Beth Israel Lahey Health
New England Baptist Hospital

2022 Community Health Needs Assessment

Acknowledgments

This 2022 Community Health Needs Assessment report for New England Baptist Hospital (NEBH) is the culmination of a collaborative process that began in September 2021. 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 collaborators in NEBH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

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, and community listening sessions. 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 Needs Assessment (CHNA)-Community Health Improvement Plan (CHIP) Collaborative (Boston CHNA-CHIP Collaborative). The Boston CHNA-CHIP Collaborative, 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 (HRiA) to support this effort. The Steering Committee engaged the City of Boston's Human Services Department to serve as a backbone organization to the CHNA and IS, with a specific focus on providing coordination on execution of the IS. 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 eleven years, NEBH 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 35 years. NEBH 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 2022 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, first responders (e.g., police, fire department and ambulance officials), 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, 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 current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were 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 2019 and the report, along with the associated 2020-2022 IS, was approved by NEBH's Board of Trustees on September 18, 2019. The 2019 CHNA report was posted on NEBH's website before September 30, 2019 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 September 2021 and September 2022, and NEBH's Board of Trustees approved the 2022 report and adopted the 2023-2025 IS, included as Attachment E, on September 14, 2022.

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 an outpatient surgery and 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 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.

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, first responders (e.g., police, fire department, and ambulance officials), 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.

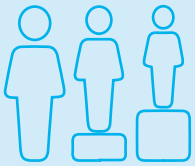
In addition to this assessment, NEBH's Community Benefits staff collaborated with the Boston Community Health Needs Assessment-Community Health Improvement Plan Collaborative (Boston CHNA-CHIP Collaborative). The Boston CHNA-CHIP Collaborative, consisting of Boston's hospitals and community health centers, 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. Facilitated through the Conference of Boston Teaching Hospitals (COBTH) and the City of Boston's Human Services Department, the Boston CHNA-CHIP Collaborative assessment focused on the social determinants of health through the lens of health equity; it aimed to uncover and understand how and why individuals in certain Boston neighborhoods or population groups experience inequities in health outcomes and barriers to care based on socioeconomic status, race and ethnicity, language, health status, sexual orientation, gender identity, and other factors. The overall approach was participatory and collaborative, engaging community residents and collaborators throughout the CHNA process. Nancy Kasen, BILH's Vice President of Community Benefits and Community Relations, served as the founding Co-Chair of the Boston CHNA-CHIP Collaborative Steering Committee, and continues to serve on its Steering Committee and workgroups. Robert Torres, BILH's Director of Community Benefits for the Boston region, served as the Co-Chair of the Community Engagement Workgroup. NEBH Community Benefits staff participated in numerous Boston CHNA-CHIP Collaborative meetings. NEBH and the Boston CHNA-CHIP Collaborative 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 CBSA, and 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 and the village of Chestnut Hill in their CBSAs. Similarly, both NEBH and BIDMC shared the information gathered in these areas as part of their processes. BIDMC also shared information from the extensive community engagement and planning activities that they are conducting as part of BIDMC's Massachusetts Determination of Need New Inpatient Building Community-based Health Initiative (NIB-CHI). Combined, these efforts helped to ensure that a sound, objective, and inclusive CHNA process was conducted across NEBH's entire CBSA.

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 needs and system capacity, while not unduly burdening the community. These efforts 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 who are unstably housed or homeless, those best served in a language other than English, recent immigrants, individuals in substance use recovery, and those who experience 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, collaboration, engagement, capacity building, and intentionality.

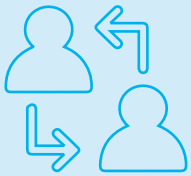


Equity:

Work toward the systemic, fair, and just treatment of all people.

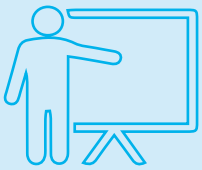
Collaboration:

Leverage resources to achieve greater impact by working with community residents and organizations.



Engagement:

Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, people most impacted by inequities, and others.



Capacity Building:

Build community cohesion and capacity by co-leading community listening sessions and training community residents on facilitation.

Intentionality:

Be deliberate in requests for and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit.

The assessment and planning process was conducted between September 2021 and September 2022 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 (for BID Needham)	Presentation of final report to CBAC and NEBH leadership
Evaluation of community benefits activities	Facilitation of community listening sessions to present and prioritize findings	Presentation to NEBH's Board of Trustees
Preliminary analysis of key themes	Compilation of resource inventory	Distribution of results via hospital website

In July of 2021, BILH hired John Snow, 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 addressing needs for 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 six 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 needs for specific communities. The data was 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. A databook that includes the quantitative data gathered for this assessment, including the Community Health Survey for BID Needham, 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 was reported for Roxbury. When data was not available for either Mission Hill or Roxbury, data was 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	COVID-19 Community Impact 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 October 2021 and February 2022, NEBH's assessment included 85 (20 by NEBH/BIDMC) one-on-one interviews with key collaborators in the community, 24 focus groups (5 by NEBH/BIDMC) with segments of the population facing the greatest health-related disparities, and two community listening sessions that engaged over 40 participants. In addition, BID Needham conducted a community health survey, which gathered information from more than 450 community residents from BID Needham's CBSA, including 86 residents from Dedham. BID Needham shared this information with NEBH. The Boston Public Health Commission fielded a COVID-19 Health Equity Survey in December 2020/January 2021; as such, NEBH and BIDMC, based on recommendations from the Boston CHNA-CHIP Collaborative Steering Committee, opted not to field a survey in Boston. This survey of a random sample of over 1,650 residents examined issues related to job loss, food insecurity, access to services, mental health, vaccination, and perceptions of risk around COVID-19.

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 BID Needham's Community Health Survey, and a copy of the Boston CHNA-CHIP Collaborative 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 key partners who may or may not be already collaborating with NEBH. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

At the outset of the strategic planning and reporting phase of the project, community listening sessions were 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 This was the first step in the prioritization process and allowed the community to discuss the assessment's findings and formally prioritize the issues that they believed were most important, using an interactive and anonymous polling software. These sessions also allowed participants to share their ideas on existing community assets and strengths, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the community listening sessions, the NEBH CBAC was engaged. The CBAC was updated on assessment progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in their own prioritization process using the

same set of interactive and anonymous polls, which allowed them to identify a set of community health priorities and cohorts that they believed should be considered for prioritization as NEBH developed its IS.

After the prioritization process, a CHNA report was developed and NEBH'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 2022 assessment, but also pose new strategies to address the newly identified priorities.

The Boston CHNA-CHIP Collaborative also conducted an extensive series of prioritization and planning meetings to facilitate the development of a city-wide Community Health Improvement Plan (CHIP). The Boston CHNA-CHIP Collaborative developed a summary and full report of findings, which was extensively referenced to develop this report. The final Boston-CHNA Chip Collaborative 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 reviewed these inputs and incorporated elements, as appropriate, before the final 2022 CHNA report and 2023-2025 IS were submitted to NEBH Board of Trustees for approval.

After the Board of Trustees formally approved the 2022 CHNA report and adopted the 2023-2025 IS, these documents were posted on NEBH's website, alongside the 2019 CHNA report and 2020-2022 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 2022 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, first responders (e.g., police, fire department and ambulance officials), 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 listening sessions, 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.

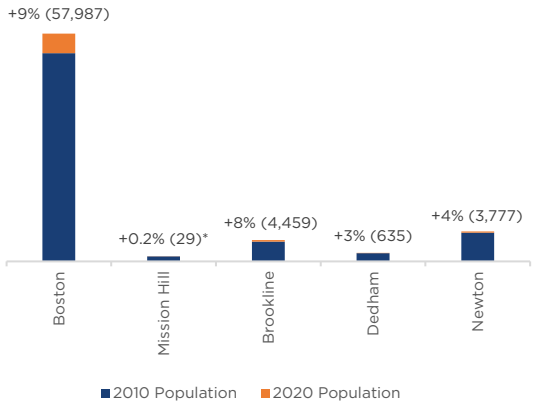
Based on the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the NEBH CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that older adults, individuals 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 highlighted 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.

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

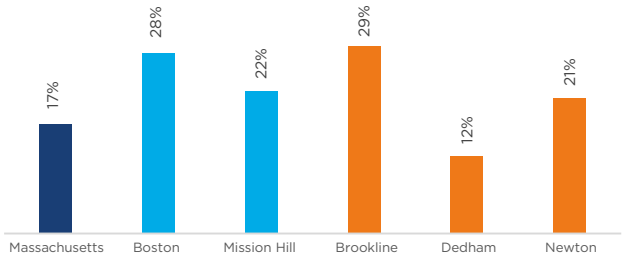
*Note that Mission Hill data point compares 2010 decennial census to 2016-2020 5-year estimate due to availability of data

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.[2]

The percentage of the population that is foreign-born was higher than the Commonwealth overall (17%) in Mission Hill and all NEBH CBSA municipalities, with the exception of Dedham (12%)

Percent of the Population that is Foreign-Born, 2016-2020



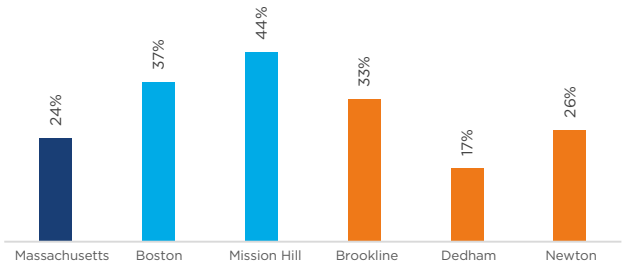
Source: US Census Bureau American Community Survey, 2016-2020

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.[3]

The percentage of the population 5 years of age and older that spoke a language other than English in their home was higher than the Commonwealth overall (24%) in Mission Hill and all NEBH CBSA municipalities, with the exception of Dedham (17%).

Percent of the Population 5 Years of Age and Older That Spoke a Language Other Than English in the Home, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Age

Age is a fundamental factor to consider when assessing individual and community health status. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.

The percentage of residents in the NEBH CBSA who were 65 years of age and older was significantly* higher than the Commonwealth overall (17%) in Newton (18%) and Dedham (19%). The percentage was similar in Brookline (16%) and significantly* lower in Mission Hill (7%). The proportion of older adults is expected to increase by 2030, which may have implications for the provision of health and social services.

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 Mission Hill (11%). 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 had a lower median age (28.4 years) compared to the City of Boston (32.4) and the Commonwealth overall (39.6). This was largely driven by the high proportion of college-aged adults that resided in the neighborhood. Given the transient nature of the college-aged population, concerns for this cohort were largely not reflected in the assessment's qualitative findings. Qualitative findings were dominated by the concerns expressed by adults, older adults, and families who make up Mission Hill's more permanent residents.

Source: US Census Bureau American Community Survey, 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Gender Identity and Sexual Orientation

Massachusetts has the second largest lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQIA+) population of any state in the nation (5%). LGBTQIA+ individuals face issues of disproportionate violence and discrimination, socioeconomic inequality, and health disparities.

8% of Boston adults identified as lesbian, gay, bisexual, or transgender; the percentage in Roxbury was slightly lower (7%). Data for Mission Hill and other NEBH CBSA communities was unavailable.

Source: Boston Public Health Commission, 2018

21% of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

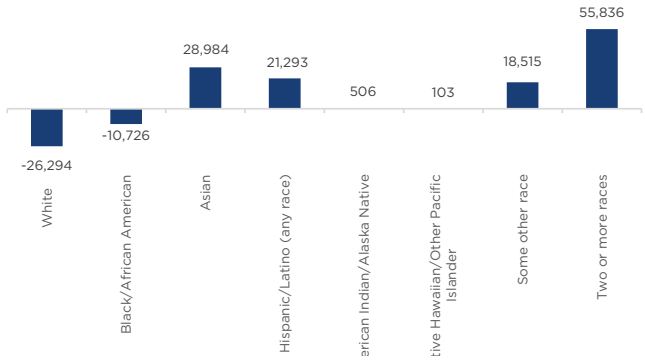
Community Characteristics

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.

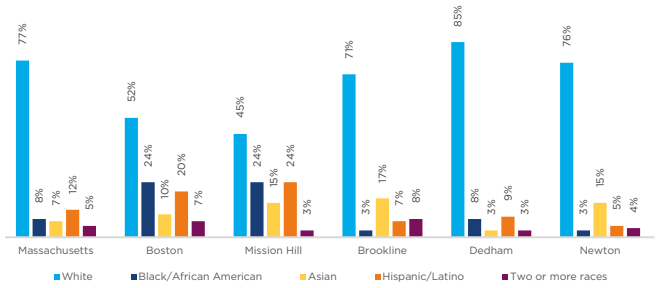
*Data for Boston, Brookline, Dedham, and Newton are included in this statistic

CBSA Population Changes by Race/Ethnicity, 2010 to 2020



Source: US Census Bureau Decennial Census, 2010 and 2020

Race/Ethnicity by Municipality, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

The percentage of the population who identify as Black/African American was higher in Mission Hill (24%) than the Commonwealth overall (8%). 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 (12%) in Mission Hill (24%).

Note: The US Census Bureau reported that the 2020 Decennial Census significantly undercounted Black/African American, American Indian or Alaska Native, Some Other Race alone, and Hispanic/Latino populations. The Census significantly overcounted 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.[4]

The percentage of NEBH CBSA households with one or more people 18 years of age or younger was significantly* lower than the Commonwealth overall (29%) in Brookline (25%) and Dedham (26%). The percentage was significantly* higher than the Commonwealth in Mission Hill (31%) and Newton (35%).

The percentage of NEBH CBSA households with one or more people 65 years of age or older was significantly* lower than the Commonwealth overall (31%) in Brookline (28%) and Mission Hill (30%). The percentage was significantly* higher than the Commonwealth in Newton (35%) and similar in Dedham (33%).

Source: US Census Bureau American Community Survey, 2016-2020
*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."[5] 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.[5]

There was limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, and listening sessions 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 was 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 was particularly challenging for residents of Mission Hill, given its steep terrain. It was 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 economically 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 groups, 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

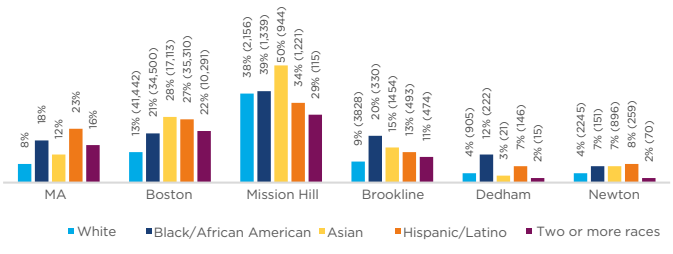
Economic stability is affected by income/poverty, financial resources, employment, and work environment, which allow people the ability to access the resources needed to lead a healthy life.[6] Lower-than-average life expectancy is highly correlated with low-income status.[7] Those who experience economic instability are also more likely to be uninsured or to 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.[8]

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 systemic racism, discrimination, and cumulative disadvantage over time.[9]

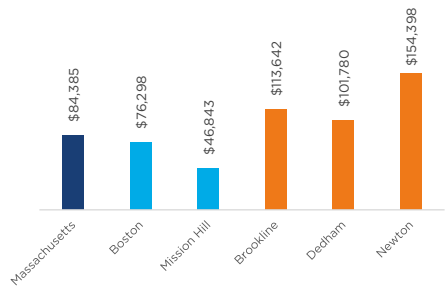
Median household income was higher than the Commonwealth in all NEBH CBSA communities, with the exception of the Mission Hill neighborhood, which was lower by over $35,000. Median household income is the total gross income before taxes, received within a one-year period by all members of a household.

Percentage of Residents Living Below the Poverty Level by Race/Ethnicity, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Median Household Income, 2016-2020



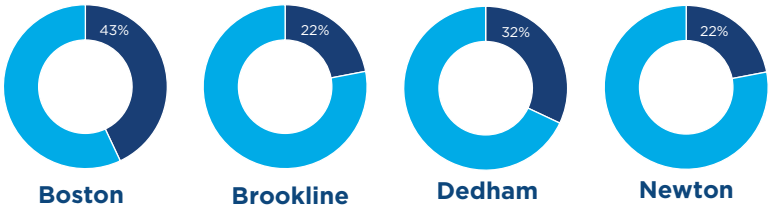
Source: US Census Bureau American Community Survey, 2016-2020

Social Determinants of Health

Economic Stability

The Massachusetts Department of Public Health (MDPH) conducted the COVID-19 Community Impact Survey in the fall of 2020 to assess emerging health needs, results of which indicated that community residents were concerned about their ability to pay their bills. Over a fifth of respondents in each NEBH CBSA municipality reported that they had worried about paying for one or more bills or types of expenses. Note that data was not available for Boston neighborhoods.

Percentage* Worried About Paying for One or More Types of Expenses/Bills in the Coming Weeks, Fall 2020



***Unweighted percentages displayed**

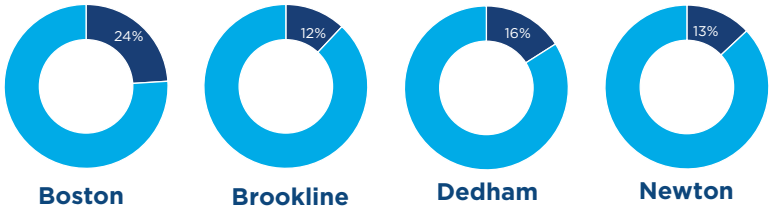
Source: MDPH COVID-19 Community Impact Survey, Fall 2020

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 factors poor physical and mental health for both children and adults.

The percentage of NEBH CBSA households that received SNAP benefits (formerly food stamps) within the past year was significantly* lower compared to the Commonwealth overall (12%) in all NEBH CBSA communities, with the exception of Mission Hill (25%), where the percentage was significantly* higher. SNAP provides benefits to low-income families to help purchase healthy foods.

Percentage Worried About Getting Food or Groceries in the Coming Weeks, Fall 2020



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020
*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.[10] Patients with higher levels 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.

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 (82%).

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 (45%) in all NEBH CBSA communities except Mission Hill, where the percentage was similar (43%).

Source: US Census Bureau American Community Survey 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Neighborhood and Built Environment

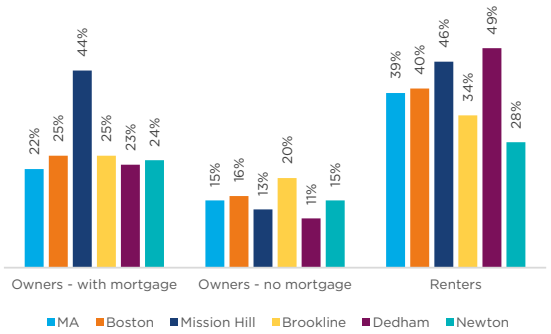
The conditions and environment in which one lives have significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks, and bike lanes improve health and quality of life.[11]

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.[12] 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.[13]

Interviewees, focus groups, 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 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, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

"Gentrification and the student rental market have driven out all of the affordable housing."

– NEBH interviewee

The percentage of housing units in the CBSA with owner costs in excess of 35% of household income was higher 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 (46%) and Dedham (49%), and lower in Brookline (34%) and Newton (28%).

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 the basic resources that allow them to live productive lives. Access to affordable and reliable transportation widens opportunity and is essential to addressing poverty and unemployment; it allows access to work, school, healthy foods, recreational facilities, and other community resources.

Transportation was identified as a concern for older adults and individuals 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.

"The services in the community are not available or accessible to those who are homebound or who struggle to get out of the house because they're physically disabled or have mental health problems. [Older adults] can't get to elder service sites if they don't have a car." – NEBH focus group participant

Approximately **14%** of adults in Roxbury reported that they had transportation difficulties in the past year, which was higher than the City of Boston average of 12%.
Source: BPHC BRFSS 2015, 2017, 2019 combined. Please note that data for Mission Hill was not available

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.

"[We need] cleaner streets and all the potholes and broken infrastructure fixed. This would make people want to get out in the community." – NEBH interviewee

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. The assessment also explored issues related to diversity, equity, and inclusion and the impacts of racism and discrimination.

Systemic barriers affect all segments of the population, but have a particularly significant impact on people of color, non-English speakers, recent immigrants, individuals 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, medical specialty care, and dental care services. Interviewees, focus groups, and listening session 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 sessions reflected on the high cost of care, including prescription medications, particularly for those who are uninsured or who have limited health insurance benefits. For individuals and families who are uninsured and have limited financial means, it can be extremely challenging to access the services they need to live a happy, productive, and fulfilling life.

Racial Equity

Racial equity is the condition where one's racial identity has no influence on how one fares in society.[14] Racism and discrimination influence the social, economic, and physical development among Black, Indigenous, and People of Color (BIPOC), resulting in poorer social and physical conditions in those communities today.[15] Race and racial health differences are not biological in nature. However, generations of inequity create consequences and differential health outcomes because of structural environments and unequal distribution of resources.

> "Local organizations need to make sure that equity is addressed in all of the services they provide. [The organizations] need to intentionally dismantle racism, and do outreach to those who are discriminated against."
>
> -NEBH interviewee

Interviewees reported that their communities were increasingly diverse in terms of race, ethnicity, sexual orientation, gender identity, and socioeconomic status. This diversity was identified as a strength.

In Mission Hill, interviewees reported that there was a strong network of community-based organizations and advocacy groups working to ensure equitable access to services for diverse populations, including individuals best served in a language other than English.

Accessing and Navigating the Health Care System

Interviewees, focus groups, 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 providers not accepting new patients, long wait lists, and an inherently complicated healthcare 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.[16]

Some clinical providers began offering care via telehealth over the course of the pandemic to mitigate COVID-19 exposure and retain continuity of care. This strategy removes barriers for some but creates new hardships for those who lack technical resources or technical savvy to take advantage of such programs.[17]

Community Connections and Information Sharing

A great strength of NEBH's CBSA was the strong community collaboratives, advocates, and task forces that convened 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 had access to the services and care that they needed. This was especially true in the realms of housing and older adult health and wellness.

"The main issues in this community are really big and require a collaborative effort. Throwing money at these problems is not the solution - we have to work collaboratively to build sustainable programs and supportive services."

-NEBH 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). According to the National Centers for Disease Control and Prevention, 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 chronic conditions.[18]

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.[19] Access to affordable healthy foods is essential to a healthy diet. Individuals who participated in interviews, focus groups, and listening sessions expressed concerns about people's ability to afford healthy and culturally appropriate foods, especially in Mission Hill.

"Food insecurity and nutrition are pressing health concerns – people make poor choices around food. We do have some promising programs like FreshTruck and Bounty Bucks."

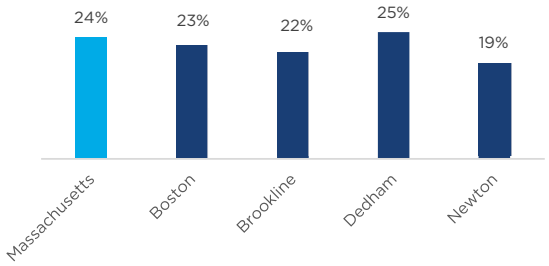
-NEBH interviewee

Physical Activity

Lack of physical fitness is a leading risk factor for obesity and a number of chronic health conditions. Interviewees, focus groups, and listening session participants reported that physical activity was 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 were obese (with a body mass index over 30) was lower than the Commonwealth in all NEBH CBSA communities, with the exception of Dedham, which was slightly higher. Note that data was not available for Boston neighborhoods.

Percentage of Adults Who Were Obese, 2018



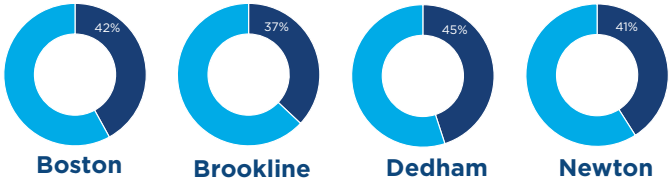
Source: Behavioral Risk Factor Surveillance System, 2018

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 an increase in substance use and relapse since the onset of the pandemic – potentially caused by increased stress and isolation and lapses in treatment. Interviewees and focus group participants also reported that marijuana and vaping tobacco was prevalent among youth and may be used as a coping mechanism for stress.

Percentage* of Current Substance Users Who Said They are Using More Substances Than Before the Pandemic, Fall 2020



Source: MDPH COVID-19 Community Impact Survey, Fall 2020

***Unweighted percentages displayed**

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.

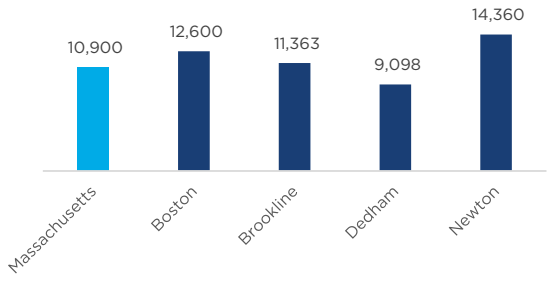
To augment and clarify this information, the assessment efforts included community engagement activities and specifically asked participants to reflect on the issues that they felt had the greatest impact on community health. Efforts were made to ensure that participants reflected on a broad range of issues, including chronic and communicable medical conditions and behavioral health disorders. Given the limitations of the quantitative data, specifically that it is often old data and is not stratified by age, race and ethnicity, the qualitative information from interviews, focus groups, and listening sessions 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. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Those who participated in the assessment also reflected on stigma, shame, and isolation that those with mental health

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



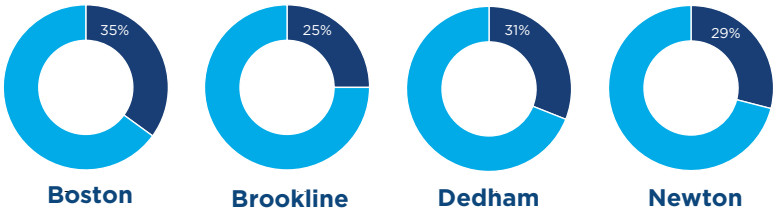
Source: Center for Health Information and Analysis, 2019

"People don't want to talk about mental health. This is part of life, but [some] seniors don't believe that mental health is a health issue. This is something that not a lot of people treat as a health issue, which makes it difficult to treat. The first step of contacting a provider is hard for people."

-NEBH interviewee

In every NEBH CBSA community, more than 25% of respondents reported more than 15 poor mental health days in the past month as of fall 2020. Note that data was not available for Boston neighborhoods.

Percentage* of Adults with 15 or More Poor Mental Health Days in the Past Month, Fall 2020



Source: MDPH COVID-19 Community Impact Survey, Fall 2020

***Unweighted percentages displayed**

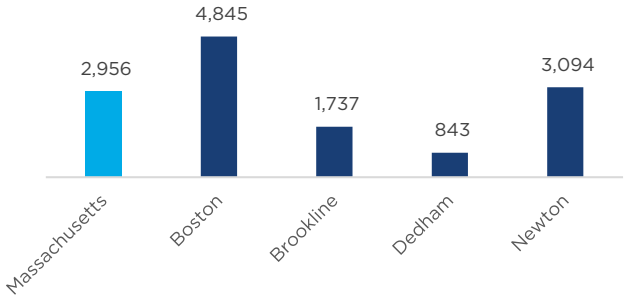
Health Conditions

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 was 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 65 years of age and older for substance use disorders were higher than the Commonwealth in Boston and Newton. Note that data was not available for Boston neighborhoods.

Inpatient Discharges for Substance Use Disorders Among Those Over 65 Years of Age, 2019



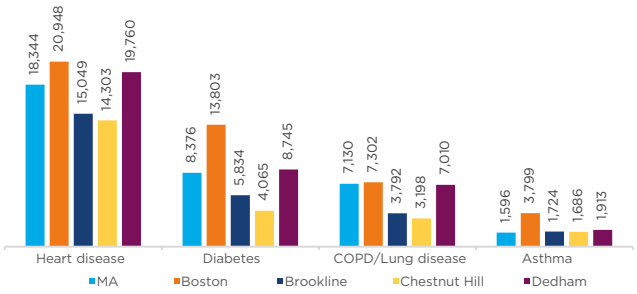
Source: Center for Health Information and Analysis, 2019

Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impacts on individuals and society.[20]

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, 2019



Source: Center for Health Information and Analysis, 2019

Roxbury had the highest percentage of adult residents with asthma (15%) among all Boston neighborhoods; this percentage was high compared to the City of Boston overall (11%).

Source: BPHC BRFSS 2015, 2017, 2019 combined. Please note that data for Mission Hill is not available

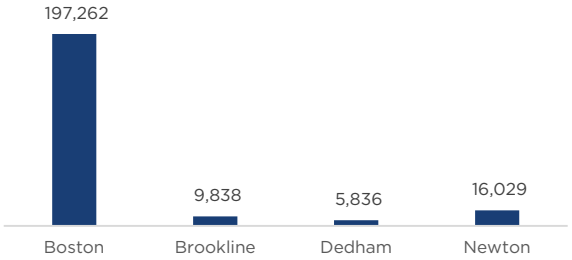
Communicable and Infectious Disease

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 forums and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

COVID-19

On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus a global pandemic. Society and systems continue to adapt and frequently change protocols and recommendations due to new research, procedures, and policies. Interviewees and focus group participants emphasized that COVID-19 was a priority concern that continues to directly impact nearly all facets of life, including economic stability, food insecurity, mental health (stress, depression, isolation, anxiety), substance use (opioids, marijuana, alcohol), and one's ability to access health care and social services.

Total COVID-19 Case Counts Through July 21, 2022



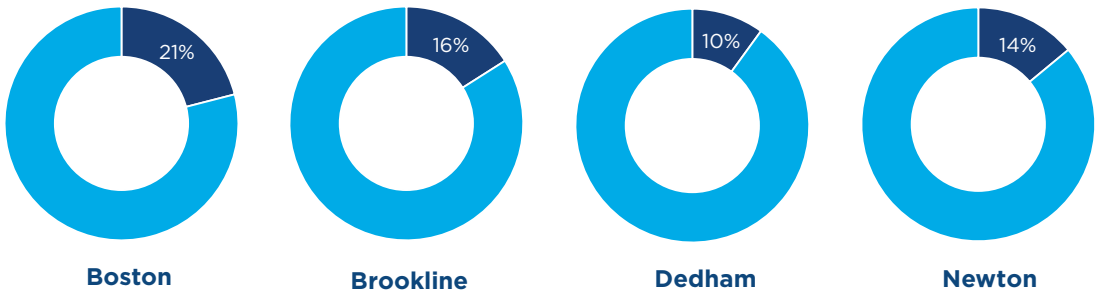
Source: Massachusetts COVID-19 Data Dashboard

COVID-19 presented significant risks for older adults and those with underlying medical conditions because they face a higher risk of complications from the virus. Interviewees described how COVID-19 exacerbated poor health outcomes, inequities, and health system deficiencies, especially for older adults and those with limited economic means.

Roxbury had the fifth highest COVID-19 incidence rates among all City of Boston neighborhoods. Data showed that the neighborhoods with the highest incidence rates were also those with the highest percentages of Black/African American and Hispanic/Latino residents. Statistics from BPHC's COVID-19 Health Equity Survey further illustrated the disparities and disproportionate impacts of COVID-19 on residents of color: higher percentages of Black/African American, Hispanic/Latino, and Asian residents reported losses in household employment income, difficulty paying their rent or mortgage, and experiencing food insecurity compared to white residents.

In all NEBH CBSA communities, more than 10% of respondents to the MDPH COVID-19 Community Impact Survey reported that they had not gotten the medical care they needed since July of 2020. Lapses in medical care may lead to increases in morbidity and mortality. Note that data was not available for Boston neighborhoods.

Percentage* Who Have Not Gotten the Medical Care They Need Since July 2020 (as of Fall 2020)



Source: MDPH COVID-19 Community Impact Survey, Fall 2020

***Unweighted percentages displayed**

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 or are disproportionately impacted by systemic racism or other forms of discrimination. Accordingly, using an interactive, anonymous polling software, NEBH's CBAC and community residents, through the community listening sessions, 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 Community Health Priorities

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.	• 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

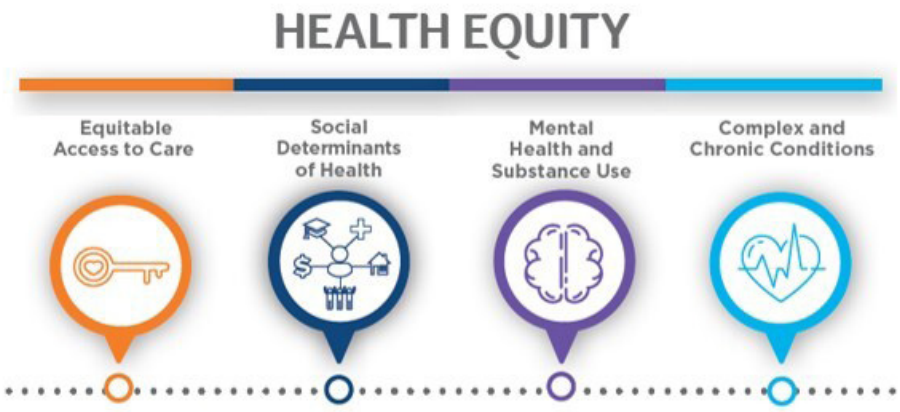
Older Adults

Racially, Ethnically and Linguistically Diverse Populations

Individuals with Disabilities

Low-Resourced Populations

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 the digital divide (i.e., promoting equitable access to the internet) supporting education across the lifespan, addressing poor air quality, and addressing gentrification were identified as community needs but were not included in NEBH's IS. 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's IS are housing issues, food insecurity, transportation, economic insecurity, diversify provider workforce, developing programs to support patients to navigate the healthcare system, bringing care to community spaces, addressing linguistic access barriers, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, respiratory illness, cancer, diabetes, heart disease, mobility issues, addressing cognitive memory decline, accessible or affordable space to exercise, accessible or affordable healthy foods, promoting neighborliness, addressing the impacts of violence and trauma, advocacy for seniors, advocacy for individuals with disabilities, need for safe youth activities, more monitoring/cameras in communities, and address drug use in community spaces.

Implementation Strategy

NEBH's current 2020-2022 IS was developed in 2019 and addressed the priority areas identified by the 2019 CHNA. The 2022 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 2023-2025 IS.

Included below, organized by priority area, are the core elements of NEBH's 2023-2025 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. Finally, NEBH supports residents in its CBSA by providing "charity" 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, leveraged, or "charity" care expenditures to carry out its community benefits mission.

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, comprehensive, high-quality access to health care services for those who face economic barriers.

Strategies to address the priority:

- Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.
- 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 the social determinants of health.

Strategies to address the priority:

- 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.

- Advocate for and support impactful programs that stabilize or create access to affordable housing.
- Increase mentorship, training, and employment opportunities for youth, young adults, and adults residing in the communities as well as hospital employees.

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:

- Enhance relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills, and reduce isolation.
- 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.

COMPLEX AND CHRONIC CONDITIONS

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions.

Strategies to address the priority:

- Increase opportunities for community members to decrease their risk for developing and/or improve their management of complex & chronic conditions.

Evaluation of Impact of 2020-2022 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 2023-2025 IS, NEBH and all BILH hospitals will review community benefit programs through an objective, consistent process using the BILH Program Evaluation and Assessment Tool. Created with Community Benefits staff across BILH hospitals, the tool scores each program using criteria focused on CHNA priority alignment, funding, impact, and equity to determine fit and inclusion in the IS.

Since 2020, many of the programs that would normally be conducted in-person were postponed or canceled because of COVID-19. When possible, programs were delivered virtually to ensure the community was able to receive services to improve their health and wellness.

For the 2020-2022 IS process, NEBH planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2019 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and charity care. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2020 and 2021. NEBH will continue to monitor efforts through FY 2022 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
Chronic and Complex Conditions and Their Risk Factors	**Walking Group:** Over 60 older adults participate in the walking group that walks twice a week **Healthy Moves:** Healthy Moves, a 12-week program is for older adults that concentrates on exercise, strength, balance, flexibility, and endurance, and education about fall prevention. Over 40 participants utilized fitness equipment while virtual on Zoom using Chromebooks. **Maintenance of McLaughlin Field:** NEBH continues to maintain the City of Boston's McLaughlin Park, Fields and Walking Path in Mission Hill. This allows the residents of Boston to use the field and parks for safe, socially distant outdoor activities.
Social Determinants of Health and Access to Care	**Transportation:** NEBH supports the Mission Link bus, which provides safe transportation to older adults living in the Mission Hill community to get to the local grocery store, pharmacy, doctor's appointment, church, library, etc. It also provides them with the opportunity to be social and active. Over 7,400 residents used the bus. Due to COVID, the number of riders decreased. **Food for a Healthy Community:** NEBH provided food and gift cards to over 500 families and individuals at Thanksgiving. NEBH provided food, Stop & Shop Gift Cards and/or meals to over 400 families/individuals throughout the year. NEBH provided financial support for the food pantry at ABCD, Parker Hill Fenway Service Center. The pantry provided emergency food for low-income families and individuals in the community. **Clothing and Basic Items:** NEBH provided much needed winter clothing, cleaning supplies, masks, hand sanitizer, etc. for individuals and families in the Mission Hill Community. Over 224 coats, boots, shoes, etc. were given to residents that included children, adults and seniors at the Tobin Community Center, Roxbury Tenants of Harvard, HERE House, Maria Sanchez House, and One Gurney Street Apartments.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2020-2022 Implementation Strategy

Appendix E: 2023-2025 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

Beth Israel Lahey Health Community Health Assessment

Interview Guide

Please complete this section for each interview:

Date:	Start Time:	End time:
Name of Interviewee:		
Name of Organization:	Affiliate Hospital:	
Facilitator Name:	Note-taker Name:	
Did all participants agree to audio recording?		
Did anything unusual occur during this interview? (Interruptions, etc.)		

Thank you for taking the time to speak with me today. Beth Israel Lahey Health (BILH) and Hospital [and any collaborators] are conducting a community health needs assessment and creating an implementation plan to address the prioritized needs identified. For the first time, all 10 hospitals in the BILH system are conducting this needs assessment together. Our hope is that we will create a plan at the individual hospital level as well as the system level that will span across the hospitals.

During this interview, we will be asking you about the strengths and challenges of the community you work in and the populations that you work with. We also want to know what BILH should focus on as we think about addressing some of the issues in the community. The data we collect during the assessment is analyzed, prioritized, and then used to create an Implementation Strategy. The Implementation Strategy outlines how the Hospital and System will address the identified priorities in partnership with community organizations. For example, if social isolation is identified as a priority, we may explore partnering with Councils on Aging on programs to engage older adults, and support policies and system changes around mental health supports.

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

If you agree, we would like to record the interview for note taking purposes to ensure that we accurately capture your thoughts and obtain exact quotes to emphasize particular themes in our final report. Do you agree?"

[*<u>if interviewee does not agree to be recorded, do not record the interview</u>]

Question	Direct Answer	Additional Information
Community Characteristics, Strengths, Challenges		
What communities/populations do you mainly work with?		
• How would you describe the community (or population) served by your organization?		
• How have you seen the community/population change over the last several years?		
What do you consider to be the community's (or population's) strengths?		
How has COVID affected this community/population?		
What are some of its biggest concerns/issues in general? What challenges does this community/population face in their day-to-day lives?		
Health Priorities and Challenges		
What do you think are the most pressing health concerns in the community/among the population you work with? Why?		
• How do these health issues affect the populations you work with? [Probes: In what way? Can you provide some examples?]		
We understand that there are differences in health concerns, including inequalities for ethnic and		

racial minority groups **/** the impacts of racism. Thinking about your community, do you see any disparities where some groups are more impacted than others?		
• What contributes to these differences?		
What are the biggest challenges to addressing these health issues?		
What barriers to accessing resources/services exist in the community?		
Community-Based Work		
What are some of the biggest challenges your organization faces while conducting your work in the community, especially as you plan for the post-COVID period?		
Do you currently partner with any other organizations or institutions in your work?		
Suggested Improvements		
When you think about the community 3 years from now, what would you like to see?		
• What would need to happen in the short term?		
• What would need to happen in the long term?		
How can we tap into the community's/population's strengths to improve the health of the community?		

In what way can BILH and [Hospital] work toward this vision? What should be our focus to help improve the health of the community/population?		
Thank you so much for your time and sharing your opinions. Before we wrap up, is there anything you want to add that you did not get a chance to bring up earlier?		

I want to thank you again for your time. Once we finish conducting survey, focus groups and interviews, we will present the data back to the community to help determine what we should prioritize. We will keep you updated on our progress and would like to invite you to the community listening sessions where we will present all of the data. Can we add you to our contact list? After the listening sessions, we will then create an implementation plan to address the priorities. We want you to know that your feedback is valuable, and we greatly appreciate your assistance in this process.

NEBH and BIDMC* Community Health Needs Assessment 2021-2022
Key informant summary

NEBH Interviewees

- City of Boston: Kenzie Bok, City Councilor
- Boston Police Department: Nora Baston, Superintendent of the Bureau of Professional Development
- Tobin Community Center: John Jackson, Administrative Coordinator
- Mission Hill Neighborhood Housing Services: Pat Flaherty, Executive Director
- Roxbury Tenants of Harvard: Karen Gately, Executive Director
- Roxbury Tenants of Harvard: Sophiya Detch, Sophia Deng, Pauline Lin - residents
- Mission Main: Miss Willie Pearl,Clark, Tenants Task Force
- Alice Taylor Housing: Matilda Drayton, Tenants Task Force
- Mission Hill Main Streets: Ellen Walker, Executive Director
- Mission Hill Link: Maggie Cohn, Board Member
- Maria Sanchez House: Elimercy Martinez, Senior Property Manager
- City of Boston, Age Strong Commission: Emily Shea, Commissioner
- Mission Hill Health Movement: Mary Anne Nelson, Executive Director
- Sociedad Latina: Alexandra Oliver-Davila, Executive Director
- ABCD, Park Hill Fenway: Jenny Sugilio, Director
- Dedham Department of Public Health: Kylee Sullivan, Director
- Dedham Drug Free Communities: Kristina King, Program Director
- Dedham Housing: Carrie Moore, Executive Director
- Nancy Ahmadifar, Community Resident, Friend of the Boston Public Library, Parker Hill Branch
- Madison Park High School: Brian Miller, Special Education Teacher

BIDMC Interviewees

- Boston Public Health Commission: Dr. Bisola Ojikutu, Executive Director
- City of Brookline: Lynne Karsten, Director of Community Health
- Town of Lexington: Melissa Interess, Director of Human Services
- LISC Boston: Karen Kelleher, Executive Director
- City of Boston, Mayor's Office of Immigrant Advancement: Yusufi Vali, Director
- Black Ministerial Alliance: Rev. David Wright
- Health Leads Boston: Sarah Primeau, Director of Programs and Jennifer Valenzuela, Chief People and Equity Officer
- City of Boston: Natalia Urtubey, Director of Small Business
- Massachusetts Affordable Housing Association: Symone Crawford, Executive Director
- Metropolitan Area Planning Council: Sharon Ron, Senior Planner
- Fenway Health: David Todisco, Director of Behavioral Health
- Boston Center for Independent Living: Bill Henning, Executive Director
- Greater Boston PFLAG: René Rives, Program Manager
- Tech Goes Home: Marvin Venay, Chief Advocacy Officer
- South Cove Community Health Center: Eugene Welch, CEO and Executive Director
- Boston Women's Fund: Netanja Craig-Oquendo, Executive Director
- Boston NAACP: Ericka Florence, Chair of Health Committee

*Note: NEBH's Community Health Needs Assessment also incorporated findings from the key informant interviews and focus groups conducted as part of the Boston Community Health Needs Assessment.

NEBH and BIDMC Community Health Needs Assessment 2021-2022
Key informant summary

Community characteristics

- Organizations willing to come together to address challenges – was especially apparent over the course of the pandemic
- Diverse neighborhoods and residents, in terms of race/ethnicity, household composition (mix of students, older adults, families)
- NEBH - sense of unity in Mission Hill neighborhood; Strong network of community organizations and history of activism

Social Determinants of Health

- Overarching – COVID exposed existing SDOH issues that inhibit access to care (transportation, internet access)
    - Especially complicating things for older adults, individuals best served in language other than English
- Housing is significant concern – gentrification, overdevelopment, students rental market displacing residents
- Economic insecurity and job loss – exacerbated by COVID
- Food insecurity is a concern, though more about cost of healthy foods rather than lack of options
- NEBH - Transportation is a perennial concern for many; especially older adults. Mission Hill can be difficult to navigate for anyone with a mobility issue

Mental health

- Significant prevalence of depression, anxiety, and stress across all segments of the population
    - Isolation a critical concern for older adults - especially those who are frail, homebound, disabled
    - Particular concerns for youth mental health – youth are stressed; lives upended by COVID. Increase in behavioral health issues among young people have ripple effect on teachers and school providers/staff
- Mental health impacts of those affected by community violence, trauma
- Need more diversity among mental health providers
    - "*We need more mental health services that are not rooted in the white dominant culture, but that are rooted in people's cultural experiences."- BIDMC key informant*

Access to care

- Access to care issues exacerbated by pandemic – long wait times or providers not taking on new patients
- Difficult for people to navigate complexities of healthcare system, including health insurance. Even more difficult for certain segments of the population (e.g., those best served in a language other than English, older adults, individuals with no family or caregiver)
- Cost/insurance barriers
- Language barriers – need for more diverse providers that speak languages other than English
- Immigration status can be a barrier to care – mistrust; fear or having to disclose immigration status

- Move to telehealth good for some; harder for those without tech resources or tech knowledge
- NEBH - Mission Hill - Difficult to secure transportation to get to and from appointments

Chronic/complex conditions

- NEBH
    - People expressed concern about respiratory illness – feeling that these issues may be exacerbated in neighborhood because of high percentage of residents in public housing, proximity to traffic
    - Mobility issues for older adults
    - Need diabetes and cancer management programs
    - Cognitive decline/memory issues a concern for older adults

Diversity, equity, inclusion

- BIDMC
    - Significant recognition of how trauma, stress, anxiety of racism and discrimination affect health
    - Concerns around discrimination against LGBTQ+ population, especially transphobia
    - Racial and ethnic disparities in health care access exposed by COVID
    - Need more targeted support/care for non-English speakers and undocumented individuals
    - *"The inequities that have been impacting Black and Brown people are still happening today, over 18 months later. We have corporations and government and city officials talking about these disparities in health access, in food, in access to affordable and safe places to live" – BIDMC key informant*
- NEBH - Homebound elders facing significant issues accessing needed care and services

Assets/Resources

- BIDMC – political will; resource sharing and collaboration among community organizations; diversity; resilience; educational opportunities; diversity
- NEBH – community cohesion; network of organizations serving the needs of older adults; resource sharing and collaboration; diverse and non-judgmental; many long term community members; green space; friendliness; libraries.

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Community Health Needs Assessment: Interview Guide

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

We want to hear your thoughts about things that impact health in your community. The information we collect will be used by Beth Israel Lahey Health to create a report about community health. We will share the results with the community in the winter and identify ways that we can work together to improve health and wellbeing. The is used to put together a plan that outlines how the Hospital and System will address the identified priorities in partnership with community organizations.

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

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

With your permission, we would like to audio record the focus group to help ensure that we took accurate notes. No one besides the project staff would have access to these recordings, and we would destroy them after the report is written. Does everyone agree with the audio recording?

If all participants agree, you can record the Zoom. If one or more person does not agree or are hesitant, do not record the focus group.

Does anyone have any questions before we begin?

Section One: Community Perceptions

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

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

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?

   If yes, move on to Section 2.

   If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)

   Let's talk more deeply about these concepts.

Section Two: Key Factors

In this section, ask participants to go more in depth about the factors they brought up in the previous section. For example, if they brought up the lack of affordable healthy foods, ask "are healthy foods available to some people, if so who? And why do you think they are not available to everyone?"

For each issue they identified:

- Are these (things that keep you healthy) available to everyone or just a few groups of people?

- Why do you think they (things that make it hard to be healthy) exist? / Why is this a challenge?

Section Three: Ideas and Recommendations

4. **Ideas:** Thinking about the issues we discussed today, what ideas do you have for ways hospitals can work with other groups or services to address these challenges?
    1. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

5. **Priorities**: What do you think should be the top 3 issues that Hospitals and community organizations should focus on to make your community healthier?

NEBH CHNA Focus Group Summary: Older Adult Residents of Mission Hill

Date: November 30, 2021	Start Time: 11:30	End time: 12:40
Group Name and Location: New England Baptist Hospital, Older Adult Residents of Mission Hill, via Zoom		

Health	
What does being healthy mean to you? - **What does it look like?** - **What does it feel like?**	**Mobility and independence** - Ability to be mobile and get around; to get to out and do things that you need to get done - Being healthy means being able to live independently, feel strong, avoid major medical issues. Being resilient and maintaining a sense of wellbeing. - Independence as elder people; ability to get around and do chores even with certain health problems **Socialization** - Agree with above, remain active. Everyone at BI, RTH and Baptist think that activity only involves healthy eating and exercise which are important, but another part of being healthy especially for folks who are older and not working is to have social contact. This is difficult right now because of all the restrictions but in order to be healthy we have to have interactions as well as healthy eating and exercise - Communication with everyone, keep yourself not just physically but mentally healthy **Independence** - Day-to-day, pay attention to what you're doing, eating, social surroundings - Being able to be my own advocate with my medical issues, keeping good mental health, being healthy and staying healthy, being happy and keep myself safe
Healthy Factors	

What are some of the things that help you stay healthy? - **Are there things in your community that help you stay healthy?**	**Group activities and building community** - Being together - Very important to communicate through groups/committees, volunteer and stay active and focused - Checking on neighbors to see if they need help with anything, thinking about others, not being selfish, help others with grocery - Like to bring food to friends who are not mobile - Like interaction that she gets from arts and crafts group - Miss going to the Tobin for exercise get together with other people in the Mission Hill community - Not enough community events right now because of COVID, think there could be more community events. Book clubs, knitting group, exercise group at the Tobin, even just walking down to the Tobin is a fun event **Staying active** - Walking - Walk around Mission Park **Impacts of COVID on staying healthy** - Lack of human contact, isolation, mental health deterioration, physical deterioration due to not being able to go outside because of health concerns, lack of sunshine, inability for many seniors to go to the doctor for cold or other issues they might have gone to the doctor for before COVID, not being able to get out of bed, food, food insecurity, you may be able to get a meal to your home but don't have resources or money to buy nutritious foods you need for your medical issues, lack of nutrients and proper nutrition - ABCD representative calls one senior every day to walk and bring some food.
Are the things that help you stay healthy available to everyone or just a few groups of people?	● Available to everyone but some might not have the ability or be able to access them due to a health problem ● This is a question we really don't know, but gut instinct says no it's not available to everyone. Such as arts and crafts, I don't want to do arts and crafts. People who don't live at RTH or near the Tobin or have an active community nearby don't have access to these things. Other than zoom there isn't a lot of activity happening right now. Activity is self-initiated and there may be folks who can't self-initiate. ● For us here at the Tobin there are inequities for the types of services available vs. seniors. Technology access is an issue for seniors. There are a lot of

	things that folks just don't have access to due to lack of technology or other resources. ● One participant just had pneumonia and wants to thanks community who helped her, important to feel not only independent but that you have social support when you need something. Important to be independent when you don't need something. ● There is stress placed on seniors, grandparents who are caring for their children's children. Elder abuse. This is very prevalent. Elder abuse is one of those issues that is not really believed in some areas, but exists more and more today, especially during COVID when medical and social services are not keeping in contact with the seniors. Children of seniors who are addicts or alcoholics who are putting stress and abuse on elderly parents. These are issues that are out there and not being dealt with for the seniors. ● Have to find ways to get people to participate who are not the regular people who always participate. Need to put effort into getting more people involved. Languages and cultures need to be spread. Have a large number of people who are not bilingual, Cape Verdean, Spanish, African American. Tried for a little and stopped because of pandemic but using the pandemic as an excuse. Need to stop using the pandemic as an excuse to not get together. Need all organizations to participate to bring people together.
Of the things that you've named as helping to keep you healthy, which would you like to see more of?	● Did not ask
<u>Unhealthy Factors</u>	
What are some of the things that make it hard for you to be healthy?	● Did not ask
Do these things (that make it hard for you to be healthy) affect everyone or just a few groups of people?	● Did not ask

Why do you think the things that make it hard for you to be healthy exist?	**Ageism** - It doesn't matter what type of skills or wisdom you have, even if you work your skillset is diminished because folks don't honor our age and wisdom - Agree with above. Working 2-3 days a week at resident services, if there is something to learn they help me learn to do it. - Doctors and nurses don't give you the same treatment they did as when you were younger. Talk to you like a two year old. Patting you on the head. Some of us still have agility and able to learn and do things but people don't want to teach you. We're not unteachable just because we age - Important to have ways of reaching out to people - Many of our seniors go to the doctor and if they aren't talking to us like we are babies they are talking to us like we are professor and hard to understand what is going on. Important to have an advocate to go with a senior who can explain test results or what happened in a way that we can understand it
<u>Section 3: Ideas and Priorities</u>	
Thinking about all that we have talked about, what ideas do you have for ways that hospitals can work with other groups to help make your community healthier?	**Social activities outside the home** ● Book club, story hours outside the home, field trips to markets, lunch dates, holiday events, groups where we can rent the theater just for seniors or to the symphony. Movies, museums. Pets, dogs, having a situation where seniors can be around animals (therapy pets). **Mobile medical services** ● Availability of mental health assessments, hearing assessments with follow up. **Accessibility and cultural sensitivity** ● Some seniors want to get involved but have accessibility issues. Cultural barriers within the senior community. Seniors isolate themselves within the groups they are most comfortable with. ● When seniors can't move around there is a difference between seniors who live in first floor vs. 5th floor of a unit. Barriers, accessibility, resources available, support, cultural sensitivity ● Don't want to be isolated and segregated just because of our age. We have younger folks who we could learn from as well as impart information to them. **Connection with youth** ● Young folks in community present music to us as well as us being in a choir ● Want to learn from youth

What do you think should be the top 3 issues that health service providers should focus on to make your community healthier?	● We need to look at the whole neighborhood and be honest with each other in terms of inequities and the situation. Different needs and situations in different parts of the neighborhood ● Provide medical advocates, wellbeing visits, address mobility issues to get seniors out into the community, providing assessments around mental health, dental, hearing with follow up treatment recommendations or providing access for addressing those particular issues. ● Need for more doctors (most of the people in her community use doctors at Brigham). Have been trying to get a primary care doctor through BI for the last 6 months. Really difficult to find a primary care doctor right now ● Twice appointment was made through BI and rescheduled without notice. If you don't go to the patient gateway first you go to the hospital for your appointment and find out your appointment has been changed without notifying you. Need to notify patients of change appointments. Trickles down to the admin staff and need for training of admin staff ● People like Dr. Clark who work with the community for years, she understood the neighborhood and different cultures. More community based and culturally sensitive care. ● Hospitals to provide training to staff and people in terms of working with people who come into medical facilities, to be respectful and not dismissive of medical concerns. Training of staff ● Trained staff in working with elders, assigning doctors and PAs who have that experience ● Top 3 things: empathy, respect, compassion ● Communication, talk about issues ● Cultural sensitivity, take some lessons from BMC, they address these issues and have a long history of understanding different cultures. ● Need for gerontology specialists ● Need for mental health issues to be taken seriously
<u>Section 4: Final Remarks & Closing</u>	
Are there other factors that influence your health that we haven't talked	

NEBH CHNA Focus Group Summary: Diverse Residents of Mission Hill

Date: 12/6/21	Start Time: 6PM	End time: 7PM
Group Name and Location: Diverse Residents of Mission Hill via Zoom		

Section 1: Community Perceptions	
Healthy: To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?	● Health services ○ Health insurance coverage ○ Health screenings and health education, helps those who don't complete physicals ○ Routine health visits ● Gym access ● Food access ● Financial support ● Community engagement (youth programming, family programming, etc) Verbatim notes: - Information and opportunity from Mosaic for community to partake in many things including food security, financial well-being, health and safety, summer camps for youth, swimming pool and lessons for youth - Clear and easy to understand - Easy access to gyms - Regular visits because of good health insurance coverage through employer - Health screenings are important, outreach helps because some people don't go to their physicals. Receive screenings and health education simultaneously - Money to households during holidays - Food access, partnerships with fresh truck, expanding access to fruits and vegetables - Future: encouraging folks to grow own food or host a community garden - Meaningful community engagement outdoors for families, challenging during

	COVID - Broaden family programming so that they are aware of available opportunities, many seniors are available

Unhealthy: What are some of the things that make it hard for you to be healthy?	● Childcare
	● Employment/finances
	● Traffic congestion/transportation/pedestrian safety/noise pollution issues
	● Health issues
	  ○ Long waiting lines, increased access to minor urgent care
	  ○ Mental health
	  ○ Preventative care and screenings, health education for proactive health approaches
	● Domestic violence
	● Child abuse
	● Difficulties getting services - finding right information, qualifying or proving need, long lines or low resources, services for disabled
	
	Verbatim notes:
	- Streetlights, traffic, parking, pedestrian safety for drivers who are inpatient or driving on one-ways, noise pollution impacting sleep/health
	- Job training for mission hill residents, pipeline program
	- Increased mental health focus, pandemic-impacts. Outreach targeted to adults, but youth also impacted, more outreach for everyone because everyone has been impacted
	- Childcare support, impacts work
	- Children need mental health support and programming, COVID-19 impacts
	- Scholarships for youth education, expanding programs from “RTH” to greater community
	- People unable to get to doctors, long waiting times. Suggests a mobile health van for people to address simple concerns like “bump on figure” “itchy throat”
	- Increased preventive screenings for youth like asthma, diabetes. Increase health education
	- Undiagnosed mental health conditions in the neighborhood, behaviors that people are unsure to link to mental health. Information is the issue
	- Housing concerns, costs create stress on fixed incomes

	- Medical impacts of stress - Looking for support, but having to prove need and that is tiring - Domestic violence and child abuse during pandemic, need outlet for families to discuss that - People don't know where to get resources and information. Navigating Boston public schools and transportation for children has been difficult, not sure where to go next for support. Difficulties locating nearby schools for speech-delayed child
Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly? *If yes, move on to Section 2.* *If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)* Let's talk more deeply about these concepts.	Top Factors 1. Mental health 2. Family support/food/childcare 3. Employment/education/financial stability 4. Access to primary care/prevention
<u>Section 2: Exploring Key Factors</u> *In this section, ask participants to go more in depth about the factors they brought up in the previous section.*	
Are these **(things that keep you healthy)** available to everyone or just a few groups of people?	- Less outreach for younger people, younger families - Resources are for seniors - Waiting lines and low resources prevent people from getting access - Services for people with disabilities - Time, transportation constraints
Why do you think they **(things that make it hard to be healthy)** exist?	● Did not ask

- Why is this a challenge?	
What are some examples of how these challenges impact someone's health?	● Did not ask
Section 3: Ideas and Priorities	
Ideas: - Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time? - Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?	● Increased, targeted outreach for programming and health education ○ Focus on youth, younger families ○ Promoting confidentiality to increase participation/engagement ● Expanding food supports - encouraging gardening or community gardens in addition to other existing food programs ● Pipeline programs between Mission Hill and NEBH to increase employment, financial security ● Addressing mental health ○ Peer community groups ○ Educating and destigmatizing mental health within a community, then focusing on access ○ Hotline phone services for immediate access, determining severity of need, confidentiality ■ Increasing resources to support both patients and medical staff ● Addressing healthcare ○ Medical mobile van to support access ● Advocacy and referral services to help people navigate questions, resources ○ Similar to resource specialist, community health worker ● Engaging youth to support community services ● Vouchers - parking, food programs, mothers Verbatim notes: - Expanding food supports - encouraging folks to grow own food or host a community garden - Affordable access to fresh fruit and vegetables in particular. Support around a gardening / food growing endeavor: maybe teens help build raised beds in a workshop, get people out in the sunshine and work

	together - helps toward mental health as well. Develop our own local food co-op which supports families in need and seniors etc. - Job training for Mission Hill residents, pipeline program - Increased mental health outreach and resources - Increasing outreach so that younger families are aware of resources - Medical van for people having issues getting to doctor - Starting to address mental health within the community, then focus on how to get services outside. Emphasis on medications but parents don't want children on medications - Targeted awareness programs for parents, peer-to-peer programs - Community support system during COVID-19 given the depression, anxiety, beginning to start over, peer community groups - Medical staff assaulted by patients, impacted by mental health of patients. Supporting patients by giving improved access to resources and information rather than having people end up in the emergency room - Advocacy services that can help people, that way people don't rely on medical providers for guidance - Support systems for families - Teens enjoy community service opportunities - Emphasizing confidentiality, worries that everyone has their information
Priorities: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	● Did not ask
<u>Section 4: Final Remarks & Closing</u>	

NEBH CHNA Focus Group Summary: Youth

Date: 11/4/21	Start Time: 4:15	End time: 5:00
Group Name and Location: Youth, Mission Hill (via Zoom)		

Community Health

Promoters: <u>What are some of the things that help you stay healthy? Are there things in your community that help you stay healthy?</u>

- Healthy eating (fruits) and drinking water
    - "my grandma makes sure I eat healthy"
- Sleeping enough hours
- Exercise (sports, running, basketball, gyms)
    - Mostly as baseball fields, Tobin, schools with open gyms
    - Mostly accessible to everyone
- Education and opportunities to get financial aid, college access
- Friends help with stress and with school, easy to stay connected

Access/Equity: <u>Are the things that help you stay healthy available to everyone or just a few groups of people?</u>

- Exercise (sports, running, basketball, gyms)
    - Mostly as baseball fields, Tobin, schools with open gyms
    - Mostly accessible to everyone because its nearby
    - Common scenarios: meeting with friends, school sports
- Most key places are located nearby, youth using public transit or walk
    - "All the options help a lot"
    - "Boston collegiate charter school and many healthy places are far"
    - "no we get free cards at my school"
- Public transit inconveniences, but doesn't usually discourage commuting
  "the train being delayed a lot"
  "doesn't work all the time. train isn't on time."
  "busses are packed"

Health Challenges

Challenges: <u>What are some of the things that make it hard for you to be healthy?</u>

- School top stressor (work, workload, teachers, getting up early)
    - Reduces sleep
        - "4 hours max"
        - "yes I try to sleep 8 hours a day but it gets hard"
    - Remote learning challenges
        - distractions/staying focused
          "being productive"
          "couldn't stay focus"

"yea because I just kept going to sleep"
"because I would just sleep and get distracted"
"it was a challenge because of the distractions in my house"
"because u get distracted very much"
"because I kept skipping classes"

- Lack of support
  "no help"
  "didn't know how to go to my classes"
- adjustments
  "it was much more difficult because I couldn't focus and it was harder for the teachers to teach"
  "it was something to get used too"
  "stressful. being in front of a screen all day. and doing online work"

- Distractions
  - Family - little brother, siblings, "I have a lot of siblings"
  - TV, phones, tik tok, videogames
  - Noisy environments
- Mental health (stress, depression)
  - "Having problems and not knowing how to deal with them"
  - Many mentioned facing more stress than previously
    - "more since I have to worry about getting in to college"
    - "my grades matter more for college"
    - "Some people have to try harder than others to pass. Making some of them give up"
    - "more stress because more work" harder work
    - "worrying about the future is stressing me"
    - "sleeping late and waking up early"
- Food and diet
  - Unhealthy foods (junk food, fast food, "i be walking and see 3 pizza shops back to back")
  - Lack of eating, also drives stress
  - Lack of exercise
  - Time management, "to little time in the day"
  - Eating unhealthy foods: fast food, junk food, lack of food, walking and seeing three pizza places back to back, lack of access to food, not all food at home is healthy
- COVID challenges:
  - Staying indoors
    "yes I had less motivation to go outside and exercise"
    "yea because I can get food all the time since I'm at home"
    "I've gotten lazy"
    "yeah it made me stay home and order online a lot"
    "yes I slept all day"
    "yea because I can get food all the time since I'm at home"
    "staying inside just eating"

        - "I couldn't see my older relatives"
        - Reduced hours "the gym hours next to my house is cut shorter due to covid which makes people not go"
- Substance use for youth and community (people 13+)
    - Weed, needles, opioids, puff bars, nicotine, cravings
    - "needles are dangerous and people can overdose"
    - Addiction an issue
    - Mental issues with drugs
    - Money "It can cause people to use lots of money to it"
    - "its not healthy to be consuming drugs at a young age"
    - Drivers of substance use
        - "stress. to get way from life" "they think its stress relieving"
        - "Peer pressure" "hanging out with the wrong friend group"
        - "Struggle"

Access/Equity: <u>Do these things (that make it hard for you to be healthy) affect everyone or just a few groups of people?</u>

- Access to healthy food, impacts some people more than others
    - "Maybe its hard for people of low income to buy healthy foods"
    - "cheap foods are often unhealthy"
    - Availability of food
        - "its just whatever there when I'm hungry"
        - "more food in general, not all food at home is healthy"
        - after school cravings, hanging out with friends, foods at home
- Individual contexts
    - "yes it depends on peoples background"
    - "The way they were raised, the people they grew up with. Their mindset because of their experiences."
    - Support systems
    - "some kids don't live with two parents"
    - "the parents must work longer hours to support their family, seeing them less"
- Money as a common driver of inequity
    - "school. clothes. resources."
    - "its harder to stay healthy if you don't have the money to support it"
    - "financial aid for higher education"
    - "resources to succeed in school"
    - "Tutors"
    - "calculators they be like 150"
    - "Basic nessecities"
    - "Bills"
    - "Having a place to live in"

Root Causes: <u>Why do you think the things that make it hard for you to be healthy exist?</u>

- Lack of resources:

    - Money, financial aid for school, resources to succeed in school
    - Basic necessities, getting food, paying the bills, getting clothes
    - Parents need to work longer hours
- What kind of things help you do well in school?
    - Friends, tutors, calculators
    - Counselors, Teachers willing to spend time to help after school
- Some people who don't live with both parents

Suggestions

Strategies: <u>Thinking about all that we have talked about, what ideas do you have for ways that hospitals can work with other groups to help make your community healthier?</u>

- "if healthcare was cheaper especially childcare"
- Increase food access
    - Provide healthier foods, "give out fruits" "donate fruits"
    - "food drives are always helpful"
    - "food trucks with fruits though"
- Education support and improved opportunities
    - "Counselors, Teachers willing to spend time to help after school"
    - "Maybe a program that can help me with my college applications"
    - Financial aid
    - Support with AP tests, college
- Destress by
    - Sleeping
    - Getting exercise
    - Drawing
    - Education
    - Music
    - Youth state they usually prefer to de-stress by spending time alone
- Clean community (recycle bins, loitering, no trash, cleaning garbage)
    - "I just want some clean streets I sometimes see needles on the ground"
    - "broken glass on the streets is dangerous"
- Address substance use
    - Support
        - "talk to them"
        - "hang out with people who wont peer pressure you"
        - "set up programs for them"
        - "Not sure, maybe figuring out different ways to deal with problems and stress with help"
        - "Centers that could help"
        - "outreach"
    - Healthy living
        - "take the drugs away from them"
        - "don't do it at all"
        - "Going outside more"

        - “Meditation”
        - “yoga”
    - “its hard but i was apart of a campaign to get rid of nicotine in stores”
- Greater supports
    - “It could be the problems mentioned but advice from othe rpeople could be usful”
    - “Just help with how to deal with things in life”
    - “More accessibility to those things'”
    - “❤️Community”
    - “Its life, and not everyone knows how to deal with the issues that come”

Prioritize: <u>What do you think should be the top 3 issues that health service providers should focus on to make your community healthier?</u>

- Mental health and stress
- Substance use and addiction
- Better sleep, productivity or engagement with new things
- Clean neighborhood
- Affordability
    - Food
    - Healthcare
    - Childcare

- mental health
-making healthy foods healthcare and childcare cheaper
-having a clean community
-staying focus on school or jobs
-having a clean community
-drugs, and having decent if not clean community
-healthy foods stop addiction programs
-more sleep, eating more, stop stressing over little things
-having a clean community, staying healthy, stopping addiction

-Doing new things in life.
-Could pull them into new interests'”

<u>What are the top things people your age deal with?</u>
more sleep, eating more, stop stressing over little things
mental health
mental health
yea mental health checkins
more sleep, interact more,
metal health drug programs
mental health and drugs
could be health issues and getting a healthy mindset about things

Summary of Focus Group at Dedham Council on Aging

Date: 11/18/2021 Start Time: 12pm End time: 1:15pm

Section 1: Community Perceptions	
Healthy: To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?	• Educational workshops and programs • Screenings • Food pantries and Meals on Wheels • Exercise classes • Norwood COA is a great community asset, as are other COAs • Social activities available at COA and other COAs • Good breadth of services, primary care, specialty care, hospitals, equipment, and mental health • Some free and accessible transportation • Transportation • "House Call" or Social "House Visits" • Urgent care is increasingly available • Concierge medicine is available
Unhealthy: What are some of the things that make it hard for you to be healthy?	• Lack of insurance or underinsurance • Appt. wait-times to get into see a doctor • Care coordination and fragmentation of services, challenges with navigating the system • Digital divide for those who do not have a computer or internet services or who struggle with technical problems with their computers (computer illiterate) • Mental health burden (Depression, anxiety stress) • Mental health service gaps • Transportation is a major issue • Urgent care sometimes does not coordinate with people's regular doctor and it is confusing as to where to go Stopped at 13 minute point I think…moving in to negatives/challenges
Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly? *If yes, move on to Section 2.* *If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)* Let's talk more deeply about these concepts.	Top Factors 1. Mental health (depression, anxiety, stress, dementia, isolation) 2. Navigating the system/Care Coordination (appointment wait-times, finding services, communicating effectively, sharing results and information) 3. Transportation 4. Healthy lifestyles (nutrition, exercise, getting out, emotional health)
Section 2: Exploring Key Factors	

In this section, ask participants to go more in depth about the factors they brought up in the previous section.	
Are these **(things that keep you healthy)** available to everyone or just a few groups of people?	• No services are not available to all. The services that are available are not available or accessible to those who are "homebound" or struggle to get out of their house, and/or are physically disabled or have mental health problems. Can't get to the elder services sites or do not have a car. People were not comfortable talking about race and discrimination. Most did not think it was a major problem in the service area
Why do you think they **(things that make it hard to be healthy)** exist? • Why is this a challenge?	• These issues are chronic issues in the older population but have been greater exacerbated due to COVID
What are some examples of how these challenges impact someone's health?	**Mental health** ○ Mental health issues are a leading issue in the service area, especially during COVID ▪ Depression, anxiety, extreme stress, isolation/ loneliness, grief/loss, ○ Older adults and youth especially burdened, but an issue for everyone ▪ "Getting worse rather than better" ○ Dementia is a major problem in older adults and it has been exacerbated by COVID ○ Isolation is a major problem, need to get out and socialize. ○ Lots of homebound seniors who are afraid to go out due to falls, fear of contracting COVID, social anxiety, nowhere to go, lack of transportation, etc. and have very little to no family or community support ▪ Fear of COVID, not sure who is vaccinated, lots of people not wearing masks was called out a leading issue re: isolation ▪ Transportation was also cited as a leading problem re: isolation ○ Many don't get the services they need because they are too proud to ask for services, Need to break down stigma related to asking for help ○ There are major gaps in MH services (counseling/therapy and med management) ▪ Can't find services, don't know where to go ▪ Long wait times for services, can't get an appointment ▪ Not covered by insurance / costly ▪ Especially a problem for older adults and youth, due to need for specialized services ▪ Also a major problem for those who do not speak English

	○ Lack of family support and caregiver support leads to isolation and depression and neglect **Navigating the system / Coordinating Care** ○ It is difficult to know what services are available and where to go ○ Trouble scheduling appointments and managing referrals from primary care providers ○ Wait times and scheduling problems are really challenging. ▪ Often get to appointments early and then have to wait an hour. ▪ It can take all day to go to one doctor appointment ○ Transportation is a major problem particularly if you need to go a long distance ▪ Transportation options are not flexible or reliable and wont always take you where you need to go. Without a car, a strong support network, or funds to pay for a taxi it is extremely difficult ○ Phone lines and communication with doctors' office can be very difficult and confusing ▪ "Trying to talk to a live person is next to impossible" ○ Silo'd services – no sense of connection between physical, mental health, substance use, and other components of the system. Services are not well integrated ○ Providers do not share information across offices and therefore it can be difficult to follow-up on referrals and make sure that care is coordinated **Transportation** ○ Transportation is a major problem for many older adults, particularly if you don't have a car, a strong support network, or funds to pay for a taxi ○ Lack of drivers to drive vans that the COAs own ○ Transportation is very hard to manage due to wait times for appointments ○ Hard to schedule transportation with the RIDE and other vendors. Have to call or go on-line and the process is often not user-friendly, patient, or clear ○ Hard to be spontaneous. Need to schedule things way in advance. Need greater flexibility, especially for doctors appointments ○ Sometime transportation services have distance or other requirements. Can only go 5 miles for example or need a certain # of days in advance ○ "The RIDE" is horrible. Poorly organized. Long wait times

	○ Transportation can be very expensive ○ Need for convening a transportation coalition to address the issue in the region. • **Healthy lifestyles issues (education, workshops, food/ nutritous, exercise)** ○ Lack of understanding of what is healthy / nutritious and how to cook it ○ Need to refine outreach strategies and address issues of pride, people don't want to accept handouts ○ Lots of meals on wheels programs require that you are financially insecure or have chronic physical conditions. The programs leave a lot of people out ○ Reaching people who are homebound or not wanting to go to community settings is very difficult. Can't find them and when you do, it can be hard to get them the services they need. • **Lack of services and supports for those who are homebound and have opted to age in their community and perhaps are not able to travel to the center** ○ Lots of people live very isolated, lonely lives with limited family and community supports ○ Need home health and home visiting programs
Section 3: Ideas and Priorities	
Ideas: • Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time? • Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?	See above • Better education and messaging regarding mask wearing and vaccination • Intergenerational support programs, high-school students with older adults living on their own • Need to address stigma and develop outreach strategies for those who may be too proud except "handouts" • Communication and awareness sessions, workshops or resources to support people related to healthy lifestyles • Need to address transportation barriers • Evening meals for cost saving and socialization (Norwood Hospital used to host dinners) • Expand access to MH services (therapy, med. management, and group sessions) • Education and awareness programs related to mental health
Priorities: • What do you think should be the top 3 issues service providers should	• Mental health • Transportation • Care coordination • Healthy lifestyles education

focus on to make your community healthier?	
Section 4: Final Remarks & Closing	
Are there other factors that influence your health that we have not discussed tonight that you feel are important?	***NONE***

Community Listening Sessions

- Presentation from Facilitation Training for community partners
- Facilitation guide for listening sessions
- Listening Session presentation
- Priority vote results and notes from January 13, 2022 listening session
- Priority vote results and notes from January 18, 2022 listening session

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

AGENDA

- What is facilitation?
- Inclusive facilitation
- Creating inclusive space
- Characteristics of a good facilitator
- Let's practice!

WHAT IS FACILITATION?

Facilitation is a dance, an artform.

INCLUSIVE FACILITATION

inclusive means including everyone

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

Depending on the size of the group, ask participants to share their name, pronouns, and in one word describe how they're feeling today.

Dedicate time for personal reflection

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

Establish community 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

We shouldn't assume everyone feels comfortable enabling their video. Make this an option as opposed to a request.

Design for different learning and processing styles

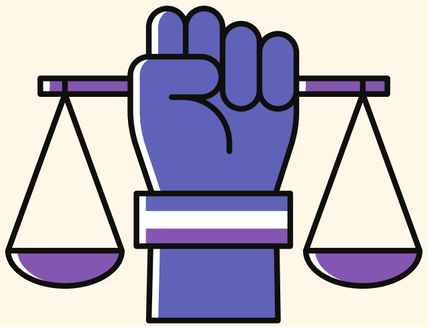
Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

Consider accessibility

Some folks may join through the dial in number, so consider walking through your agenda as if you were only on the phone. Consider language interpretation and closed captioning services.

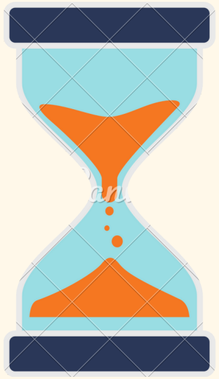
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

LET'S CONSIDER THE FOLLOWING

1

A participant seems to dominate the conversation.

2

A participant has a lot of experience in the topic but is too shy to share them in a group setting.

3

A participant is talking about something not related to the topic of discussion.

THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

Feel free to send in any questions to **corina_pinto@jsi.com.**

BILH Community Listening Session: Breakout Discussion Guide

Session name, date, time: [Filled in by notetaker]
Community Facilitator: [Filled in by notetaker]
Notetaker: [Filled in by notetaker]

Mentimeter link:
Jamboard link:

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 approximately 45 minutes. 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, your community, and one word to describe how you're feeling today. If you don't want to share, just say pass. I'll start. I'm ____ from ____ and today I'm feeling _____."
(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 for our discussion today?"

Question 1 (5 minutes)

Facilitator: What is your reaction to data and preliminary priorities we saw today?

- *Probe: Did anything from the presentation surprise you, or did this confirm what you already know?*
- *Probe: What stood out to you the most?*

Notes:

Question 2 (15 minutes)

Part 1: 10 minutes

Notetaker: *List preliminary priority areas from presentation in the Zoom chat.*

Facilitator: "We're going to move on to Question 2. Our notetaker has listed the preliminary priority areas from the presentation in our Zoom chat. Looking at this list – are there any priority areas that you think are missing?"

Notes on missing priority areas:

[After 5 minutes, the Meeting Host will pop into your Breakout Room to collect any additional priority areas.]

Part 2: 5 minutes

[Meeting host will send Broadcast message when it's time to move on to Part 2]

Facilitator: "We want to know what priority areas are most important to you. Right now, our notetaker is going to put a link into the Zoom chat. (Notetaker copies & pastes Mentimeter link: <<**https://www.menti.com/yqztahwt4c**>>. When you see that link, please click on it.

"Within this poll, we want you to choose the 4 priority areas that are most concerning to you. The order in which you choose is not important. We'll give you a few minutes to make your selections.

"If you're unable to access the poll, go ahead and put your top 4 priority areas into the chat, or you can say them out loud and we can cast your vote for you.

After a few minutes, the poll results will be screen shared to our group."

[Meeting Host will pop in to your room to ensure all votes have been cast. After confirmation, Meeting Host will broadcast poll results to all Breakout Groups]

Facilitator: "It looks like (A, B, C, D) are the top four priority areas for this session. Our Notetaker will type these into the Chat box so we can reference them during our next activity."

Question 3 (25 minutes)

Facilitator: "Next, we'd like to discuss how issues within these priority areas might be addressed. We know that no single entity can address all of these priorities, and that it usually takes many organizations and individuals working together. For each priority area we want to know about existing resources and assets – what's already working? – and gaps and barriers – what is most needed to be able to successfully address these issues."

Let's start with [Priority Area 1].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 2].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 3].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 4].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?"

Notetakers will be taking notes within Jamboard.

[Meeting Host will send a broadcast message when there are 2 minutes left in the Breakout Session]

Wrap Up (1 minute)

Facilitator: "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 about some of the things discussed in the groups today, and to talk about the next steps in the Needs Assessment process. Is there anything else people would like to share before we're moved out of the breakout room?"

Notes:

NEW ENGLAND BAPTIST HOSPITAL COMMUNITY LISTENING SESSION

January 13, 2022
January 18, 2022

Beth Israel Lahey Health

New England Baptist Hospital Community Listening Session

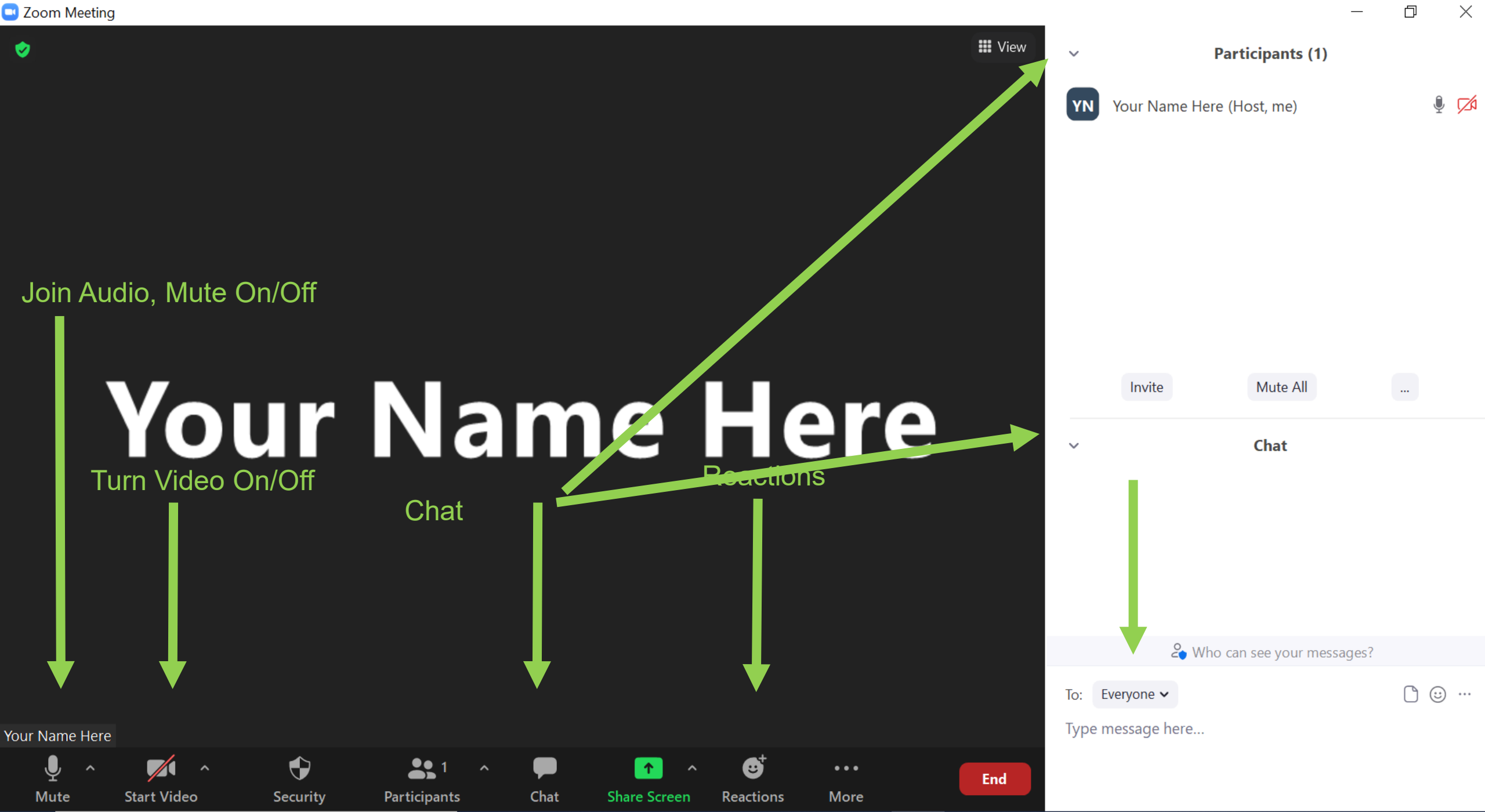
Beth Israel Lahey Health
New England Baptist Hospital

Beth Israel Lahey Health

NEBH Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
12:00-12:10	Opening Remarks	JSI
12:10-12:20	Overview of assessment purpose, process, and guiding principles	Christine Dwyer, Director of Community and Government Affairs, NEBH
12:20-12:35	Presentation of preliminary themes and data findings	JSI
12:35-1:20	Breakout Groups	Community Facilitators
1:20-1:25	Sharing back	JSI
1:25-1:30	Wrap up: Closing statements and next steps	Christine Dwyer


Zoom Meeting
View
Participants (1)
YN
Your Name Here (Host, me)
Invite
Mute All
...
Chat
Join Audio, Mute On/Off
Your Name Here
Turn Video On/Off
Chat
Reactions
Who can see your messages?
To:
Everyone
Type message here...
Your Name Here
Mute
Start Video
Security
Participants
1
Chat
Share Screen
Reactions
More
End

Assessment Purpose and Process

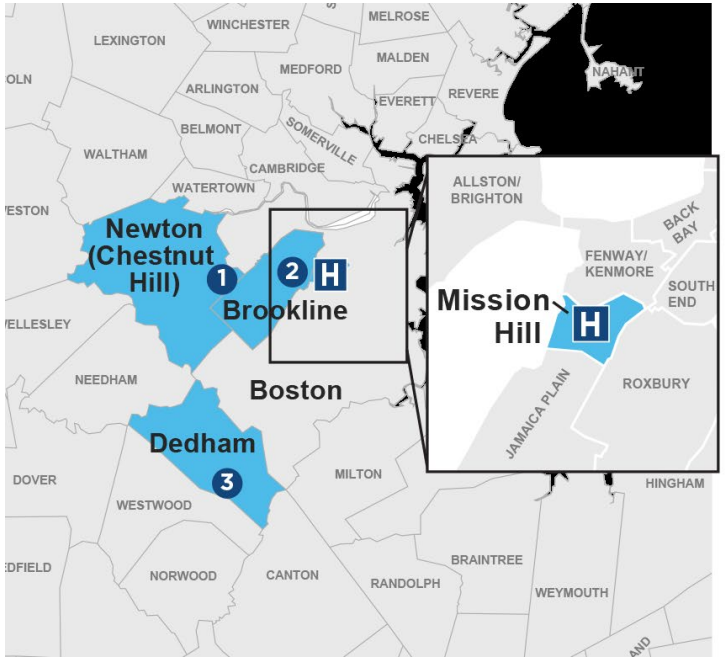
Assessment Purpose and Process

Purpose

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

- A **Community Health Needs Assessment** 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 Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) 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

Assessment Purpose and Process

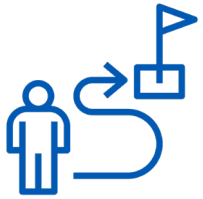
FY22 CHNA and Implementation Strategy Guiding Principles

Equity: Work toward the systemic, fair and just treatment of all people; engage cohorts most impacted by COVID-19

Collaboration: Leverage resources to achieve greater impact by working with community residents and organizations

Engagement: Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, communities most impacted by inequities, and others

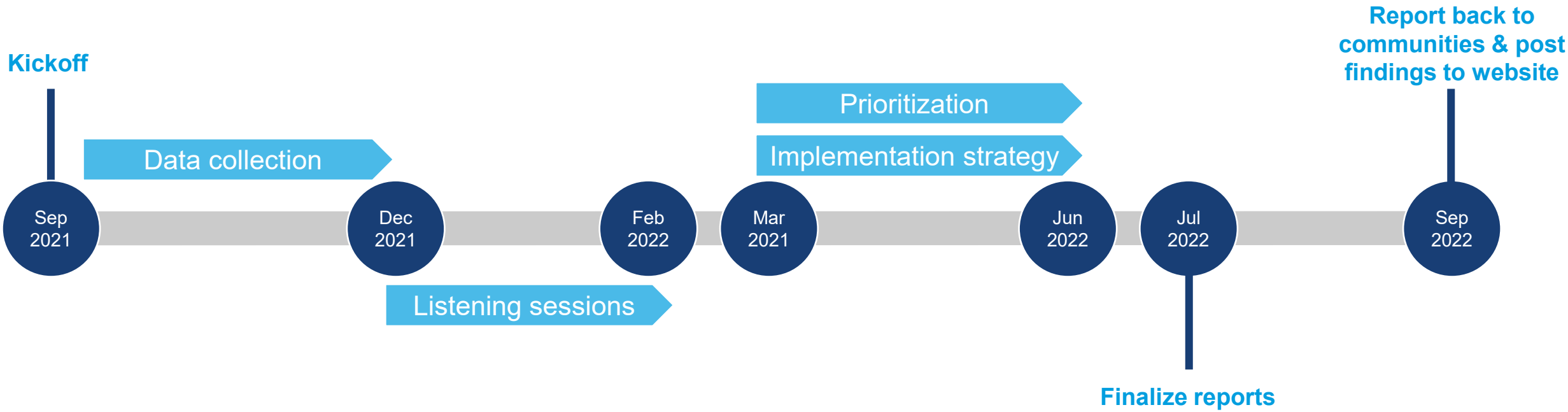
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



Intentionality: Be deliberate in our engagement and our request and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit

Assessment Purpose and Process

FY22 CHNA and Implementation Strategy Process

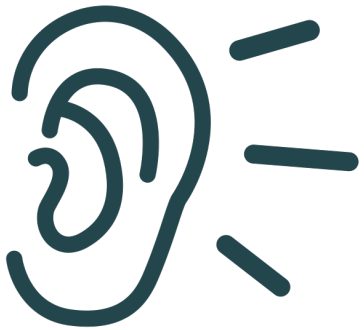


Assessment Purpose and Process

Meeting goals

Goals:

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

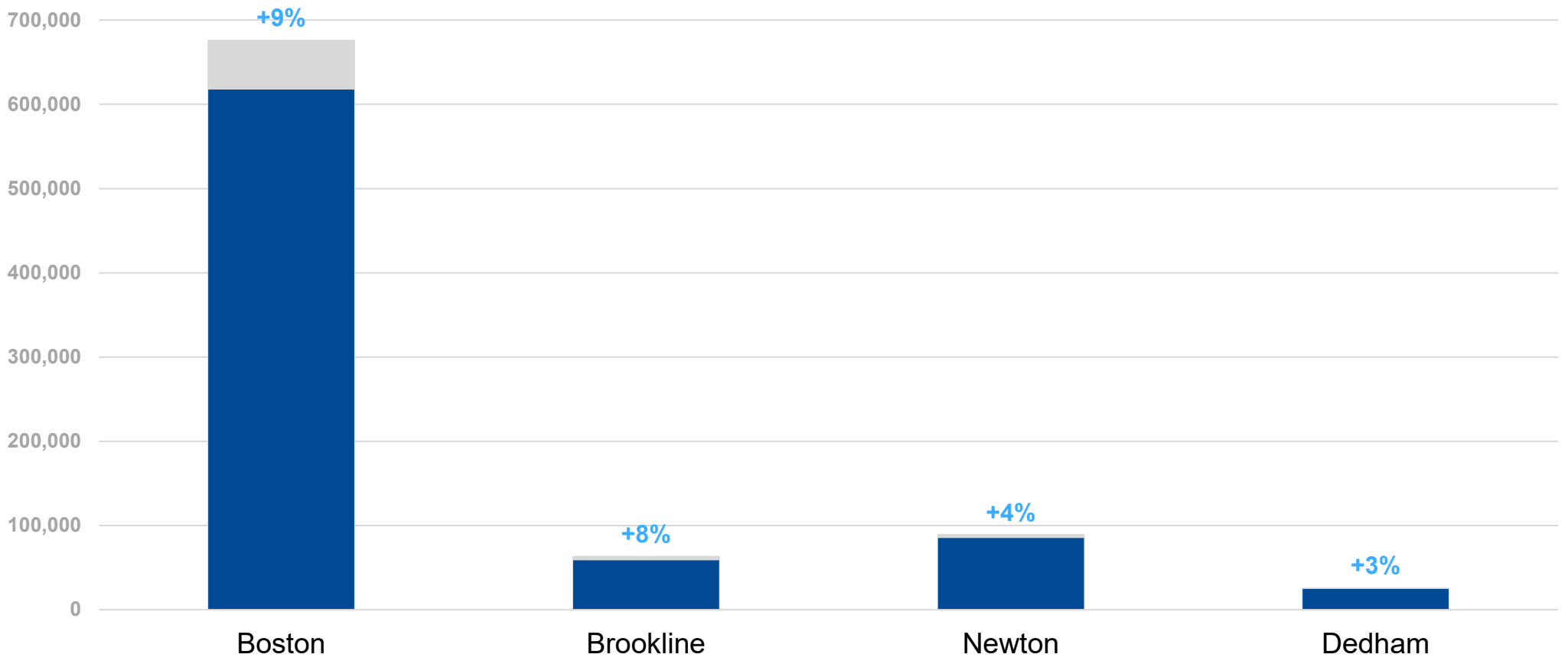


We want to hear from you.
Please speak up, raise your hand, or use the chat when we get to Breakout Sessions

Preliminary Themes & Data Findings

CHNA Progress

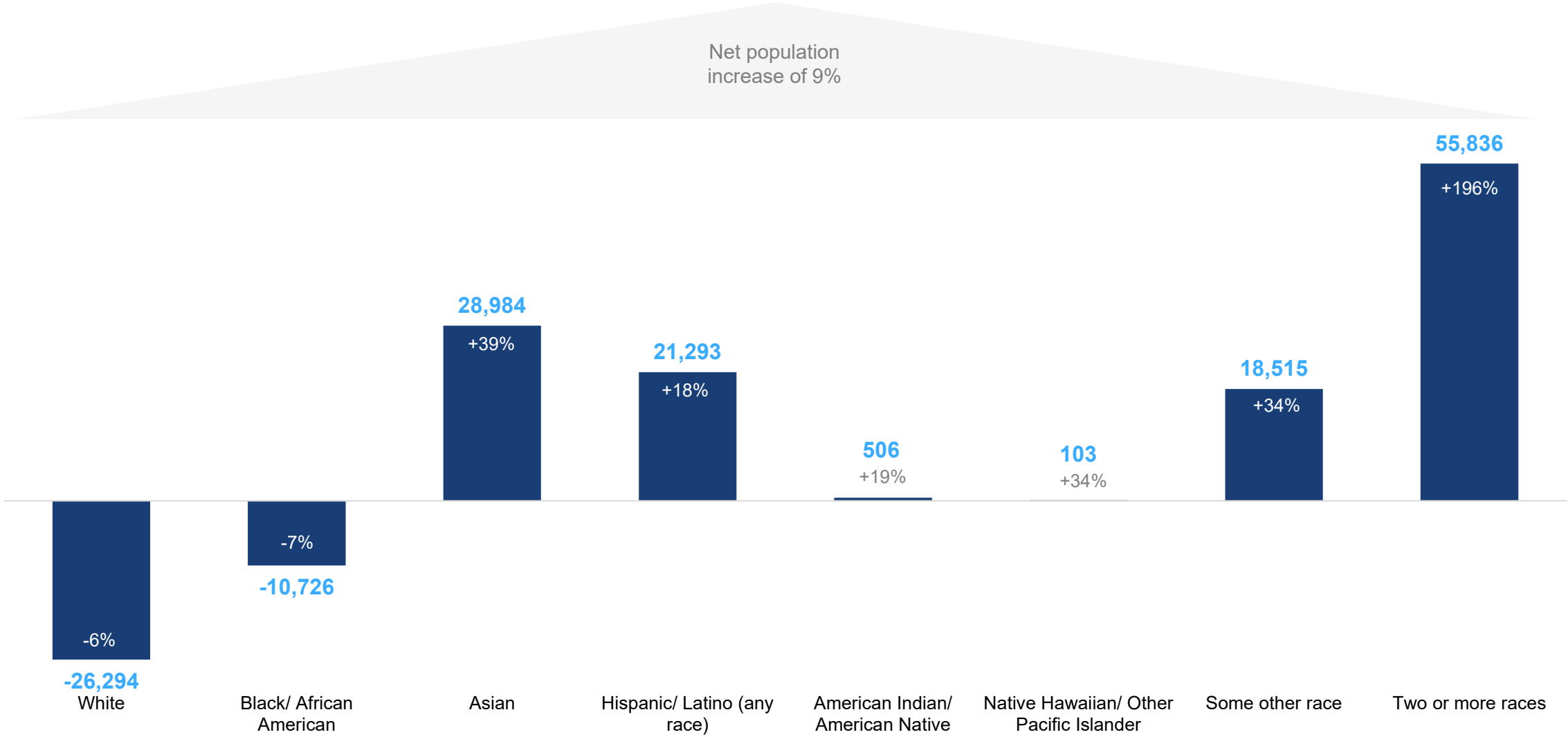
Population Change in Community Benefits Service Area 2010-2020



Total population increase of 9% (66,858)

CHNA Progress

Race/Ethnicity Population Change in Community Benefits Service Area, 2010-2020



CHNA Progress
Service Area Strengths

- Sense of unity among older adult population
- Strong network of community organizations
- Diverse, in terms of age, race/ethnicities, household composition
- Strong history of community activism

CHNA Progress
Preliminary key themes

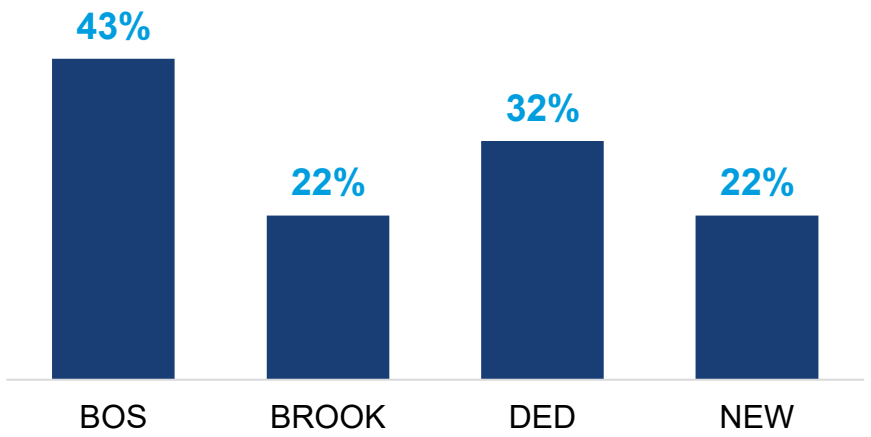
- Social determinants of health
- Mental health
- Access to care
- Chronic/complex conditions

CHNA Progress
Preliminary Themes: Social Determinants of Health

Primary concerns:

- Lack of affordable housing
- Economic insecurity/job loss due to COVID/high cost of living
- Food insecurity

Percentage* worried about paying for one or more type of expense/bills in the coming weeks (Fall 2020)



Housing issues discussed in Mission Hill:

- Gentrification
- Over-development
- Student rental market has driven out affordable housing
- Homelessness
- Difficulty keeping older adults in their homes
- Lack of organizations providing rental assistance

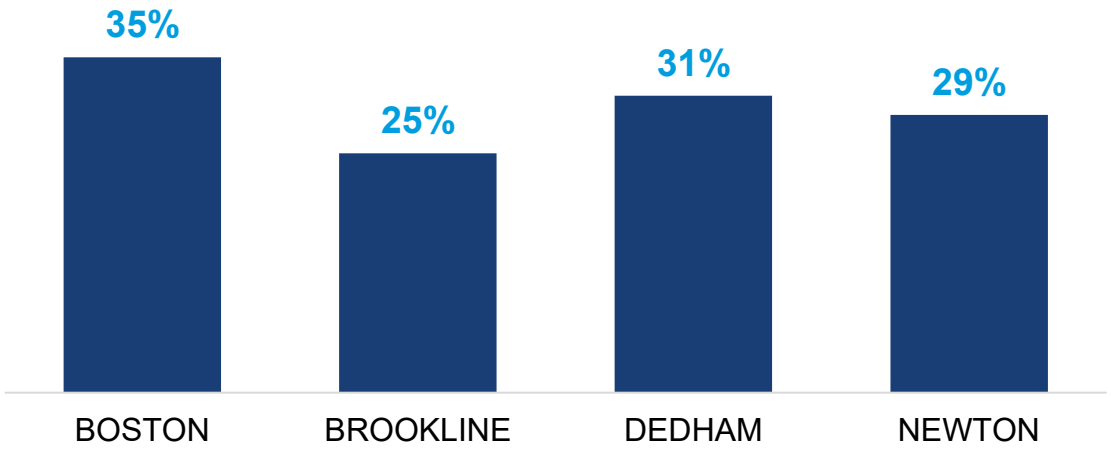
Beth Israel Lahey Health

Data source: COVID-19 Community Impact Survey, MDPH
**Unweighted percentages displayed*

CHNA Progress
Preliminary Themes: Mental Health

- Depression, anxiety, and stress among all segments of the population
- Isolation and depression are critical concerns for older adults, especially those who are homebound
- Suicide ideation among youth
- Mental health impacts and trauma for those impacted by violence

Percentage* with 15 or more poor mental health days in the past month (Fall 2020)



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

"We do not have a system that addresses the mental health needs of older adults."

-Focus group participant

CHNA Progress
Preliminary Themes: Access to Care

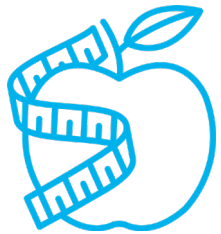
- Difficulty navigating complexities of healthcare system (including health insurance) – even more difficult for non-English speakers, homebound elders, and individuals with no family or caregivers
- Difficult to secure transportation to and from medical appointments
- Significant support for programs that bring health services and information to community spaces (e.g., screenings, lectures, etc.)

CHNA Progress

Preliminary Themes: Chronic/complex conditions and risk factors

- Respiratory illnesses, especially asthma
- Cancer
- Diabetes
- Mobility issues for older adults
- Cognitive decline/memory issues

CONCERNING RISK FACTORS



Lack of access to affordable healthy foods, namely fresh fruits and vegetables

Need more affordable physical activity programs. Hilly neighborhood and poor sidewalks/crosswalks make walking difficult

Poor air quality due to traffic pollution, overcrowding, poor ventilation in public housing

Breakout Sessions

Reconvene

Wrap-up
New England Baptist Hospital Community Benefits

Christine Dwyer
Director of Community and Government Affairs
617-754-5403
cdwyer1@nebh.org

Community Benefits Information on website:
https://www.nebh.org/who-we-are/giving-back/

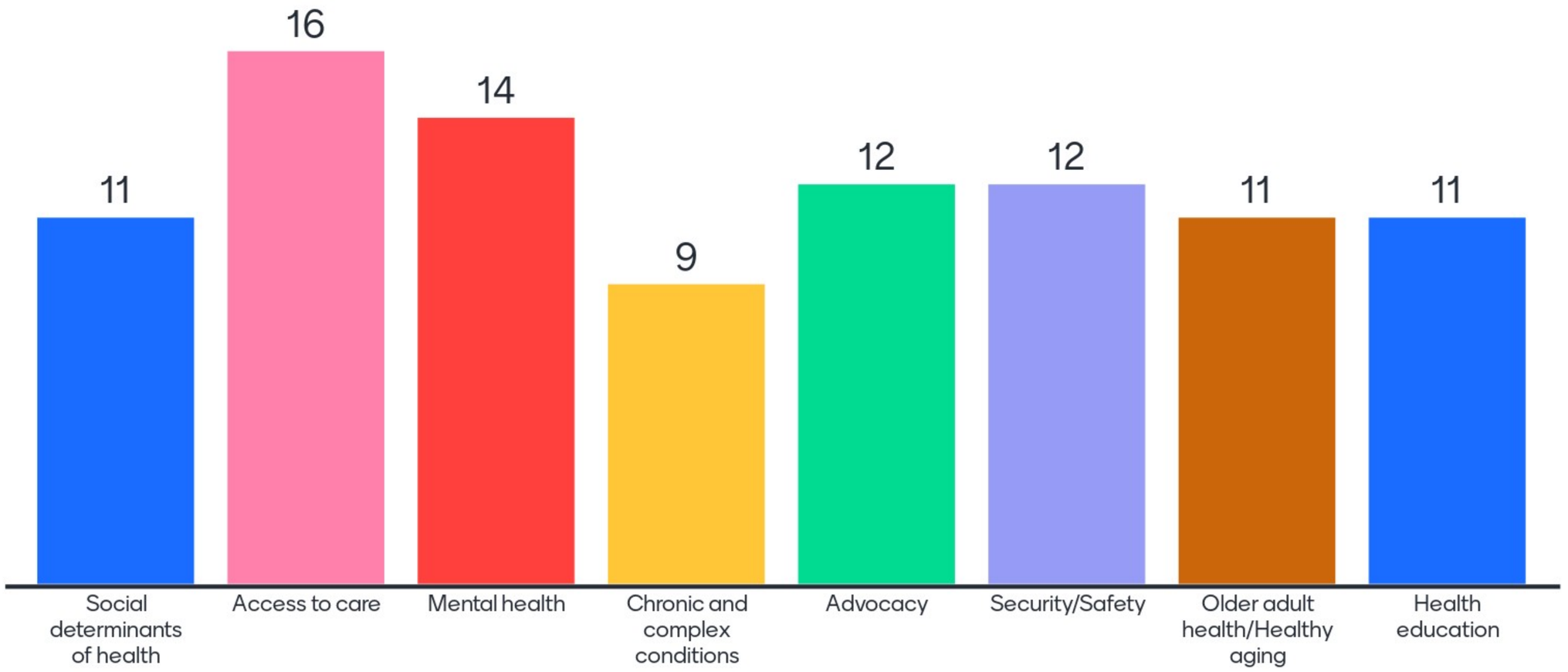
Community Benefits Annual Meeting in June (More info TBD)

Thank you!

Choose your top 4 priority areas.

Mentimeter

Results from January 13, 2022 session



24

Priority Area 1: Access to Care

Resources/Assets

Community Partners; linkages between social workers, primary care providers

Educating people on options available

library and community settings

New England Baptist have done a lot, not sure what more they can do

telehealth and technology (but keep in-person visits)

Gaps/Barriers

Lacking awareness on what services people are eligible for

To get PT from Baptist, have to travel to outpatient, rather than being available in hospital

Inefficiencies by insurance companies; MassHealth - members don't know what they qualify for

we need more hospital shuttle buses

medical trucks, mobile medical vans, outreach workers in central locations

mobility, transportation

Access to care amongst seniors and young disabled folks

doctors aren't seeing you, waiting lists, available times (wknd, evening hours needed)

Priority Area 2: Mental Health

Resources/Assets

- Mass Mental (what's left of it, just a doorway with a sign)
- mutual aid systems that could promote community resources and connections

Gaps/Barriers

- social-emotional needs of students in schools
- Making referrals for young residents/youth
- Frustration with youth referral system having to be through school - not every child is on an IP in school.
- costs
- lack of activities to bring people together
- stigma
- Huge, Long Waitlists for accessing Mental Health Services
- Getting referrals

Priority Area 3: Advocacy

Resources/Assets

Mission department of advocacy

people changing systemic issues

Collaborating with other agencies - local, regional, city-wide

Gaps/Barriers

Language Barriers - hard to find multilingual service coordinators

Lack of platforms for disabled people

Lack of advocacy for effective medicare for seniors (right now it's horrible)

Solitary seniors need advocates to ensure adequate services

Priority Area 4: Security/Safety

Resources/Assets

- Street workers programming
- strong relationships with the Boston Police
- 24 hours security, 7 days a week

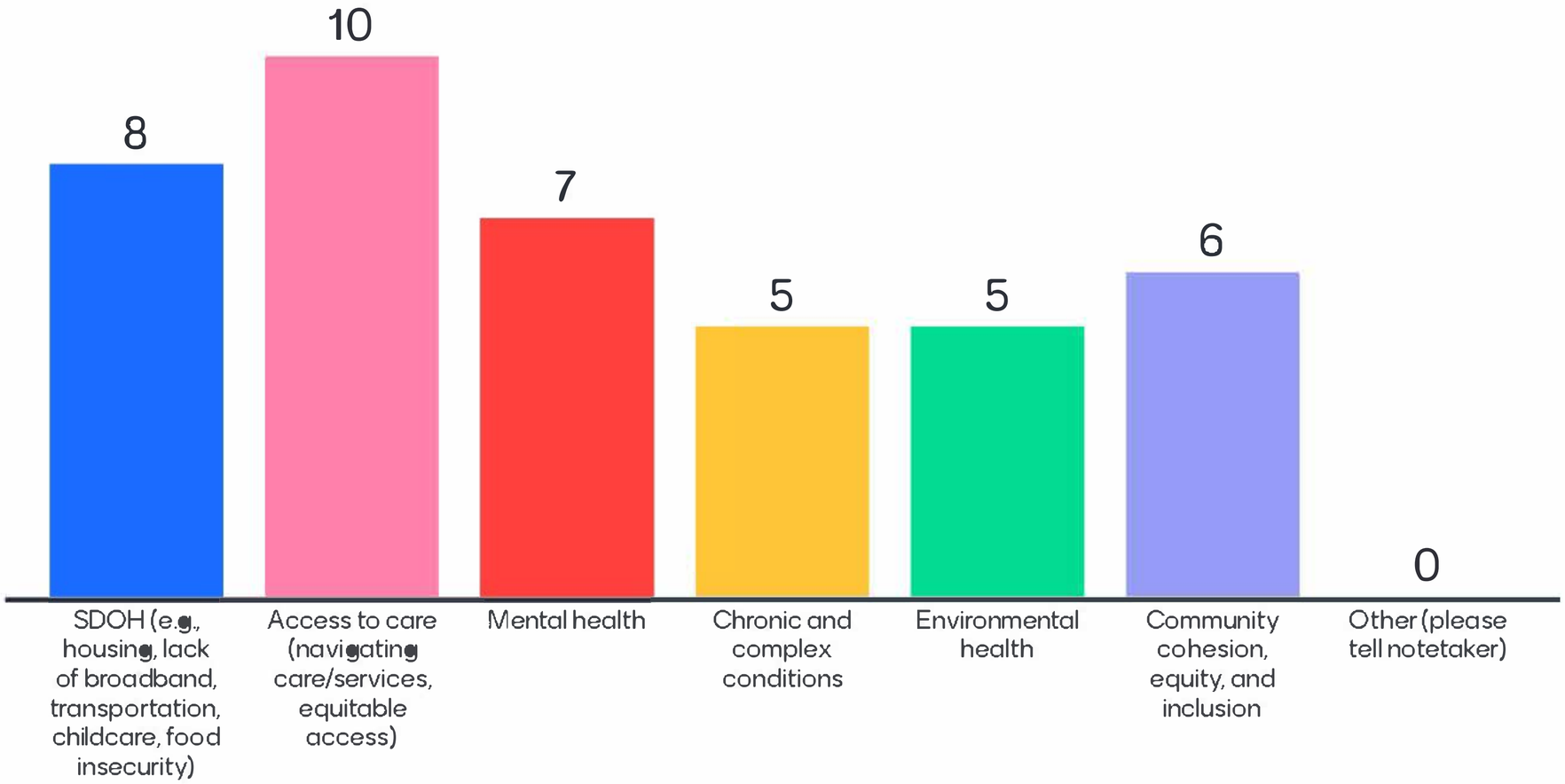
Gaps/Barriers

- more cameras in the community
- a lot of people are on the streets
- infrastructure - sidewalks, areas needing repair
- not enough activities for youth
- increase in drug use in the community that makes it feel unsafe

Choose your top 4 priority areas.

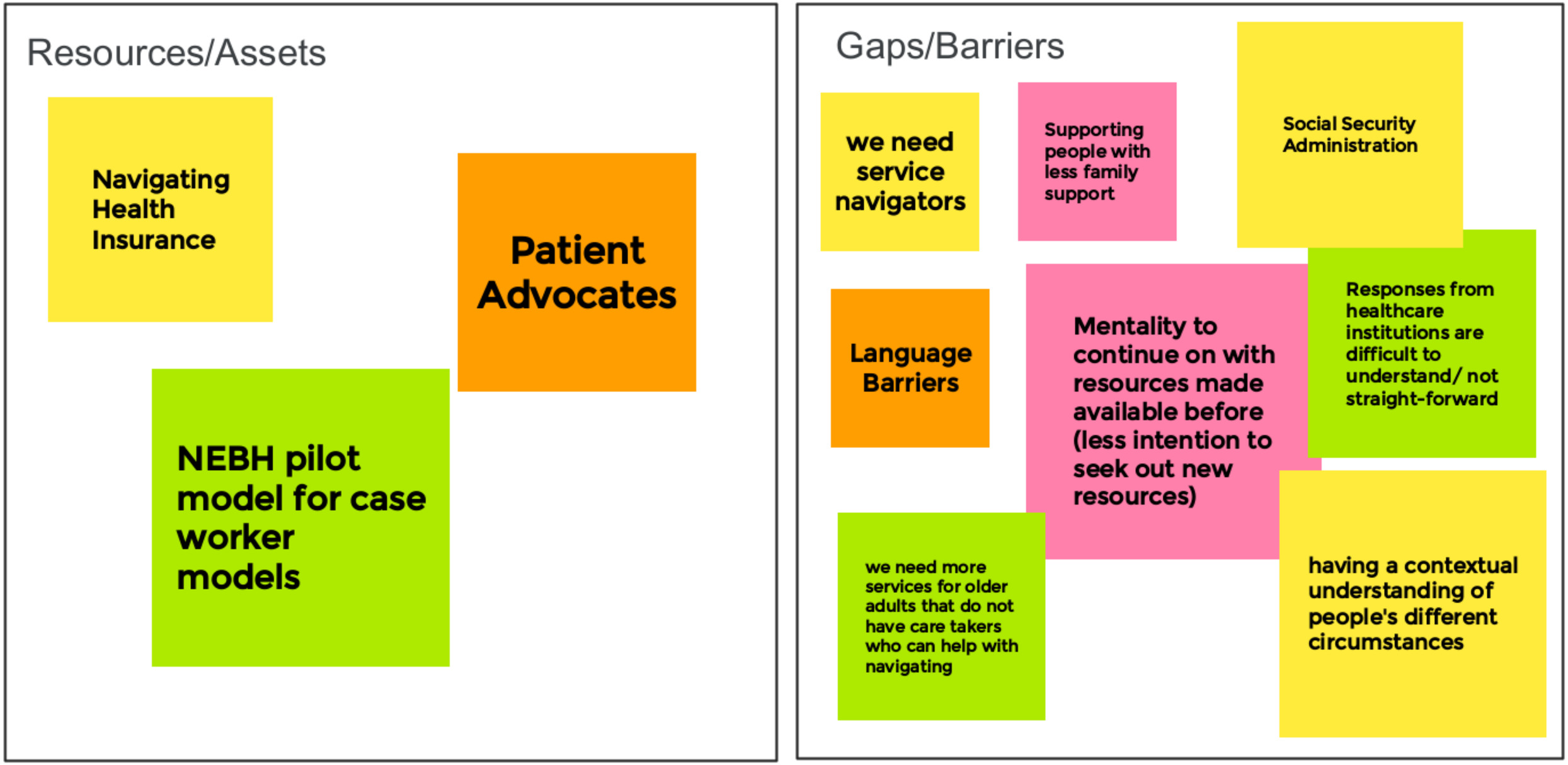
Mentimeter

Results from January 18, 2022 session



Notes from January 18, 2022 session

Priority Area 1: Access to Care



Priority Area 2: SDOH

Resources/Assets

- Strong inter-personal relationships within the community
- our neighborhood supports affordable housing advocacy
- Mobile Van operations by Health Centers
- Mission Hill Link Bus is major resource - but need for community specific transportation and continued funding

Gaps/Barriers

- we do not have a strong condo market
- Linkage dollars need to go back into Mission Hill specific projects
- Homelessness is a huge issue impacting the neighborhood
- Transportation as it relates to SDOH
- Expressing levels of care for the community
- Funding through Baptist for the Link is limited
- Isolation in COVID times

Priority Area 3: Mental Health

Resources/Assets

we were able to reach out to our residents with the support from NEBH

Gaps/Barriers

figuring out ways to make people aware that they are part of the community

Tech literacy amongst elders - barrier to accessing community in covid times

Isolation in COVID times

Priority Area 4: Community cohesion, equity, inclusion

Resources/Assets

Promoting community network groups / support groups & conversations

Gaps/Barriers

Gentrification by affluent student population

Neighborliness - need for programming to promote this

Lack of active prevention towards gentrification

Appendix B:
Data Book

Secondary Data

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Demographics										
Population										US Census Bureau, American Community Survey 2016-2020
Total Population	6,873,003	1,605,899	703,740	801,162	689,326	59,223	25,330	15,210	88,322	
Male	48.5%	49.0%	48.1%	48.20%	48.0%	46.8%	46.6%	52.4%	47.0%	
Female	51.5%	51.0%	51.9%	51.80%	52.0%	53.2%	53.4%	47.6%	53.0%	
Age Distribution										US Census Bureau, American Community Survey 2016-2020
Under 5 years (%)	5.2%	5.3%	5.3%	5.2%	4.9%	4.8%	6.7%	2.5%	4.3%	
5 to 9 years	5.3%	5.4%	5.5%	4.3%	4.1%	5.5%	3.8%	4.2%	5.9%	
10 to 14 years	5.7%	5.6%	6.2%	4.4%	4.2%	6.0%	5.4%	2.3%	6.6%	
15 to 19 years	6.6%	6.3%	6.4%	6.9%	7.1%	5.2%	3.8%	10.4%	10.0%	
20 to 24 years	7.1%	7.0%	6.2%	9.6%	10.2%	10.2%	7.0%	30.2%	7.2%	
25 to 34 years	14.3%	15.5%	12.9%	23.3%	24.4%	18.7%	13.6%	21.7%	9.1%	
35 to 44 years	12.2%	13.2%	12.6%	12.9%	12.5%	12.6%	11.1%	6.3%	11.9%	
45 to 54 years	13.3%	13.4%	14.1%	11.0%	10.6%	11.7%	15.9%	7.9%	14.1%	
55 to 59 years	7.1%	7.0%	7.4%	5.5%	5.4%	4.7%	6.2%	3.8%	6.3%	
60 to 64 years	6.5%	6.0%	6.5%	4.9%	4.7%	4.8%	7.2%	3.8%	6.3%	
65 to 74 years	9.5%	8.7%	9.4%	6.9%	6.8%	8.9%	8.9%	4.1%	10.2%	
75 to 84 years	4.6%	4.4%	4.8%	3.3%	3.3%	5.1%	5.8%	1.9%	5.1%	
85 years and over	2.4%	2.3%	2.6%	1.8%	1.7%	2.0%	4.6%	0.9%	2.9%	
Under 18 years of age	19.8%	19.8%	20.9%	16.6%	15.8%	19.0%	18.5%	11.2%	21.3%	
Over 65 years of age	16.5%	15.3%	16.8%	12.0%	11.8%	16.0%	19.4%	6.9%	18.3%	
Race/Ethnicity										US Census Bureau, American Community Survey 2016-2020
White alone (%)	76.6%	75.2%	76.1%	53.8%	52.1%	70.8%	84.6%	45.2%	76.0%	
Black or African American alone (%)	7.5%	5.3%	7.2%	21.5%	24.2%	3.1%	7.6%	23.5%	3.0%	
Asian alone (%)	6.8%	12.4%	11.3%	8.9%	0.3%	17.4%	2.9%	15.2%	15.2%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.1%	0.0%	0.0%	9.8%	0.0%	0.1%	0.0%	0.0%	

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.3%	0.1%	0.2%	0.1%	0.7%	0.1%	
Some Other Race alone (%)	4.2%	2.9%	1.7%	6.6%	6.3%	1.0%	1.5%	12.5%	1.8%	
Two or More Races (%)	4.8%	4.0%	3.5%	8.8%	7.2%	7.5%	3.2%	2.9%	4.0%	
Hispanic or Latino of Any Race (%)	12.0%	8.1%	4.7%	22.9%	19.5%	6.7%	9.3%	24.2%	4.5%	
Race/Ethnicity of Students in Public Schools										School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021
African American (%)	9.3				29.3	6.2	29.3		4.6	
Asian (%)	7.2				9.1	20.0	9.1		20.0	
Hispanic (%)	22.3				42.4	10.8	42.4		8.2	
White (%)	56.7				15.3	52.2	15.3		59.3	
Native American (%)	0.2				0.3	-	0.3		0.1	
Native Hawaiian, Pacific Islander (%)	0.1				0.2	0.1	0.2		0.1	
Multi-Race, Non-Hispanic (%)	4.10				3.4	10.8	3.4		7.7	
Foreign-born	17.0%	21.3%	18.5%	29.7%	28.2%		12.2%	22.0%	21.3%	US Census Bureau, American Community Survey 2016-2020
Naturalized U.S. Citizen	54.2%	50.2%	60.6%	48.2%	50.0%	47.9%	65.9%	38.8%	64.3%	
Not a U.S. Citizen	45.8%	49.8%	39.4%	51.8%	50.0%	52.1%	34.1%	61.2%	35.7%	
Region of birth: Europe	20.0%	18.8%	23.0%	11.7%	11.8%	30.4%	42.6%	7.9%	31.3%	
Region of birth: Asia	31.1%	43.8%	47.0%	23.4%	27.1%	54.9%	21.9%	48.2%	49.4%	
Region of birth: Africa	9.3%	7.2%	7.3%	10.3%	10.8%	3.4%	7.1%	9.4%	5.3%	
Region of birth: Oceania	0.3%	0.5%	0.3%	0.3%	0.3%	0.2%	0.4%	0.0%	0.6%	
Region of birth: Latin America	36.7%	26.9%	20.1%	53.1%	48.5%	8.4%	26.8%	33.0%	10.6%	
Region of birth: Northern America	2.5%	2.8%	2.3%	1.3%	1.5%	2.8%	1.2%	1.5%	2.9%	
Language										US Census Bureau, American Community Survey 2016-2020
English only	76.1%	73.4%	77.8%	60.5%	62.9%	67.0%	82.8%	56.2%	74.5%	
Language other than English	23.9%	26.6%	22.2%	39.5%	37.1%	33.0%	17.2%	43.8%	25.5%	
Speak English less than "very well"	9.2%	9.0%	8.2%	18.6%	16.9%	9.2%	4.5%	13.1%	6.3%	
Spanish	9.1%	5.8%	3.1%	19.3%	16.3%	4.7%	5.7%	22.2%	3.3%	
Speak English less than "very well"	3.8%	2.1%	0.6%	9.6%	7.7%	0.5%	0.9%	8.7%	0.6%	
Other Indo-European languages	9.0%	11.7%	9.1%	11.0%	11.1%	13.3%	7.4%	9.7%	10.4%	

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Speak English less than "very well"	3.0%	3.6%	2.8%	4.5%	4.4%	2.5%	2.1%	0.9%	2.5%	
Asian and Pacific Islander languages	4.4%	7.4%	8.3%	6.7%	7.5%	11.5%	2.5%	9.8%	10.0%	
Speak English less than "very well"	2.0%	2.9%	4.3%	3.7%	4.1%	5.2%	0.5%	3.3%	3.1%	
Other languages	1.4%	1.7%	1.7%	2.4%	2.3%	3.4%	1.6%	2.1%	1.8%	
Speak English less than "very well"	0.4%	0.5%	0.5%	0.8%	0.7%	1.0%	1.0%	0.2%	0.1%	
Percent of public school student population that are English language learners (%)	10.5				29.2	9.4	5.4		5.4	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Employment										US Census Bureau, American Community Survey 2016-2020
Unemployment rate	5.1%	4.2%	4.5%	6.8%	6.9%	3.1%	3.7%	13.1%	3.3%	
Unemployment rate by race/ethnicity										
White alone	4.5%	3.9%	4.1%	5.3%	5.3%	2.9%	2.7%	12.5%	3.3%	
Black or African American alone	8.3%	7.0%	8.2%	9.8%	9.9%	1.7%	11.7%	11.9%	10.0%	
American Indian and Alaska Native alone	10.7%	12.1%	0.0%	8.7%	8.1%	0.0%	0.0%	0.0%	0.0%	
Asian alone	4.2%	4.1%	3.4%	6.1%	6.2%	3.2%	6.4%	13.1%	2.9%	
Native Hawaiian and Other Pacific Islander alone	5.4%	14.6%	0.0%	1.9%	1.9%	-	0.0%	-	0.0%	
Some other race alone	8.3%	5.7%	5.8%	9.8%	10.9%	12.4%	12.1%	15.8%	0.1%	
Two or more races	9.1%	5.6%	7.7%	9.1%	8.3%	3.8%	0.0%	24.0%	1.2%	
Hispanic or Latino origin (of any race)	8.3%	6.0%	6.3%	8.7%	9.2%	4.5%	1.8%	14.9%	3.7%	
Unemployment rate by educational attainment										
Less than high school graduate	9.7%	7.8%	8.2%	10.7%	11.2%	7.2%	0.0%	17.2%	2.5%	
High school graduate (includes equivalency)	5.9%	5.1%	6.6%	8.5%	8.8%	6.4%	1.9%	15.7%	3.8%	
Some college or associate's degree	4.5%	4.0%	3.6%	7.2%	7.4%	3.0%	2.2%	9.7%	7.0%	
Bachelor's degree or higher	2.8%	2.7%	2.6%	3.4%	3.4%	2.8%	3.4%	7.1%	2.6%	
Income and Poverty										US Census Bureau, American Community Survey 2016-2020
Median household income (dollars)	84,385	106,202	105,320	74,881	76,298	113,642	101,780	46,843	154,398	
Population living below the federal poverty line in the last 12 months										
Individuals	9.8%	7.2%	6.0%	17.4%	18.0%	10.8%	4.8%	39.8%	4.3%	

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Families	6.6%	4.5%	4.0%	12.6%	12.8%	4.9%	2.7%	24.2%	2.6%	
Individuals under 18 years of age	12.2%	7.6%	5.4%	24.1%	25.0%	6.7%	5.3%	47.3%	3.0%	
Individuals over 65 years of age	8.9%	7.5%	7.2%	18.9%	19.8%	11.0%	5.7%	36.4%	4.8%	
Female head of household, no spouse present	20.5%	16.2%	14.4%	26.8%	27.1%	18.6%	13.7%	34.9%	10.5%	
White alone	7.9%	6.0%	5.1	12.5%	12.5%	9.3%	4.4%	37.8%	3.6%	
Black or African American alone	17.6%	14.6%	11.2	21.0%	21.2%	19.7%	12.4%	38.8%	6.7%	
American Indian and Alaska Native alone	23.3%	26.9%	7.4	24.1%	25.3%	10.8%	0.0%	21.2%	46.2%	
Asian alone	11.8%	9.4%	7.7	27.2%	27.9%	14.5%	2.9%	49.8%	7.2%	
Native Hawaiian and Other Pacific Islander alone	11.9%	14.6%	2.6	4.9%	4.9%	-	31.6%	-	0.0%	
Some other race alone	22.2%	14.7%	10.9	26.5%	29.7%	26.3%	0.0%	41.1%	6.9%	
Two or more races	15.5%	8.7%	7.7	20.8%	21.5%	10.9%	1.9%	28.6%	2.2%	
Hispanic or Latino origin (of any race)	23.0%	17.3%	11.5	24.0%	27.2%	12.7%	6.5%	34.4%	7.8%	
Less than high school graduate	23.2%	18.4%	15.8	29.6%	32.2%	21.1%	11.8%	52.2%	9.2%	
High school graduate (includes equivalency)	11.7%	10.6%	9.2	18.8%	20.2%	30.3%	8.3%	36.9%	11.7%	
Some college, associate's degree	8.4%	7.1%	6.6	14.0%	14.8%	18.1%	4.6%	22.5%	4.9%	
Bachelor's degree or higher	3.9%	3.5%	3.1	7.2%	7.3%	5.7%	2.9%	22.2%	3.1%	
With Social Security	30.2%	26.3%	29.5%	21.4%	20.2%	22.9%	30.9%	19.3%	29.4%	
With retirement income	19.3%	17.4%	19.7%	11.1%	10.6%	13.5%	20.3%	6.6%	18.7%	
With Supplemental Security Income	5.9%	4.0%	3.5%	7.6%	7.7%	2.3%	2.3%	12.8%	3.6%	
With cash public assistance income	2.8%	2.0%	1.9%	3.3%	3.3%	1.7%	2.8%	7.9%	1.8%	
With Food Stamp/SNAP benefits in the past 12 months	11.6%	6.7%	6.7%	16.6%	16.8%	6.3%	5.7%	24.8%	3.8%	
Public School Distric Students Who are Low Income (%)	36.6				63.0	10.8	29.8		10.4	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Housing										US Census Bureau, American Community Survey 2016-2020
Occupied housing units										
Owner-occupied	62.5%	62.1%	68.8%	36.3%	35.3%	48.5%	71.3%	7.0%	71.5%	
Renter-occupied	37.5%	37.9%	31.2%	63.7%	64.7%	51.5%	28.7%	93.0%	28.5%	

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Lacking complete plumbing facilities	0.3%	0.3%	0.2%	0.4%	0.3%	0.2%	0.5%	0.4%	0.3%	
Lacking complete kitchen facilities	0.8%	0.8%	0.7%	0.8%	0.8%	1.1%	1.7%	1.2%	0.6%	
No telephone service available	1.2%	1.0%	1.0%	1.7%	1.7%	1.1%	1.5%	1.2%	0.2%	
Monthly housing costs <35% of total household income										
Among owner-occupied housing units with a mortgage	22.0%	20.5%	21.2%	25.9%	24.8%	24.6%	21.4%	43.7%	24.3%	
Among owner-occupied units without a mortgage	15.2%	15.4%	16.4%	16.2%	15.5%	19.8%	23.0%	12.5%	15.1%	
Among occupied units paying rent	39.1%	35.1%	37.5%	40.2%	39.6%	33.9%	48.5%	46.2%	28.2%	
Eviction filings, 2018	34,200	5,400	2,000	6,500	315	79	79		111	Eviction Lab, 2018 Evictions
Access to Technology										US Census Bureau, American Community Survey 2016-2020
Among households										
Has smartphone	83.3%	85.9%	85.4%	79.7%	80.6%	92.4%	81.1%	82.9%	92.5%	
Has desktop or laptop	82.2%	87.6%	87.1%	86.1%	86.6%	90.5%	83.8%	75.9%	89.2%	
Has tablet or other portable wireless computer	64.8%	69.5%	70.3%	60.0%	60.3%	71.0%	69.7%	53.6%	75.0%	
No computer	7.4%	5.8%	5.4%	7.8%	7.5%	3.8%	6.6%	10.7%	4.3%	
With broadband internet	88.2%	91.3%	91.5%	86.7%	87.1%	93.6%	91.4%	82.7%	94.7%	
Transportation										US Census Bureau, American Community Survey 2016-2020
Mode of transportation to work for workers aged 16+										
Car, truck, or van -- drove alone	68.0%	64.1%	65.0%	39.60%	37.50%	30.70%	71.7%	24.3%	58.50%	
Car, truck, or van -- carpooled	7.3%	6.7%	6.3%	6.50%	5.70%	4.50%	6.5%	4.7%	6.70%	
Public transportation (excluding taxicab)	9.5%	11.4%	13.5%	30.00%	30.70%	26.80%	9.6%	35.4%	12.90%	
Walked	4.8%	4.9%	3.6%	13.20%	14.60%	16.20%	2.3%	26.7%	6.50%	
Other means	2.1%	2.7%	1.7%	3.80%	4.00%	7.00%	3.1%	3.0%	1.50%	
Worked from home	8.3%	10.2%	9.9%	6.90%	7.30%	14.80%	6.7%	5.8%	13.90%	
Mean travel time to work (minutes)	30	31.1	34.6	31.1	30.7	29.1	32.6	27.8	28.4	
Vehicles available among occupied housing units										
No vehicles available	12.2%	10.5%	9.3%	33.5%	30.0%	3.3%	7.1%	51.1%	6.1%	
1 vehicle available	35.1%	35.1%	33.5%	42.5%	46.0%	27.6%	36.3%	38.7%	33.1%	
2 vehicles available	36.1%	38.6%	40.5%	18.8%	20.3%	47.0%	42.1%	7.5%	47.2%	
3 or more vehicles available	16.5%	15.8%	16.7%	5.3%	3.7%	22.1%	14.5%	2.7%	13.6%	

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Education										US Census Bureau, American Community Survey 2016-2020
Educational attainment of adults 25 years and older										
Less than 9th grade (%)	4.2%	3.2%	2.6%	7.5%	6.8%	1.5%	1.7%	8.2%	1.6%	
9th to 12th grade, no diploma (%)	4.7%	3.2%	3.3%	5.6%	5.4%	1.3%	3.3%	10.2%	1.0%	
High school graduate (includes equivalency) (%)	23.5%	18.5%	18.7%	21.0%	18.9%	6.2%	20.1%	15.6%	7.8%	
Some college, no degree (%)	15.3%	12.2%	13.5%	13.3%	13.0%	5.5%	14.3%	19.8%	7.1%	
Associate's degree (%)	7.7%	5.9%	7.3%	4.8%	4.6%	2.0%	5.2%	3.6%	3.7%	
Bachelor's degree (%)	24.5%	28.1%	28.8%	26.3%	27.8%	29.0%	30.1%	26.5%	29.4%	
Graduate or professional degree (%)	20.0%	28.9%	25.8%	21.4%	23.5%	54.6%	25.3%	16.1%	49.3%	
High school graduate or higher (%)	91.1%	93.7%	94.1%	86.9%	87.9%	97.2%	94.9%	81.7%	97.3%	
Bachelor's degree or higher (%)	44.5%	57.1%	54.6%	47.7%	51.3%	83.6%	55.4%	42.7%	78.7%	
Educational attainment by race/ethnicity										
White alone										
High school graduate or higher	93.3%	95.3%	96.4%	96.1%	96.8%	99.3%	95.6%		98.0%	
Bachelor's degree or higher	46.3%	57.7%	55.9%	66.6%	72.3%	86.0%	56.5%		79.3%	
Black alone										
High school graduate or higher	86.2%	89.9%	88.9%	84.6%	84.4%	73.5%	94.9%		90.3%	
Bachelor's degree or higher	27.6%	36.1%	36.9%	23.5%	23.2%	38.8%	39.5%		65.9%	
American Indian or Alaska Native alone										
High school graduate or higher	81.0%	83.0%	81.3%	83.2%	53.9%	100.0%	82.1%		100.0%	
Bachelor's degree or higher	21.9%	18.5%	28.6%	28.8%	10.8%	0.0%	32.1%		7.3%	
Asian alone										
High school graduate or higher	85.7%	90.0%	83.3%	79.2%	79.4%	94.5%	98.5%		97.4%	
Bachelor's degree or higher	61.8%	70.4%	57.9%	53.5%	54.4%	83.7%	78.9%		82.7%	
Native Hawaiian and Other Pacific Islander alone										
High school graduate or higher	89.1%	95.3%	76.3%	83.9%	83.9%	-	68.4%		100.0%	
Bachelor's degree or higher	36.4%	25.5%	52.6%	50.9%	50.9%	-	68.4%		0.0%	
Some other race alone										
High school graduate or higher	69.9%	72.1%	83.7%	72.3%	72.9%	99.0%	74.9%		75.9%	

					Community Benefits Service Area					
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Mission Hill (ZCTA 02120)	Newton	Source
Bachelor's degree or higher	15.7%	20.2%	33.0%	19.8%	21.9%	80.9%	39.9%		39.4%	
Two or more races										
High school graduate or higher	81.3%	89.7%	91.6%	67.6%	73.9%	94.7%	85.2%		95.1%	
Bachelor's degree or higher	34.9%	52.7%	61.1%	29.7%	37.8%	82.5%	39.9%		74.3%	
Hispanic or Latino Origin										
High school graduate or higher	72.4%	77.8%	91.3%	70.2%	71.9%	96.0%	89.5%		87.6%	
Bachelor's degree or higher	20.9%	32.1%	46.8%	22.4%	25.7%	81.5%	45.7%		59.5%	
4-Year Graduation Rate Among Public High School Students (%)	89.0				75.40	94.50	91.5		96.00	Massachusetts Department of Elementary and Secondary Education, 2020
Safety/Crime										Massachusetts Crime Statistics, 2021
Property Crimes Offenses (#)										
Burglary	9,592.0				1300	61	15		74	
Larceny-theft	55,672.0				9312	479	270		416	
Motor vehicle theft	7,045.0				1163	29	18		21	
Arson	312.0				26	0	0		0	
Crimes Against Persons Offenses (#)										
Murder/non-negligent manslaughter	151				38	0	0		0	
Sex offenses	4,171				385	4	0		13	
Assaults	67,690				14,137	136	67		165	
Access to Care										
Ratio of population to primary care physicians	960 to 1	780 to 1	780 to 1	650 to 1						County Health Rankings, 2019
Ratio of population to mental health providers	140 to 1	160 to 1	150 to 1	110 to 1						County Health Rankings, 2021
Ratio of population to dentists	930 to 1	980 to 1	800 to 1	450 to 1						County Health Rankings, 2020
Health insurance coverage among civilian noninstitutionalized population (%)										American Community Survey (U.S. Census Bureau), 2016-2020
With health insurance coverage	97.3%	97.4%	98.2%	96.2%	96.5%	98.3%	98.1%	95.0%	98.6%	
With private health insurance	74.5%	81.0%	82.9%	66.5%	68.3%	87.1%	86.3%	68.3%	88.5%	
With public coverage	36.1%	28.5%	28.4%	37.9%	36.0%	20.5%	30.0%	33.7%	23.4%	
No health insurance coverage	2.7%	2.6%	1.8%	3.8%	3.5%	1.7%	1.9%	5.0%	1.4%	

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

					Community Benefits Service Area				
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton	Source
Overall Health									
Mortality rate (age-adjusted per 100,000)	654	574.2	623.3	600.4	602.1	418.5	596.8	428.6	Massachusetts Death Report, 2019
Premature mortality rate (per 100,000)	272.8	210.4	242.2	262.8	263.9	136.6	246.5	122.5	
Leading causes of death (counts)									
Cancer	12,584	2,613	1314	962	770	74	67	128	
Heart Disease	11,779	2,426	1247	909	723	67	44	147	
Chronic Lower Respiratory Disease	2,842	474	243	192	140	9	12	10	
Stroke	2,463	454	244	195	169	14	17	21	
Disability									US Census Bureau, American Community Survey 2016-2020
Percent of population with a disability	11.7%	9.5%	9.5%	11.9%	11.8%	7.0%	10.8%	8.2%	
Under 18	4.7%	3.8%	3.2%	5.7%	5.7%	1.2%	4.6%	3.5%	
18-64	8.9%	6.6%	6.8%	8.8%	8.8%	4.0%	7.4%	4.9%	
65+	31.3%	29.3%	27.8%	39.5%	39.3%	26.3%	28.7%	25.0%	
Healthy Living									
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	26	22	26	29					Behavioral Risk Factor Surveillance System, 2019
Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%)	22.2								Behavioral Risk Factor Surveillance System, 2019
Population with adequate access to locations for physical activity (%)	89	95	88	100					County Health Rankings, 2021
Adults who consumed fruit less than one time per day (%)	32.7								Behavioral Risk Factor Surveillance System, 2019
Adults who consumed vegetables less than one time per day (%)	15.5								Behavioral Risk Factor Surveillance System, 2019
Population with limited access to healthy foods (%)	4	3	4	0					USDA Food Environment Atlas, 2019
Total Population that Did Not Have Access to a Reliable Source of Food During Past Year (food insecurity rate) (%)	8.2								Feeding America, Map the Meal Gap, 2019
Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted) (%)	34	33	35	38					Behavioral Risk Factor Surveillance System, 2018
Mental Health									
Average number of mentally unhealthy days in past 30 days (adults)	4.2	4	4.1	4.4					County Health Rankings, 2019
Youth Risk Behavior Survey (YRBS)									Youth Risk Behavior Survey - Report years indicated
	2019				**2019**	**2017**	**2018**	**2018**	
% of students (grades 6-8) bullied on school property (%)	35.3				40.0 (ever)	--	--	15.4	
% of students (grades 6-8) bullied electronically (%)	15.2				20.5 (ever)	13.0	--	11.1	
% of students (grades 9-12) bullied on school property (%)	16.3				11.2	13.0	--	8.3	
% of students (grades 9-12) bullied electronically (%)	13.9				9.1	7.0	20.5 (ever)	8.3	
% of students (grades 6-8) reporting self harm (%)	21				--	14.0 (ever)	11.2	5.7	
% of students (grades 9-12) reporting self harm (%)	16.4				15.0	--	10.6	11.6	
% of students (grades 6-8) reporting suicide ideation (%)	11.3				22.8 (ever)	14.0	13.1	8.2	
% of students (grades 9-12) reporting suicide ideation (%)	17.5				15.6	4.0	13.2	10.4	
% of students (grades 6-8) reporting suicide attempt (%)	5				11.2 (ever)	4.0	2.3	1.1	
% of students (grades 9-12) reporting suicide attempt (%)	7.3				9.3	<1	3.7	3.0	
Admissions to DPH-funded treatment programs (count)	98944				14780	0-100	234	227	MA DPH, Bureau of Substance Abuse Services, 2017

					Community Benefits Service Area				
	Massachusetts	**Middlesex County**	**Norfolk County**	**Suffolk County**	**Boston**	**Brookline**	**Dedham**	**Newton**	Source
Rate of injection drug user admissions to DPH-funded treatment program (%)	52.4				52.9	68.2	48.1	56.8	MA DPH, Bureau of Substance Abuse Services, 2017
Primary substance of use when entering treatment									MA DPH, Bureau of Substance Abuse Services, 2017
Alcohol (%)	32.8				29.9	47.7	32.2	44.5	
Crack/Cocaine (%)	4.1				4.5	-	3	2.6	
Heroin (%)	52.8				56.9	31.8	54.5	41	
Marijuana (%)	3.5				3	10.2	3	4.8	
Other Opioids (%)	4.6				2.4	-	5.6	4.4	
Other Sedatives/Hypnotics (%)	1.5				2.1	-	-	-	
Other Stimulants (%)	0.5				1	-	-	-	
Other (%)	0.3				0.3	-	-	-	
Adults who are current smokers (age-adjusted) (%)	12	12	12	13					Behavioral Risk Factor Surveillance System, 2019
Adults who report excessive drinking (binge or heavy drinking) (%)	22	23	26	22					Behavioral Risk Factor Surveillance System, 2019
Youth Risk Behavior Survey (YRBS)									Youth Risk Behavior Survey - Report years indicated
	2019				**2019**	**2017**	**2013**	**2018**	
Students (grades 6-8) reporting lifetime alcohol use (%)	13.6				21.0	11.0	16.0	7.9	
Students (grades 6-8) reporting current alcohol use (%)	4.4				5.4	4.0	6.0	1.7	
Students (grades 9-12) reporting lifetime alcohol use (%)	--				--	36.0	66.0	56.5	
Students (grades 9-12) reporting current alcohol use (%)	29.8				21.2	30.0	41.0	31.1	
Students (grades 6-8) reporting current binge alcohol use (%)	0.9				--	--	2.0	0.0	
Students (grades 9-12) reporting current binge alcohol use (%)	15.0				9.8	13.0	26.0	16.7	
Students (grades 6-8) reporting lifetime cigarette use (%)	5.2				--	3.0	4.0	1.6	
Students (grades 6-8) reporting current cigarette use (%)	--				1.4	--	1.0	0.0	
Students (grades 9-12) reporting lifetime cigarette use (%)	17.7				--	17.0	37.0	14.5	
Students (grades 9-12) reporting current cigarette use (%)	5.0				2.8	5.0	19.0	3.0	
Students (grades 6-8) reporting lifetime marijuana use (%)	7.0				8.0	2.0	4.0	1.4	
Students (grades 6-8) reporting current marijuana use (%)	3.0				5.9	1.0	3.0	0.4	
Students (grades 9-12) reporting lifetime marijuana use (%)	41.9				--	26.0	41.0	40.4	
Students (grades 9-12) reporting current marijuana use (%)	26.0				22.6	17.0	27.0	25.4	
Students (grades 6-8) reporting lifetime electronic tobacco use (%)	14.7				--	--	--	4.4	
Students (grades 6-8) reporting current electronic tobacco use (%)	--				7.6	--	--	2.2	
Students (grades 9-12) reporting lifetime electronic tobacco use (%)	50.7				--	--	--	32.1	
Students (grades 9-12) reporting current electronic tobacco use (%)	32.2				12.2	--	--	18.4	
Chronic Disease (more data on CHIA data tabs)									
Cancer mortality (all types, age-adjusted rate per 100,000)	149.92	140.37	144.67	147.38					Massachusetts Cancer Registry, 2014-2018
Cancer incidence (age-adjusted per 100,000)									
All sites	498.16	483.79	478.46	462.14					
Breast Cancer	176.35	189.2	196.7	150.1					
Cervical Cancer	5.5	4.66	4.17	5.5					

					Community Benefits Service Area				
	Massachusetts	**Middlesex County**	**Norfolk County**	**Suffolk County**	**Boston**	**Brookline**	**Dedham**	**Newton**	Source
Coloretal Cancer	35.96	35.38	36.22	32.76					
Lung and Bronchus Cancer	61.41	54.88	60.42	59.62					
Prostate Cancer	108.84	106.55	113.74	110.6					
Risk factors									
Percent of Adults who are Obese (%)	24				23.4	21.8	24.7	19.1	Behavioral Risk Factor Surveillance System, 2018
Diagnosed diabetes among adults aged >=18 years (%)	8.6				10	6.5	6.7	5.9	Behavioral Risk Factor Surveillance System, 2018
Age-adjusted mortality due to heart disease per 100,000 population (%)	138.7								Massachusetts Department of Public Health, Population Health Information Tool, 2015
Adults ever told by doctor that they had angina or coronary heart disease (age-adjusted) (%)	4.7				5.7	4.3	4.7	4	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high blood pressure (age adjusted) (%)	26.8				28.5	24.8	26.6	22.6	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high cholesterol (age-adjusted) (%)	33.1				29.8	28.8	29.1	25.8	Behavioral Risk Factor Surveillance System, 2017
Reproductive Health									
Infant Mortality Rate (per 1,000 live births)	3.7	2.8	2.9	4.3					March of Dimes, 2019
Low birth weight (%)	7.4	7	7.2	7.4					March of Dimes, 2020
Mothers with late or no prenatal care (%)	3.9%	3.4	3	5.2					March of Dimes, 2020
Births to adolescent mothers (per 1,000 females ages 15-19)	8	4	2	9					National Center for Health Statistics, 2014-2020
Percent of mothers receiving publicly funded prenatal care 2016	38.60%								Massachusetts Births 2016
Women screened for postpartum depression within 6 months after delivery (%)									MDPH January 2016-December 2016
White (non-Hispanic)	13.60%								
Black (non-Hispanic)	9.70%								
Asian or Pacific Islander (non-Hispanic)	14.60%								
American Indian/Alaska Native (non-Hispanic)	10.30%								
Other race (non-Hispanic)	13.30%								
Unknown race	12.40%								
Less than a high school diploma	8.00%								
With a high school diploma or GED	9.30%								
Some College/Associate Degree	11.40%								
Bachelor Degree	14.10%								
Graduate Degrees	15.20%								
Among individuals who had a full-term birth	12.10%								
Among individuals who had a pre-term birth	11.50%								
Among individuals who are not married	9.70%								
Among individuals who are married	13.70%								
Frequency of self-reported postpartum depressive symptoms 2017									MDPH 2019. CY18 Summary of Activities Related to Screening for Postpartum Depression
Rarely/Never	61.4%								
Often/Always	10.7%								
Sometimes	27.9%								
Communicable and Infectious Disease									
HIV prevalence (per 100,000 population 13 years and older)	355	288	234	814					National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention, 2019
STI infection cases									Massachusetts Population Health Information Tool, 2018
Syphillis (case count)	1,164				317	Less than 5	Less than 5	9	
Gonorrhea (case count)	7,629				2119	51	23	56	
Chlamydia	30,297				6201	156	94	236	
Rate of Hepatitis C (per 100,000)	97.9				103	28.3	74.6	30.8	Massachusetts Population Health Information Tool, 2018

					Community Benefits Service Area				
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton	Source
Tuberculosis (case count)	204				34	1	0	1	Massachusetts Population Health Information Tool, 2018
Medicare enrollees that had annual flu vaccination (%)	56%	59%	59	49					Mapping Medicare Disparities, 2019

*Suppressed

					Community Benefits Service Area				
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Newton	Source
COVID-19 Community Impact Survey									MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole.
% very worried about getting infected with COVID-19		28%	27%	34%	33%	27%	27%	30%	
% ever been tested for COVID		48%	42%	58%	55%	44%	56%	40%	
% who have not gotten the medical care they needed since July 2020		19%	14%	20%	21%	16%	10%	14%	
% with 15 or more of poor mental health days in the past 30 days		32%	29%	34%	35%	25%	31%	29%	
% of substance users who said they are now using more substances than before the pandemic		42%	39%	42%	42%	37%	45%	41%	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks		31%	34%	44%	43%	22%	32%	22%	
% Worried about getting food or groceries in the coming weeks		18%	19%	24%	24%	12%	16%	13%	
% Worried about getting face masks in the coming weeks		11%	11%	16%	17%	7%	11%	9%	
% Worried about getting medication in the coming weeks		10%	10%	12%	12%	7%	10%	10%	
% Worried about getting broadband in the coming weeks		10%	8%	13%	13%	6%	6%	6%	
% of Employed residents who experienced job loss		8%	8%	37%	7%	5%	7%	6%	
% of employed residents who experienced reduced work hours		12%	11%	13%	13%	10%	11%	9%	
% Worried about paying mortgage, rent, or utilities related expenses		21%	24%	33%	33%	17%	21%	14%	
% Worried they may have to move out of where they live in the next few months		17%	14%	20%	21%	13%	7%	10%	
Boston Indicators: COVID Community Data Lab									Boston Indicators
Unemployment claims (#) reported on 10/30/21	5,901								
Unemplyment rate as of 10/21/21	5.3%								
COVID-19 Layoff									Metropolitian Area Planning Council, The COVID-19 Layoff Housing Gap (October 2020)
Estimated number of households in need of assistance with no government aid (without any unmployment benefits)					23148.18	727.18	249	1192.15	
Unemployment claims (#)					42072	1487	1,157	2425	

Community Health Needs Assessment - New England Baptist Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 0-17, NEBH Community Benefits Service Area defined by BILH Community Benefits
Boston includes zip codes 02119, 02120,

		New England Baptist Hospital Community Benefits Service Area			
	MA	Boston	Brookline	Chestnut Hill	Dedham
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,000	1,735	3,065	1,557	1,264	1,684
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-5%	-22%	-50%	-13%
FY19 ED Volume (all cause) rate per 100,000	19,530	32,347	10,703	9,458	12,175
Change in ED Volume Rate FY17 to FY19	-1%	-5%	-7%	-7%	-25%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	333	873	230	195	223
Change in Inpatient Discharge Rate FY17 to FY19	-12%	-20%	-22%	14%	-45%
FY19 ED Volume rate per 100,000	2,481	7,004	1,426	1,094	1,705
Change in ED Volume Rate FY17 to FY19	2%	-11%	-10%	10%	-24%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	53	53	44	0	41
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	-50%	-100%	0%
FY19 ED Volume rate per 100,000	117	234	88	73	81
Change in ED Volume Rate FY17 to FY19	-2%	100%	300%	-25%	-20%
Obesity					
FY19 Inpatient Discharges rate per 100,000	61	96	22	0	20
Change in Inpatient Discharge Rate FY17 to FY19	6%	-36%	-33%	-100%	0%
FY19 ED Volume rate per 100,000	81	128	11	24	61
Change in ED Volume Rate FY17 to FY19	0%	33%	-50%	0%	0%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	125	224	66	97	81
Change in Inpatient Discharge Rate FY17 to FY19	2%	-36%	20%	-43%	-43%
FY19 ED Volume rate per 100,000	1,874	2,384	921	1,143	1,400
Change in ED Volume Rate FY17 to FY19	-1%	-51%	-58%	-41%	-25%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	18%	0%	0%	0%	-100%
FY19 ED Volume rate per 100,000	1	0	0	0	0
Change in ED Volume Rate FY17 to FY19	-23%	0%	0%	0%	0%
Infections					
FY19 Inpatient Discharges rate per 100,000	767	1,543	779	997	690
Change in Inpatient Discharge Rate FY17 to FY19	-2%	22%	-8%	-35%	-8%
FY19 ED Volume rate per 100,000	7,457	13,007	2,752	2,772	3,571
Change in ED Volume Rate FY17 to FY19	4%	-15%	-12%	-7%	-16%
Injuries					
FY19 Inpatient Discharges rate per 100,000	345	532	241	340	284
Change in Inpatient Discharge Rate FY17 to FY19	-4%	6%	-35%	-7%	-7%
FY19 ED Volume rate per 100,000	7,024	9,920	5,055	4,449	4,485
Change in ED Volume Rate FY17 to FY19	-8%	3%	-7%	3%	-37%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	85	138	33	0	41
Change in Inpatient Discharge Rate FY17 to FY19	-30%	-43%	0%	-100%	-60%
FY19 ED Volume rate per 100,000	501	394	197	195	264
Change in ED Volume Rate FY17 to FY19	32%	12%	29%	100%	-35%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	213	404	110	219	203
Change in Inpatient Discharge Rate FY17 to FY19	3%	-3%	-52%	-10%	25%
FY19 ED Volume rate per 100,000	1,098	1,139	285	122	690
Change in ED Volume Rate FY17 to FY19	38%	39%	53%	-55%	31%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	4	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	7%	-100%	0%	0%	0%
FY19 ED Volume rate per 100,000	35	181	0	0	0
Change in ED Volume Rate FY17 to FY19	15%	42%	-100%	0%	-100%

Other					
Attention Deficit Hyperactivity Disorder					
FY19 Inpatient Discharges rate per 100,000	141	149	77	73	142
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-55%	0%	-40%	17%
FY19 ED Volume rate per 100,000	588	1,362	428	389	710
Change in ED Volume Rate FY17 to FY19	17%	24%	22%	23%	-22%
Learning Disorders					
FY19 Inpatient Discharges rate per 100,000	135	383	121	195	203
Change in Inpatient Discharge Rate FY17 to FY19	12%	33%	-52%	-27%	67%
FY19 ED Volume rate per 100,000	103	681	88	97	61
Change in ED Volume Rate FY17 to FY19	84%	83%	-27%	33%	200%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	772	1,022	581	438	832
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-25%	-20%	-49%	-11%
FY19 ED Volume rate per 100,000	2,592	4,598	1,623	1,167	2,009
Change in ED Volume Rate FY17 to FY19	5%	9%	23%	-6%	-32%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	53	11	11	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-8%	-50%	0%	0%	-100%
FY19 ED Volume rate per 100,000	343	692	88	170	304
Change in ED Volume Rate FY17 to FY19	-5%	195%	-11%	75%	36%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	229	532	274	292	223
Change in Inpatient Discharge Rate FY17 to FY19	-4%	79%	-42%	-40%	-31%
FY19 ED Volume rate per 100,000	208	309	175	195	122
Change in ED Volume Rate FY17 to FY19	3%	4%	14%	-38%	-14%

Community Health Needs Assessment - New England Baptist Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 45-64, NEBH Community Benefits Service Area defined by BILH Community Benefits

		New England Baptist Hospital Community Benefits Service Area			
	MA	Boston	Brookline	Chestnut Hill	Dedham
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,000	9,762	14,988	5,007	3,882	9,327
Change in Inpatient Discharge Rate FY17 to FY19	0%	-8%	0%	-2%	-8%
FY19 ED Volume (all cause) rate per 100,000	24,003	53,994	10,421	7,382	18,231
Change in ED Volume Rate FY17 to FY19	2%	1%	6%	-1%	-2%
Cancer					
Breast Cancer					
FY19 Inpatient Discharges rate per 100,000	258	344	253	297	325
Change in Inpatient Discharge Rate FY17 to FY19	-5%	22%	56%	-13%	53%
FY19 ED Volume rate per 100,000	195	521	136	233	339
Change in ED Volume Rate FY17 to FY19	18%	47%	-35%	83%	14%
Colorectal Cancer					
FY19 Inpatient Discharges rate per 100,000	116	240	127	64	99
Change in Inpatient Discharge Rate FY17 to FY19	0%	53%	250%	-25%	-36%
FY19 ED Volume rate per 100,000	27	104	18	21	0
Change in ED Volume Rate FY17 to FY19	12%	150%	100%	0%	-100%
GYN Cancer					
FY19 Inpatient Discharges rate per 100,000	182	146	136	42	254
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-42%	0%	-33%	80%
FY19 ED Volume rate per 100,000	82	115	117	0	14
Change in ED Volume Rate FY17 to FY19	21%	-39%	333%	-100%	-83%
Lung Cancer					
FY19 Inpatient Discharges rate per 100,000	358	510	217	191	452
Change in Inpatient Discharge Rate FY17 to FY19	5%	48%	-20%	-44%	10%
FY19 ED Volume rate per 100,000	97	115	9	21	170
Change in ED Volume Rate FY17 to FY19	21%	-21%	-75%	-67%	100%
Prostate Cancer					
FY19 Inpatient Discharges rate per 100,000	133	260	81	85	141
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-24%	200%	-43%	-38%
FY19 ED Volume rate per 100,000	60	354	18	0	42
Change in ED Volume Rate FY17 to FY19	30%	386%	0%	-100%	-25%
Other Cancer					
FY19 Inpatient Discharges rate per 100,000	1,984	3,000	1,491	1,485	2,643
Change in Inpatient Discharge Rate FY17 to FY19	3%	6%	-11%	-24%	32%
FY19 ED Volume rate per 100,000	597	958	371	318	636
Change in ED Volume Rate FY17 to FY19	27%	-6%	-25%	15%	-22%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	1,051	2,614	497	509	961
Change in Inpatient Discharge Rate FY17 to FY19	-17%	-26%	-17%	-4%	8%
FY19 ED Volume rate per 100,000	1,944	5,895	795	403	1,300
Change in ED Volume Rate FY17 to FY19	0%	1%	49%	-49%	-17%
Congestive Heart Failure					
FY19 Inpatient Discharges rate per 100,000	1,292	3,573	461	339	1,088
Change in Inpatient Discharge Rate FY17 to FY19	10%	1%	0%	-11%	-21%
FY19 ED Volume rate per 100,000	396	1,719	81	0	452
Change in ED Volume Rate FY17 to FY19	41%	101%	-25%	-100%	129%
COPD and Lung Disease					
FY19 Inpatient Discharges rate per 100,000	1,994	2,760	606	127	1,865
Change in Inpatient Discharge Rate FY17 to FY19	1%	10%	40%	-40%	-18%
FY19 ED Volume rate per 100,000	1,388	1,969	298	42	975
Change in ED Volume Rate FY17 to FY19	10%	-1%	27%	-33%	-18%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	2,808	5,708	1,482	1,039	2,318
Change in Inpatient Discharge Rate FY17 to FY19	3%	-11%	22%	17%	-7%
FY19 ED Volume rate per 100,000	4,109	13,749	1,943	679	3,038
Change in ED Volume Rate FY17 to FY19	10%	10%	24%	-3%	-4%

Heart Disease					
FY19 Inpatient Discharges rate per 100,000	3,609	7,833	1,446	1,315	3,081
Change in Inpatient Discharge Rate FY17 to FY19	4%	-1%	-14%	19%	-9%
FY19 ED Volume rate per 100,000	1,448	3,250	660	827	1,837
Change in ED Volume Rate FY17 to FY19	17%	54%	24%	22%	29%
Hypertension					
FY19 Inpatient Discharges rate per 100,000	4,045	6,364	1,826	1,379	3,618
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-5%	4%	14%	-20%
FY19 ED Volume rate per 100,000	7,878	24,133	3,055	2,185	6,897
Change in ED Volume Rate FY17 to FY19	10%	16%	6%	3%	1%
Liver Disease					
FY19 Inpatient Discharges rate per 100,000	1,562	2,364	868	382	2,077
Change in Inpatient Discharge Rate FY17 to FY19	5%	-12%	28%	20%	1%
FY19 ED Volume rate per 100,000	404	448	181	42	283
Change in ED Volume Rate FY17 to FY19	19%	5%	233%	-50%	-23%
Obesity					
FY19 Inpatient Discharges rate per 100,000	2,410	3,093	786	997	2,643
Change in Inpatient Discharge Rate FY17 to FY19	5%	-27%	-10%	18%	9%
FY19 ED Volume rate per 100,000	675	2,021	271	148	523
Change in ED Volume Rate FY17 to FY19	17%	50%	30%	-36%	-36%
Stroke and Other Neurovascular Diseases					
FY19 Inpatient Discharges rate per 100,000	443	740	253	127	565
Change in Inpatient Discharge Rate FY17 to FY19	2%	-3%	-13%	-45%	18%
FY19 ED Volume rate per 100,000	119	83	27	21	170
Change in ED Volume Rate FY17 to FY19	6%	-11%	-50%	-75%	20%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	1,314	2,646	705	615	1,427
Change in Inpatient Discharge Rate FY17 to FY19	20%	31%	30%	61%	80%
FY19 ED Volume rate per 100,000	4,000	7,093	3,154	2,058	3,985
Change in ED Volume Rate FY17 to FY19	59%	270%	693%	194%	228%
Hepatitis					
FY19 Inpatient Discharges rate per 100,000	492	1,896	280	127	537
Change in Inpatient Discharge Rate FY17 to FY19	-19%	-24%	-14%	-25%	6%
FY19 ED Volume rate per 100,000	211	583	18	0	28
Change in ED Volume Rate FY17 to FY19	-11%	-57%	-75%	0%	-87%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	157	958	45	21	42
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-17%	-58%	0%	-25%
FY19 ED Volume rate per 100,000	236	1,469	99	0	155
Change in ED Volume Rate FY17 to FY19	-3%	-15%	-48%	0%	0%
Infections					
FY19 Inpatient Discharges rate per 100,000	3,824	6,114	2,025	1,209	3,915
Change in Inpatient Discharge Rate FY17 to FY19	3%	-16%	-5%	2%	0%
FY19 ED Volume rate per 100,000	3,618	7,499	1,618	1,252	2,261
Change in ED Volume Rate FY17 to FY19	-4%	-2%	-1%	55%	-4%
Injuries					
FY19 Inpatient Discharges rate per 100,000	3,425	5,760	1,790	1,336	3,151
Change in Inpatient Discharge Rate FY17 to FY19	6%	14%	-2%	-21%	-7%
FY19 ED Volume rate per 100,000	7,959	16,519	4,329	2,185	6,020
Change in ED Volume Rate FY17 to FY19	-2%	7%	16%	-30%	-20%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	232	448	145	64	240
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-10%	0%	-50%	21%
FY19 ED Volume rate per 100,000	395	875	145	21	184
Change in ED Volume Rate FY17 to FY19	5%	-11%	-33%	-83%	-19%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	1,135	1,375	389	318	947
Change in Inpatient Discharge Rate FY17 to FY19	8%	-3%	-9%	-35%	-9%
FY19 ED Volume rate per 100,000	555	979	271	212	396
Change in ED Volume Rate FY17 to FY19	11%	-6%	43%	100%	22%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	24	83	0	21	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-20%	-100%	0%	0%
FY19 ED Volume rate per 100,000	38	333	9	21	0

Change in ED Volume Rate FY17 to FY19	5%	100%	0%	0%	-100%
Tuberculosis					
FY19 Inpatient Discharges rate per 100,000	18	62	0	21	28
Change in Inpatient Discharge Rate FY17 to FY19	-3%	100%	0%	0%	100%
FY19 ED Volume rate per 100,000	6	52	0	0	0
Change in ED Volume Rate FY17 to FY19	7%	25%	0%	0%	0%
Other					
Dementia and Cognitive Disorders					
FY19 Inpatient Discharges rate per 100,000	868	1,354	515	127	975
Change in Inpatient Discharge Rate FY17 to FY19	10%	-19%	8%	-45%	-16%
FY19 ED Volume rate per 100,000	325	510	181	106	198
Change in ED Volume Rate FY17 to FY19	-5%	-9%	11%	150%	-46%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	7,268	10,895	4,537	2,821	7,137
Change in Inpatient Discharge Rate FY17 to FY19	4%	-4%	-2%	14%	-3%
FY19 ED Volume rate per 100,000	6,209	11,447	3,543	1,549	4,353
Change in ED Volume Rate FY17 to FY19	17%	5%	14%	-20%	-18%
Parkinsons and Movement Disorders					
FY19 Inpatient Discharges rate per 100,000	252	531	127	42	339
Change in Inpatient Discharge Rate FY17 to FY19	8%	104%	-18%	-67%	4%
FY19 ED Volume rate per 100,000	185	365	181	64	141
Change in ED Volume Rate FY17 to FY19	5%	-20%	150%	0%	-47%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	3,820	7,083	1,564	636	3,674
Change in Inpatient Discharge Rate FY17 to FY19	0%	1%	7%	15%	-19%
FY19 ED Volume rate per 100,000	7,619	23,227	2,043	870	4,268
Change in ED Volume Rate FY17 to FY19	3%	11%	21%	-5%	-16%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	1,870	3,323	1,247	785	2,304
Change in Inpatient Discharge Rate FY17 to FY19	7%	-2%	33%	-8%	28%
FY19 ED Volume rate per 100,000	472	1,281	226	85	424
Change in ED Volume Rate FY17 to FY19	8%	7%	-7%	33%	3%

Community Health Needs Assessment - New England Baptist Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 18-44, NEBH Community Benefits Service Area defined by BILH Community Benefits

		New England Baptist Hospital Community Benefits Service Area			
	MA	Boston	Brookline	Chestnut Hill	Dedham
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,000	6,072	5,447	3,537	1,859	6,525
Change in Inpatient Discharge Rate FY17 to FY19	0%	-10%	2%	20%	-5%
FY19 ED Volume (all cause) rate per 100,000	25,053	33,706	7,923	4,062	18,317
Change in ED Volume Rate FY17 to FY19	-1%	3%	1%	1%	0%
Cancer					
Breast Cancer					
FY19 Inpatient Discharges rate per 100,000	32	13	9	8	12
Change in Inpatient Discharge Rate FY17 to FY19	-10%	-63%	-50%	0%	0%
FY19 ED Volume rate per 100,000	27	22	38	0	12
Change in ED Volume Rate FY17 to FY19	25%	-55%	80%	-100%	0%
Colorectal Cancer					
FY19 Inpatient Discharges rate per 100,000	15	17	13	8	36
Change in Inpatient Discharge Rate FY17 to FY19	17%	0%	-40%	0%	-25%
FY19 ED Volume rate per 100,000	4	17	13	0	0
Change in ED Volume Rate FY17 to FY19	21%	0%	0%	0%	0%
GYN Cancer					
FY19 Inpatient Discharges rate per 100,000	41	39	34	72	48
Change in Inpatient Discharge Rate FY17 to FY19	11%	0%	167%	800%	100%
FY19 ED Volume rate per 100,000	30	13	4	0	0
Change in ED Volume Rate FY17 to FY19	23%	-63%	-67%	0%	-100%
Lung Cancer					
FY19 Inpatient Discharges rate per 100,000	26	17	34	56	84
Change in Inpatient Discharge Rate FY17 to FY19	3%	300%	0%	133%	-13%
FY19 ED Volume rate per 100,000	7	13	4	0	12
Change in ED Volume Rate FY17 to FY19	47%	0%	0%	0%	0%
Prostate Cancer					
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-15%	-100%	0%	0%	0%
FY19 ED Volume rate per 100,000	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	150%	0%	0%	0%	0%
Other Cancer					
FY19 Inpatient Discharges rate per 100,000	304	324	196	287	371
Change in Inpatient Discharge Rate FY17 to FY19	2%	39%	21%	38%	-23%
FY19 ED Volume rate per 100,000	142	285	68	8	84
Change in ED Volume Rate FY17 to FY19	29%	10%	0%	-50%	17%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	745	1,210	320	88	611
Change in Inpatient Discharge Rate FY17 to FY19	-5%	0%	-25%	-39%	-18%
FY19 ED Volume rate per 100,000	2,649	4,402	772	407	1,975
Change in ED Volume Rate FY17 to FY19	3%	2%	17%	34%	-20%
Congestive Heart Failure					
FY19 Inpatient Discharges rate per 100,000	124	255	34	0	12
Change in Inpatient Discharge Rate FY17 to FY19	14%	20%	300%	-100%	0%
FY19 ED Volume rate per 100,000	56	112	9	0	24
Change in ED Volume Rate FY17 to FY19	42%	-10%	100%	0%	0%
COPD and Lung Disease					
FY19 Inpatient Discharges rate per 100,000	136	117	43	24	144
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-21%	100%	-25%	71%
FY19 ED Volume rate per 100,000	127	69	9	0	144
Change in ED Volume Rate FY17 to FY19	16%	-47%	-50%	-100%	50%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	478	540	119	16	323
Change in Inpatient Discharge Rate FY17 to FY19	5%	-39%	-35%	-86%	17%
FY19 ED Volume rate per 100,000	1,167	1,940	277	80	635
Change in ED Volume Rate FY17 to FY19	7%	2%	2%	-17%	39%

Heart Disease					
FY19 Inpatient Discharges rate per 100,000	445	562	111	24	323
Change in Inpatient Discharge Rate FY17 to FY19	6%	-12%	0%	-70%	69%
FY19 ED Volume rate per 100,000	375	596	171	112	419
Change in ED Volume Rate FY17 to FY19	31%	37%	74%	1300%	218%
Hypertension					
FY19 Inpatient Discharges rate per 100,000	606	501	205	48	527
Change in Inpatient Discharge Rate FY17 to FY19	1%	-41%	33%	20%	-14%
FY19 ED Volume rate per 100,000	1,838	3,041	311	160	1,065
Change in ED Volume Rate FY17 to FY19	8%	0%	18%	67%	-13%
Liver Disease					
FY19 Inpatient Discharges rate per 100,000	427	233	137	24	551
Change in Inpatient Discharge Rate FY17 to FY19	15%	-7%	-6%	-82%	64%
FY19 ED Volume rate per 100,000	185	117	17	0	287
Change in ED Volume Rate FY17 to FY19	25%	50%	-20%	0%	700%
Obesity					
FY19 Inpatient Discharges rate per 100,000	919	894	235	168	802
Change in Inpatient Discharge Rate FY17 to FY19	6%	-25%	-7%	91%	-11%
FY19 ED Volume rate per 100,000	530	1,136	107	56	335
Change in ED Volume Rate FY17 to FY19	11%	12%	9%	75%	-10%
Stroke and Other Neurovascular Diseases					
FY19 Inpatient Discharges rate per 100,000	71	39	13	16	108
Change in Inpatient Discharge Rate FY17 to FY19	9%	-40%	-73%	0%	50%
FY19 ED Volume rate per 100,000	28	4	0	0	24
Change in ED Volume Rate FY17 to FY19	11%	0%	-100%	0%	0%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	553	505	205	168	539
Change in Inpatient Discharge Rate FY17 to FY19	13%	-23%	-2%	31%	15%
FY19 ED Volume rate per 100,000	3,482	4,665	1,592	918	3,184
Change in ED Volume Rate FY17 to FY19	44%	166%	147%	188%	131%
Hepatitis					
FY19 Inpatient Discharges rate per 100,000	344	380	55	16	180
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-15%	-24%	-33%	-38%
FY19 ED Volume rate per 100,000	195	207	21	0	251
Change in ED Volume Rate FY17 to FY19	1%	-38%	-64%	-100%	24%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	44	121	21	8	12
Change in Inpatient Discharge Rate FY17 to FY19	2%	100%	-17%	0%	-75%
FY19 ED Volume rate per 100,000	102	315	21	0	72
Change in ED Volume Rate FY17 to FY19	11%	9%	25%	-100%	20%
Infections					
FY19 Inpatient Discharges rate per 100,000	1,534	1,715	678	407	1,604
Change in Inpatient Discharge Rate FY17 to FY19	2%	10%	-1%	11%	25%
FY19 ED Volume rate per 100,000	5,547	8,501	1,762	926	3,807
Change in ED Volume Rate FY17 to FY19	-6%	2%	-8%	-9%	19%
Injuries					
FY19 Inpatient Discharges rate per 100,000	1,103	1,179	435	168	1,125
Change in Inpatient Discharge Rate FY17 to FY19	5%	-9%	-14%	5%	4%
FY19 ED Volume rate per 100,000	7,762	11,153	2,726	1,349	6,082
Change in ED Volume Rate FY17 to FY19	-4%	14%	0%	-11%	0%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	189	121	47	48	72
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-40%	-45%	20%	-67%
FY19 ED Volume rate per 100,000	693	618	201	88	563
Change in ED Volume Rate FY17 to FY19	-8%	-15%	-31%	-21%	-10%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	286	328	73	32	335
Change in Inpatient Discharge Rate FY17 to FY19	8%	15%	-23%	33%	100%
FY19 ED Volume rate per 100,000	588	687	124	120	419
Change in ED Volume Rate FY17 to FY19	27%	30%	-6%	88%	52%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	80	99	21	24	60
Change in Inpatient Discharge Rate FY17 to FY19	-9%	-38%	0%	200%	-55%
FY19 ED Volume rate per 100,000	262	981	68	16	120

Change in ED Volume Rate FY17 to FY19	15%	16%	-24%	-60%	-23%
Tuberculosis					
FY19 Inpatient Discharges rate per 100,000	9	65	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	650%	0%	0%	0%
FY19 ED Volume rate per 100,000	5	35	0	0	0
Change in ED Volume Rate FY17 to FY19	0%	300%	0%	0%	0%
Other					
Dementia and Cognitive Disorders					
FY19 Inpatient Discharges rate per 100,000	177	117	77	24	192
Change in Inpatient Discharge Rate FY17 to FY19	9%	-33%	0%	0%	33%
FY19 ED Volume rate per 100,000	201	156	98	16	108
Change in ED Volume Rate FY17 to FY19	-11%	-33%	77%	-60%	29%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	4,382	3,564	1,903	1,101	4,465
Change in Inpatient Discharge Rate FY17 to FY19	5%	-10%	-4%	31%	-13%
FY19 ED Volume rate per 100,000	7,907	8,540	2,197	1,061	5,830
Change in ED Volume Rate FY17 to FY19	16%	10%	-9%	-6%	-12%
Parkinsons and Movement Disorders					
FY19 Inpatient Discharges rate per 100,000	41	26	34	32	24
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-50%	60%	33%	100%
FY19 ED Volume rate per 100,000	95	112	60	32	84
Change in ED Volume Rate FY17 to FY19	-4%	-49%	133%	33%	40%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	2,012	1,581	367	192	1,712
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-20%	-22%	-20%	-28%
FY19 ED Volume rate per 100,000	8,347	10,043	1,515	774	4,585
Change in ED Volume Rate FY17 to FY19	0%	3%	8%	3%	-19%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	2,698	2,441	2,244	1,165	3,125
Change in Inpatient Discharge Rate FY17 to FY19	5%	0%	5%	28%	1%
FY19 ED Volume rate per 100,000	582	803	213	80	371
Change in ED Volume Rate FY17 to FY19	14%	27%	0%	-9%	-14%

Community Health Needs Assessment - New England Baptist Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 65+, NEBH Community Benefits Service Area defined by BILH Community Benefits

		New England Baptist Hospital Community Benefits Service Area			
	MA	Boston	Brookline	Chestnut Hill	Dedham
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,000	25,473	27,396	21,785	18,071	27,933
Change in Inpatient Discharge Rate FY17 to FY19	5%	-1%	10%	6%	3%
FY19 ED Volume (all cause) rate per 100,000	26,010	42,802	19,836	18,542	25,393
Change in ED Volume Rate FY17 to FY19	10%	17%	12%	29%	-5%
Cancer					
Breast Cancer					
FY19 Inpatient Discharges rate per 100,000	1,253	1,342	1,591	1,710	1,860
Change in Inpatient Discharge Rate FY17 to FY19	6%	13%	3%	60%	-8%
FY19 ED Volume rate per 100,000	480	662	650	793	751
Change in ED Volume Rate FY17 to FY19	42%	19%	40%	19%	-18%
Colorectal Cancer					
FY19 Inpatient Discharges rate per 100,000	271	279	119	74	143
Change in Inpatient Discharge Rate FY17 to FY19	2%	45%	-25%	-73%	-47%
FY19 ED Volume rate per 100,000	42	0	40	0	18
Change in ED Volume Rate FY17 to FY19	9%	0%	0%	-100%	-75%
GYN Cancer					
FY19 Inpatient Discharges rate per 100,000	508	627	305	347	590
Change in Inpatient Discharge Rate FY17 to FY19	6%	0%	-23%	-60%	57%
FY19 ED Volume rate per 100,000	145	227	66	124	161
Change in ED Volume Rate FY17 to FY19	47%	-35%	25%	-62%	-36%
Lung Cancer					
FY19 Inpatient Discharges rate per 100,000	1,347	1,516	1,021	1,116	1,574
Change in Inpatient Discharge Rate FY17 to FY19	9%	30%	33%	18%	13%
FY19 ED Volume rate per 100,000	282	331	172	124	429
Change in ED Volume Rate FY17 to FY19	26%	27%	44%	-17%	-11%
Prostate Cancer					
FY19 Inpatient Discharges rate per 100,000	1,270	1,812	1,299	1,958	1,717
Change in Inpatient Discharge Rate FY17 to FY19	6%	21%	-9%	14%	10%
FY19 ED Volume rate per 100,000	434	854	517	818	733
Change in ED Volume Rate FY17 to FY19	36%	-29%	77%	43%	-2%
Other Cancer					
FY19 Inpatient Discharges rate per 100,000	7,146	6,762	8,645	8,577	9,317
Change in Inpatient Discharge Rate FY17 to FY19	13%	-9%	12%	15%	18%
FY19 ED Volume rate per 100,000	1,519	1,551	1,631	2,405	2,361
Change in ED Volume Rate FY17 to FY19	33%	-1%	29%	1%	-7%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	1,596	3,799	1,724	1,686	1,913
Change in Inpatient Discharge Rate FY17 to FY19	-16%	-15%	-20%	1%	-26%
FY19 ED Volume rate per 100,000	1,257	3,695	1,246	1,289	1,234
Change in ED Volume Rate FY17 to FY19	8%	8%	45%	13%	-17%
Congestive Heart Failure					
FY19 Inpatient Discharges rate per 100,000	8,161	10,840	6,828	5,454	8,995
Change in Inpatient Discharge Rate FY17 to FY19	9%	-1%	13%	17%	-3%
FY19 ED Volume rate per 100,000	1,705	3,764	1,008	1,438	2,289
Change in ED Volume Rate FY17 to FY19	34%	53%	46%	107%	-4%
COPD and Lung Disease					
FY19 Inpatient Discharges rate per 100,000	7,130	7,302	3,792	3,198	7,010
Change in Inpatient Discharge Rate FY17 to FY19	5%	-4%	9%	15%	-9%
FY19 ED Volume rate per 100,000	2,422	3,486	955	1,190	2,682
Change in ED Volume Rate FY17 to FY19	18%	43%	16%	118%	-7%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	8,376	13,803	5,834	4,065	8,745
Change in Inpatient Discharge Rate FY17 to FY19	5%	2%	14%	12%	16%
FY19 ED Volume rate per 100,000	5,867	17,497	4,018	2,578	5,186
Change in ED Volume Rate FY17 to FY19	18%	31%	48%	24%	2%

Heart Disease					
FY19 Inpatient Discharges rate per 100,000	18,344	20,948	15,049	14,303	19,760
Change in Inpatient Discharge Rate FY17 to FY19	6%	-5%	10%	13%	-7%
FY19 ED Volume rate per 100,000	3,975	6,257	3,368	4,338	5,508
Change in ED Volume Rate FY17 to FY19	16%	39%	33%	48%	-20%
Hypertension					
FY19 Inpatient Discharges rate per 100,000	10,397	10,335	7,982	7,288	11,016
Change in Inpatient Discharge Rate FY17 to FY19	-1%	-3%	2%	-4%	-10%
FY19 ED Volume rate per 100,000	12,665	25,636	9,215	9,246	13,197
Change in ED Volume Rate FY17 to FY19	14%	22%	12%	30%	-11%
Liver Disease					
FY19 Inpatient Discharges rate per 100,000	1,956	2,841	1,525	917	2,432
Change in Inpatient Discharge Rate FY17 to FY19	16%	-13%	21%	-10%	43%
FY19 ED Volume rate per 100,000	258	261	40	50	215
Change in ED Volume Rate FY17 to FY19	36%	-17%	-70%	0%	-43%
Obesity					
FY19 Inpatient Discharges rate per 100,000	3,869	4,409	2,029	1,264	3,809
Change in Inpatient Discharge Rate FY17 to FY19	14%	-7%	0%	-25%	30%
FY19 ED Volume rate per 100,000	367	1,150	225	248	340
Change in ED Volume Rate FY17 to FY19	26%	94%	70%	11%	-21%
Stroke and Other Neurovascular Diseases					
FY19 Inpatient Discharges rate per 100,000	2,064	2,440	1,870	1,487	2,504
Change in Inpatient Discharge Rate FY17 to FY19	5%	-4%	18%	46%	0%
FY19 ED Volume rate per 100,000	380	366	252	223	501
Change in ED Volume Rate FY17 to FY19	10%	24%	46%	13%	-33%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	3,711	4,130	3,275	3,619	4,238
Change in Inpatient Discharge Rate FY17 to FY19	32%	23%	59%	68%	106%
FY19 ED Volume rate per 100,000	5,138	7,128	5,436	6,346	4,345
Change in ED Volume Rate FY17 to FY19	88%	657%	832%	341%	119%
Hepatitis					
FY19 Inpatient Discharges rate per 100,000	273	1,429	292	174	429
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-2%	0%	0%	41%
FY19 ED Volume rate per 100,000	70	261	66	25	36
Change in ED Volume Rate FY17 to FY19	36%	-42%	25%	0%	100%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	53	279	13	25	0
Change in Inpatient Discharge Rate FY17 to FY19	2%	-20%	-75%	0%	-100%
FY19 ED Volume rate per 100,000	47	401	0	0	0
Change in ED Volume Rate FY17 to FY19	34%	0%	0%	0%	-100%
Infections					
FY19 Inpatient Discharges rate per 100,000	12,591	12,426	11,098	8,775	15,433
Change in Inpatient Discharge Rate FY17 to FY19	6%	-2%	2%	12%	6%
FY19 ED Volume rate per 100,000	4,213	5,594	3,381	3,297	3,362
Change in ED Volume Rate FY17 to FY19	3%	13%	30%	39%	-5%
Injuries					
FY19 Inpatient Discharges rate per 100,000	11,877	13,576	12,875	11,849	15,612
Change in Inpatient Discharge Rate FY17 to FY19	15%	31%	14%	6%	21%
FY19 ED Volume rate per 100,000	10,393	14,674	8,101	8,726	12,965
Change in ED Volume Rate FY17 to FY19	11%	30%	7%	39%	-7%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	281	261	292	248	215
Change in Inpatient Discharge Rate FY17 to FY19	7%	-40%	16%	100%	-25%
FY19 ED Volume rate per 100,000	185	174	133	149	125
Change in ED Volume Rate FY17 to FY19	27%	-9%	43%	-14%	133%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	4,188	3,294	3,036	2,851	4,632
Change in Inpatient Discharge Rate FY17 to FY19	0%	-9%	-6%	34%	-5%
FY19 ED Volume rate per 100,000	569	767	451	471	644
Change in ED Volume Rate FY17 to FY19	1%	0%	26%	12%	29%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	30	122	40	0	89
Change in Inpatient Discharge Rate FY17 to FY19	9%	40%	-25%	-100%	150%
FY19 ED Volume rate per 100,000	5	0	0	0	0

Change in ED Volume Rate FY17 to FY19	0%	-100%	0%	0%	0%
Tuberculosis					
FY19 Inpatient Discharges rate per 100,000	52	192	13	50	54
Change in Inpatient Discharge Rate FY17 to FY19	-11%	57%	-88%	0%	50%
FY19 ED Volume rate per 100,000	6	35	0	0	0
Change in ED Volume Rate FY17 to FY19	13%	0%	0%	0%	-100%
Other					
Dementia and Cognitive Disorders					
FY19 Inpatient Discharges rate per 100,000	6,264	7,494	6,881	4,983	7,493
Change in Inpatient Discharge Rate FY17 to FY19	6%	4%	36%	14%	-13%
FY19 ED Volume rate per 100,000	2,053	2,353	1,392	793	3,201
Change in ED Volume Rate FY17 to FY19	11%	50%	3%	-3%	-19%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	10,900	12,600	11,363	9,098	14,360
Change in Inpatient Discharge Rate FY17 to FY19	15%	27%	19%	20%	24%
FY19 ED Volume rate per 100,000	3,500	4,671	3,872	2,702	3,183
Change in ED Volume Rate FY17 to FY19	35%	25%	80%	38%	-2%
Parkinsons and Movement Disorders					
FY19 Inpatient Discharges rate per 100,000	1,523	1,481	1,591	1,140	2,325
Change in Inpatient Discharge Rate FY17 to FY19	10%	9%	-1%	2%	37%
FY19 ED Volume rate per 100,000	602	627	477	793	769
Change in ED Volume Rate FY17 to FY19	11%	6%	-10%	113%	-37%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	2,956	4,845	1,737	843	3,094
Change in Inpatient Discharge Rate FY17 to FY19	13%	-1%	20%	-26%	9%
FY19 ED Volume rate per 100,000	2,258	6,501	835	421	1,359
Change in ED Volume Rate FY17 to FY19	22%	24%	37%	0%	7%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	4,867	6,309	5,158	3,966	5,436
Change in Inpatient Discharge Rate FY17 to FY19	13%	5%	10%	-5%	8%
FY19 ED Volume rate per 100,000	835	1,412	544	942	966
Change in ED Volume Rate FY17 to FY19	9%	25%	-21%	73%	-36%

Notes:

Population counts: Sg2 Claritas Demographic Data, 2021.

Data is broken out into four age groupings (0-17, 18-44, 45-64, 65+). One age group per tab.

Included data is a calculated rate of inpatient discharge or ED volume per 100,000 population, by town. Inpatient discharge and ED data retrieved from CHIA FY17 and FY19.

Categorization of the Health Conditions listed above determined by Sg2 CARE Family (ICD-9 and -10 diagnosis code to disease grouping)

Percent change based on rate per 100,000 in FY17 compared to rate per 100,000 in FY19, using identical Sg2 CARE Family definitions. Please note the % change in rate for some health conditions is large, likely due to small volumes or coding changes.

Volumes noted as <11 are supressed per CHIA cell suppression guidelines.

Community Health Survey

- Survey (used for BID Needham)
- Survey Distribution Channels

Beth Israel Lahey Health

Community Health Survey for Beth Israel Lahey Health
2022 Community Health Needs Assessment

Beth Israel Lahey Health and its member hospitals are conducting a Community Health Needs Assessment to better understand the most pressing health-related issues for residents in the communities we serve. It is important that each hospital gather input from people living, working, and learning in the community. The information gathered will help each hospital to 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.

You will have the option at the end of the survey to enter a drawing for a $100 gift card

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

Time in Community

1. We are interested in your experiences in the community where you spend the most time. This may be the place where you live, work, play, or learn.
   Please enter the zip code of the community in which you spend the most time.
   Zip code: _____

1. How many years have you lived in the selected community?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years but not all my life
   - ❑ I have lived here all my life
   - ❑ I used to live here, but not anymore
   - ❑ I have never lived here

2. How many years have you worked in the selected community?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years
   - ❑ I do not work here

3. If you do not live or work in the selected community, how are you connected to it?
   _____

Your Community

4. 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 things like 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, day care, after school programs, housing, and places to play)	☐	☐	☐	☐	☐
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.).	☐	☐	☐	☐	☐

5. What are the most important things you would like 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 (_____)

Social + Cultural Environment

6. We are interested to know about your experiences finding support in your community. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
There are people and/or organizations in my community that support me during times of stress and need.	☐	☐	☐	☐	☐
I believe that all residents, including myself, can make the community a better place to live.	☐	☐	☐	☐	☐
During COVID-19, information I need to stay healthy and safe has been readily available in my community.	☐	☐	☐	☐	☐
During COVID-19, resources I need to stay healthy and safe have been readily available in my community.	☐	☐	☐	☐	☐

Natural + Built Environment

7. The natural and built environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
My community feels safe.	☐	☐	☐	☐
People like me have access to safe, clean parks and open spaces.	☐	☐	☐	☐
People like me have access to reliable transportation.	☐	☐	☐	☐
People like me have housing that is safe and good quality.	☐	☐	☐	☐
The air in my community is healthy to breathe.	☐	☐	☐	☐
The water in my community is safe to drink.	☐	☐	☐	☐
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards.	☐	☐	☐	☐
During extreme heat, people like me have access to options for staying cool.	☐	☐	☐	☐

Economic + Educational Environment

8. The economic and educational environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
People like me have access to good local jobs with living wages and benefits.	☐	☐	☐	☐
People like me have access to local investment opportunities, such as owning homes or businesses.	☐	☐	☐	☐
Housing in my community is affordable for people with different income levels.	☐	☐	☐	☐
People like me have access to affordable childcare services.	☐	☐	☐	☐
People like me have access to good education for their children.	☐	☐	☐	☐

9. How much do you agree or disagree with the statements below?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The built, economic, and educational environments in my community are impacted by **systemic racism**. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose.	☐	☐	☐	☐	☐
The built, economic, and educational environments in my community are impacted by **individual racism**. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly.	☐	☐	☐	☐	☐

Health + Access to care

10. The healthcare environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
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.	☐	☐	☐	☐

11. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

	I needed this type of care and was able to access it.	I needed this type of care but was not able to access it.	I did not need this type of care.
Routine medical care	☐	☐	☐
Dental (mouth) care	☐	☐	☐
Mental health care	☐	☐	☐
Reproductive health care	☐	☐	☐
Emergency care for a mental health crisis, including suicidal thoughts	☐	☐	☐
Treatment for a substance use disorder	☐	☐	☐
Vision care	☐	☐	☐
Medication for a chronic illness	☐	☐	☐

12. For any types of care that you needed <u>but were not able to access</u>, select the reason(s) why you were unable to access care.

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed
Routine medical care	☐	☐	☐	☐	☐	☐	☐
Dental care	☐	☐	☐	☐	☐	☐	☐
Mental health care	☐	☐	☐	☐	☐	☐	☐
Reproductive health care	☐	☐	☐	☐	☐	☐	☐
Emergency care for a mental health crisis, including suicidal thoughts	☐	☐	☐	☐	☐	☐	☐
Treatment for a substance use disorder	☐	☐	☐	☐	☐	☐	☐
Vision care	☐	☐	☐	☐	☐	☐	☐
Medication for a chronic illness	☐	☐	☐	☐	☐	☐	☐

If you selected "Another reason not listed" in the table above, please explain why you were unable to get the care you needed:

_____

13. How much do you agree with the following statements?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose.	☐	☐	☐	☐	☐
Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly.	☐	☐	☐	☐	☐

Experiences with Discrimination

14. It has been shown that experiencing discrimination negatively impacts the health and well-being of individuals and communities. In order to better understand these impacts, BILH would like to hear about your lived experience regarding discrimination. In the following questions, we are interested in the ways you are treated. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise.	☐	☐	☐	☐	☐	☐
You are unfairly stopped, searched, questioned, threatened, or abused by the police.	☐	☐	☐	☐	☐	☐
You receive worse service than other people at stores, restaurants, or service providers.	☐	☐	☐	☐	☐	☐
Landlords or realtors refused to rent or sell you an apartment or house.	☐	☐	☐	☐	☐	☐
Healthcare providers treat you with less respect or provide worse services to you compared to other people.	☐	☐	☐	☐	☐	☐

15. If you answered a few times a year or more, what do you think is the main reason for these experiences? You may select more than one.

- ☐ Ableism (discrimination on the basis of disability)
- ☐ Ageism (discrimination on the basis of age)
- ☐ Discrimination based on income or education level
- ☐ Discrimination based on the basis of religion
- ☐ Discrimination based on the basis of weight or body size
- ☐ Homophobia (discrimination against gay, lesbian, bisexual, or queer people)
- ☐ Racism (discrimination on the basis of racial or ethnic group identity)
- ☐ Sexism (discrimination on the basis of sex)
- ☐ Transphobia (discrimination against transgender or gender non-binary people)
- ☐ Xenophobia (discrimination against people born in another country)
- ☐ Don't know
- ☐ Prefer not to answer

16. Is there anything else you would like to share about the community you selected in the first question? If not, leave blank.

_____

_____

_____

About You

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

17. What is your age?

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

18. What is your current gender identity?

- ☐ Genderqueer or gender non-conforming
- ☐ Man
- ☐ Transgender
- ☐ Woman
- ☐ Prefer to self-describe: _____

19. What is your sexual orientation?

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

20. Which of these groups best represents your race? You will have space to enter ethnicity in the next question. (Please check all that apply.)

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

21. What is your ethnicity? (You can specify one or more)

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

22. 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: _____
- ☐ Prefer not to answer

23. What is the highest grade or level of school that you have completed?
- ☐ Never attended school
- ☐ Grades 1 through 8
- ☐ Grades 9 through 11/ Some high school
- ☐ Grade 12/Completed high school or GED
- ☐ Some college, Associates Degree, or Technical Degree
- ☐ Bachelor's Degree
- ☐ Any post graduate studies
- ☐ Prefer not to answer

24. 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

25. How long have you 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
- ☐ I have always lived in the United States
- ☐ Prefer not to answer

26. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?
- ☐ Never served in the military
- ☐ On active duty now (in any branch)
- ☐ On active duty in the past, but not now (includes retirement from any branch)
- ☐ Prefer not to answer

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

28. How would you describe your current housing situation?
- ☐ I rent my home
- ☐ I own my home
- ☐ I am staying with another household
- ☐ I am experiencing homelessness or staying in a shelter
- ☐ Other (specify_____)
- ☐ Prefer not to answer

29. Are you the parent or caregiver of a child under the age of 18?
- ☐ Yes (Please answer question 30)
- ☐ No
- ☐ Prefer not to answer

30. If you are the parent or caregiver for a child under 18, please indicate the age(s) of the child(ren) you care for. (Please check all that apply.)
- ☐ 0-3 years
- ☐ 4-5 years
- ☐ 6-10 years
- ☐ 11-14 years
- ☐ 15-17 years

31. 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 you 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 (Feel free to share: _____)

If you would like to be entered into the drawing to win a $100 gift card, please enter your name and the best way to contact you in the box (phone number or email). This information will not be used to identify your answers to the survey in any way. Please detach this sheet, and return the survey and this sheet to the place you picked it up.

First Name and Email or Phone:

If you would like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities, please enter your email address below. This information will not be used to identify your answers to the survey in any way. Please detach this sheet, and return the survey and this sheet to the place you picked it up.

Email:

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

Next
Back
Done

Beth Israel Lahey Health

Survey Distribution Channels: Global View Communications

Engaging with Diverse Communities

Survey Campaign Dates: November 1, 2021 – November 15, 2021.

Connecting with our diverse communities to understand and address the most pressing health-related concerns for residents is priority for BILH. GVC have deployed a marketing campaign to reach our target populations through a three-phase approach. First is an online survey which is followed by a listening session and then an annual meeting.

Our Approach

Research was conducted to determine the diverse target audiences based on zip codes surrounding our 10 hospitals and then cross-referenced with the top 2-to-3 diverse populations and languages based on the largest cohorts. That research indicated the following audiences: Hispanic, Black/African American, Chinese, Haitian, Indian, and Cape Verdean.

Winchester Hospital	Beverly/Addison Gilbert Hospital	Lahey Hospital and Medical Center	Anna Jaques Hospital	Beth Israel Deaconess Medical Center
01801 01806 01807 01808 01813 01815 01864 01867 01876 01880 01887 01888 01889 01890 02155 02156 02180 02153	01901 01902 01903 01904 01905 01910 01915 01923 01929 01930 01931 01937 01938 01944 01965 01966 01949	02420 02421 02474 02475 02476 01850 01851 01852 01853 01854 01960 01961 01730 01731 01803 01805 01821 01822 01862 01865 01940	01830 01831 01832 01833 01834 01835 01860 01913 01950 01951 01952 01985 01969	02445 02446 02447 02173 02492 02467
Mt. Auburn Hospital	**New England Baptist**	**BID – Milton Hospital**	**BID - Needham Hospital**	**BID – Plymouth Hospital**
02138 02139 02140 02141 02142 02143 02144 02145 02238 02239 02451 02452 02453 02454 02455 02474 02472 02474 02475 02476 02477 02478 02479	02445 02446 02447 02467 02026 02027	02169 02170 02171 02186 02187 02269 02368	02492 02494 02026 02027 02030 02090	02330 02331 02332 02345 02355 02360 02361 02362 02364 02366 02381

Channels

GVC utilized three types of marketing channels to expand our reach. Diverse print publications, precision audio, and digital advertising.

1. Print

The following print publications were selected based on reach or hyper targeted audiences. Translation was used if the publication publishes in languages other than English.

A. El Mundo – Spanish Translation

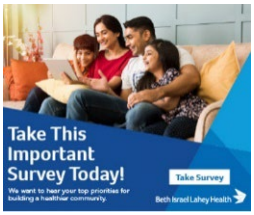
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

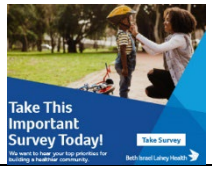
D. Bay State Banner – Black/African American, Cape Verdean/English

E. Chelsea Record – Hispanic/English

F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



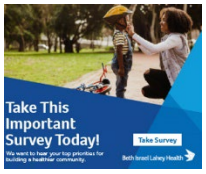
For the printed newspapers the publish dates are as follows:

Bay State	4-Nov
El Mundo	4-Nov
Sampan	5-Nov
Haitian Report (digital only)	2 weeks
Thang Long	2-Nov
India New England (digital only)	2 weeks
Chelsea	4-Nov

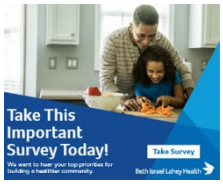
2. Digital Advertising

Digital ads will be served across various websites. GVC utilized a people-based marketing approach. The digital ads will be served up based on the zip codes provided and will include both English and translations based on user preferences. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

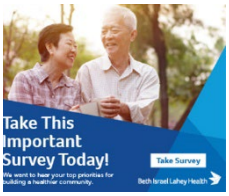
A. African American/Black, Haitian, Cape Verdean



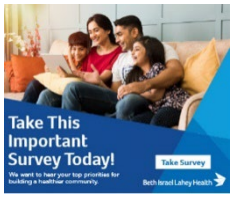
B. Hispanic



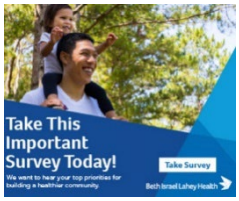
C. Chinese



D. Indian



E. Vietnamese



C. Precision Audio

GVC streamed :30 audio spots across multiple platforms (iHeart, NPF, PODcasts, Pandora, Spotify, etc.). GVC served up audio commercial voiceover for each hospital using zip codes. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

Sample audio script. Note: Script was customized for each of the 10 hospitals.

New England Baptist Hospital in Boston wants to hear what you think the most important health-related priorities are in our community. Please take an online survey at bilh.org/chna. Your responses will help to inform innovative solutions to improve the health of our community. Simply go to bilh.org/chna and fill out the survey. That's b-i-l-h.org/c-h-n-a.

Note: For social media and precision audio, this campaign is people based, so GVC is following each audience member and serving ad messaging where ever and whenever they are consuming online content (within the set frequency for the campaign).

For example, one person could be more active online early mornings – reading articles when he/she/they wake up; listening to streamed music while he/she/they commute – so GVC would then be sure to serve Mike his daily ad frequency during the times he is more active online, increasing the likelihood for click conversion with display ads – or in the case of audio, listening to the ad through to 100% completion. So basically going off of the targets media consumption.

Boston CHNA-CHIP Collaborative Community Health Needs Assessment Report

Boston CHNA-CHIP Collaborative

2022 Community Health Needs Assessment

Boston CHNA-CHIP Collaborative
2022 Community Health Needs Assessment

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EXECUTIVE SUMMARY

BACKGROUND

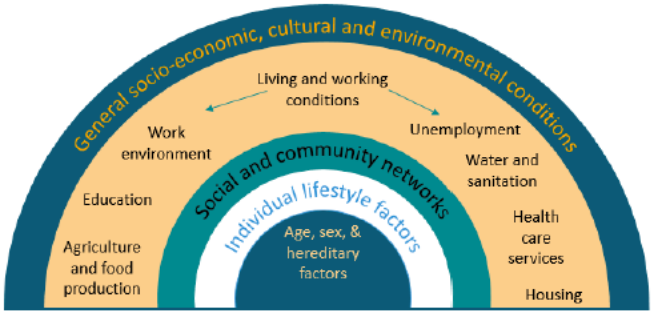
The Boston CHNA-CHIP Collaborative (the Collaborative) is a group of Boston health centers, community-based organizations, community residents, hospitals, and the Boston Public Health Commission. The Collaborative aims to achieve sustainable positive change in the health of the city by partnering with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. In 2019, the Collaborative conducted the first large-scale joint citywide community health needs assessment (CHNA) which then guided the city's community health improvement plan (CHIP), a blueprint describing how the Collaborative would focus on collectively addressing the key priorities.

In 2021-2022, the Collaborative worked together to develop the 2022 Boston CHNA. The 2022 Boston CHNA builds on the 2019 CHNA and takes a deep dive into the key priority areas identified in the 2020 community health improvement plan: housing, financial stability and mobility, behavioral health, and accessing services. The 2022 CHNA was conducted during an unprecedented time, including the COVID-19 pandemic and a reckoning with systemic racism.

METHODS

This CHNA focuses on the social determinants of health and is guided by a health equity lens. In the U.S., social, economic, and political processes work together to assign social status based on race and ethnicity, which may affect access to opportunities, such as educational and occupational mobility and housing options, each of which are intimately linked with health. Historical oppression, institutional racism, discriminatory policies, and economic inequality are several root factors that shape health inequities across the U.S.

Social Determinants of Health Framework



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

Existing secondary data were reviewed from national, state, and city sources, including datasets such as the American Community Survey, Boston Behavioral Risk Factor Surveillance System (BBRFSS), BBRFSS COVID-19 Health Equity Survey, and vital records, among other sources. For new data collection, key informant interviews were conducted with 62 leaders across sectors and 29 focus groups were facilitated with 309 residents who have been particularly burdened by social, economic, language, and health challenges. We use the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

COMMUNITY ASSETS AND STRENGTHS

- Residents described their communities as deeply connected, resilient, committed to solving problems, and comprised of several supportive community-based organizations.
- Key informants and focus group participants talked about their communities as being vibrant, full of rich cultural traditions, having a strong history of activism and art, intelligent, innovative, and committed to solving problems.

> *"The community has come together for food distributions, to work together as a community to support the community with food access. There is always more to do, but this is a way that we have improved and supported each other."*
> - Focus group participant

OVERALL HEALTH AND MORTALITY

- Community Health Perceptions: Top of mind health concerns for focus group and interview participants were mental health, substance use, heart disease, diabetes, asthma, and obesity, all of which they perceived as being harder to tackle during the pandemic.
- Leading Causes of Death: COVID-19 was the leading cause of death for Black, Latino, and Asian residents in Boston in 2020. Additional leading causes of death were chronic diseases and accidents.

Leading Causes of Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	**COVID-19** 138.4	**COVID-19** 95.1	**COVID-19** 238.1	**COVID-19** 143.5	**Cancer** 117.6
2	**Cancer** 117.4	**Cancer** 92.8	**Heart Disease** 183.6	**Heart Disease** 86.1	**Heart Disease** 113.1
3	**Heart Disease** 114.9	**Heart Disease** 55.4	**Cancer** 166.7	**Cancer** 78.8	**COVID-19** 103.5
4	**Accidents** 53.7	**Cerebrovascular Diseases** 22.2 †	**Accidents** 82.7	**Accidents** 59.5	**Accidents** 53.2
5	**Cerebrovascular Diseases** 27.4	**Accidents** 17.1 †	**Cerebrovascular Diseases** 52.8	**Diabetes** 27.4	**Chronic Lower Respiratory Diseases** 24.7

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office

FINANCIAL STABILITY AND MOBILITY: Jobs, Employment, Income, Education, and Workforce Training

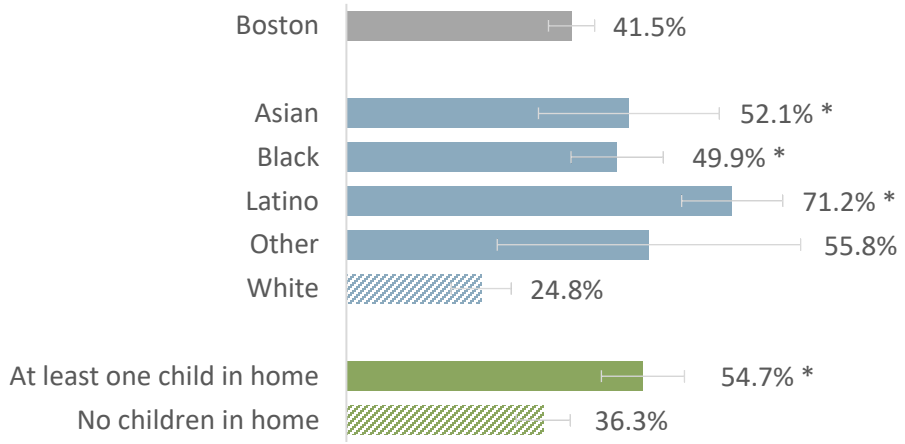
- Income and Poverty: Community leaders and residents described financial stability as critical for health and shared that low-wage work and minimum wage is insufficient for many families to survive in Boston. Residents noted that the pandemic has worsened poverty for low-income residents across Boston. Based on the COVID-19 Health Equity Survey, income loss during the pandemic has disproportionately affected residents of color and low-income residents.

- Food Insecurity: Barriers to accessing healthy, affordable food emerged as a priority issue, which worsened during the pandemic and by the rising cost of food. According to the COVID-19 Health Equity Survey, food insecurity is greatest among residents of color and adults with children at home.
- Employment: Interview and focus group participants described significant job loss linked with the pandemic and noted that finding and securing stable jobs is more difficult for residents of color, immigrants, people with disabilities, and residents with a criminal record. They also shared that low-wage workers, especially immigrants, worked in high-risk job settings during the pandemic.
- Education: Focus group and interview participants described remote learning and the pandemic as particularly hard for youth who already face disproportionate challenges in school. According to the COVID-19 Health Equity Survey, 14.5% of Boston adults with children reported unmet educational needs for children or teens during the pandemic.

HOUSING: Affordability, Quality, Homelessness, Homeownership, Gentrification, and Displacement

- Housing Affordability: Interview and focus group participants cited housing affordability as a dominant concern that has been exacerbated by the pandemic due to high housing costs and employment fluctuations. In the COVID-19 Health Equity Survey, 41.5% of adults reported having trouble paying their rent or mortgage during the pandemic, with highest proportions reported among residents of color and adults with children at home.
- Housing Instability and Transiency: Community leaders and residents described housing assistance as insufficient to meet the needs of low-income residents and expressed concern about ending rental assistance programs instituted during the pandemic. Residents underscored how the lack of affordable housing contributes to homelessness and housing instability, overcrowded housing, and housing displacement – which adversely affect mental health.
- Housing Conditions, Overcrowding, and COVID-19: Residents noted that COVID-19 cases often affected several household members, which they linked to dense living conditions that make it difficult to isolate or quarantine and people working multiple jobs outside of the home.

Percent Adults Reporting Having Trouble Paying Their Rent or Mortgage During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Questionnaire, December 2020 - January 2021

BEHAVIORAL HEALTH: Mental Health and Substance Use

- Trauma, Discrimination, and Racism: Residents discussed that some groups are disproportionately affected by trauma, discrimination, and racism, including: residents of color, lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) communities, veterans, people with disabilities, people who have experienced violence, low-income residents, and those who lost loved ones during the pandemic. In the 2015-2019 BBRFSS, reports of being threatened at least a few times a month due to discrimination were highest among Black and Latino residents.

> *"The trauma also perpetuates these issues, and the environment also perpetuates these issues and systemically the services that we don't get perpetuates these issues. So that is why racism is a public health crisis."*- Key informant interview

- Community Violence and Interactions with Police: Some residents discussed community violence and safety concerns as well as increased neighborhood conversations about community and police relations. In 2015-2019, the most recent years for which data are available, BBRFSS respondents' reports of feeling like they were stopped by police due to their race or ethnicity were highest among residents of color.
- Mental Health, Depression, and Suicide: Mental health was a key issue pre-pandemic and the impact of the pandemic only heightened that concern, particularly for children, youth, and caregivers. According to the COVID-19 Health Equity Survey, during the pandemic 16.8% of Boston adults reported experiencing persistent sadness and 21.9% reported persistent anxiety during the pandemic for more than half of the days in the past 2 weeks. Notably, 29.2% of LGBTQIA+ Youth Risk Behavior Survey (YRBS) student respondents reported having had suicidal thoughts in 2015-2019.
- Behavioral and Mental Health Care Access and Barriers to Care: Residents discussed several barriers to accessing mental health care, including a limited number of mental health providers, financial barriers, a lack of culturally appropriate and linguistically congruent care, and stigma surrounding mental health care. Based on the COVID-19 Health Equity Survey, 9.9% of Boston adults reported delaying mental health care due to the pandemic and 7.1% reported delaying mental health care because of cost.
- Substance Use: Substance use concerns that emerged include misuse of drugs, overusing prescriptions and over-the-counter medicines, and smoking nicotine and marijuana, particularly among LGBTQIA+ residents and youth. According to COVID-19 Health Equity Survey, 27.8% of Boston adults reported increased drinking habits during the pandemic.

ACCESSING SERVICES: Childcare, Social Services, and Health Care

- Accessing Childcare Services: In focus groups and interviews, childcare emerged as a growing need due to the pandemic. According to the COVID-19 Health Equity Survey, 14.3% of Boston adults reported that children in their households experienced unmet childcare needs during the pandemic.
- Accessing Social and Other Services: Residents and community leaders discussed rising and acute social and economic needs among a growing segment of low-income residents and significant barriers to accessing services, such as: transportation, difficulty navigating application processes, limited Internet, and lack of eligibility due to immigration status. Several participants also discussed systemic racism, racial injustice, and discrimination. In 2015-2019 BBRFSS data, 28.4% of Boston residents reported receiving poor service at restaurants or stores in day-to-day life due to their race or ethnicity, with a higher proportion of respondents of color indicating having this experience.

- Accessing Health Care Services: Residents identified barriers to accessing health care, including: income, health insurance, distrust towards providers, difficulty navigating the health care system, transportation, difficulty securing a medical appointment, language barriers, and limited culturally relevant care. Residents described how racial and ethnic inequities in health care access and social factors – such as transportation and Internet access – have been magnified by the COVID-19 pandemic.

> *"Due to my language barriers, I was not able to express my health concerns and had a hard time to communicate with doctors to get right treatment."*- Focus group participant

COMMUNITY'S VISION AND COMMUNITY SUGGESTIONS FOR THE FUTURE

Interview and focus group participants were asked for their suggestions for addressing identified needs and their vision for the future. Suggestions included the following:

- Deepen Partnerships with Local Communities and Collaborate to Promote Health Equity
- Focus on Dismantling Systemic Racism
- Create Opportunities that Foster Economic Stability and Mobility
- Improve Housing Affordability
- Improve Access to and Quality of Behavioral Health Care
- Strengthen Health Care Policies and Improve Health Care Access and Quality
- Promote Child and Youth Development
- Create a Healthier Built and Physical Environment

PRIORITIES FOR COLLABORATIVE ACTION

For the past two years, the Boston CHNA-CHIP Collaborative has been implementing the 70 strategies outlined in the 2020 community health improvement plan. Great progress has been made on many of these strategies, while other strategies have not been implemented as extensively given constrained capacity and the current context of the COVID-19 pandemic.

Given this backdrop, the 2022 prioritization process focused on:

1) reaffirming the previous priorities and identifying any new issues that have emerged; and
2) prioritizing specific strategies within these major areas that should be lifted up for future action.

In May-June 2022, 62 participants were engaged in four community listening sessions to discuss the CHNA findings, provide feedback on the data and key priority areas, and systematically vote on the 2020 CHIP strategies for more focused implementation. The results reaffirmed the CHIP's priorities of:

- **Housing** (including affordability, quality, homelessness, ownership, gentrification, and displacement)
- **Financial Security and Mobility** (including jobs, employment, income, education, and workforce training which comprised this priority in the past CHIP, and including food security which emerged as a salient issue in the 2022 CHNA)
- **Behavioral Health** (including mental health and substance use)
- **Accessing Services** (including health care, childcare and social services)

Boston CHNA-CHIP Collaborative
2022 Community Health Needs Assessment

BACKGROUND

This report is the 2022 community health needs assessment for the Boston CHNA-CHIP Collaborative. A community health needs assessment, or CHNA, gathers community input and data to gain a greater understanding of the strengths of the community, the issues that residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. CHNAs provide a data-informed foundation for planning and the development of initiatives.

The Boston CHNA-CHIP Collaborative (the Collaborative) is a group of Boston community residents, community-based organizations, community development corporations, health centers, the hospitals, and the Boston Public Health Commission. This group has come together to achieve sustainable positive change in the health of the city by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. One of the fundamental approaches for this work is to conduct a community health needs assessment so efforts are informed by data and community members themselves. While community health assessment and planning have been long-standing endeavors among organizations across the city, the Collaborative aims to leverage, align, and coordinate efforts and resources across multi-sector stakeholders in Boston. More details about the Collaborative's structure and engagement can be found in the Methods section of this report, Appendices A-C, and at http://www.bostonchna.org/.

Purpose and Context of the 2022 Community Health Needs Assessment

In 2019, the Collaborative conducted the first large-scale joint citywide CHNA which then guided the city's community health improvement plan (CHIP), a blueprint describing how the Collaborative would focus on collectively addressing the key priorities. The 2022 Boston CHNA builds on those efforts by taking a deep dive into the key priority areas identified in the previous CHIP: housing, financial stability and mobility, behavioral health, and accessing services.

This 2022 CHNA was conducted during an unprecedented time, including the COVID-19 pandemic, which exacerbated many social and economic inequalities that have been present for generations. The pandemic contributed to a staggering number of COVID-19 cases, deaths, and ongoing health challenges which disproportionately affected marginalized populations. During this same period, there has been a growing national movement calling for racial equity to address racial injustices in the U.S. The growth of this movement has been sparked by the killings of several Black Americans including George Floyd and Ahmaud Arbery. In 2020, the City of Boston declared racism as a public health crisis, underscoring the City's commitment to dismantle structural racism and recognize historical injustice.

This context shaped the assessment approach and content, in that the 2022 Boston CHNA also explores how the pandemic and racial injustices have affected priorities that emerged from the previous CHIP.

These processes have been guided by the Collaborative's shared values of:

- **Equity**: Focus on inequities that affect health with an emphasis on race and ethnicity;
- **Inclusion**: Engage diverse communities and respect diverse viewpoints;
- **Data driven**: Be systematic in our process and employ evidence-informed strategies to maximize impact;
- **Innovative**: Implement approaches that embrace continuous improvement, creativity, and change;
- **Integrity**: Carry out our work with transparency, responsibility, and accountability;
- **Partnership**: Build trusting and collaborative relationships between communities and organizations to foster sustainable, community-centered change.

Definition of Community Served

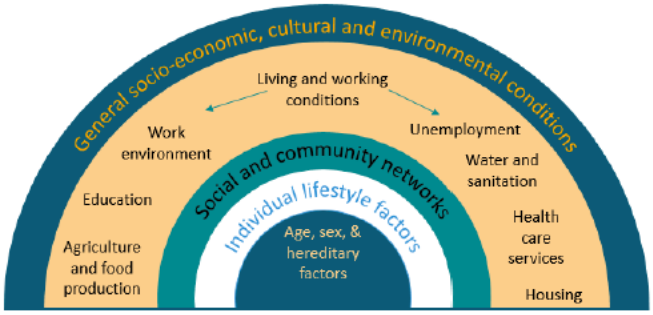
The 2022 Boston CHNA focused on the geographic area of the City of Boston. When available and appropriate, the data are presented for Boston overall and by different sub-populations. This includes by race/ethnicity, neighborhood, and other defining characteristics.

METHODS

Social Determinants of Health Framework

This CHNA focuses on the social determinants of health and is guided by a health equity lens (Figure 1). The contexts in which population groups live, learn, work, and play have a profound impact on health. There is often a deep connection between how race, ethnicity, income, geography, and other factors shape health patterns. In the U.S., social, economic, and political processes work together to assign social status based on race and ethnicity, which may affect access to opportunities, such as educational and occupational mobility and housing options, each of which are intimately linked with health. Historical oppression, institutional racism, discriminatory policies, and economic inequality are several of the root factors that shape persistent and emerging health inequities across the U.S.

Figure 1. Social Determinants of Health Framework



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

Review of Secondary Data

The 2022 Boston CHNA data gathering effort included a review of existing secondary data on social, economic, and health indicators. These indicators provide insights into patterns across Boston, by Boston neighborhood, and by population groups within Boston. Secondary data sources included U.S. Census/American Community Survey, vital statistics (birth/death records), hospital case mix data,

Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), BBRFSS COVID-19 Health Equity Survey, Youth Risk Behavior Survey (YRBS), and the Massachusetts Department of Public Health Bureau of Substance Addiction Services treatment data.

The Secondary Data Work Group of the Collaborative included 16 members representing a range of organizations, including hospitals, health centers, and local public health. The Secondary Data Work Group's charge was to provide guidance on secondary data approach and indicators and foster connections with key networks and groups to provide relevant data (See Appendix B for list of members).

To identify the list of social, economic, and health indicators, Secondary Data Work Group members reviewed the indicator list from the 2019 Boston CHNA and prioritized which indicators should be revisited for the 2022 report. The secondary data work group engaged in multiple discussions and prioritized the secondary data that aligned with the 2019 priority areas; that COVID-19 had a disproportionate impact on, and/or where there were the greatest inequities by race/ethnicity, neighborhood, or other characteristics.

Secondary data in the 2022 CHNA represent the most recent data available, and in several cases overlap with data included in the 2019 CHNA due to the need to combine data across years to look at patterns by neighborhood and social and demographic factors. Qualitative discussions (described in the section that follows) build upon the secondary data by shedding light on residents' recent experiences with and perspectives on many factors, including the social determinants of health and how these issues have been affected by the COVID-19 pandemic. Additional detail on the secondary data approach can be found in Appendix D, while Appendix F presents numerous additional data tables and graphs beyond what is covered in the body of this report.

Qualitative Discussions and Community Engagement

The Community Engagement Work Group includes 24 members representing a range of organizations, including health centers, local public health, community development, community-based organizations, and hospitals. The Work Group's charge is to provide guidance on the approach to community engagement, input on primary data collections methods, and support with logistics for primary data collection (See Appendix B for list of members). The Collaborative's Community Engagement Work Group led efforts to gain insight into community needs and strengths as well as priorities from community leaders and residents, especially among those where there has been a gap in representation in previous processes. Altogether, they facilitated 29 virtual and in-person focus group discussions with a total of 309 residents who have been disproportionately burdened by social, economic, and health challenges including: youth and adolescents, older adults, persons with disabilities, low-resourced individuals and families, LGBTQIA+ populations, racially/ethnically diverse populations (e.g., African American, Latino, Haitian, Cape Verdean, Vietnamese, Chinese), limited-English speakers, immigrant and asylee communities, families affected by incarceration and/or violence, and veterans. Some focus groups were conducted in languages other than English, including Spanish, Chinese, and Vietnamese. Please see Appendix D for more details on the community engagement process and qualitative data approach.

Collaborative members conducted key informant interviews with 62 individuals. These represented a cross-section of sectors to identify areas of action and perspectives on the community. These interviewees included leaders and staff from public health, health care, behavioral health, the faith community, immigrant services, housing organizations, economic development, community

development, racial justice organizations, social service organizations, education, community coalitions, the business community, childcare centers, elected government offices, and others. Please see Appendix E for a list of key informant interviewee organizations.

Additionally, Collaborative members conducted four 90-minute virtual Community Listening Sessions in January 2022. A total of 122 community members participated in these four sessions. These sessions occurred mid-way into the CHNA process and provided an opportunity to gather feedback and insights on preliminary data findings and potential priorities at this point in time. During these sessions, Collaborative members shared preliminary themes from focus groups, interviews, and the review of secondary data. The participants discussed their reactions and feedback to these preliminary findings in small groups and identified areas that were their highest priority for action.

To deepen understanding of issues that were salient to respondents, interview, focus group, and community listening session discussion guides used open-ended questions and did not ask about specific topics. Community engagement work group members and their partners conducted the focus groups and interviews, and then summarized the key themes from the discussions they facilitated. These summaries were then analyzed to identify common themes and sub-themes across population groups as well as unique challenges and perspectives identified by populations and sectors, with an emphasis on diving deep into the root causes of inequities. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. Additional information on the qualitative data collection and analysis process can be found in Appendix D. We use the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

Limitations

While the data sources used in this CHNA are highly credible, there are some important limitations and considerations that are important to keep in mind. Qualitative discussions use small sample sizes and non-random sampling methods, the latter of which is an important approach to incorporating the perspectives of communities who were underrepresented in previous processes. Moreover, due to the ongoing COVID-19 pandemic, Collaborative members conducted the majority of interviews and focus group discussions remotely, which may have affected participation – both in terms of who is able to participate remotely and the information elicited in remote discussions.

Secondary data may have a time lag and apply different ways of measuring variable such as neighborhoods. Additionally, BBRFSS data from 2015-2019 are the most recent data available regarding the experiences, health behaviors, and self-reported health and health care patterns among Boston residents. Given the need to aggregate data across years to look at patterns across neighborhoods and population groups, data from the 2015-2019 period overlap with data reported in the 2019 community health needs assessment. Finally, COVID-19 data provide a snapshot in one moment in time in the ongoing pandemic and are not representative of the entire pandemic.

2022 CHNA: A Snapshot in Time during the COVID-19 Pandemic

The COVID-19 pandemic has been an important and evolving backdrop to the 2022 Boston CHNA, and thus shapes how the COVID-19 pandemic has affected priority areas identified in the 2019 CHNA. Despite access to vaccinations beginning in late 2020 and early 2021, there have been multiple increases in case rates linked with the onset of the Delta and Omicron variants. The COVID-19 pandemic is marked by significant changes and inequities in health, the economy, and the workforce. Given the unprecedented nature of the COVID-19 pandemic, it is critical now, more than ever, to understand community needs, experiences, and opportunities for the future.

We also recognize how the pandemic has shaped this process. As part of the BBRFSS, a separate COVID-19 Health Equity Survey was conducted by the Boston Public Health Commission to better understand experiences among residents who have been most impacted by the pandemic. This survey of a random sample of over 1,650 residents in multiple languages was conducted in December 2020/January 2021 and examined issues related to job loss, food insecurity, access to services, mental health, as well as COVID-19 risk perceptions, vaccination, and information sources.

Additionally, the COVID-19 pandemic affected the data collection methods as most of the focus groups and interviews occurred by telephone or video conference. Not surprisingly, the COVID-19 pandemic came up quite a bit during the discussions – but less about the disease itself, and more about how the pandemic has highlighted long-standing and existing inequities that have been pervasive in Boston and the U.S. For these reasons, findings should be understood as capturing a snapshot in an unprecedented moment in time.

BOSTON POPULATION – RACE, ETHNICITY, AND LANGUAGE

Boston's population is incredibly diverse in terms of race and ethnicity, country of birth, and language use. While the racial and ethnic distribution across Boston has remained similar since the 2019 CHNA, the racial and ethnic composition is changing across neighborhoods.

Race and Ethnic Diversity

Historic disinvestment in communities of color are the root causes of racial inequities in the social determinants of health.[1] Racial and ethnic health and health care inequities are persistent and are among the leading public health challenges of our time. For example, people of color experienced a disproportionate burden of COVID-19-related income loss, cases, and deaths, whereas White residents appeared to weather the COVID-19 pandemic with fewer social, economic, and health costs.[2,3] Understanding the racial, ethnic, and language profiles of Boston residents provides context to data about health status and the structural, discriminatory, and social factors that contribute to health inequities.

Focus group participants and key informants discussed the racial diversity of residents across Boston as a unique strength, highlighting Black/African American, African, Latino, Cape Verdean, Haitian, Asian, and other Caribbean communities in the Boston area. According to Census estimates (

Table 1), approximately 3 in 5 (60.0%) Boston residents identify as people of color. Mattapan, Hyde Park, Dorchester, and Roxbury are home to the largest proportion of Boston residents who identify as Black. East Boston, Roxbury, Hyde Park, and Dorchester's 02121 and 02125 zip codes have the largest percent of residents who identify as Latino, while Fenway and Allston/Brighton are home to the largest proportion of Asian residents.

Table 1. Racial and Ethnic Distribution, by Boston and Neighborhood, 2020

	Asian	Black	Latino	White	Two or More Races
Boston	9.7%	25.2%	19.8%	44.5%	5.3%
Allston/Brighton	19.3%	4.9%	11.1%	59.0%	4.2%
Back Bay	12.7%	3.5%	7.4%	71.9%	3.7%
Charlestown	8.6%	5.2%	10.9%	71.3%	3.5%
Dorchester (02121, 02125)	11.4%	33.5%	23.7%	17.7%	9.5%
Dorchester (02122, 02124)	8.6%	39.5%	15.5%	29.1%	5.3%
East Boston	4.5%	3.3%	50.4%	36.6%	3.6%
Fenway	24.1%	6.6%	9.0%	55.0%	3.6%
Hyde Park	2.2%	45.7%	24.7%	21.9%	4.2%
Jamaica Plain	7.6%	10.0%	20.3%	56.2%	5.0%
Mattapan	1.0%	68.3%	21.0%	2.5%	5.6%
Roslindale	3.7%	15.4%	20.4%	55.3%	4.2%
Roxbury	11.0%	35.7%	27.3%	19.4%	5.0%
South Boston	5.1%	4.2%	10.4%	76.6%	2.9%
South End	15.6%	12.6%	14.7%	52.4%	3.9%
West Roxbury	7.4%	13.3%	13.0%	62.2%	3.3%

DATA SOURCE: U.S. Census, Decennial Census of Population and Housing, 2020
NOTE: Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Latino includes residents who identify as Latino regardless of race and race categories may include residents who identify as Latino; therefore, the percentages may not add up to 100%

Language and Immigrant Communities

A theme across several interviews and focus groups was that immigrant communities in the Boston area are hardworking, family- and community-oriented, willing to help others, eager to contribute socially and economically, and passionate about local issues and issues in their home countries. Several key informants and focus group participants observed that undocumented immigrants experienced additional barriers to housing, health insurance, and accessing resources and assistance programs, which they perceived were based on legal status and fear of deportation.

> *"I think [specific neighborhoods] are great for new immigrants. When you first come to the United States, you need help from others."*
> - Focus group participant

Key informants and focus group participants noted many languages spoken among residents, including Cantonese, Mandarin, Russian, Spanish, Haitian Creole, Cape Verdean Creole, and indigenous languages. Some residents described free English classes as an important resource for residents for whom English is not their first language. However, language barriers still emerged as an important issue affecting immigrant communities.

COMMUNITY ASSETS AND STRENGTHS

Residents described their communities as deeply connected, resilient, committed to solving problems, and comprised of several supportive community-based organizations.

Understanding the strengths of community members and community resources and services helps to identify the assets that can be drawn upon to promote community health and address any existing gaps. When asked about community strengths, residents discussed a strong sense of community among residents, especially those who have lived in neighborhoods for years. They described their neighbors as supporting each other even when they themselves have limited resources. Focus group participants described their neighbors as *"resilient"* and *"resourceful"* even under difficult circumstances. Key informants and focus group participants talked about their communities as being vibrant, full of rich cultural traditions, having a strong history of activism and art, intelligent, innovative, and committed to solving problems.

Focus group participants and key informants discussed the breadth of community-based institutions and services that they knew of, especially those focused on early childhood, youth, young men of color, food security, housing, mental health, health care, caregiver support, workforce development, and the LGBTQIA+ population. Resource sharing and collaboration among a network of community-based organizations was also discussed as a strength. Residents described other community strengths, including engaged elected officials, educational opportunities and the school system, green space (e.g., parks), accessible libraries, and easy access to the transportation system.

> *"The community has come together for food distributions, to work together as a community to support the community with food access. There is always more to do, but this is a way that we have improved and supported each other."*
> - Focus group participant

OVERALL HEALTH AND MORTALITY

Top of mind health concerns for focus group and interview participants were mental health, substance use, heart disease, diabetes, asthma, and obesity, all of which they perceived as being harder to tackle during the pandemic. Meanwhile, COVID-19 was the leading cause of death for Black, Latino, and Asian residents in Boston in 2020.

Community Perceptions of Health

Mental health, substance use, heart disease, diabetes, asthma, and obesity were most frequently brought up as health concerns during interviews and focus group discussions. Key informants and focus

group participants also described a high case rate of COVID-19 for immigrants and communities of color (e.g., Haitian, Cape Verdean, Latino) and for residents of color and low-wage workers who were not able to work from home**.**

Other health concerns discussed by community leaders and residents included cancer, dementia, Alzheimer's, osteoporosis, oral health, Black women's maternal health, and chronic obstructive pulmonary disease (COPD). Some key informants and focus group participants underscored how pre-existing conditions have worsened during the COVID-19 pandemic, including chronic conditions that are difficult to manage, conditions that have remained undiagnosed, and chronic conditions linked with trauma. Youth and LGBTQIA+ focus group participants described sleep as critical to promoting health and identified stress and anxiety as barriers to living a healthy lifestyle and getting adequate sleep. Several focus group participants, particularly youth and residents in Chinatown, cited environmental quality as being linked with health, including air pollution, poor ventilation, smoke from tobacco and marijuana use, and lack of cleanliness in the neighborhood.

Several focus group participants described physical activity, including going for a walk, playing sports, and working out, as important for feeling good, relieving stress, and overall health. Focus group participants explained that during the COVID-19 pandemic they have not been able to do as much physical activity and have been quite sedentary. As one participant mentioned, *"People have not been active through COVID – kids and adults have put on so much weight – some have become obese. I am worried about the kids – they don't get enough activity."* Focus group participants cited the importance of and need for green space (e.g., parks, access to walking paths) to enable residents to spend time outside safely and to be physically active in an affordable way. Several focus group participants noted the importance of clean neighborhoods, including air quality and trash. LGBTQIA+ focus group participants also described a need for gyms that are more welcoming to LGBTQIA+ residents.

> *"It seems like almost every family has high blood pressure, high cholesterol, or diabetes."*
> -Focus group participant

Additional data on health issues such as asthma, birth outcomes, and physical activity can be found in Appendix F.

Overall Mortality

In 2020, COVID-19 was the leading cause of death for Black, Latino, and Asian residents in Boston, whereas cancer was the leading cause of death for White residents (

Table 2). Additional leading causes of death were accidents and chronic diseases, such as cancer, heart disease, and cerebrovascular diseases. In the 2019 Boston CHNA, cancer was the leading cause of death across each of the largest racial and ethnic groups in Boston.

Table 2. Leading Causes of Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	**COVID-19** 138.4	**COVID-19** 95.1	**COVID-19** 238.1	**COVID-19** 143.5	**Cancer** 117.6
2	**Cancer** 117.4	**Cancer** 92.8	**Heart Disease** 183.6	**Heart Disease** 86.1	**Heart Disease** 113.1
3	**Heart Disease** 114.9	**Heart Disease** 55.4	**Cancer** 166.7	**Cancer** 78.8	**COVID-19** 103.5
4	**Accidents** 53.7	**Cerebrovascular Diseases** 22.2 †	**Accidents** 82.7	**Accidents** 59.5	**Accidents** 53.2
5	**Cerebrovascular Diseases** 27.4	**Accidents** 17.1 †	**Cerebrovascular Diseases** 52.8	**Diabetes** 27.4	**Chronic Lower Respiratory Diseases** 24.7

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable

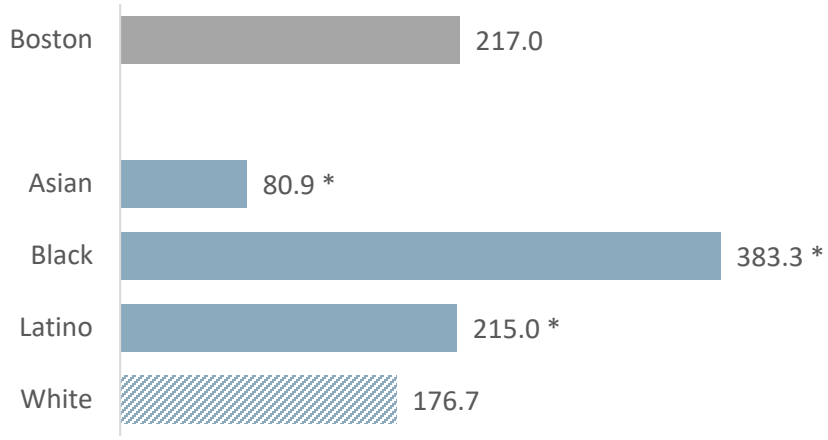
Of note, the cancer mortality rate for each of Boston's largest racial and ethnic groups in 2020 was lower than that reported in the 2019 community health needs assessment. During this same period, the heart disease mortality rate appeared to increase among Black residents, decrease for Asian and White residents, and remained relatively stable for Latino residents. Since the 2019 community health needs assessment, the accident-related mortality rate increased for Black and Latino residents, remained relatively stable for White residents, and emerged as a leading cause of death for Asian residents. The rate of mortality due to cerebrovascular disease increased for Black residents, remained stable for Asian residents, and did not emerge as the top five causes of mortality for Latino and White residents, likely due to COVID-19 becoming a leading cause of death in 2020. The diabetes-related mortality rate remained stable for Latino residents since the 2019 community health needs assessment. (It should be noted that changes in mortality rates over time were not tested for statistically significant differences.)

Premature mortality refers to deaths among persons under 65 years of age. The premature mortality rate in 2020-2021 was highest among Black and Latino residents (

Figure 2). Of note, the premature mortality rate for Black residents is more than double the premature mortality rate for White residents.

Accidents was the leading cause of premature mortality among all race/ethnicities in Boston except for Asian residents, who experienced cancer as the leading cause of premature death (Table 3). COVID-19 was the second leading cause of premature mortality among Latino residents, underscoring the impact of the pandemic among this community. Notably, homicide is the fifth leading cause of death in Black and Latino communities and the homicide mortality rate for Black residents exceeds the cancer mortality rate for White residents.

Figure 2. Premature Mortality Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



DATA SOURCE: Boston Public Health Commission, Boston resident deaths, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Premature deaths are defined as deaths at an age under 65 years; Bars with pattern indicate reference group for its specific category; Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events.
Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05).

Table 3. Leading Causes of Premature Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	**Accidents** 48.0	**Cancer** 28.7 †	**Accidents** 77.0	**Accidents** 56.7	**Accidents** 46.5
2	**Cancer** 31.1	**Accidents** 12.9 †	**Heart Disease** 58.9	**COVID-19** 33.3	**Cancer** 25.7
3	**Heart Disease** 28.4	**Heart Disease** 11.9 †	**Cancer** 53.7	**Cancer** 23.2	**Heart Disease** 24.2
4	**COVID-19** 17.8	**Suicide** 6.1 †	**COVID-19** 34.1	**Heart Disease** 20.9	**COVID-19** 8.9
5	**Homicide** 7.5		**Homicide** 30.6	**Homicide** 8.8 †	**Chronic Liver Disease & Cirrhosis** 8.6

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Premature deaths are defined as deaths at an age under 65 years; Insufficient number of records for analysis for Asian residents; Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events;
Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable

CHIP PRIORITY AREA - FINANCIAL STABILITY AND MOBILITY: JOBS, EMPLOYMENT, INCOME, EDUCATION, AND WORKFORCE TRAINING

Community leaders and residents discussed how the COVID-19 pandemic has worsened already existing income inequalities and the level and severity of poverty for low-income residents across Boston.

Financial stability and mobility - including income, jobs, employment, education, and workforce training - was a priority area in the 2019 Boston CHNA-CHIP. Income, work, and education are powerful social determinants of health. Jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access to affordable healthy foods), and provide income and benefits to access health care.[4] In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, goods and services that are linked with health, and health care, and also contribute to stressful life circumstances that affect multiple aspects of health.[5]

Income and Poverty

In the 2019 Boston CHNA, poverty and economic instability emerged as key areas of concern among residents and there were substantial differences in income and financial security across Boston neighborhoods and by race and ethnicity.

> *"My husband has 2 jobs so we can pay the rent and food, clothing, everything. It is really difficult now, this situation that is happening."*- Focus group participant

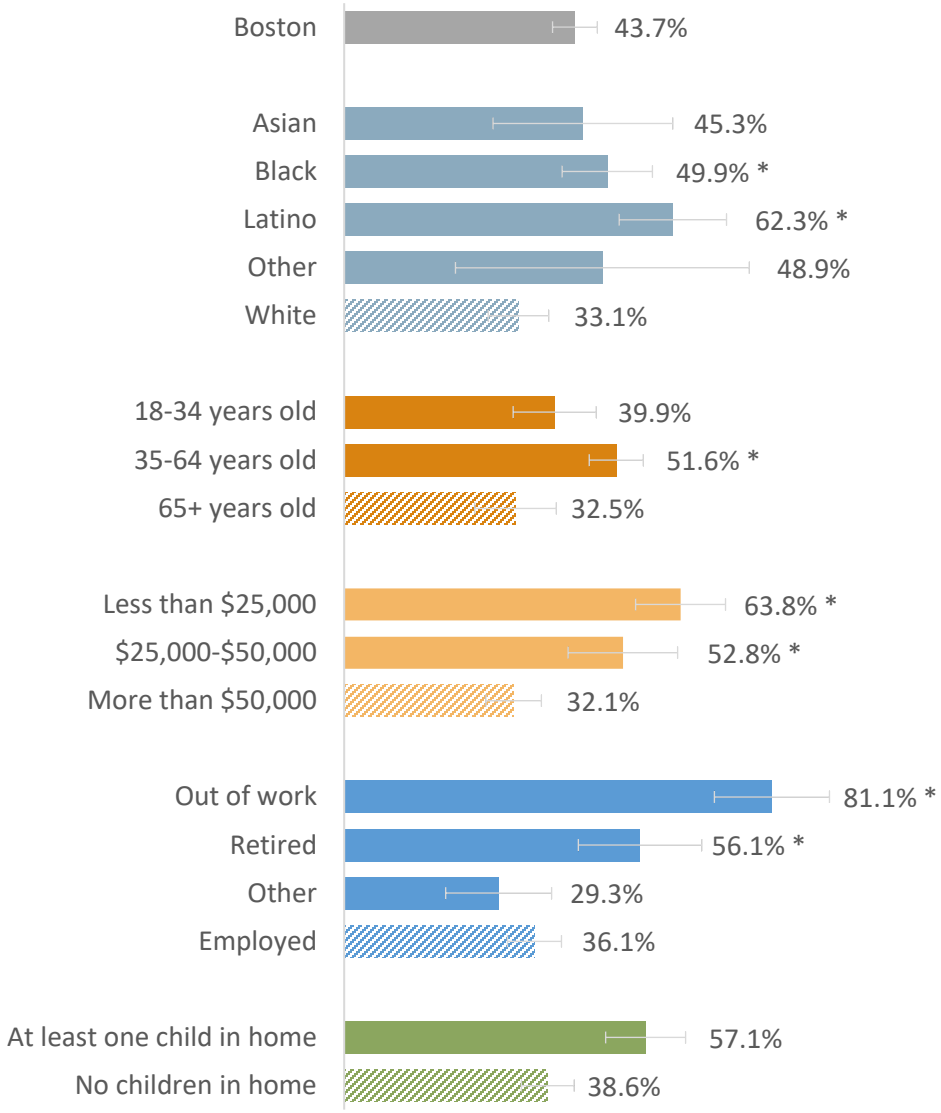
Similar to the past process, focus group participants and key informants engaged in the 2022 Boston CHNA described financial stability as critically important for health. Key informant interviewees and focus group participants shared that the COVID-19 pandemic has worsened income inequalities and the level and severity of poverty for low-income residents across Boston. According to the COVID-19 Health Equity Survey, income loss during the pandemic has disproportionately affected residents of color and low-income residents, described in more detail below. Key informants and focus group participants noted that low-income communities in Boston generally include residents of color, immigrants, people with disabilities, LGBTQIA+ residents, and older adults on fixed incomes.

Focus group participants and key informants noted that low-wage work and minimum wage is not enough for many families to survive in Boston, and that many residents are having to work multiple jobs to make ends meet. Several interviewees and focus group participants discussed that while income loss has affected many people, they were most concerned about those residents who were already struggling before the pandemic – this includes low-income communities, residents of color and in particular immigrants, people with disabilities, and residents with a criminal record. They described the cost of living as high and rising, including escalating housing and food costs while wages have not increased. As one participant noted, *"Food prices have gone up a lot while my wage has stayed the same."* From April 2021 to April 2022, food prices increased an estimated 9.4%.[6]

Some key informants noted that neighborhoods that have historically experienced disinvestment continue to experience greater challenges to growth and development, and small businesses in low-income communities have been hit hard by the COVID-19 pandemic. Some elected officials described insufficient access to capital and financial instability as barriers to community development. Some key informants perceived that limited funding – and competition for this limited funding – contributes to some organizations not collaborating to provide access to resources.

As shown in Figure 3, over 4 in 10 Boston adults (43.7%) reported that they had experienced a loss of income during the COVID-19 pandemic. Residents who identified as Black or Latino were most affected by income loss, with about 62.3% of Latino respondents indicating that they had income loss during the pandemic and nearly half of Black residents reporting income loss. More than half of adults 35-64 years of age, adults with lower incomes, and adults with at least one child in the home reported income loss during the pandemic. When looking at income loss by occupational status, a higher proportion of adults who were out of work or retired reported income loss during the pandemic, compared to employed adults.

Figure 3. Percent Adults Reporting Experiencing an Income Loss During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting their household had experienced a loss of employment income since COVID-19 occurred; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

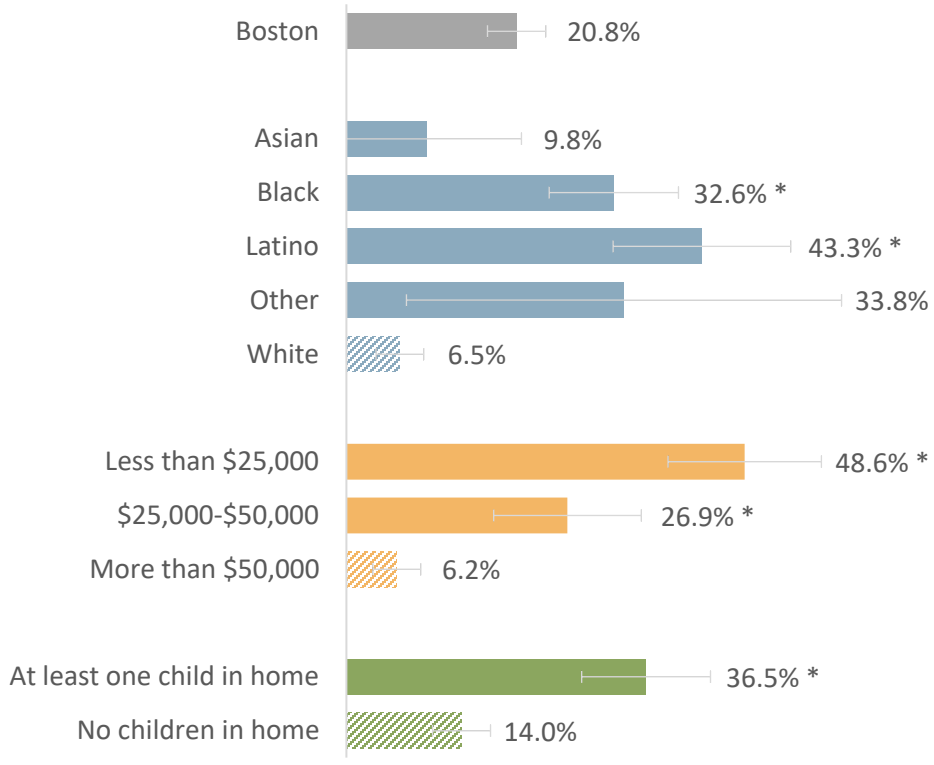
Food Insecurity

Struggling to make ends meet is directly linked with struggling to put food on the table. Food insecurity, namely barriers to accessing healthy, affordable food emerged as a key priority issue across many interviews and focus groups. Food insecurity patterns indicate that a greater proportion of residents report experiencing food insecurity since the COVID-19 pandemic.

> *"Folks are struggling with [food] affordability. Inflation on goods has been astronomical."* - Focus group participant

Pre-pandemic, 2015-2019 BBRFSS data show that about 17.8% of Boston residents were identified as food insecure – in that the food they purchased ran out before they had money to buy more (see Figure 42 in Appendix F). The burden of food insecurity was even greater in Mattapan, Dorchester, and East Boston compared to the rest of Boston (see Figure 43 in Appendix F). Many residents reported being food insecure during the pandemic. According to the COVID-19 Health Equity Survey, while 20.8% of Boston residents were considered food insecure during the pandemic, about 43.3% of Latino residents were food insecure, as well as 32.6% of Black residents (**Figure 4**). The prevalence of food insecurity was also higher among adults who had a child at home compared to adults without children.

Figure 4. Percent Adults Reporting Food Purchased Did Not Last and Did Not Have Money to Get More During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



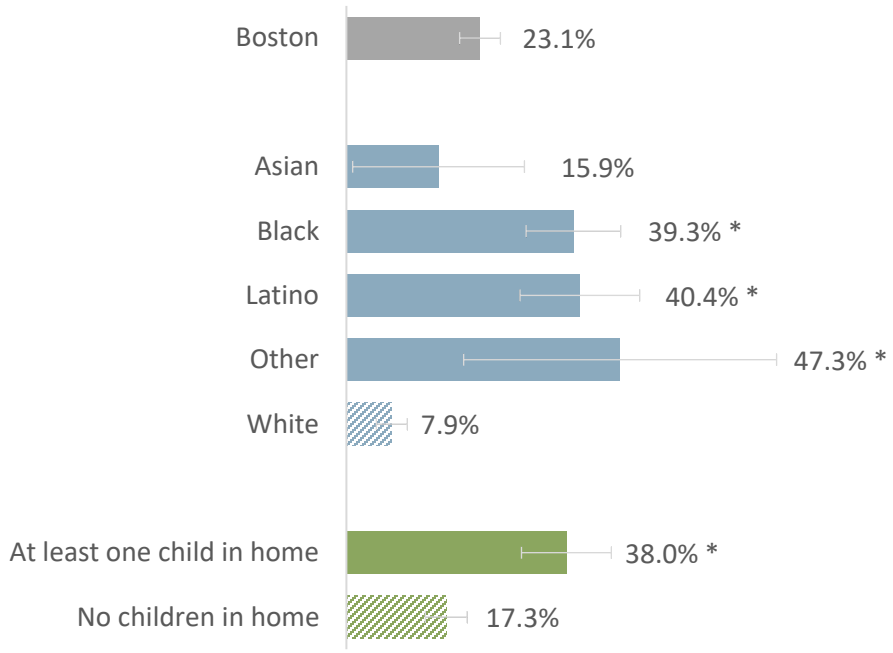
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Community leaders and residents discussed that healthy food is available, but not accessible to lower-income residents. As noted by a focus group participant, *"We live in a food desert. I have to travel out of town to find healthy food. The grocery store in [my neighborhood] doesn't carry the same healthy foods as towns that are more affluent. I feel badly for those who don't have a car and don't have access to healthier food*."

Participants also talked about how the cost of food is rising, contributing to growing levels of food insecurity as residents struggled to afford food, let alone healthy food. As one focus group participant mentioned, *"Access to healthy food is challenging because food costs are so high. When you have a big family, it gets very complicated. Healthy food is very connected to a healthy community."* Several residents underscored that many low-income residents have not been able to eat healthy foods during the COVID-19 pandemic due to financial constraints and some residents – such as older adults – face barriers to safely accessing food due to concern about virus transmission.

Many residents are accessing food assistance. According to the COVID-19 Health Equity Survey, about 23.1% of Boston adults reported using food assistance services during the COVID-19 pandemic (Figure 5), compared to 16.1% reported pre-pandemic. Approximately 40% of Latino (40.4%) and Black (39.3%) adults reported using food assistance services during the COVID-19 pandemic, compared to 7.9% of White adults. Additionally, 38.0% of adults with children in the home reported using food assistance during the COVID-19 pandemic, compared to 17.3% of adults who did not have children in the home.

Figure 5. Percent Adults Reporting Utilizing Food Assistance Services During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Food assistance services include food banks, food stamps, or other sources; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Employment

Employment provides income, benefits, and economic stability, which is important for health.[7] While pre-pandemic Boston enjoyed a low unemployment rate, unemployment was highest during that time in Roxbury, Dorchester, Fenway, and Mattapan (see Figure 46 in Appendix F).

A key pattern that emerged from interviews and focus groups was significant job loss linked with the COVID-19 pandemic. Similar to the rest of the country, the greater Boston metropolitan area fluctuated dramatically in unemployment rate during the pandemic. According to the Bureau of Labor Statistics, the Boston metro area's unemployment rate was 16.0% during the early stages of the pandemic in April 2020 and has dropped to 3.7% nearly two years later in February 2022. Additionally, as of December 2021, an estimated 56,900 workers in Massachusetts have left the labor force; this pattern is not reflected in current unemployment rates.[8]

> *"I see that there is work and people apply […]. I've applied [to] a lot of places and am not given jobs. It says 'apply, help wanted,' but if you don't know anyone you won't be considered."* - Focus group participant

Employment Challenges

Even with more opportunities available, focus group and interview participants observed that some residents are still struggling to find jobs after losing work during the COVID-19 pandemic. Residents explained that it has been more difficult for residents of color, immigrants, people with disabilities, and residents with a criminal record to find and secure stable jobs. For example, interviewees discussed the barrier of being flagged for a criminal record: *"People can have a CORI for the silliest thing, and it follows [them] for the rest of [their] life and can prevent them from being hired."* Immigrant focus group participants discussed the challenges of being undocumented, as one resident mentioned, *"If you don't have a social [security number], you can't get a job. Even at McDonald's."* Others talked about the importance of needing to know someone at the place of employment to even be considered for a job.

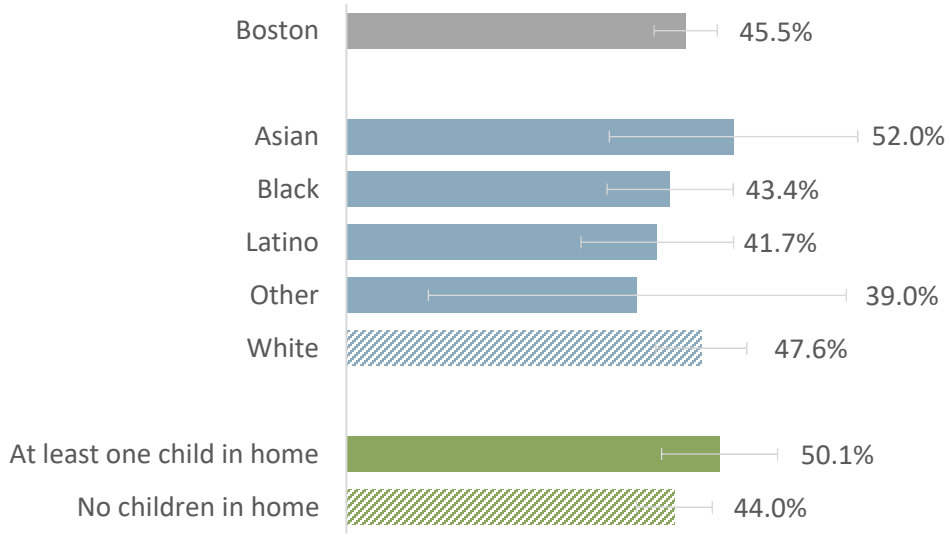
Elected officials and focus group participants cited lack of access to workforce development training as a concern. As one focus group participant commented, *"[I]f you don't have the training, you won't be considered. There need to be more options."* Some participants described experiencing discrimination in hiring, citing that Black men and those with disabilities seem to be the least likely to be hired for some positions. Some youth focus group participants observed that college is too expensive and expressed interest in more resources to pursue career options that do not require a college degree.

Employment and the COVID-19 Pandemic

Residents also discussed their employment challenges during the height of the pandemic. They recalled how unemployment applications were a major burden, and many working undocumented immigrants who are paid informally were not able to apply for or access payroll protection or COVID-19 relief funds. Focus group participants and key informants mentioned that low-wage workers, especially immigrants, worked in high-risk job settings with limited personal protective equipment (PPE). As shown in Figure 6, nearly half -- 45.5% -- of Boston residents indicated that they worked outside of their home during the COVID-19 pandemic.

On the positive side, some participants in focus groups and interviews mentioned a growth in the ability to work remotely, which they described as helpful for residents who experience transportation barriers and persons with complex health issues.

Figure 6. Percent Adults Reporting Working Outside of the Home During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting they worked at least part of the time at a workplace outside of home since the COVID-19 pandemic began; Percentage does not include adults who did not work for pay at all; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Education

Education is an important issue to Boston residents and a critical factor affecting health. Community leaders and residents discussed how many children struggle in school, especially during the pandemic. Based on the COVID-19 Health Equity Survey, about 14.5% of Boston adults with children reported that they had unmet educational needs for children or teens during the COVID-19 pandemic (see Appendix F for data tables).

> *"If you have an asthmatic student and they are constantly out especially in the wintertime […] asthma doctors should educate parents and tell them about resources like getting a 504 plan […] so they won't get in trouble for truancy and ensure the child has support while there in school."*- Key informant interview

Focus group and interview participants discussed that remote learning and the COVID-19 pandemic was particularly hard for youth who already face disproportionate challenges in school. In the 2021-2022 school year, 30.1% of Boston Public School students were identified as Limited English Proficient (LEP) or English Language Learners (ELL) and nearly 68.9% of students were considered economically disadvantaged (participating in one or more state-administered programs of SNAP, TAFDC, DCF, or MassHealth). Interview and focus group participants discussed the need for greater investment to meet

the social, emotional, and academic needs of these children and youth. In particular, participants discussed their insufficient access to early childhood education, the need for more after school programs, support for enrolling children in school with proper educational plans in place, school dropout, health and economic barriers that affect school attendance, and the need for adult English classes for residents for whom English is not their primary language. From the 2020 to 2021 academic school year, PreK-12th grade Massachusetts student enrollment declined by 37,396 students.[9]

CHIP PRIORITY AREA - HOUSING: AFFORDABILITY, QUALITY, HOMELESSNESS, HOMEOWNERSHIP, GENTRIFICATION, AND DISPLACEMENT

As in previous assessments, housing affordability is a dominant concern among Boston residents and leaders and has only been exacerbated during the pandemic.

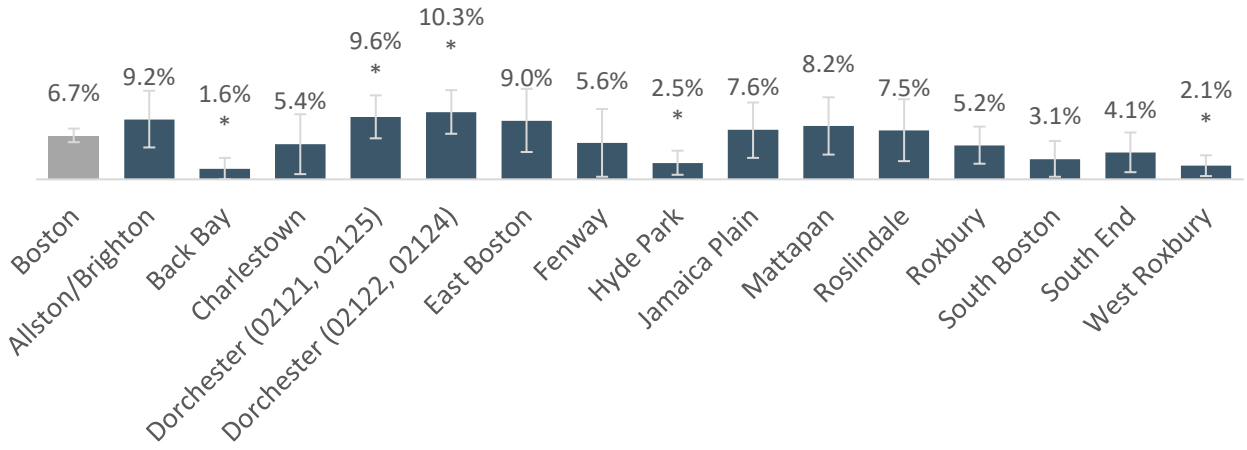
Housing - including housing affordability, quality, homelessness, homeownership, gentrification, and displacement - was a priority area identified in the 2019 community health needs assessment and community health improvement plan. Housing is typically the largest household expense, and, for homeowners, housing can be an important source of wealth.[10,11] For low-income residents, housing instability, the stress of unaffordable housing costs, and poor housing quality increase the risk of adverse health outcomes.[12] Housing concerns in the city have been pervasive for years. The sentiment has not changed, and many residents have been even more concerned about being able to afford where they live during the COVID-19 pandemic.

> *"Every year they raise the rent. They stopped during the pandemic, but I was told that they are going to raise it again. I can't imagine how much they are going to raise it. I can't move to other places because it's worse there."*
> -Focus group participant

Housing Affordability

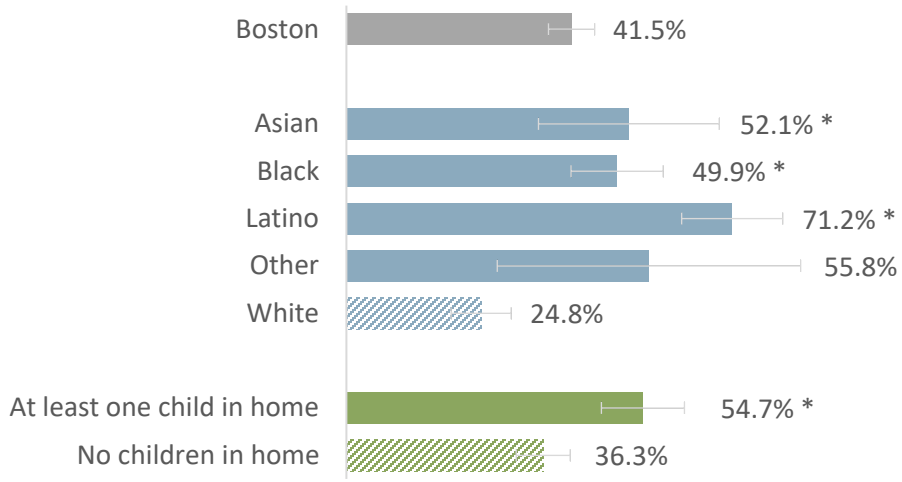
Pre-pandemic, an estimated 6.7% of Boston BBRFSS adult respondents in 2015-2019 reported moving in the past three years due to housing affordability. Reports of moving due to housing costs were highest for residents in Dorchester, Allston/Brighton, and Mattapan (Figure 7). In discussions, residents and leaders were even more concerned about high housing costs during the pandemic, especially given fluctuations in employment. In the COVID-19 Health Equity Survey, more than 4 in 10 respondents reported that they have had trouble paying their rent or mortgage during the COVID-19 pandemic, with highest proportions reported among Latino, Asian and Black adults, and adults with children in the home (Figure 8).

Figure 7. Percent Adults Reporting Moving in Past Three Years Because They Could No Longer Afford Their Home, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 8. Percent Adults Reporting Having Trouble Paying Their Rent or Mortgage During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that it was somewhat or very difficult to pay the full amount of their rent or mortgage now; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Key informants and focus group participants underscored that high housing costs affect low-income residents, residents of color, older adults, undocumented immigrants, immigrants more broadly, and people with disabilities. When discussing a lack of affordable housing, several residents in focus groups described a backdrop of gentrification and overdevelopment as a contributor to housing displacement for low-income residents. Some residents also discussed racism around unfair housing prices, language barriers to accessing housing, and discrimination in acceptance of housing vouchers by landlords and among those previously incarcerated. Focus group participants discussed high and rising rent, rising costs of housing and property taxes, and prioritizing paying rent over other health-promoting factors such as food and physical activity.

Housing Instability and Transiency

Participants discussed how the intersection between housing assistance and housing instability was a tenuous one. Some focus group participants noted that many landlords do not participate in rental assistance programs offered by the government, and that they are concerned that rental assistance programs instituted during the COVID-19 pandemic are coming to an end.

However, some residents also discussed the paradox of qualifying for low-income housing assistance, observing that the income threshold for affordable housing means that if residents earn higher wages, they stand to lose their housing voucher, yet they cannot afford housing at the market rate. Additionally, some key informants observed that while there were several policies enacted during the pandemic that aimed to help tenants stay in their homes (e.g., rent control, eviction moratorium), the increases in housing costs and limited availability of affordable housing were still major challenges.

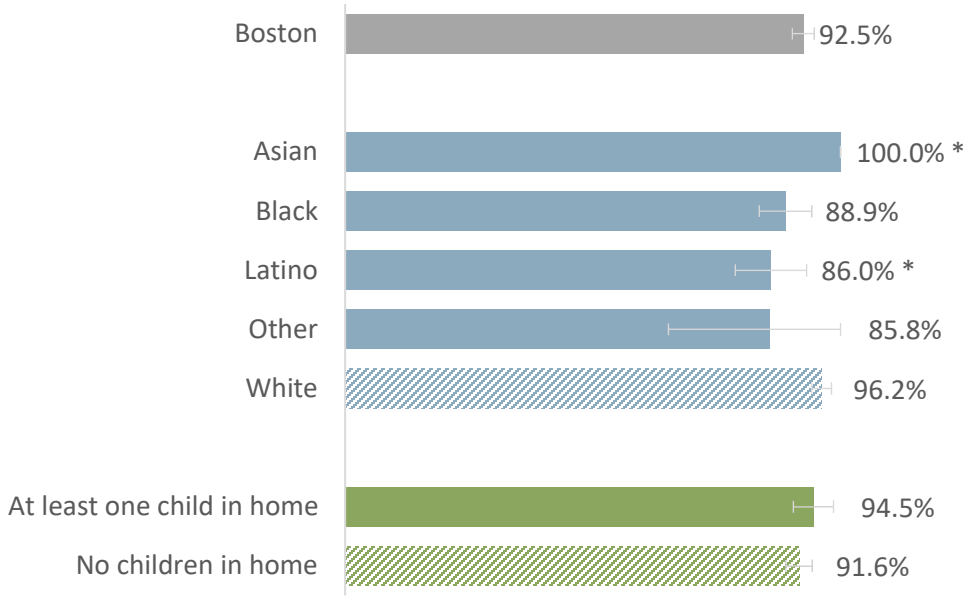
Residents shared that lack of affordable housing contributes to experiences of homelessness and housing instability, overcrowded housing, and housing displacement, each of which are linked with poor mental health outcomes.[13] Some interview and focus group participants noted that people experiencing homelessness include families and residents who were evicted from their homes and observed that people experiencing homelessness are often criminalized.

Housing Conditions, Overcrowding, and COVID-19

Focus group and interview participants discussed how the COVID-19 pandemic affected housing instability, homelessness, and increasingly residents moving in with others due to income loss, which contributes to overcrowded housing. Residents noted that COVID-19 cases often affect several household members, which they linked to multiple generations living in household and people working multiple jobs outside of the home. They noted that it is difficult to isolate or quarantine from family members due to dense living conditions. Participants discussed that these conditions, especially during COVID lockdown, also contribute to worsening mental health. As one focus group participant commented, "*When folks lost their jobs 2 years ago, they were suddenly crammed in houses, which affected physical health and mental well-being."*

Another critical aspect to housing infrastructure, especially during the pandemic is access to Internet. As discussed in the Access to Services section, Internet access became a critical household resource during the COVID-19 pandemic given the dependence on remote work, education, and health care for many populations. While about 9 in 10 Boston adults reported having Internet access at home during the COVID-19 pandemic, it is notable that a smaller percent of Latino adults reported Internet access at home compared to White adults (86.0% and 96.2%, respectively) (Figure 9).

Figure 9. Percent Adults Reporting Having Internet Access at Home During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

CHIP PRIORITY AREA - BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE USE

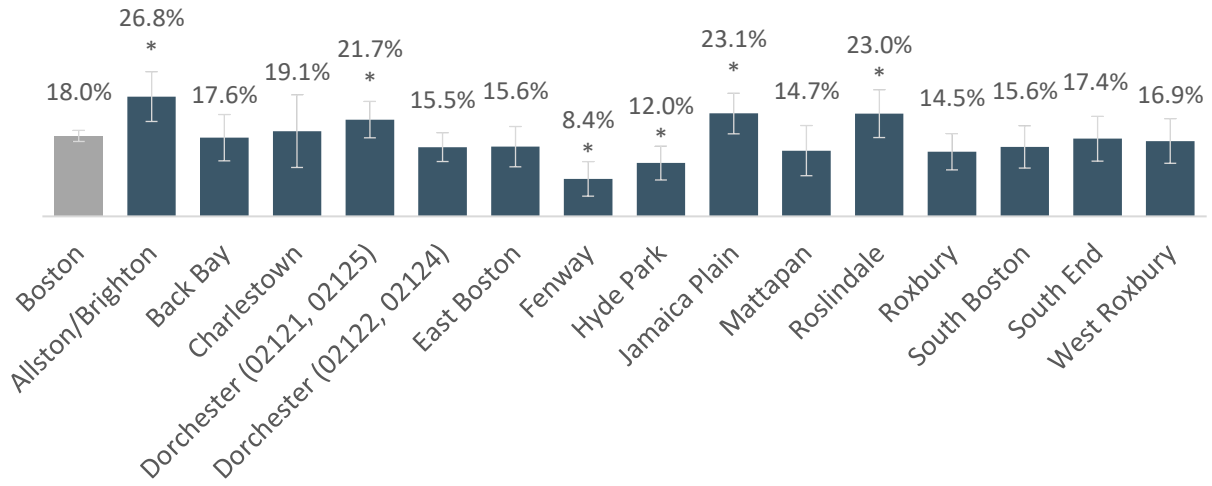
Community leaders and residents described trauma, stress, depression, and anxiety as top-of-mind concerns among all populations, but some groups were cited as being disproportionately impacted – such as youth, low-income households, caregivers, elders, and people of color.

Behavioral health, including mental health and substance use, was another priority area identified in the 2019 Boston community health needs assessment and improvement plan. Behavioral health is an overarching term for the connection between behaviors and people's mental and physical health.

Trauma, Racism, and Discrimination
Trauma and related issues were discussed among a number of residents and leaders in assessment conversations. Several participants discussed the characteristics of childhood trauma – such as racism, violence, poverty, home environments, housing conditions, addiction, neglect, and the loss of loved ones – and how they have affected all aspects of a person's life, including their health and their economic opportunity.

The mental health of caregivers is one of many potential sources of childhood trauma. About 18.0% of Boston residents reported having lived with a caregiver with mental illness as a child (Figure 10). About 1 in 4 adults in Allston/Brighton reported having lived with a caregiver with a mental illness when they were young, followed by about one in five adults in Jamaica Plain, Roslindale, and Dorchester (02121, 02125).

Figure 10. Percent Adults Reporting Having Lived with a Caregiver with Mental Illness as a Child (ACE), by Boston and Neighborhood, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was depressed, mentally ill, or suicidal; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

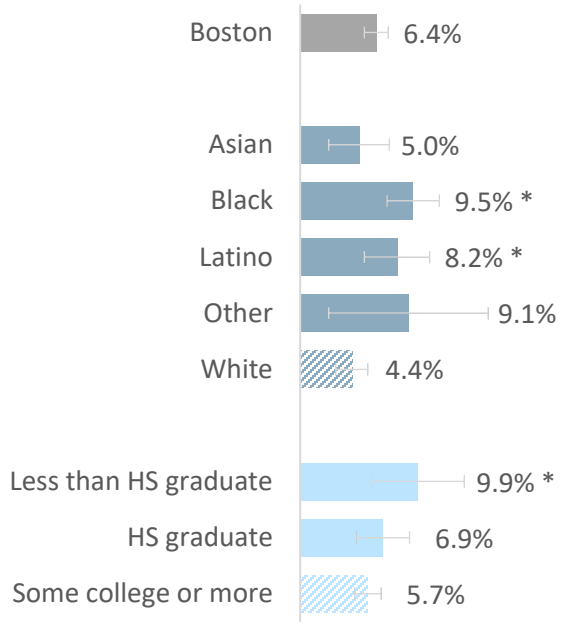
Veterans in focus groups discussed post-traumatic stress disorder as an issue pervasive in their community, while people with disabilities in focus groups noted how they experience mental health issues and trauma linked with their disability, such as bullying. Interview and focus group participants noted that these concerns have all increased during the pandemic. Additional traumatic stressors identified by key informants and focus group participants include community violence, domestic violence (especially during the pandemic and the challenges of staying home when in an abusive relationship), grief from loss of loved ones during the COVID-19 pandemic, and poverty.

Several participants described how racism and discrimination affects the mental well-being of residents of color, citing the role of intergenerational trauma, such as the history of slavery; stereotypes that devalue people of color; and "white-washing" critical histories and cultural practices of people of color. Several participants mentioned systemic racism and white supremacy as affecting multiple opportunities and facets of life, including jobs, housing, safety, and educational opportunities.

> *"The trauma also perpetuates these issues, and the environment also perpetuates these issues and systemically the services that we don't get perpetuates these issues. So that is why racism is a public health crisis."*- Key informant interview

As shown in Figure 11, 6.4% of BBRFSS respondents in 2015-2019 indicated that they have been threatened at least a few times a month due to discrimination. This is significantly greater among Black and Latino residents (9.5% and 8.2%, respectively). These numbers increase dramatically for residents who indicated they have been threatened at least once *a year* because of discrimination, with 17.3% of all Boston residents reporting this (see Appendix F for data tables).

Figure 11. Percent Adults Reporting Being Threatened At Least a Few Times a Month Due to Discrimination, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting being threatened or harassed due to discrimination a few times a month, at least once a week, or almost every day; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

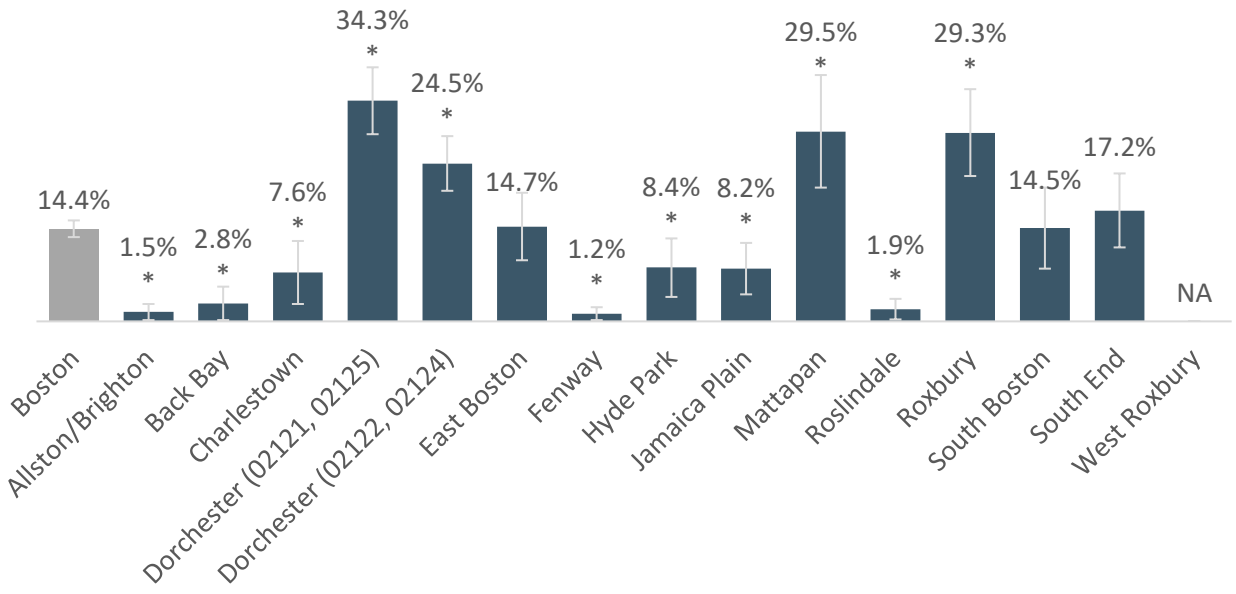
Focus group and interview participants also discussed discrimination specifically against LGBTQIA+ communities, particularly transphobia, as an important driver of mental health issues affecting

LGBTQIA+ communities. Participants also noted that LGBTQIA+ residents of color experience stress related to discriminatory experiences that target multiple aspects of their identities.

Community Violence and Interactions with the Police

Community violence and interactions with the police are public health issues that contribute to trauma and affect physical and mental health. Neighborhood safety concerns were a discussion topic among focus group and interview participants. According to 2015-2019 BBRFSS data, 14.4% of Boston residents perceived their neighborhoods as unsafe, with the highest percentage of residents from Dorchester (all zip codes), Mattapan, and Roxbury indicating concerns about neighborhood safety (Figure 12). Many focus group and interview participants reiterated these sentiments and also discussed that they were concerned about a decrease in neighborhood safety, particularly around gang-affiliated violence, during the pandemic.

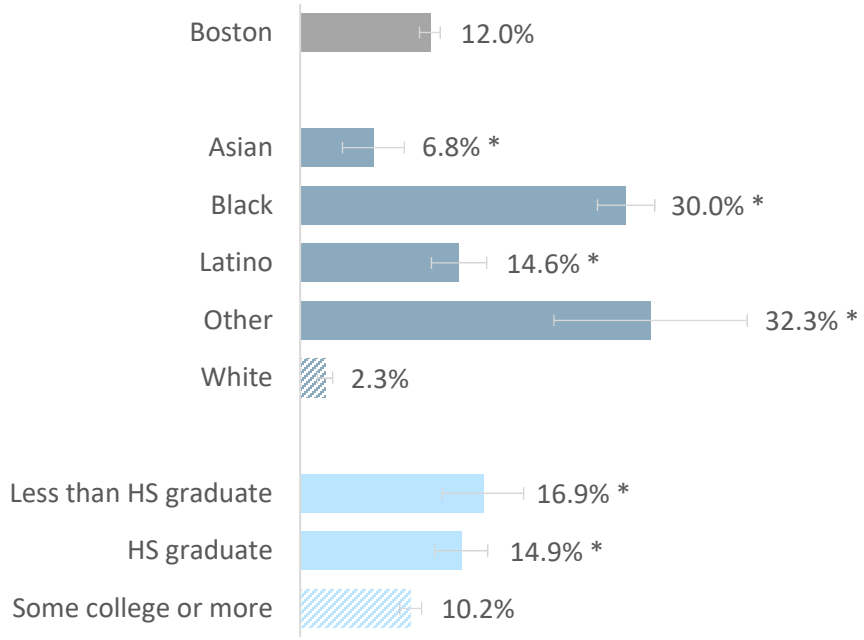
Figure 12. Percent Adults Reporting Their Neighborhood Unsafe, by Boston and Neighborhood, 2017 and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting considering their neighborhood to be unsafe from crime; NA denotes where data are not presented due to insufficient sample size; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Some focus group and interview participants also discussed the increased neighborhood conversations about the relationship between the community and police. While they saw an increase in greater dialogue around police violence towards communities of color, community leaders and residents noted that greater strides still needed to be made. According to 2015-2019 BBRFSS data, about 30.0% of Black adults in Boston and 14.6% of Latino adults reported ever feeling like they were stopped by police due to their race or ethnicity, compared to just 2.3% of White adults (Figure 13).

Figure 13. Percent Adults Reporting Ever Feeling They Were Stopped by Police Due to Race or Ethnic Background, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting ever feeling they were stopped by the police just because of their race or ethnic background; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

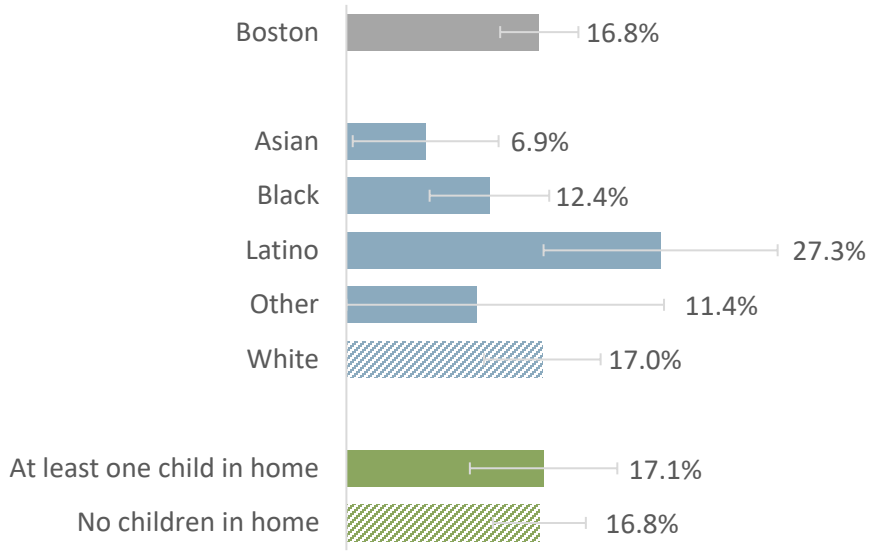
Mental Health, Depression, and Suicide

Mental health overall was a key issue pre-pandemic, and not surprisingly, the impact of the pandemic only heightened that concern. According to the COVID-19 Health Equity Survey, during the COVID-19 pandemic 16.8% of Boston adults reported experiencing persistent sadness – defined as feeling down, depressed, or hopeless more than half of the days in the previous 2 weeks (Figure 14). Overall, 21.9% of Boston adults reported feeling persistent anxiety during the pandemic – having felt nervous, anxious, or on edge for more than half of the days in the past 2 weeks (Figure 15).

Several focus group and interview participants discussed how the COVID-19 pandemic worsened mental health issues, including: social isolation, fear about contracting the virus, feeling overwhelmed by constant and changing information about the pandemic, and uncertainty about what the pandemic holds. In several discussions, participants also attributed the COVID-19 pandemic to worsening the high levels of stress that many low-income families already experience. They also noted that the resources that facilitate community connections, such as in-person meeting spaces and community centers, have been closed at times due to COVID-19 safety measures, and these closures hamper community building efforts. Some also noted that the COVID-19 pandemic contributes to trauma for older adults, who have lost many friends and family during the pandemic.

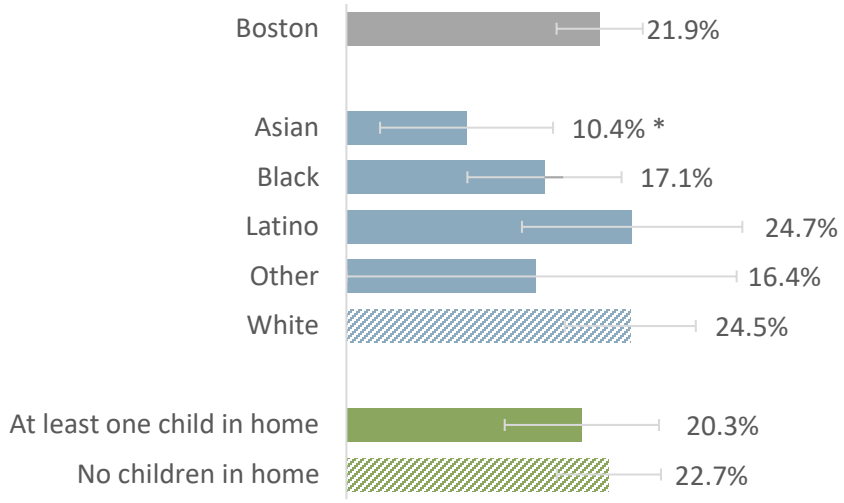
> *"Everything is so interwoven. [There are] a lot of young people with significant depression and anxiety, but [we're] also talking about a lot of PTSD, implications related to trauma, poverty, and neglect."*
> - Key informant interview

Figure 14. Percent Adults Reporting Persistent Sadness During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent sadness is defined as feeling down, depressed or hopeless for more than half of the days within the past 2 weeks; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 15. Percent Adults Reporting Persistent Anxiety During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



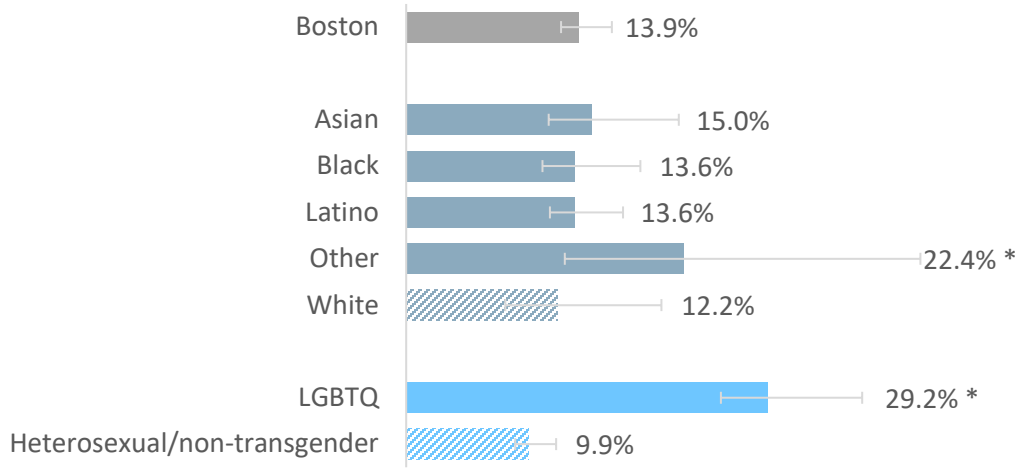
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent anxiety is defined as feeling nervous, anxious or on the edge for more than half of the days within the past 2 weeks; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Prior to the pandemic, mental health among youth was a concern. Pre-pandemic, about 13.9% of Boston high school students reported having had suicidal thoughts, according to 2015-2019 data from the YRBS. About 29.2% of LGBTQIA+ students reported having had suicidal thoughts, based on the YRBS (Figure 16).

Focus group and interview participants discussed that they were especially concerned about mental health worsening among youth during the pandemic. Youth focus group members cited insufficient sleep, family issues, unhealthy relationships, the stress of school, busy schedules that make it difficult to practice self-care, peer pressure, and unhealthy coping mechanisms as factors that affect their mental health.

Several interviews and focus group discussions emphasized the impact of the COVID-19 pandemic on children and youth, including the disruption of their routines and trauma, despair, adverse childhood experiences, overcrowded housing, and addiction. Youth described being exposed to toxic environments at home during stay-at-home phase of the COVID-19 pandemic. The well-being of adults who support youth also emerged as a concern, including caregivers who have taken care of others during the COVID-19 pandemic and have not have the opportunity to also care for themselves and teachers and school staff who respond to behavioral health issues in school settings.

Figure 16. Percent Boston Public High School Students Reporting Having Suicidal Thoughts, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



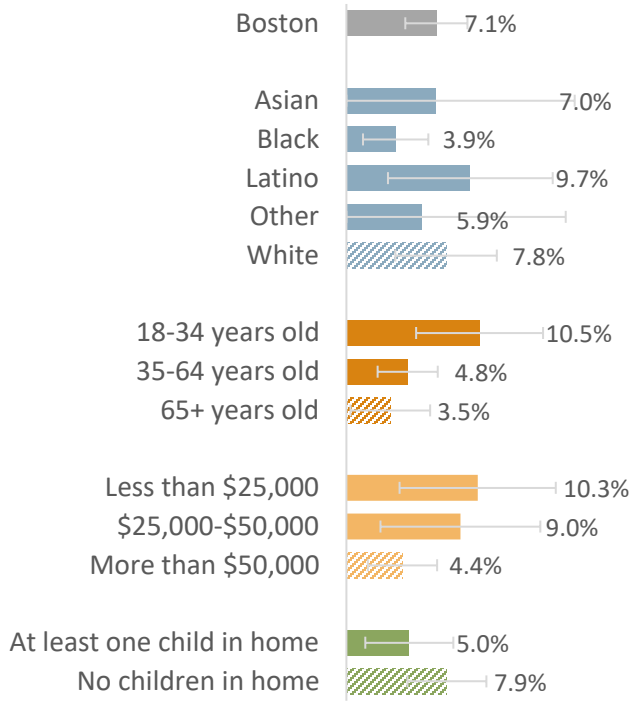
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Behavioral and Mental Health Care Access and Barriers to Care

Based on the COVID-19 Health Equity Survey, 9.9% of Boston adults reported delaying mental health care due to the pandemic (see Appendix F for data tables), and about 7.1% reported delaying mental health care specifically because of cost (Figure 17).

Participants discussed several barriers to accessing mental health care. On the supply and demand side, community leaders and residents in interviews and focus groups observed a limited number of mental health providers in the community and in school settings, long wait lists, and few mental health services for children. One provider noted that behavioral health referrals were at the highest level that they could recall. Financial barriers to mental health care identified by key informants and focus group participants included bureaucratic barriers, such as needing a referral from a primary care provider, and limited mental health options for low-income communities. Several focus group participants described a lack of culturally appropriate and linguistically congruent care for low-income residents, residents of color, and LGBTQIA+ residents. Some focus group participants discussed stigma surrounding mental health care, particularly for immigrant communities, communities of color, and youth. As one resident noted, *"They think asking for help is a weakness, not a strength."*

Figure 17. Percent Adults Reporting Not Seeking Mental Health Care Due to Cost During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting there was a time when they needed to see a mental health professional but could not because of cost since March 1, 2020; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Substance Use

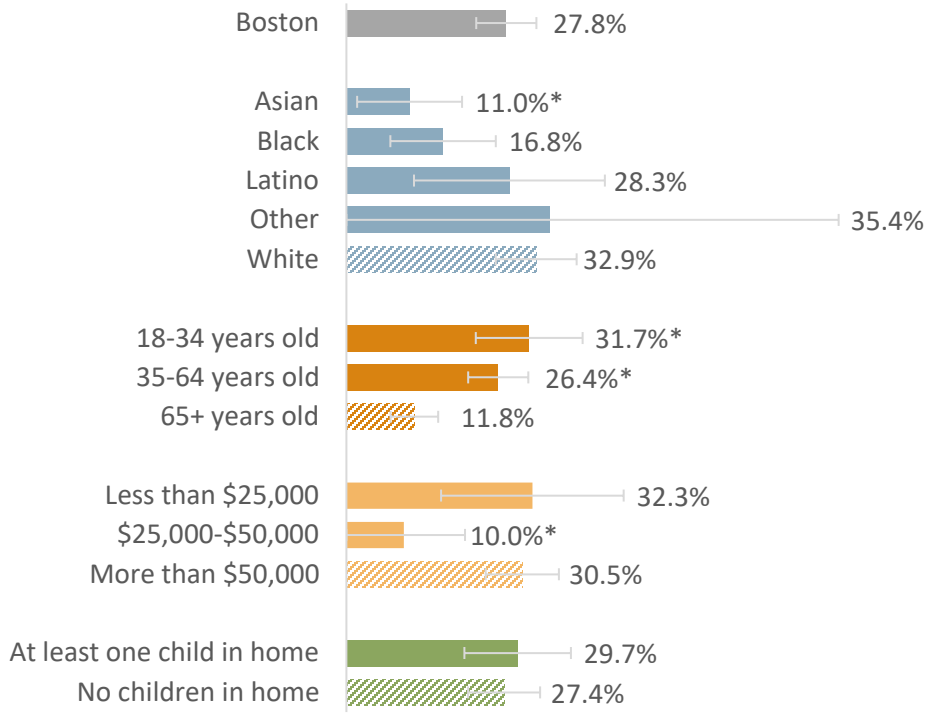
While substance use emerged as a key concern among Boston residents prior to the pandemic, substance use was less commonly discussed as a health concern in recent focus groups and interviews perhaps because residents largely discussed how the COVID-19 pandemic worsened inequities in the social determinants of health. However, mortality data continues to indicate that overdose deaths are an important health issue. In the 2019 community health needs assessment, unintentional opioid overdoses accounted for the majority of deaths due to accidents in 2016. In 2020-2021, the unintentional opioid overdose mortality rate was highest in Dorchester (all zip codes), Roxbury, and the South End (Figure 75 in Appendix F). The unintentional opioid overdose mortality rate for Black and Latino residents exceeded that for White residents in 2020-2021 (Figure 76 in Appendix F). Additionally, the unintentional opioid overdose death rate among Black residents was 50.7 per 100,000 residents in 2020-2021 whereas it was 21.1 per 100,000 residents in 2016. The difference was much less stark for Latino and White residents over this time period.

Some focus group participants discussed substance use concerns, including misuse of drugs, overusing prescriptions and over-the-counter medicines, and smoking nicotine and marijuana. Residents discussed substance use concerns as particularly affecting LGBTQIA+ residents and youth, and described substance use as a coping mechanism for dealing with stress. Several participants perceived that substance use was increasing, particularly among Cape Verdean, Asian, and Vietnamese communities. As one

participant described, *"I can remember as a child how it was; it was a close-knit community. When drugs started being introduced to [our] community, the children dropping out of school, it started to change."*

According to the COVID-19 Health Equity Survey, about 27.8% of Boston adults reported increased drinking habits during the COVID-19 pandemic (Figure 18). Almost 1 in 3 adults 18-34 years of age and over 1 in 4 of adults 35-64 years of age reported increased drinking during the COVID-19 pandemic, compared to 11.8% of adults 65 years of age or over.

Figure 18. Percent Adults Reporting Increased Drinking Habits During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Increased drinking habits is defined as increased weekly alcohol intake or started drinking and did not before since March 1, 2020; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

CHIP PRIORITY AREA - ACCESSING SERVICES: CHILDCARE, SOCIAL SERVICES, AND HEALTH CARE

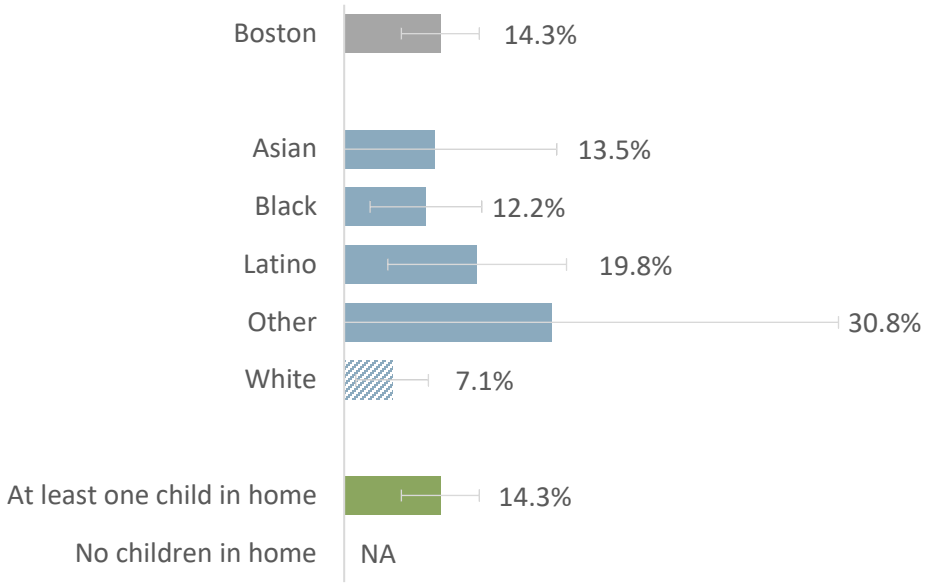
Residents and community leaders continued to cite numerous barriers to accessing childcare, social services, and health care including cost, transportation, language barriers, limited Internet, discrimination and systemic racism, immigration/documentation status, limited culturally appropriate services, and the difficulties in navigating the complex social service and health care systems.

Accessing childcare, social services, and health care was identified as a prominent theme and priority area in the previous community health needs assessment and improvement plan. Some aspect of access limitations came up in nearly every conversation in this recent process, and many issues were exacerbated during the pandemic.

Accessing Childcare Services

Pre-pandemic, Boston residents identified economic and access barriers to affording childcare, and in recent focus groups and interviews childcare emerged as a growing need due to the COVID-19 pandemic. While focus group participants and key informants described several community-based organizations that provide services for historically marginalized groups, they also observed rising and acute social and economic needs among a growing segment of low-income residents. Affordable, quality childcare was difficult to find before the pandemic, but with parents' unpredictable work schedules, unforeseen childcare closings, and the need for many parents to work outside the home, finding care for young children was even more challenging during the pandemic. According to the COVID-19 Health Equity Survey, about 50.1% of adults with at least one child at home indicated that they worked outside the home during the COVID-19 pandemic (see Appendix F for data tables). In the same survey, 14.3% of Boston adults reported that children in their households experienced unmet childcare needs during the pandemic (Figure 19).

Figure 19. Percent Adults with Children Reporting Having Unmet Childcare Needs During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: NA denotes where data are not available because only respondents who indicated having at least one child present in the household were asked this question; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Some focus group participants and key informants discussed how some students have not been adequately challenged academically or able to reach their full potential during their schooling during the COVID-19 pandemic. Focus group participants and key informants also discussed significant and growing social and emotional needs for children and teens since the onset of the pandemic, particularly low-income children and youth. Barriers to early childhood education cited by residents include the costs of early childhood education, restrictions on vouchers for subsidized childcare for low-income families, limited availability of early childhood education centers, and limited understanding of the benefits of early childhood education.

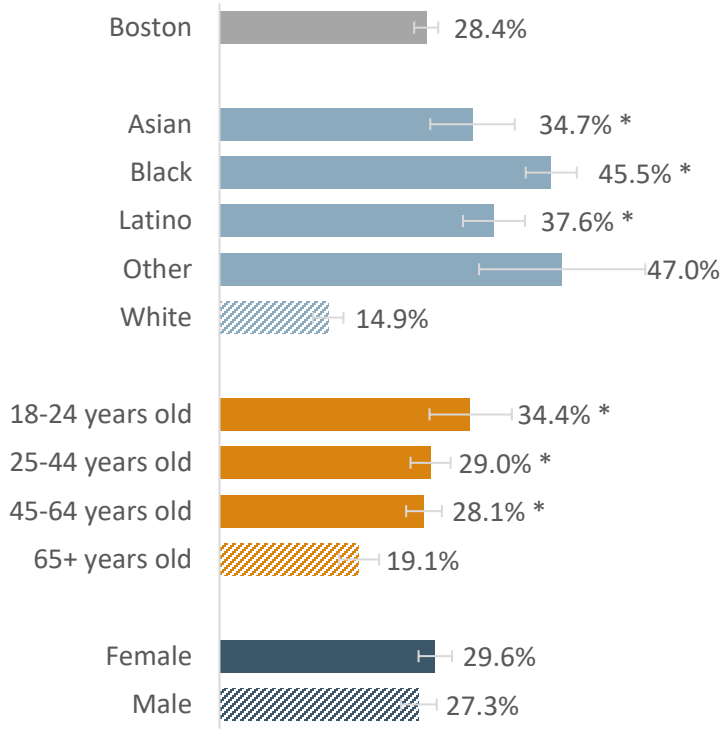
Accessing Social and Other Services

Focus group and interview participants discussed additional challenges of accessing the range of social and other services that might be available. These barriers included limited transportation, difficulty navigating application processes, limited Internet for completing applications, and lack of eligibility due to immigration/documentation status.

A number of participants across conversations also discussed systemic racism, racial injustice, and discrimination as interwoven into U.S. social, economic, educational, and health care systems. Many discussed how our current systems are set up to perpetuate current inequities. Others talked about facing discrimination themselves, in stores, restaurants, employment, or housing. From 2015-2019 BBRFSS data, about 28.4% of Boston residents reported receiving poor service at restaurants or stores in day-to-day life due to their race or ethnicity (Figure 20). About 45.5% of Black adults reported

experiencing poor service, while 37.6% of Latino adults and 34.7% of Asian adults indicated having this experience.

Figure 20. Percent Adults Reporting Receiving Poor Service Due to Their Race/Ethnicity, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting receiving poorer service than other people at restaurants or stores in day-to-day life due to race/ethnicity; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Accessing Health Care Services

Although about 95.8% of Boston residents have health insurance (see Appendix F for detailed data), focus group and interview participants cited numerous barriers to accessing health care services in general and especially during the pandemic.

Overall Barriers to Health Care

Key informants and focus group participants in 2022 cited some very similar barriers to accessing health care as they did in the previous community health needs assessment. Recent focus group participants noted that income-related barriers to accessing care were common and included income restrictions for qualifying for MassHealth, a lack of insurance benefits linked with employment, unaffordable out-of-pocket and surprise medical expenses not covered by health insurance, the high cost of medications (particularly

> *"Due to my language barriers, I was not able to express my health concerns and had a hard time to communicate with doctors to get right treatment."*- Focus group participant

for people with chronic illnesses), and the challenge of finding a job that provides insurance benefits. Participants also discussed distrust towards health care systems and health providers, concern about undocumented legal status, difficulty navigating the health care system, lack of cultural sensitivity among providers, long waits for medical appointments, transportation barriers, and difficulty securing a medical appointment.

Residents shared that language barriers and limited culturally relevant care make it difficult to navigate and access health care and social services and to follow treatment plans for residents for whom English is not their first language. This was particularly salient in conversations with Cape Verdean Creole speakers.

Barriers Specific to People with Disabilities and Older Adults

Some participants described limited staffing and support for home health care as a concern, particularly for older adults and residents with disabilities. Participants with disabilities described several barriers to health care, including: lack of accessible equipment (e.g., exam tables, scales, assistance with wheelchair transfers), communication barriers (e.g., interpretation), the need for support in completing forms, limited training among providers in treating patients with a range of disabilities, denial of access to care (e.g., psychological services, rehabilitation, nursing homes) for people with developmental disabilities, limited information about available resources or services needed, and lack of reliable Internet service.

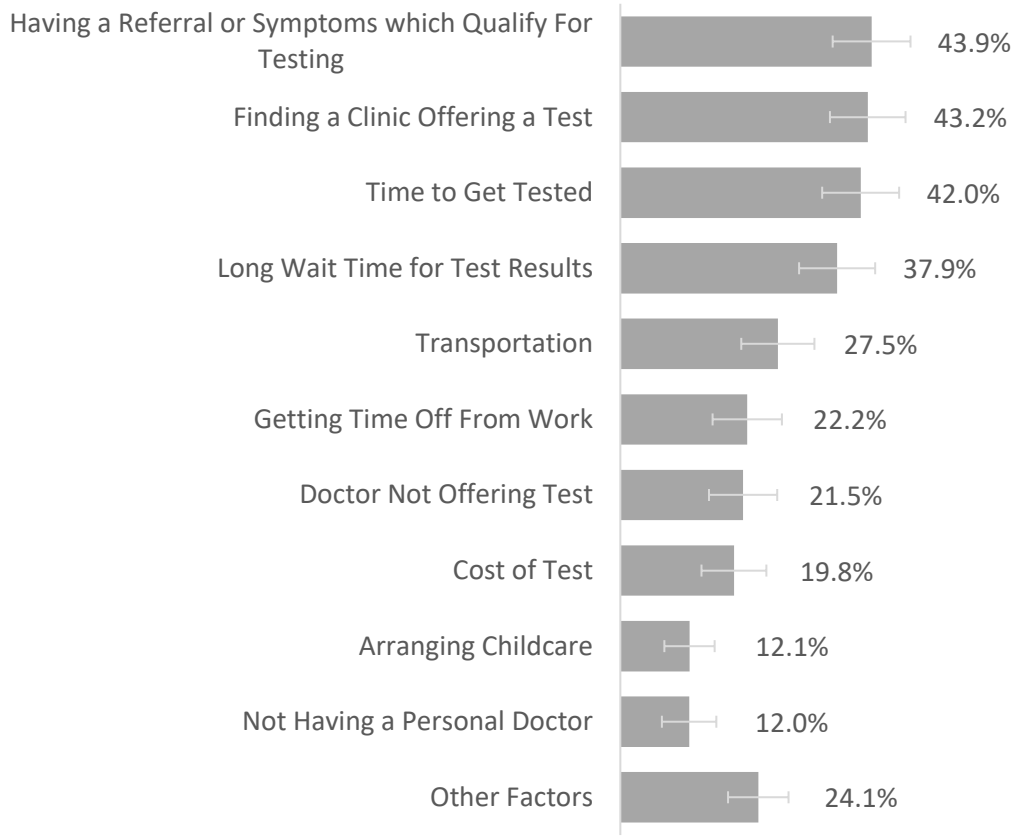
Participants also described a growth in telehealth visits. They noted that conducting assessments and developing treatment plans can be difficult during telehealth visits and that telehealth visits can be a barrier for older adults, immigrants, and persons with disabilities. Participants noted that some patients prefer in-person visits and cited several barriers to using telehealth, including technological resources, support, and training needed.

Health Care Access Specific to the COVID-19 Pandemic

Residents described how racial/ethnic inequities in health care access and social factors that impact health care access – such as transportation and Internet access – have been magnified by the COVID-19 pandemic. Some residents noted that patients who rely on family support for interpretation during visits have lost this support due to COVID-19 policies that limit visits to the patient only. Some key informants and focus group participants discussed how residents with chronic health conditions and those with undiagnosed conditions have been affected by delayed health care and ongoing lack of a medical home.

Getting tested for COVID-19 had its own set of challenges. Respondents of the COVID-19 Health Equity Survey cited a number of barriers to getting tested for COVID-19. Having a referral or symptoms to qualify for a test, finding a clinic that offered COVID testing, the length of time that it takes to get tested, and long wait times to receive COVID test results were the leading barriers to COVID-19 testing among Boston residents in December 2020/January 2021 (Figure 21). However, according to the COVID-19 Health Equity Survey, more than one in five Boston residents also cited issues such as transportation, getting time off of work, and cost of a test as barriers to getting a COVID test in December 2020-January 2021. Appendix F has the breakdown of data by race/ethnicity and age for each of these barriers.

Figure 21. Percent Adults Reporting Barriers to COVID-19 Testing, by Specific Barriers, by Boston and Selected Indicators, 2020-2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Residents explained that at multiple points during the pandemic, COVID-19 information was not clear enough and residents for whom English was not their first language encountered language barriers to accessing changing and time-sensitive COVID-19 information. Lack of access to technology also emerged as a barrier to COVID-19 information, particularly for older adults who relied on family and friends to use technological devices to sign up for COVID-19 resources or access COVID-19 information. Residents also described rampant misinformation about COVID-19.

COMMUNITY'S VISION AND COMMUNITY SUGGESTIONS FOR THE FUTURE

Interview and focus group participants shared numerous ideas for collective action for the future including: addressing systemic racism, strengthening collaboration, improving economic development and housing, improving access to behavioral health and health care services, promoting youth development, and creating a healthier environment.

Deepen Partnerships with Local Communities and Collaborate to Promote Health Equity

While some interviewees described effective collaboration happening throughout the city, they discussed several barriers to collaboration. These challenges included decentralized partnerships and competition for funding among local non-profit organizations, which they noted undermines relationship building. Several interviewees called for creating and strengthening partnerships that create and implement long-term strategic plans to promote community health and developing and deepening long-term relationships between City of Boston agencies (e.g., schools, housing, public health), hospitals, and smaller community-based organizations. To accomplish these goals, key informants recommended centering the voices of affected residents in planning and implementation processes, engaging community builders and community organizers, funding community-based initiatives to implement strategies to address health inequities, and creating centralized mechanisms to share information and resources with residents. Key informants also recommended disseminating CHNAs and CHIPs in modes that improve access to the general public and center resident voices.

> *"[There is opportunity] for closer collaborative work in the city. There is a challenge and advantage of having so many different institutions that are working in the same or overlapping neighborhoods."*– Key informant interview

Focus on Dismantling Systemic Racism

Interview participants' recommendations to address systemic racism included developing hospital-based reparations funds for neighborhoods such as Roxbury, in which hospital campuses are based and which also experience persistent health inequities and developing land trusts that can serve as community spaces. Another recommendation pertained to providing continual education (e.g., Equity, Diversity, and Inclusion training) for institutions and people who work with people of color and low-income communities to improve understanding of and build capacity to address systemic racism and implicit bias. One key informant recommended that schools, businesses, non-profit organizations, governmental, and health care sectors participate in this training.

Create Opportunities that Foster Economic Stability and Mobility

Recommendations for improving employment opportunities included partnering with small businesses to recruit and hire local residents and pay workers a living wage, fostering work environments that are inclusive of LGBTQIA+ communities, and addressing discrimination in hiring and work environments. Additional recommendations included creating opportunities for immigrant health professionals who trained and practiced in their home country to work in the local health care system, improving job training opportunities designed to facilitate economic mobility for youth and

> *"Economic justice goes along with health. To have a healthy community, there's going to be healthy economic activity because it takes psychological, mental, emotional, good way of being for a business to function effectively."* – Key informant interview

adults, and bringing hospitals and community-based organizations together to create health careers training programs for youth.

Strategies to address growing income inequities, as recommended by key informants and interview participants, included containing rising costs, taxing wealthy households and corporations, ensuring residents have life insurance, and forgiving student loans. While several key informants noted that there are several social and economic resources available to support Boston residents, key informants and focus group participants emphasized the importance of connecting residents with these resources and services. Recommendations for supporting immigrants include creating pathways for immigrants to complete any credentialing needed to enable them to work locally, supporting immigrants seeking asylum, and increasing volunteer-based programs to support immigrant communities. Improving resources and services for veterans and LGBTQIA+ communities also emerged as recommendations.

Improve Housing Affordability

Community leaders' and residents' recommendations for promoting housing affordability and stability pertained to improving the availability of low-income housing, increasing access to affordable housing through programs such as rent control and rental assistance, and using vacant buildings as homeless shelters. Another set of recommendations by participants pertained to investing in homeownership models for low-income residents, including asset building programs such as rent-to-own programs for affordable housing and housing loans for low-income residents. Institutionally, one recommendation pertained to ensuring that development projects include credits that are returned to the community to improve housing access and quality.

Improve Access to and Quality of Behavioral Health Care

Recommendations by interview and focus group participants to improve access to mental health care included making therapy accessible to low-income communities and in the primary language of patients; strengthening mental health care in community health centers; improving access to mental health for youth; and increasing awareness about and addressing stigma around mental health services. In terms of improving quality of mental health care, recommendations included increasing culturally congruent care for residents of color and LGBTQIA+ communities; providing peer-to-peer and group therapy models; and incorporating art therapy to engage youth in mental health care. Other recommendations included providing a list of mental health resources that is available in residents' primary language; training community-based stakeholders to respond to mental health crises; and addressing substance use and addiction through mental health care.

> *"We need more mental health services that are not rooted in the white dominant culture, but that are rooted in people's cultural experiences."* – Key informant interview

Strengthen Health Care Policies and Improve Health Care Access and Quality

To improve health care coverage and access, key informants and focus group participants recommended supporting residents in enrolling in MassHealth and other programs for low-income residents such as food and cash aid benefits; lowering health insurance rates; providing access to a wider range of affordable health plans; compensating spouses as personal care assistants under MassHealth; and covering personal protective equipment through health insurance.

Interview and focus group participants also discussed the importance of improving access to preventive and specialty care (e.g., audiology, ophthalmology, podiatry) and collaborating with grassroots organizations when designing efforts to improve health care access. Residents also cited the need to make health care more accessible by providing care in patients' primary language, ensuring that health care is available at times that are feasible for residents who work multiple jobs, addressing transportation barriers to accessing health care. To improve provider sensitivity to patients' needs, residents recommended recruiting more bilingual providers and providers of color to more closely reflect underserved patient populations; training providers to better serve people of color, low-income residents, and people with disabilities; and ensuring providers are connected with the communities they serve.

A recommendation related to the social determinants of health and health care access included providing wrap-around services by addressing multiple health care needs (e.g., preventive care, vaccines). Relatedly, key informants and focus group participants suggested connecting residents with community-based resources in clinic or other community-based (e.g., churches, schools, YMCA) settings located in low-income communities and communities of color. Key informants and focus group participants recommended using this local, centralized setting to connect patients with community resources, leverage medical-legal partnerships to improve residents' access to legal supports, coordinate care for seniors, support the transition from pediatric to adult care, and improve care and support for people with disabilities. One key informant recommended building the capacity of community health workers or other peer-to-peer models to support residents in navigating social and health care systems and to build resident awareness of health issues.

Promote Child and Youth Development

Key informants and focus group participants recommended a number of strategies to promote child and youth development. In the school context, recommendations included providing more funding for schools and creating programs where school nurses provide hygiene kits for students. Another set of recommendations pertained to creating more community-based spaces for youth, such as fully-staffed libraries and community centers, which could provide support with academics, opportunities to be active, workforce development opportunities, connect residents to resources, and bring longstanding and new residents together. Another recommendation included affirming LGBTQIA+ youth. Supporting caregivers and low-income families also emerged as a recommendation, including improving parent supports to access resources and services and navigate educational and criminal justice systems.

Create a Healthier Built and Physical Environment

Having a healthier built and physical environment – built environment, green space, and air quality—was important to focus group and interview participants, and they cited a number of suggestions for the future. Residents described the importance of improving air quality, providing families with air filters, cleaning up vandalism and trash, improving transportation, and providing affordable Internet access and improving digital literacy for low-income residents and older adults. Focus group participants described opportunities for promoting physical activity, such as creating affordable access to gyms, yoga, meditation, and community walks and bike rides. Recommendations for improving access to healthy and affordable food included bringing healthy food to neighborhoods that lack access to healthy, affordable food; improving school lunches to offer healthy, fresh food; and providing nutrition education to LGBTQIA+ communities.

PRIORITIES FOR COLLABORATIVE ACTION

The Boston CHNA-CHIP Collaborative aims to undertake a collaborative planning process May -September 2022 to identify the prioritized issues on which this cross-sector group will take action.

For the past two years, the Boston CHNA-CHIP Collaborative has been focused on four priority areas and implementing the 70 strategies outlined in the 2020 community health improvement plan. Great progress has been made on many of these strategies, while other strategies have not been implemented as extensively given constrained capacity and the current context of the COVID-19 pandemic.

Given this backdrop, the 2022 prioritization process focused on:

1) reaffirming the previous priorities and identifying any new issues that have emerged; and
2) prioritizing specific strategies within these major areas that should be lifted up for future action.

To this end, in May-June 2022, the Collaborative undertook a collaborative prioritization process to solicit community input on the key strategies for collective impact to focus their 2022 community health improvement plan.

Identified and Reaffirmed Priorities

The prioritization process was centered on the data from this 2022 CHNA and the current CHIP which has four main priority areas and an overarching central focus of achieving racial and ethnic health equity:

1: Housing

Focusing on affordability, quality, homelessness, ownership, gentrification and displacement

2: Financial Security and Mobility

Focusing on jobs, employment, income, education, and workforce training which comprised this priority in the past CHIP, and including food security which emerged as a salient issue in the 2022 CHNA

3: Behavioral Health

Focusing on mental health and substance use

4: Accessing Services

Focusing on healthcare, childcare, and social services

Criteria for Prioritization

The Collaborative aimed to use a systemic, engaged approach informed by data to confirm the larger priority areas and prioritize the specific strategies for focus in future planning and implementation efforts. The following criteria were used to help participants identify priority strategies from the current CHIP.

- **Burden:** How much does this issue affect health in Boston?
- **Equity:** Will addressing this issue substantially benefit those most in need?

- **Impact:** Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Is it possible to address this issue given infrastructure, capacity, and political will?
- **Collaboration/Engagement:** Are there existing groups across sectors willing to work together on this issue? Is there an opportunity for engaging these groups?
- **Data:** Do we have data to support this objective and strategy?

Prioritization Process

The prioritization process was multi-stepped and aimed to be inclusive, participatory, and data driven. During May-June 2022, several steps were taken to confirm the larger priority areas and identify the prioritized strategies for the upcoming planning process. A total of 62 participants were part of the prioritization process, and activities included the following:

- Three separate 90-minute virtual listening sessions were conducted in late May and early June. In each of these sessions, Collaborative members presented key findings and high-level themes from this current CHNA to provide context for prioritization. Following the data presentation, listening session participants (n=15) were asked to complete an online survey to select priority strategies using the criteria described above.

- Based on low participation during the scheduled listening sessions, the survey and a pre-recorded data presentation were sent to all registered participants who did not attend. The survey was open for an additional 24-hours, and an additional 5 respondents completed the prioritization survey.

- To increase participation in the process, Collaborative members attended a Union Capital Boston (UCB) meeting on 6/7/22 to gather additional feedback. 42 community members participated in a break-out session that included a brief data presentation and dialogue about the prioritization process. These participants discussed which areas most resonated with them and provided feedback on which strategies to prioritize.

- Feedback from this session was incorporated with the earlier survey responses, and these results were posted on the Collaborative's website in 10 languages (Arabic, Cape Verdean, Chinese traditional – Cantonese, Chinese simplified – Mandarin, Haitian Creole, Portuguese, Russian, Somali, Spanish, and Vietnamese) to gather additional community input prior to the late June planning session. The feedback form was shared with the Collaborative Steering Committee for distribution to communities via email.

These discussions reaffirmed these four priority areas. The cross-cutting and overarching focus of the planning process will continue to be around ***Achieving Racial and Ethnic Health Equity*** recognizing that institutional racism and structural inequities are what drive the health disparities we see around race, ethnicity, and language in the city for nearly all issues.

The Collaborative will meet to develop a CHIP that will provide a blueprint to address the prioritized strategies listed above. The CHIP development process will include a virtual planning session in late June 2022 to refine the CHIP document based on community input. A 2022 CHIP will be finalized in Fall 2022.

APPENDIX A. STRUCTURE OF THE BOSTON CHNA-CHIP COLLABORATIVE

The Boston CHNA-CHIP Collaborative (the Collaborative) is a group of Boston community residents, community-based organizations, community development corporations, health centers, the hospitals, and the Boston Public Health Commission. This group has come together to achieve sustainable positive change in the health of the city by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. One of the fundamental approaches for this work is to conduct a community health needs assessment so efforts are informed by data and community members themselves. While community health assessment and planning have been long-standing endeavors among organizations across the city, the Collaborative aims to leverage, align, and coordinate efforts and resources across multi-sector stakeholders in Boston. More details about the Collaborative's structure and engagement can be found in the Methods section of this report, Appendices A-C, and at http://www.bostonchna.org/.

The Collaborative's structure provides a framework for large-scale engagement to improve the community's health. This structure includes:

- *Steering Committee* – comprising of 19 members representing hospitals, health centers, Boston Public Health Commission, a public health organization focused on community, community development corporations, and community representatives. Its role is to provide strategic direction and oversight of the process (See Appendix B for list of Steering Committee members).

- *Operations Committee* – comprising of the Steering Committee co-chairs and the Collaborative's Coordinator. This Committee resolves operational issues requiring immediate actions.

- *Work groups* – comprising of Steering Committee members and general membership. The two Work Groups for the CHNA provided input and assistance on implementing activities (See Appendix B for members). For the Boston CHNA, these two Work Groups were:

    - *Community Engagement/Primary Data Work Group* – including 24 members representing a range of organizations, including hospitals, health centers, local public health, community development, and community-based organizations. The Work Group's charge is to provide guidance on the approach to community engagement, input on primary data collections methods, and support with logistics for primary data collection.

    - *Secondary Data Work Group* – including 16 members representing a range of organizations, including hospitals, health centers, and local public health. The Work Group's charge is to provide guidance on secondary data approach and indicators and foster connections with key networks and groups to provide relevant data.

    - *Additional Work Groups* – Additionally, the Collaborative has comprised work groups for the planning and implementation of the Community Health Improvement Plan (CHIP). This includes a work group to prepare for the 2022 CHIP process and four work groups that are focused on overseeing and implementing the strategies of the 2019 CHIP (one per priority area: behavioral health, financial security and mobility, housing, and access to services)

- *General membership* attends events, shares information, and participates in work groups. Over 400 people are engaged in communication with the Collaborative's activities.

APPENDIX B. STEERING COMMITTEE AND WORK GROUP MEMBERS

Boston CHNA-CHIP Collaborative
Steering Committee Membership

Organization	Name
Massachusetts League of Community Health Centers	Mary Ellen McIntyre (co-chair)
Dana-Farber Cancer Institute	Magnolia Contreras (co-chair)
Black Boston COVID-19 Coalition	Louis Elisa
Community Resident	Ricky Guerra
Madison Park Development Corporation	Leslie Reid
Mattapan Food and Fitness Coalition	Vivien Morris
Urban Edge	Emilio Dorcely
Beth Israel Deaconess Medical Center	Nancy Kasen
Boston Children's Hospital	Shari Nethersole, MD
Boston Medical Center	Thea James, MD
Brigham & Women's Hospital	Michelle Keenan
Brigham & Women's Faulkner Hospital	Tracy Mangini Sylven
East Boston Neighborhood Community Health Center	Hollis Graham
Harbor Health Services	Amanda Mastrangelo
Massachusetts General Hospital	Leslie Aldrich
Mass Eye and Ear	Tavinder Phull
Tufts Medical Center	Sherry Dong
Boston Public Health Commission	Catherine Fine

Community Engagement (Primary Data) Work Group Membership
Boston CHNA-CHIP Collaborative

Organization	Name
Beth Israel Deaconess Medical Center	Robert Torres (co-chair)
Jamaica Plain Neighborhood Development Corporation	Ricky Guerra (co-chair)
Mattapan Food and Fitness Coalition	Vivian Morris
Beth Israel Deaconess Medical Center	Danelle Marable
Boston Children's Hospital	Ayesha Cammaerts
Boston Children's Hospital	Carolyn King
Brigham & Women's Hospital	Sarah Ingerman
Brigham & Women's Hospital	Madison Louis
Dana-Farber Cancer Institute	Magnolia Contreras
East Boston Neighborhood Community Health Center	Joanna Cataldo
East Boston Neighborhood Community Health Center	Alexis Davis
East Boston Neighborhood Community Health Center	Gloria DeVine
East Boston Neighborhood Community Health Center	Joanne Suarez
East Boston Neighborhood Community Health Center	Carly Wellington
Mass General Brigham	Tavinder Phull
Massachusetts General Hospital	Leslie Aldrich
Massachusetts General Hospital	Kelly Washburn
Massachusetts League of Community Health Centers	Mary Ellen McIntyre
Tufts Medical Center	Lisa Hy
Tufts Medical Center	Karen Peterson
Tufts Medical Center	Danchen Xu
Boston Public Health Commission	Catherine Fine
Boston Public Health Commission	Trinese Polk
City of Boston Health and Human Services	Krystal Garcia

Secondary Data Work Group Membership
Boston CHNA-CHIP Collaborative

Organization	Name
Mass General Brigham	Trang Hickman (co-chair)
Boston Public Health Commission	Johnna Murphy (co-chair)
Boston Children's Hospital	Ayesha Cammaerts
Boston Children's Hospital	Carolyn King
Brigham & Women's Hospital	Sarah Ingerman
Brigham & Women's Hospital	Madison Louis
Brigham & Women's Hospital	RonAsia Rouse
Dana-Farber Cancer Institute	Magnolia Contreras
Harbor Health Services	Amanda Mastrangelo
Mass General Brigham	Tanner Parente
Mass General Brigham	Tavinder Phull
Massachusetts General Hospital	Nikki Reyes
Tufts Medical Center	Sherry Dong
Tufts Medical Center	Karen Peterson
Boston Public Health Commission	Catherine Fine
City of Boston Health and Human Services	Krystal Garcia

APPENDIX C. ONGOING PARTNER AND COMMUNITY ENGAGEMENT AND THE COLLABORATIVE PROCESS

Ongoing Partner and Community Engagement
Community health improvement efforts can only be accomplished through ongoing and meaningful engagement of community members and partners across a multitude of sectors. Through the work group structure, open community meetings, email dissemination, and the vast network of partners, the Collaborative aims to engage a range of sectors in the community. The Steering Committee of the Collaborative includes local public health, hospitals, community development, health centers, and numerous community organizations. Each Steering Committee member is a champion, engaging a wide network of organizations and residents. Each Collaborative work group comprises dozens of members across sectors to advance their charge. When gaps are identified within the activities of the work groups, work group co-chairs make a concerted effort to engage those involved in that area (e.g., bringing in additional representatives from the childcare sector in Access to Services during the implementation process.)

The community engagement process was carried out in accordance with the Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning Guideline, consistent with state law, Determination of Need (DoN) Regulation found at 105 CMR 100.000 as well as The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals. These standards establish procedures for defining the community, required stakeholders, and process steps and requirements.

Through email communications, virtual and in-person meetings and listening sessions run by the Collaborative, and meetings via Steering Committee members' own structures (e.g., hospital Community Benefit Advisory Committees), community members have been and will be continuously engaged in this process from assessment to planning to implementation.

This includes inviting broad resident and stakeholder participation in the CHIP Working Groups for each priority area. These CHIP working groups meet monthly or bi-monthly throughout the CHIP implementation period and are led by two Co-Chairs who manage and oversee these meetings. The CHIP Working Group Co-Chairs also update and present to the larger Collaborative Steering Committee at least three times annually and meet as a group six times annually to explore and discuss synergies and cross-collaboration in key CHIP implementation objectives.

At the Collaborative's annual community meeting, the CHIP Working Group Co-Chairs provide updates to the larger community and move into breakout sessions to strategize, strengthen and update CHIP working group activities and objectives, and to recruit new members to the CHIP Working Groups.

Communicating about the Assessment Findings
As mentioned in the Priorities for Collaborative Action section in this report, the CHNA findings were shared with community members in four different listening sessions in May-June 2022. During these sessions, Collaborative members presented on the assessment findings and engaged in a discussion with community members on what resonated with them and where there are gaps to inform a systematic prioritization process for planning. In total, 62 community members participated in this process.

Once this report is final, it will be posted on the Collaborative's website, and an announcement with the link to the report will be emailed out to the Collaborative mailing list, nearly 400 people that comprise of residents and community organization staff from across sectors including housing, transportation, economic development, public health, healthcare, and the faith community.

Continuous Updating and Revising of the Assessment

Review of data is a critical part of the planning and implementation process. The Collaborative has data sharing agreements with the Boston Public Health Commission and strong relationships with institutions and organizations across the city. These institutions are part of the Community Health Improvement Planning (CHIP) implementation work groups. During these work group meetings, data from the specific priority areas will be continuously examined to ensure that strategies are appropriate for and aligned to the community's needs.

In the past cycle, the ongoing CHIP implementation work groups (one per priority area) used the 2019 CHNA data to develop their initial list of strategies. In 2020 and on, they continually worked with the Boston Public Health Commission and community-based organizations to collect and synthesize new data, particularly with a focus on how the COVID-19 pandemic exacerbated inequities and identified areas of urgent need. For example, during the process, real-time data indicated that many residents were facing a loss of income, increased risk of eviction, and loss of childcare during the pandemic. This guided the CHIP implementation work groups so that they could nimbly adjust to current circumstances: the Financial Security and Mobility group focused more on employment-related strategies, the Housing work group focused more on eviction issues, and the Access to Services ramped up their strategies addressing childcare needs. This was only made possible via the broad cross-section of partnerships within each work group. These issue areas were identified as critical for further review during the 2022 CHNA process.

In addition to carrying forward the foregoing processes into the next cycle, the Collaborative plans to hold annual community meetings in order to provide updates to the community on CHIP progress and objectives, and to gain additional input and recommendations from Community Members on current and future activity within each working group. The Collaborative has held annual community meetings each year, with the exception of 2021 when virtually all Collaborative members shifted to responding to a significant surge in community transmission of COVID-19 and increased hospitalizations.

As new data and community input is generated and synthesized through these processes, it will also be reviewed at least annually for the purposes of identifying any potential enhancements or additions to the CHNA.

APPENDIX D. TECHNICAL NOTES ON CHNA QUANTITATIVE AND QUALITATIVE METHODS AND DATA

Quantitative Data – Secondary Data

How Indicators and Data Sources were Identified

The Secondary Data Work Group members identified the goals of the secondary data as: 1) to examine inequities by population group specifically among those with disproportionate burden and 2) to dig deeply into areas of need most exacerbated by the COVID-19 pandemic.

The Secondary Data Work Group was instrumental in developing and providing feedback on list of data indicators, identifying potential data sources, and making connections to those sources. The secondary data work group began their work of reviewing the indicator list from the 2019 CHNA. These indicators were identified through multiple methods – 1) review of existing, validated indicators for social, economic, and health issues; 2) multiple discussions with a 30 person secondary data work group to brainstorm gaps in the initial list: and 3) review and refinement of the longer indicator list among the work group and work group co-chairs to prioritize those indicators that were available, focused on upstream issues, could be tracked over time, and where there were significant inequities.

The 2022 CHNA process started with this 2019 list and then further refined and prioritized for this report. The secondary data work group engaged in multiple discussions and prioritized indicators: that aligned with the 2019 priority areas; that COVID-19 had a disproportionate impact on, and/or where there were the greatest inequities by race/ethnicity, neighborhood, or other characteristics.

Secondary Data Sources

Numerous data sources were reviewed and included in the 2022 CHNA. Secondary data sources included U.S. Census/American Community Survey, vital statistics (birth/death records), hospital case mix data, Bureau of Labor Statistics, Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), BBRFSS COVID-19 Health Equity Survey, Youth Risk Behavior Survey (YRBS), and the Massachusetts Department of Public Health Bureau of Substance Addiction Services treatment data.

Analyses

All secondary data on birth and death records, BBRFSS, YRBS, and Acute Hospital Case Mix were analyzed by the Research and Evaluation Office of the Boston Public Health Commission. Other data were analyzed by the organizations cited in the data source. Analyses were conducted for frequencies (percentages) and rates (per 100,000 residents), where applicable. Confidence intervals (or error bars in the figures) were calculated for survey data from the ACS and surveillance systems, such as the BBRFSS and YRBS. Statistical significance testing by sub-groups was conducted at $p<0.05$.

Secondary data were included in the main body of the CHNA report that were most relevant to the themes that emerged in the focus groups and interviews, that aligned with the CHIP priority areas, that COVID-19 had a disproportionate impact on, and where there were the most significant inequities by race/ethnicity, neighborhood, or other characteristics

Qualitative Data – Focus Groups and Interviews

How Populations and Interviewees were Identified

The Community Engagement Work Group identified one of its main goals as ensuring that diverse and historically underrepresented community voices are lifted throughout the CHNA-CHIP process using an equity framework. To that end, the Community Engagement work group conducted a thorough review of the 2019 CHNA and identified areas where there were gaps in representation. Concerted efforts were made in the 2022 process to ensure that those voices were included (e.g., expanded engagement with residents of Chinatown and Boston's Chinese community.)

Additionally, each hospital involved their Community Benefit Advisory Committee (CBAC) in the process as well, which included engagement of stakeholders at the neighborhood level across a range of sectors. The list of population segments for focus groups and stakeholders were vetted through each CBAC and additional ideas were brainstormed where there were gaps. CBACs were also asked to identify neighborhoods and population segments most impacted by COVID-19 (e.g., essential workers).

Focus group discussions were conducted with those who have been disproportionately burdened by social, economic, and health challenges including: youth and adolescents, older adults, persons with disabilities, low-resourced individuals and families, LGBTQI+ populations, racially/ethnically diverse populations and/or limited-English speakers (e.g., African American, Latino, Haitian, Cape Verdean, Vietnamese, Chinese), immigrant and asylee communities, families affected by incarceration and/or violence, and veterans. Key informant interviews were conducted with a cross-section of sectors to identify areas of action and perspectives on the community. These interviewees included leaders and staff from public health, health care, behavioral health, the faith community, immigrant services, housing organizations, economic development, community development, racial justice organizations, social service organizations, education, community coalitions, the business community, childcare centers, elected government offices, and others.

Discussion Guides and Process

Members of the Community Engagement Work Group and their partners -- Boston Children's Hospital, John Snow Inc. on behalf of Beth Israel Medical Center and New England Baptist Hospital, Massachusetts General Hospital, Brigham and Women's Hospital, Brigham and Women's Hospital Faulkner Hospital, Tufts Medical Center, East Boston Neighborhood Health Center, EASTIE Coalition at East Boston Neighborhood Center, Soccer without Borders, Veronica Robles Cultural Center, and Maverick Landing Community Services – conducted the focus groups and interviews. Members of the community engagement work group divvied up key informant interviews and focus groups that they conducted using a consistent guide which focused on community needs and strengths and particularly which aspects of life were most impacted by the pandemic. Each organization organized their own discussions and made slight variations to the guide where appropriate.

Qualitative data were from 62 key informant community leaders across a range of sectors and 29 focus groups with 309 community residents. The selection process for both the qualitative and quantitative data were guided by the Collaborative's shared values of equity.

Analysis

Each organization that conducted the focus groups and interviews initially synthesized the data they collected. The organizations summarized key themes into a consistent template that identified

feedback from the discussions on the community strengths, impact of COVID, priority health issues, factors that promote community health, barriers to healthy living, specific findings among the four priority areas (housing, financial security and mobility, behavioral health, and accessing services), and proposed ideas and recommendations for the future. Findings under each of these were summarized, along with notations among which sub-populations they mapped to. Additionally, the template provided space for organizations to pull out illustrative quotes.

These summaries were submitted to Health Resources in Action (HRiA), a non-profit public health organization, that helped support the analysis and development of the CHNA report. HRiA analyzed the qualitative summaries to identify common themes across population groups as well as unique challenges and perspectives identified by populations and sectors, with an emphasis on diving deep into the root causes of inequities. Frequency and intensity were key factors used for extracting main themes and sub-themes, as well as its alignment with the Collaborative's focus on equity.

Asset Mapping and Community Resources

Leading up to the 2022 CHNA, most of the CHIP work groups (one per priority area: behavioral health, access to services, housing, and financial stability & mobility) developed a comprehensive resources list to identify where there were current resources and where there were gaps. This information guided which strategies were prioritized, how they were implemented, and which partners needed to be involved in the discussions. This information then informed the 2022 CHNA. Additionally, in the 2022 CHNA, 62 key informant community leaders in interviews and 309 community residents in 29 focus groups were asked about what they saw as the strengths and assets in their community. This feedback was synthesized in this report.

APPENDIX E. KEY INFORMANT INTERVIEWEE ORGANIZATIONS

Organization
Alice Taylor Housing
Black Ministerial Alliance TenPoint
Boston Center for Independent Living
Boston City Council
Boston Higher Education Resource Center
Boston Housing Authority
Boston Police Community Liaison
Boston Police Department
Boston Public Health Commission
Boston Public Schools
Boston Senior Home Care
Boston Women's Fund
Boys & Girls Club of Boston
Brigham and Women's Hospital
Cape Verdean Association of Boston
Cape Verdean Community Leader
Community Servings
Dimock Center
East Boston Neighborhood Health Center
East Boston Social Centers
Ecumenical Social Action Committee Boston
Family Nurturing Center
Fenway Health
Friends of the Boston Public Library
Greater Boston Parents, Families, and Friends of Lesbians and Gays
Haitian Americans United
Haitian Community Leader
Health Leads Boston
Hyde Park Community Physicians
Italian Home for Children
Jamaica Plain Neighborhood Development Corporation
Local Initiatives Support Corporation
Madison Park Development Corporation
Madison Park High School
Maria Sanchez House
Massachusetts Affordable Housing Alliance
Massachusetts Association of Community Development Corporations
Massachusetts General Hospital Asylum Clinic
Massachusetts Office on Disability
Massachusetts State Legislature
Maverick Landing Community Services
Metropolitan Area Planning Council
Mission Hill Health Movement

Mission Hill Link
Mission Hill Main Streets
Mission Hill Neighborhood Housing Services
Mission Main
NAACP
Parker Hill Fenway
Partners for Youth with Disabilities
Roxbury Main Streets
Roxbury Tenants of Harvard
Sociedad Latina
South Cove Community Health Center
Tech Goes Home
Tobin Community Center
YMCA Hyde Park

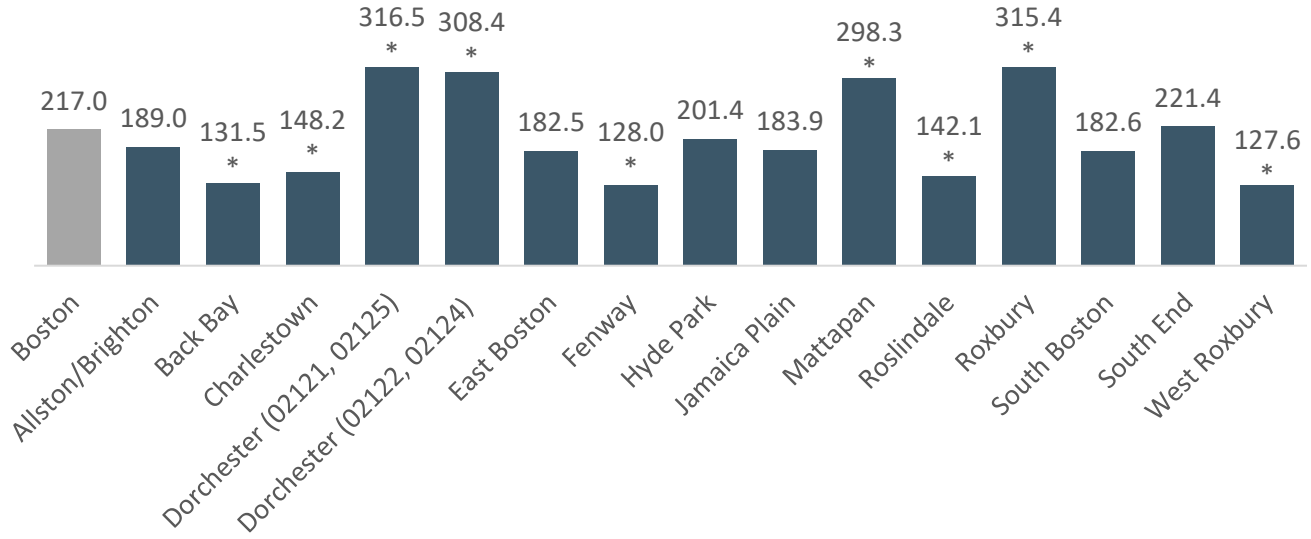
APPENDIX F. ADDITIONAL DATA TABLES

The main CHNA report focused on including data that were most relevant to the themes that emerged in the focus groups and interviews, that aligned with the CHIP priority areas, that COVID-19 had a disproportionate impact on, and where there were the most significant inequities by race/ethnicity, neighborhood, or other characteristics. Appendix F includes additional data to complement what is presented in the body of the report.

Community Health

Premature Mortality

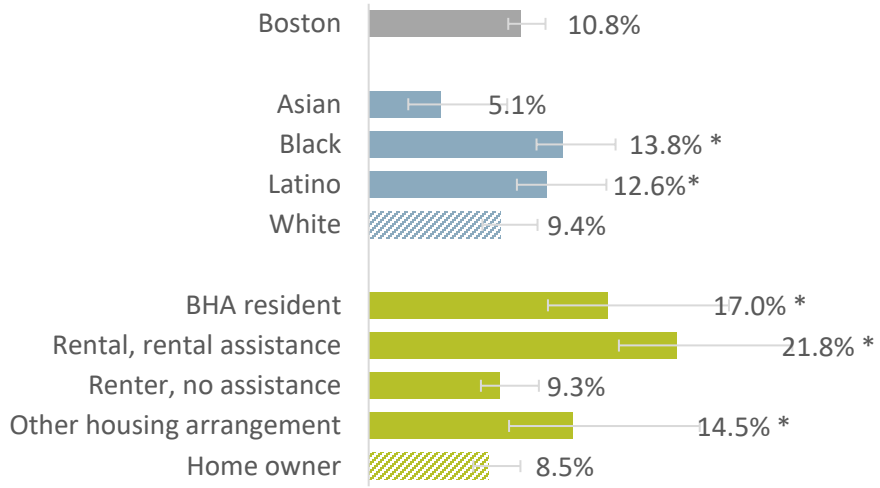
Figure 22. Premature Mortality Rate, by Boston and Neighborhood, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



DATA SOURCE: Boston Public Health Commission, Boston resident deaths, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Premature deaths are defined as deaths at an age under 65 years; Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$)

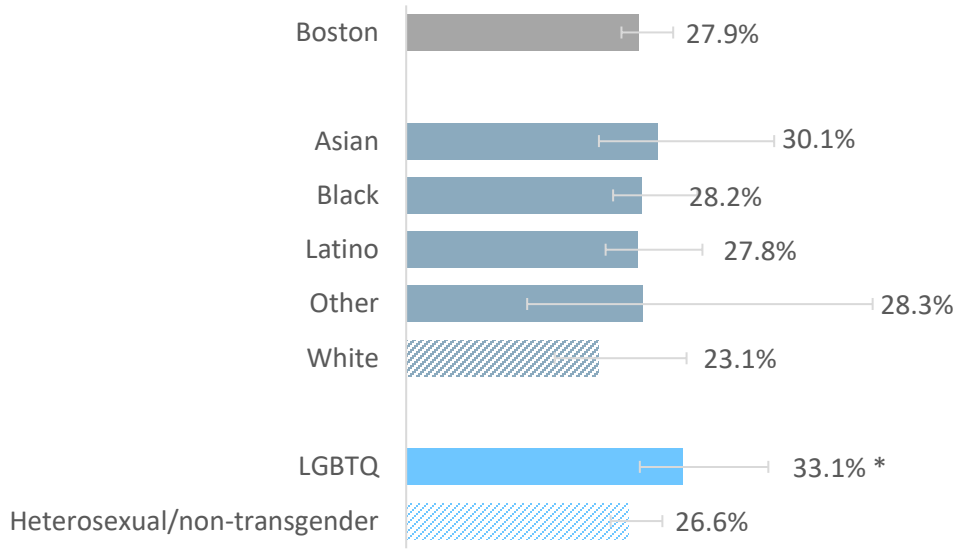
Asthma

Figure 23. Percent Adults Reporting Having Asthma, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



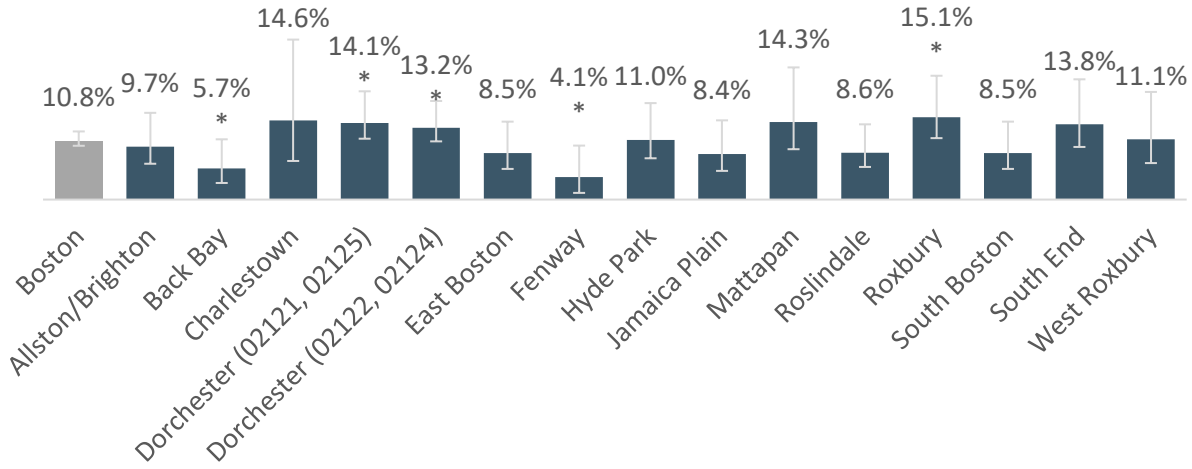
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 24. Percent Boston Public High School Students Reporting Having Asthma, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



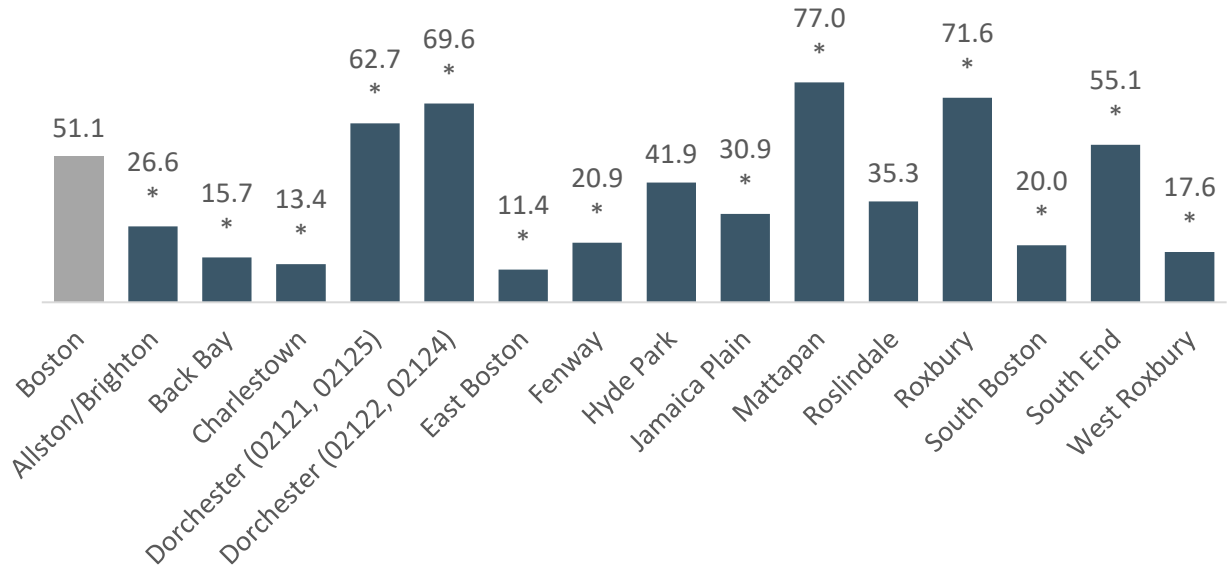
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 25. Percent Adults Reporting Having Asthma, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



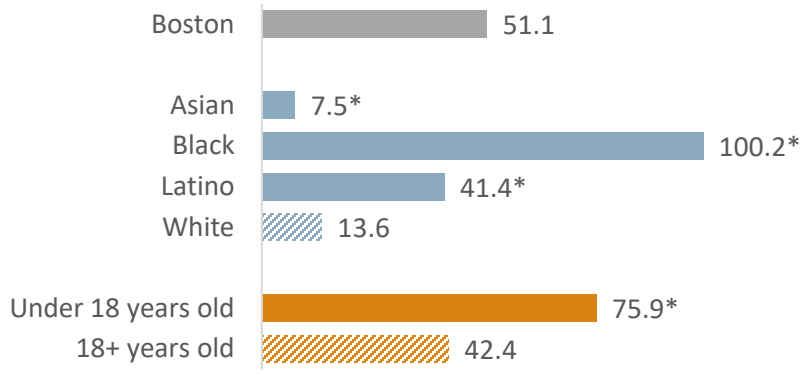
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 26. Asthma-Related Hospital Patient Encounter Rate, by Boston and Neighborhood, Age-Adjusted Rate per 10,000 Residents, 2020



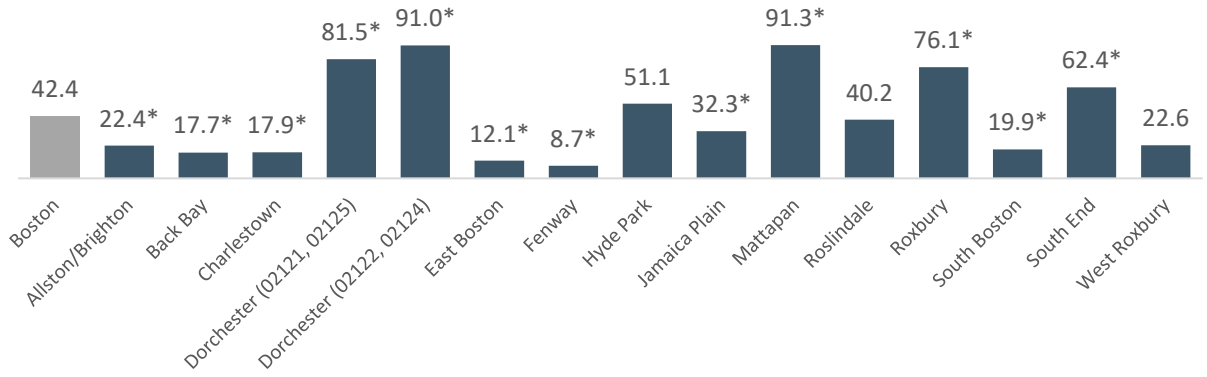
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 27. Asthma-Related Hospital Patient Encounter Rate, by Boston and Selected Indicators, Age-Adjusted Rate per 10,000 Residents, 2020



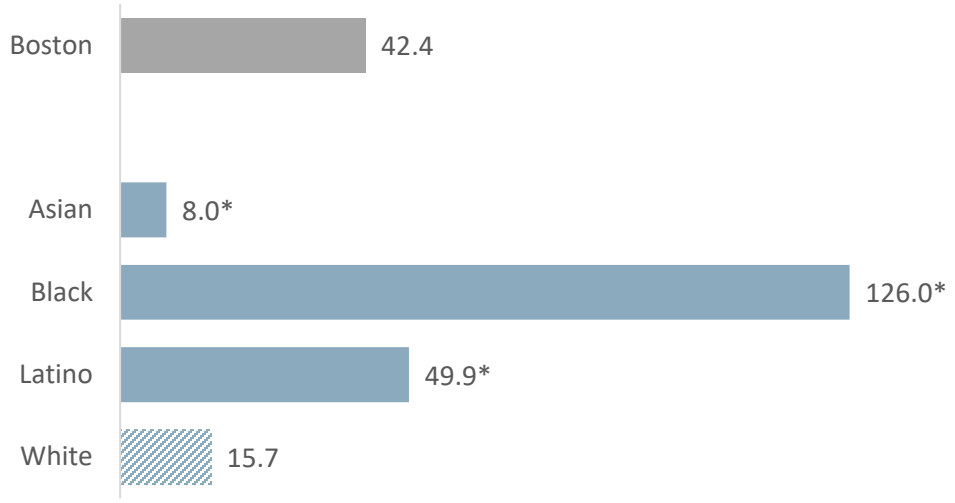
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations. Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 28. Asthma Hospital Patient Encounters (Adults Over 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



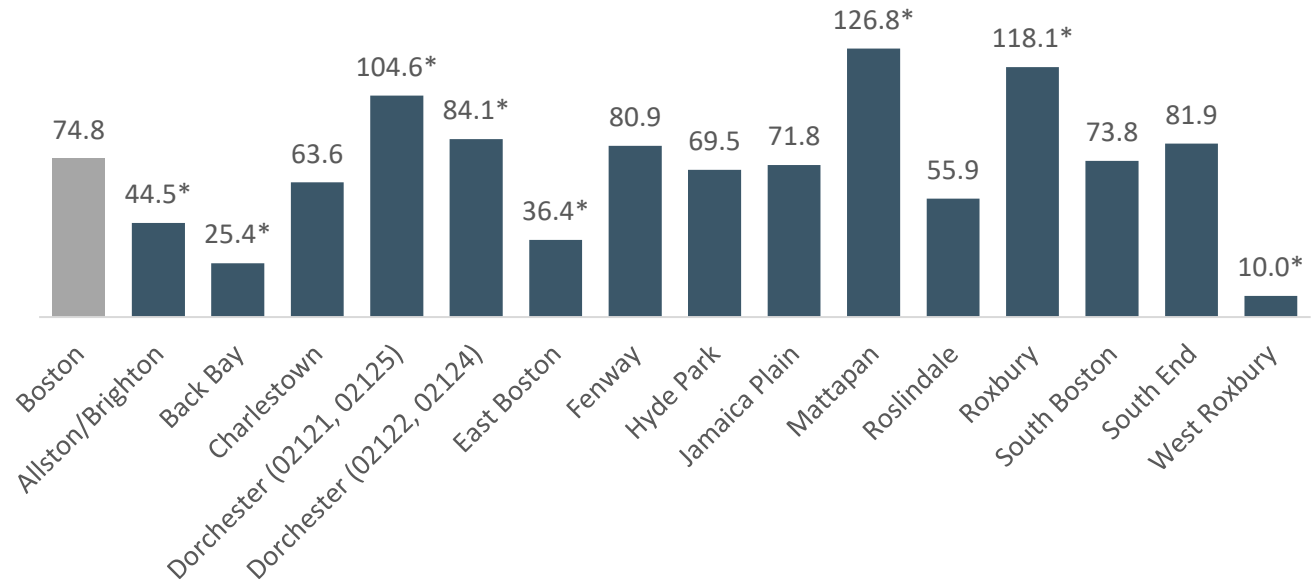
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 29. Asthma Hospital Patient Encounters (Adults Over 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



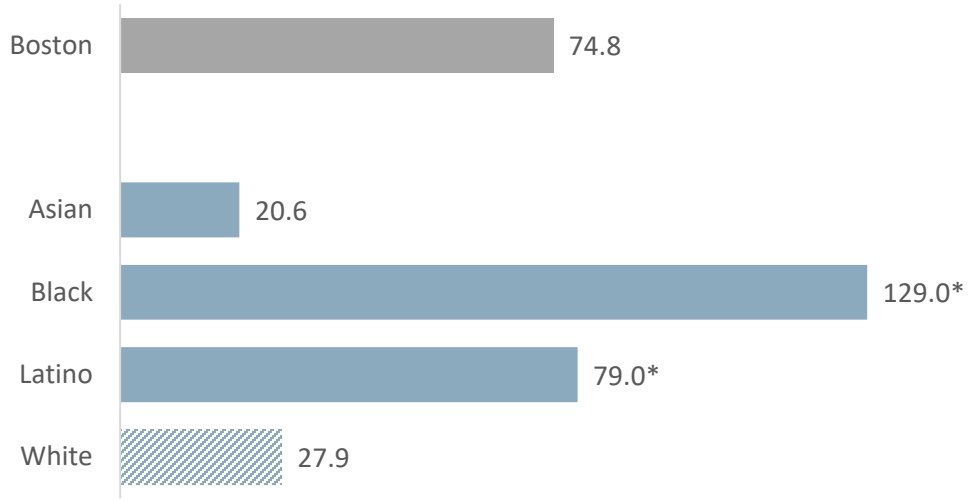
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 30. Asthma Hospital Patient Encounters (Children Under 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



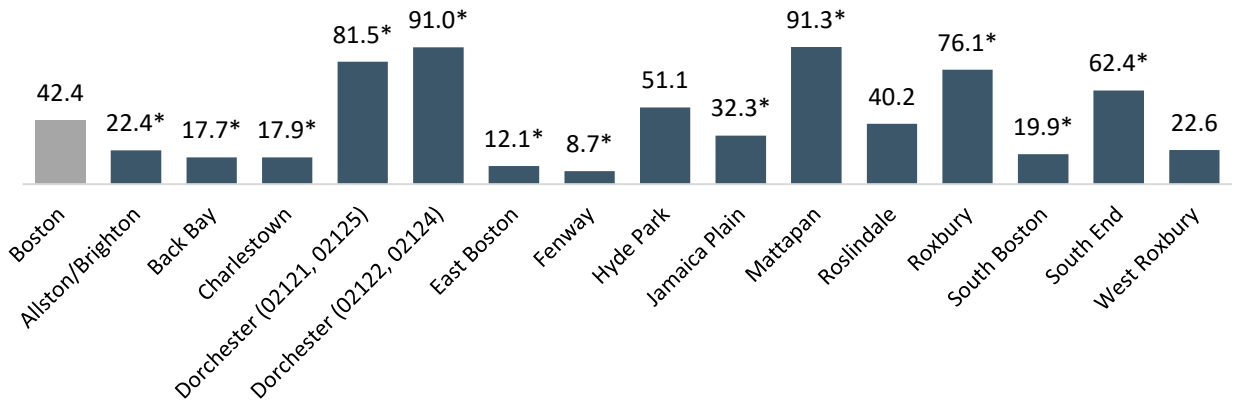
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 31. Asthma Hospital Patient Encounters (Children Under 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



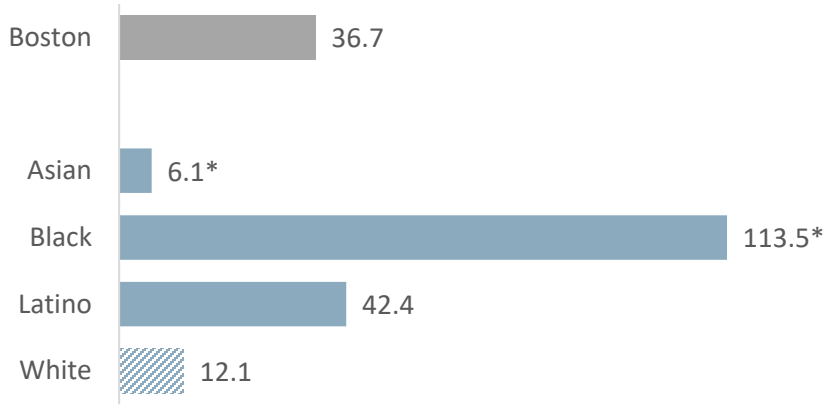
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 32. Asthma Emergency Department Visits (Adults Over 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



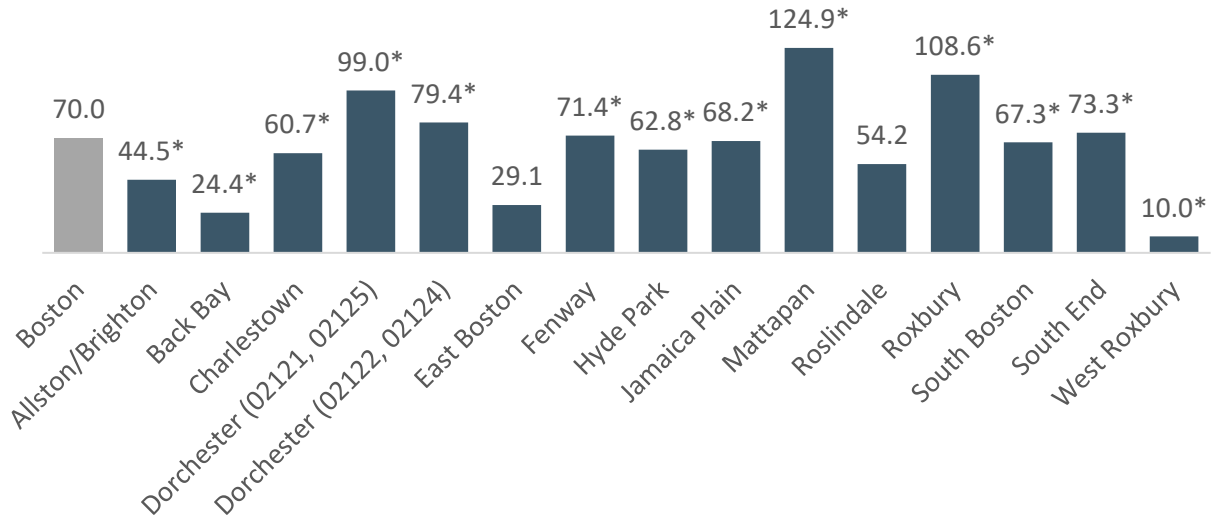
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 33. Asthma Emergency Department Visits (Adults Over 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



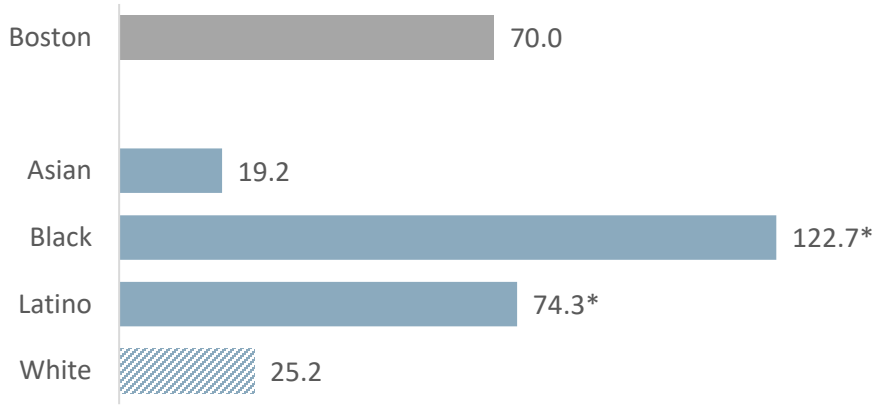
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 34. Asthma Emergency Department Visits (Children Under 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

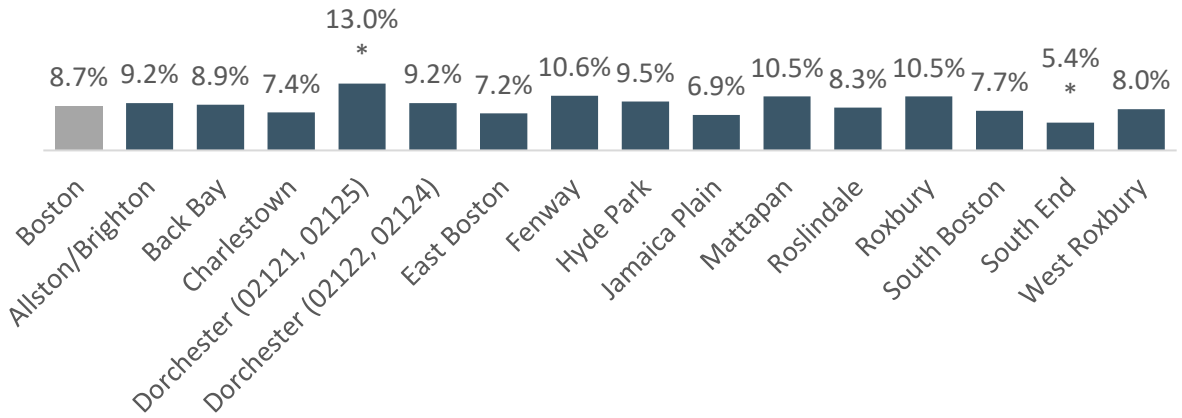
Figure 35. Asthma Emergency Department Visits (Children Under 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

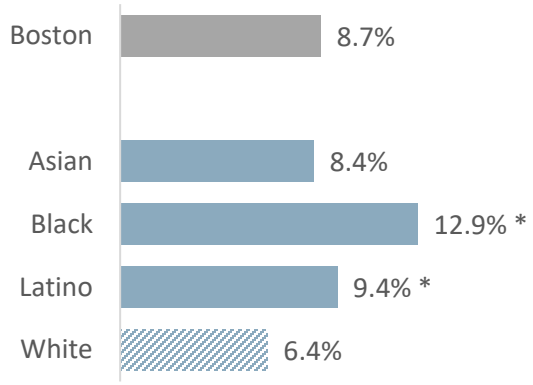
Birth Outcomes

Figure 36. Percent Low Birthweight Births, by Boston and Neighborhood, 2019



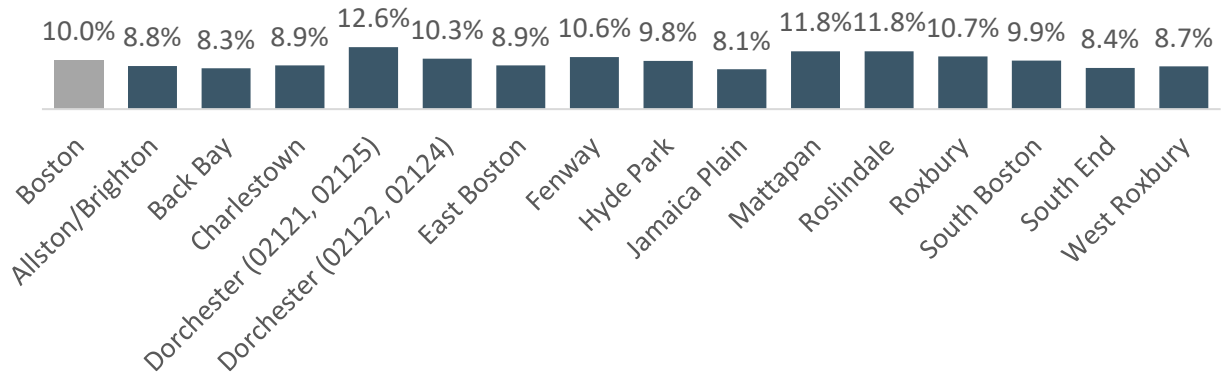
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Low birthweight is defined as weighing less than 5 pounds, 8 ounces; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 37. Percent Low Birthweight Births, by Boston and Race/Ethnicity, 2019



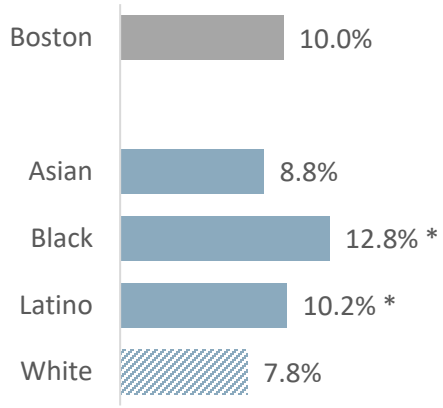
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Low birthweight is defined as weighing less than 5 pounds, 8 ounces; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 38. Percent Preterm Births, by Boston and Neighborhood, 2019



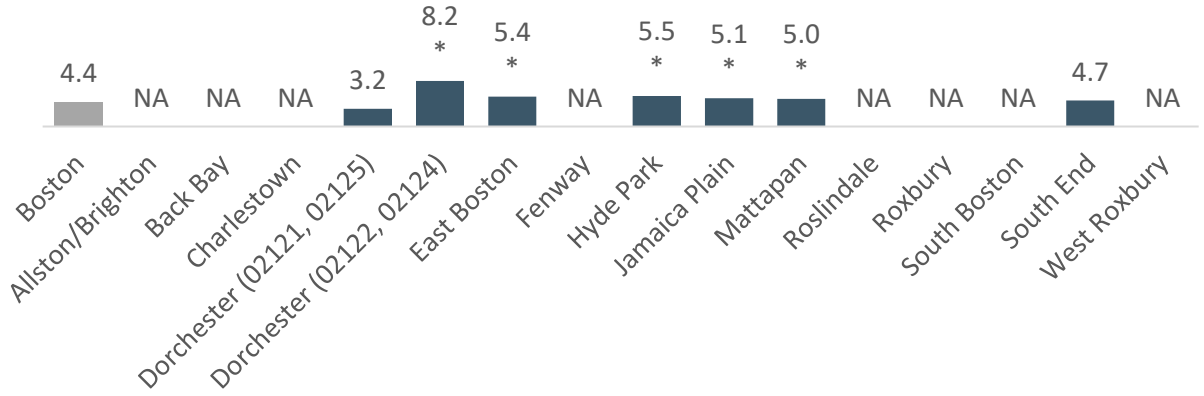
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Preterm birth is defined as being born before 37 weeks of gestation; No significant differences between neighborhood estimates compared to the rest of Boston were observed (p>0.05)

Figure 39. Percent Preterm Births, by Boston and Race/Ethnicity, 2019



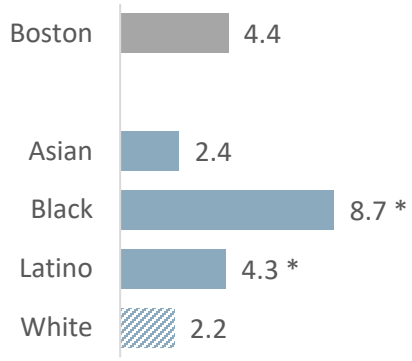
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Preterm birth is defined as being born before 37 weeks of gestation; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 40. Infant Mortality Rate, by Boston and Neighborhood, Rate per 1,000 Live Births, 2017-2019 Combined



DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2017-2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Infant mortality is defined as the death of an infant before 1 year of age; NA denotes where rates are not shown due to insufficient sample size; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

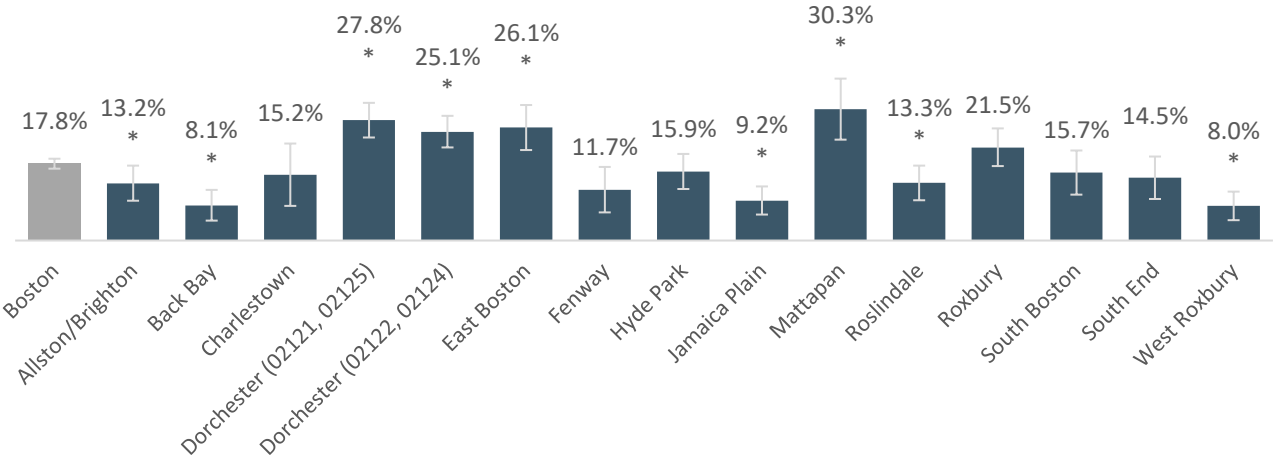
Figure 41. Infant Mortality Rate, by Boston and Race/Ethnicity, Rate per 1,000 Live Births, 2017-2019 Combined



DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2017-2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Infant mortality is defined as the death of an infant before 1 year of age; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

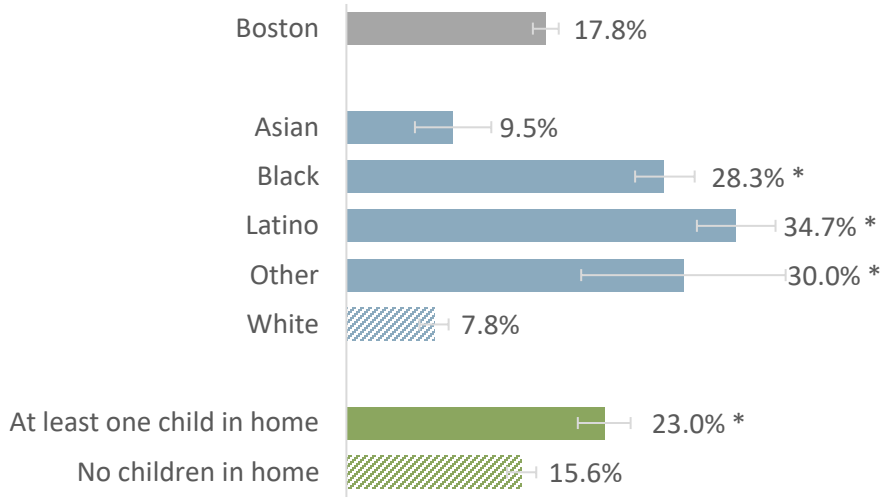
Financial Security and Mobility

Figure 42. Percent Adults Reporting Food Purchased Did Not Last and Did Not Have Money to Get More, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



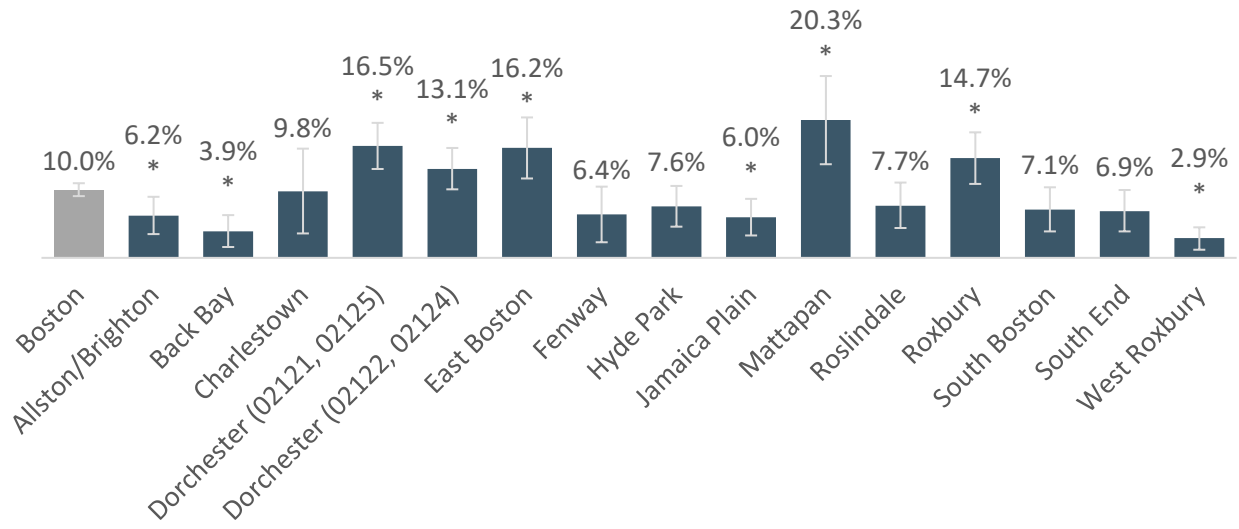
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true that the food did not last and they did not have money to get more; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05); Error bars show 95% confidence interval

Figure 43. Percent Adults Reporting Food Purchased Did Not Last and Did Not Have Money to Get More, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



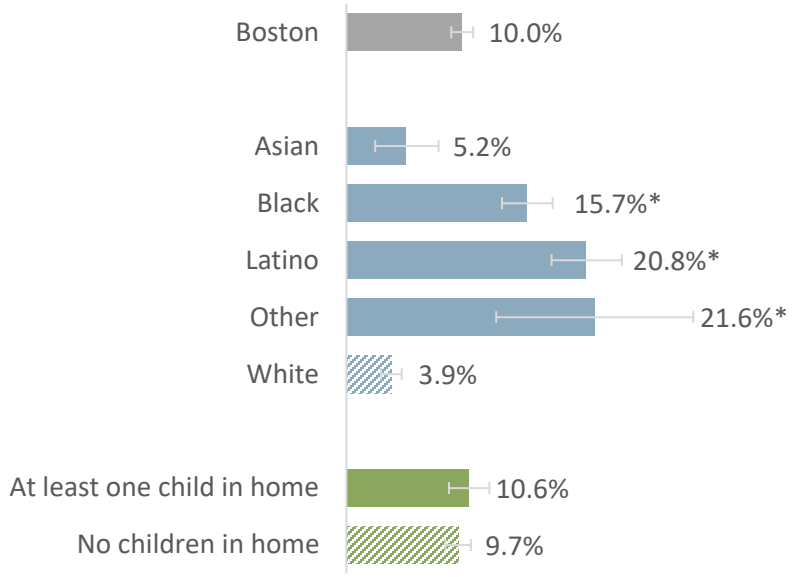
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true that the food didn't last and they did not have money to get more; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 44. Percent Adults Reporting Feeling Hungry But Did Not Eat Because Could Not Afford Food, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



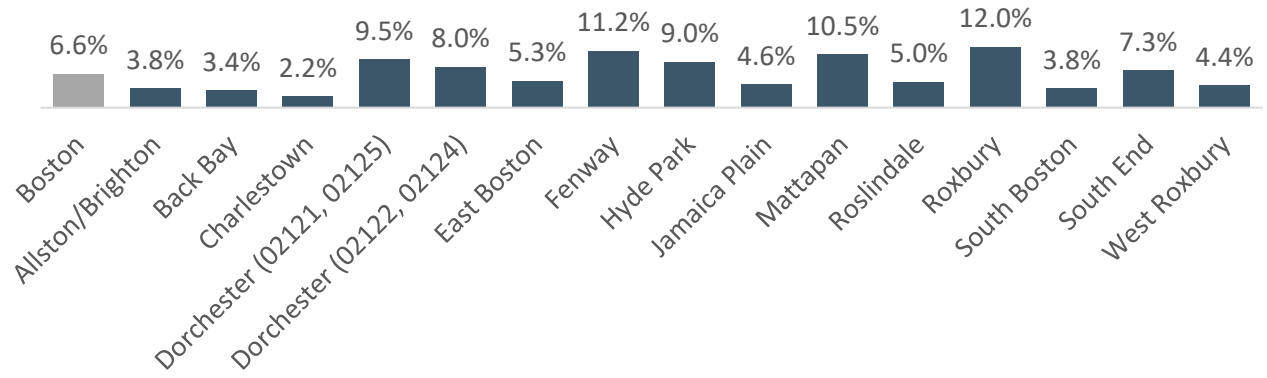
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true in the past 12 months they remained hungry because they could not afford food; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 45. Percent Adults Reporting Feeling Hungry But Did Not Eat Because Could Not Afford Food, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



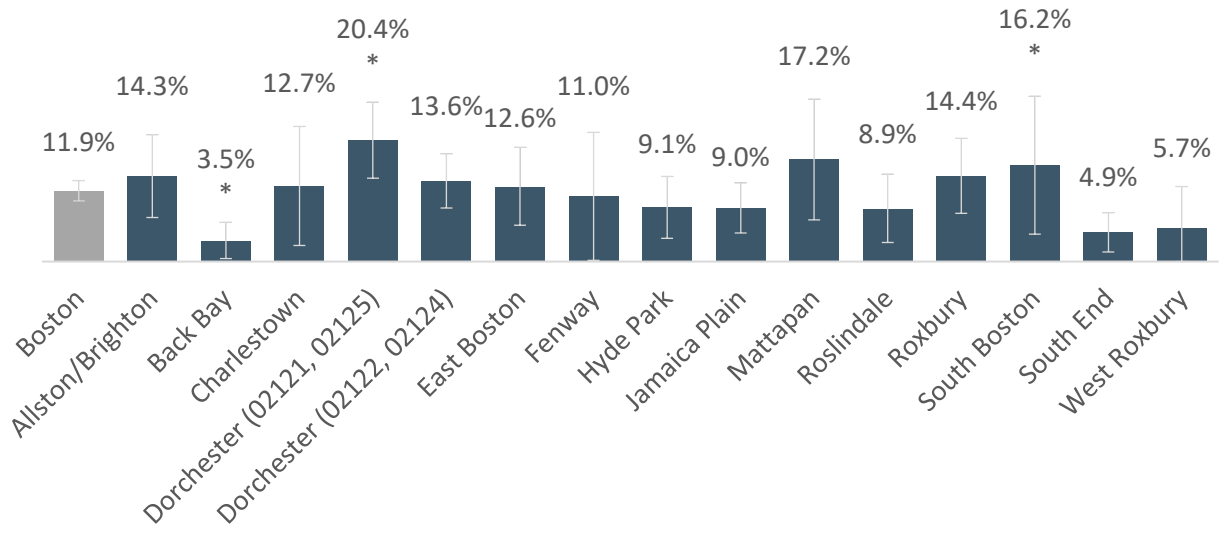
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true in the past 12 months they remained hungry because they could not afford food; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 46. Percent Population 16 Years and Over Unemployed, by Boston and Neighborhood, 2015-2019



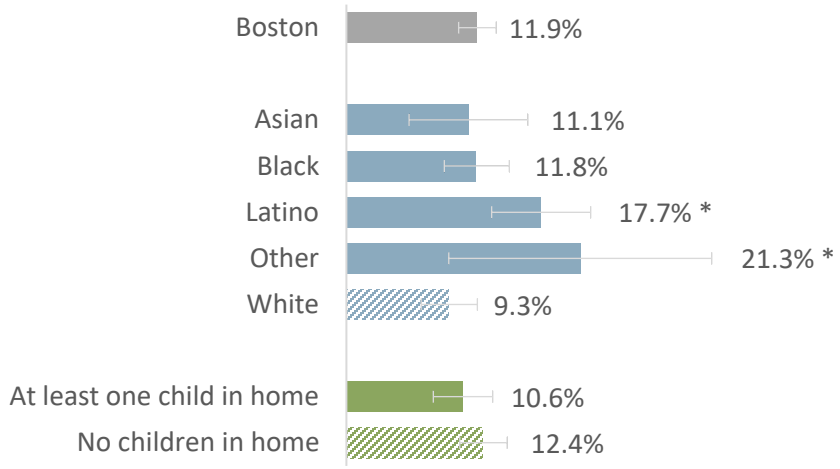
DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2015-2019

Figure 47. Percent Adults Reporting Having Transportation Difficulties in Past Year, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



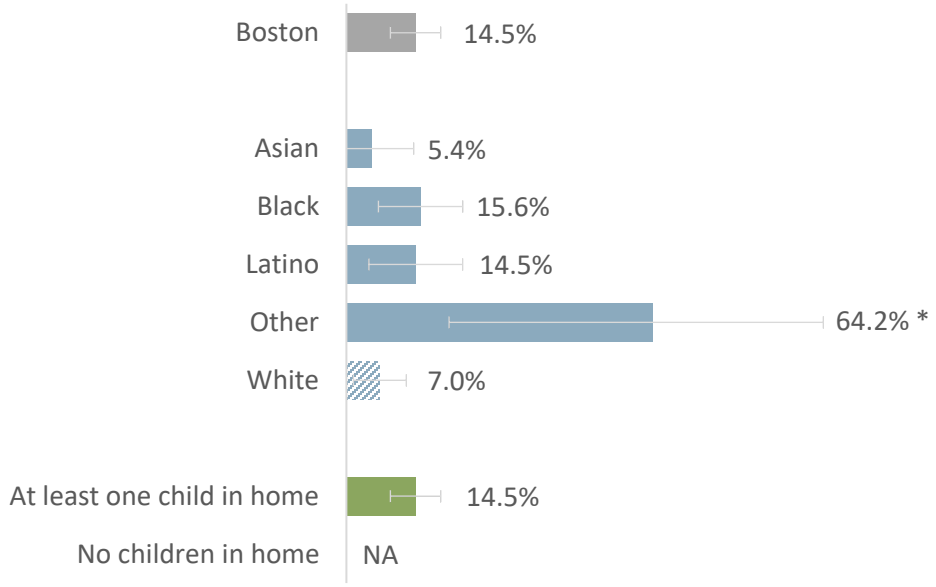
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting to that transportation difficulties have kept them from medical appointments, meetings, work, or from getting things needed for daily living in the past 12 months; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 48. Percent Adults Reporting Having Transportation Difficulties in Past Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting to that transportation difficulties have kept them from medical appointments, meetings, work, or from getting things needed for daily living in the past 12 months; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

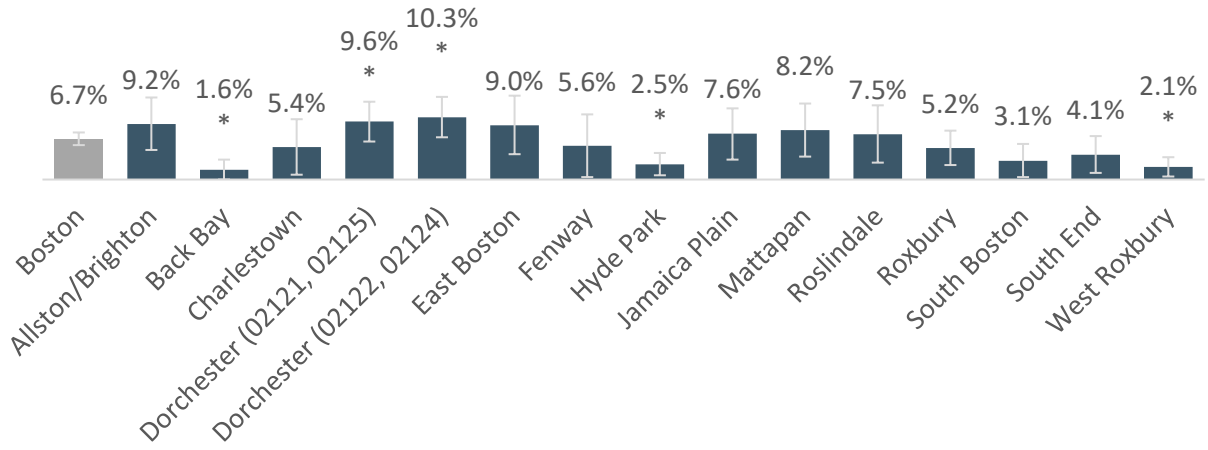
Figure 49. Percent Adults with Children Reporting Having Unmet Education Needs for Children or Teens in Household During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: NA denotes where data are not available because only respondents who indicated having at least one child present in the household were asked this question; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

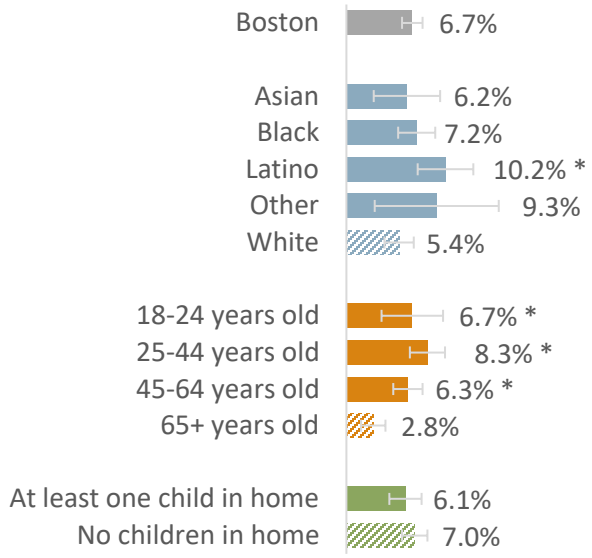
Housing

Figure 50. Percent Adults Reporting Moving in Past Three Years Because They Could No Longer Afford Their Home, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



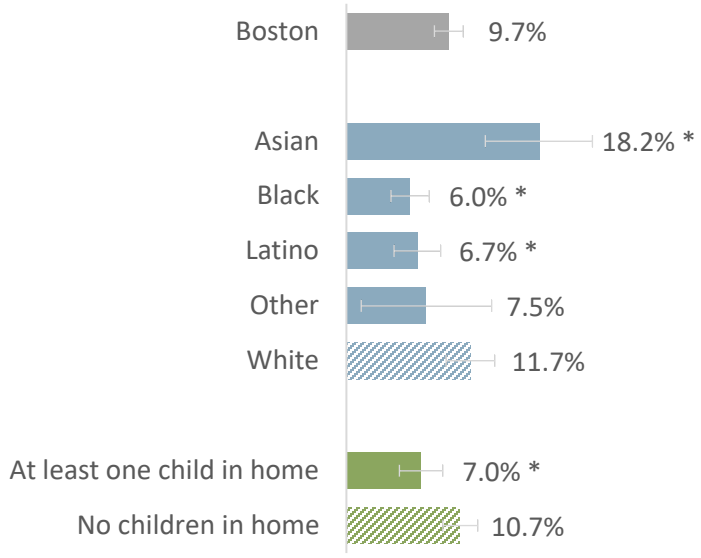
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 51. Percent Adults Reporting Moving in Past Three Years Because They Could No Longer Afford Their Home, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

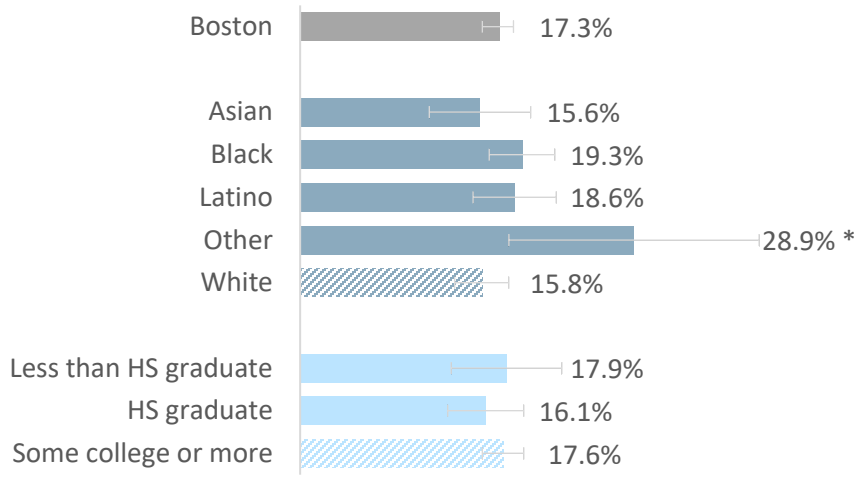
Figure 52. Percent Adults Reporting Living in Their Zip Code for Less Than One Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting they have lived in their zip code for less than one year in a row, excluding time as a student living on a college or university campus; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

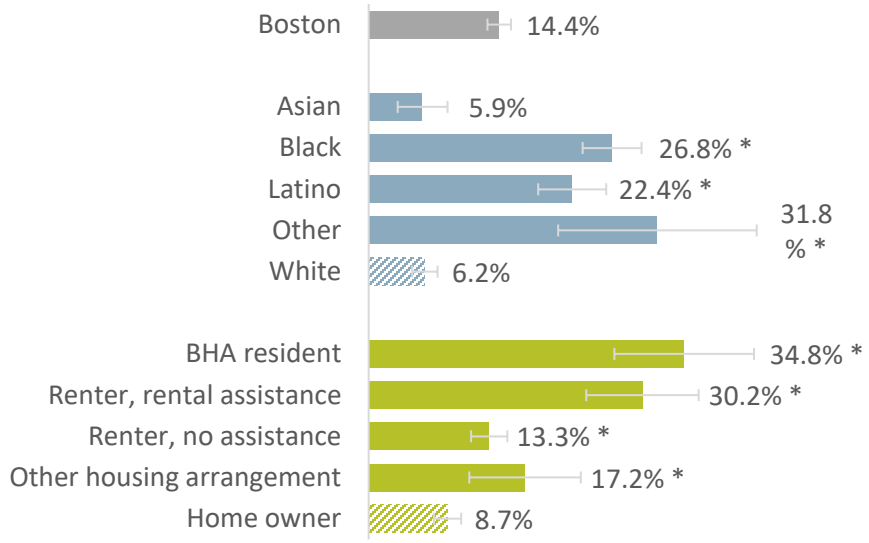
Behavioral Health

Figure 53. Percent Adults Reporting Being Threatened At Least Once a Year Due to Discrimination, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



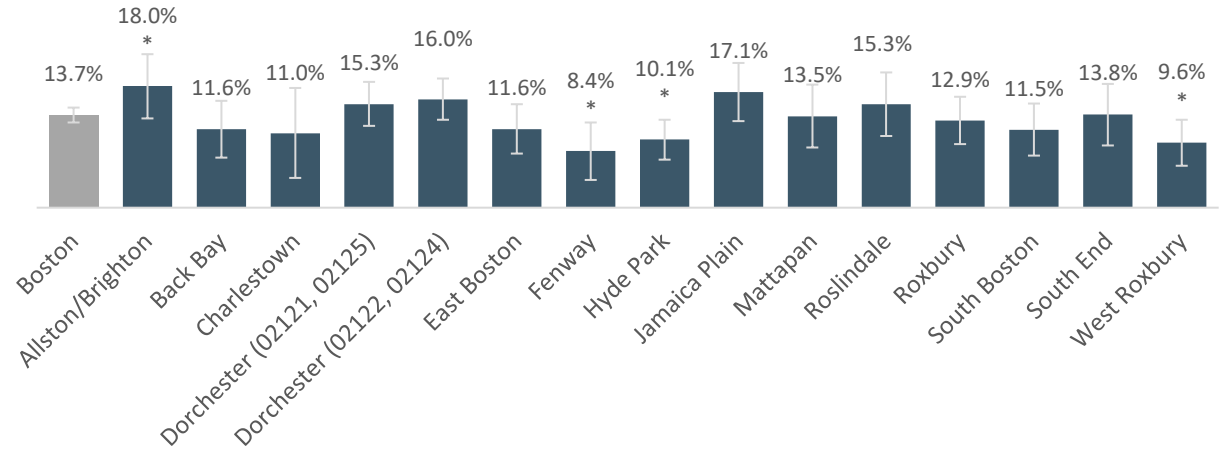
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting being threatened or harassed due to discrimination a few times a year, a few times a month, at least once a week, or almost every day; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 54. Percent Adults Reporting Their Neighborhood Unsafe, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



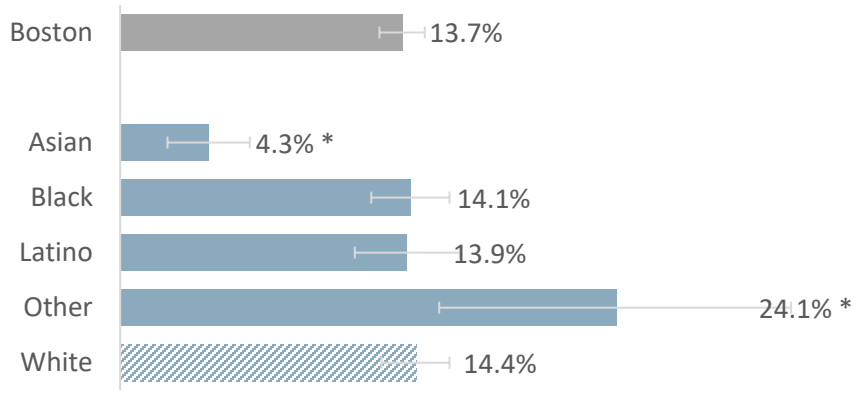
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting considering their neighborhood to be unsafe from crime; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 55. Percent Adults Reporting Experiencing Violence in Adult Lifetime, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



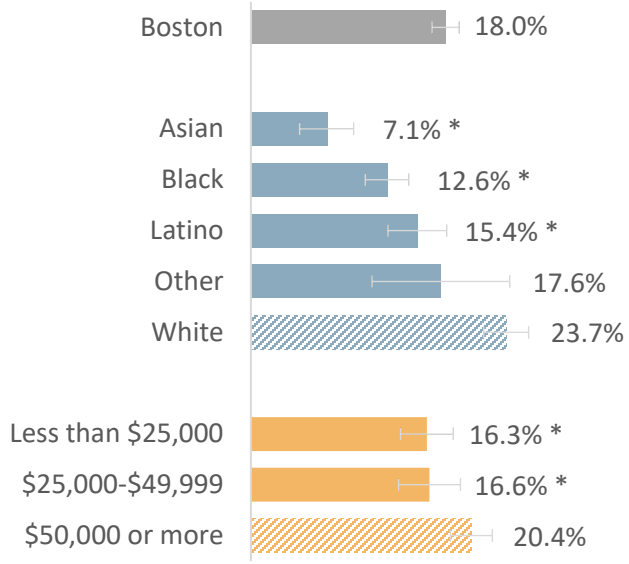
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults who reported to have experienced any physical or sexual violence since turning 18 years old; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 56. Percent Adults Reporting Experiencing Violence in Lifetime, by Boston and Race/Ethnicity, 2015, 2017, and 2019 Combined



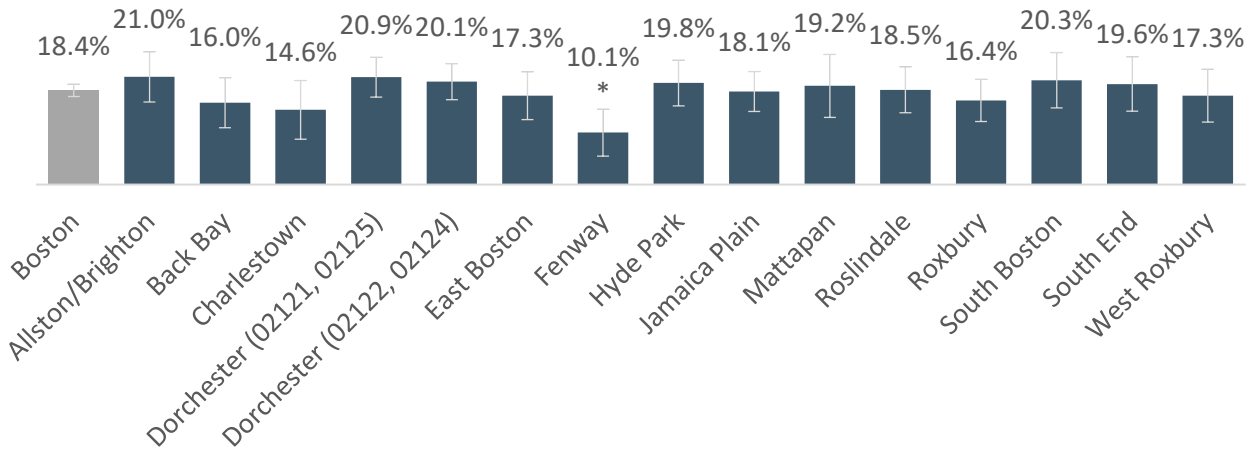
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults who reported to have experienced any physical or sexual violence since turning 18 years old; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 57. Percent Adults Reporting Having Lived with a Caregiver with Mental Illness as a Child (ACE), by Boston and Selected Indicators, 2015, 2017, 2019 Combined



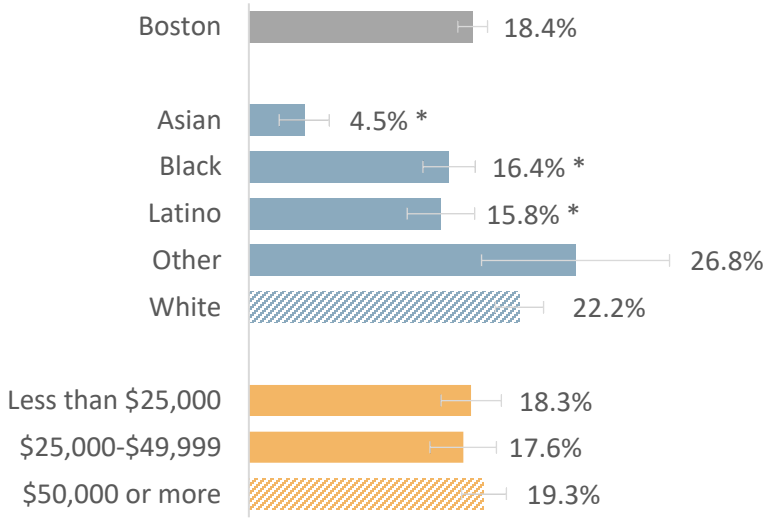
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was depressed, mentally ill, or suicidal; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 58. Percent Adults Reporting Having Lived with a Caregiver with Substance Misuse as a Child (ACE), by Boston and Neighborhood, 2015, 2017, and 2019 Combined



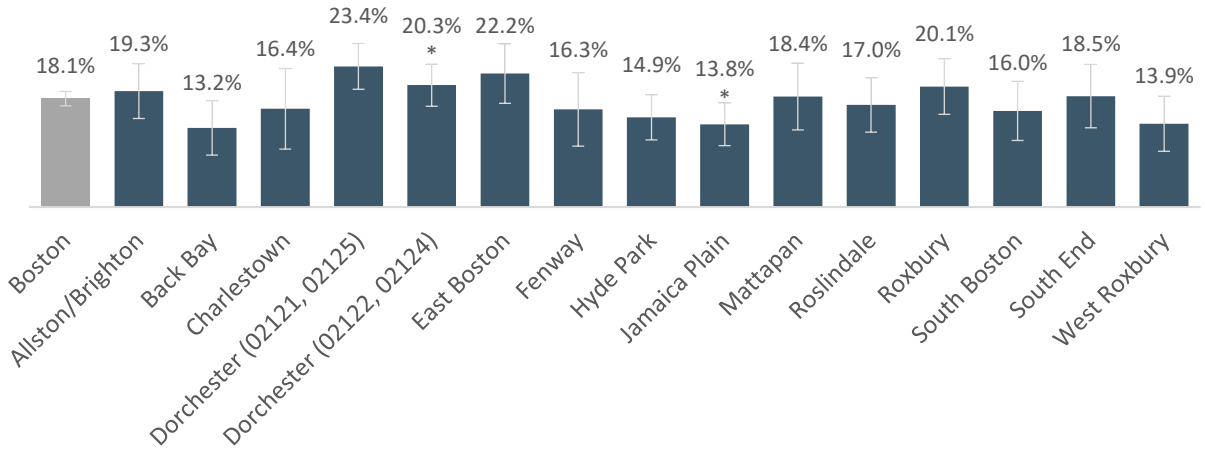
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was a problem drinker or alcoholic, or who used illegal street drugs or abused prescription medications; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 59. Percent Adults Reporting Having Lived with a Caregiver with Substance Misuse as a Child (ACE), by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



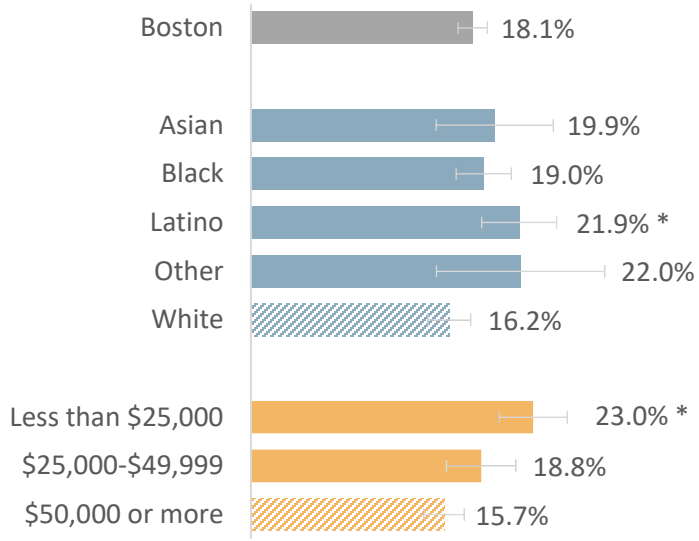
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was a problem drinker or alcoholic, or who used illegal street drugs or abused prescription medications; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 60. Percent Adults Reporting Having Lived with Adults who Physically Abused Each Other as a Child (ACE), by Boston and Neighborhood, 2015, 2017, and 2019 Combined



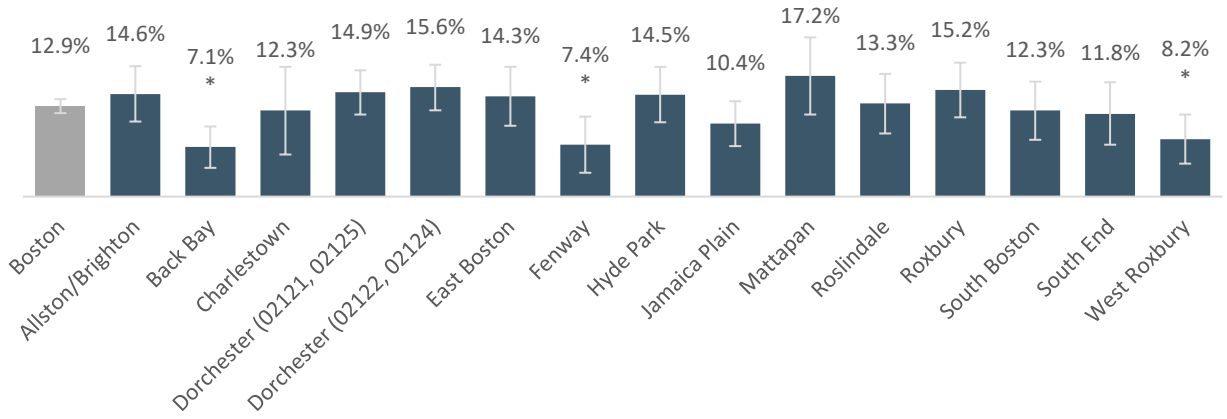
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that their parents or the adults in their home ever slapped, hit, kicked, punched, or beat each other up; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 61. Percent Adults Reporting Having Lived with Adults who Physically Abused Each Other as a Child (ACE), by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



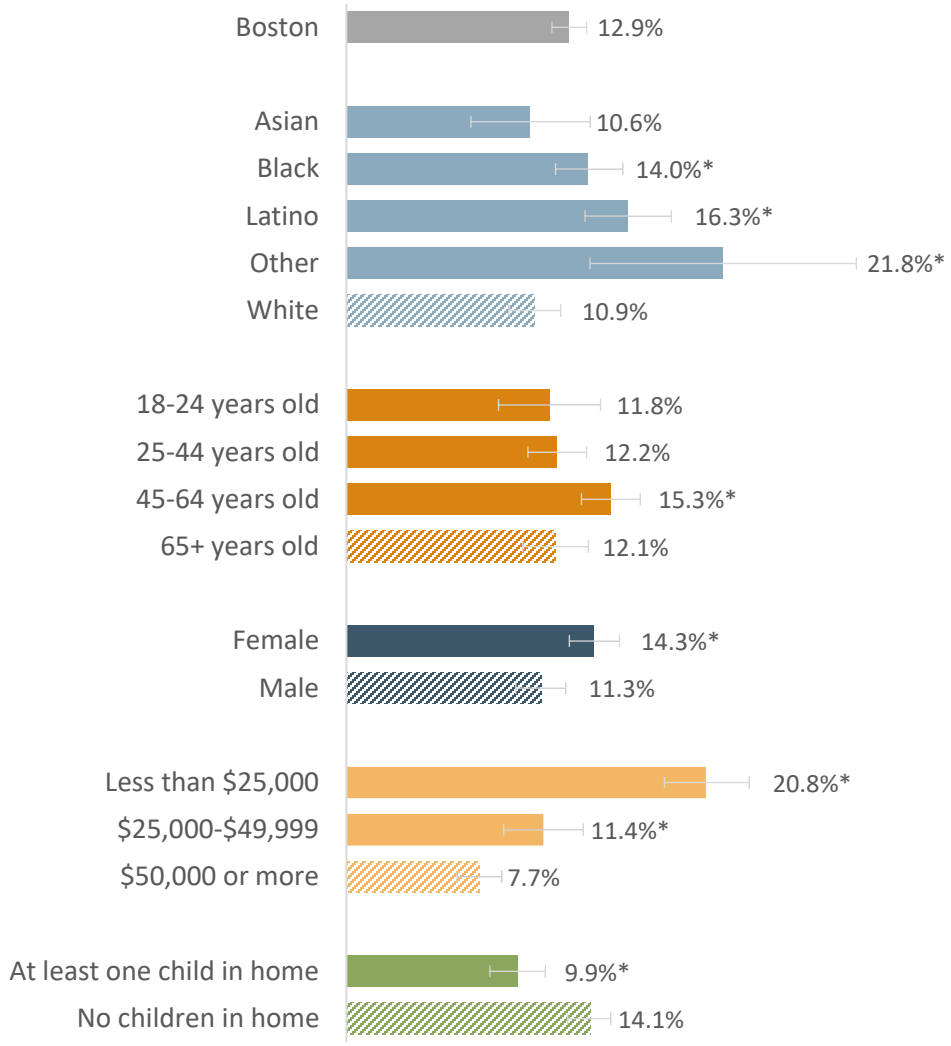
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that their parents or the adults in their home ever slapped, hit, kicked, punched, or beat each other up; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 62. Percent Adults Reporting Persistent Sadness, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



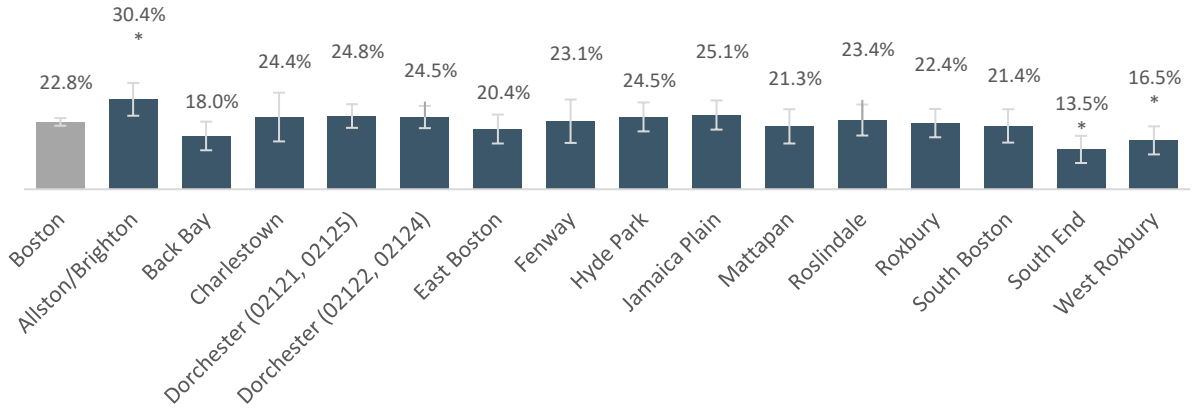
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent sadness is defined as feeling sad, blue, or depressed for more than 15 days within the past 30 days; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 63. Percent Adults Reporting Persistent Sadness, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



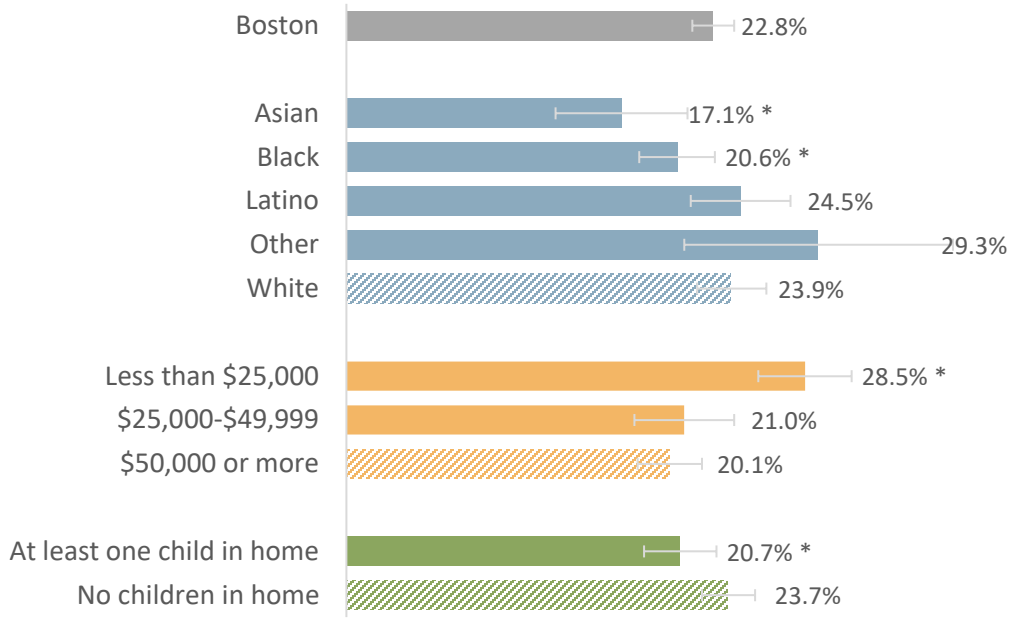
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent sadness is defined as feeling sad, blue, or depressed for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 64. Percent Adults Reporting Persistent Anxiety, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



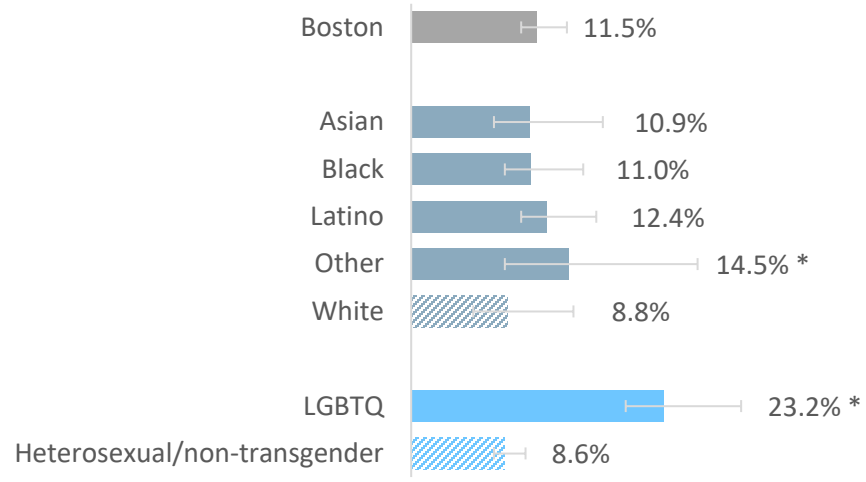
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent anxiety is defined as feeling worried, tense, or anxious for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 65. Percent Adults Reporting Persistent Anxiety, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



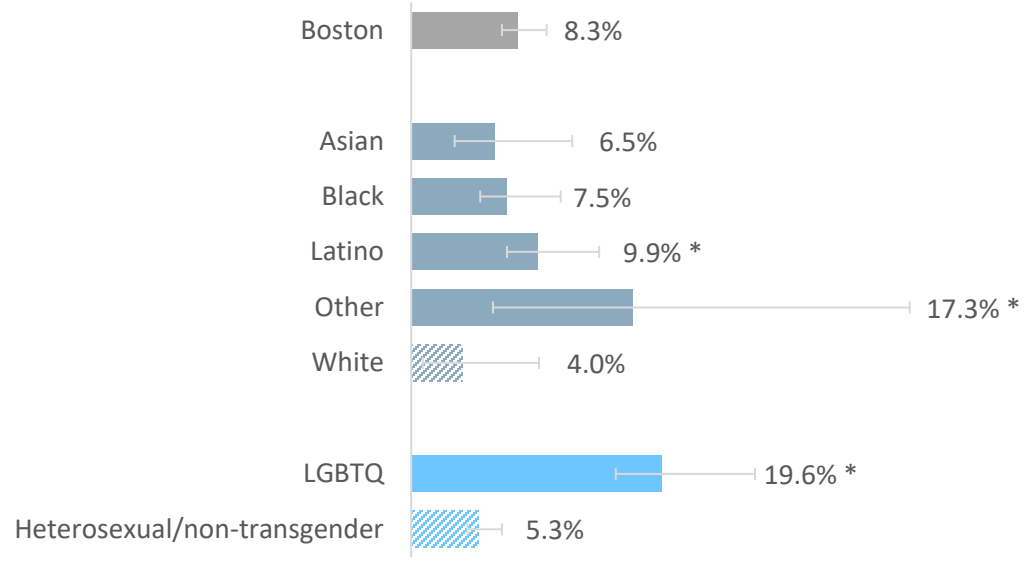
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent anxiety is defined as feeling worried, tense, or anxious for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 66. Percent Boston Public High School Students Reporting Having Had a Suicidal Plan, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



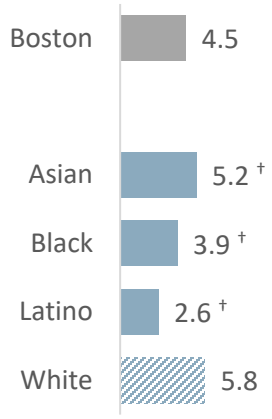
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 67. Percent Boston Public High School Students Reporting Attempting Suicide, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



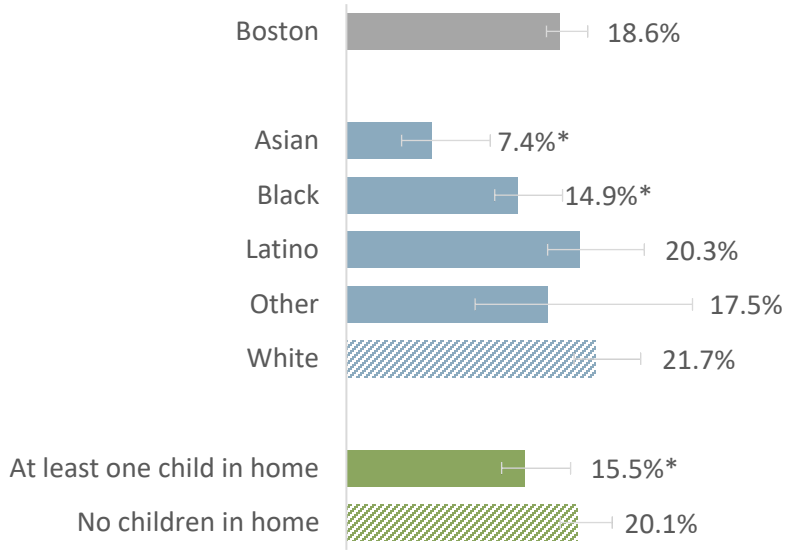
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 68. Suicide Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



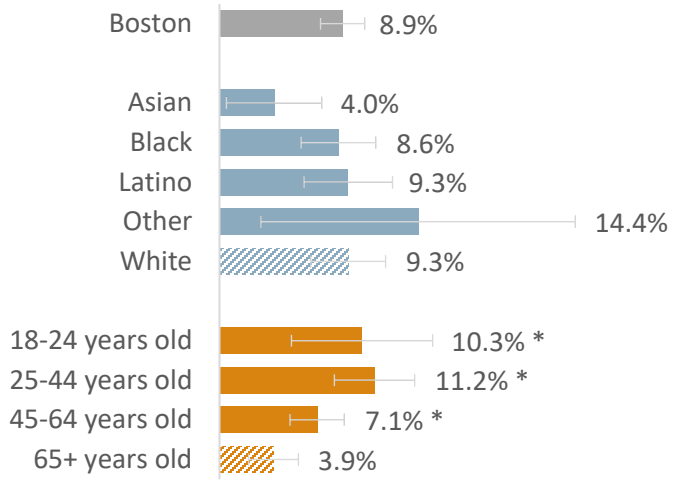
DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2020-2021 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable; No significant differences between estimates compared to the reference group were observed (p>0.05)

Figure 69. Percent Adults Reporting Receiving Treatment for Depression in the Past Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



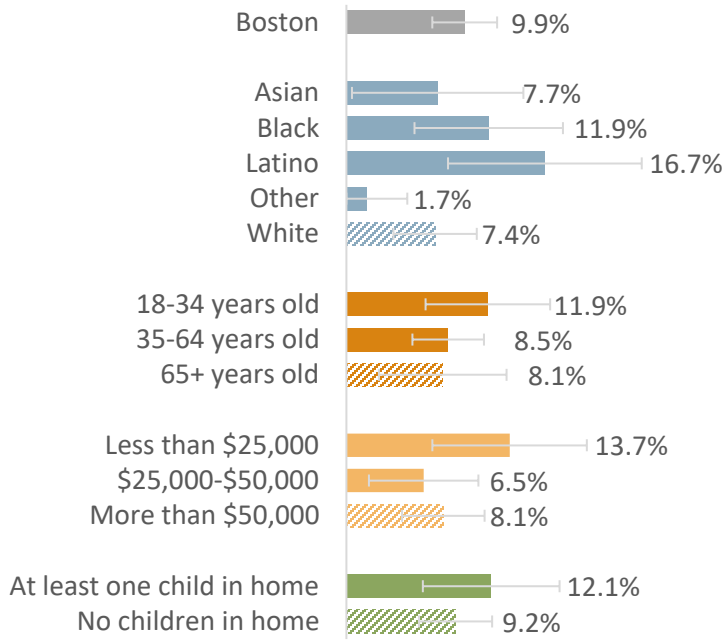
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 70. Percent Adults Reporting They Did Not Seek Mental Health Care Due to Cost in Past Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting there was a time in the past 12 months when they would have seen a therapist, psychologist, or psychiatrist but did not because of cost; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

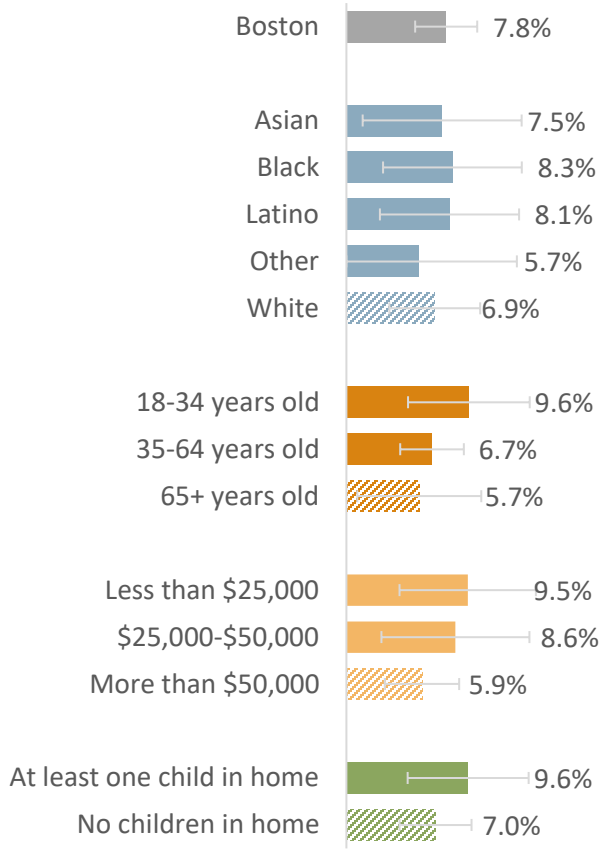
Figure 71. Percent Adults Reporting Delaying Mental Health Care Due to COVID-19 Concerns During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office

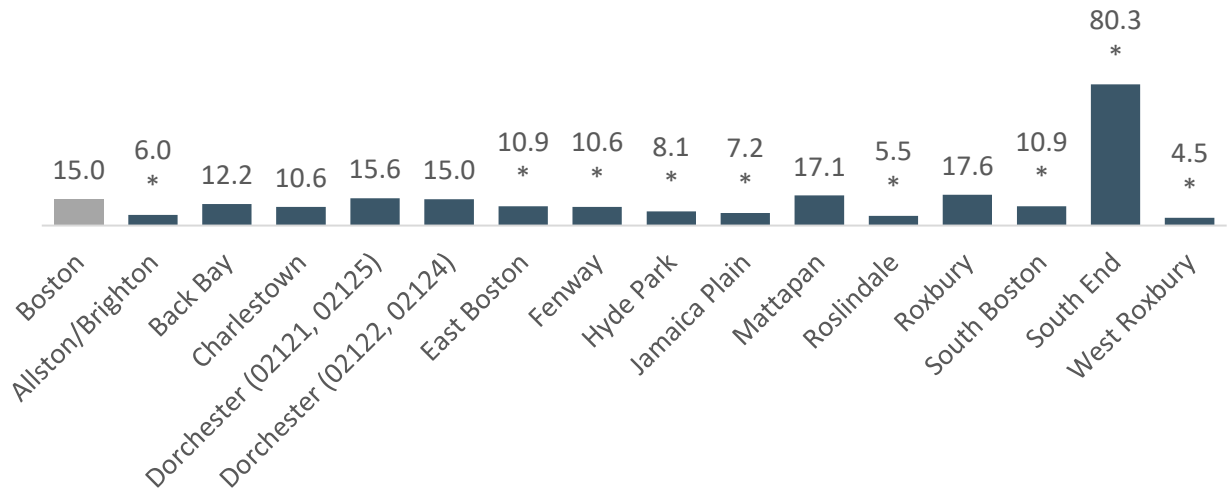
NOTES: Data show percentage of adults reporting to have avoided seeing a therapist or healthcare professional for mental health services due to concerns about COVID-19 since March 1, 2020; Percentage does not include adults reporting their appointments were canceled for them; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 72. Percent Adults Reporting Still Delaying Mental Health Care due to COVID-19 Concerns, by Boston and Selected Indicators, December 2020-January 2021



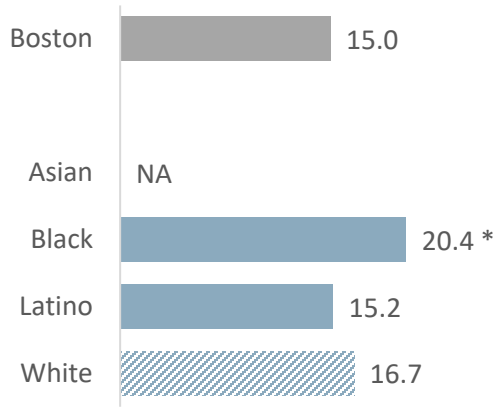
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Still delaying mental health care is defined as currently postponing or cancelling mental health services; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 73. Opioid Overdose-Related Hospital Patient Encounter Rate, by Boston and Neighborhood, Age-Adjusted Rate per 10,000 Residents, 2020



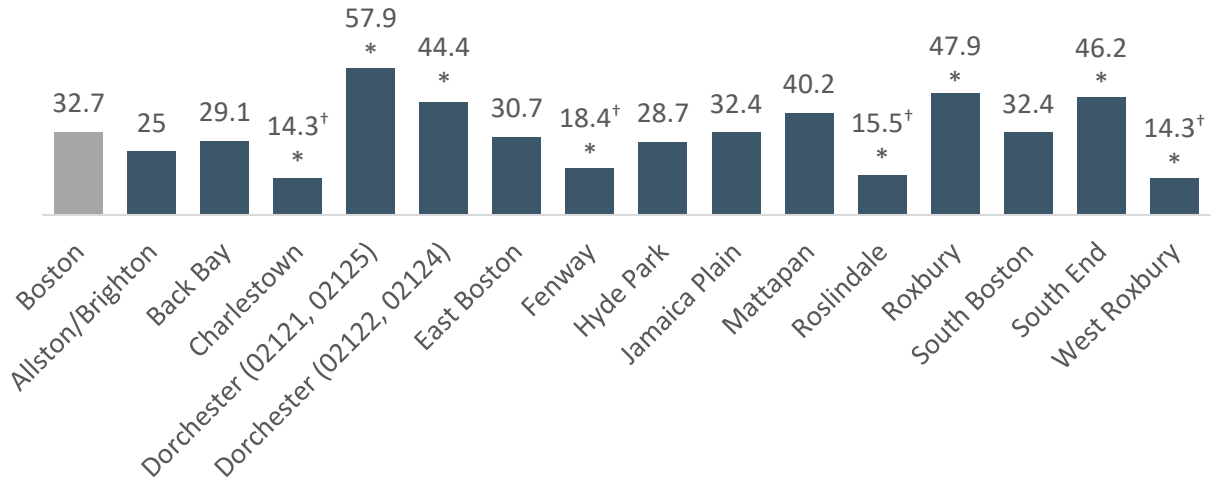
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$). Please note, opioid overdose hospital patient encounter levels are substantially impacted by patients identifying as homeless with residential zip codes reflecting corresponding homeless shelter zip codes. The people experiencing homelessness impact on neighborhood overdose rates varies considerably with specific neighborhoods (e.g., South End) experiencing substantially higher rates as a result.

Figure 74. Opioid Overdose-Related Hospital Patient Encounter Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 10,000 Residents, 2020



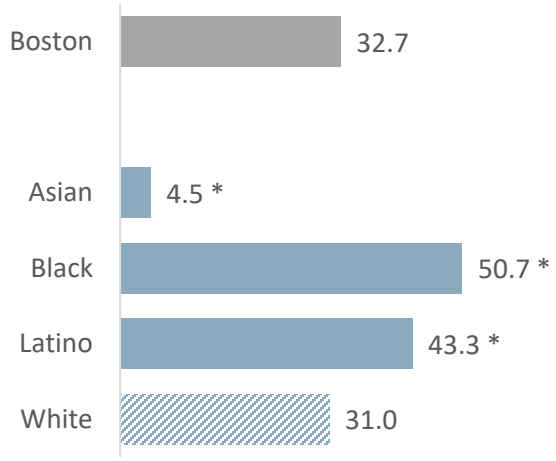
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$). NA denotes where data are not presented due to insufficient sample size

Figure 75. Unintentional Opioid Overdose Mortality Rate, by Boston and Neighborhood, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



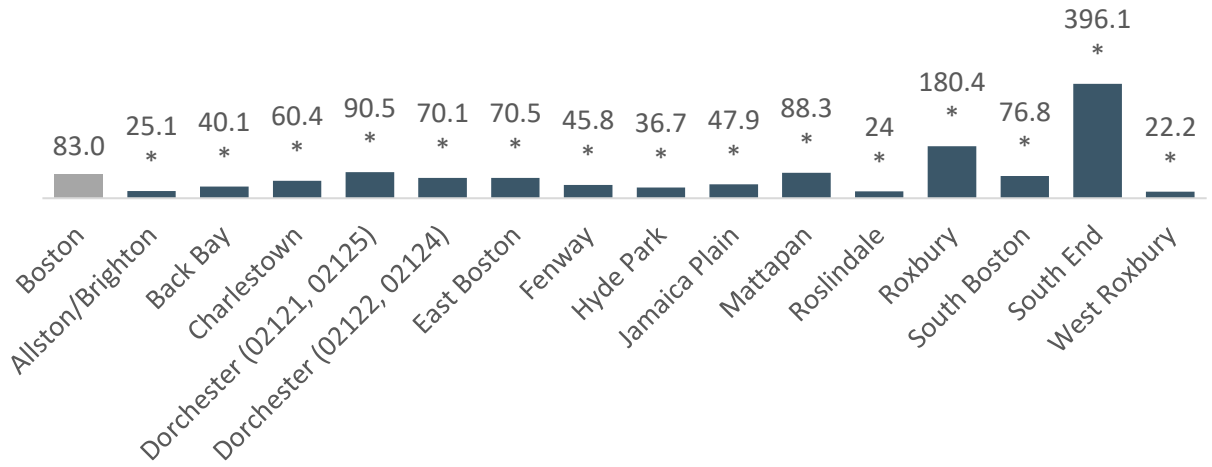
DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2020-2021 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$). Please note, opioid overdose hospital patient encounter levels are substantially impacted by patients identifying as homeless with residential zip codes reflecting corresponding homeless shelter zip codes. The people experiencing homelessness impact on neighborhood overdose rates varies considerably with specific neighborhoods (e.g., South End) experiencing substantially higher rates as a result.

Figure 76. Unintentional Opioid Overdose Mortality Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



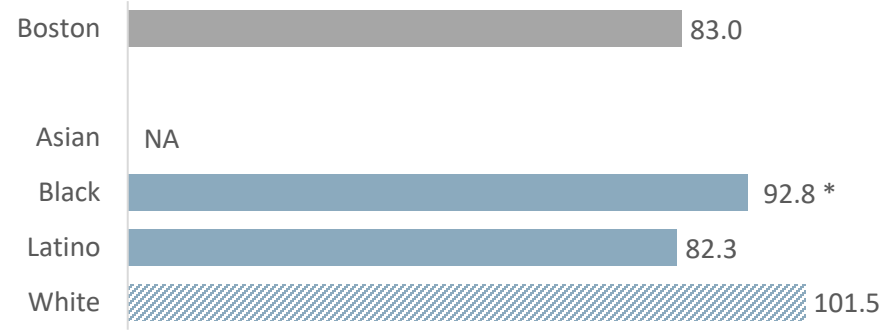
DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2020-2021 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 77. Unique Substance Use Treatment Admission Rate, by Boston and Neighborhood, Age-Adjusted Rate per 10,000 Residents, 2020-2021 Combined



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

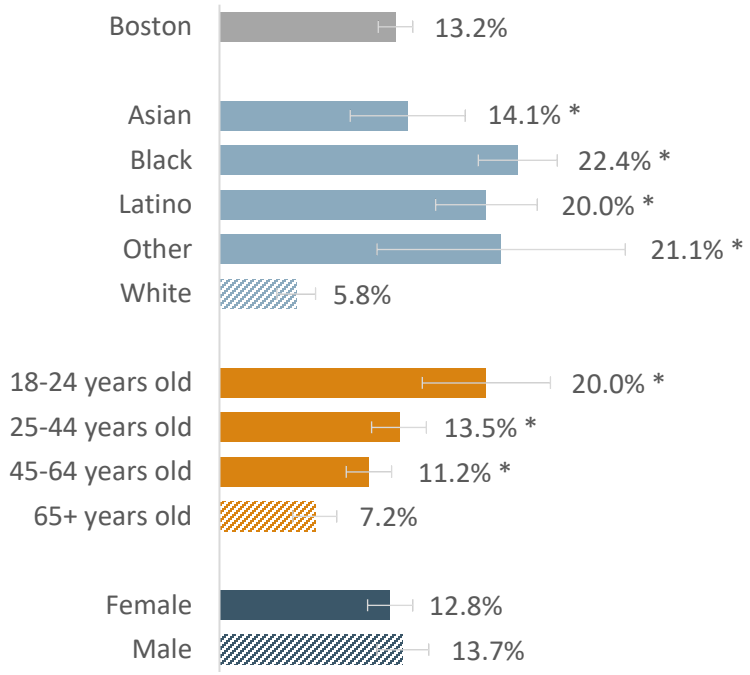
Figure 78. Unique Substance Use Treatment Admission Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 10,000 Residents, 2020-2021 Combined



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); NA denotes where data are not presented due to insufficient sample size

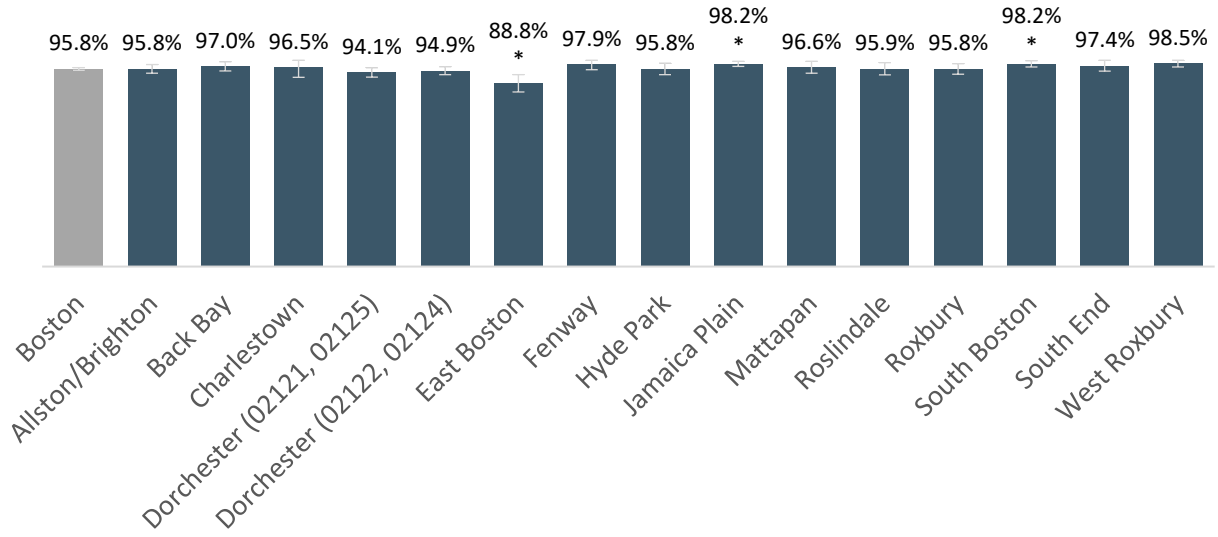
Access to Services

Figure 79. Percent Adults Reporting Receiving Poor Service At Least a Few Times a Month Due to Race/Ethnicity, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



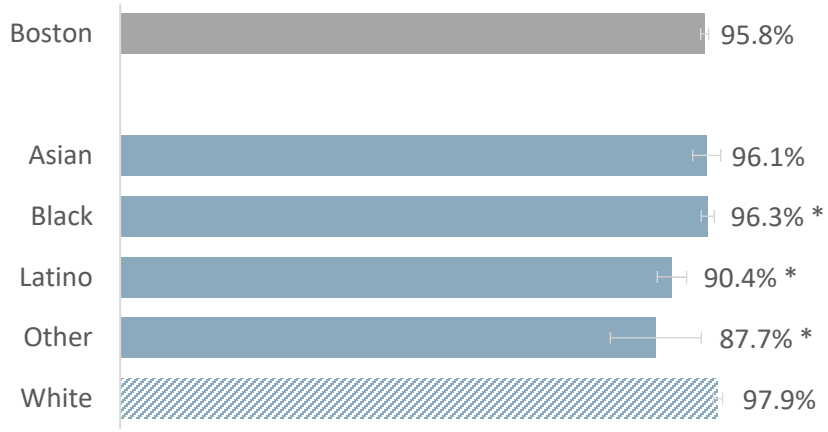
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting receiving poorer service than other people at restaurants or stores in day-to-day life due to race/ethnicity a few times a month, at least once a week, or almost every day; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 80. Percent Adults Reporting Having Health Insurance, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



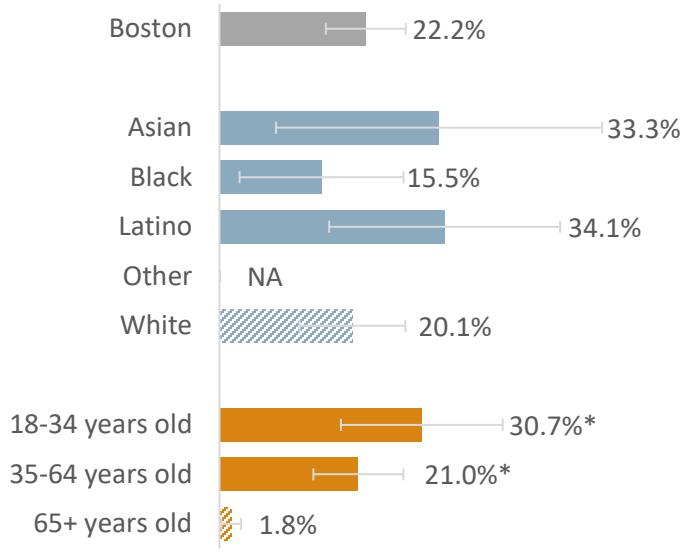
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentages of adults who reported that they have some kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 81. Percent Adults Reporting Having Health Insurance, by Boston and Race/Ethnicity, 2015, 2017, and 2019 Combined



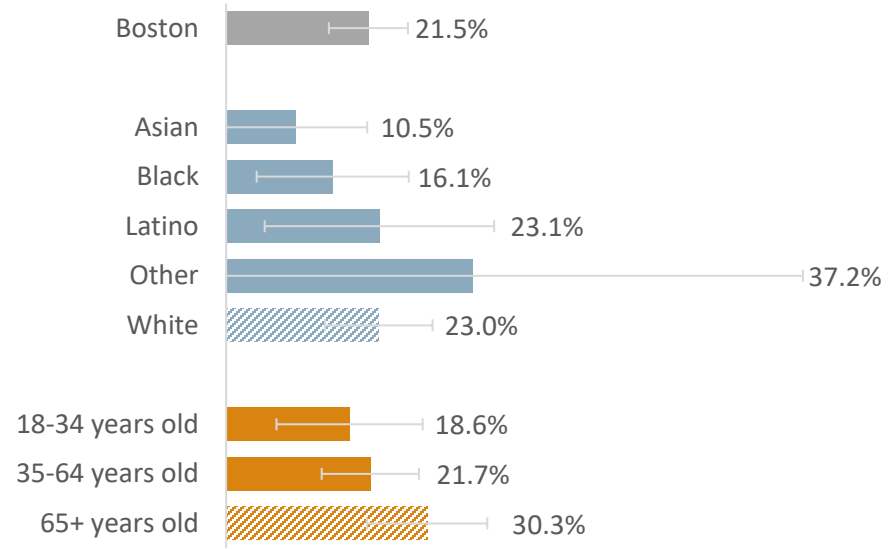
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentages of adults who reported that they have some kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 82. Percent Adults Reporting Getting Time Off from Work as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



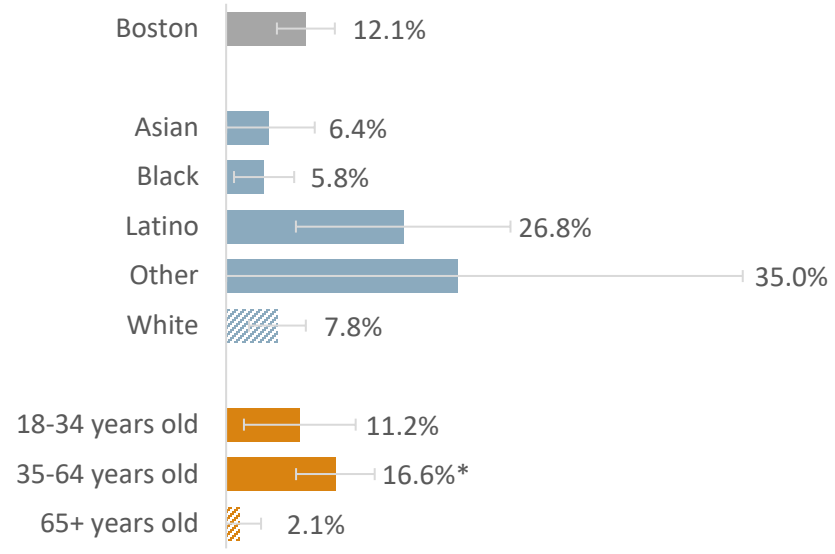
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval. NA denotes where data are not presented due to insufficient sample size.

Figure 83. Percent Adults Reporting Doctor Not Offering Test as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



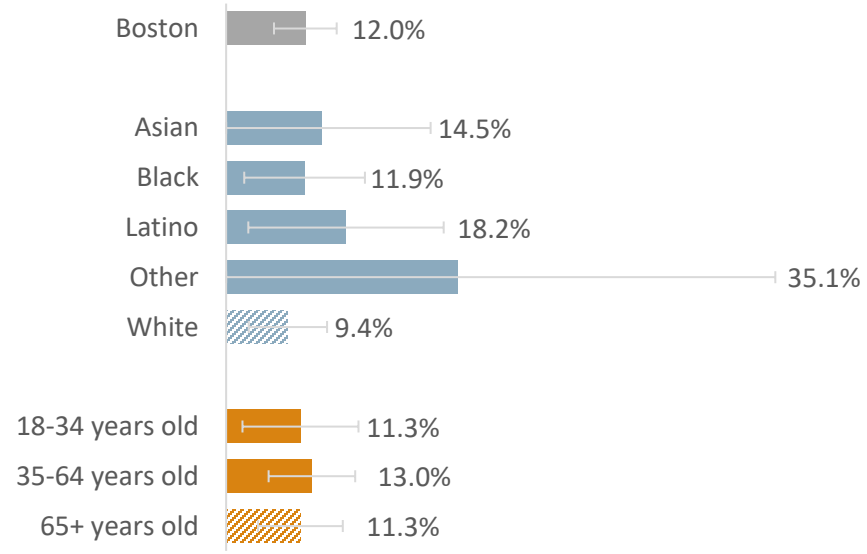
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 84. Percent Adults Reporting Arranging Childcare as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



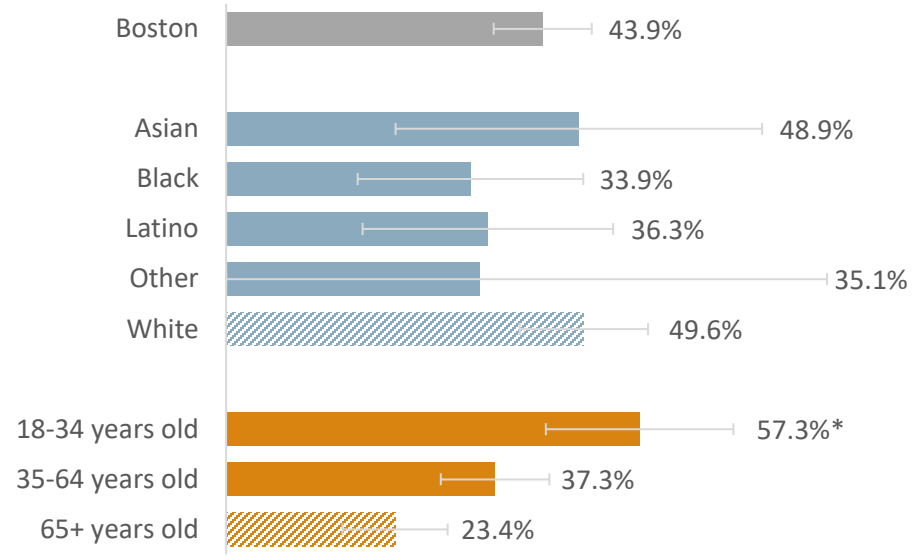
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 85. Percent Adults Reporting Not Having a Personal Doctor as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



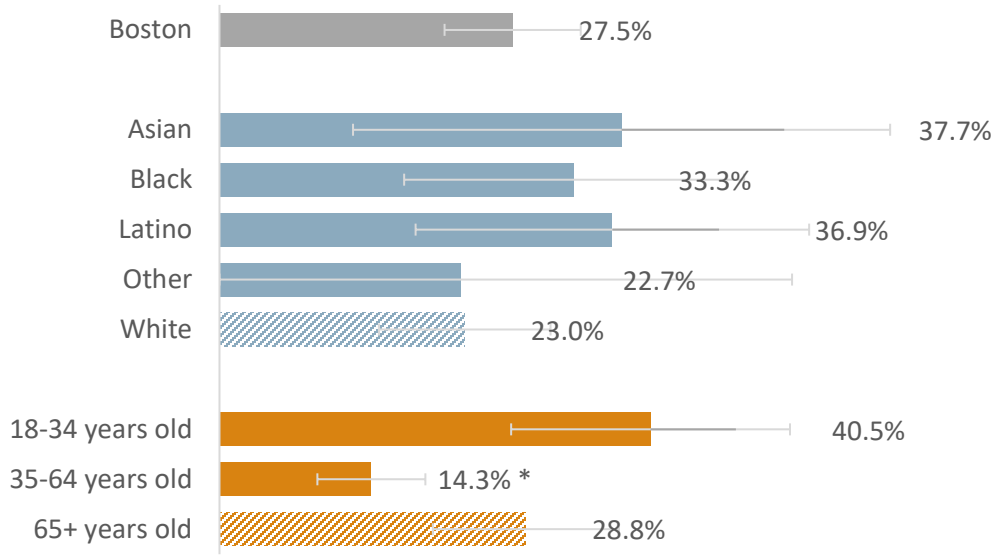
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 86. Percent Adults Reporting Having a Referral or Symptoms which Qualify For Testing as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



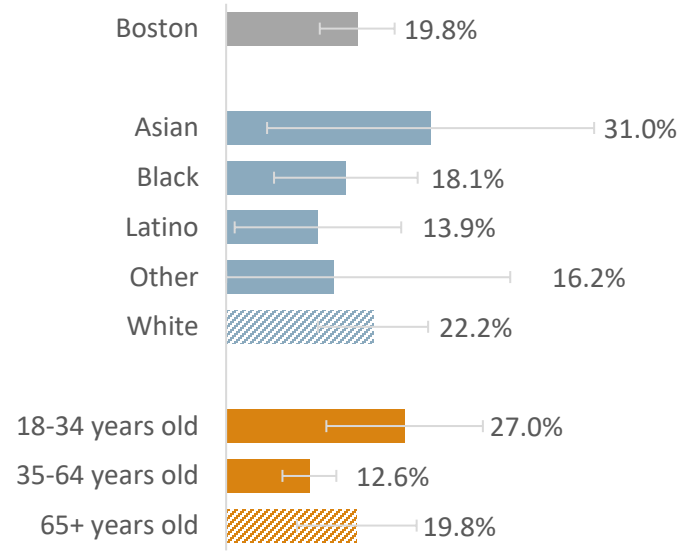
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 87. Percent Adults Reporting Getting to Test Location/Transportation as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



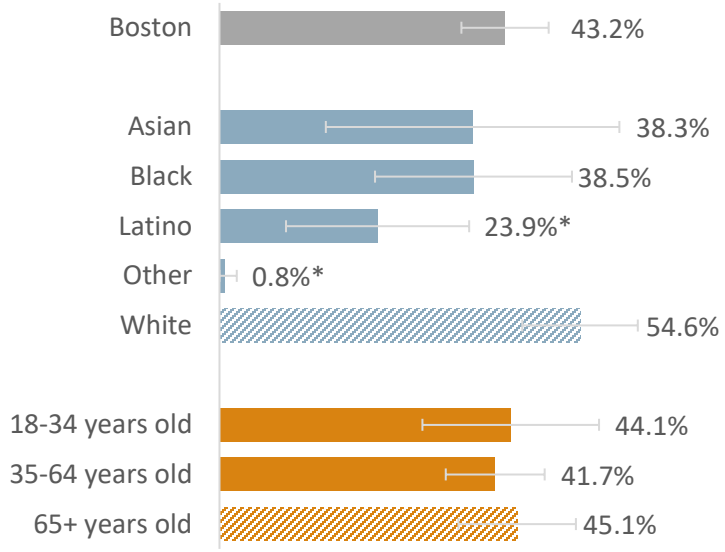
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 88. Percent Adults Reporting Cost of Test as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



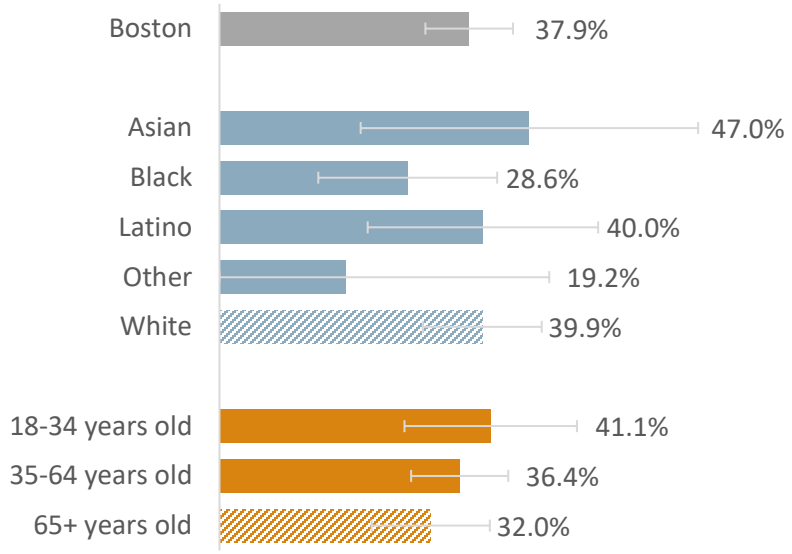
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 89. Percent Adults Reporting Finding a Clinic Offering a Test as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



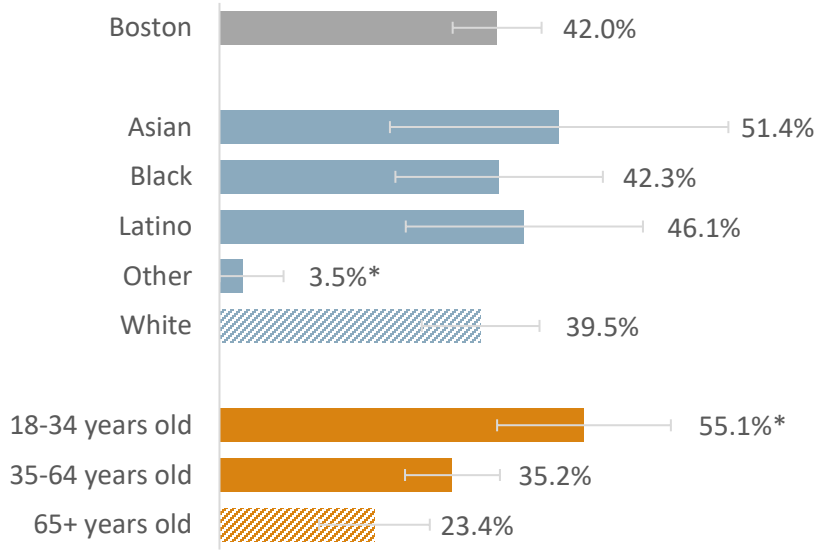
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 90. Percent Adults Reporting Long Wait Time for Test Results as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

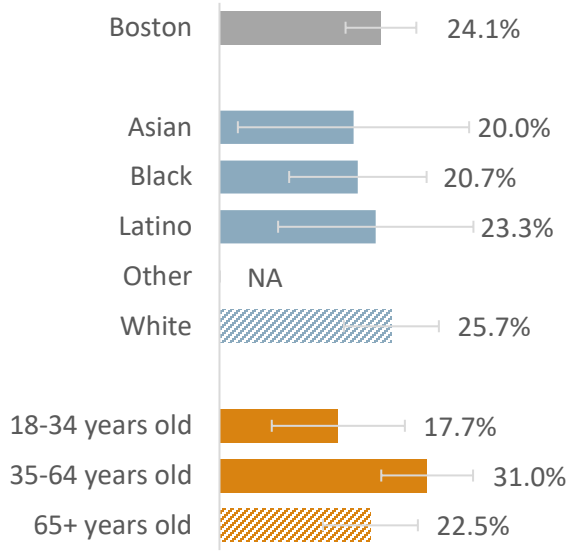
Figure 91. Percent Adults Reporting Time it Takes to Get Tested as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office

NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 92. Percent Adults Reporting Other Factors as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: NA denotes where data are not presented due to insufficient sample size; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

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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
Statewide Resources	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.			www.handholdma.org
	Executive Office of Elder Affairs	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 5th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-elder-affairs
	MA 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 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 5th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-elder-affairs
	MA 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
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for finding substance use treatment and recovery services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		800.273.8255	www.suicidepreventionlifeline.org

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
Statewide Resources	Network of Care Massachusetts	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.			www.massachusetts.networkofcare.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		800.645.8333	www.projectbread.org/get-help
	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/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.		800.273.8255	www.veteranscrisisline.net
Domestic Violence	Boston Area Rape Crisis Center	Provides free, confidential support and services to survivors of sexual violence.	989 Commonwealth Ave Boston	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

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
	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	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
	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
Housing Support	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/parker hill-fenway-nsc
	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

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
Housing Support	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.	405 Shawmut Ave 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.nebhealth.org
	Boston Treatment Center	Provides inpatient detoxification and treatment services to both men and women from alcohol, opiates and benzodiazepines.	784 Massachusetts Ave Boston	617.247.1001	www.nebhealth.org
	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	781.646.0500 x301	www.cfpsych.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

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
Senior Services	Brookline Senior Center	Provides services for older adults in Brookline including fitness, education, social services, and recreation.	93 Winchester St Brookline	617.730.277	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
Transportation	Massachusetts Bay Transportation Authority (MBTA)	Provides transportation thru out Boston and surrounding communities.			www.mbta.com
Additional Resources	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.	481 Tremont St Roxbury	617.635.5216	www.boston.gov/departments/boston-centers-youth-families/bcyf-tobin
	Louis D Brown Peace Institute	Serves as a center of healing, teaching, and learning for families and communities impacted by murder, trauma, grief, and loss.	15 Christopher St Dorchester	617.825.1917	www.ldbpeaceinstitute.org
	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

Appendix D:

Evaluation of 2020-2022 Implementation Strategy

New England Baptist Hospital (NEBH)

Evaluation of 2020-2022 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 Community Benefits office (https://massago.onbaseonline.com/massago/1801CBS/annualreport.aspx).

Priority: Social Determinants of Health and Access to Care

Goal 1: Enhance Access to Care and Reduce the Impact of Social Determinants			
Population	Objectives	Activities	Progress, Outcomes, and Impact
-Youth -Older Adults -Low to Moderate Income Populations -Individuals with Chronic/ Complex Conditions	-Increase partnerships and collaboration with social service and other community-based organizations. -Increase educational opportunities related to the importance and impact of social determinants. -Decrease the number of people who struggle with financial insecurity. -Increase access to low-cost healthy foods with an emphasis on priority population segments. -Increase access to affordable, safe transportation options with	-Community Benefit and other Hospital staff (e.g., nursing) participate in coalition and other community meetings to promote collaboration, share knowledge, and coordinate community health improvement activities -Maintain McLaughlin Field to engage youth and promote physical activity -Make community improvements to walkways and other public areas to address transportation issues and promote physical activity -Provide trash truck and clean public areas after move-in day to promote community engagement and physical activity	**Food for a Healthy Community** -NEBH provided food and gift cards to over 1,000 families and individuals at Thanksgiving. -NEBH provided food, Stop & Shop Gift Cards and/or meals to over 800 families/individuals throughout the year. -NEBH provided financial support for the food pantry at ABCD, Parker Hill Fenway Service Center. The pantry provided emergency food for low-income families and individuals in the community. **Elder Isolation** -NEBH participated in an outdoor concert, holiday visits, and outdoor bingo at the Maria Sanchez House. **Transportation for Seniors** -Over 7,400 residents used the Mission Link bus. Due to COVID-19, the number of riders has decreased. The Mission Link board is working with the City of Boston to increase ridership. **Back to School Supplies**

-Youth -Older Adults -Low to Moderate Income Populations -Individuals with Chronic/ Complex Conditions	an emphasis on priority population segments. -Increase training and employment opportunities for low to moderate income residents with an emphasis on priority population segments. -Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports. -Educate individuals and families about healthy eating, meal planning, household budgeting, etc. -Increase partnerships and collaboration with social service and other community-based organizations -Increase educational opportunities related to the importance and impact of social determinants -Decrease the number of people who struggle with financial insecurity	-Support Food Access and Nutrition Programming to low and moderate income populations living in public housing, Councils on Aging, and other community venues -Provide essential household items to support those living in poverty or low income households -Provide Transportation Support to community residents to enhance access to affordable, safe, accessible transportation options -Organize and support Workforce Mentorship and Training Programs for youth and adults to job training, skills development, and career advancement with an emphasis on priority populations -Continue to support the Meredith Cameron Youth Opportunity Internship Program to support skills development and career advancement -Provide Linguistically and Culturally Appropriate Health Education and Care Management Support though targeted community events for those with or identified as at-risk of chronic/ complex conditions with an emphasis on priority populations	-The Back to School Program serves more than 250 elementary through high school children living in low-income housing in Mission Hill. We provide students with the tools they need to learn, so that they can return to the classroom prepared and on track for success. New backpacks are filled with essential school supplies to kids whose families cannot afford them. **Bridging the Digital Divide** -NEBH donated 10 Chromebooks for older adults to Roxbury Tenants of Harvard (RTH). The Chromebooks were available for use to older adults for Telehealth visits, meetings, exercise program Healthy Moves, Arts and Crafts, and Chair Yoga. Over 220 older adults reserved the Chromebooks throughout the year for appointments, arts and crafts and exercise. **Clothing and Household Essentials Program** -Over 450 coats, hats, boots, shoes were given to residents that included children, adults and seniors at the Tobin Community Center, Roxbury Tenants of Harvard, HERE House, Maria Sanchez House, and One Gurney Street Apartments. Over 500 residents received masks, hand sanitizer, cleaning supplies, soap, etc. **Healthy Neighborhood**

-Youth -Older Adults -Low to Moderate Income Populations -Individuals with Chronic/ Complex Conditions	-Increase access to low cost healthy foods with an emphasis on priority population segments -Increase access to affordable, safe transportation options with an emphasis on priority population segments -Increase training and employment opportunities for low to moderate income residents with an emphasis on priority population segments -Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports -Educate individuals and families about healthy eating, meal planning, household budgeting, etc. -Decrease the number of individuals and families who suffer from food insecurity	-Support activities sponsored by Mission Hill Senior Legacy Project -Support community food pantry	-NEBH continues to beautify the neighborhood by working with community members, Problem Properties Committee and Mission Main Streets on keeping Mission Hill clean. This includes hiring a trash truck during student move in week, helping with street sweeping and snow removal for the streets that surround the hospital and McLaughlin Park and Field. -NEBH continues to maintain the City of Boston's McLaughlin Park, Fields and Walking Path in Mission Hill. This allows the residents of Boston to use the field and parks for safe, socially distant outdoor activities. **Mission Grammar School** -To provide financial assistance to students at Mission Grammar School. Over 78% of students that attend Mission Grammar School, receive financial aid **Obesity Prevention** -NEBH provided financial support for the summer camp at the Tobin Community Center. The support allows 20 youth to participate in the summer camp. The camp encourages young children to exercise and keep active helping in the prevention of obesity. The camp was held during the summer, practicing social distancing and limited the number of participants. **Sociedad Latina Building and Renovation**

-Youth -Older Adults -Low to Moderate Income Populations -Individuals with Chronic/ Complex Conditions	and/or lack basic household items.		-Support for the purchase of Sociedad Latina's building and renovation so that they can continue to offer programs to 5,000 Latino Youth. NEBH continues to financially support Sociedad Latina's building and renovation so that they can continue to offer programs to 5,000 Latino youth. **Violence Prevention** -NEBH continues to work with community groups in Mission Hill and the Boston Police to help educate and keep our youth engaged in activities to prevent violence in our community. NEBH does security rounds throughout the Mission Hill area. This service provides detection and deterrence in the neighborhood, 7 Days a week 24 hours a day at scheduled and unscheduled intervals. NEBH continually reviews and upgrades its video system to enhance recording quality and does rounds on an average of 10 times a day. NEBH is called upon by the Boston Police for video surveillance. NEBH supports programs at the Tobin Community Center and retreats. Due to Covid, programs were not held.

Goal 2: Reduce Elder Falls and Promote Aging in Place			
Population	Objectives	Activities	Progress, Outcomes, and Impact
Older Adults	-Reduce fear of falling Reduce Falls Increase activity levels –Increase the number of older adults living independently in their homes	Support or organize Matter of Balance workshops for priority populations	**Boston Police Senior Walking Group** Boston Police report over 65 older adults have started walking again, many have been inside due to Covid. **Healthy Moves** Due to Covid, the program was held virtually, hybrid, and then offered in person outside, socially distancing. Over 40 participants utilized fitness equipment while virtual on Zoom using Chromebooks. **Walking Group at RTH** Over 60 older adults participate in the walking group that walks twice a week.

Priority: Chronic and Complex Conditions and their Risk Factors

Goal 1: Enhance Access to Health Education, Screening, Referral, and Chronic Disease Management Services in Clinical and Non-Clinical Settings			
Population	Objectives	Activities	Progress, Outcomes, and Impact
-Youth –Older Adults –Low to Moderate Income Populations -Individuals with Chronic/ Complex Conditions	-Increase the number of people who are educated about chronic disease risk factors and protective behaviors –Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services for diabetes, hypertension, asthma, cancer, and other chronic/complex conditions –Increase the number of people with chronic/complex conditions whose conditions are under control	-Community Benefit and other Hospital staff (e.g., nursing) Participate in Coalition and Other Community Meetings to promote collaboration, share knowledge, and coordinate community health improvement activities -Support Little League and Summer Camp programs to engage youth and promote physical activity -Support Jr. and Sr. Celtics program to promote community engagement -Provide Evidence-based Health Education on risk/protective factors, and Self-Management Support Programs through partnerships with community-based organizations with an emphasis on Priority Population Segments -Fitness Classes	**Yoga For Older Adults** -Due to Covid, classes were held outside, socially distancing. Over 25 older adults participated in the yoga class weekly. **Healthy Moves** -Due to Covid, the program was held virtually, hybrid, and then offered in person outside, socially distancing. Over 40 participants utilized fitness equipment while virtual on Zoom using Chromebooks. **Walking Group at RTH** -Over 60 older adults participate in the walking group that walks twice a week. **Senior Celtics Program** -NEBH collaborates with the Boston Celtics to offer the Sr. Celtics program to Mission Hill seniors. Two events were held with over 150 seniors attending each event. The program focused on exercise and keeping seniors moving, fall prevention and nutrition. Participants received a healthy lunch and a Sr. Celtics t-shirt. Raffles were held for Celtics gear and Stop & Shop gift cards.

-Youth –Older Adults –Low to Moderate Income Populations -Individuals with Chronic/ Complex Conditions		-Support Screening, Education, and Referral Programs in clinical and non-clinical settings that screen, educate, and refer patients in need of further assessment and chronic disease management supports (e.g., Blood pressure, diabetes, Stroke, cancer) -Organize NEBH "House Call" events hosted by Hospital clinical staff related to awareness, education, and the management of chronic and complex conditions in targeted community-based settings -Support Yoga for older adults -Support and promote the development of community workshops, weight loss classes, and educational sessions.	**Arthritis and Lupus Support Group** -Because of Covid-19, all in person meetings have been suspended. Zoom meetings were attempted but many do not have access to technology.

Goal 2: Reduce the Prevalence of Tobacco Use			
Population	Objectives	Activities	Progress, Outcomes, and Impact
-Youth –Older Adults –Low to Moderate Income Populations –Individuals with Chronic/ Complex Conditions	-Increase the number of people who are able to stop smoking cigarettes vaping, or using e-cigarettes –Increase access to tobacco, vaping/e-cigarette cessation programs	Organize, facilitate, or support Smoking Cessation Programs geared to reducing tobacco, vaping and e-cigarette use	Activities/programs were not held due to Covid and lack of community interest. NEBH reached out to its partners to offer help to those who smoke or vape and there was not an interest from community members. NEBH reached out to the Tobin Community Center and they have seen a decrease in the number of youth who vape. This may be due to Covid and students being at home.

Appendix E:
2023-2025 Implementation Strategy

Beth Israel Lahey Health
New England Baptist Hospital

FY23-FY25 Implementation Strategy

Implementation Strategy

About the FY23-FY25 Implementation Strategy

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 eleven 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, operates outpatient care centers in Brookline, Chestnut Hill, and Dedham, and has been the official hospital of the Boston Celtics for over 35 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's Community Benefits staff collaborated with the Boston Community Health Needs Assessment-Community Health Improvement Plan Collaborative (Boston CHNA-CHIP Collaborative). The Boston CHNA-CHIP Collaborative, consisting of Boston's hospitals and community health centers, 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. Facilitated through the Conference of Boston Teaching Hospitals (COBTH) and the City of Boston's Human Services Department, the Boston CHNA-CHIP Collaborative assessment focused on the social determinants of health through the lens of health equity; it aimed to uncover and understand how and why individuals in certain Boston neighborhoods or population groups experience inequities in health outcomes and barriers to care based on socioeconomic status, race and ethnicity, language, health status, sexual orientation, gender identity, and other factors. 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 as the founding Co-Chair of the Boston CHNA-CHIP Collaborative Steering Committee and continues to serve on its Steering Committee and workgroups. Robert Torres, BILH's Director of Community Benefits for the Boston region, served as the Co-Chair of the Community Engagement Workgroup for the 2022 CHNA. NEBH Community Benefits staff participated in numerous Boston CHNA-CHIP Collaborative meetings. Both organizations 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 Community Benefits Service Areas (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. BIDMC also shared information from the extensive community engagement and planning activities that they are conducting as part of BIDMC's Massachusetts Determination of Need New Inpatient Building Community-based Health Initiative (NIB-CHI). 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 October 2021 and February 2022, NEBH's assessment included 85 (20 by NEBH/BIDMC) one-on-one interviews with key collaborators in the community, 24 focus groups (3 by NEBH/BIDMC) with segments of the population facing the greatest health-related disparities, and two community listening sessions that engaged over 40 participants. In addition, BILH and BID Needham conducted a community health survey, which gathered information from more than 450 community residents from BID Needham's CBSA, including 86 residents from Dedham. BID Needham shared this information with NEBH. The Boston Public Health Commission fielded a COVID-19 Health Equity Survey in December 2020/January 2021; as such, NEBH and BIDMC, based on recommendations from the Boston CHNA-CHIP Collaborative Steering Committee, opted not to field a survey in Boston. This survey of a random sample of over 1,650 residents in multiple languages examined issues related to job loss, food insecurity, access to services, mental health, vaccination, and perceptions of risk around COVID-19.

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. Accordingly, using an interactive, anonymous polling software, NEBH's CBAC and community residents, through the community listening sessions, 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.

NEBH's IS was 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).

The following goals and strategies were 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.

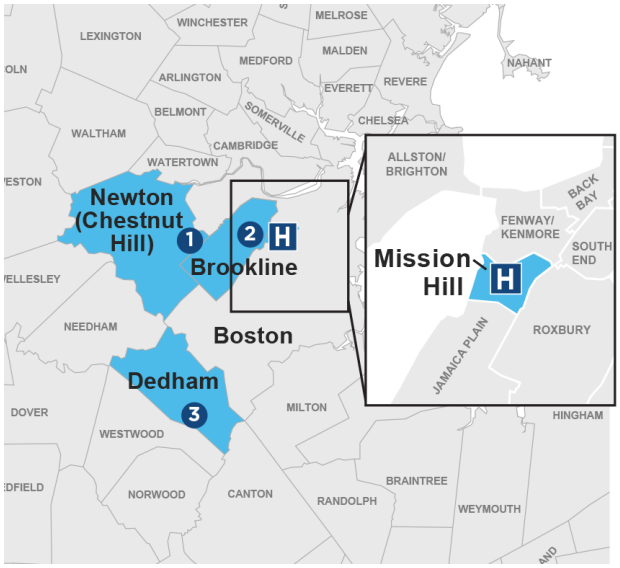
Recognizing that community benefits planning is ongoing and will change with continued community input, NEBH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues that may arise, which may require a change 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 an outpatient surgery and 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.



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

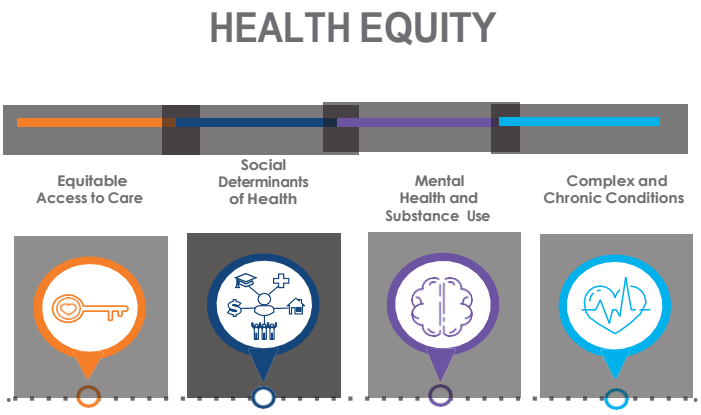
Prioritized Community Health Needs and Cohorts

NEBH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, NEBH 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 with Disabilities

NEBH Community Health 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 the digital divide (i.e., promoting equitable access to the internet) supporting education across the lifespan, addressing poor air quality, and addressing gentrification were identified as community needs but were not included in NEBH's IS. 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, developing programs to support patients to navigate the healthcare system, bringing care to community spaces, addressing linguistic access barriers, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, respiratory illness, cancer, diabetes, heart disease, mobility issues, addressing cognitive memory decline, accessible or affordable space to exercise, accessible or affordable healthy foods, promoting neighborliness, addressing the impacts of violence and trauma, advocacy for seniors, advocacy for individuals with disabilities, need for safe youth activities, more monitoring/cameras in communities, and address drug use in community spaces.

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 "charity" 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, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Provide equitable and comprehensive access to high-quality health care services for those who face economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.	• Low-resourced populations • Individuals with disabilities • Racially, ethnically, and linguistically diverse populations	Mission Link bus	# of riders	Mission Hill Link	Social Determinants of Health
Advocate for and support policies and systems that improve access to care.	• Low-resourced populations • Individuals with disabilities • Racially, ethnically and linguistically diverse populations	• Resource directory • Support linguistic services • Financial counselors • Support relevant policies when proposed	• # of directories • # of opportunities • # of patients assisted • # of languages provided • # policies reviewed • # of policies supported	• Mission Hill Neighborhood Housing Services • Roxbury Tenants of Harvard • Tobin Community Center • Mission Hill Sr. Legacy	Not Applicable

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 sessions, and the BID Needham 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.

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 "charity" 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, leveraged, or "charity" care expenditures to carry out its community benefits mission. .

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
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.	• Low-resourced populations • Older adults • Youth • Individuals with disabilities • Racially, ethnically and linguistically diverse populations	• 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	• # of participants • # of sites • Improvement in food insecurity	• Roxbury Tenants of Harvard (RTH) • Tobin Community Center • Action for Boston Community Development (ABCD) • Mission Hill	Chronic and Complex Conditions

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Advocate for and support impactful programs that stabilize or create access to affordable housing.	• Low-resourced populations • Older adults • Individuals with disabilities • Racially, ethnically and linguistically diverse populations	• Mission Hill Neighborhood Housing Services board • Mission Hill Neighborhood Housing Services resident services coordinator • Household essentials, clothing, and school supply program	• # of participants • #of residents assisted with applications • # of families prevented from homelessness	Mission Hill Neighborhood Housing Services	Not Applicable
Increase mentorship, training, and employment opportunities for youth, young adults, and adults residing in the communities, as well as hospital employees.	• Low-resourced populations • Youth • Individuals with disabilities • Racially, ethnically, and linguistically diverse populations	• 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 classes	• #of students • # of students hired at NEBH • # of employees who participated • # of staff hired or promoted	• BPS-Madison Park High School • Goodwill • Private Industry Council (PIC) • Tobin Community Center • Sociedad Latina • Roxbury Tenants of Harvard (RTH) • BILH Workforce Development	Not Applicable

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 on youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Those who participated in the assessment also reflected on the stigma, shame, and isolation that those with mental health challenges face that limit their ability to access care and cope with their illness.

Substance use continued to have a major impact on the CBSA; the opioid epidemic was an area of focus and concern, and there was 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.

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 "charity" care to individuals who are low-resourced individuals and to pay for care and services. Moving forward, NEBH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Enhance relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills, and reduce isolation.	• Youth • Older adults	• 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	• # of students • Increased youth resiliency • # of participants	• Police Athletic League (PAL) Program • Mighty Missions BB Team • Tobin Community Center • Roxbury Tenants of Harvard (RTH) • Boston Celtics • Mission Hill Neighborhood Housing Services • Mission Hill Sr. Legacy	Not Applicable
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.	• Low-resourced populations • Older adults • Youth • Racially, ethnically and linguistically diverse populations	Explore and support opportunities for training of key leaders and residents	• # of participants • # of programs	• Tobin Community Center • Roxbury Tenants of Harvard (RTH)	Not Applicable

Priority: Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

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 "charity" 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, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Increase opportunities for community members to decrease their risk for developing and/or improve their management of complex & chronic conditions.	• Low-resourced populations • Older adults • Individuals with disabilities	• Mindful Matters-Yoga for older adults • Healthy Moves • Walking Group at • Roxbury Tenants of Harvard (RTH) • Senior Celtics	• # of residents participating	• Boston Public Library-Parker Hill branch • Mission Hill Health Movement • Roxbury Tenants of Harvard (RTH) • Tobin Community Center • City of Boston • Mission Hill Sr. Legacy	Social Determinants of Health Mental Health

General Regulatory Information

Contact Person:	Christine Dwyer, Director of Community and Government Affairs
Date of written plan:	June 30, 2022
Date written plan was adopted by authorized governing body:	September 14, 2022
Date written plan was required to be adopted	February 15, 2023
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?	**0** Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 18, 2019
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

nebh.org