.1%	9.1%	9.9%	10.9%	6.6%	6.8%
25 to 34 years	14.1%	15.1%	12.9%	22.5%	23.5%	18.2%	11.9%	9.9%
35 to 44 years	12.9%	13.8%	13.2%	13.6%	13.3%	13.2%	13.4%	11.6%
45 to 54 years	12.6%	12.8%	13.3%	10.7%	10.2%	11.2%	13.6%	14.0%
55 to 59 years	7.0%	6.8%	7.3%	5.5%	5.5%	5.3%	6.8%	6.2%
60 to 64 years	6.8%	6.2%	6.7%	5.2%	5.0%	4.9%	7.5%	6.5%
65 to 74 years	10.3%	9.3%	10.0%	7.7%	7.6%	8.3%	10.6%	11.1%
75 to 84 years	4.9%	4.6%	4.9%	3.5%	3.4%	5.3%	5.4%	5.5%
85 years and over	2.2%	2.1%	2.4%	1.8%	1.7%	1.8%	4.3%	2.5%
Under 18 years of age	19.6%	19.6%	20.7%	16.2%	15.2%	19.3%	18.7%	20.8%
Over 65 years of age	17.5%	16.0%	17.4%	13.0%	12.7%	15.4%	20.3%	19.1%

Demographics

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Race/Ethnicity								
White alone (%)	70.7%	69.0%	71.4%	48.1%	47.8%	67.7%	82.4%	71.1%
Black or African American alone (%)	7.0%	5.0%	7.2%	19.1%	21.5%	3.1%	5.1%	2.2%
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.4%	0.3%	0.2%	0.0%	0.4%
Asian alone (%)	7.1%	13.2%	12.1%	9.0%	10.0%	17.7%	3.1%	16.6%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%
Some Other Race alone (%)	5.4%	4.2%	2.3%	7.8%	7.1%	1.8%	2.4%	2.4%
Two or More Races (%)	9.5%	8.4%	6.8%	15.5%	13.2%	9.7%	6.8%	7.3%
Hispanic or Latino of Any Race (%)	12.9%	9.0%	5.5%	22.8%	18.9%	6.0%	7.5%	4.8%
Foreign-born								
Foreign-born population	1,236,518	366,954	138,392	230,245	182,633	17,300	3,315	20,831
Naturalized U.S. citizen	54.5%	51.0%	60.1%	50.3%	53.2%	43.4%	61.5%	65.8%
Not a U.S. citizen	45.5%	49.0%	39.9%	49.7%	46.8%	56.6%	38.5%	34.2%
Region of birth: Europe	18.1%	16.9%	20.0%	10.9%	11.0%	26.5%	40.9%	31.4%
Region of birth: Asia	30.5%	42.9%	47.6%	23.9%	28.2%	55.8%	21.3%	50.3%
Region of birth: Africa	9.5%	7.6%	7.3%	10.4%	11.1%	3.8%	5.2%	4.3%
Region of birth: Oceania	0.3%	0.5%	0.3%	0.2%	0.3%	0.2%	0.3%	0.6%
Region of birth: Latin America	39.4%	29.7%	22.8%	53.1%	47.8%	10.0%	29.4%	10.0%
Region of birth: Northern America	2.2%	2.4%	2.0%	1.4%	1.6%	3.7%	3.0%	3.5%
Language								
English only	75.2%	71.7%	77.0%	61.6%	64.8%	69.6%	83.7%	72.5%
Language other than English	24.8%	28.3%	23.0%	38.4%	35.2%	30.4%	16.3%	27.5%
Speak English less than "very well"	9.7%	9.9%	8.4%	17.9%	15.5%	7.3%	6.2%	7.9%

Demographics

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Spanish	9.6%	6.4%	3.5%	19.2%	15.5%	4.1%	5.4%	3.2%
Speak English less than "very well"	4.1%	2.4%	0.9%	9.8%	7.3%	0.7%	2.1%	0.7%
Other Indo-European languages	9.2%	12.2%	9.0%	10.1%	10.1%	11.6%	7.3%	11.2%
Speak English less than "very well"	3.2%	4.1%	2.8%	3.9%	3.8%	2.3%	3.1%	3.1%
Asian and Pacific Islander languages	4.4%	7.8%	8.6%	6.5%	7.3%	10.8%	2.0%	10.2%
Speak English less than "very well"	1.9%	2.9%	4.3%	3.5%	3.9%	3.8%	0.7%	3.5%
Other languages	1.6%	2.0%	1.9%	2.6%	2.3%	3.8%	1.6%	2.8%
Speak English less than "very well"	0.4%	0.5%	0.4%	0.8%	0.6%	0.6%	0.4%	0.5%
Employment								
Unemployment rate	5.1%	4.2%	4.9%	6.2%	6.0%	3.5%	3.6%	3.3%
Unemployment rate by race/ethnicity								
White alone	4.5%	4.0%	4.6%	4.4%	4.1%	3.4%	3.8%	3.5%
Black or African American alone	7.9%	6.4%	8.0%	8.6%	8.6%	10.2%	0.9%	3.6%
American Indian and Alaska Native alone	6.9%	5.5%	16.0%	7.6%	10.4%	0.0%	-	0.0%
Asian alone	4.0%	3.5%	4.1%	4.7%	4.7%	3.6%	4.9%	3.1%
Native Hawaiian and Other Pacific Islander alone	4.8%	10.9%	0.0%	0.0%	0.0%	-	-	0.0%
Some other race alone	8.0%	6.4%	6.1%	10.4%	11.1%	4.8%	5.6%	1.5%
Two or more races	7.9%	5.4%	6.2%	8.9%	8.3%	2.5%	1.1%	2.1%
Hispanic or Latino origin (of any race)	8.1%	6.2%	5.5%	9.6%	9.4%	3.9%	0.0%	2.0%
Unemployment rate by educational attainment								
Less than high school graduate	9.1%	8.1%	7.5%	10.6%	9.7%	5.4%	1.1%	1.1%
High school graduate (includes equivalency)	6.4%	5.9%	7.1%	8.7%	9.2%	18.5%	1.9%	2.7%
Some college or associate's degree	5.2%	4.9%	5.1%	7.6%	8.1%	3.8%	1.7%	8.2%
Bachelor's degree or higher	2.7%	2.7%	2.6%	2.9%	2.9%	2.6%	2.4%	2.5%

Demographics

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Income and Poverty								
Median household income (dollars)	101,341	126,779	126,497	92,859	94,755	140,631	124,375	184,989
Population living below the federal poverty line in the last 12 months								
Individuals	10.0%	7.5%	6.6%	16.5%	16.9%	9.8%	4.6%	4.7%
Families	6.6%	6.7%	4.7%	4.6%	3.3%	4.7%	3.7%	3.0%
Individuals under 18 years of age	11.8%	7.4%	5.8%	21.2%	21.8%	4.9%	3.2%	2.4%
Individuals over 65 years of age	10.2%	8.6%	8.7%	20.3%	21.0%	11.6%	9.5%	6.1%
Female head of household, no spouse	19.1%	15.4%	14.9%	23.3%	23.2%	11.6%	9.0%	14.7%
White alone	7.6%	6.0%	5.6%	11.6%	11.7%	9.0%	4.3%	3.9%
Black or African American alone	17.1%	15.4%	11.7%	19.7%	19.8%	8.8%	9.6%	14.6%
American Indian and Alaska Native alone	19.1%	12.7%	11.1%	13.1%	15.4%	0.0%	-	14.0%
Asian alone	11.0%	8.6%	8.1%	23.5%	24.3%	13.4%	7.3%	6.9%
Native Hawaiian and Other Pacific Islander alone	21.7%	4.7%	40.9%	35.2%	35.2%	-	0.0%	-
Some other race alone	20.1%	14.2%	12.3%	20.9%	23.5%	18.7%	1.9%	5.0%
Two or more races	15.7%	10.5%	7.4%	20.9%	21.2%	7.3%	3.7%	4.6%
Hispanic or Latino origin (of any race)	20.6%	15.1%	9.4%	22.6%	25.3%	6.4%	3.7%	8.6%
Less than high school graduate	24.4%	20.4%	19.5%	30.3%	33.1%	34.4%	15.6%	22.0%
High school graduate (includes equivalency)	12.7%	12.1%	10.4%	19.0%	20.5%	34.5%	8.4%	13.2%
Some college, associate's degree	9.2%	8.2%	8.2%	14.8%	15.9%	20.8%	6.0%	6.0%
Bachelor's degree or higher	4.0%	3.4%	3.2%	6.7%	6.8%	4.2%	2.7%	3.4%
With Social Security	29.8%	25.8%	28.6%	20.9%	19.8%	21.8%	33.6%	27.3%
With retirement income	22.9%	20.9%	22.7%	13.7%	13.2%	17.4%	24.9%	22.4%
With Supplemental Security Income	5.6%	3.9%	3.8%	6.5%	6.6%	2.4%	2.7%	2.5%
With cash public assistance income	3.5%	2.8%	2.5%	3.8%	3.7%	2.0%	3.6%	2.1%
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.6%	8.7%	18.7%	18.6%	6.0%	7.4%	4.4%

Demographics

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Housing								
Occupied housing units	91.6%	95.5%	95.9%	91.0%	90.7%	94.8%	96.7%	94.6%
Owner-occupied	62.6%	61.6%	68.5%	36.6%	35.4%	46.1%	72.7%	71.0%
Renter-occupied	37.4%	38.4%	31.5%	63.4%	64.6%	53.9%	27.3%	29.0%
Lacking complete plumbing facilities	0.3%	0.3%	0.3%	0.4%	0.4%	0.1%	0.1%	0.2%
Lacking complete kitchen facilities	0.8%	0.9%	0.7%	1.0%	1.0%	0.6%	1.1%	0.5%
No telephone service available	0.8%	0.6%	0.5%	1.2%	1.2%	0.2%	0.2%	0.2%
Monthly housing costs <35% of total household income								
Among owner-occupied units with a mortgage	22.7%	20.7%	21.6%	25.6%	24.1%	25.8%	21.5%	23.4%
Among owner-occupied units without a mortgage	15.4%	15.2%	16.9%	15.0%	14.0%	14.5%	27.9%	15.4%
Among occupied units paying rent	41.3%	37.4%	40.7%	41.7%	41.0%	35.9%	43.4%	33.5%
Access to Technology								
Among households								
Has smartphone	89.2%	91.5%	90.7%	90.5%	90.9%	94.3%	85.3%	93.9%
Has desktop or laptop	83.2%	88.4%	87.7%	81.9%	83.2%	92.6%	85.4%	94.0%
With a computer	95.1%	96.5%	96.5%	94.6%	94.8%	97.4%	94.7%	97.8%
With a broadband Internet subscription	91.8%	94.2%	94.2%	90.3%	90.6%	96.0%	91.0%	96.9%
Transportation								
Car, truck, or van -- drove alone	62.7%	56.0%	59.0%	36.6%	34.1%	28.1%	65.2%	49.6%
Car, truck, or van -- carpooled	6.9%	6.4%	5.6%	6.2%	5.4%	3.3%	6.9%	5.6%
Public transportation (excluding taxicab)	7.0%	8.0%	9.5%	23.6%	24.0%	20.1%	5.4%	8.7%
Walked	4.2%	4.2%	3.2%	12.3%	13.8%	15.2%	2.6%	5.4%
Other means	2.5%	3.2%	2.1%	3.8%	4.0%	6.2%	1.2%	1.9%
Worked from home	16.7%	22.2%	20.6%	17.5%	18.8%	27.0%	18.6%	28.7%
Mean travel time to work (minutes)	29.3	30.0	32.9	30.9	30.2	28.1	30.2	26.7

Demographics

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Vehicles available among occupied housing units								
No vehicles available	11.8%	10.4%	8.9%	31.8%	33.5%	27.4%	7.9%	5.7%
1 vehicle available	35.8%	36.5%	35.4%	43.5%	43.2%	47.7%	36.0%	35.2%
2 vehicles available	35.8%	37.8%	39.1%	18.9%	17.8%	20.3%	40.2%	45.3%
3 or more vehicles available	16.6%	15.3%	16.6%	5.9%	5.5%	4.7%	16.0%	13.8%
Education								
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	3.3%	3.0%	7.4%	6.5%	1.7%	1.5%	1.4%
9th to 12th grade, no diploma	4.4%	3.2%	2.7%	5.0%	4.6%	0.9%	4.4%	1.3%
High school graduate (includes equivalency)	22.8%	17.5%	17.4%	20.5%	18.3%	5.0%	20.4%	6.6%
Some college, no degree	14.4%	11.2%	12.4%	12.1%	11.6%	5.2%	12.3%	5.9%
Associate's degree	7.5%	5.7%	7.0%	5.1%	4.9%	2.2%	6.3%	4.2%
Bachelor's degree	25.3%	28.8%	30.0%	26.8%	28.5%	27.3%	29.2%	28.2%
Graduate or professional degree	21.4%	30.2%	27.7%	23.1%	25.6%	57.8%	25.9%	52.4%
High school graduate or higher	91.4%	93.4%	94.4%	87.6%	88.9%	97.4%	94.1%	97.3%
Bachelor's degree or higher	46.6%	59.0%	57.6%	49.9%	54.1%	85.0%	55.1%	80.7%
Educational attainment by race/ethnicity								
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	96.0%	97.0%	95.5%	96.4%	98.9%	95.6%	98.4%
Bachelor's degree or higher	49.4%	60.9%	59.3%	66.0%	72.5%	86.8%	56.3%	81.9%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	89.6%	90.0%	86.4%	86.4%	78.4%	86.2%	94.2%
Bachelor's degree or higher	30.7%	40.0%	39.4%	27.4%	26.7%	41.6%	39.9%	60.4%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	69.1%	78.6%	73.3%	77.5%	78.1%	-	72.8%
Bachelor's degree or higher	24.4%	31.3%	41.8%	30.2%	44.0%	17.1%	-	66.1%

Demographics

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton
Demographics								
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	90.3%	84.2%	80.8%	80.9%	96.9%	92.6%	95.2%
Bachelor's degree or higher	64.0%	71.3%	61.0%	57.0%	57.4%	88.5%	71.3%	79.9%
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	98.5%	65.9%	100.0%	100.0%	-	-	-
Bachelor's degree or higher	40.0%	20.9%	44.5%	63.0%	63.0%	-	-	-
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	73.6%	81.9%	71.5%	71.6%	81.9%	91.4%	89.9%
Bachelor's degree or higher	20.0%	27.1%	40.3%	22.2%	24.8%	63.1%	58.1%	55.2%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	85.6%	92.3%	72.7%	77.3%	97.3%	80.6%	95.1%
Bachelor's degree or higher	33.6%	46.1%	57.3%	30.3%	36.6%	85.8%	39.3%	83.5%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	77.6%	90.0%	70.6%	72.8%	92.1%	84.4%	91.0%
Bachelor's degree or higher	23.3%	34.9%	53.2%	22.5%	26.6%	79.9%	46.9%	73.5%
Health insurance coverage among civilian noninstitutionalized population (%)								
With health insurance coverage	97.4%	97.6%	98.1%	96.7%	97.0%	98.8%	98.3%	98.6%
With private health insurance	73.8%	80.0%	82.0%	67.5%	69.9%	88.1%	84.7%	88.6%
With public coverage	37.1%	29.9%	29.1%	38.1%	35.8%	20.4%	29.5%	22.3%
No health insurance coverage	2.6%	2.4%	1.9%	3.3%	3.0%	1.2%	1.7%	1.4%
Disability								
Percent of population with a disability	12.1%	9.8%	9.7%	12.3%	12.1%	7.5%	11.6%	7.3%
Under 18 with a disability	4.9%	4.1%	3.6%	6.0%	5.8%	3.7%	5.8%	3.4%
18-64	9.4%	7.1%	6.9%	9.2%	9.1%	4.7%	8.3%	4.5%
65+	30.2%	27.9%	27.3%	38.1%	37.2%	24.5%	27.7%	20.6%

Health Status

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Access to Care							
Ratio of population to primary care physicians	103.5	128.3	125.7	150.0	150.0	125.7	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.1	94.3	94.2	145.3	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	16.4	47.3	50.0	7.9	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health							
Adults age 18+ with poor or fair general health (crude %)	13.8	Data unavailable	Data unavailable	Data unavailable	16.4	8.9	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9	871.1	645.8			CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0	233.2	180.6			Massachusetts Death Report, 2021
Risk Factors							
Farmers Markets Accepting SNAP, Rate per 100,00 low-income population	1.8	4.8	2.2	1.3	1.6	10.9	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	7.6	8.1	11.1	10.6	5.1	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	35.7	1.0	0.6	3.8	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	Data unavailable	Data unavailable	27.3	24.4	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	Data unavailable	Data unavailable	28.2	22.6	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	Data unavailable	Data unavailable	29.5	31.1	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	Data unavailable	Data unavailable	23.3	14.3	BRFSS, 2022

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Chronic Conditions							
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	Data unavailable	11.7	10.3	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	Data unavailable	Data unavailable	10.1	7.1	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	Data unavailable	5.5	3.4	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	Data unavailable	Data unavailable	5.5	4.4	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	Data unavailable	3.2	2	BRFSS, 2022
Cancer							
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	Data unavailable	83.4	86.1	BRSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	Data unavailable	60.8	66	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)							
All sites	449.4	426.6	462.7	408.9	408.9	463.3	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	56.3	54.9	54.8	56.1	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	117.7	111.7	111.8	116.6	State Cancer Profiles, 2016-2020
Prevention and Screening							
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	Data unavailable	Data unavailable	77.4	79.7	Behavioral Risk Factor Surveillance System, 2022
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	18.2	15.5	15.9	20.4	20.6	0.0	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	Data unavailable	86.1	90.3	Behavioral Risk Factor Surveillance System, 2021

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Communicable and Infectious Disease							
STI infection cases (per 100,000)							
Chlamydia	385.8	264.0	358.2	264.0	807.8	264.0	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	9.8	6.9	25.8	25.8	6.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	84.2	64.0	298.0	298.0	64.0	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	234.1	832.2	832.2	234.1	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	1.7	4.6	4.6	1.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19							
Percent of Adults Fully Vaccinated	78.1	87.7	87.8	81.3	83.3	85.8	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.0	3.8	4.4	4.4	3.8	
Vaccine Coverage Index	0.0	0.0	0.0	0.1	0.1	0.0	
Substance Use							
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	Data unavailable	Data unavailable	11.8	6.9	BRFSS, 2021
Binge drinking % (adults), age-adjusted	17.2	Data unavailable	Data unavailable	Data unavailable	19	19.9	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	Data unavailable	Data unavailable	Data unavailable			CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)	17.9	18.2	18.8	17.7			Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6	38.5	51.0			
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0	14.2	15.2			

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Substance-related deaths (Age-adjusted rate per 100k)							MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance	61.9	41.1	40.3	74.2	74.3	16.1	
Opioid-related deaths	33.7	20.1	21.8	45.0	45.4	10.9	
Alcohol-related deaths	29.1	20.4	18.6	30.2	29.6	*	
Stimulant-related deaths	23.0	13.6	13.6	35.3	37.6	*	
Substance-related ER visits (age-adjusted rate per 100K)							MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	1182.2	2674.7	2862.5	700.0	
Opioid-related ER visits	169.3	102.9	89.8	253.0	278.4	18.6	
Opioid-related EMS Incidents	248.8	176.3	138.6	379.2	395.9	87.0	
Alcohol-related ER visits	1235.6	962.1	929.9	2156.4	2312.2	529.2	
Stimulant-related ER visits	15.7	13.6	9.9	29.2	34.5	*	
Substance Addiction Services							MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	352.4	932.9	966.6	80.7	
Number of BSAS providers		201.0	88.0	231.0	217.0	5.0	
Number of clients of BSAS services (residents)		3702.0	1540.0	4681.0	4225.0	38.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	19.0	11.0	11.0	17.0	
Buprenorphine RX's filled	9982.0	6002.1	7796.8	7972.3	7412.3	1487.6	
Individuals who received buprenorphine RX's		508.3	668.1	764.1	744.2	150.3	
Naloxone kits received		35323.0	16008.0	34809.0	33510.0	551.0	
Naloxone kids: Opioid deaths Ratio		78.0	55.0	97.0	113.0	56.0	
Fentanyl test strips received		50130.0	21900.0	69000.0	66100.0	1600.0	

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Environmental Health							
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	72.4	55.9	97.8	98.3	100.0	Population in Neighborhoods Meeting Environmental Justice Health Criteria, Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead screening %	68.0				67.0	54.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6				14.8	5.3	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0				75.0	83.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6				42.2	8.1	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9				14.4	6.9	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	5.5	7.0	5.2	5.0	0.0	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3	0.3	0.4			EPA - National Air Toxics Assessment, 2018

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Mental Health							
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	41.2	47.8	47.8	41.2	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	Data unavailable	22.9	20	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	Data unavailable	35.1	28.9	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	Data unavailable	Data unavailable	25.6	18.9	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	Data unavailable	17	13	Behavioral Risk Factor Surveillance System, 2022
Adults age 18+ with depression (crude %)	20.9	19.3	19.2	21.1	22.0	20.1	Behavioral Risk Factor Surveillance System, 2021
Adults age 18 and older who reported 14 or more days of poor mental health in the past 30 days (crude %)	14.7	12.9	13.1	16.0	17.3	13.3	Behavioral Risk Factor Surveillance System, 2021
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.1	0.0	0.0	0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health							
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	5.0	5.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	8.0	8.4	6.9	County Health Rankings, 2016-2022

Health Status: Boston – Brookline

					Areas of Interest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Source
Safety/Crime							
Property Crimes Offenses (#)							Massachusetts Crime Statistics, 2023
Burglary	10028.0				1265.0	45.0	
Larceny-theft	60647.0				9359.0	500.0	
Motor vehicle theft	7224.0				1200.0	35.0	
Arson	377.0				32.0	0.0	
Crimes Against Persons Offenses (#)							
Murder/non-negligent manslaughter	162.0				51.0	0.0	
Sex offenses	4365.0				372.0	9.0	
Assaults	72086.0				15157.0	173.0	
Human trafficking	0.0				9.0	0.0	
Hate Crimes Offenses (#)							
Race/Ethnicity/Ancestry Bias	222.0				82.0	1.0	
Religious Bias	88.0				23.0	1.0	
Sexual Orientation Bias	80.0				36.0	1.0	
Gender Identity Bias	22.0				9.0	1.0	
Gender Bias	2.0				0.0	0.0	
Disability Bias	0.0				0.0	0.0	

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Access to Care								
Ratio of population to primary care physicians	103.5	128.3	125.7	150.0	125.7		128.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.1	94.3	144.9		145.4	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	16.4	47.3	7.9		3.4	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health								
Adults age 18+ with poor or fair general health (crude %)	13.8	Data unavailable	Data unavailable	Data unavailable	11.8		8.6	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9	871.1	645.8				CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0	233.2	180.6				Massachusetts Death Report, 2021
Risk Factors								
Farmers Markets Accepting SNAP, Rate per 100,00 low-income population	1.8	4.8	2.2	1.3	0.0		0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	7.6	8.1	11.1	7.1		3.2	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	35.7	1.0	30.3		9.9	USDA - Food Access Research Atlas, 2019

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Chronic Conditions								
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	Data unavailable	11.3		10.3	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	Data unavailable	Data unavailable	7.6		6.3	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	Data unavailable	5		3.3	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	Data unavailable	Data unavailable	5.3		4.2	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	Data unavailable	2.4		1.9	BRFSS, 2022
Cancer								
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	Data unavailable	85.2		85	BRSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	Data unavailable	64.8		68.8	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)								
All sites	449.4	426.6	462.7	408.9	463.0		426.3	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	56.3	54.9	57.8		52.2	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	117.7	111.7	115.7		108.5	State Cancer Profiles, 2016-2020
Prevention and Screening								
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	Data unavailable	Data unavailable	85.2		77	Behavioral Risk Factor Surveillance System, 2022
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	18.2	15.5	15.9	20.4	64.8		15.2	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	Data unavailable	89.3		89	Behavioral Risk Factor Surveillance System, 2021

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Communicable and Infectious Disease								
STI infection cases (per 100,000)								
Chlamydia	385.8	264.0	358.2	264.0	264.0		293.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	9.8	6.9	25.8	6.9		9.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	84.2	64.0	298.0	64.0		84.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	234.1	832.2	234.1		288.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	1.7	4.6	1.7		2.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19								
Percent of Adults Fully Vaccinated	78.1	87.7	87.8	81.3	85.8		87.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.0	3.8	4.4	3.8		4.0	
Vaccine Coverage Index	0.0	0.0	0.0	0.1	0.0		0.0	
Substance Use								
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	Data unavailable	Data unavailable	10.6		6.7	BRFSS, 2021
Binge drinking % (adults), age-adjusted	17.2	Data unavailable	Data unavailable	Data unavailable	22.1		18.9	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	Data unavailable	Data unavailable	Data unavailable				CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)	17.9	18.2	18.8	17.7				Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6	38.5	51.0				
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0	14.2	15.2				

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Substance-related deaths (Age-adjusted rate per 100k)								MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance	61.9	41.1	40.3	74.2	54.9		15.4	
Opioid-related deaths	33.7	20.1	21.8	45.0	38.3		*	
Alcohol-related deaths	29.1	20.4	18.6	30.2	30.1		7.5	
Stimulant-related deaths	23.0	13.6	13.6	35.3	24.4		*	
Substance-related ER visits (age-adjusted rate per 100K)								MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	1182.2	2674.7	1231.6		665.7	
Opioid-related ER visits	169.3	102.9	89.8	253.0	82.9		24.9	
Opioid-related EMS Incidents	248.8	176.3	138.6	379.2	161.6		59.6	
Alcohol-related ER visits	1235.6	962.1	929.9	2156.4	982.1		459.5	
Stimulant-related ER visits	15.7	13.6	9.9	29.2	*		*	
Substance Addiction Services								MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	352.4	932.9	362.7		115.8	
Number of BSAS providers		201.0	88.0	231.0	1.0		3.0	
Number of clients of BSAS services (residents)		3702.0	1540.0	4681.0	53.0		59.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	19.0	11.0	20.0		23.0	
Buprenorphine RX's filled	9982.0	6002.1	7796.8	7972.3	8196.7		2170.4	
Individuals who received buprenorphine RX's		508.3	668.1	764.1	666.3		275.5	
Naloxone kits received		35323.0	16008.0	34809.0	124.0		335.0	
Naloxone kids: Opioid deaths Ratio		78.0	55.0	97.0	12.0		*	
Fentanyl test strips received		50130.0	21900.0	69000.0	3800.0		1430.0	

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Environmental Health								
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	72.4	55.9	97.8	100.0		91.4	Population in Neighborhoods Meeting Environmental Justice Health Criteria, Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead screening %	68.0				78.0		62.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6				3.8		5.4	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0				75.0		81.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6				18.6		9.8	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9				9.8		7.2	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	5.5	7.0	5.2	NS		NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3	0.3	0.4				EPA - National Air Toxics Assessment, 2018

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Mental Health								
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	41.2	47.8	41.2		36.9	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	Data unavailable	22.3		22.6	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	Data unavailable	30.4		32.3	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	Data unavailable	Data unavailable	20.2		21.1	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	Data unavailable	15.6		13.2	Behavioral Risk Factor Surveillance System, 2022
Adults age 18+ with depression (crude %)	20.9	19.3	19.2	21.1	20.0		19.2	Behavioral Risk Factor Surveillance System, 2021
Adults age 18 and older who reported 14 or more days of poor mental health in the past 30 days (crude %)	14.7	12.9	13.1	16.0	13.1		11.9	Behavioral Risk Factor Surveillance System, 2021
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.1	0.0	0.0		0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health								
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	5.0	3.0		3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	8.0	6.9		7.1	County Health Rankings, 2016-2022

Health Status: Dedham – Newton

					Areas of Interest			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Safety/Crime								
Property Crimes Offenses (#)								Massachusetts Crime Statistics, 2023
Burglary	10028.0				4.0		62.0	
Larceny-theft	60647.0				156.0		502.0	
Motor vehicle theft	7224.0				8.0		11.0	
Arson	377.0				0.0		2.0	
Crimes Against Persons Offenses (#)								
Murder/non-negligent manslaughter	162.0				0.0		1.0	
Sex offenses	4365.0				5.0		16.0	
Assaults	72086.0				112.0		214.0	
Human trafficking	0.0				0.0		0.0	
Hate Crimes Offenses (#)								
Race/Ethnicity/Ancestry Bias	222.0				1.0		9.0	
Religious Bias	88.0				0.0		6.0	
Sexual Orientation Bias	80.0				0.0		1.0	
Gender Identity Bias	22.0				0.0		1.0	
Gender Bias	2.0				0.0		0.0	
Disability Bias	0.0				0.0		0.0	

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

- Note 1: Sample sizes (N) and percentages are displayed below for each survey question. The percentages are weighted by statewide age, race and gender identity distributions. See data notes for more information.
- Note 2: The CHES was not designed to be a representative survey of all MA residents and percentages displayed may not be representative of the state.

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Housing	Current living situation	No steady place	1908	1.30%	528	1.10%	*	*	*	*	*	*	*	*
		Worried about losing	1908	2.60%	528	2.70%	163	3.70%	186	4.80%	*	*	*	*
		Steady place	1908	95.10%	528	95.80%	163	95.70%	186	92.50%	70	98.60%	40	95.00%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	510	22.00%	155	15.50%	180	48.30%	68	36.80%	37	24.30%
Basic Needs	Food insecurity, past month	Never	1963	87.80%	546	90.80%	164	93.90%	192	70.30%	72	83.30%	40	90.00%
		Sometimes	1963	9.90%	546	7.00%	164	4.30%	192	25.00%	72	11.10%	*	*
		A lot	1963	2.30%	546	2.20%	*	*	192	4.70%	*	*	*	*
Basic Needs	Current internet access	No internet	1938	1.30%	538	0.90%	*	*	189	3.20%	*	*	*	*
		Does not work well	1938	6.60%	538	5.20%	*	*	189	14.80%	71	8.50%	*	*
		Works well	1938	92.20%	538	93.90%	164	98.20%	189	82.00%	71	90.10%	40	95.00%

CHES – Youth

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Neighborhood	Able to get where you need to go	Somewhat or strongly disagree	1864	2.50%	516	1.60%	*	*	184	3.80%	*	*	*	*
		Somewhat agree	1864	14.60%	516	10.30%	160	6.30%	184	29.30%	69	21.70%	39	12.80%
		Strongly agree	1864	82.80%	516	88.20%	160	93.10%	184	66.80%	69	76.80%	39	87.20%
Neighborhood	Experienced neighborhood violence, lifetime	Never	1833	65.00%	504	73.80%	159	79.20%	182	30.20%	68	35.30%	39	74.40%
		Rarely	1833	22.80%	504	19.20%	159	16.40%	182	31.90%	68	36.80%	39	20.50%
		Somewhat often	1833	8.50%	504	4.60%	159	3.80%	182	30.80%	68	19.10%	*	*
		Very often	1833	3.70%	504	2.40%	*	*	182	7.10%	68	8.80%	*	*
Safety & Support	Have someone to talk to if needed help	No	1739	3.90%	469	3.20%	*	*	177	4.00%	*	*	*	*
		Yes, adult in home	1739	80.50%	469	83.80%	152	86.80%	177	70.10%	66	71.20%	38	84.20%
		Yes, adult outside home	1739	37.30%	469	36.20%	152	35.50%	177	39.00%	66	33.30%	38	50.00%
		Yes, friend or non-adult family	1739	43.00%	469	44.80%	152	39.50%	177	39.00%	66	39.40%	38	44.70%
Safety & Support	Feel safe with my family/caregivers	Not at all	1768	1.00%	473	1.70%	*	*	*	*	*	*	*	*
		Somewhat	1768	7.70%	473	6.80%	155	4.50%	178	11.20%	66	7.60%	*	*
		Very much	1768	91.30%	473	91.50%	155	94.80%	178	87.60%	66	90.90%	38	92.10%
Safety & Support	Feel I belong at school	Not at all	1760	5.90%	472	5.50%	*	*	179	4.50%	66	10.60%	*	*
		Somewhat	1760	29.10%	472	28.60%	155	21.90%	179	35.80%	66	34.80%	38	28.90%
		Very much	1760	65.00%	472	65.90%	155	76.80%	179	59.80%	66	54.50%	38	65.80%
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	467	3.20%	*	*	178	2.80%	*	*	*	*
		Somewhat	1745	17.10%	467	15.40%	153	12.40%	178	27.00%	66	27.30%	37	24.30%
		Very much	1745	80.50%	467	81.40%	153	86.90%	178	70.20%	66	71.20%	37	73.00%

CHES – Youth

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	471	66.50%	155	63.20%	179	70.40%	66	57.60%	38	71.10%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	471	5.30%	155	3.90%	179	22.30%	66	18.20%	*	*
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	471	18.30%	155	20.00%	179	24.60%	66	24.20%	38	39.50%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	471	13.40%	155	10.30%	179	11.20%	66	9.10%	38	13.20%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	471	6.40%	155	5.80%	179	7.80%	*	*	*	*
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	471	13.00%	155	9.70%	179	24.00%	66	18.20%	*	*
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	471	72.20%	155	68.40%	179	79.90%	66	66.70%	38	84.20%
Safety & Support	Experienced intimate partner violence (a)	Ever	1589	13.10%	442	8.60%	122	9.00%	157	15.30%	59	8.50%	35	17.10%
		In past year	1567	7.80%	440	5.20%	122	4.10%	154	9.10%	*	*	*	*
Safety & Support	Experienced household violence (b)	Ever	1536	14.20%	420	11.00%	118	7.60%	152	12.50%	58	10.30%	*	*
		In past year	1519	5.50%	417	5.30%	118	4.20%	148	4.10%	*	*	*	*
Safety & Support	Experienced sexual violence (c)	Ever	1558	9.20%	430	7.70%	121	6.60%	150	10.00%	*	*	*	*
		In past year	1551	3.10%	428	2.10%	*	*	*	*	*	*	*	*

Data Notes:

a. 6.1% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
b. 9.1% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
c. 8.2% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES – Youth

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Experienced discrimination	Ever	1674	45.20%	446	44.80%	152	35.50%	171	55.00%	61	47.50%	37	56.80%
		In past year	1674	19.60%	446	19.50%	152	15.80%	171	15.80%	61	21.30%	37	27.00%
Employment	Worked for pay, past year	No	1652	51.50%	433	56.10%	149	62.40%	170	51.20%	62	66.10%	37	40.50%
		Yes, <10 hours per week	1652	18.10%	433	21.70%	149	22.80%	170	12.90%	62	11.30%	37	24.30%
		Yes, 11-19 hours per week	1652	13.30%	433	12.20%	149	7.40%	170	14.10%	62	8.10%	37	16.20%
		Yes, 20-34 hours per week	1652	10.30%	433	6.50%	*	*	170	16.50%	62	12.90%	*	*
		Yes, >35 hours per week	1652	6.80%	433	3.50%	149	4.70%	170	5.30%	*	*	*	*
Education	Educational challenges, past year	None of these	1484	66.80%	386	67.60%	142	77.50%	159	67.90%	56	73.20%	36	66.70%
		Frequent absences	1484	7.60%	386	8.30%	*	*	159	8.20%	*	*	*	*
		Needed more support in school	1484	7.00%	386	6.50%	142	3.50%	159	8.20%	*	*	*	*
		Needed more support outside school	1484	6.30%	386	8.00%	*	*	159	8.20%	*	*	*	*
		Safety concerns	1484	5.10%	386	5.20%	*	*	*	*	*	*	*	*
		Temperature in classroom	1484	18.50%	386	16.60%	142	18.30%	159	17.60%	56	16.10%	36	25.00%
Education	Hurt or harassed by school staff, past year	Never	1503	87.70%	391	90.50%	143	93.00%	160	88.10%	56	89.30%	37	86.50%
		Once or twice	1503	9.10%	391	6.90%	143	6.30%	160	8.10%	*	*	*	*
		Monthly	1503	1.60%	391	1.30%	*	*	*	*	*	*	*	*
		Daily	1503	1.60%	391	1.30%	*	*	*	*	*	*	*	*
Education	Helpful school resources provided	College-preparation	1459	57.90%	382	61.30%	142	64.10%	156	55.80%	54	50.00%	37	73.00%
		Extracurricular activities	1459	74.40%	382	82.20%	142	83.10%	156	60.30%	54	63.00%	37	89.20%
		Guidance counselor	1459	58.80%	382	59.40%	142	66.90%	156	62.80%	54	59.30%	37	70.30%
		Programs to reduce bullying, violence, racism	1459	19.10%	382	24.30%	142	19.00%	156	13.50%	54	24.10%	*	*

CHES – Youth

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	139	5.00%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	106	5.70%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	72	20.80%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those needing care)	Yes	62	7.90%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	ANY unmet heath care need, past year (among those needing any care)	Yes	857	10.30%	234	10.70%	67	7.50%	70	14.30%	*	*	*	*
		Low	1376	22.10%	362	22.10%	101	22.80%	131	22.90%	48	29.20%	34	20.60%
		Medium	1376	33.00%	362	34.00%	101	38.60%	131	38.20%	48	39.60%	34	41.20%
		High	1376	18.40%	362	20.20%	101	21.80%	131	15.30%	48	12.50%	34	23.50%
Mental Health	Psychological distress, past month	Very high	1376	26.60%	362	23.80%	101	16.80%	131	23.70%	48	18.80%	34	14.70%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	394	14.70%	136	6.60%	161	18.00%	56	16.10%	*	*
Mental Health	Suicide ideation, past year (d)	Yes	1338	14.60%	352	12.80%	104	13.50%	138	7.20%	*	*	*	*

Data Notes: d. 12.0% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES – Youth

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Tobacco use, past month	Yes	1499	8.00%	390	6.70%	136	3.70%	163	11.70%	58	8.60%	*	*
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	382	8.40%	134	8.20%	160	5.60%	*	*	*	*
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*	*	*	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*	*	*	160	3.10%	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	382	7.30%	134	5.20%	159	9.40%	55	9.10%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	383	9.40%	134	7.50%	160	15.00%	56	14.30%	*	*
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*	*	*	*	*	*	*

CHES – Youth

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	376	8.00%	*	*	160	9.40%	*	*	*	*
		Not sure	1445	5.70%	376	6.40%	128	5.50%	160	10.00%	*	*	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (1)	Yes	767	25.40%	190	22.10%	70	21.40%	94	27.70%	36	19.40%	*	*
Emerging Issues	Flooding in home or on street, past 5 years (1)	Yes	767	5.50%	190	7.40%	70	7.10%	*	*	*	*	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (1)	Yes	767	20.20%	190	20.50%	70	22.90%	94	12.80%	*	*	*	*
Emerging Issues	Power outages, past 5 years (1)	Yes	767	25.40%	190	26.80%	70	20.00%	94	23.40%	36	33.30%	*	*
Emerging Issues	School cancellation due to weather, past 5 years (1)	Yes	767	39.40%	190	38.90%	70	21.40%	94	24.50%	36	36.10%	*	*
Emerging Issues	Unable to work due to weather, past 5 years (1)	Yes	767	7.60%	190	6.80%	*	*	94	6.40%	*	*	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (1)	Yes	767	33.30%	190	28.90%	70	31.40%	94	36.20%	36	27.80%	*	*
Emerging Issues	Other climate impact, past 5 years (1)	Yes	767	0.90%	*	*	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (1)	Yes	767	59.70%	190	56.30%	70	48.60%	94	56.40%	36	52.80%	*	*

Data Notes: 1. Asked on 2 splits (~50% of respondents)

Community Health Equity Survey (CHES) – Adult

CHES Adult: Boston – Brookline

Data Notes:

- Note 1: Sample sizes (N) and percentages are displayed below for each survey question. The percentages are weighted by statewide age, race and gender identity distributions. See data notes for more information.
- Note 2: The CHES was not designed to be a representative survey of all MA residents and percentages displayed may not be representative of the state.

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	3353	1.70%	1313	1.10%	1279	5.70%	1124	5.50%	468	1.10%
		Worried about losing	14888	8.00%	3353	6.50%	1313	6.60%	1279	9.30%	1124	9.10%	468	8.10%
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	1313	92.10%	1279	84.50%	1124	84.90%	468	90.60%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	1006	31.70%	965	45.10%	845	43.70%	361	38.00%
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	630	4.00%	665	5.00%	583	5.00%	216	3.70%
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	630	11.70%	665	21.20%	583	19.90%	216	10.60%
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	1689	13.30%	630	10.30%	665	16.10%	583	16.00%	216	7.40%
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	630	11.10%	665	22.70%	583	22.00%	216	8.80%
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	630	4.90%	665	9.30%	583	8.90%	216	4.20%
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	630	7.60%	665	14.60%	583	14.10%	216	5.10%
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	630	9.40%	665	16.10%	583	14.80%	216	5.10%
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	1689	27.10%	630	24.90%	665	40.50%	583	37.90%	216	19.00%
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	3366	12.40%	1317	13.40%	1278	34.30%	1122	34.40%	461	10.20%

CHES Adult: Boston – Brookline

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Not enough money	13814	16.50%	3141	11.00%	1201	11.00%	1191	19.80%	1054	18.90%	429	9.10%
		Just enough money	13814	31.10%	3141	24.90%	1201	28.10%	1191	40.00%	1054	40.30%	429	21.40%
Basic Needs	End of month finances	Money left over	13814	52.40%	3141	64.10%	1201	60.90%	1191	40.20%	1054	40.80%	429	69.50%
		No internet	11425	3.00%	2514	1.60%	1030	0.90%	981	5.50%	861	4.90%	*	*
		Does not work well	11425	9.30%	2514	7.00%	1030	6.10%	981	9.00%	861	8.10%	368	6.00%
Basic Needs	Current internet access (2)	Works well	11425	87.70%	2514	91.50%	1030	93.00%	981	85.50%	861	87.00%	368	92.90%
		Somewhat or strongly disagree	11064	7.00%	2521	5.50%	968	4.90%	965	6.30%	840	6.30%	326	3.10%
		Somewhat agree	11064	22.00%	2521	21.70%	968	17.30%	965	19.50%	840	18.10%	326	10.70%
Neighborhood	Able to get where you need to go (2)	Strongly agree	11064	71.00%	2521	72.80%	968	77.90%	965	74.20%	840	75.60%	326	86.20%
		Never	11008	58.60%	2509	63.50%	967	64.60%	960	43.90%	835	46.90%	327	67.90%
		Rarely	11008	28.90%	2509	28.60%	967	28.70%	960	31.90%	835	31.70%	327	29.10%
		Somewhat often	11008	9.10%	2509	5.80%	967	5.50%	960	15.00%	835	12.80%	327	2.80%
Neighborhood	Experienced neighborhood violence, lifetime (2)	Very often	11008	3.40%	2509	2.10%	967	1.10%	960	9.30%	835	8.50%	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	3236	83.50%	1285	84.10%	1256	75.20%	1103	75.60%	461	84.60%
		Not sure	14393	6.50%	3236	6.60%	1285	5.60%	1256	5.80%	1103	5.40%	461	5.00%
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	3233	75.50%	1281	75.40%	1252	68.20%	1098	68.50%	459	73.20%
		Not sure	14366	10.20%	3233	10.80%	1281	9.90%	1252	10.10%	1098	9.70%	459	11.10%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	3226	72.50%	1281	73.00%	1242	60.00%	1091	61.70%	460	76.30%
		Not sure	14325	12.90%	3226	11.60%	1281	10.80%	1242	12.50%	1091	12.20%	460	8.30%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	3222	82.70%	1277	83.60%	1250	77.20%	1099	77.40%	458	84.70%
		Not sure	14336	7.00%	3222	6.80%	1277	6.10%	1250	6.10%	1099	5.90%	458	6.10%
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	3212	66.10%	1266	66.70%	1247	60.40%	1093	62.10%	451	66.70%
		Not sure	14247	16.30%	3212	17.40%	1266	16.40%	1247	13.30%	1093	13.10%	451	16.90%

CHES Adult: Boston – Brookline

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Experienced intimate partner violence (a)	Ever	13621	29.70%	3068	26.50%	1207	23.80%	1174	26.90%	1036	25.80%	431	21.60%
		In past year	13359	4.50%	3029	3.20%	1195	3.20%	1152	5.20%	1018	4.70%	430	2.10%
Safety & Support	Experienced sexual violence (b)	Ever	13628	21.00%	3073	22.60%	1211	18.10%	1194	21.30%	1049	22.00%	432	16.40%
		In past year	13593	1.40%	3070	1.20%	1210	0.40%	1190	2.20%	1046	2.20%	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	3160	59.10%	1256	57.60%	1235	59.20%	1084	57.80%	452	61.90%
		In past year	14130	18.00%	3160	17.20%	1256	16.80%	1235	22.00%	1084	21.30%	452	12.60%
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	563	21.00%	600	20.50%	536	20.00%	182	20.90%
Employment	Location of work (among all workers)	At home only	9173	7.50%	2091	10.40%	771	10.00%	762	6.60%	678	6.60%	238	14.70%
		Outside home only	9173	54.60%	2091	42.40%	771	43.70%	762	50.10%	678	49.70%	238	29.00%
		Both at home/outside home	9173	37.40%	2091	46.60%	771	46.00%	762	42.90%	678	43.20%	238	55.50%
Employment	Paid sick leave at work (among all workers) (2)	Yes	6903	75.30%	1543	76.80%	564	74.30%	599	75.60%	534	75.80%	182	64.80%
		Not sure	6903	4.20%	1543	3.60%	564	4.40%	599	4.00%	534	3.60%	182	5.50%

Data Notes:

a. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
b. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Boston – Brookline

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	635	65.00%	578	64.50%	510	64.50%	229	63.80%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	849	5.90%	331	6.00%	281	11.00%	253	11.10%	135	5.20%
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	443	7.70%	152	4.60%	116	7.80%	103	7.80%	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	713	6.60%	275	8.70%	290	6.90%	270	6.70%	94	6.40%
Healthcare Access	Unmet need for home and community-based services (among those who needed this care) (2)	Yes	334	25.40%	69	34.80%	40	27.50%	48	16.70%	44	18.20%	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care) (2)	Yes	2441	21.10%	596	17.40%	222	21.60%	220	21.80%	198	21.20%	85	16.50%
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care) (2)	Yes	998	7.00%	243	6.60%	77	10.40%	116	6.90%	104	5.80%	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care) (2)	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care) (2)	Yes	760	12.80%	174	11.50%	72	11.10%	53	24.50%	41	17.10%	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	1655	12.60%	635	13.70%	634	15.80%	567	15.20%	237	11.40%

CHES Adult: Boston – Brookline

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Telehealth visit, past year (1)	One or more visit	6747	51.20%	1504	58.80%	636	56.10%	579	51.60%	511	52.10%	233	62.20%
		Offered, didn't have	6747	7.00%	1504	7.60%	636	6.90%	579	7.80%	511	8.00%	233	6.90%
		Not offered	6747	22.10%	1504	19.00%	636	20.80%	579	20.60%	511	20.70%	233	16.70%
		No healthcare visits	6747	20.30%	1504	14.80%	636	16.70%	579	20.60%	511	19.80%	233	14.60%
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	1016	19.20%	394	18.80%	259	18.10%	219	18.30%	138	17.40%
		Not sure	4184	3.80%	1016	3.60%	394	4.60%	259	5.00%	219	5.00%	138	5.10%
Mental Health	Psychological distress, past month	Low	13267	36.80%	3024	38.70%	1183	40.20%	1146	34.80%	1014	36.50%	428	40.40%
		Medium	13267	32.00%	3024	34.30%	1183	35.20%	1146	29.50%	1014	28.60%	428	41.10%
		High	13267	13.90%	3024	13.70%	1183	11.70%	1146	15.80%	1014	15.50%	428	10.00%
		Very high	13267	17.30%	3024	13.40%	1183	12.80%	1146	19.90%	1014	19.40%	428	8.40%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	906	9.70%	905	11.60%	789	11.00%	312	7.70%
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	2981	7.00%	1168	4.70%	1119	6.80%	985	7.00%	423	2.80%

Data Notes: c. 4.7% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Boston – Brookline

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	908	6.30%	915	15.00%	808	14.20%	339	2.90%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	1209	52.10%	1187	40.20%	1042	41.00%	438	55.00%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	1221	4.40%	1192	3.90%	1047	3.20%	441	3.40%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	1224	5.00%	1195	4.80%	1049	4.00%	442	4.10%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	1223	10.80%	1195	14.90%	1049	15.40%	442	9.70%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	1224	13.20%	1195	20.60%	1049	21.50%	442	13.60%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	3061	0.40%	*	*	1195	0.70%	1049	0.70%	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	1195	1.10%	1049	0.90%	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	3061	0.80%	1224	0.40%	1195	1.50%	1049	1.30%	*	*
Substance Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	1195	0.50%	1049	0.50%	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	3061	0.30%	*	*	1195	0.70%	1049	0.80%	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	1195	0.80%	1049	0.90%	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	1224	1.30%	1195	1.30%	1049	1.10%	442	1.40%
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	1224	0.70%	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	1224	1.10%	1195	2.40%	1049	2.40%	442	1.60%

CHES Adult: Boston – Brookline

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Boston		Brookline	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	COVID-19 vaccination, past year (1)	Yes	6729	67.80%	1506	76.40%	636	78.50%	568	68.10%	501	69.90%	239	90.40%
		Not sure	6729	3.60%	1506	3.30%	636	2.50%	568	3.70%	501	3.00%	239	2.50%
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	554	15.50%	475	21.70%	413	20.80%	186	12.40%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	902	38.50%	938	38.90%	827	39.90%	337	40.90%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	902	10.90%	938	9.80%	827	9.80%	337	11.60%
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	902	23.90%	938	16.70%	827	17.30%	337	22.30%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	902	20.40%	938	14.10%	827	14.30%	337	18.40%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	902	15.20%	938	12.00%	827	12.20%	337	16.30%
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	902	10.90%	938	13.10%	827	13.50%	337	9.80%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	902	24.50%	938	29.20%	827	29.70%	337	29.10%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	902	1.90%	938	1.50%	827	1.50%	337	1.50%
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	902	63.30%	938	59.30%	827	59.30%	337	64.10%

CHES Adult: Dedham – Newton

Data Notes:

- Note 1: Sample sizes (N) and percentages are displayed below for each survey question. The percentages are weighted by statewide age, race and gender identity distributions. See data notes for more information.
- Note 2: The CHES was not designed to be a representative survey of all MA residents and percentages displayed may not be representative of the state.

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Dedham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	3353	1.70%	1313	1.10%	1279	5.70%	*	*	*	*
		Worried about losing	14888	8.00%	3353	6.50%	1313	6.60%	1279	9.30%	*	*	310	3.90%
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	1313	92.10%	1279	84.50%	34	94.10%	310	95.50%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	1006	31.70%	965	45.10%	*	*	229	34.10%
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	630	4.00%	665	5.00%	*	*	156	3.80%
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	630	11.70%	665	21.20%	*	*	156	5.10%
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	1689	13.30%	630	10.30%	665	16.10%	*	*	156	6.40%
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	630	11.10%	665	22.70%	*	*	156	8.30%
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	630	4.90%	665	9.30%	*	*	156	3.80%
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	630	7.60%	665	14.60%	*	*	156	3.80%
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	630	9.40%	665	16.10%	*	*	156	5.10%
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	1689	27.10%	630	24.90%	665	40.50%	*	*	156	12.20%
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	3366	12.40%	1317	13.40%	1278	34.30%	*	*	313	5.80%

CHES Adult: Dedham – Newton

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Dedham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Not enough money	13814	16.50%	3141	11.00%	1201	11.00%	1191	19.80%	33	15.20%	282	7.40%
		Just enough money	13814	31.10%	3141	24.90%	1201	28.10%	1191	40.00%	33	18.20%	282	17.40%
Basic Needs	End of month finances	Money left over	13814	52.40%	3141	64.10%	1201	60.90%	1191	40.20%	33	66.70%	282	75.20%
		No internet	11425	3.00%	2514	1.60%	1030	0.90%	981	5.50%	*	*	*	*
	Current internet access	Does not work well	11425	9.30%	2514	7.00%	1030	6.10%	981	9.00%	*	*	239	2.10%
Basic Needs	(2)	Works well	11425	87.70%	2514	91.50%	1030	93.00%	981	85.50%	*	*	239	97.50%
		Somewhat or strongly disagree	11064	7.00%	2521	5.50%	968	4.90%	965	6.30%	*	*	226	5.80%
	Able to get where you	Somewhat agree	11064	22.00%	2521	21.70%	968	17.30%	965	19.50%	*	*	226	17.30%
Neighborhood	need to go (2)	Strongly agree	11064	71.00%	2521	72.80%	968	77.90%	965	74.20%	*	*	226	77.00%
		Never	11008	58.60%	2509	63.50%	967	64.60%	960	43.90%	*	*	225	69.80%
	Experienced	Rarely	11008	28.90%	2509	28.60%	967	28.70%	960	31.90%	*	*	225	27.10%
	neighborhood violence,	Somewhat often	11008	9.10%	2509	5.80%	967	5.50%	960	15.00%	*	*	225	2.20%
Neighborhood	lifetime (2)	Very often	11008	3.40%	2509	2.10%	967	1.10%	960	9.30%	*	*	*	*
Safety &	Can count on someone	Yes	14393	80.60%	3236	83.50%	1285	84.10%	1256	75.20%	33	87.90%	294	90.80%
Support	for favors	Not sure	14393	6.50%	3236	6.60%	1285	5.60%	1256	5.80%	*	*	294	5.40%
Safety &	Can count on someone to	Yes	14366	73.20%	3233	75.50%	1281	75.40%	1252	68.20%	32	75.00%	293	80.50%
Support	care for you if sick	Not sure	14366	10.20%	3233	10.80%	1281	9.90%	1252	10.10%	*	*	293	9.90%
Safety &	Can count on someone to	Yes	14325	64.60%	3226	72.50%	1281	73.00%	1242	60.00%	33	66.70%	293	84.30%
Support	lend money	Not sure	14325	12.90%	3226	11.60%	1281	10.80%	1242	12.50%	33	15.20%	293	7.20%
Safety &	Can count on someone for support with family	Yes	14336	79.20%	3222	82.70%	1277	83.60%	1250	77.20%	33	78.80%	292	90.80%
Support	trouble	Not sure	14336	7.00%	3222	6.80%	1277	6.10%	1250	6.10%	*	*	292	4.10%

CHES Adult: Dedham – Newton

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Dedham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	3212	66.10%	1266	66.70%	1247	60.40%	33	69.70%	291	69.40%
		Not sure	14247	16.30%	3212	17.40%	1266	16.40%	1247	13.30%	33	15.20%	291	20.60%
Safety & Support	Experienced intimate partner violence (a)	Ever	13621	29.70%	3068	26.50%	1207	23.80%	1174	26.90%	33	30.30%	284	22.50%
		In past year	13359	4.50%	3029	3.20%	1195	3.20%	1152	5.20%	*	*	283	2.10%
Safety & Support	Experienced sexual violence (b)	Ever	13628	21.00%	3073	22.60%	1211	18.10%	1194	21.30%	33	24.20%	283	23.30%
		In past year	13593	1.40%	3070	1.20%	1210	0.40%	1190	2.20%	*	*	283	1.80%
Safety & Support	Experienced discrimination	Ever	14130	55.20%	3160	59.10%	1256	57.60%	1235	59.20%	34	64.70%	287	60.60%
		In past year	14130	18.00%	3160	17.20%	1256	16.80%	1235	22.00%	34	23.50%	287	14.30%
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	563	21.00%	600	20.50%	*	*	144	19.40%
Employment	Location of work (among all workers)	At home only	9173	7.50%	2091	10.40%	771	10.00%	762	6.60%	*	*	180	16.10%
		Outside home only	9173	54.60%	2091	42.40%	771	43.70%	762	50.10%	*	*	180	32.80%
		Both at home/outside home	9173	37.40%	2091	46.60%	771	46.00%	762	42.90%	*	*	180	51.10%
Employment	Paid sick leave at work (among all workers) (2)	Yes	6903	75.30%	1543	76.80%	564	74.30%	599	75.60%	*	*	142	76.10%
		Not sure	6903	4.20%	1543	3.60%	564	4.40%	599	4.00%	*	*	*	*

Data Notes:

a. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
b. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Dedham – Newton

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Dedham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	635	65.00%	578	64.50%	*	*	131	55.70%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	849	5.90%	331	6.00%	281	11.00%	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	443	7.70%	152	4.60%	116	7.80%	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	713	6.60%	275	8.70%	290	6.90%	*	*	55	9.10%
Healthcare Access	Unmet need for home and community-based services (among those who needed this care) (2)	Yes	334	25.40%	69	34.80%	40	27.50%	48	16.70%	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care) (2)	Yes	2441	21.10%	596	17.40%	222	21.60%	220	21.80%	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care) (2)	Yes	998	7.00%	243	6.60%	77	10.40%	116	6.90%	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care) (2)	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care) (2)	Yes	760	12.80%	174	11.50%	72	11.10%	53	24.50%	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	1655	12.60%	635	13.70%	634	15.80%	*	*	145	7.60%

CHES Adult: Dedham – Newton

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Dedham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Low	13267	36.80%	3024	38.70%	1183	40.20%	1146	34.80%	32	34.40%	271	42.80%
		Medium	13267	32.00%	3024	34.30%	1183	35.20%	1146	29.50%	32	40.60%	271	35.80%
		High	13267	13.90%	3024	13.70%	1183	11.70%	1146	15.80%	*	*	271	10.70%
Mental Health	Psychological distress, past month	Very high	13267	17.30%	3024	13.40%	1183	12.80%	1146	19.90%	32	18.80%	271	10.70%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	906	9.70%	905	11.60%	*	*	208	7.20%
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	2981	7.00%	1168	4.70%	1119	6.80%	*	*	266	6.80%
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	908	6.30%	915	15.00%	*	*	219	5.00%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	1209	52.10%	1187	40.20%	32	50.00%	276	62.00%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	1221	4.40%	1192	3.90%	*	*	277	5.10%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	1224	5.00%	1195	4.80%	*	*	277	6.10%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	1223	10.80%	1195	14.90%	33	21.20%	277	8.70%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	1224	13.20%	1195	20.60%	33	21.20%	277	13.00%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	3061	0.40%	*	*	1195	0.70%	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	1195	1.10%	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	3061	0.80%	1224	0.40%	1195	1.50%	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	1195	0.50%	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*

Data Notes: c. 4.7% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Dedham – Newton

			Massachusetts		Middlesex County		Norfolk County		Suffolk County		Dedham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	3061	0.30%	*	*	1195	0.70%	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	1195	0.80%	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	1224	1.30%	1195	1.30%	*	*	277	2.20%
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	1224	0.70%	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	1224	1.10%	1195	2.40%	*	*	277	1.80%
Emerging Issues	COVID-19 vaccination, past year (1)	Yes	6729	67.80%	1506	76.40%	636	78.50%	568	68.10%	*	*	126	85.70%
		Not sure	6729	3.60%	1506	3.30%	636	2.50%	568	3.70%	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	554	15.50%	475	21.70%	*	*	141	11.30%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	902	38.50%	938	38.90%	*	*	218	41.30%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	902	10.90%	938	9.80%	*	*	218	17.00%
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	902	23.90%	938	16.70%	*	*	218	26.60%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	902	20.40%	938	14.10%	*	*	218	22.00%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	902	15.20%	938	12.00%	*	*	218	24.80%
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	902	10.90%	938	13.10%	*	*	218	11.90%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	902	24.50%	938	29.20%	*	*	218	33.00%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	902	1.90%	938	1.50%	*	*	218	2.30%
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	902	63.30%	938	59.30%	*	*	218	71.10%

Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume

CHIA – Ages 0-17

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
All Cause						
FY24 ED Volume (all cause) rate per 100,000	4923	1297	4016	1923	3260	561
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	322	1747	885	1451	221
Allergy						
FY24 ED Volume rate per 100,000	293	78	313	143	270	50
FY24 Inpatient Discharges rate per 100,000	29	10	97	11	23	3
Asthma						
FY24 ED Volume rate per 100,000	347	146	459	157	266	44
FY24 Inpatient Discharges rate per 100,000	67	25	55	14	51	7
Attention Deficit Hyperactivity Disorder						
FY24 ED Volume rate per 100,000	77	22	125	52	67	10
FY24 Inpatient Discharges rate per 100,000	27	8	48	6	15	4
Complication of Medical Care						
FY24 ED Volume rate per 100,000	33	8	48	15	27	7
FY24 Inpatient Discharges rate per 100,000	49	21	285	35	27	14
Diabetes						
FY24 ED Volume rate per 100,000	21	6	6	3	3	
FY24 Inpatient Discharges rate per 100,000	8	4	34	1	3	
HIV/AIDS						
FY24 ED Volume rate per 100,000	0					
FY24 Inpatient Discharges rate per 100,000	0					
Infection						
FY24 ED Volume rate per 100,000	1314	352	884	320	731	127
FY24 Inpatient Discharges rate per 100,000	131	49	382	59	83	20

CHIA – Ages 0-17

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Injuries						
FY24 ED Volume rate per 100,000	922	222	619	483	636	148
FY24 Inpatient Discharges rate per 100,000	49	16	111	23	31	6
Learning Disorders						
FY24 ED Volume rate per 100,000	22	18	83	20	23	15
FY24 Inpatient Discharges rate per 100,000	24	11	48	9	19	11
Mental Health						
FY24 ED Volume rate per 100,000	292	57	90	76	214	26
FY24 Inpatient Discharges rate per 100,000	75	18	97	51	63	12
Obesity						
FY24 ED Volume rate per 100,000	7	2	6	1	3	
FY24 Inpatient Discharges rate per 100,000	12	5	13	6	11	2
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	150	28	90	30	75	11
FY24 Inpatient Discharges rate per 100,000	32	8	55	4	19	2
Poisonings						
FY24 ED Volume rate per 100,000	59	10	27	17	23	2
FY24 Inpatient Discharges rate per 100,000	6	1	13			2
STIs						
FY24 ED Volume rate per 100,000	4	2	6		3	
FY24 Inpatient Discharges rate per 100,000	1	0				
Substance Use						
FY24 ED Volume rate per 100,000	48	8	6	12	31	5
FY24 Inpatient Discharges rate per 100,000	11	1	13	1	11	
Age 0-17 Total	**4923**	**1297**	**4016**	**1923**	**3260**	**561**

CHIA – Ages 18-44

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
All Cause						
FY24 ED Volume (all cause) rate per 100,000	11106	3977	21623	4089	7240	931
FY24 Inpatient Discharges (all causes) rate per 100,000	2251	544	2053	1205	2278	287
Allergy						
FY24 ED Volume rate per 100,000	952	455	3446	650	1304	171
FY24 Inpatient Discharges rate per 100,000	206	44	160	89	170	16
Asthma						
FY24 ED Volume rate per 100,000	552	198	536	102	469	30
FY24 Inpatient Discharges rate per 100,000	266	99	257	114	254	14
Breast Cancer						
FY24 ED Volume rate per 100,000	7	1	13		7	1
FY24 Inpatient Discharges rate per 100,000	9	1		1	11	
CHF						
FY24 ED Volume rate per 100,000	14	4	34	7	7	
FY24 Inpatient Discharges rate per 100,000	50	17	55	14	39	1
Complication of Medical Care						
FY24 ED Volume rate per 100,000	120	36	271	33	131	10
FY24 Inpatient Discharges rate per 100,000	645	156	543	400	763	111
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	30	5	13	1	15	1
FY24 Inpatient Discharges rate per 100,000	40	8	62	3	75	3
Diabetes						
FY24 ED Volume rate per 100,000	309	95	403	59	226	14
FY24 Inpatient Discharges rate per 100,000	173	50	146	44	75	6

CHIA – Ages 18-44

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
GYN Cancer						
FY24 ED Volume rate per 100,000	2	0				
FY24 Inpatient Discharges rate per 100,000	4					3
Heart Disease						
FY24 ED Volume rate per 100,000	12	3	6	1		
FY24 Inpatient Discharges rate per 100,000	56	19	83	9	51	5
Hepatitis						
FY24 ED Volume rate per 100,000	26	11	27	4	19	2
FY24 Inpatient Discharges rate per 100,000	70	27	146	7	59	5
HIV/AIDS						
FY24 ED Volume rate per 100,000	24	17	48	3	11	5
FY24 Inpatient Discharges rate per 100,000	14	12	48			1
Hypertension						
FY24 ED Volume rate per 100,000	447	116	452	66	262	16
FY24 Inpatient Discharges rate per 100,000	210	59	215	51	135	9
Infection						
FY24 ED Volume rate per 100,000	1595	624	3815	582	998	139
FY24 Inpatient Discharges rate per 100,000	338	103	424	119	298	31
Injuries						
FY24 ED Volume rate per 100,000	1775	645	3104	661	1129	133
FY24 Inpatient Discharges rate per 100,000	237	73	313	105	218	24
Liver Disease						
FY24 ED Volume rate per 100,000	99	22	139	28	79	9
FY24 Inpatient Discharges rate per 100,000	191	49	187	66	127	11

CHIA – Ages 18-44

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Mental Health						
FY24 ED Volume rate per 100,000	1310	511	2756	387	795	102
FY24 Inpatient Discharges rate per 100,000	834	225	939	413	795	88
Obesity						
FY24 ED Volume rate per 100,000	135	26	62	17	59	7
FY24 Inpatient Discharges rate per 100,000	324	78	215	98	194	35
Other Cancer						
FY24 ED Volume rate per 100,000	12	1	13	1	7	2
FY24 Inpatient Discharges rate per 100,000	23	3	20	7	31	15
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	122	42	320	39	55	7
FY24 Inpatient Discharges rate per 100,000	85	19	90	20	119	5
Poisonings						
FY24 ED Volume rate per 100,000	182	43	285	73	139	6
FY24 Inpatient Discharges rate per 100,000	33	10	41	7	43	1
Prostate Cancer						
FY24 ED Volume rate per 100,000	0					
FY24 Inpatient Discharges rate per 100,000	0					
STIs						
FY24 ED Volume rate per 100,000	77	73	264	22	67	5
FY24 Inpatient Discharges rate per 100,000	37	11	27	19	43	3

CHIA – Ages 18-44

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	8	1		3	3	
FY24 Inpatient Discharges rate per 100,000	19	3	20	6	11	3
Substance Use						
FY24 ED Volume rate per 100,000	2079	839	3724	446	1280	111
FY24 Inpatient Discharges rate per 100,000	588	159	626	141	473	21
Tuberculosis						
FY24 ED Volume rate per 100,000	2	0				
FY24 Inpatient Discharges rate per 100,000	8	3		1	7	
Age 18-44 Total	11106	3977	21623	4089	7240	931

CHIA – Ages 45-64

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
All Cause						
FY24 ED Volume (all cause) rate per 100,000	6844	1947	7365	2014	5097	591
FY24 Inpatient Discharges (all causes) rate per 100,000	2291	529	2220	642	1980	142
Allergy						
FY24 ED Volume rate per 100,000	797	288	1907	468	1208	188
FY24 Inpatient Discharges rate per 100,000	330	79	410	87	214	32
Asthma						
FY24 ED Volume rate per 100,000	299	88	201	33	214	19
FY24 Inpatient Discharges rate per 100,000	254	89	320	65	198	13
Breast Cancer						
FY24 ED Volume rate per 100,000	40	6	27	11	31	4
FY24 Inpatient Discharges rate per 100,000	57	11	20	17	75	5
CHF						
FY24 ED Volume rate per 100,000	78	22	55	7	75	2
FY24 Inpatient Discharges rate per 100,000	344	127	417	54	322	14
Complication of Medical Care						
FY24 ED Volume rate per 100,000	100	27	104	38	166	12
FY24 Inpatient Discharges rate per 100,000	428	111	396	137	421	24
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	239	34	13	27	91	
FY24 Inpatient Discharges rate per 100,000	415	86	327	49	330	9
Diabetes						
FY24 ED Volume rate per 100,000	759	202	703	169	429	31
FY24 Inpatient Discharges rate per 100,000	688	195	800	145	425	27

CHIA – Ages 45-64

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
GYN Cancer						
FY24 ED Volume rate per 100,000	4	1		1		2
FY24 Inpatient Discharges rate per 100,000	16	2	20	20	43	5
Heart Disease						
FY24 ED Volume rate per 100,000	37	3	13	7	35	4
FY24 Inpatient Discharges rate per 100,000	280	85	348	62	294	21
Hepatitis						
FY24 ED Volume rate per 100,000	23	7	6		7	
FY24 Inpatient Discharges rate per 100,000	83	52	389	23	67	3
HIV/AIDS						
FY24 ED Volume rate per 100,000	34	28	201	28	11	3
FY24 Inpatient Discharges rate per 100,000	34	30	292	15	19	
Hypertension						
FY24 ED Volume rate per 100,000	1377	321	1134	272	990	81
FY24 Inpatient Discharges rate per 100,000	918	207	856	207	723	50
Infection						
FY24 ED Volume rate per 100,000	813	231	953	258	596	74
FY24 Inpatient Discharges rate per 100,000	627	154	682	162	528	31
Injuries						
FY24 ED Volume rate per 100,000	1351	399	1719	408	1057	118
FY24 Inpatient Discharges rate per 100,000	534	145	619	126	441	48
Liver Disease						
FY24 ED Volume rate per 100,000	113	20	118	28	115	2
FY24 Inpatient Discharges rate per 100,000	383	99	577	114	326	16

CHIA – Ages 45-64

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Mental Health						
FY24 ED Volume rate per 100,000	703	213	849	167	238	28
FY24 Inpatient Discharges rate per 100,000	1042	262	1427	323	994	65
Obesity						
FY24 ED Volume rate per 100,000	138	16	27	15	27	4
FY24 Inpatient Discharges rate per 100,000	619	133	501	116	493	30
Other Cancer						
FY24 ED Volume rate per 100,000	30	3		14	19	1
FY24 Inpatient Discharges rate per 100,000	100	16	97	59	59	11
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	73	17	83	12	55	5
FY24 Inpatient Discharges rate per 100,000	228	52	194	33	166	10
Poisonings						
FY24 ED Volume rate per 100,000	82	23	76	19	23	5
FY24 Inpatient Discharges rate per 100,000	36	14	20	6	27	1
Prostate Cancer						
FY24 ED Volume rate per 100,000	12	2		1	3	1
FY24 Inpatient Discharges rate per 100,000	28	8	48	14	7	1

CHIA – Ages 45-64

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
STIs						
FY24 ED Volume rate per 100,000	10	9	34	1	7	
FY24 Inpatient Discharges rate per 100,000	6	2	20	1	7	1
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	24	3	20	3	47	1
FY24 Inpatient Discharges rate per 100,000	92	21	41	25	95	9
Substance Use						
FY24 ED Volume rate per 100,000	1492	624	2318	234	763	24
FY24 Inpatient Discharges rate per 100,000	858	248	1162	173	660	19
Tuberculosis						
FY24 ED Volume rate per 100,000	1	0				
FY24 Inpatient Discharges rate per 100,000	11	5		1		
Age 45-64 Total	6844	1947	7365	2014	5097	591

CHIA – Ages 65+

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
All Cause						
FY24 ED Volume (all cause) rate per 100,000	5485	1027	5673	2912	6294	835
FY24 Inpatient Discharges (all causes) rate per 100,000	4476	710	4170	2209	5821	708
Allergy						
FY24 ED Volume rate per 100,000	798	179	1448	933	1399	274
FY24 Inpatient Discharges rate per 100,000	671	99	717	315	763	140
Asthma						
FY24 ED Volume rate per 100,000	155	19	48	36	190	20
FY24 Inpatient Discharges rate per 100,000	314	91	396	151	385	66
Breast Cancer						
FY24 ED Volume rate per 100,000	69	3	27	30	95	20
FY24 Inpatient Discharges rate per 100,000	216	30	243	141	385	66
CHF						
FY24 ED Volume rate per 100,000	270	30	104	94	457	30
FY24 Inpatient Discharges rate per 100,000	1445	249	1239	644	2222	183
Complication of Medical Care						
FY24 ED Volume rate per 100,000	158	30	111	73	123	22
FY24 Inpatient Discharges rate per 100,000	809	155	891	553	1061	168
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	350	31	69	98	337	13
FY24 Inpatient Discharges rate per 100,000	1111	153	758	344	1443	106

CHIA – Ages 65+

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Diabetes						
FY24 ED Volume rate per 100,000	860	165	668	296	898	89
FY24 Inpatient Discharges rate per 100,000	1509	336	1656	585	1666	186
GYN Cancer						
FY24 ED Volume rate per 100,000	7	0		4	15	6
FY24 Inpatient Discharges rate per 100,000	27	4	20	22	71	6
Heart Disease						
FY24 ED Volume rate per 100,000	90	5	34	23	119	7
FY24 Inpatient Discharges rate per 100,000	1079	168	974	588	1705	202
Hepatitis						
FY24 ED Volume rate per 100,000	7	2	6	1		1
FY24 Inpatient Discharges rate per 100,000	51	36	146	17	51	1
HIV/AIDS						
FY24 ED Volume rate per 100,000	7	4	62	1		
FY24 Inpatient Discharges rate per 100,000	14	16	83	4	7	
Hypertension						
FY24 ED Volume rate per 100,000	1774	266	1448	763	2182	230
FY24 Inpatient Discharges rate per 100,000	1758	280	1837	866	2003	288
Infection						
FY24 ED Volume rate per 100,000	718	138	751	341	838	82
FY24 Inpatient Discharges rate per 100,000	1455	238	1357	760	2059	227

CHIA – Ages 65+

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Injuries						
FY24 ED Volume rate per 100,000	1257	212	1204	650	1562	214
FY24 Inpatient Discharges rate per 100,000	1365	234	1594	912	2123	299
Liver Disease						
FY24 ED Volume rate per 100,000	65	10	104	39	87	3
FY24 Inpatient Discharges rate per 100,000	421	91	438	234	500	55
Mental Health						
FY24 ED Volume rate per 100,000	347	46	264	145	166	27
FY24 Inpatient Discharges rate per 100,000	1456	219	1712	934	2170	265
Obesity						
FY24 ED Volume rate per 100,000	72	4	13	15	31	3
FY24 Inpatient Discharges rate per 100,000	764	120	703	275	707	76
Other Cancer						
FY24 ED Volume rate per 100,000	58	5	20	9	87	22
FY24 Inpatient Discharges rate per 100,000	285	40	348	207	441	70
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	79	9	76	38	123	4
FY24 Inpatient Discharges rate per 100,000	627	78	466	291	926	59

CHIA – Ages 65+

		New England Baptist Hospital Community Benefits Service Area				
	Massachusetts	Boston - ALL	Boston - Mission Hill	Brookline	Dedham	Newton - Chestnut Hill
Poisonings						
FY24 ED Volume rate per 100,000	30	6	13	12	39	3
FY24 Inpatient Discharges rate per 100,000	44	8	76	25	63	6
Prostate Cancer						
FY24 ED Volume rate per 100,000	62	9	48	20	71	6
FY24 Inpatient Discharges rate per 100,000	221	52	306	118	270	56
STIs						
FY24 ED Volume rate per 100,000	1	1	6		3	
FY24 Inpatient Discharges rate per 100,000	7	4	20	4	3	
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	63	5	55	35	91	18
FY24 Inpatient Discharges rate per 100,000	290	50	341	90	369	39
Substance Use						
FY24 ED Volume rate per 100,000	391	122	445	157	306	11
FY24 Inpatient Discharges rate per 100,000	552	124	438	181	596	24
Tuberculosis						
FY24 ED Volume rate per 100,000	1	1	6			
FY24 Inpatient Discharges rate per 100,000	15	13	69	12	15	1
Age 65+ Total	5485	1027	5673	2912	6294	835

Community Health Survey

- FY25 NEBH Community Health Survey
  - Survey output

Beth Israel Lahey Health

Community Health Survey for Beth Israel Lahey Health
2025 Community Health Needs Assessment

Beth Israel Lahey Health and its member hospitals are conducting a Community Health Needs Assessment to better understand the most important health-related issues for community residents. Each hospital must gather input from people living, working, and learning in the community. The information collected will help each hospital improve its patient and community services.

Please take about 15 minutes to complete this survey. Your responses will be private. If you do not feel comfortable answering a question, you may skip it. Taking this survey will not affect any services that you receive. Findings from this survey that are shared back with the community will be combined across all respondents. It will not be possible to identify you or your responses. Thank you for completing this survey.

At the end of the survey, you will have the option to enter a drawing for a $100 gift card.

We have shared this survey widely. Please complete this survey only once.

Select a language

About Your Community

1. We want to know about your experiences in the community where you spend the most time. This may be where you live, work, play, pray or worship, or learn.

Please enter the zip code of the community where you spend the most time.

Zip code: _____

2. Please select the response(s) that best describes your relationship to the community:

- ☐ I live in this community
- ☐ I work in this community
- ☐ Other (specify: _____)

3. Please check the response that best describes how much you agree or disagree with each statement about your community.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
I feel like I belong in my community.	☐	☐	☐	☐	☐
Overall, I am satisfied with the quality of life in my community. (Think about health care, raising children, getting older, job opportunities, safety, and support.)	☐	☐	☐	☐	☐
My community is a good place to raise children. (Think about things like schools, daycare, after-school programs, housing, and places to play)	☐	☐	☐	☐	☐

Beth Israel Lahey Health

My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support)	☐	☐	☐	☐	☐
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.).	☐	☐	☐	☐	☐
My community feels safe.	☐	☐	☐	☐	☐
My community has housing that is safe and of good quality	☐	☐	☐	☐	☐
My community is prepared for climate disasters like flooding, hurricanes, or blizzards.	☐	☐	☐	☐	☐
My community offers people options for staying cool during extreme heat.	☐	☐	☐	☐	☐
My community has services that support people during times of stress and need.	☐	☐	☐	☐	☐
I believe that all residents, including myself, can make the community a better place to live.	☐	☐	☐	☐	☐

4. What are the things you want to improve about your community? Please select up to 5 items from the list below.

- ☐ Better access to good jobs
- ☐ Better access to health care
- ☐ Better access to healthy food
- ☐ Better access to internet
- ☐ Better access to public transportation
- ☐ Better parks and recreation
- ☐ Better roads
- ☐ Better schools
- ☐ Better sidewalks and trails
- ☐ Cleaner environment
- ☐ Lower crime and violence
- ☐ More affordable childcare
- ☐ More affordable housing
- ☐ More arts and cultural events
- ☐ More effective city services (like water, trash, fire department, and police)
- ☐ More inclusion for diverse members of the community
- ☐ Stronger community leadership
- ☐ Stronger sense of community
- ☐ Other (_____)

Health and Access to care

5. Please check the response that best describes how much you agree or disagree with each statement about your access to health care in your community.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Health care in my community meets the physical health needs of people like me.	☐	☐	☐	☐
Health care in my community meets the mental health needs of people like me.	☐	☐	☐	☐

6. Where do you primarily receive your routine health care? Please choose one.

- ☐ A doctor's or nurse's office
- ☐ A public health clinic or community health center
- ☐ Urgent care provider
- ☐ A hospital emergency room
- ☐ No usual place
- ☐ Other, please specify: _____

7. What barriers, if any, keep you from getting needed health care? Please select all that apply.

- ☐ Fear or distrust of the health care system
- ☐ Not enough time
- ☐ Insurance problems
- ☐ No providers or staff speak my language
- ☐ Can't get an appointment
- ☐ Cost
- ☐ Concern about COVID or other disease exposure
- ☐ Transportation
- ☐ Other, please specify: _____
- ☐ No barriers

8. What health issues matter the most in your community? Please select up to 5 issues from the list below.

- ☐ Aging problems (like arthritis, falls, hearing/vision loss)
- ☐ Alcohol or drug misuse
- ☐ Asthma
- ☐ Cancer
- ☐ Child abuse/neglect
- ☐ Diabetes
- ☐ Domestic violence
- ☐ Environment (like air quality, traffic, noise)
- ☐ Heart disease and stroke
- ☐ Hunger/malnutrition
- ☐ Homelessness
- ☐ Housing
- ☐ Infant death
- ☐ Mental health (anxiety, depression, etc.)
- ☐ Obesity
- ☐ Poor diet/inactivity
- ☐ Poverty
- ☐ Rape/sexual assault
- ☐ Sexually transmitted infections (STIs)
- ☐ Smoking
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Trauma
- ☐ Underage drinking
- ☐ Vaping/E-cigarettes
- ☐ Violence
- ☐ Youth use of social media

About You

The following questions help us better understand how people of diverse identities and life experiences may have similar or different experiences in the community. You may skip any question you prefer not to answer.

9. What is the highest grade or school year you have finished?

- ☐ 12th grade or lower (no diploma)
- ☐ High school (including GED, vocational high school)
- ☐ Started college but not finished
- ☐ Vocational, trade, or technical program after high school
- ☐ Associate degree (for example, AA, AS)
- ☐ Bachelor's degree (for example, BA, BS, AB)
- ☐ Graduate degree (for example, master's, professional, doctorate)
- ☐ Other (specify below)
- ☐ Prefer not to answer

10. What is your race or ethnicity? *Select all that apply*.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latine/a/o
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other (specify below)
- ☐ Not sure
- ☐ Prefer not to answer
- ☐ Other: _____

11. What is your sexual orientation?

- ☐ Asexual
- ☐ Bisexual and/or Pansexual
- ☐ Gay or Lesbian
- ☐ Straight (Heterosexual)
- ☐ Queer
- ☐ Questioning/I am not sure of my sexuality
- ☐ I use a different term (specify: _____)
- ☐ I do not understand what this question is asking
- ☐ I prefer not to answer

12. What is your current gender identity?

- ☐ Female, Woman
- ☐ Male, Man
- ☐ Nonbinary, Genderqueer, not exclusively male or female
- ☐ Questioning/I am not sure of my gender identity
- ☐ I use a different term (specify: _____)
- ☐ I do not understand what this question is asking
- ☐ I prefer not to answer

13. In the **past 12 months**, did you have trouble paying for any of the following? *Select all that apply*.

- ☐ Childcare or school
- ☐ Food or groceries
- ☐ Formula or baby food
- ☐ Health care (appointments, medicine, insurance)
- ☐ Housing (rent, mortgage, taxes, insurance)
- ☐ Technology (computer, phone, internet)
- ☐ Transportation (car payment, gas, public transit)
- ☐ Utilities (electricity, water, gas)
- ☐ Other (specify: _____)
- ☐ None of the above

14. What is your age?

- ☐ Under 18
- ☐ 18-24
- ☐ 25-44
- ☐ 45-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and over
- ☐ Prefer not to answer

15. What is the primary language(s) spoken in your home? (Please check all that apply.)

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

16. Are you currently:

- ☐ Employed full-time (40 hours or more per week)
- ☐ Employed part-time (Less than 40 hours per week)
- ☐ Self-employed (Full- or part-time)
- ☐ A stay-at-home parent
- ☐ A student (Full- or part-time)
- ☐ Unemployed
- ☐ Unable to work for health reasons

☐ Retired
☐ Other (specify_____)
☐ Prefer not to answer

17. Do you identify as a person with a disability?
☐ Yes
☐ No
☐ Prefer not to answer

18. I currently:
☐ Rent my home
☐ Own my home (with or without a mortgage)
☐ Live with parent or other caretakers who pay for my housing
☐ Live with family or roommates and share costs
☐ Live in a shelter, halfway house, or other temporary housing
☐ Live in senior housing or assisted living
☐ I do not currently have permanent housing
☐ Other

19. How long have you lived in the United States?
☐ I have always lived in the United States
☐ Less than one year
☐ 1 to 3 years
☐ 4 to 6 years
☐ More than 6 years, but not my whole life
☐ Prefer not to answer

20. Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? (Select all that apply)
☐ My neighborhood or building
☐ Faith community (*such as a church, mosque, temple, or faith-based organization)*
☐ School community *(such as a college or education program that you attend or a school that your child attends)*
☐ Work community *(such as your place of employment or a professional association)*
☐ A shared identity or experience *(such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)*
☐ A shared interest group *(such as a club, sports team, political group, or advocacy group)*
☐ Another city or town where I do not live
☐ Other (_____)

May14, 2024

Beth Israel Lahey Health

Enter to Win a $100.00 Gift Card!

To enter the drawing to win a $100 gift card, please:

- Complete the form below by providing your contact information.
- Detach this sheet from your completed survey.
- Return both forms (completed survey and drawing entry form) to the location that you picked up the survey.

---

1. Please enter your first name and the best way to contact you. This information will not be used to identify your answers to the survey in any way.

   First Name: _____

   Email: _____

   Daytime Phone #: _____

2. Would you like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities? ☐ Yes ☐ No
   (If yes, please be sure you have listed your email address above).

Thank you very much for your help in improving your community!

FY25 BILH CHNA Survey - New England Baptist Hospital

Response Counts

Completion Rate:	**95.8%**	
	Complete	299
	Partial	13

Totals: 312

1. Select a language.

Value	Percent	Responses
Take the survey in English	90.1%	201
参加简体中文调查	2.7%	6
Reponn sondaj la nan lang kreyòl ayisyen	0.9%	2
Пройдите анкету на русском языке	3.6%	8
Responda la encuesta en español	2.7%	6

Totals: 223

2. Please select the response(s) that best describes your relationship to the community. You can choose more than one answer.

Value	Percent	Responses
I live in this community	89.8%	202
I work in this community	20.9%	47
Other, please specify:	1.8%	4

3. Please check the response that best describes how much you agree or disagree with each statement about your community.

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
I feel like I belong in my community. Count Row %	116 37.4%	147 47.4%	31 10.0%	9 2.9%	7 2.3%	310
Overall, I am satisfied with the quality of life in my community. *(Think about health care, raising children, getting older, job opportunities, safety, and support.)* Count Row %	76 24.9%	166 54.4%	41 13.4%	18 5.9%	4 1.3%	305
My community is a good place to raise children. *(Think about things like schools, daycare, after-school programs, housing, and places to play)* Count Row %	83 26.8%	142 45.8%	53 17.1%	13 4.2%	19 6.1%	310
My community is a good place to grow old. *(Think about things like housing, transportation, houses of worship, shopping, health care, and social support)* Count Row %	86 27.7%	146 47.1%	44 14.2%	22 7.1%	12 3.9%	310
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	93 30.3%	156 50.8%	39 12.7%	10 3.3%	9 2.9%	307
My community feels safe. Count Row %	71 23.1%	142 46.3%	61 19.9%	27 8.8%	6 2.0%	307

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	79 25.8%	157 51.3%	51 16.7%	14 4.6%	5 1.6%	306
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	31 14.2%	85 39.0%	34 15.6%	5 2.3%	63 28.9%	218
My community offers people options for staying cool during extreme heat. Count Row %	57 18.7%	151 49.5%	49 16.1%	9 3.0%	39 12.8%	305
My community has services that support people during times of stress and need. Count Row %	40 18.3%	98 44.7%	33 15.1%	9 4.1%	39 17.8%	219
I believe that all residents, including myself, can make the community a better place to live. Count Row %	131 43.0%	144 47.2%	15 4.9%	10 3.3%	5 1.6%	305
Totals Total Responses						310

4. What are the things you want to improve about your community? Please select up to 5 items from the list below.

Value	Percent	Responses
Better access to good jobs	23.0%	70
Better access to health care	18.4%	56
Better access to healthy food	33.9%	103
Better access to internet	6.9%	21
Better access to public transportation	26.3%	80
Better parks and recreation	16.8%	51
Better roads	22.4%	68
Better schools	22.7%	69
Better sidewalks and trails	29.6%	90
Cleaner environment	22.0%	67
Lower crime and violence	29.6%	90
More affordable childcare	16.1%	49
More affordable housing	46.4%	141
More arts and cultural events	16.4%	50
More effective city services (like water, trash, fire department, and police)	21.4%	65
More inclusion for diverse members of the community	16.4%	50

Value	Percent	Responses
Stronger community leadership	10.2%	31
Stronger sense of community	11.5%	35
Other, please specify:	3.0%	9

5. Please check the response that best describes how much you agree or disagree with each statement about your access to health care in your community.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	14 6.6%	31 14.6%	119 55.9%	41 19.2%	8 3.8%	213
Health care in my community meets the mental health needs of people like me. Count Row %	10 4.9%	52 25.2%	92 44.7%	28 13.6%	24 11.7%	206
Totals Total Responses						213

6. Where do you primarily receive your routine health care? Please choose one.

Value	Percent	Responses
A doctor's or nurse's office	62.3%	165
A public health clinic or community health center	15.1%	40
Urgent care provider	6.0%	16
A hospital emergency room	10.2%	27
No usual place	3.0%	8
Other, please specify:	3.4%	9

Totals: 265

7. What barriers, if any, keep you from getting needed health care? You can choose more than one answer.

Value	Percent	Responses
Fear or distrust of the health care system	12.5%	26
Not enough time	24.0%	50
Insurance problems	16.8%	35
No providers or staff speak my language	2.4%	5
Can’t get an appointment	26.9%	56
Cost	25.0%	52
Concern about COVID or other disease exposure	9.6%	20
Transportation	14.9%	31
Other, please specify:	7.2%	15
No barriers	29.3%	61

8. What health issues matter the most in your community? Please select up to 5 issues from the list below.

Value	Percent	Responses
Aging problems (like arthritis, falls, hearing/vision loss)	41.4%	120
Alcohol or drug misuse	31.4%	91
Asthma	11.7%	34
Cancer	13.1%	38
Child abuse/neglect	4.8%	14
Diabetes	17.6%	51
Domestic violence	10.0%	29
Environment (like air quality, traffic, noise)	18.3%	53
Heart disease and stroke	20.3%	59
Hunger/malnutrition	17.6%	51
Homelessness	20.0%	58
Housing	32.8%	95
Mental health (anxiety, depression, etc.)	44.1%	128
Obesity	13.4%	39
Poor diet/inactivity	11.7%	34
Poverty	12.8%	37

Value	Percent	Responses
Sexually transmitted infections (STIs)	3.1%	9
Smoking	12.4%	36
Suicide	5.9%	17
Trauma	5.9%	17
Underage drinking	4.8%	14
Vaping/E-cigarettes	10.3%	30
Violence	13.1%	38
Youth use of social media	13.1%	38
Infant death	1.4%	4
Rape/sexual assault	2.8%	8
Teenage pregnancy	2.4%	7

9. What is the highest grade or school year you have finished?

Value	Percent	Responses
12th grade or lower (no diploma)	10.2%	29
High school (including GED, vocational high school)	12.3%	35
Started college but not finished	8.4%	24
Vocational, trade, or technical program after high school	5.3%	15
Associate degree (for example, AA, AS)	8.4%	24
Bachelor's degree (for example, BA, BS, AB)	26.7%	76
Graduate degree (for example, master's, professional, doctorate)	24.6%	70
Other, please specify:	0.4%	1
Prefer not to answer	3.9%	11

Totals: 285

10. What is your race or ethnicity? You can choose more than one answer.

Value	Percent	Responses
American Indian or Alaska Native	1.8%	5
Asian	3.5%	10
Black or African American	25.7%	73
Hispanic or Latine/a/o	19.7%	56
Middle Eastern or North African	0.4%	1
Native Hawaiian or Pacific Islander	0.7%	2
White	51.1%	145
Other, please specify:	3.5%	10
Prefer not to answer	2.5%	7

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.4%	4
Bisexual and/or Pansexual	2.5%	7
Gay or Lesbian	4.3%	12
Straight (Heterosexual)	84.8%	239
Queer	1.1%	3
Questioning/I am not sure of my sexuality	0.4%	1
I use a different term, please specify:	0.7%	2
I do not understand what this question is asking	1.1%	3
I prefer not to answer	3.9%	11

Totals: 282

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	68.3%	198
Male, Man	29.0%	84
Nonbinary, Genderqueer, not exclusively male or female	1.4%	4
Questioning/I am not sure of my gender identity	0.3%	1
I prefer not to answer	1.0%	3

Totals: 290

13. In the past 12 months, did you have trouble paying for any of the following? You can choose more than one answer.

Value	Percent	Responses
Childcare or school	4.9%	13
Food or groceries	28.6%	76
Formula or baby food	3.0%	8
Health care (appointments, medicine, insurance)	15.0%	40
Housing (rent, mortgage, taxes, insurance)	25.6%	68
Technology (computer, phone, internet)	12.4%	33
Transportation (car payment, gas, public transit)	12.8%	34
Utilities (electricity, water, gas)	16.9%	45
Other, please specify:	1.5%	4
None of the above	49.2%	131

14. What is your age?

Value	Percent	Responses
Under 18	7.1%	21
18-24	9.5%	28
25-44	28.7%	85
45-64	21.3%	63
65-74	17.6%	52
75-84	11.5%	34
85 and over	2.4%	7
Prefer not to answer	2.0%	6

Totals: 296

15. What is the primary language(s) spoken in your home? You can choose more than one answer.

Value	Percent	Responses
Armenian	2.4%	7
Cape Verdean Creole	1.4%	4
Chinese (including Mandarin and Cantonese)	0.7%	2
English	85.3%	244
Haitian Creole	1.4%	4
Portuguese	1.4%	4
Russian	4.2%	12
Spanish	15.0%	43
Other, please specify:	2.1%	6
Prefer not to answer	1.7%	5

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	38.5%	82
Employed part-time (Less than 40 hours per week)	11.3%	24
Self-employed (Full- or part-time)	2.8%	6
A stay-at-home parent	1.4%	3
A student (Full- or part-time)	5.6%	12
Unemployed	8.9%	19
Unable to work for health reasons	4.2%	9
Retired	22.5%	48
Other, please specify:	2.3%	5
Prefer not to answer	2.3%	5

Totals: 213

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

Value	Percent	Responses
Yes	20.0%	57
No	76.5%	218
Prefer not to answer	3.5%	10

Totals: 285

18. I currently:

Value	Percent	Responses
Rent my home	38.3%	110
Own my home (with or without a mortgage)	33.1%	95
Live with parent or other caretakers who pay for my housing	11.8%	34
Live with family or roommates and share costs	6.6%	19
Live in a shelter, halfway house, or other temporary housing	2.4%	7
Live in senior housing or assisted living	2.8%	8
Other	4.9%	14

Totals: 287

19. How long have you lived in the United States?

Value	Percent	Responses
I have always lived in the United States	79.1%	231
Less than one year	1.0%	3
1 to 3 years	3.4%	10
4 to 6 years	1.0%	3
More than 6 years, but not my whole life	14.0%	41
Prefer not to answer	1.4%	4

Totals: 292

20. Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? You can choose more than answer.

Value	Percent	Responses
My neighborhood or building	61.5%	126
Faith community (such as a church, mosque, temple, or faith-based organization)	21.0%	43
School community (such as a college or education program that you attend or a school that your child attends)	15.1%	31
Work community (such as your place of employment or a professional association)	31.2%	64
A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)	10.2%	21
A shared interest group (such as a club, sports team, political group, or advocacy group)	24.4%	50
Another city or town where I do not live	10.2%	21
Other, please feel free to share:	4.4%	9

21. Would you like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities? If yes, please be sure you have listed your email address above.

Value	Percent	Responses
Yes	30.6%	30
No	69.4%	68

Totals: 98

Appendix C:
Resource Inventory

New England Baptist Hospital Community Resource List

Community Benefits Service Area includes: Brookline, Chestnut Hill, Dedham, Mission Hill, and Roxbury

Health Issue	Organization	Brief Description	Address	Phone	Website
	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
	Executive Office of Aging & Independence	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	Find Help	Provides resources for financial assistance, food pantries, medical care, and other free or reduced-cost help.			www.findhelp.org
	Mass 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Behavioral Health Help Line	Available 24 hours a day, 7 days a week, connects individuals and families to the full range of treatment services for mental health and substance use.		833.773.2445	www.masshelpline.com
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 10th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-aging-independence
	Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program?
	MassOptions	Provides connection to services for older adults and persons with disabilities.		800.243.4636	www.massoptions.org

Statewide Resources	Massachusetts Behavioral Health Help Line (BHHL) Treatment Connection	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.		833.773.2445	www.masshelpline.com/MABHHLTreatmentConnectionResourceDirectory
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for substance use treatment, recovery, and problem gambling services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		988	www.988lifeline.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	www.projectbread.org/foodsource-hotline
	SafeLink	Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence.		877.785.2020	www.casamyrna.org/get-support/safelink
	SAMHSA's National Helpline	Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders.		800.662.HELP (4357)	www.samhsa.gov/find-help/helplines/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps?
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		988	www.veteranscrisisline.net
	Boston Area Rape Crisis Center-Family Justice Center	Provides free, confidential support and services to survivors of sexual violence.	99 Bishop Allen Dr Cambridge	617.492.8306 24/7 Hotline: 800.841.8371	www.barcc.org
	Casa Myrna	Provides domestic violence awareness efforts, shelter and supportive services to survivors.	451 Blue Hill Ave Boston	617.521.0100	www.casamyrna.org

Domestic Violence	REACH Beyond Domestic Violence	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 540024 Waltham	781.891.0724 24/7 Hotline: 800.899.4000	www.reachma.org
Food Assistance	ABCD Parker Hill/Fenway Neighborhood	Provides food assistance to residents of Greater Boston.	714 Parker St Roxbury	617.445.6000	www.bostonabcd.org/service/food-accesscenters/
	Brookline Food Pantry	Provides food assistance to Brookline residents.	210 Harvard St Brookline	617.566.4953	www.brooklinefoodpantry.org
	Community Servings	Provides meals to chronically and critically ill individuals and their families.	179 Amory St Jamaica Plain	617.522.7777	www.servings.org
	Daily Table	Provides food assistance to residents of Greater Boston.	2201 Washington St Roxbury	617.516.8174	www.dailytable.org
	Dedham Food Pantry	Provides food assistance to Dedham residents.	600 Washington St Dedham	781.320.9442	www.dedhamfoodpantry.org
	Fresh Truck	Provides food assistance to residents of Greater Boston via mobile markets.	69 Shirley St Boston	617.297.7685	www.aboutfresh.org
	Greater Boston Food Bank	Provides healthy food and resources to agencies and direct distribution programs across Eastern Massachusetts.	70 South Bay Ave Boston	617.427.5200	www.gbfb.org
	ABCD Parker Hill/Fenway Neighborhood Service Center	Provides access to resources and services for low-resource individuals in the Greater Boston area.	714 Parker St Roxbury	617.445.6000	www.bostonabcd.org/location/parkerhill-fenway-nsc
Housing Support	Boston Housing Authority	Provides housing assistance programs to low-resource individuals.	52 Chauncy St Boston	617.988.4000	www.bostonhousing.org
	Brookline Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	90 Longwood Ave #1 Brookline	617.277.2022	www.brooklinehousing.org
	Dedham Housing Authority	Provides housing assistance programs to low-resource individuals and families.	163 Dedham Blvd Dedham	781.326.3543	www.dedhamhousing.org
	ESAC Boston	Provides innovative programs in home ownership, education, and community service focusing on children and older adults.	434 Jamaicaway Jamaica Plain	617.524.2555	www.esacboston.org

	Hospitality Homes	Provides short-term housing for families/friends of patients receiving medical care in the Boston area.	PO Box 15265 Boston	888.595.4678	www.hosp.org
	Inquilinos Boricuas Accion (IBA)	Provides affordable, subsidized rental housing, education, and arts programs.	2 San Juan St Boston	617.927.1707	www.ibaboston.org
	Metro Housing Boston	Provides information and resources for low and moderate resource families and individuals.	1411 Tremont St Boston	617.859.0400	www.MetroHousingBoston.org
Mental Health and Substance Use	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.bilhbehavioral.org
	Boston Medical Center CBHC	Provides a comprehensive and highly integrated system of crisis evaluation, intervention, and treatment.	850 Harrison Ave Boston	800.981.4357	www.bmc.org/emergency-services-program
	Brookline Community Mental Health Center	Provides high-quality mental health care and social services for individuals and families.	41 Garrison Rd Brookline	617.277.8107	www.brooklinecenter.org
	LifeStance Health	Provides mental health treatment services for patients of all ages with telehealth and in-person appointments	1 Brookline Place Ste 321 Brookline	781.551.0999	www.lifestance.com/welcome/child-and-family-psychological-services/
	Riverside Community Behavioral Health	Provides treatment for mental health, substance use, and co-occurring disorders.	190 Lenox St Norwood	781.769.8670	www.riversidecc.org/adult-services/community-behavioral-health-centers/
	Riverside Community Care	Offers comprehensive mental health services for children and families.	270 Bridge St Ste 301 Dedham	781.329.0909	www.riversidecc.org
	Boston Age Strong Commission	Provides access to resources and programs for older adults in Boston.	1 City Hall Sq. Room 271 Boston	617.635.4366	www.boston.gov/departments/age-strong-commission
Senior Services	Brookline Senior Center	Provides services for older adults in Brookline including fitness, education, social services, and recreation.	93 Winchester St Brookline	617.730.2770	www.brooklineseniorcenter.org
	Dedham Senior Center	Provides services for older adults in Dedham including fitness, education, social services, and recreation.	450 Washington St Dedham	781.751.9495	www.dedham-ma.gov/departments/council-on-aging

	Boston Age Strong Commission	Provides access to free shuttles for door-to-door service for non-emergency doctor's appointments within the City of Boston for Boston residents 60+. Provides discounted taxi coupons to Boston residents 65+ and persons with disabilities.	1 City Hall Square Room 271 Boston	617.635.3000	www.boston.gov/departments/age-strong-commission
	Brookline Council on Aging	Provides transportation services for older adults in Brookline.	333 Washington St Brookline	617.730.2644	www.brooklinema.gov/1502/Transportation-Services
Transportation	Dedham Council on Aging	Provides transportation services for older adults in Dedham.	450 Washington St Dedham	781.751.9495	www.dedham-ma.gov/town-departments/council-on-aging/transportation-services
	Massachusetts Bay Transportation Authority (MBTA)	Provides transportation throughout Boston and surrounding communities.			www.mbta.com
	Boston Center for Youth and Families-Tobin Community Center	Offers a wide range of programs for adults, youth, and families geared to the neighborhood it serves.	1481 Tremont St Roxbury	617.635.5216	www.boston.gov/departments/boston-centers-youth-families/bcyf-tobin
	YMCA of Greater Boston, Charles River Branch	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	380 Chestnut St Needham	781.444.6400	www.ymcaboston.org/charlesriver
Additional Resources	Huntington Avenue YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	316 Huntington Ave. Boston	617.927.8060	www.ymcaboston.org/huntington
	Roxbury YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	285 Martin Luther King Blvd Roxbury	617.427.5300	www.ymcaboston.org/roxbury
	The Salvation Army Boston Kroc Center	Offers a wide range of programs for adults, youth and families. Fitness and wellness, arts, science, and education, youth leadership, and culinary arts.	650 Dudley St Boston	617.318.6900	www.easternusa.salvationarmy.org/boston-kroc/home/

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

New England Baptist Hospital (NEBH)

Evaluation of 2023-2025 Implementation Strategy

Below are highlights of the work that has been accomplished since the last Implementation Strategy. For full reports, please see submissions to the Massachusetts Attorney General's Office.

Priority: Equitable Access to Care

Goal: Provide equitable and comprehensive access to high-quality health care services for those who face economic barriers.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations ● Individuals with disabilities ● Racially, ethnically and linguistically diverse populations	● Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.	● Mission Link bus	● NEBH is a major financial supporter of the Mission Link bus. (FY23) (FY24) ● Mission Hill residents used the Mission Link bus to get to places like the grocery store, pharmacy or doctor's appointment. The bus also provided transportation to and from events for older adults giving them the opportunity to be more social and active. (FY23: over 7,000) (FY24: over 7,000)
● Low-resourced populations ● Individuals with disabilities ● Racially, ethnically and linguistically diverse populations	● Advocate for and support policies and systems that improve access to care.	● Resource directory ● Support linguistic services ● Financial counselors ● Support relevant policies when proposed	● NEBH provided interpreters for patients, including Spanish, Korean and Chinese. (FY23: 1,644) (FY24: 2,222) ● BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for

			● bills supporting equitable health care access for all Massachusetts residents. (FY23: 6) (FY24: 23)

Priority: Social Determinants of Health

Goal: Enhance the built, social, and economic environment where people live, work, play, and learn in order to improve the social determinants of health.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Low-resourced populations • Older adults • Youth • Individuals with disabilities • Racially, ethnically and linguistically diverse populations	• Promote healthy eating and active living by advocating for system changes, increasing opportunities for physical activity, and providing healthy, low-cost food resources to communities and school environments.	• Grocery gift card program • ABCD food pantry • RTH's food pantry • Food box delivery to homebound residents • Fair Food bags • School Food Access and Physical Activities Programs • Maintain McLaughlin Field and Park • Neighborhood beautification services	• Worked with 11 housing development sites • NEBH provided food, meals and gift cards to the local grocery store to individuals and families living in Mission Hill. (FY23: over 600) (FY24: over 800) • NEBH Provided financial support for the food pantry at Roxbury Tenants of Harvard (RTH). The pantry provided emergency food for families and individuals that live at RTH. (FY23:104) (FY24: 115) • Provided financial support for bags of fresh fruit and vegetables to Roxbury Tenants of Harvard. (FY23: 645) (FY24: 650) • NEBH collaborated with Stop & Shop to donate turkeys and bags of food to Mission Hill residents during the holidays.(FY23: 500) (FY24: 500) • McLaughlin Field was maintained during spring, summer and fall (over 30 weeks), and was maintained during the winter as needed. (FY23: over 30 weeks) (FY24: over 30 weeks)

			● NEBH staff collaborated with residents and Mission Main Streets to beautify and help make the community a safer, cleaner place to live. (FY23) (FY24)
● Low-resourced populations ● Older adults ● Individuals with disabilities ● Racially, ethnically and linguistically diverse populations	● Advocate for and support impactful programs that stabilize or create access to affordable housing.	● Mission Hill Neighborhood Housing Services board ● Mission Hill Neighborhood Housing Services resident services coordinator ● Household essentials, clothing, and school supply program	● NEBH collaborated with Mission Hill Neighborhood Housing Services to provide a Resident Services Coordinator intern. The Resident Services Coordinator worked with residents on their financial, social, and physical wellbeing, assisting them with applications and resources, encouraging older adults to attend events, connecting youth to programs in the community, etc. (FY23: 150 residents) (FY24: over 200 residents) ● Clothing, shoes, household essentials, etc. were distributed to over 350 families/individuals that live in Mission Hill. (FY23) (FY24) ● NEBH provided elementary and high school children living in low-income housing in Mission Hill the supplies they need to learn, so that they can return to the classroom prepared and on track for success. (FY23:225) (FY24: 350) ● NEBH provided tuition assistance to two Mission Hill students so that they would be able to finish high school and go onto college on full scholarship. (FY23)

			● NEBH collaborated with Mission Hill Neighborhood Housing Services to provide a Resident Services Coordinator intern. The Resident Services Coordinator worked with residents on their financial, social, and physical wellbeing, assisting them with applications and resources, encouraging older adults to attend events, connecting youth to programs in the community, etc. (FY23: 150 residents) (FY24: over 200 residents)
● Low-resourced populations ● Youth ● Individuals with disabilities ● Racially, ethnically and linguistically diverse populations	● Increase mentorship, training, and employment opportunities for youth, young adults, and adults residing in the communities as well as hospital employees.	● Project Search ● Meredith Cameron Youth Opportunity Internship ● CSPD course ● Nursing Assistant Program ● Career and academic advising ● Hospital-sponsored community college courses ● Hospital-sponsored English Speakers of Other Language (ESOL) classes	● NEBH collaborated with Madison Park High School on the Project Search High School Transition program that offered life work experience combined with training in employability and independent living skills to youth with significant disabilities. (FY23:6 students) (FY24: 6 students) ● NEBH offered paid summer internships to Mission Hill/City of Boston Youth that offered career development and health care training. (FY23: 5 students) (FY24: 5 students) ● Workforce Development will encourage community referrals and hires. (FY 23: 225 referrals and 70 hires) (FY 24: 412 referrals and 111 hires) NEBH participated in these hirings.

			● The Workforce Development team attended and hosted events and gave presentations about employment opportunities to community partners across BILH service area. (FY23: 67) (FY24: 33) ● Workforce Development will offer employees career development services. (FY 24: 1,044 BILH employees received career development services). ● Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. Citizenship classes, (FY23: 20) (FY:24 14); Career development workshops, (FY23:135) (FY24: 15); Financial literacy classes (FY23: 189) (FY24: 207). NEBH employees participated in these offerings. ● Workforce Development offered English for Speakers of Other Languages (ESOL) classes to BILH employees. (FY 23: 45) (FY24: 82) NEBH employees participated in these classes. ● Workforce Development will offer internships in BILH hospitals to community members over the age of 18. (FY23: 54) (FY24: 107) ● Workforce Development will hire interns after internships and place in BILH

			hospitals. (FY 24: 37 interns were hired permanently in BILH hospitals) ● Workforce Development will offer paid trainings for community members across BILH. (FY 23: 89) (FY 24: 99) NEBH participated in offering these trainings.

Priority: Mental Health and Substance Use

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Youth • Older adults	• Enhance relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills, and reduce isolation.	• Tobin Community Center's Summer Camp • Police Athletic League (PAL) Program • Mighty Missions BB Team • Prom for seniors • Maria Sanchez House social events • Quarterly birthday parties	• NEBH provided financial support for the summer camp at the Tobin Community Center, 15 youth were able to participate. (FY23, FY24) • NEBH provided financial support for the After-School Program at the Tobin Community Center. This allows 10 youth to participate in tutoring, and extracurricular activities including sports programs. (FY23) (FY24) • NEBH provides financial assistance to the Mission Hill Little League and the Mission Grammar School basketball team. (FY23) • NEBH provides financial assistance to the Mission Hill Little League. (FY24) • NEBH collaborated with the Tobin Community Center to offer four birthday celebrations for seniors. And, collaborated with Mission Hill Neighborhood Housing Services on two BBQs for seniors. This helps with isolation. (FY23: over 140 seniors) (FY24: over 140 seniors) • McLaughlin Field was maintained during spring, summer and fall (over 30 weeks), and was maintained during the winter as needed. (FY23: over 30 weeks) (FY24: over 30 weeks)

			● NEBH worked with neighborhood organizations including the Boston Police Department to collaborate and provide violence prevention education and other activities for youth. (FY23) (FY24)
● Low-resourced populations ● Older adults ● Youth ● Racially, ethnically and linguistically diverse populations	● Build the capacity of community members to understand the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.	● Explore and support opportunities for training of key leaders and residents	● BILH offered Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area. More than 350 community residents and BILH staff attended one of the 21 MHFA trainings. Two trainings were held at NEBH. (FY24: 350 participants) ● BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for bills supporting access to mental health and substance use services for all Massachusetts residents. (FY23:data not available) (FY24: 8)

Priority: Complex and Chronic Conditions

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Low-resourced populations • Older adults • Individuals with disabilities	Increase opportunities for community members to decrease their risk for developing and/or improve their management of complex & chronic conditions.	• Mindful Matters-Yoga for older adults • Healthy Moves • Walking Group at Roxbury Tenants of Harvard (RTH) • Sr. Celtics	• NEBH collaborated with the Boston Celtics to offer the Sr. Celtics program to Mission Hill seniors. Three events were held with over 140 seniors attending each event. (FY23) (FY24) • NEBH collaborated with the Tobin Community Center to offer four birthday celebrations for seniors. This helps with isolation. And, held two BBQs. Over 140 seniors attend the events. (FY23) (FY24) • NEBH provided financial support for Mindful Movement, a weekly yoga class for older adults living in Mission Hill. Over 30 older adults participated in the yoga class. Participants have stated they feel better, have more flexibility, feel less stress and isolated. (FY23) • NEBH provided financial support for Mindful Movement, a weekly yoga class for older adults living in Mission Hill. Over 35 older adults participated in the yoga class. Participants have stated they feel better, have more flexibility, feel less stress and isolated. (FY24) • NEBH continues to maintain the City of Boston's McLaughlin Park, Ball Fields and Walking Path in

			Mission Hill. This allows the residents of Boston to use the field and parks for outdoor physical and social activities. (FY23) (FY24)

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
New England Baptist Hospital

FY26–FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

New England Baptist Hospital is Beth Israel Lahey Health's center of excellence and the premier regional provider for orthopedic surgery, spine surgery and musculoskeletal care. The hospital has 118 licensed inpatient beds with more than 1,000 employees and over 360 clinicians on active medical staff. New England Baptist offers fellowship training and residency programs in collaboration with Tufts University School of Medicine.

In addition to this assessment, NEBH's Community Benefits staff collaborated with the Boston Community Health Collaborative (BCHC)'s Community Health Needs Assessment. The BCHC, consisting of Boston's hospitals, The Boston Public Health Commission, community-based organizations and community residents, conducted a robust and collaborative community health needs assessment for the City of Boston as a whole. The BCHC's Community Health Needs Assessment serves as a foundational resource for policymakers and community leaders, and informs community health improvement planning, priority setting, program and policy development, and collaboration. This is the third city-wide coordinated Community Health Needs Assessment and builds upon previous coordinated efforts in 2019 and 2022. The overall approach was participatory and collaborative, engaging community residents and collaborators throughout the CHNA process. Nancy Kasen, Beth Israel Lahey Health's Vice President of Community Benefits and Community Relations, served on the BCHC Community Health Needs Assessment Steering Committee. NEBH and the BCHC shared information with each other to support each other's assessment efforts.

Finally, NEBH participated in the Beth Israel Lahey Health (BILH) CHNA and collaborated with Beth Israel Deaconess Needham Hospital (BID Needham) and Beth Israel Deaconess Medical Center (BIDMC). With respect to BID Needham, NEBH and BID Needham both include Dedham in their CBSAs and, as a result, both gathered and shared information on this municipality as part of their assessment processes. With respect to BIDMC, NEBH and BIDMC both include the Roxbury and Mission Hill neighborhoods of Boston in their CBSAs. Similarly, both NEBH and BIDMC shared the information gathered on these neighborhoods as part of their processes. Combined, these efforts helped to ensure that a sound, objective, and inclusive CHNA process was conducted across NEBH's entire Community Benefits Service Area (CBSA).

NEBH collected a wide range of quantitative data to characterize the communities served across its CBSA. NEBH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs of specific communities. The data were tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Between June 2024 and February 2025, NEBH conducted 15 one-on-one interviews with key collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,300 residents, and organized a community listening session. In total, the assessment process collected information from more than 1,400 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, NEBH's CBAC and community residents, through the community listening session, formally prioritized the community health issues and cohorts that they believed should be the focus of NEBH's IS. This prioritization process helps to ensure that NEBH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying NEBH's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

NEBH's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening , and referral secondary prevention), and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the fair, and just treatment of all people
- Could be scaled to other BILH hospitals
- Are flexible to respond to emerging community needs

Recognizing that community benefits planning is ongoing and will change with continued community input, NEBH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. NEBH is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

NEBH's primary facility is in the Mission Hill neighborhood of Boston, where it provides a broad range of medical, surgical, and rehabilitation services that promote wellness, restore function, lessen disability, alleviate pain, and advance knowledge of musculoskeletal diseases and related disorders. In addition, NEBH operates a multi-specialty clinic in Dedham, a physical therapy clinic and a radiology clinic in Chestnut Hill, and a surgery center in Brookline. Collectively, the CBSA is diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment) and geography (e.g., urban, suburban). There is also diversity with respect to community needs. There are segments of NEBH's CBSA population that are healthy and have limited unmet health needs and other segments that face significant disparities in access, underlying social determinants, and health outcomes. NEBH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. NEBH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

NEBH's CHNA focused on identifying the leading community health needs and priority populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who are marginalized due to their race, ethnicity, immigration status, disability status, or other personal characteristics. By prioritizing these cohorts, NEBH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

Beth Israel Lahey Health
New England Baptist Hospital

Community Benefits Service Area

- H New England Baptist Hospital
- 1 New England Baptist Outpatient Care Center at Chestnut Hill
- 2 New England Baptist Outpatient Care Center at Brookline
- 3 New England Baptist Outpatient Care Center at Dedham

Prioritized Community Health Needs and Cohorts

NEBH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.

NEBH Priority Cohorts

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically, and Linguistically Diverse Populations
- Individuals Living with Disabilities

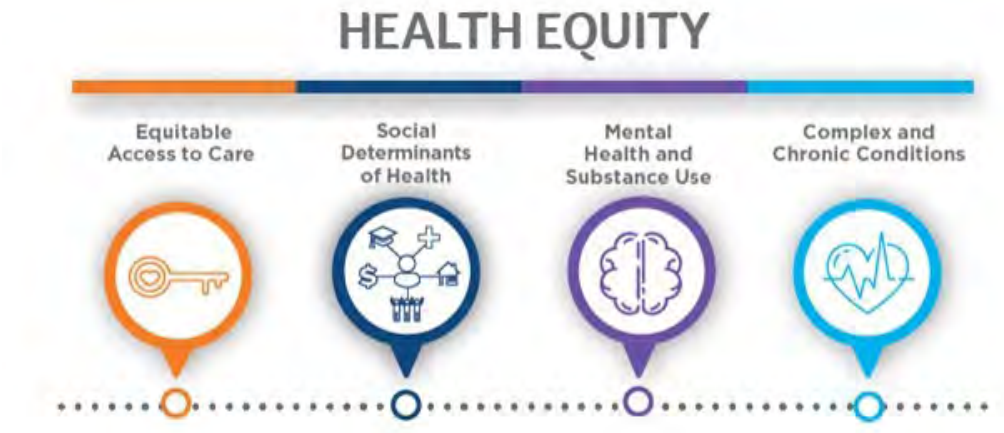
Community Health Needs Not Prioritized by NEBH

It is important to note that there are community health needs that were identified by NEBH's assessment that were not prioritized for investment or included in NEBH's IS. Specifically, addressing issues in the built environment (e.g., improving roads and sidewalks). While these issues are important, NEBH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in other areas were both more feasible and likely to have great impact. As a result, NEBH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. NEBH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in NEBH's IS

The issues that were identified in the NEBH CHNA and are addressed in some way in the hospital IS are housing issues, food insecurity, transportation, economic insecurity, community safety, long wait times for care, navigating a complex health care system, health insurance and cost barriers, language and cultural barriers, social isolation among older adults, depression/anxiety/stress, youth mental health, navigating the behavioral health system, supportive services for individuals with substance use disorder, community-based education and screenings, conditions associated with aging, support for caregivers, and care navigation support.

NEBH Community Health Priority Areas



Implementation Strategy Details

Priority: Equitable Access to Care

Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, and stem from the way in which the system does or does not function. System-level issues included providers not accepting new patients, long wait lists, and an inherently complicated health care system that is difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Resources/Financial Investment: NEBH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by NEBH and/or its partners to improve the health of those living in its CBSA. Additionally, NEBH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, NEBH supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, NEBH will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening outpatient clinical capacity and connecting patients to health insurance, essential medications, and financial counseling.	• Racially, ethnically, and linguistically diverse populations	• Programs and activities to support culturally/ linguistically competent care and interpreter services	• # of people served • # of languages provided	• Hospital-based activities
Advocate for and support policies and systems that improve access to care.	• All priority populations	• Advocacy activities • Emergency medical services training, leadership, & community preparedness activities	• # of policies supported • # of drills participated in	• Hospital-based activities

Priority: Social Determinants of Health

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, and other important social factors.

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, listening session, and the NEBH Community Health Survey reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food insecurity/nutrition, transportation, and economic instability.

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Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• All priority populations	• Food access, nutrition support, and educational programs and activities	• # of people served • lbs of food distributed • # of pantries and other sites supported	• Private, non-profit, and health-related agencies • Hospital based activities
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• All priority populations	• Community investment and affordable housing initiatives • Housing stability and homeless prevention programs and activities	• # of people served • # of community meetings attended	• Housing support and community development agencies
Support programs and activities that increase employment, earnings and financial security.	• Low-resourced populations	• Clothing, household essentials, and financial assistance programs and activities	• # of people served	• Private, non-profit, health-related agenies

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support community/regional programs and partnerships to enhance access to affordable and safe transportation.	• All priority populations	• Public transit and mobility enhancement programs	• # of people • served # of rides provided	• Local and regional public transportation agencies
Support programs and activities that foster social connections, strengthen community cohesion and resilience and address causes and impacts of violence.	• All priority populations	• Community connection, social engagement, and beautification activities	• # of people served • # of community members and NEBH staff participating	• Local public agencies
Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.	• All priority populations	• Youth employment and internship programs • Career advancement and mobility programs	• # of people served • # of people hired • # of classes or programs organized	• Local public primary and secondary schools • Vocational and technical schools • Hospital-based activities
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults, and social isolation among older adults.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options. Those who participated in the assessment also reflected on the difficulties individuals face when navigating the behavioral health system.

Substance use continued to have a major impact on the CBSA; the opioid epidemic and alcohol use continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health and economic insecurity.

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Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• Youth • Older adults	• Health education, awareness, and wellness activities for children/youth • Health education, awareness, and wellness activities for older adults	• # of people served • # of classes, events, activities organized	• Private, non-profit, health-related agencies
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Health education, awareness, and wellness activities	• # of people served • # of classes, events, and activities organized • # of pieces of educational materials distributed	• Private, non-profit, health related agencies
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

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Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/o complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	• Older adults	• Fitness, nutrition, and healthy living programs and activities	• # of people served • # of classes, events, and activities organized	• Private, non-profit, and health-related agencies
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

General Regulatory Information

Contact Person:	Christine Dwyer, Director, Community & Government Affairs
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 10, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 10, 2025
Date written plan was required to be adopted	February 15, 2026
Authorized governing body that adopted the written plan:	New England Baptist Hospital Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 14, 2022
Name and EIN of hospital organization operating hospital facility:	New England Baptist Hospital: 04-2103612
Address of hospital organization:	125 Parker Hill Avenue Boston, MA 02120

Beth Israel Lahey Health
New England Baptist Hospital

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