



Acknowledgments

This 2025 Community Health Needs Assessment (CHNA) report for Beth Israel Deaconess Medical Center (BIDMC) is the culmination of a collaborative process that began in June 2024. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/ appointed officials, medical center leadership, and other key collaborators throughout the medical center's Community Benefits Service Area. Substantial efforts were made to ensure Health Needs Assessment effort. that all segments of the community had

the opportunity to participate, with an intentional focus on engaging cohorts who have been historically underserved.

BIDMC, including the BIDMC Community Benefits Advisory Committee (CBAC) which oversaw this entire process, would like to extend its sincere appreciation to everyone who invested their time, effort, and expertise to ensure the development of the medical center's CHNA and its Implementation Strategy (IS).

BIDMC thanks the Steering Committee of the Boston Community Health Collaborative (BCHC) for their collaboration in this assessment process. The BCHC. comprised of Boston area teaching hospitals and medical centers, community health centers, the Boston Public Health Commission, community-based organizations and residents, hired Health Resources in Action to support their effort. The Boston Public Health Commission (BPHC) serves as the backbone organization to the BCHC and their Community

Per federal and Commonwealth requirements, local health departments need to be involved in CHNA activities and BPHC more than fulfilled this requirement. Special thanks are also due to the North Suffolk Integrated Community Health Needs Assessment initiative for their support and their contributions to this assessment.

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It should be noted that the CHNA and IS were greatly informed and supported by staff and clinicians at the community health centers who are part of Beth Israel Lahey Health's Community Care Alliance. These health centers are a significant part of Boston's health care safety net and do excellent work on behalf of some of Boston's most historically underserved populations.

Finally, BIDMC's Community Benefits staff and senior leadership acknowledge the great work, support, and commitment of the BIDMC CBAC. The CBAC is made up of community members, clinical and social service providers, and other key stakeholders that either live in or work in BIDMC's Community Benefits Service Area. The CBAC oversaw every aspect of the needs assessment. The work of the CBAC has strengthened BIDMC's connections with the people and the communities it serves.

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Cambridge Health Alliance

Chelsea Public Schools Health Service

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North Suffolk Mental Health Association

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Introduction

Background

Beth Israel Deaconess Medical Center (BIDMC) is one of the nation's premier academic medical centers and a primary teaching hospital and research affiliate of Harvard Medical School. The medical center has 766 licensed inpatient beds, with more than 10,000 employees and over 3,000 clinicians on active medical staff. BIDMC is devoted to advancing the science and practice of medicine through groundbreaking research and education, taking particular pride in centers of excellence, including in cardiovascular, cancer, neuroscience, digestive health and obstetrics and gynecology. BIDMC, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA).

This 2025 Community Health Needs Assessment (CHNA) report is an integral part of BIDMC's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BIDMC 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 BIDMC to engage the community and strengthen the community partnerships that are essential to BIDMC's success now and in the future. The assessment engaged thousands of people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, other government officials, faith-based leaders, 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 BIDMC's mission.

Finally, this report allows BIDMC to meet its federal and Commonwealth community benefits requirements per the federal Internal Revenue Service (as part of the Affordable Care Act), as well as the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

ASSESS

Community health, defined broadly to include health status, social determinants, environmental factors, and service system strengths/weaknesses.

Members of the community including local health departments, clinical service providers, community-based organizations, community residents, and hospital leadership/staff.

PRIORITIZE

Leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence.

A three-year Implementation Strategy to address community health needs in collaboration with community partners.

Purpose

The CHNA is at the heart of BIDMC'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 injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BIDMC serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

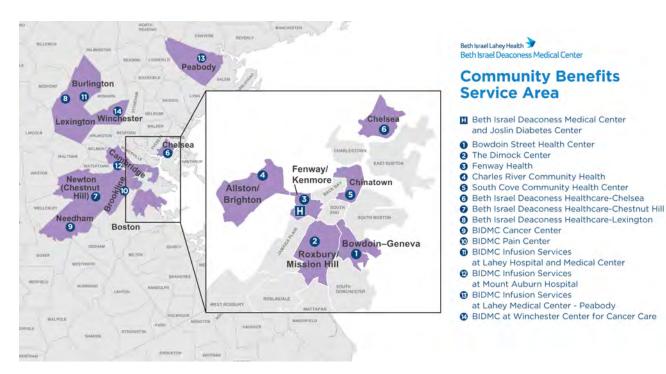
BIDMC completed its last CHNA in 2022 and the report, along with the associated 2023-2025 IS, was approved by the BIDMC Board of Trustees on September 21, 2022. The 2022 CHNA report was posted on BIDMC's website before September 30, 2019 and, per federal compliance requirements, made available in paper copy, without charge, upon request. The assessment and planning work for this current report was conducted between June 2024 and September 2025, and BIDMC's Board of Trustees approved the 2025 CHNA report and adopted the 2026-2028 IS, included as Appendix E, on September 3, 2025.

Definition of Community Served

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

Description of Community Benefits Service Area

BIDMC's main campus is in the Longwood Medical Area of Boston, where it operates a Level 1 trauma center and provides a full range of medical, surgical, critical care, OB/ GYN, and emergency services. In addition to the medical center facility in the Longwood area, BIDMC operates licensed multi-specialty outpatient facilities in Chelsea, Lexington, and Chestnut Hill*, the BIDMC Cancer Center in Needham, the BIDMC Pain Center in Brookline, and infusion centers in Burlington, Cambridge, Peabody, and Winchester. BIDMC also operates a licensed health center in the Bowdoin/Geneva neighborhood of Dorchester and has strong, long-standing partnerships with five Federally Qualified Health Centers (FQHCs). Four of these FQHCs - Charles River Community Health, The Dimock Center, Fenway Health, and South Cove Community Health Center - are located in BIDMC's CBSA and the fifth - Outer Cape Health Services - is in Barnstable County, Massachusetts. These FQHCs are key community benefits partners as they are rooted in their communities and are dedicated to treating those who are traditionally underserved. These FQHCs have been a vital part of BIDMC's community health strategy since 1968, when the medical center first joined forces with The Dimock Center to address maternal and child health issues.



*Chestnut Hill - a village west of Boston - is located partially within Brookline and partially within Newton. Throughout this report, data for Brookline and Newton are included if data was unavailable for Chestnut Hill.

BIDMC's CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns that are part of the Community Care Alliance of licensed and affiliated health centers and/or where BIDMC operates licensed facilities. BIDMC's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the considerable health disparities that exist in some communities in its CBSA, BIDMC 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 city of Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/ Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury.

While there are segments of the populations in Brookline, Burlington, Cambridge, Chestnut Hill, Lexington, Needham, Peabody, and Winchester who are under-resourced and have limited access to the care they need, the greatest disparities exist for those who live in Chelsea and the Boston neighborhoods specified above.

By prioritizing these cohorts, BIDMC can promote health and well-being, address health disparities, and maximize the impact of its community benefits resources. Further, while BIDMC operates licensed facilities in Burlington, Cambridge, Needham, Peabody, and Winchester, these service locations are in other BILH CBSAs. The Town of Burlington and the City of Peabody are located within Lahey Hospital and Medical Center's (LHMC) CBSA, the Town of Needham is located within Beth Israel Deaconess Needham's (BID Needham) CBSA, the City of Cambridge is located within Mount Auburn Hospital's (MAH) CBSA, and the Town of Winchester is located within Winchester Hospital's (WH) CBSA. As a result, the community benefits activities for these municipalities have been delegated to LHMC, BID Needham, MAH, and WH. This helps to ensure that activities are properly coordinated and address the identified needs.



Assessment Approach & Methods

Approach

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

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

In addition to its own CBSA assessment, BIDMC's Community Benefits staff gathered information from two other assessments conducted by organizations or collectives of organizations in Boston and/or Chelsea: 1) The Boston Community Health Collaborative's Community Health Needs Assessment, and 2) The North Suffolk Community Health Needs Assessment.

- The Boston Community Health 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. The Boston Community Health Collaborative worked with health data and community input to improve the health of Boston residents, which comes together in a Community Health Needs Assessment. The assessment informs public health planning and guides the work in making Boston a healthier city for all. The overall approach was participatory and collaborative, engaging community residents 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.
- The North Suffolk Public Health Collaborative Community Health Needs Assessment was a comprehensive assessment and planning effort which gathered information from a broad geographic area

to the north of Boston, including Chelsea. The assessment was overseen by a steering committee comprised of municipal leaders, community organizations, and representatives from the five health systems that serve the North Suffolk region. The BIDMC Executive Director of Ambulatory Operations served on the assessment's Steering Committee and participated in the primary data collection process. The Steering Committee was responsible for monitoring the completion of assessment tasks, coordinating communication efforts with key partners and the publicat-large, and making final decisions on priority areas and strategies. The Steering Committee worked with the Metropolitan Area Planning Council to identify key assessment findings, identify community health priorities and priority populations for investment, and develop the CHNA report and a community health improvement plan (CHIP). Additional information on the North Suffolk Community Needs Assessment is provided in Appendix A.

BIDMC also participated in the BILH CHNA process and collaborated with BID Needham, LHMC, NEBH, MAH, and WH. With respect to BID Needham, BIDMC and BID Needham both include Needham in their CBSAs. With respect to LHMC, BIDMC and LHMC both include Burlington and Peabody in their CBSAs. With respect to MAH, BIDMC and MAH both include Cambridge in their CBSAs. With respect to NEBH, BIDMC and NEBH both include Mission Hill, Chestnut Hill, and Brookline in their CBSAs. With respect to WH, BIDMC and WH both include Winchester in their CBSAs. BIDMC shared the information they gathered on these overlapping neighborhood, cities and towns with its other BILH hospital partners as part of its processes. It should be noted that 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 BIDMC and the other hospitals involved to fully leverage the breadth of resources being invested across their CBSA to understand community need and system capacity, while not unduly burdening the community. This involvement also facilitated important and valuable collaboration between BIDMC and the other health service organizations outside of the CHNA process.

Combined, these efforts helped to ensure that a sound, objective, and inclusive CHNA process was conducted across BIDMC's entire CBSA. This process involved extensive data collection activities, substantial efforts to engage BIDMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes.

Special care was taken across all the assessment's individual components to include the voices of community residents who have been historically underserved, such as those who

are unstably housed or homeless, those who do not speak English, those who are recent immigrants, those who are 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, accountability, community engagement, and impact.



Equity:

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



Accountability:

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



Community Engagement:

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



Impact:

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

The assessment and planning process was conducted between June 2024 and September 2025 in three phases:

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

In April of 2024, BIDMC hired JSI Research & Training Institute, Inc. (JSI), a public health consulting firm based in Boston, to integrate the information gathered across these concurrent assessments and augment the information gathered, where appropriate. BIDMC worked with JSI to ensure that the final BIDMC 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 BIDMC's assessment and planning activities. BIDMC's CBAC is made up of staff from the medical center's Community Benefits Department, other medical center administrative/clinical staff, and members of the medical center's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Additional municipal staff (such as elected officials, planning, etc.)
- Education
- Community Health Centers
- Housing (such as community development corporations, local public housing authority, etc.)
 - » Local Public Health Departments/Boards of Health
 - » Regional planning and transportation agencies
- Social services
- Private sectors
- Community-based organizations

These institutions are committed to serving everyone throughout the region and are particularly focused on meeting the needs of those who are 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 BIDMC's staff in the CBAC promotes transparency and communication and ensures that there is a direct link between BIDMC and many of the community's leading health and social service community-based organizations. The CBAC meets quarterly to support BIDMC's community benefits work and met five times during the assessment and planning process. During these meetings, the CBAC provided invaluable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities. It is worth noting that all BIDMC CBAC meetings are open to the public and the CBAC welcomes oral and written comments.

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, BIDMC collected a wide range of quantitative data to characterize the communities served across its CBSA. BIDMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic

segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the

quantitative data gathered for this assessment is included in Appendix B.

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

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

^{*}Socioeconomic status

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, BIDMC applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.¹

To meet these standards, BIDMC employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Across all three components, the assessment included 35 one-on-one interviews with key collaborators in the community, 17 focus groups with segments of the population facing the greatest health-related disparities, 5 sector-based focus groups with community partners, and 1 community listening session that engaged approximately 40 participants. In addition, BIDMC's BILH partners, BID Needham and LHMC, conducted a community health

survey, which gathered information from more than 1,400 community residents from BID Needham's, LHMC's, MAH's, and WH's CBSAs, including 143 residents from Cambridge, 251 residents from Needham, 457 residents of Burlington, 187 residents of Peabody, and 291 residents of Winchester. BID Needham, LHMC, MAH, and WH shared this information with BIDMC.

The Boston Community Health Collaborative fielded a Community Health Needs Assessment survey in the fall of 2024. This survey of a random sample of over 1,650 residents in multiple languages examined issues related to factors that would improve quality of life and health in the community, community health concerns, barriers to care, and perceptions of community health and safety. In a collaborative effort, the BCHC and BILH aligned survey questions to facilitate the merging of data.

The North Suffolk Public Health Collaborative also fielded a community health survey. The survey collected data from



^{**}Social determinants of health

^{***}Sexual orientation and gender identity

nearly 400 respondents from the City of Chelsea, which were integrated into survey results discussed in this report. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials. Survey materials for the BILH Community Health Survey are included in Appendix B, and survey results for the Boston Community Health Collaborative and North Suffolk Public Health Collaborative are in the reports linked in Appendix A.

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

Prioritization, Planning, and Reporting

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

After prioritization with the CBAC, a community listening session was organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA.

Using the same set of anonymous polls, community listening session participants were asked to prioritize the issues that they believed were most important. The session also allowed participants to share their ideas on existing community strengths and assets, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the prioritization process, a CHNA report was developed and BIDMC's existing IS was augmented, revised, and tailored. When developing the IS, BIDMC's Community Benefits staff retained community health initiatives that worked well and aligned with the priorities from the 2025 CHNA.

The Boston Community Health Collaborative conducted a meeting with the Steering Committee and a subsequent meeting with community-based organizations to facilitate the development of a city-wide Community Health Improvement Plan (CHIP). The BCHC developed a summary and full report of findings. A link to the full BCHC report is provided in Appendix A.

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

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

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

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Assessment Findings

This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community-based organizations, faith leaders, other government officials and community residents engaged in supporting the health and well-being of residents throughout BIDMC 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 and focus groups, is included in Appendix A and B.

Please note:

Data has been reported for the Boston neighborhoods that are part of BIDMC's CBSA when possible. When data was not available at the neighborhood level, then data was reported for the City of Boston overall. It should also be noted that BIDMC'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 when data for Chestnut Hill was unavailable.

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 BIDMC's and its partners' efforts to develop its IS, as it must focus on specific segments of the population that face the greatest healthrelated 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 BIDMC CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition,

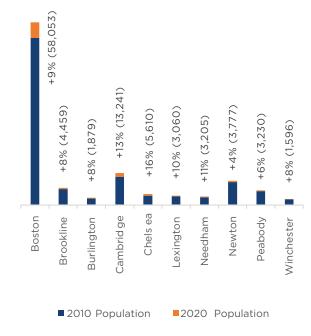
and economic security. There was consensus among interviewees, as well as focus group and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to disparities in access and health outcomes.

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

Population Growth

Looking at the 2010 and 2020 US Census Bureau decennial census data, the population in BIDMC's CBSA increased by approximately 9%, from 1,059,214 to 1,157,324 people. Chelsea saw the greatest percentage increase (16%), while Newton saw the lowest percentage increase (4%).

Population Changes by, Municipality, 2010 to 2020



Source: US Census Bureau Decennial Surveys, 2010 and 2020

Nation of Origin

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

Boston and Chelsea

28%

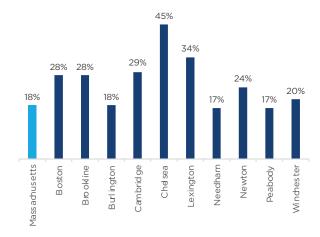
of Boston residents were foreign-born; among those, 47% were not US citizens.

45%

of Chelsea residents were foreign-born; among those, 67% were not US citizens. 84% foreign-born residents in Chelsea were born in Latin America.

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

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



Source: US Census Bureau American Community Survey 5-Year Estimates, 2019-2023



Among the other municipalities in the BIDMC CBSA, the percentage of the population that is foreign born was significantly* higher than the Commonwealth, except for Needham, Peabody, and Winchester where the percentage was similar.

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

Language

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

Boston and Chelsea

35%

of Boston residents 5 years of age and older spoke a language other than English in the home; of those, 16% had limited English proficiency.

70%

of Chelsea residents 5 years of age and older spoke a language other than English in the home; of those, 43% had limited English proficiency. Among non-English speakers, 59% spoke Spanish. In 2024-2025, nearly half (47%) of students in Chelsea Public Schools were English language learners.

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



Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth, the percentage of residents 5 years of age and older who speak a language other than English in the home was significantly* higher in Cambridge (34%), Lexington (40%), Newton (28%), Brookline (30%), Boston (35%), and Chelsea (70%), and significantly* lower in Burlington (20%) and Needham (20%).

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

Age

Age is a fundamental factor to consider when assessing individual and community health status. Older adults are at a higher risk of experiencing physical and mental health challenges and are more likely to rely on immediate

Boston and Chelsea



The percentage of the population under 18 years of age was significantly* lower in Boston (15%) and significantly* higher in Chelsea (25%) compared to the Commonwealth overall (20%).



The percentage of the population over 65 years of age was significantly* lower in both Boston (13%) and Chelsea (11%) compared to the Commonwealth overall (18%).

Other Municipalities in the BIDMC CBSA

The median age was significantly* higher than the Commonwealth (40) in all other BIDMC CBSA municipalities, with the exception of Cambridge (31) and Brookline (35), where the median age was significantly* lower. Among all municipalities, the median age was highest in Lexington and Peabody (47).

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

Gender Identity and Sexual Orientation



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

7% of adults in Massachusetts identify as LGBTQIA+. Data was not available at the municipal level.

Source: Gallup/Williams, 2023

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

Source: Gallup/Williams, 2019

Interviewees, focus groups, and listening session participants shared concerns around discrimination faced by the LGBTQIA+ population, especially transphobia. There is a need for affirming care that recognizes the impacts that gender identity and sexual orientation have on health and holistically attends to social, mental, and physical needs.

Boston and Chelsea

Approximately 5% of Boston adults identify as lesbian, gay, bisexual, or transgender. According to a 2018 Boston Public Health Commission report, percentages in the neighborhoods that are part of BIDMC's CBSA were higher than the city overall: 7% in Fenway/Kenmore, 11% in Allston Brighton, 7% in Roxbury, and 8% Dorchester. Source: Boston Public Health Commission, 2018

Other Municipalities in the BIDMC CBSA

In a focus group with LGBTQIA+ individuals in Cambridge, participants shared many concerns, including mental health struggles (e.g., anxiety, social isolation), lack of training among healthcare providers, misinformation about gender-affirming care, harmful language, and stigma and biases against the community.

Race and Ethnicity

In the BIDMC CBSA overall, the number of residents who identify as white, Black/African American, and Hispanic/ Latino (any race) decreased between 2016-2020 and 2019-2023, while there was an increase in other census categories. An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals and cohorts. In 2023, nationally, American Indian/Alaska Native (AIAN)

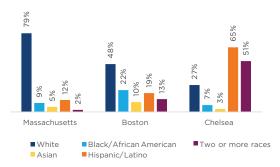
and Hispanic individuals under the age of 65 had the highest uninsured rates among all races (18.7% and 17.9%, respectively). AIAN (29%) and Hispanic (23%) individuals were also most likely to report fair or poor health status compared to other races.

Between 2019 and 2022, life expectancy at birth has waned in the United States. There are also stark differences in life expectancy by race/ethnicity. Life expectancy at birth was highest among Asian individuals (84.5 years), followed by 80 years among Hispanics, 77.5 years among whites, 72.8 among Black/African Americans, and 67.9 among Al/AN individuals. This data reinforces the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes.⁷

Boston and Chelsea

Both municipalities were more diverse compared to the Commonwealth overall. Chelsea had the second highest percentage of Hispanic/Latino residents of all municipalities in the Commonwealth (65%). In Boston, the percentage of Black/African American (22%), Asian (10%), and Hispanic/Latino (19%) residents was significantly* higher than the Commonwealth overall.

Race/Ethnicity of Residents in Boston and Chelsea, 2019-2023



Source: US Census Bureau American Community Survey 5-Year Estimates, 2019-2023

Other Municipalities in the BIDMC CBSA

In Brookline, Burlington, Lexington, and Newton, the percentage of the population that identified as Asian was significantly* higher compared to the Commonwealth.

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

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

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.8

Boston and Chelsea

Compared to the Commonwealth (29%), the percentage of households with one or more people under 18 years of age was significantly* lower in Boston (20%) and significantly* higher in Chelsea (33%). The percentage of households with an individual 65 years of age or older was significantly lower* compared to the Commonwealth (32%) in both cities. (US Census, 2016-2020)

Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth (28%), the percentage of households with one or more people under 18 years of age was significantly* lower in Peabody (25%), Cambridge (18%), and Brookline (25%), and significantly* higher in Lexington (43%), Newton (33%), Winchester (43%), and Needham (43%). The percentage of households with an individual 65 years of age or older was significantly* lower in Brookline (27%) and Cambridge (23%), and significantly* higher in Peabody (44%), Burlington (38%), Lexington (38%), and Newton (36%).

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

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

Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, access to care/navigation issues, and other important social factors. 9

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, surveys, and the listening session 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 stability.

Interviewees, focus group, and listening session participants shared that access to safe, affordable housing was a challenge for many residents. This was particularly true for those experiencing poverty and those living on an inadequate fixed income. Participants also noted that there is a population of individuals who are homeless or unstably housed in the BIDMC CBSA, particularly in Boston.

Interviewees, focus group, and listening session participants identified food insecurity, hunger, and poor nutrition as challenges, particularly for individuals and families experiencing economic insecurity. These issues were largely driven by issues related to job loss, the inability to find employment that paid a livable wage, or living on an inadequate, fixed income, which impacted the ability of individuals and families to eat a healthy diet. In the suburban BIDMC CBSA municipalities, issues related to transportation were also identified as a critical barrier to maintaining one's health and accessing care, especially for those who do not have a personal vehicle or are without caregivers, family, and social support networks.

Finally, those participating in interviews, focus groups, and the community listening session identified issues related to violence, including community violence. Beyond the physical health impacts for survivors, research shows that there are short- and long-term health impacts for those exposed to violence, including post-traumatic stress disorder and other mental health issues. Research shows that the death of a child was associated with a 21% increased risk of ischemic heart disease among parents.¹⁰

Other social factors that were highlighted in a more limited way during the assessment and thought to have an impact on health status and access to care were educational attainment and the built environment, including the importance of safe streets, sidewalks, and recreational areas.

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. Lower-than-average life expectancy is highly correlated with low-income status. Those who experience economic instability are also more likely to be uninsured or to have health insurance coverage 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.

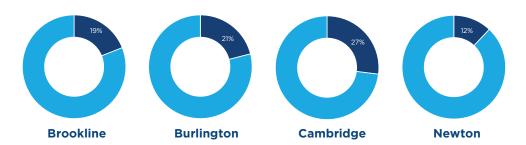
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the effects of job loss and unemployment, contributing to ongoing financial hardship. Meanwhile, the cost of living continues to rise, yet wages have not kept pace. Even for those who are employed, earning a livable wage remains essential for meeting basic needs and preventing further economic insecurity.

Percent of Adults Who Had Trouble Paying for Basic Needs, 2023



Source: MDPH Community Health Equity Survey, 2023

Percent of Adults Who Had Trouble Paying for Basic Needs, 2023



Boston and Chelsea

The percentage of individuals living in poverty tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of cumulative disadvantage over time. ¹⁴ Compared to the Commonwealth overall (\$101,341), median household income was significantly* lower in Chelsea (\$72,220).

32%

of BCHC CHNA Survey respondents identified economic insecurity, employment, and job opportunities as a top 5 concern in their neighborhood. Percentages were higher among residents in Allston/Brighton (44%), Dorchester (35%), and Mission Hill (37%).

Source: Boston Community Health Needs Assessment, Boston Community Health Collaborative, 2024

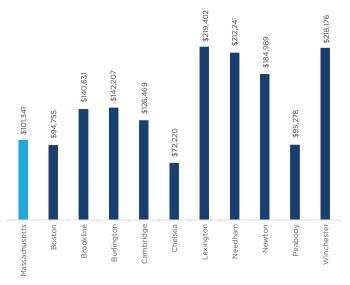
Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth overall (\$101,341), median household income was significantly* higher in Brookline, Burlington, Cambridge, Lexington, Needham, Newton, and Winchester.

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

Data unavailable for Lexington, Needham, Peabody, and Winchester Source: MDPH Community Health Equity Survey, 2023

Median Household Income, 2019-2023



Source: US Census Bureau American Community Survey 5-Year Estimates, 2019-2023

Social Determinants of Health

Education



Research shows that those with more education live longer, healthier lives. Patients with a higher level of educational attainment can better understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers.¹⁵

Boston and Chelsea

Over half (51%) of Boston residents 25 years of age or older have a bachelor's degree or higher, which was higher compared to the Commonwealth overall (45%). Despite this, there were significant differences in educational attainment by race and ethnicity. Percentages were lowest among Black/African American (27%) and Hispanic/Latino (27%) residents.

In Chelsea, the percentage of the population 25 years of age or older that are high school graduates (69%) was significantly* lower compared to the Commonwealth (91%).

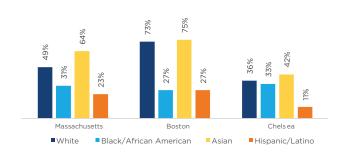
Compared to the Commonwealth overall (2%), the percentage of students in Boston (5%) and Chelsea public schools who drop out of school were higher (7%). Source: Massachusetts School and District Profiles, 2023-2024

Other Municipalities in the BIDMC CBSA

The percentage of the population 25 years of age or older with a bachelor's degree or higher was significantly* higher than the Commonwealth overall (47%) in all municipalities except Peabody (34%), where the percentage was significantly* lower.

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

Percentage of Residents 25 Years of Age and Older With a High School Degree or Higher by Race/Ethnicity, 2019-2023



Source: US Census Bureau American Community Survey 5-Year Estimates, 2019-2023

Food Insecurity and Nutrition

Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity and hunger are also factors contributing to poor physical and mental health for both children and adults. While it is important to have grocery stores placed throughout a community to promote access, there are other factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food and cultural appropriateness of food offerings. Food pantries and community meal programs have evolved from providing temporary or emergency food assistance

40% of Boston/Chelsea respondents to the 2025 BIDMC Community Health Survey said "better access to healthy food" is something they want to improve in their community

to providing ongoing support for individuals, families, seniors living fixed incomes, and people living with disabilities and/or chronic health conditions.



Boston and Chelsea

Compared to the Commonwealth (14%), the percentage of households who received Supplemental Nutrition Assistance Program (SNAP) benefits in the past year was higher in Boston (19%) and Chelsea (24%).

17% of respondents to the BCHC Boston Community Health Needs Assessment survey identified hunger and food insecurity as a top 5 concern in their community. Percentages were higher in Allston/Brighton (22%) and Roxbury (19%).

Source: BCHC Boston Community Health Needs Assessment Survey, 2023

Other Municipalities in the BIDMC CBSA

Interviewees, focus groups, and listening session participants expressed ongoing concerns about food insecurity, particularly among individuals with limited economic means, frail older adults, individuals with chronic or complex health conditions, and those without reliable transportation. The pandemic highlighted and exacerbated food access challenges, while also demonstrating the potential for strong community collaboration—such as efforts to ensure children continued to receive meals despite school closures. Participants emphasized the importance of sustaining and expanding these partnerships, and encouraged food pantries and organizations to diversify their offerings by including more culturally appropriate options and increasing access to fresh produce.

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.¹⁶

Housing



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

Interviewees, focus group participants, and survey respondents expressed concern over the limited options for affordable housing throughout BIDMC's CBSA - including urban and suburban municipalities.

Boston and Chelsea

Looking across occupied housing types (owner occupied with a mortgage, owner-occupied without a mortgage, and rented units), the percentage of units with housing costs that exceed 35% of household income was higher than the Commonwealth in both Boston and Chelsea.

4 in 10

Boston adults identified "housing quality or affordability" as a top 5 concern in their community or neighborhood.

Source: BCHC Boston Community Health Needs Assessment Survey, 2024

32%

of Boston/Chelsea respondents to the 2025 BIDMC Community Health Needs Assessment survey reported that they had trouble paying for housing costs (rent, mortgage, taxes, insurance) sometime in the past year.

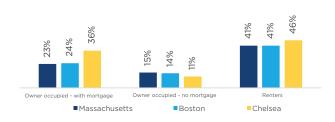
Other Municipalities in the BIDMC CBSA

Among the other municipalities in BIDMC's CBSA, the percentage of owner occupied units with a mortgage with housing costs in excess of 35% of household income was similar to the Commonwealth overall (23%), with the exception of Lexington (17%) and Winchester (17%) where costs were significantly* lower.

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

Focus group participants in Chelsea identified persistent housing issues, including landlord neglect, mold, rent increases, and lack of timely maintenance

Percentage of Housing Units with Housing Costs that Exceed 35% of Total Household Income, 2019-2023



Source: US Census Bureau American Community Survey 5-Year Estimates, 2019-2023

Transportation



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

Boston and Chelsea

Transportation was identified as a barrier to care and services for some segments of the population that may have difficulty accessing public transportation, including older adults and individuals with physical disabilities.

Chelsea focus group participants reported that transportation barriers limit residents' economic and social mobility and contributes to broader issues of economic instability.

Other Municipalities in the BIDMC CBSA

Many of the municipalities in BIDMC's CBSA have options for public transportation (e.g., buses, trains, commuter rail) in and out of Boston and other surrounding communities. In all communities except Lexington (7%), Peabody (3%), and Burlington (4%), the percentage of residents who utilized public transportation to commute to work was significantly* higher compared to the Commonwealth (9%). Interviewees, focus groups, and community listening session participants identified access to transportation as an issue in their community, especially for older adults without access to a personal vehicle or a caretaker.

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

Community Safety and Environmental Health

Creating safe outdoor spaces for people to commute, exercise, and relax is an important component in establishing healthy lifestyle habits that protect against poor health outcomes. While concerns related to the built environment were not key themes emerging from all communities in BIDMC's CBSA, these issues can work to either prevent or contribute to disease and disability in the community.

Boston and Chelsea

Focus group participants in Chelsea highlighted persistent environmental health concerns, including lead paint exposure near the Tobin Bridge, inadequate maintenance of school water refill stations, and limited preparedness for fire and extreme heat events. These findings underscore the need for sustained infrastructure investment and proactive community safety planning.

Crime and Violence

Crime and violence, including domestic violence and intimate partner violence, are public health issues that influence health status on many levels, from death and injury to emotional trauma, anxiety, isolation, and absence of community cohesion.

Boston and Chelsea

Interviewees reported concerns about community safety in Boston, including hate crimes, voter suppression, and physical violence. Interviewees also agreed that individuals affected by violence and incarceration are a priority population.

36%

of Boston and Chelsea residents who responded to the 2025 BIDMC Community Health Needs Assessment Survey identified "lower crime and violence" as one of the top five things they'd like to improve in their community.

Other Municipalities in the BIDMC CBSA

Crime and violence were not critical concerns in any of the other municipalities in BIDMC's CBSA. Violent crime counts (e.g., aggravated assault) were low in all communities. Property crime counts (e.g., burglary, arson, larceny) were also low.

Systemic Factors

In the context of the healthcare system, systemic factors include a broad range of different considerations that influence a person's ability to access timely, equitable, accessible, and high-quality services. There is a growing appreciation for the importance of these factors as they are seen as critical to ensuring that people can 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 (e.g., cost of care, health insurance status, language access, cultural competence), care coordination, and information sharing.

Systemic barriers affect all segments of the population but have a particularly significant impact on people of color, people whose first language is not English, foreign-born individuals, individuals living with

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

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, meaning that the issues stemmed from the ways in which the system did or did not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.¹⁸

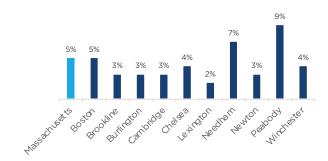
Boston and Chelsea

Compared to the Commonwealth (5%), the percentage of individuals who were uninsured was similar in Boston (5%) and lower in Chelsea (4%).

Interviewees, focus groups, and community listening session participants identified a need for more diversity among health care and service providers; research shows that patients experience fewer barriers to care when doctors reflect their own race or ethnicity.

Focus group participants in Chelsea reported a lack of culturally competent or bilingual mental health providers, and limited provider ability that causes extensive wait times.

Percentage of Individuals Who are Uninsured, 2019-2023



Source: US Census Bureau American Community Survey 5-Year Estimates, 2019-2023

Other Municipalities in the BIDMC CBSA

Interviewees, focus groups, and community listening session participants reported that many residents face challenges navigating a complex and fragmented healthcare system, including primary care, behavioral health, insurance coverage, and specialty care. Long wait times for appointments, limited provider availability, and high out-of-pocket costs or insurance-related barriers were frequently cited as obstacles to accessing timely and appropriate care.

Behavioral Factors

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

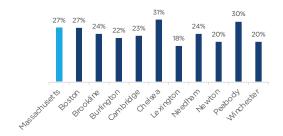
death due to the chronic conditions mentioned above.¹⁹

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. While these issues were ultimately not selected during BIDMC's prioritization process, the information from the assessment supports the importance of incorporating these issues in BIDMC's IS.

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.²⁰ Access to affordable healthy foods is essential to a healthy diet. Access to opportunities for physical activity was not identified as a significant need in the BIDMC CBSA, though there was recognition that lack of physical fitness is a leading risk factor for obesity and several chronic health conditions.

Percentage of Adults who Are Obese, 2022



Source: Behavioral Risk Factor Surveillance System, 2022

Boston and Chelsea

Compared to the Commonwealth (27%), the percentage of adults who were obese was similar in Boston (27%) and higher in Chelsea (31%).

Other Municipalities in the BIDMC CBSA

The percentage of adults who were obese was lower than the Commonwealth in all other BIDMC CBSA communities, with the exception of Peabody (30%).

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.

Boston and Chelsea

11%

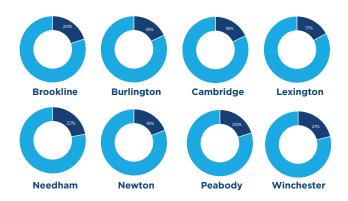
of Boston and Chelsea respondents to the 2025 BIDMC Community Health Survey identified vaping and e-cigarette use as a top 5 health concern in their community.

Source: 2025 BIDMC Community Health Survey

Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth overall (17%), the percentage of adults who reported binge drinking was higher in all communities except for Lexington (17%), where the percentage was similar.

Binge Drinking Among Adults, 2022



Source: CDC Places, 2022

Health Conditions

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

To augment and clarify this information, the assessment efforts included community engagement activities and specific requests asks for 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 issues.

Given the limitations of quantitative data, specifically that it is often out-of-date data and is not stratified by race and ethnicity, the qualitative information from interviews, focus groups, and community listening session was of critical importance.

Mental Health

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

In addition to the overall burden and prevalence of mental health issues, residents identified a need for assistance navigating a complex behavioral health system, as it can be overwhelming for individuals experiencing mental health challenges. Providing navigation assistance ensures people can access the right services at the right time, improving continuity of care and health outcomes.

Youth mental health was a concern in the BIDMC CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Boston and Chelsea

The percentage of adults who report that they usually or always feel isolated from others was similar to the Commonwealth (13%) in Chelsea (14%) and slightly lower in Boston (11%).

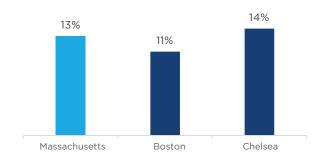
Source: MDPH Community Health Equity Survey, 2023

45%

of Boston/Chelsea residents who responded to the 2025 BIDMC Community Health Survey identified mental health (anxiety, depression, etc.) as one of the top five health issues that matter most in their community.

Interviewees, focus groups, and community listening session participants identified a need for a more diverse mental health workforce. Research shows that culture has significant implications on how individuals view mental health issues and seek treatment.

Percentage of Adults Who Usually or Always Feel Isolated from Others, 2023



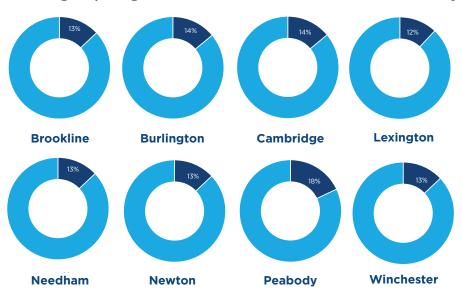
Source: MDPH Community Health Equity Survey, 2023

Other Municipalities in the BIDMC CBSA

In most BIDMC CBSA communities, mental health emerged as the leading health concern. Interviewees, focus groups, and community listening session participants reported a high prevalence of anxiety, depression, stress, and social isolation among older adults.

In all communities except for Peabody (18%), the percentage of respondents to the MDPH Community Health Equity Survey who reported poor mental health within the past 30 days was similar or lower than the Commonwealth overall (14%).



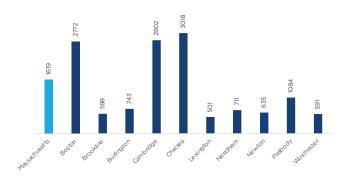


Source: CDC Places, 2022

Substance Use

Substance use continued to have a major impact on the BIDMC CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Interviewees, focus groups, and community listening session participants identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Substance Use Related Emergency Room Department Visits (Per 100,000), 2023-2024



Source: Massachusetts Bureau of Substance Addiction Services, 2023-2024

Boston and Chelsea

Interviewees, focus groups, and community listening session participants identified a need for more supportive services for individuals diagnosed with substance use disorders, including mental health services, transitional housing, support for employment and workforce development.

The rate of admissions to emergency departments for substance use was higher than the Commonwealth (1,619 per 100,000) in both Boston (2,772 per 100,000) and Chelsea (3,018 per 100,000).

Other Municipalities in the BIDMC CBSA

The rate of admissions to emergency departments for substance use was lower than the Commonwealth in all other CBSA municipalities with the exception of Cambridge (2,802 per 100,000).

Chronic and Complex Conditions



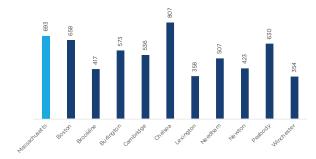
In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is

estimated that there are more than \$41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.²¹

Boston and Chelsea

The age-adjusted mortality rate was lower than the Commonwealth (694 per 100,000) overall in Boston (658), and higher than the Commonwealth in Chelsea (869).

All-Cause Mortality Rates (Per 100,000) Among Adults, 2021



Source: MDPH Registry of Vital Records and Statistics, 2021

Emergency room discharges for pediatric asthma were lower than the Commonwealth (347 per 100,000) in Boston (146) and higher than the Commonwealth in Chelsea (431).

Among all adults, age-adjusted heart disease morality rates were lower than the Commonwealth (127 per 100,000) in Boston (114) and higher in Chelsea (145).

Source: MDPH Registry of Vital Records and Statistics, 2021

Other Municipalities in the BIDMC CBSA

Age-adjusted mortality rates (all-cause) were lower than the Commonwealth overall in all other CBSA municipalities.

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

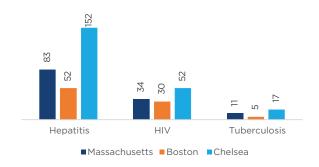
Boston and Chelsea

Data from the Center for Health Information and Analysis indicated that adults in Chelsea had higher inpatient discharge rates than the Commonwealth across several conditions, including Hepatitis, HIV, and Tuberculosis.

Other Municipalities in the BIDMC CBSA

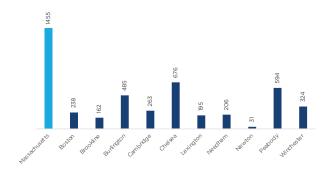
The rate of inpatient discharges among those 65 years of age and older for flu/pneumonia was higher than the Commonwealth (4188 per 100,000) in several CBSA communities: Burlington (5,346), Chelsea (5,615), Needham (4,645) and Peabody (4,571).

Inpatient Discharge Rates (per 100,000) Among Those 45-64 Years of Age, 2024



Source: Center for Health Information and Analysis, 2024

Inpatient Discharge Rates (per 100,000) for Infections Among Those 65 Years of Age and Older, 2024



Source: Center for Health Information and Analysis, 2024



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 are faced with health-related disparities. Accordingly, using an interactive, anonymous polling software, BIDMC's CBAC and community residents, through the community listening session, formally prioritized the community health

issues and cohorts that they believed should be the focus of BIDMC's IS. This prioritization process helps to ensure that BIDMC 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 BIDMC'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 Maternal health equity 	 Built environment Social environment Housing Violence Education Employment
Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy	Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)

Community Health Priorities and Priority Cohorts

BIDMC is committed to promoting health, enhancing access and delivering the best care for those in its CBSA. Over the next three years, the medical center will work with its community partners, with a focus on Chelsea and the Boston neighborhoods in its CBSA, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. 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 and community health priority areas.



Youth



Low-Resourced Populations





Older Adults

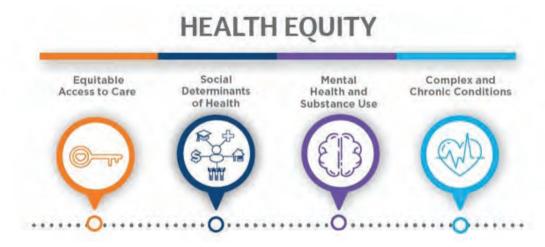


Racially, Ethnically, and Linguistically **Diverse Populations**



Families Affected by Violence and/or **Incarceration**

BIDMC Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BIDMC

It is important to note that there are community health needs that were identified by BIDMC's assessment that were not prioritized for investment or included in BIDMC's IS. Specifically, issues related to the built environment (e.g., improving sidewalks and roads) were identified as community needs but were not included in BIDMC's IS. While these issues are important, BIDMC's CBAC and senior leadership team decided that these issues were outside of the medical center's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. As a result, BIDMC recognized that other public and private organizations in its CBSA, Boston, and the Commonwealth were better positioned to focus on these issues. BIDMC 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 BIDMC's IS

The issues that were identified in the BIDMC CHNA and are addressed in the hospital IS are housing issues, food insecurity, transportation, environmental justice/climate, economic insecurity, community safety, workforce development, language and cultural barriers to care, long wait times for care, navigating a complex health care system, health insurance and cost barriers, youth mental health, depression/anxiety/stress, support for individuals with substance use disorder, social isolation among older adults, navigating the behavioral health system, trauma, conditions associated with aging, education and prevention around chronic disease risk factors, emergency preparedness, and care navigation and management.

Implementation Strategy

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

Included below, organized by priority area, are the core elements of BIDMC's 2026-2028 IS. The IS is designed to address the underlying social determinants of health, barriers to accessing care, and 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 BIDMC will invest to address the priorities identified by the CBAC and BIDMC's senior leadership team. Following the discussion of resources are summaries of each of the selected priority areas and a listing of the goals that were established for each priority area.

Community Benefits Resources

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

Recognizing that community benefits planning is ongoing and will change with continued community input, BIDMC'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. BIDMC is committed to assessing information and updating the plan as needed.

The following are brief descriptions of each priority area, along with the goals established by BIDMC to respond to the CHNA findings and the prioritization and planning processes. Please refer to the full FY26-28 IS in Appendix E for more details.

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

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

Strategies to address the priority:

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

SOCIAL DETERMINANTS OF HEALTH

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

Strategies to address the priority:

- Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.
- Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.
- · Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.
- Support programs and activities that increase employment, earnings and financial security.
- · Support programs and activities that foster social connections, strengthen community cohesion and resilience, and address public safety and the causes and impacts of violence.
- · Advance environmental sustainability and climate resilience by reducing carbon emissions, conserving natural resources, strengthening community and infrastructure preparedness for climate-related disruptions, and addressing the health impacts of climate change, with a focus on support for those most affected.
- · Advocate for and support policies and systems that address social determinants of health.

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

- · Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with chronic and complex conditions and/or their caregivers.
- · Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.
- · Advocate for and support policies and systems that address those with chronic and complex conditions.

Evaluation of Impact of 2023-2025 Implementation Strategy

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

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

Priority Area

Summary of Accomplishments and Outcomes

Social Determinants of Health

BIDMC addressed social determinants of health through investments in housing stability, workforce development, community resilience, violence prevention, and food access. Housing programs served more than 1,800 individuals, leading to improved satisfaction and control over housing situations, while policy advocacy contributed to local and state housing reforms. Financial security programs helped hundreds improve financial habits and job readiness, and youth initiatives provided employment, mentorship, and leadership opportunities. The hospital supported neighborhood improvement efforts, trauma and violence prevention programs, and community wellness programs. Food security initiatives provided thousands of grocery bags, meals, and market vouchers to patients and community members. Sustainability efforts included reducing greenhouse gas emissions and increasing local food sourcing.

Equitable Access to Care

BIDMC enhanced equitable access through expanded interpreter services, workforce initiatives, and strengthened support for uninsured patients. Interpreter encounters were approximately 300,000 annually in over 70 languages. Financial counselors screened patients for insurance eligibility and enrolled them in entitlement programs. BIDMC also provided over 5,500 taxi or ride-sharing vouchers per year and advanced equity-focused research and advocacy efforts, including nearly \$5 million in disparities research funding per year.

Mental Health and Substance Use

BIDMC expanded access to culturally and linguistically appropriate behavioral health services through partnerships, integrated care models, and trauma-informed approaches. Over 340 staff and trainees received trauma-informed care training, and behavioral health navigation, counseling, and first aid trainings reached both patients and community members. BIDMC collaborated with The Dimock Center for stabilization services and supported behavioral health policy advocacy. Early outcomes showed reduced symptoms, increased confidence, and greater willingness to seek care among program participants.

Complex and Chronic Conditions

BIDMC promoted chronic disease prevention and management through a range of community-based services, screenings, and multilingual programs. Nearly 120,000 patients received care at affiliated federally qualified health centers, and over 355,000 medical visits were recorded in FY24. Clinical quality measures for patients at affiliated federally qualified health centers showed 75% of diabetic patients maintained controlled A1c levels, while 63% of hypertensive patients achieved blood pressure control in FY24. Lung cancer screenings increased to over 1,360 annually, and the hospital offered multilingual cardiovascular services, cancer patient navigation, and support groups. Programs such as the Bowdoin Street Health Center's Wellness Center and diabetes disparity initiatives supported patients in managing chronic and complex conditions across diverse populations.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: FY26-FY28 Implementation Strategy

Appendix A: Community Engagement Summary

Community Partner Assessments

Boston Community Health
Collaborative Community Health
Needs Assessment

North Suffolk Integrated
Community Health Needs
Assessment

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

Introduction:

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

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

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

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

Are there any questions before we begin?

- 1. Please tell me a bit about yourself. What is your role at your organization, how long have you been in that position, and do you participate in any community or regional collaboratives or task forces? Do you also live in the community?
- 2. In [name of Hospital's] last assessment, we identified [4-5] community health priority areas [list them]. When you think about the large categories of issues that people struggle with the most in your community, do these seem like the right priorities to you?
 - a. Would you add any additional priority areas?
 - b. I'd like to ask you about the specific issues within each of these areas that are most relevant to your community. For example, in the area of Social Determinants of Health, which issues do people struggle with the most (e.g., housing, transportation, access to job training)?

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

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

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

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

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

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

Exeter: Older adults, Individuals Living with Disabilities, LGBTQIA+, Low resource populations

- 4. I want to ask you about community assets and partnerships.
 - a. What is the partnership environment in your community? Are organizations, collaboratives/task forces, municipal leadership, and individuals open to working with one another to address community issues?
 - i. Are there specific multi-sector collaboratives that are particularly strong?
 - b. Are there specific organizations that you think of as the "backbone" of your community who work to get individuals the services and support that they need?
- 5. Thank you so much for your time, and sharing your perspectives. Before we hang up, is there anything I didn't ask you about that you'd like us to know?

Beth Israel Deaconess Medical Center (BIDMC) Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Sigalle Reiss, Director of Public Health and Human Services, Town of Brookline
- Shin-Yi Lao, Commissioner of Health and Human Services, City of Newton
- Tim McDonald (Director of Health and Human Services) and Tiffany Benoit (Assistant Director of Public Health), Town of Needham
- Magalis Troncoso-Lama, Executive Director, Dominican Development Center
- Nadine Alvarez (Assistant Director of School-Based Services) and Jenna Parafinczuk (Director of Social Work), Boston Public Schools
- Reverend David Wright, Executive Director, BMA TenPoint
- Sarah Cluggish, Chief Program Officer, Project Bread
- Amber Haskell, Senior Director of Economic Inclusion, Boston Chamber of Commerce
- Rachel Heller, CEO, Citizen's Housing and Planning Association (CHAPA)
- Barry Keppard, Director of Public Health, Metropolitan Area Planning Council (MAPC)
- Harry Weissman, Executive Director, Disability Policy Consortium
- Karen Chen, Executive Director, Chinese Progressive Association
- Lorena Estrada-Martinez, Associate Professor of Environmental and Public Health, UMass Boston
- Jennifer Cedor, Supervising Attorney for the Immigrant Health Initiative, Health Law Advocates
- Tracy Nowicki, Director of Health and Human Services, City of Chelsea

Community Health Priority Areas

Social Determinants of Health

- Economic insecurity
 - Access to employment, jobs, and livable wages are critical
 - o Potential solutions should focus on education and workforce development (e.g., job training programs for young people, union apprenticeships)
 - There are Chinatown-based organizations fighting for worker justice and equality
 - o There may be jobs available, but we need jobs that offer livable wage
 - "Gig work" is growing but is extractive, not livable, and offers poor work/life balance
- Housing was identified by nearly every interviewee as a top concern
 - Housing affordability people are house poor, with a high percentage of income going towards housing costs.
 - "You shouldn't have to have multiple jobs to afford your housing."
 - Housing in Boston is aging and can be unsafe (e.g., faulty heating/cooling systems, not up to code)
 - o Abusive and predatory landlords are a concern, especially for immigrant populations
 - o Gentrification and displacement
 - o Independent living for individuals living with disabilities is key to be able to do this, people must have access to personal care attendants and accessible housing options

Food insecurity

- There are food resources throughout the city, but people need access to affordable healthy foods. Food pantries don't provide enough healthy food – need more fruits and vegetables.
- o Food insecurity exacerbates health conditions
- Need more programs that connect people with healthy food vouchers and programs directly from the clinical setting

Transportation

- Is primarily an issue in suburban communities in the service area, where public transportation may not be as accessible
- o Transportation barriers primarily affect older adults, individuals living with disabilities, and those with a fixed income.
- Language and cultural barriers to services
 - "Cultural competence and responsiveness is really important. Not all Hispanic and Latino populations are the same."
 - Health education should be tailored to culture

Community safety

- o Identified as an issue in Chinatown. Organizations in the neighborhood know that people have experienced hate crimes, voter suppression, and physical violence
- Environmental health and justice
 - Health is tied to climate change and environmental justice issues clinicians are not thinking about how extreme heat and cold are affecting their patients with COPD, Diabetes, disabilities, etc.
 - In an urban area, concerns center around heat, pollution/unhealthy air, unhealthy housing, and access to resources like food and electricity if there is a climate/natural disaster
 - Investments should be made in updating our community infrastructure, including housing, schools, and community spaces

Access to Care

- Need for more integration between primary care and other care settings
- Access is primarily an issue for those who are low-income, those who speak a language other than English, and those with mental health diagnoses
- Language/cultural barriers
 - o There is a lack of culturally diverse providers
 - o Individuals want to see providers that speak their language and know their culture
 - Community health workers and peer-based models have been successful in bridging these gaps and could be expanded

- Lack of navigation services
 - o People are unsure of where to go for care, depending on their situation
 - Especially true for residents who speak a language other than English
 - Need tailored community interventions where people naturally gather (e.g., bodegas, community centers, barber shops) to bring care directly to people
 - Individuals with complex health care needs and disabilities often need intensive case management and a care coordination team. Too much of the onus falls onto the patient/individual.
- Access to care is a primary concern for immigrants, mostly because of insurance issues. There is
 a lack of education around coverage people need more education about what they're eligible
 for and where they can go to be covered.

Mental Health and Substance Use

- Broad agreement that mental health, including stress, anxiety, depression, continues to be a critical concern in communities
 - "The impacts of COVID have been huge and dramatic. People are more isolated, more anxious, less social, less trusting, and less confident."
- Need for providers with more linguistic and cultural competence
- Behavioral health prevention and education continue to be important
- Integration of behavioral health across sectors and settings (e.g., need to continue to embed behavioral health resources in primary care, schools, etc.)
- Older adult isolation and loneliness is an issue, even in the city where there are resources
 - This issue is compounded by transportation issues, which keeps some older adults in their homes
- Immigrant/refugee/migrant trauma
 - Fear of deportation; very few resources outside of Boston. The resources that do exist are not enough
- Youth behavioral health
 - Need more access to behavioral health in schools
- Substance use
 - o Opioids, alcohol, marijuana
 - Need to continue to provide resources and support to individuals struggling with substance use disorder, including navigation and supportive services (e.g., job training, getting identification)

Chronic and Complex Conditions

- Chronic disease prevention, including vaccination and promotion of public health, are important issues that should continue to be invested in, particularly for recent immigrants
- Health education should be tailored to culture
- Healthy eating/active living
 - o "10 years ago, when people came from my country, they were healthy. Now [after living in the United States], they are unhealthy."
 - o Obesity is a concern
 - People want access to foods that are healthy, fresh, and affordable
- Navigation assistance for people who are managing multiple chronic conditions

 Health care system is hard to navigate, especially for older adults, people who do not speak English, and people with disabilities. This often requires some sort of care navigator or professional team (e.g., personal care attendants)

Priority Populations

- Agreement across interviewees that the following populations should continue to be the priority, as they face the most significant barriers to care and services:
 - Youth
 - Racially/ethnically/linguistically diverse (including immigrants and refugees primarily those that have newly arrived)
 - Low-resourced/low-income populations
 - o LGBTQIA+
 - o Individuals living with disabilities
 - o Families impacted by violence and incarceration
 - Older adults
- Interviewees also identified concerns for individuals that are homeless/unstably housed, and individuals with mental health conditions, and individuals with substance use disorder

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout the City of Boston, but silos do exist by neighborhood or by sector
 - Specific organizations identified as critical resources: City of Boston services (schools, housing authority), hospitals, SNAP program, Project Bread, Community Servings, Fresh Truck, Nubian Market, Children's Health Watch, Boston Public Health Commission, Home Health Workforce Program, South Cove
- Interviewees identified the YMCA, William James Interface, Food Banks, and Neighbors Helping Neighbors as community resources in Newton. There has also been a notable increase in mutual aid organizations since Covid
- Interviewees identified GreenRoots and La Colaborativa as community resources in Chelsea

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

Beth Israel Deaconess Medical Center Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Newly arrived families from Haiti Location: AFAB/The Association of Haitian Women

Date, time: 8/29/2024 Facilitator: JSI/AFAB staff Language: Haitian-Creole

Approximate number of participants: 8

Question 1

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

- Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?
 - i. I take care of myself and avoid things that can disturb my health. I avoid eating things that are unhealthy
 - ii. If an activity is too much for me (like lifting heavy things), I avoid doing it.
 - iii. I listen to my doctor's advice. I do everything he tells me to do.
 - iv. My health is not too good, but I control my size. I don't eat fat anymore
 - v. I don't eat late at night.
 - vi. I don't eat fatty meat because my doctor says not to
 - vii. I'm thanking God that I don't go to the hospital, and I don't have any illnesses
- What stops you from being as physically healthy as you'd like to be?
 - i. Stress. Haiti has many problems; every time I hear bad news, it stresses me out.
 - ii. I'm in a new country, and I'm not working, so I'm at home with my family. My family is not doing well.
 - iii. The children [in the US] are causing problems because they are different from the children raised in Haiti.
 - iv. Illness makes me stressed.
 - v. I would like to return to Haiti one day, but bad news makes me lose hope.
 - vi. My family stresses me out. My partner goes out whenever he wants, I am not allowed to ask questions and he doesn't listen when I talk to him. He yelled at me.
 - vii. My job stresses me out.

Question 2

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

- a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?
 - a. I manage my emotions.
 - b. If people do something to me that makes me angry, I can cry. When I receive bad news of something, like a death, I have to accept the things that I cannot change.
 - c. I seek to do what I love. I manage my relationships with friends well so that I can always have people to talk to because we cannot live without people.
 - d. I talk to friends and family and I go to church

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

- a. Sometimes bad things happen that ruin my day. I live with my brother, sister, me, and my child. My sister lost her job, and it creates a lot of problems at home.
- b. Bad news from Haiti.
- c. The bills and work here are different from what it was like in Haiti.
- d. This country is always stressful, especially for a person who cares for his body and for those who are living at home, but unemployed.
- e. You can't help but be stressed in this country.
- f. Insecurity in Haiti. There is always bad news from Haiti, so I am worried for my family. The news gives [me] a headache.
- g. The United States is not our home. If they throw me out, I don't have a good country for me to return to.
- h. I was living well in Haiti. But living in the United States makes me feel humiliated. This country causes me to stress a lot.
- i. I have been in this country for 2 years and I live badly. I left my home in Haiti and thugs almost reached me. Things are stressing me out so much that I can't sleep.

Question 3

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

- a. What social factors are most problematic in your community?
 - a. Language barriers; it is difficult for me to learn English, so it is difficult for me to express myself. When I go to the doctor, I don't want anyone else to know my business, but I have to, because I need an interpreter.
 - b. Housing is expensive.
 - c. Food is expensive.
 - d. Even if I am sick, I have to go to work because life is expensive and I have bills I need to pay. Since I came to this country, I have a broken heart that I've never had before.
 - e. Housing is hard to find and when I found it, the owner of the house did not respect me
 - f. I'm in a house, but the owner is so annoying; it's like hell.
 - g. When I first came, people helped me, but after a while, they stopped.

- h. There is security in the country, and I've met people who are really hospitable, but things are difficult because housing is so difficult for me to find.
- i. I'm always afraid that the landlord will kick me out when it's cold.
- j. Employment. We have talent and we come with knowledge on how to do things like we did in Haiti, but it's hard to get a job here because we don't speak English. We can do the jobs, but the language is a big barrier.
- b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?

Did not get to this question

Question 4

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

- a. Tell me about the resources in your community which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?
 - a. I found a place to learn a trade (Certified Nurses Assistant CNA) An organization called JVS. They give free English lessons and train us to get jobs.
 - b. Hospitals. When I go to the hospital, they take care of me without me paying anything.
 - c. Living in Boston helps me a lot because me and my children can go to the hospital. I gave birth in Boston, and I didn't pay a penny.
 - d. AFAB helps me with my English courses and supports me.
 - e. School. My child goes to school here for free.
 - f. Hospital social workers help me with transportation when I need to go to the hospital
 - g. IFSI helped me with the DTA application.
 - h. AFAB motivates me to move forward. We are all in English classes here.
- b. What kind of resources are not available in your community, but you'd like them to be?
 - a. I can't find work
 - b. They don't help us find housing

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?

Are there community health issues in your community that we didn't identify?

Are there any other types of resources or supports you'd like to see available in your community?

• I would like to have a welcome center for Haitians who have just arrived and do not speak English, to help us find what we need: work, homes, education, etc.

Beth Israel Deaconess Medical Center Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Spanish speaking young adults

Location: La Colaborativa, Chelsea

Date, time: 11/16/2024

Facilitator: JSI and La Colaborativa

Language: Spanish

Approximate number of participants: 9

Question 1

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

- a. What kinds of things do people your age do to stay physically healthy?
 - i. In our community, a lot of us try to stay physically healthy by getting involved in activities like sports and fitness programs.
 - ii. We've found that being part of the Basement Trybe is really important for us. It's a program where we use physical movement and exercise not just to stay in shape, but to express our emotions. It helps us release stress, deal with tough situations, and stay active, all while doing something that feels good.
 - iii. We also try to eat healthy, but sometimes that's hard because not all of us have access to the same resources.
 - iv. For those of us who are not doing a sport; most people just stay inside their homes and "bed rot"- as in they don't do anything but stay in bed all day.

b. What prevents people your age from being physically healthy?

- i. A lot of the time, it's the lack of access to resources or programs that really help.
- ii. Many of us don't have enough money to join gyms or have access to sports programs that teach us how to be healthy.
- iii. There's also the challenge of not having spaces that support us or make us feel comfortable being ourselves. Sometimes, programs like Basement Trybe are the only space where we can move, be ourselves, and get that emotional release through physical exercise.

Question 2

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

- a. What kinds of things do you and the people you know do to stay mentally healthy?
 - a. Staying mentally healthy is harder than it sounds. For some of us, programs like Basement Trybe and La Colaborativa give us a safe space where we can express

- our emotions . It helps us deal with things we don't always know how to talk about.
- b. Besides that, we try to be there for each other—sometimes just talking to friends or family can make a big difference.
- c. But honestly, it's tough because there aren't a lot of mental health resources for young people in our community. We don't have enough counselors in schools, and sometimes it feels like our feelings are just ignored or brushed off.

b. What prevents you and other people your age from having the mental health you would like to have?

- a. The biggest thing is the lack of resources. We don't have enough access to therapy or mental health services. If we have any issues, like anxiety or depression, there's not much help available.
- b. Even in schools, there's no real focus on mental health.
- c. And, honestly, mental health isn't something people openly talk about in our community. It can feel like you're alone, and that's really hard for us as teens.

Question 3

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

- a. What are the key places or people that help people your age stay healthy? What do they do to show that they support you?
 - a. The people at La Colaborativa have been key in helping us stay healthy. They offer programs like Basement Trybe, where we can exercise and express ourselves through physical movement. It's been really empowering to be part of that.
 - b. In addition, some of our family members and teachers try to support us, but it's not always enough.
 - c. The staff at La Colaborativa really understand what we're going through. They create programs that are built to help us grow in many ways—whether it's through earning income, learning new skills, or finding emotional support. They really care about our futures, and that makes a big difference for us.

b. Are there any types of places or resources you wish were available to you, but are not?

- a. Our community needs more places where we can learn about healthy living, mental health, and even sexual health.
- b. We wish there were more resources focused on mental health. There aren't enough counselors or support groups that are geared toward teens.
- c. Also, sexual health education is something that's missing. Many of us are learning things the hard way—like how some teens in middle school are getting pregnant because they didn't have the right information. We need

- more sexual health education programs, especially ones that are inclusive and talk about queer issues.
- d. There's also not enough visibility or representation for queer youth, and that's something we need in our community.
- e. While La Colaborativa does a lot for us, we wish there were more spaces that could also offer income-earning opportunities, especially for those of us who need to support our families. It's tough when you're a teenager, trying to balance school, personal life, and supporting your family at the same time. We need more programs that offer jobs, not just internships or volunteer work, but paid positions that help us provide for ourselves and our families.
- f. Definitely the lack of sexual health education and mental health services for young people. The only sexual health education we get is from the internet or sometimes from friends who don't really know what they're talking about. We need more formal education in schools and community centers.
- g. There's also a huge stigma around mental health in our community, and that needs to change.

Question 4

Is there anything we did not ask you about, that you were hoping to discuss today?

Are there community health issues in your community that we didn't identify?

Are there any other types of resources or supports you'd like to see available in your community?

- Honestly, we just want to see more spaces that focus on LGBTQ+ visibility and inclusion. It's hard being a queer teen in a space where no one talks about it. We need support to navigate our identities, and that's something we don't see in the programs we have now.
- We really wish there were more programs that focus on mental health and sexual health, especially ones that are tailored to our age group and speak to our experiences. Also, more inclusive spaces where LGBTQ+ youth can feel seen and heard would make a huge difference.

Beth Israel Deaconess Medical Center Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Cape Verdean Association of Boston Location: Cape Verdean Association of Boston

Date, time: 11/22/2024 Facilitator: JSI and CVAB staff Language: Cape Verdean Creole

Approximate number of participants: 15

Question 1

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

- a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?
 - i. Eating healthy.
 - ii. Exercising for at least 30 minutes a day.
 - iii. Taking medication as needed.
 - iv. Staying hydrated.
 - v. Attending regular medical checkups.
 - vi. Getting adequate sleep.
 - vii. Avoiding trouble or risky behavior.
 - viii. Going to a primary care physician
 - ix. Learning about healthy habits like diet and exercise in high school classes
- b. What stops you from being as physically healthy as you'd like to be?
 - i. Laziness or lack of motivation.
 - ii. Feeling too tired.
 - iii. Limited time to work out or prepare healthy meals.
 - iv. Unhealthy work-life balance.
 - v. Physical injuries.
 - vi. Financial constraints prevent a healthy lifestyle.
 - vii. Finding a doctor is challenging for individuals without a primary care physician, especially immigrants
 - viii. There is limited access to information about physical health, especially for elderly patients who often rely solely on their primary care physicians. Language barriers and discomfort with interpreters exacerbate this issue.

Question 2

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

- a. Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?
 - a. Listening to music and dancing.
 - b. Spending time with family and watching TV.
 - c. Participating in community activities and volunteering.
 - d. Praying, eating, playing sports, exercising, and getting adequate sleep.
 - e. Practicing self-care, including haircuts, nails, and eyelashes (noted by younger participants).
 - f. Elderly participants engage in activities at senior centers, crocheting, or participating in programs at elderly housing.
- b. What stops you from being as mentally healthy as you'd like to be?
 - a. Issues at school, work, or home.
 - b. Financial struggles, including low salaries and insufficient funds to pay for desired activities.
 - c. Lack of community support and personal space.
 - d. Substance abuse (drugs and alcohol).
 - e. Self-doubt, lack of confidence, and hunger.
 - f. Gossip and its effects.
 - g. High school students have access to mental health information online, but noted significant stigma around mental health, especially for men and boys.
 - h. Cultural and societal norms often discourage men from seeking help, emphasizing the need to "man up" or "tough it out."

Question 3

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

- a. What social factors are most problematic in your community?
 - a. Lack of affordable, healthy food.
 - b. Elderly participants rely on family for transportation to access affordable food options.
 - c. Community safety concerns, particularly at night.
 - d. Language barriers, especially for Cape Verdean Creole and Spanish speakers.
 - e. Limited public transportation and delays in bus services.
- b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?

- a. Elderly individuals, due to language barriers and reliance on others for resources.
- b. Immigrants and non-English speakers struggling with limited language resources.

Question 4

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

- a. Tell me about the resources in your community which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?
 - a. Bowdoin Street Health Center and Uphams Corner Health Center
 - b. Schools, senior centers, and the Cape Verdean Association of Boston
 - c. Family Nurturing Center, Kroc Center Gym, and local parks (Ronan Park, Ceylon Park)
 - d. Catholic Charities Teen Center at Saint Peter's and local churches (Saint Peter's and Saint Patrick's)
 - e. Dorchester House, Madison Park, and soccer fields at Boston Tech Academy
- b. What kind of resources are not available in your community, but you'd like them to be?
 - a. Improved housing aid and utilities assistance
 - b. Better access to affordable, healthy food
 - c. Enhanced community safety, particularly at night
 - d. Language resources and management personnel fluent in Cape Verdean Creole or Spanish at elderly housing organizations
 - e. More reliable public transportation
 - f. Improved school cafeteria food, as high school students often avoid eating it

Beth Israel Deaconess Medical Center Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Transgender and Non-binary Adults

Location: Zoom

Date, time: 12/3/2024

Facilitator: JSI

Approximate number of participants: 4

Question 1

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

- a. What sorts of things do you do to stay physically healthy?
 - i. Go to the gym three times a day, go for runs, and keep an active workspace
 - ii. I am recovering from surgery, but I do pole dancing and I swim. It can be hard with a chronic disability
 - iii. I go to the gym three times a week
 - iv. My insurance reimburses me for my gym membership
- b. What prevents you from being as physically active as you want to be?
 - My disability and also the price; gym memberships are pricey. Maintaining motivation is hard
 - ii. Time and scheduling

Question 2

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

- a. What sorts of things do you do to stay mentally healthy?
 - I am a social work student and have been seeing a therapist and psychiatrist for years. I have lots of thoughts about the [academic medical center] psychologist department
 - b. My cat is a huge help; I like our snuggles
 - c. I have a therapist and attend as many support groups as possible. I go to therapy twice a month, but many support groups have disappeared
 - d. Going to therapy, reading more, and spending less time on my phone

b. What prevents you from being as mentally healthy as you want to be?

- Therapists are coming and going since the system is causing burn out. Creating a routine is hard and healthcare insurance also prevents from me from seeing certain people
- b. Insurance is huge and waitlists are like a year long. At [the academic medical center] they keep on recommending [the LGBTQIA+ health center], but that's difficult as I previously went to [the LGBTQIA+ health center] and the waitlist is long. Finding someone who specializes in trauma and trans-related issues, is seemingly rare, especially on MassHealth
- c. Even with larger private insurance, I had difficulty finding therapists who are flexible when working with someone who has disability
- d. A lot of people don't want to take Beacon, the healthcare for MassHealth mental care

Question 3

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

a. What has been difficult in accessing care?

- a. There is a lack of trans doctors and providers. Trans people have different healthcare needs, and many cisgender doctors don't care to know the differences.
- b. In my experience with [the LGBTQIA+ health center] and their [speciality care hospital partner], the population is very white and college educated. The second I am referred to care outside of the [LGBTQIA+ health center] it's a shitshow. Cisgender clinicians who don't understand letters of recommendation for surgeries, doctors misgender me, and psychiatric providers refuse to see me as my identity. I feel like when I walk into [the hospital] I have to prove my identity; dress more masculine and go out of my way to prove my identity
- c. I was assigned a doctor and actually really enjoy my doctor, but booking appointments is difficult. Things are not available for a month; putting primary care doctors in a bad space
- d. Lack of education, misgendering, and need for more sensitivity training
- e. Misgendering in pre-operation causes distrust between the patient and the doctor.
- f. Religious trauma
- g. Religious trauma in religious hospitals
- h. Having to take care of people
- i. I get misgendered all the time in Boston

b. What change would make you feel more welcome?

- a. Increased sensitivity training education for doctors so there's no assumptions
- b. Need to include more education in the rapid nursing program. I went for two years, full time, and they had no LGBT curriculum built into the program. That is concerning; exposure is an important step.

c. More folks that are trans in healthcare. I don't have trust in cisgender white doctors. Remove the barriers for trans people to become doctors. Provide better pay, better insurance, and student loan paybacks; that's why these hospitals aren't able to maintain a diverse workforce.

Question 4

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

- a. What resources do you rely on for healthcare?
 - a. Abby's house in Worcester, APW [AIDS Project Worcester], good resources for trans women, and Trans Emergency Fund (TEF)
 - b. TEF, Mass Trans Political Coalition for name changes and document changes
 - c. The struggle is always organizations that have spaces to just hangout and create community, in JP there's the meeting point, third spaces are difficult to find

b. What resources do you think are missing that would improve care and access?

- a. Space. It is hard finding spaces that people can use and just pop into that's what we're dealing with at TEF. There's also insurance issues, and the more complicated things like safety, accessibility, and alternative modes of transportation
- b. More resources for HIV+ trans people, there's a huge lack right now. Places like APW and Victory Programs help, but there's not really a lot of trans and nonbinary HIV+ safe places and finding HIV+ community, especially for trans women of color, is really really hard in Massachusetts
- c. More sober third spaces, a lot revolves around alcohol; more queer cafes and bookshops and open spaces. Spaces like the library, leather dyke community and queer space; we want more queer owned thrift spaces and bookshops

Question 5

Is there anything we did not ask you about, that you were hoping to discuss today?

Are there community health issues in your community that we didn't identify?

Are there any other types of resources or supports you'd like to see available in your community?

- This is about the report for the community fund, at TEF housing is a huge concern and shelters. There is a huge lack of shelter spaces for trans folks, they can't access health care, and have a hard time maintaining continuity/ Once you reach 25 and up the support just stops, there is a huge gap of support that is missing
- We need more funding from the state for organizations like TEF and United Way in Worcester. It
 would be nice to see more funding for trans organizations and even trans shelters; a lot of trans
 people don't feel safe going to run of the mill shelters. It's hard to place gender nonconforming
 people. Three years ago at TEF we all sat down with the Mayor and said, 'this is what we need'
 and the city hasn't come through

- It all goes together with housing. The Healey administration cut HIV and harm reduction funding, so Aids Action got shut down, the acupuncture clinic at [LGBTQIA+ health center] shut down, and wraparound services. I was a housing manager for folks with HIV, and saw funds that could have been used for these programs vanish; it took away support for queer folks and caused a lot of queer folks to also lose their jobs. When the numbers go down it isn't a time to take away funding, because the numbers will just start to rise again.
- We used to have lobbying days and we used to be great at keeping funding, but HIV funding has been cut and mental health funding has been cut. It affects trans and nonbinary people greatly who already struggle to find adequate care. There are no providers because there's no funding.
- I would love to see a trans lobby day at the state house, a spin-off of HIV lobby day, and hopefully get more funding, (wants more trans support and community)
- Trans people are tired; cis people need to stand up. Being able to get funding while centering trans folks is important; there are so many different issues and with the new administration coming in January it's going to get worse
- Making sure the funding is going straight to the organizations, that things aren't super onerous, money going direct to the organizations so they can use it for whatever's best

Beth Israel Deaconess Medical Center Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Adults Living with a Disability

Location: Zoom

Date, time: 12/12/2024

Facilitator: JSI

Language: English and American Sign Language

Approximate number of participants: 8

Question 1

Think about your experiences getting the health care resources that you need. Health care is defined broadly, including primary care, behavioral health care, specialty care, and dental care.

- a. Have you experienced barriers to getting the care you need, when and where you want it? If so, can you describe those barriers?
 - i. Accessibility
 - One participant, who is a manual wheelchair user, shared that it is difficult to access many offices including primary care, behavioral health offices, dental offices, and even spaces within hospitals. There is a lack of accessible exam tables, and an attitude of not understanding why the patient would want or need these resources.
 - a. A participant also shared that it does not feel appropriate or welcoming to be in a space where there is no exam table for them to use. This sets a bad tone for the rest of the appointment.
 - b. A participant also shared that they had an experience with [academic medical center] and noted the lack of masking from providers. The participant scheduled (months in advance) a private room for a breathing test and masks were not worn. They [the staff] were dismissive of their concern and their specific request.
 - c. Another participant, who uses a power wheelchair, said that "even some of the accessibility accommodations that they [providers] make aren't necessarily adequate." The participant also shared: "I am left feeling like I am more of a problem than a patient. There is a feeling that you're more of a burden and a problem for someone to solve."
 - d. One participant wondered why accommodations are such a problem for providers and facilities. "Is it because they can't get it [accommodations], can't afford it, or is it because they don't know where to store it?"

- 2. Another participant had to leave their long-term primary care provider office because the practice changed policies; they announced that they would no longer be able to assist the participant or others with physical assistance getting on and off exam tables. This delayed care and diagnostic testing, since the participant had to find a new provider, and they had to secure their own person to accompany them to appointments for assistance.
 - a. The participant also shared that in their new practice, they've been affected by staff turnover. The shortage of primary care providers is a barrier to care.
- A participant underscored (and others agreed) that lack of accessibility not only happens in doctor's offices/primary care, but also in hospitals and other settings.
 - a. The participant shared that they've transferred to another health system where things have gotten better. "The simple ask of what my needs might be made me feel good." I would like to see more forward thinking and anticipating needs in advance of appointments.
- 4. A participant shared that there have been times that they've been asked about accommodations in advance of an appointment, but this typically only happens in specialty care settings that are more well-versed in caring for people with disabilities.
- 5. It feels as if there is a lack of planning and preparation on the part of the provider
- 6. One participant shared that the only time they've been weighed is when they've been admitted to the hospital; their regular doctors' office does not have the necessary equipment. This participant also reported having to bring their own medical supplies to hospital stays, since hospitals are not equipped with items that they need.

ii. Disrespect/DIsmissiveness

- 1. A participant detailed an experience of going to the emergency room. Upon arrival, the participant was told that they could be admitted under observation and/or that they could be admitted to a nursing home. This was done before the participant had been examined or given any sort of diagnosis. The staff at the emergency room said they could see that the participant was having difficulty, so sending them to a nursing home was an option. The participant said that when they pushed back, the clinician mentioned a condition that they had for many decades; the participant had to clarify that it wasn't what they were there for. This delayed them in getting the care that they needed/wanted.
 - a. "I think when you present with a disability, even though they [the provider] has access to records, it's faster for them to send you to somebody else."

- b. Several participants shared instances of when providers made assumptions about their health status, their abilities, and about their wants/needs based on experiences with others who have a similar diagnosis or disability, instead of regarding each person as an individual.
- 2. Many participants agreed that clinicians and staff are often not welcoming or kind. This has happened in all care settings, from primary care, to hospitals, to outpatient settings.
- 3. One participant said that they wished there was more collaboration between the provider and the patient. "I've spent 43 years with my disability. They act as if, 'I'm the doctor, so I know what I'm talking about.' They don't really understand how my disability affects my body. I don't get to put my body away – I've had to deal with it every second of my whole life."

iii. Other Barriers

- One participant shared feedback about The Ride (transportation service)
 The need to schedule ahead of time can be problematic. There are often long wait times once you get to an office or an appointment, and the participant has experienced negative attitudes from drivers and lack of flexibility around timing.
- 2. It is difficult to find dental providers that accept MassHealth
- 3. Calling medical providers can be hit or miss; sometimes patients experience long wait times.

Question 2

- a. If you could provide specific recommendations to providers about how to better care and improve care experiences for individuals living with disabilities, what would those recommendations be?
 - a. Provider Education
 - Many participants agreed that there is a significant need for more provider education, specifically around how to communicate and treat individuals living with disabilities
 - ii. There is also a need for more education about specific conditions. Participants reported that there have been instances where the provider does not seem educated or knowledgeable about their condition, which erodes trust.
 - Participants also reported that this extends beyond physicians to include support and front-line staff in medical facilities
 - **b.** Make Spaces More Accessible
 - i. Several participants agreed that there need to be efforts to make exam rooms and medical equipment more accessible

c. Ask Questions

- Many participants shared a similar sentiment; asking about needs and wants before an appointment goes a long way in helping patients feel more comfortable and trusting of their provider.
 - 1. "Instead of assuming, ask questions about what I need."
 - 2. "Be more proactive rather than reactive."

d. Wait Times and Access to Care

- i. Acknowledgement that there is a shortage of primary care physicians, but your primary care physician is rarely available in an acute situation, which causes stress and may delay care
- ii. It's helpful to be with your primary care physician who knows about you and your condition

e. Other Items

- i. More knowledge about getting and fixing wheelchairs
- ii. Fax accuracy

Question 3

a. Are there other barriers, concerns, and experiences we haven't discussed?

- a. A participant had difficulty finding accessible mammograms; but has finally found someone who "moves around you, rather than expecting your body to move around them." This participant detailed experiences with clinicians where they can't understand why you can't move into positions or spacing that they're asking you to move into. This underscores the need for more accessible equipment and provider education
- b. Advocating for hospitals to keep providing telehealth options; hoping that institutions are advocating strongly that these services continue.
- c. A participant reported a negative experience at an academic medical center. The staff had bad attitudes, there were accessibility issues (almost 24 hours until they had access to their wheelchair), and there was no reassurance from providers. They also had prescribed medication withheld. This experience has made them not want to get care there in the future
- d. Insurance barriers. One participant explained that their insurance only covers specialty doctors, but does not cover their primary care physician. This limits their ability to get the care they need.

Community Listening Sessions

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



JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

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

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

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

Goals:

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



BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

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

Participants will be asked to:

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

ROLE OF COMMUNITY FACILITATOR



Establish ground rules



Initiate and guide discussion



Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

JSI will email your event-specific guide 2 days prior to event date Provides a "script" for the questions you'll ask in the Breakout Sessions

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

LET'S REVIEW.



CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Authentic



Enthusiastic

Patient



Active listener



INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish group agreements

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

Identify ways to make people feel welcomed

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

Consider accessibility

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

CREATING INCLUSIVE SPACE

move at the speed of trust

THANK YOU!

Feel free to send in any questions to Madison maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

Session name, date, time: [filled in before session]
Community Facilitator: [filled in before session]

Notetaker: [filled in before session]

Mentimeter link: [filled in before session]

Miro board: [filled in before session]

Ground rules and introductions (5 minutes)

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

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

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

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

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

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

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

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

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

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

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

BILH Community Listening Session 2025: Breakout Discussion Guide

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

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

Notetakers will be taking notes within Google Slides.

Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Priority Area 2: Access to Care (12 minutes)

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

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

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

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

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

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

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

Notetakers will be taking notes within Google Slides.

Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

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

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

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

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

BILH Community Listening Session 2025: Breakout Discussion Guide

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

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

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

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

Notetakers will be taking notes within Google Slides.

Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

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

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

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

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

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

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

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

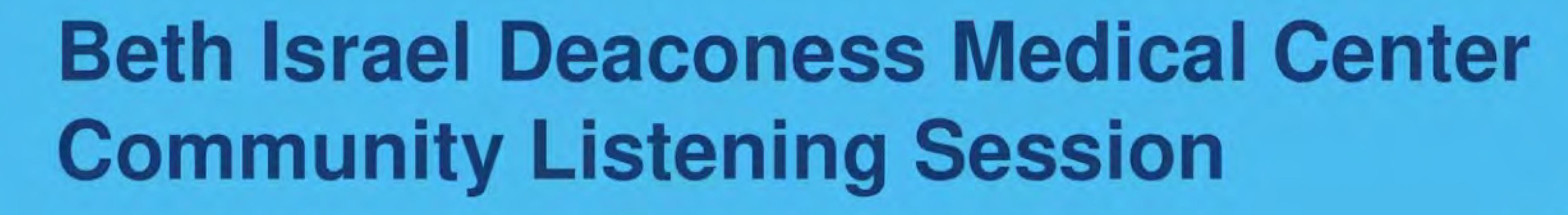
• **Possible probes (if needed):** Are there already programs in your community that are working to address these issues? Have they been effective (why or why not?)

Notetakers will be taking notes within Google Slides.

Meeting Host will give groups a 2-minute warning before moving to the next section, and another prompt on when to move on.

Wrap up (1 minute)

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



February 26, 2025 | 5:00-6:30pm



BIDMC Community Listening Session

Join a language channel / 加入語言頻道

1. Find Interpretation or Language icon on your Zoom toolbar /在 Zoom 工具列上尋找口譯或語言圖標



- 2. Choose your preferred language / 選擇您的首選語言
- 3. Mute original audio to only hear the interpreted audio 將原始音頻靜音以僅聽到解釋後的音頻







BIDMC Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
5:00-5:05	Zoom orientation and Welcome	JSI
5:05-5:10	Overview of assessment purpose, process, and guiding principles	Anna Spier, Community Benefits & Community Relations Manager, BIDMC
5:10-5:25	Presentation of preliminary themes and data findings	JSI
5:25-5:30	Transition to Breakout Groups	JSI
5:30-6:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
6:25-6:30	Wrap up and Next Steps	Anna Spier

Assessment Purpose and Process

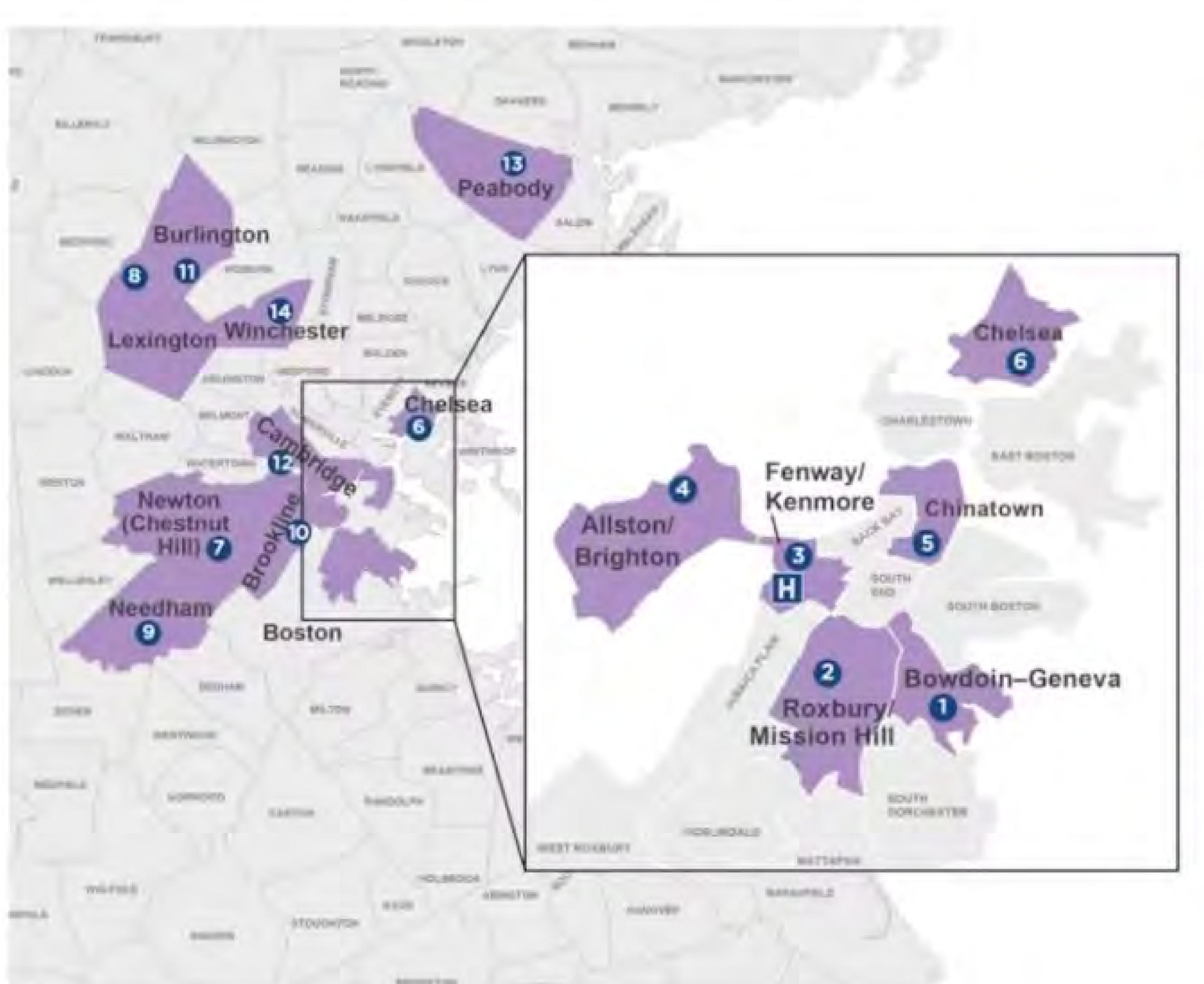
Assessment Purpose and Process

Purpose

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

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

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



Beth Israel Lahey Health

Beth Israel Deaconess Medical Center

Community Benefits Service Area

- Beth Israel Deaconess Medical Center and Joslin Diabetes Center
- Bowdoin Street Health Center
- The Dimock Center
- Fenway Health
- Charles River Community Health
- South Cove Community Health Center
- Beth Israel Deaconess Healthcare-Chelsea
- Beth Israel Deaconess Healthcare-Chestnut Hill
- Beth Israel Deaconess Healthcare-Lexington
- BIDMC Cancer Center
- BIDMC Pain Center
- BIDMC Infusion Services
 at Lahey Hospital and Medical Center
- BIDMC Infusion Services at Mount Auburn Hospital
- at Lahey Medical Center Peabody
- BIDMC Infusion Services at Winchester Hospital

Community Benefits and Community Relations Guiding Principles





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



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



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

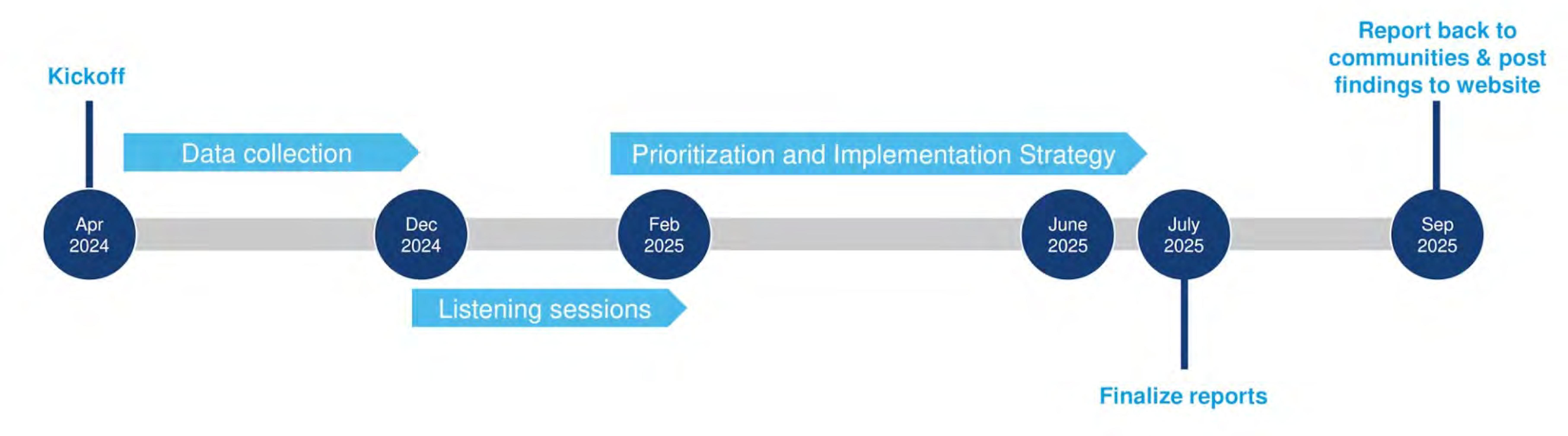


Impact: Employ evidence-based and evidence-informed strategies that align with system and community priorities to drive measurable change in health outcomes.

1

Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process

Meeting goals

Goals:

- Conduct listening sessions that are interactive, inclusive, participatory and reflective of the populations served by BIDMC
- 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

Key Themes & Data Findings

Activities to date

Collection of secondary data, e.g.:

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



5 Interviews



FY25 BIDMC Community
Health Survey Respondents
(includes data from BCHC, CHA,
Tufts, and North Suffolk Public

Health Collaborative)



Focus Groups

- Spanish-speaking Young Adults (La Colaborativa)
- Newly arrived families from Haiti (Association of Haitian Women in Boston)
- Cape Verdean Speakers (Cape Verdean Association of Boston)
- Adults with Disabilities (Boston Center for Independent Living)
- Transgender and non-binary residents (Transgender Emergency Fund)

FY25 Community Health Survey Responses

2,296 responses

(Includes responses from BILH, CHA, Tufts, and BCHC Surveys)



19% of respondents report a language other than English as the primary language spoken in their home



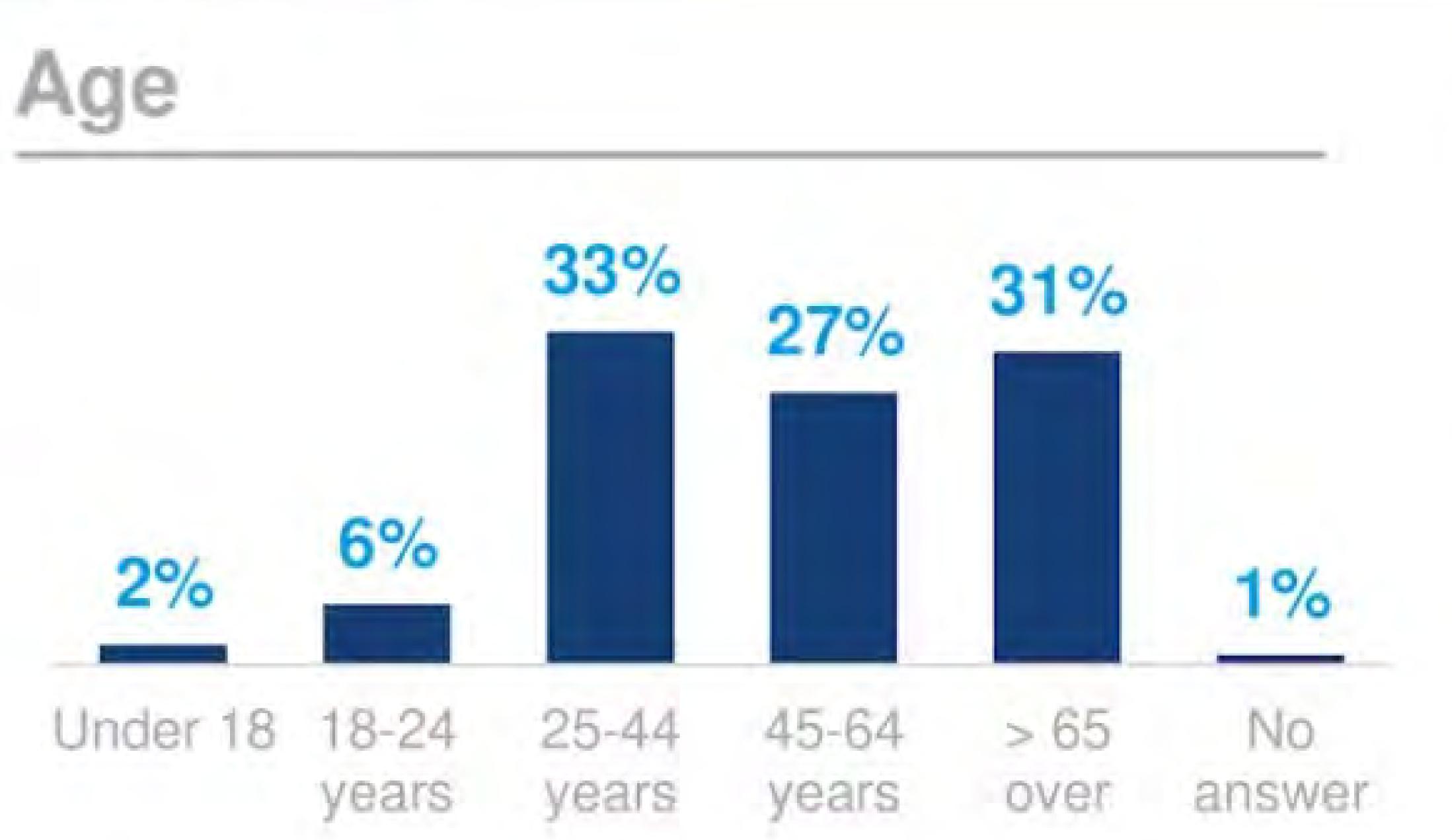
72% of the respondents are women

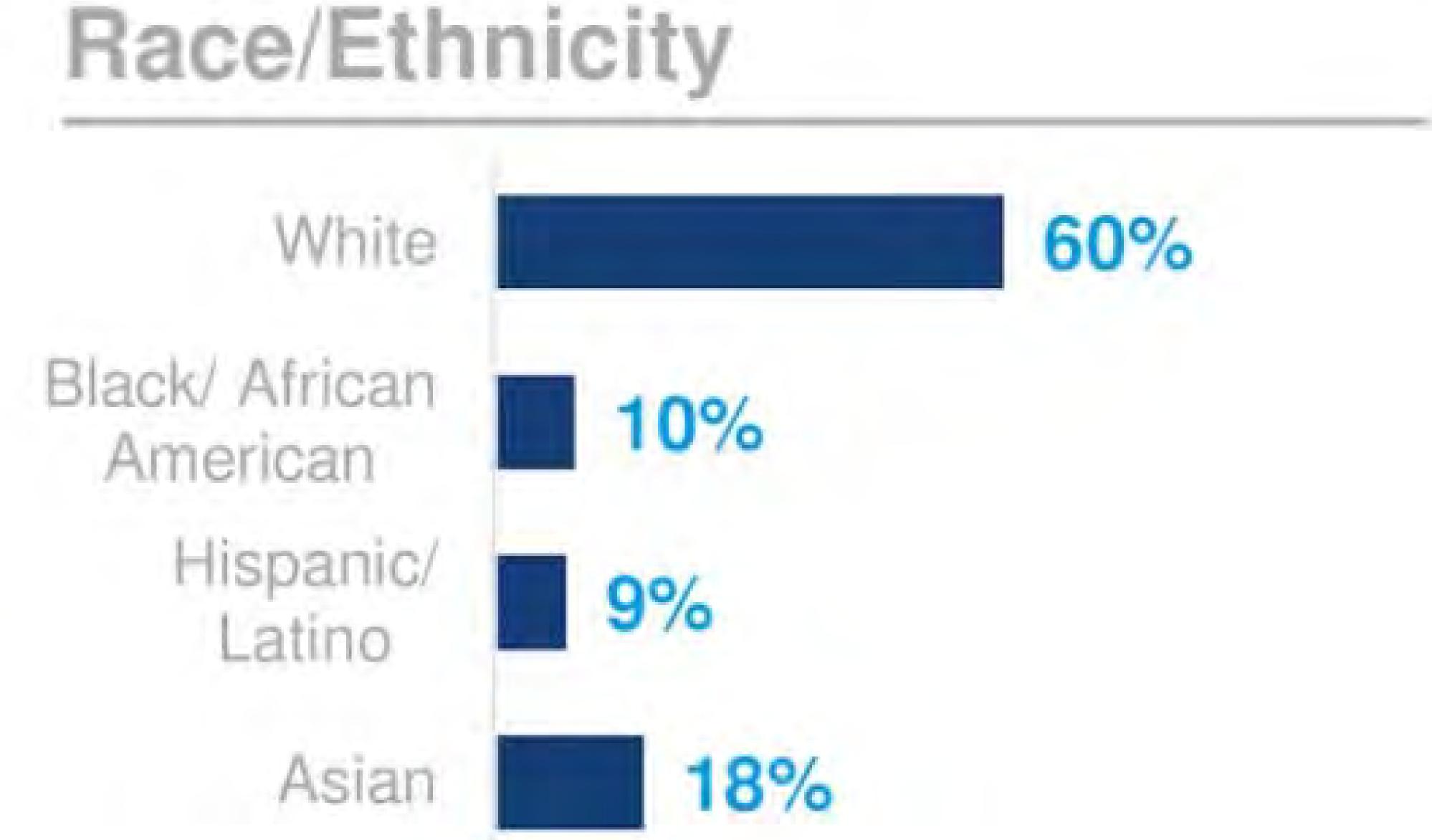


16% of the respondents identify as having a disability



11% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning





Collaboration

Established data sharing agreements with the Boston Community Health Collaborative, North Suffolk Public Health Collaborative, Tufts Medical Center, Cambridge Health Alliance to get robust and representative survey results

Community Benefits Service Area Strengths

FROM INTERVIEWS & FOCUS GROUPS:

- Boston's neighborhoods are rich in resources
- Immigrants enhance the diversity and character of Boston's neighborhoods
- There are many successful community health and social support programs that can be expanded and replicated throughout the city

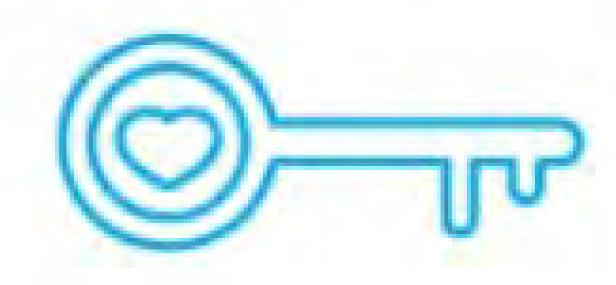
FROM FY25 BIDMC COMMUNITY HEALTH SURVEY:



Preliminary priorities and key themes



Social Determinants of Health



Equitable Access to Care



Mental Health and Substance Use



Complex and Chronic Conditions

Interviews and survey results show that community health concerns remained remarkably consistent between FY22 and FY25, with the same 4 categories emerging as the preliminary priority areas. Information from focus groups reinforced findings from interviews and survey results.

Social Determinants of Health

Primary concerns:

- Housing issues (displacement, affordability, homelessness)
- Economic insecurity and high cost of living
- Access to healthy and affordable food
- Transportation
- Community safety
- Environmental health issues
- Racism and discrimination



24% (26% Boston/Chelsea) of Community Health Survey respondents identified environmental issues, like air quality, traffic, and noise as a health issue that matters most in their community



When asked what they'd like to improve in their community, 48% (44% Boston/Chelsea) of FY25 Community Health Survey respondents reported more affordable housing (#1 response)



43% of Boston and Chelsea respondents to the FY25 Community Health Survey respondents selected better access to healthy food as something they'd like to improve in their community



33% (26% for Boston/Chelsea) of FY25 Community
Health Survey respondents selected better access to
public transportation as something they'd like to improve
in their community

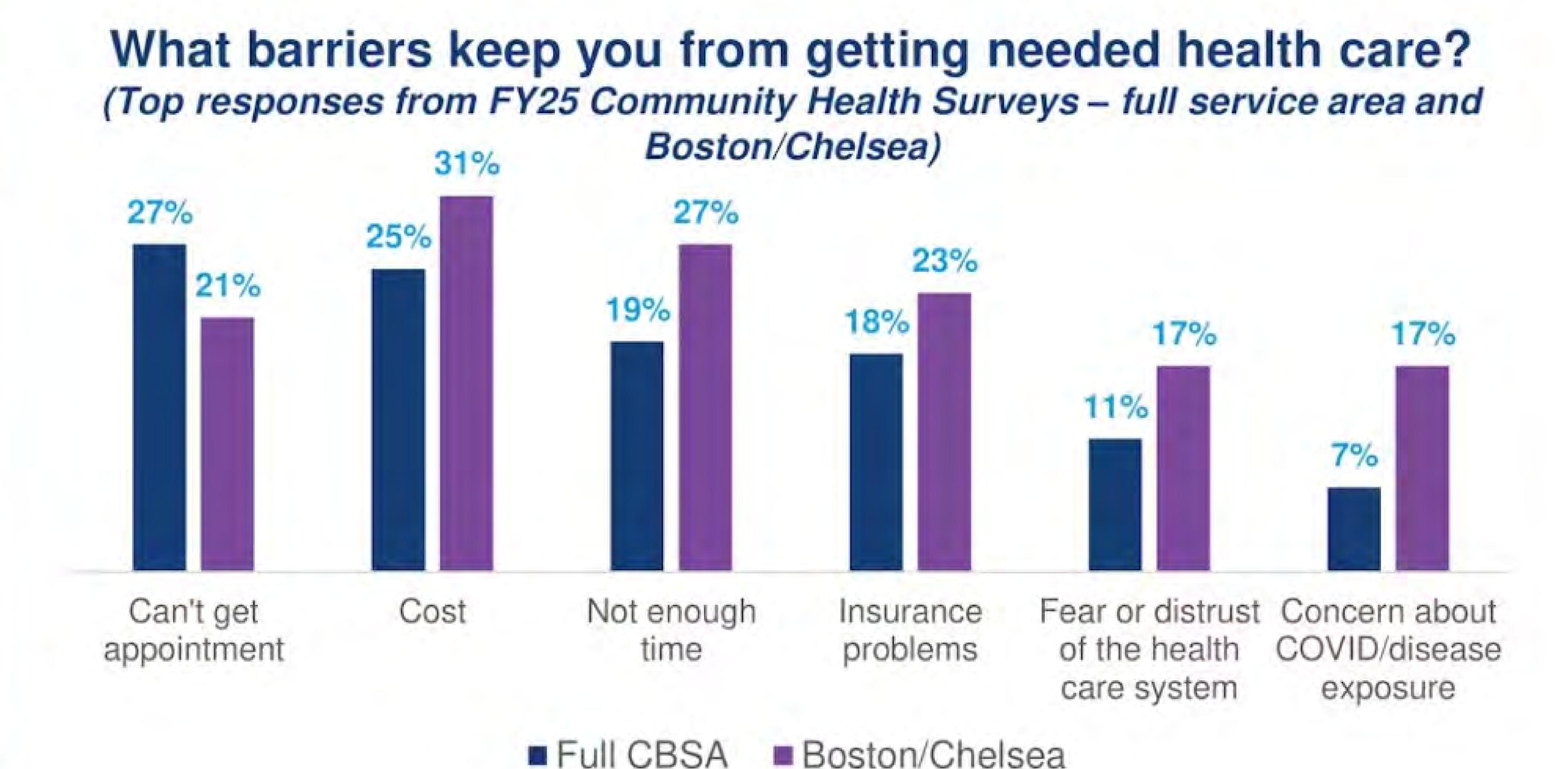
"Economic insecurity and the wealth gap is absolutely a leading issue. Housing and food insecurity are important, but employment, jobs and livable wages are critical."

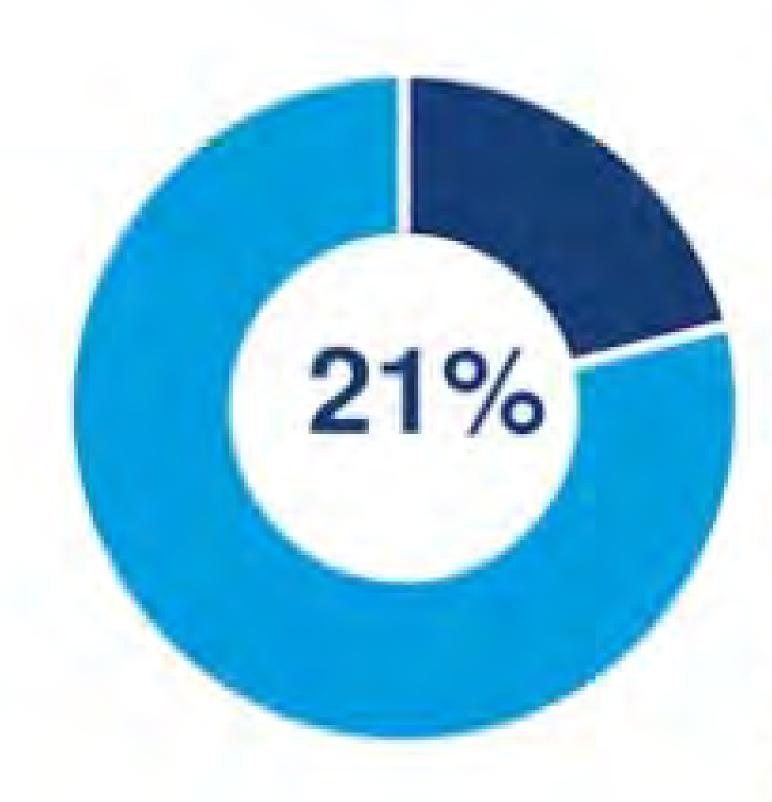
- Interviewee

Preliminary Themes: Equitable Access to Care

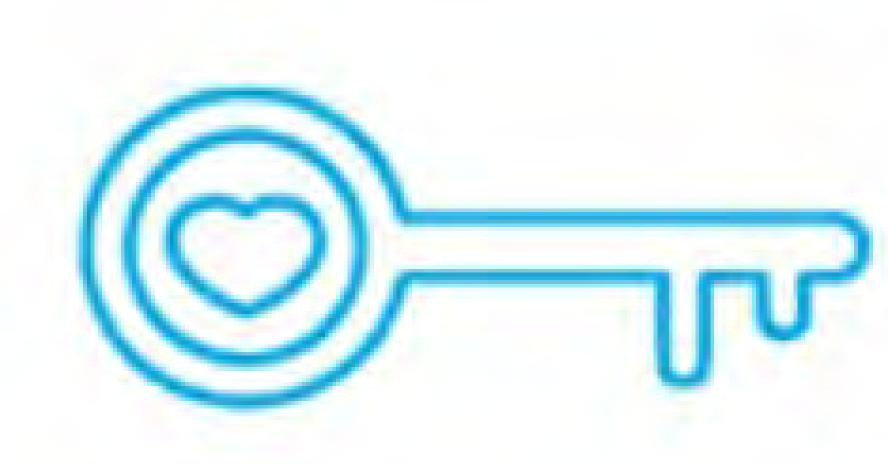
Primary concerns:

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





21% (22% Boston/Chelsea) of FY25 Community Health Survey respondents said health care does not meet the physical health needs in their community



"Cultural competency and responsiveness is really important. For example, not all Hispanic or Latino populations have the same needs. Health education is also an issue – education needs to be tailored to culture."

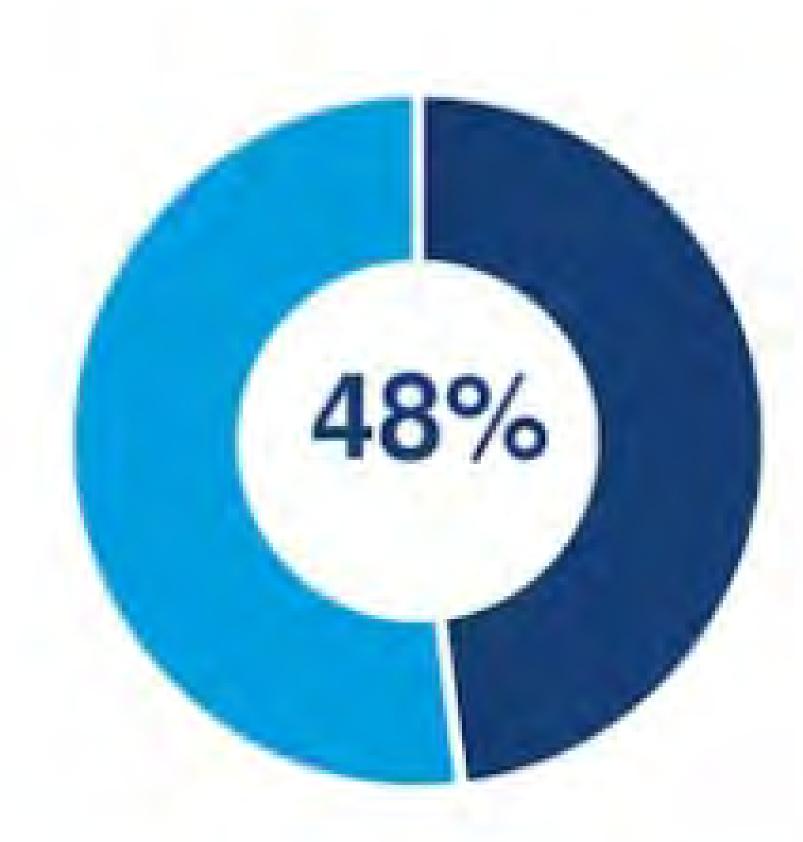
- Interviewee

Preliminary Themes: Mental Health and Substance Use

Primary Concerns:

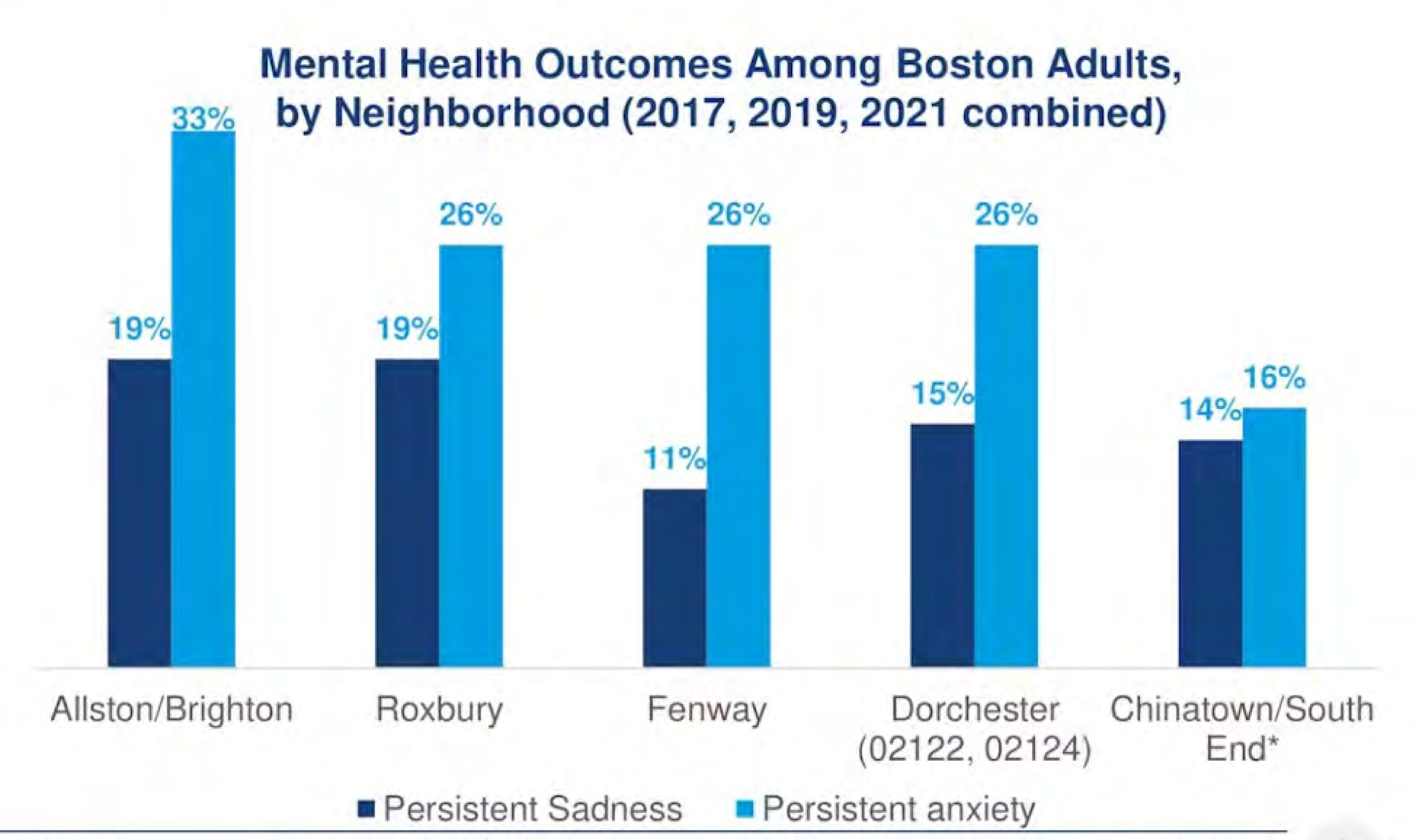
- Youth mental health
- Depression, anxiety, and stress
- Support for individuals with substance use disorder
- Social isolation among older adults
- Language and cultural barriers to care
- Navigating the behavioral health system
- Trauma among migrants, immigrants, and refugees

AMONG FY25 COMMUNITY HEALTH SURVEY RESPONDENTS:



48% (42% Boston/Chelsea) identified mental health as a heath issue that matters most in their community (#1 response)

44% of Boston Public High School students reported that they felt sad or hopeless every day for two weeks or more sometime in the past 12 months. Percentages were higher among students who identified as female (47%) and LGBQ+ (67%) (2017, 2019, 2021 combined)

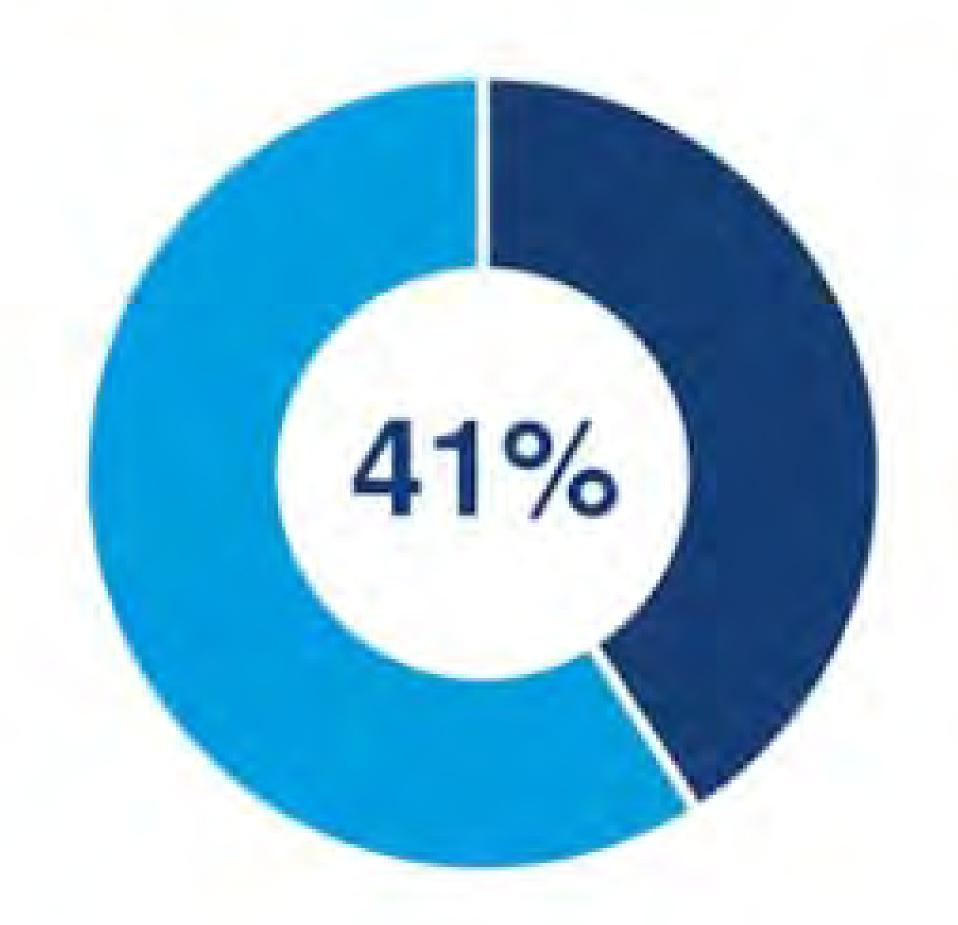


Preliminary Themes: Complex and Chronic Conditions

Primary Concerns:

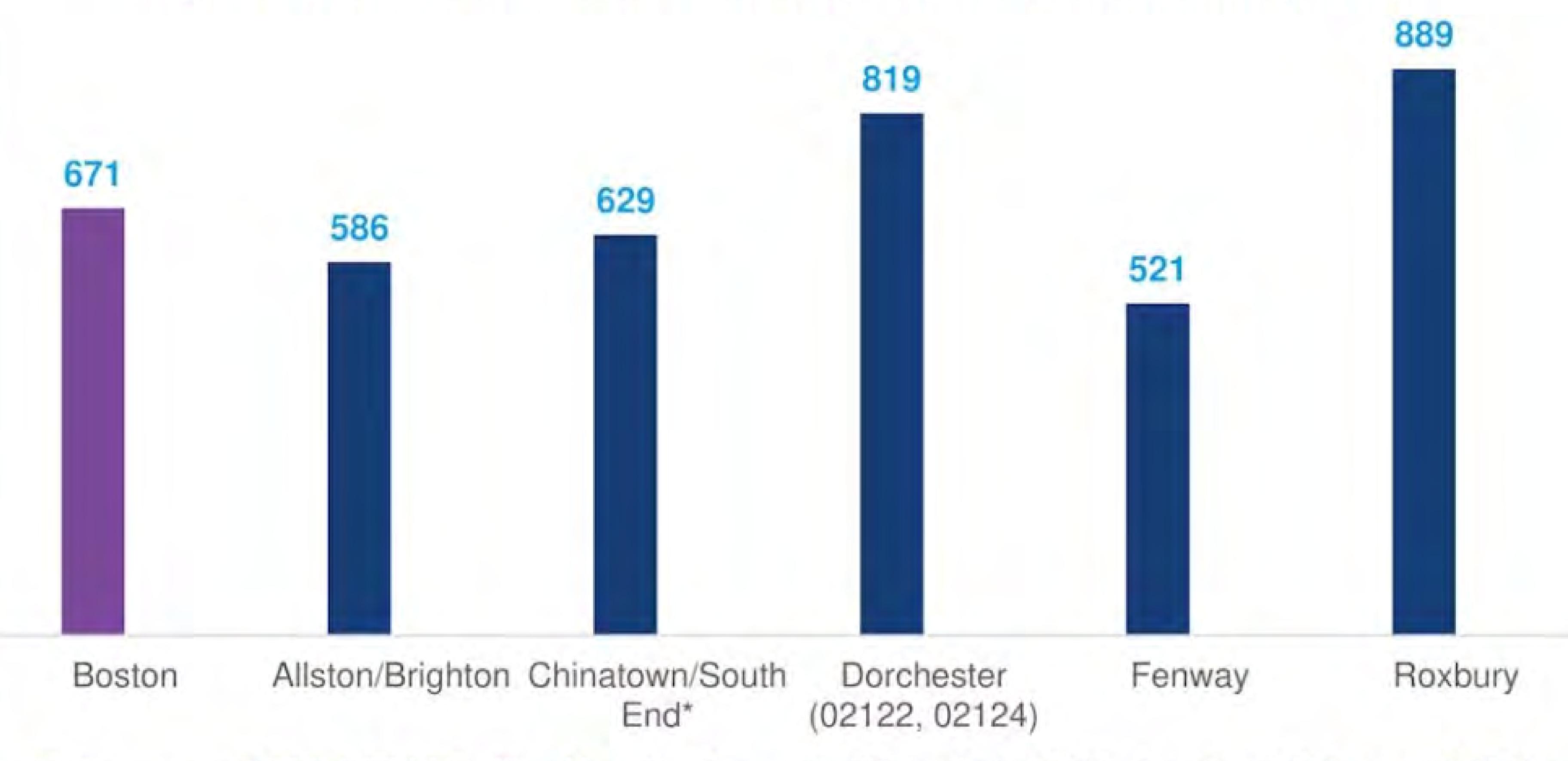
- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Education/prevention around chronic disease risk factors (e.g., healthy eating, active living)
- Care navigation and management

AMONG FY25 COMMUNITY HEALTH SURVEY RESPONDENTS:



41% (35% for Boston/Chelsea)
identified aging issues (e.g.,
arthritis, falls, hearing/vision loss)
as a heath issue that matters most
in their community

Age-Adjusted All-Cause Mortality, by Neighborhood (2021)



Data source: 2023-2024 Health of Boston Report | *Note that BPHC denotes 02111 and 02118 as "South End"

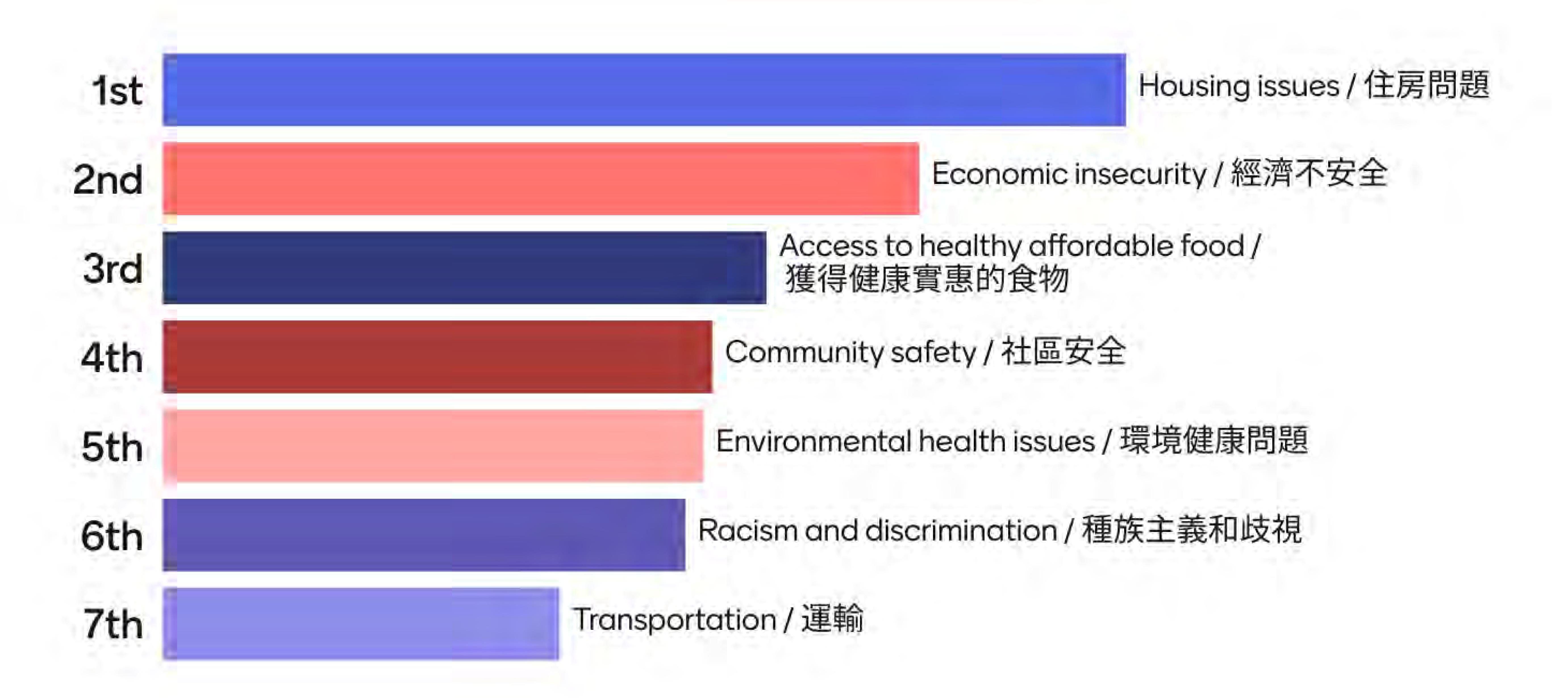
"When people came to this country ten years ago, they were healthy. Now they are unhealthy. We are seeing high rates of diabetes, obesity, and high blood pressure." -Interviewee

Instructions

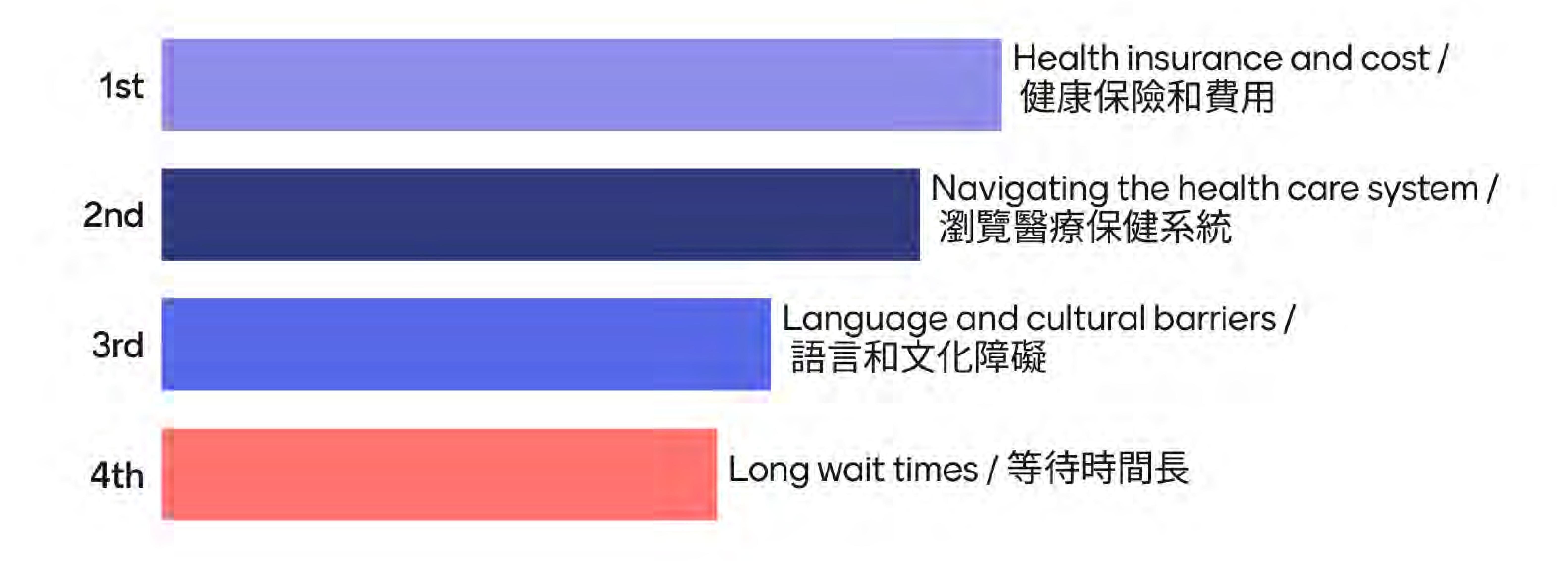




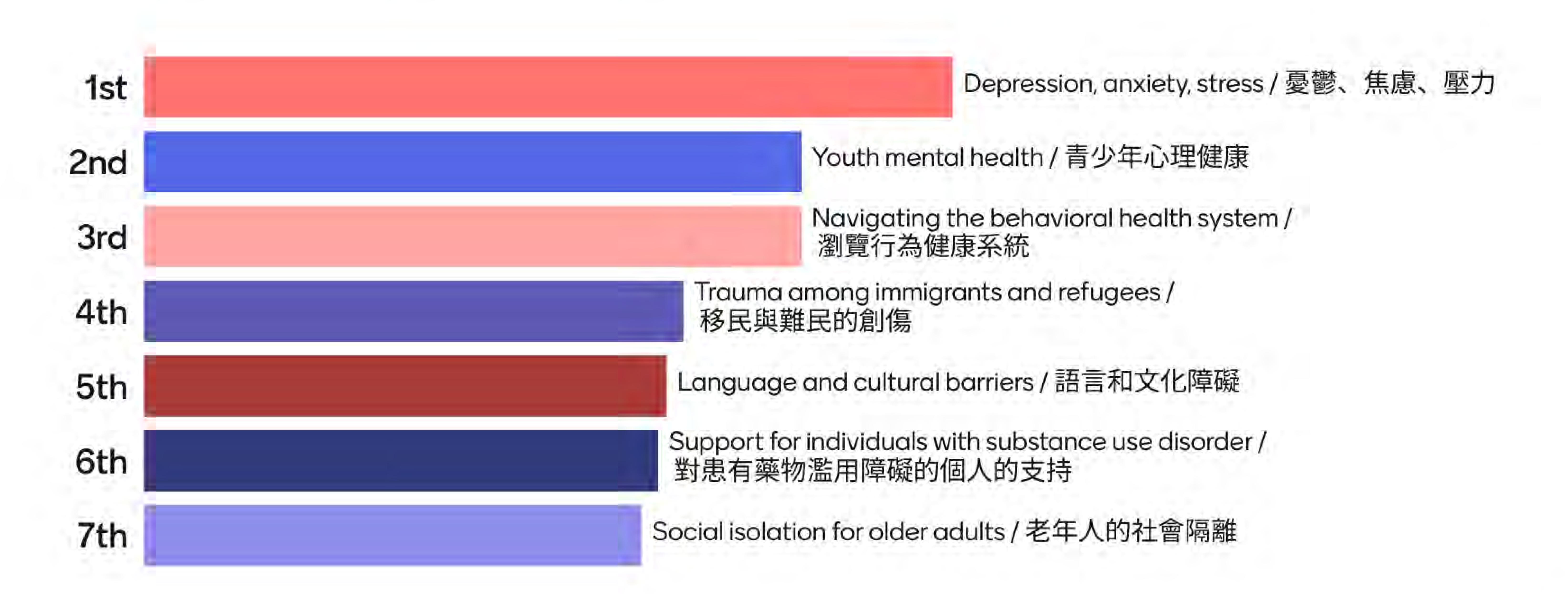
Social Determinants: Rank the following in order of what you feel should be the highest priority, based on needs in your community



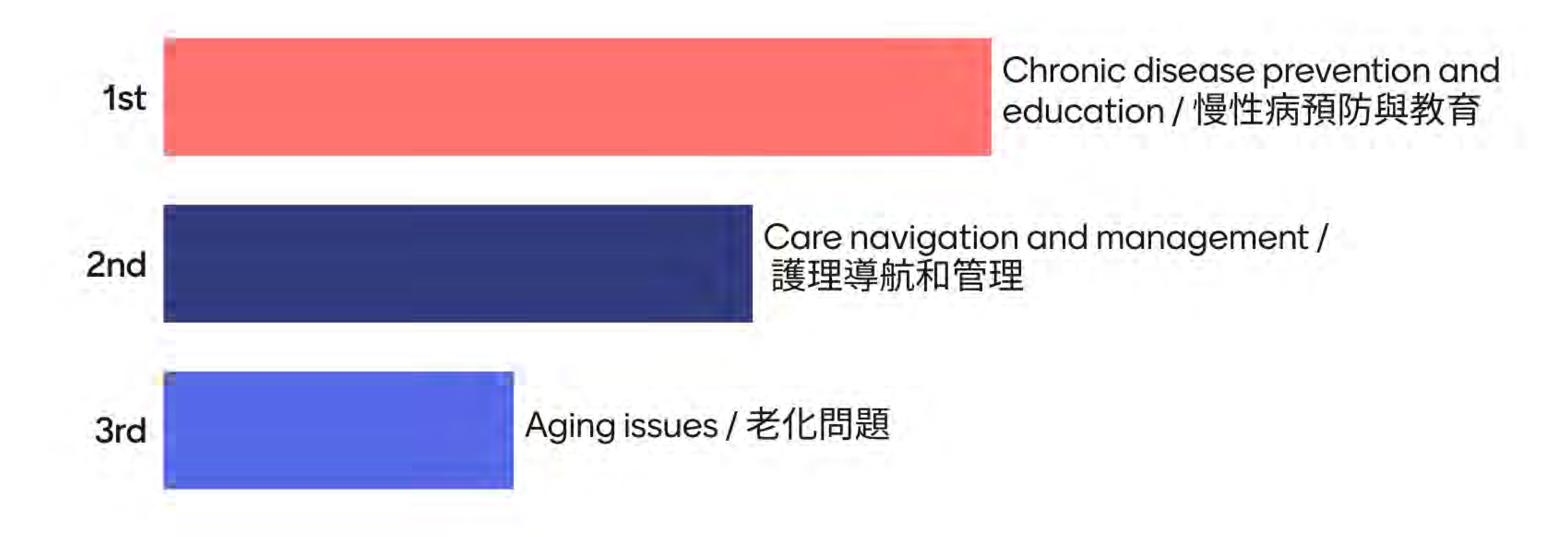
Equitable Access to Care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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



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



Breakout Sessions

Reconvene

Next Steps

Anna Spier

Manager, Community Benefits and Community Relations | BIDMC

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Community Health and Community Benefits Information on Website:

https://www.bidmc.org/about-bidmc/helping-our-community/community-initiatives/community-benefits

Community Benefits Annual Meeting on September 17th

Appendix B: Data Book

Secondary Data

Demographics

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

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

							Areas o	of Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Population									
Total population	6992395	807258	1622896	724540	782172	663972	62822	26223	117794
Male	48.9%	48.6%	49.4%	48.5%	48.3%	48.1%	46.0%	48.2%	49.9%
Female	51.1%	51.4%	50.6%	51.5%	51.7%	51.9%	54.0%	51.8%	50.1%
Age Distribution									
Under 5 years (%)	5.0%	5.4%	5.1%	5.2%	4.9%	4.6%	5.3%	4.8%	4.0%
5 to 9 years	5.2%	5.6%	5.4%	5.5%	4.1%	3.8%	4.9%	6.5%	3.4%
10 to 14 years	5.7%	6.2%	5.6%	6.1%	4.6%	4.4%	6.0%	4.9%	2.9%
15 to 19 years	6.5%	6.4%	6.3%	6.4%	6.9%	7.1%	4.6%	4.0%	7.5%
20 to 24 years	6.8%	6.2%	6.8%	6.1%	9.1%	9.9%	10.9%	5.7%	14.8%
25 to 34 years	14.1%	12.5%	15.1%	12.9%	22.5%	23.5%	18.2%	10.3%	26.9%
35 to 44 years	12.9%	12.6%	13.8%	13.2%	13.6%	13.3%	13.2%	14.0%	12.9%
45 to 54 years	12.6%	12.8%	12.8%	13.3%	10.7%	10.2%	11.2%	13.6%	7.9%
55 to 59 years	7.0%	7.3%	6.8%	7.3%	5.5%	5.5%	5.3%	7.9%	3.7%
60 to 64 years	6.8%	7.0%	6.2%	6.7%	5.2%	5.0%	4.9%	7.0%	3.8%
65 to 74 years	10.3%	10.7%	9.3%	10.0%	7.7%	7.6%	8.3%	10.8%	7.5%
75 to 84 years	4.9%	5.0%	4.6%	4.9%	3.5%	3.4%	5.3%	6.8%	3.4%
85 years and over	2.2%	2.4%	2.1%	2.4%	1.8%	1.7%	1.8%	4.0%	1.3%
Under 18 years of age	19.6%	21.0%	19.6%	20.7%	16.2%	15.2%	19.3%	17.9%	12.3%
Over 65 years of age	17.5%	18.0%	16.0%	17.4%	13.0%	12.7%	15.4%	21.5%	12.2%

							Areas o	f Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Race/Ethnicity									
White alone (%)	70.70%	70.3%	69.0%	71.4%	48.1%	47.8%	67.7%	76.5%	57.5%
Black or African American alone (%)	7.0%	4.1%	5.0%	7.2%	19.1%	21.5%	3.1%	2.5%	10.5%
American Indian and Alaska Native (%)									
alone	0.2%	0.3%	0.2%	0.1%	0.4%	0.3%	0.2%	0.0%	0.1%
Asian alone (%)	7.1%	3.5%	13.2%	12.1%	9.0%	10.0%	17.7%	13.5%	19.7%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Some Other Race alone (%)	5.4%	12.1%	4.2%	2.3%	7.8%	7.1%	1.8%	1.5%	2.5%
Two or More Races (%)	9.5%	9.7%	8.4%	6.8%	15.5%	13.2%	9.7%	5.9%	9.6%
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	5.5%	22.8%	18.9%	6.0%	4.3%	9.0%
Foreign-born									
Foreign-born population	1,236,518	151,560	366,954	138,392	230,245	182,633	17,300	4,790	33,920
Naturalized U.S. citizen	54.5%	56.4%	51.0%	60.1%	50.3%	53.2%	43.4%	59.8%	40.4%
Not a U.S. citizen	45.5%	43.6%	49.0%	39.9%	49.7%	46.8%	56.6%	40.2%	59.6%
Region of birth: Europe	18.1%	13.4%	16.9%	20.0%	10.9%	11.0%	26.5%	18.8%	20.5%
Region of birth: Asia	30.5%	14.5%	42.9%	47.6%	23.9%	28.2%	55.8%	61.5%	47.2%
Region of birth: Africa	9.5%	5.5%	7.6%	7.3%	10.4%	11.1%	3.8%	6.2%	9.8%
Region of birth: Oceania	0.3%	0.2%	0.5%	0.3%	0.2%	0.3%	0.2%	2.2%	1.2%
Region of birth: Latin America	39.4%	64.4%	29.7%	22.8%	53.1%	47.8%	10.0%	8.4%	18.2%
Region of birth: Northern America	2.2%	2.0%	2.4%	2.0%	1.4%	1.6%	3.7%	3.0%	3.2%
Language									
English only	75.2%	71.6%	71.7%	77.0%	61.6%	64.8%	69.6%	80.5%	65.8%
Language other than English	24.8%	28.4%	28.3%	23.0%	38.4%	35.2%	30.4%	19.5%	34.2%
Speak English less than "very well"	9.7%	12.2%	9.9%	8.4%	17.9%	15.5%	7.3%	4.7%	7.9%

							Areas o	of Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Spanish	9.6%	18.8%	6.4%	3.5%	19.2%	15.5%	4.1%	2.3%	6.6%
Speak English less than "very well"	4.1%	8.8%	2.4%	0.9%	9.8%	7.3%	0.7%	0.8%	1.4%
Other Indo-European languages	9.2%	6.4%	12.2%	9.0%	10.1%	10.1%	11.6%	9.5%	12.0%
Speak English less than "very well"	3.2%	2.2%	4.1%	2.8%	3.9%	3.8%	2.3%	1.9%	2.6%
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	8.6%	6.5%	7.3%	10.8%	6.0%	11.5%
Speak English less than "very well"	1.9%	0.9%	2.9%	4.3%	3.5%	3.9%	3.8%	1.8%	2.5%
Other languages	1.6%	1.2%	2.0%	1.9%	2.6%	2.3%	3.8%	1.8%	4.0%
Speak English less than "very well"	0.4%	0.4%	0.5%	0.4%	0.8%	0.6%	0.6%	0.2%	1.4%
Employment									
Unemployment rate	5.1%	5.1%	4.2%	4.9%	6.2%	6.0%	3.5%	3.6%	3.4%
Unemployment rate by race/ethnicity									
White alone	4.5%	4.3%	4.0%	4.6%	4.4%	4.1%	3.4%	3.5%	3.0%
Black or African American alone	7.9%	4.6%	6.4%	8.0%	8.6%	8.6%	10.2%	0.3%	6.2%
American Indian and Alaska Native									
alone	6.9%	1.8%	5.5%	16.0%	7.6%	10.4%	0.0%	0.0%	23.5%
Asian alone	4.0%	3.3%	3.5%	4.1%	4.7%	4.7%	3.6%	3.3%	2.9%
Native Hawaiian and Other Pacific									
Islander alone	4.8%	0.0%	10.9%	0.0%	0.0%	0.0%	-	0.0%	0.0%
Some other race alone	8.0%	7.9%	6.4%	6.1%	10.4%	11.1%	4.8%	0.0%	3.9%
Two or more races	7.9%	8.6%	5.4%	6.2%	8.9%	8.3%	2.5%	7.5%	4.4%
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	5.5%	9.6%	9.4%	3.9%	7.3%	7.8%
Unemployment rate by educational attain									
Less than high school graduate	9.1%	10.0%	8.1%	7.5%	10.6%	9.7%	5.4%	0.0%	20.8%
High school graduate (includes									
equivalency)	6.4%	5.3%	5.9%	7.1%	8.7%	9.2%	18.5%	6.5%	8.3%
Some college or associate's degree	5.2%	4.8%	4.9%	5.1%	7.6%	8.1%	3.8%	5.6%	5.3%
Bachelor's degree or higher	2.7%	3.1%	2.7%	2.6%	2.9%	2.9%	2.6%	1.2%	2.3%

							Areas o	of Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Income and Poverty									
Median household income (dollars)	101,341	99,431	126,779	126,497	92,859	94,755	140,631	142,207	126,469
Population living below the federal pove	erty line in the last								
12 months									
Individuals	10.0%	9.4%	7.5%	6.6%	16.5%	16.9%	9.8%	5.6%	12.4%
Families	6.6%	4.4%	6.7%	4.7%	4.6%	3.3%	4.7%	2.0%	2.7%
Individuals under 18 years of age	11.8%	12.1%	7.4%	5.8%	21.2%	21.8%	4.9%	4.9%	14.2%
Individuals over 65 years of age	10.2%	10.8%	8.6%	8.7%	20.3%	21.0%	11.6%	9.2%	10.2%
Female head of household, no spouse	19.1%	18.2%	15.4%	14.9%	23.3%	23.2%	11.6%	9.2%	23.5%
White alone	7.6%	7.2%	6.0%	5.6%	11.6%	11.7%	9.0%	5.4%	8.8%
Black or African American alone	17.1%	14.1%	15.4%	11.7%	19.7%	19.8%	8.8%	25.9%	26.8%
American Indian and Alaska Native									
alone	19.1%	19.0%	12.7%	11.1%	13.1%	15.4%	0.0%	0.0%	32.9%
Asian alone	11.0%	9.3%	8.6%	8.1%	23.5%	24.3%	13.4%	2.9%	15.3%
Native Hawaiian and Other Pacific									
Islander alone	21.7%	0.0%	4.7%	40.9%	35.2%	35.2%	-	0.0%	0.0%
Some other race alone	20.1%	19.0%	14.2%	12.3%	20.9%	23.5%	18.7%	9.1%	19.1%
Two or more races	15.7%	11.1%	10.5%	7.4%	20.9%	21.2%	7.3%	4.8%	11.6%
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	9.4%	22.6%	25.3%	6.4%	6.2%	15.8%
Less than high school graduate	24.4%	22.8%	20.4%	19.5%	30.3%	33.1%	34.4%	12.8%	27.7%
High school graduate (includes									
equivalency)	12.7%	11.8%	12.1%	10.4%	19.0%	20.5%	34.5%	10.5%	24.3%
Some college, associate's degree	9.2%	8.6%	8.2%	8.2%	14.8%	15.9%	20.8%	3.6%	17.9%
Bachelor's degree or higher	4.0%	3.5%	3.4%	3.2%	6.7%	6.8%	4.2%	4.4%	6.6%
With Social Security	29.8%	31.4%	25.8%	28.6%	20.9%	19.8%	21.8%	35.1%	18.1%
With retirement income	22.9%	22.5%	20.9%	22.7%	13.7%	13.2%	17.4%	27.4%	14.6%
With Supplemental Security Income	5.6%	5.8%	3.9%	3.8%	6.5%	6.6%	2.4%	2.7%	2.9%
With cash public assistance income	3.5%	4.6%	2.8%	2.5%	3.8%	3.7%	2.0%	1.3%	2.8%
With Food Stamp/SNAP benefits in									
the past 12 months	13.8%	16.0%	8.6%	8.7%	18.7%	18.6%	6.0%	4.5%	8.1%

							Areas o	of Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Housing									
Occupied housing units	91.6%	94.9%	95.5%	95.9%	91.0%	90.7%	94.8%	95.5%	90.8%
Owner-occupied	62.6%	64.0%	61.6%	68.5%	36.6%	35.4%	46.1%	74.6%	33.7%
Renter-occupied	37.4%	36.0%	38.4%	31.5%	63.4%	64.6%	53.9%	25.4%	66.3%
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.3%	0.4%	0.4%	0.1%	0.0%	0.5%
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.7%	1.0%	1.0%	0.6%	1.3%	1.0%
No telephone service available	0.8%	0.8%	0.6%	0.5%	1.2%	1.2%	0.2%	0.4%	0.5%
Monthly housing costs <35% of total household income									
Among owner-occupied units with a									
mortgage	22.7%	24.6%	20.7%	21.6%	25.6%	24.1%	25.8%	23.8%	22.4%
Among owner-occupied units without									
a mortgage	15.4%	16.6%	15.2%	16.9%	15.0%	14.0%	14.5%	11.6%	8.3%
Among occupied units paying rent	41.3%	46.3%	37.4%	40.7%	41.7%	41.0%	35.9%	44.5%	35.2%
Access to Technology									
Among households									
Has smartphone	89.2%	88.7%	91.5%	90.7%	90.5%	90.9%	94.3%	90.3%	94.3%
Has desktop or laptop	83.2%	81.0%	88.4%	87.7%	81.9%	83.2%	92.6%	92.4%	92.1%
With a computer	95.1%	94.8%	96.5%	96.5%	94.6%	94.8%	97.4%	96.2%	97.9%
With a broadband Internet									
subscription	91.8%	91.4%	94.2%	94.2%	90.3%	90.6%	96.0%	95.7%	94.0%
Transportation									
Car, truck, or van drove alone	62.7%	69.3%	56.0%	59.0%	36.6%	34.1%	28.1%	68.7%	20.9%
Car, truck, or van carpooled	6.9%	7.0%	6.4%	5.6%	6.2%	5.4%	3.3%	7.0%	3.1%
Public transportation (excluding									
taxicab)	7.0%	3.7%	8.0%	9.5%	23.6%	24.0%	20.1%	3.0%	19.4%
Walked	4.2%	2.8%	4.2%	3.2%	12.3%	13.8%	15.2%	0.5%	19.3%
Other means	2.5%	2.6%	3.2%	2.1%	3.8%	4.0%	6.2%	0.6%	9.0%
Worked from home	16.7%	14.6%	22.2%	20.6%	17.5%	18.8%	27.0%	20.2%	28.3%
Mean travel time to work (minutes)	29.3	28.9	30.0	32.9	30.9	30.2	28.1	28.0	26.1

							Areas	of Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Vehicles available among occupied housing units									
No vehicles available	11.8%	9.6%	10.4%	8.9%	31.8%	33.5%	27.4%	3.1%	33.7%
1 vehicle available	35.8%	34.6%	36.5%	35.4%	43.5%	43.2%	47.7%	30.0%	48.3%
2 vehicles available	35.8%	37.4%	37.8%	39.1%	18.9%	17.8%	20.3%	45.3%	15.2%
3 or more vehicles available	16.6%	18.4%	15.3%	16.6%	5.9%	5.5%	4.7%	21.6%	2.8%
Education									
Educational attainment of adults 25 years and									
older									
Less than 9th grade	4.2%	5.2%	3.3%	3.0%	7.4%	6.5%	1.7%	1.6%	2.6%
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	2.7%	5.0%	4.6%	0.9%	1.9%	1.7%
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	17.4%	20.5%	18.3%	5.0%	19.0%	6.0%
Some college, no degree	14.4%	15.2%	11.2%	12.4%	12.1%	11.6%	5.2%	12.8%	7.1%
Associate's degree	7.5%	8.2%	5.7%	7.0%	5.1%	4.9%	2.2%	6.5%	2.4%
Bachelor's degree	25.3%	24.9%	28.8%	30.0%	26.8%	28.5%	27.3%	32.5%	29.8%
Graduate or professional degree	21.4%	17.5%	30.2%	27.7%	23.1%	25.6%	57.8%	25.7%	50.4%
High school graduate or higher	91.4%	90.1%	93.4%	94.4%	87.6%	88.9%	97.4%	96.5%	95.7%
Bachelor's degree or higher	46.6%	42.3%	59.0%	57.6%	49.9%	54.1%	85.0%	58.2%	80.2%
Educational attainment by race/ethnicity									
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	94.7%	96.0%	97.0%	95.5%	96.4%	98.9%	97.3%	97.5%
Bachelor's degree or higher	49.4%	47.7%	60.9%	59.3%	66.0%	72.5%	86.8%	54.6%	85.1%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	85.3%	89.6%	90.0%	86.4%	86.4%	78.4%	93.9%	84.9%
Bachelor's degree or higher	30.7%	31.0%	40.0%	39.4%	27.4%	26.7%	41.6%	60.3%	36.6%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	85.2%	69.1%	78.6%	73.3%	77.5%	78.1%	100.0%	100.0%
Bachelor's degree or higher	24.4%	19.7%	31.3%	41.8%	30.2%	44.0%	17.1%	100.0%	44.1%

							Areas o	f Interest	
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Cambridge
Demographics									
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	83.9%	90.3%	84.2%	80.8%	80.9%	96.9%	94.2%	97.1%
Bachelor's degree or higher	64.0%	55.0%	71.3%	61.0%	57.0%	57.4%	88.5%	83.4%	92.1%
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	100.0%	98.5%	65.9%	100.0%	100.0%	-	100.0%	100.0%
Bachelor's degree or higher	40.0%	95.2%	20.9%	44.5%	63.0%	63.0%	-	0.0%	62.5%
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	67.5%	73.6%	81.9%	71.5%	71.6%	81.9%	75.4%	89.1%
Bachelor's degree or higher	20.0%	12.9%	27.1%	40.3%	22.2%	24.8%	63.1%	46.3%	55.2%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	81.1%	85.6%	92.3%	72.7%	77.3%	97.3%	95.2%	92.3%
Bachelor's degree or higher	33.6%	29.6%	46.1%	57.3%	30.3%	36.6%	85.8%	47.4%	71.7%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	71.1%	77.6%	90.0%	70.6%	72.8%	92.1%	79.5%	85.6%
Bachelor's degree or higher	23.3%	16.9%	34.9%	53.2%	22.5%	26.6%	79.9%	49.3%	60.7%
Health insurance coverage among civilian noninstitutionalized population (%)									
With health insurance coverage	97.4%	97.2%	97.6%	98.1%	96.7%	97.0%	98.8%	97.1%	98.2%
With private health insurance	73.8%	71.0%	80.0%	82.0%	67.5%	69.9%	88.1%	82.5%	85.8%
With public coverage	37.1%	39.9%	29.9%	29.1%	38.1%	35.8%	20.4%	27.9%	21.4%
No health insurance coverage	2.6%	2.8%	2.4%	1.9%	3.3%	3.0%	1.2%	2.9%	1.8%
Disability									
Percent of population with a disability	12.1%	12.1%	9.8%	9.7%	12.3%	12.1%	7.5%	9.3%	7.4%
Under 18 with a disability	4.9%	5.0%	4.1%	3.6%	6.0%	5.8%	3.7%	4.9%	2.8%
18-64	9.4%	9.1%	7.1%	6.9%	9.2%	9.1%	4.7%	5.9%	5.7%
65+	30.2%	31.0%	27.9%	27.3%	38.1%	37.2%	24.5%	22.6%	22.7%

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

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

							Areas of Interes	t
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham
Demographics								
Population								
Total population	6992395	807258	1622896	724540	782172	39460	34085	32059
Male	48.9%	48.6%	49.4%	48.5%	48.3%	50.4%	47.6%	48.0%
Female	51.1%	51.4%	50.6%	51.5%	51.7%	49.6%	52.4%	52.0%
Age Distribution								
Under 5 years (%)	5.0%	5.4%	5.1%	5.2%	4.9%	7.8%	3.7%	4.7%
5 to 9 years	5.2%	5.6%	5.4%	5.5%	4.1%	5.3%	6.6%	8.9%
10 to 14 years	5.7%	6.2%	5.6%	6.1%	4.6%	7.3%	9.8%	9.2%
15 to 19 years	6.5%	6.4%	6.3%	6.4%	6.9%	6.5%	8.1%	7.6%
20 to 24 years	6.8%	6.2%	6.8%	6.1%	9.1%	5.4%	2.7%	4.0%
25 to 34 years	14.1%	12.5%	15.1%	12.9%	22.5%	18.7%	4.2%	4.8%
35 to 44 years	12.9%	12.6%	13.8%	13.2%	13.6%	14.7%	11.6%	14.3%
45 to 54 years	12.6%	12.8%	12.8%	13.3%	10.7%	13.0%	19.2%	15.5%
55 to 59 years	7.0%	7.3%	6.8%	7.3%	5.5%	5.3%	7.4%	7.5%
60 to 64 years	6.8%	7.0%	6.2%	6.7%	5.2%	4.8%	5.8%	6.0%
65 to 74 years	10.3%	10.7%	9.3%	10.0%	7.7%	6.2%	11.5%	9.3%
75 to 84 years	4.9%	5.0%	4.6%	4.9%	3.5%	3.1%	6.3%	4.5%
85 years and over	2.2%	2.4%	2.1%	2.4%	1.8%	1.9%	3.2%	3.7%
Under 18 years of age	19.6%	21.0%	19.6%	20.7%	16.2%	24.5%	26.4%	28.1%
Over 65 years of age	17.5%	18.0%	16.0%	17.4%	13.0%	11.2%	21.0%	17.5%

							Areas of Interes	t
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham
Demographics								
Race/Ethnicity								
White alone (%)	70.70%	70.3%	69.0%	71.4%	48.1%	26.9%	56.8%	81.7%
Black or African American alone (%)	7.0%	4.1%	5.0%	7.2%	19.1%	7.0%	2.1%	1.5%
American Indian and Alaska Native (%)								
alone	0.2%	0.3%	0.2%	0.1%	0.4%	0.7%	0.0%	0.1%
Asian alone (%)	7.1%	3.5%	13.2%	12.1%	9.0%	2.9%	32.9%	10.5%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%
Some Other Race alone (%)	5.4%	12.1%	4.2%	2.3%	7.8%	11.7%	1.9%	0.3%
Two or More Races (%)	9.5%	9.7%	8.4%	6.8%	15.5%	50.9%	6.2%	5.7%
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	5.5%	22.8%	65.0%	3.3%	3.7%
Foreign-born								
Foreign-born population	1,236,518	151,560	366,954	138,392	230,245	17,859	11,496	5,349
Naturalized U.S. citizen	54.5%	56.4%	51.0%	60.1%	50.3%	33.5%	60.3%	71.8%
Not a U.S. citizen	45.5%	43.6%	49.0%	39.9%	49.7%	66.5%	39.7%	28.2%
Region of birth: Europe	18.1%	13.4%	16.9%	20.0%	10.9%	3.7%	16.3%	38.2%
Region of birth: Asia	30.5%	14.5%	42.9%	47.6%	23.9%	5.6%	71.4%	42.3%
Region of birth: Africa	9.5%	5.5%	7.6%	7.3%	10.4%	6.3%	3.0%	6.1%
Region of birth: Oceania	0.3%	0.2%	0.5%	0.3%	0.2%	0.0%	0.8%	0.6%
Region of birth: Latin America	39.4%	64.4%	29.7%	22.8%	53.1%	84.0%	5.7%	11.3%
Region of birth: Northern America	2.2%	2.0%	2.4%	2.0%	1.4%	0.4%	2.8%	1.6%
Language								
English only	75.2%	71.6%	71.7%	77.0%	61.6%	29.6%	60.0%	79.9%
Language other than English	24.8%	28.4%	28.3%	23.0%	38.4%	70.4%	40.0%	20.1%
Speak English less than "very well"	9.7%	12.2%	9.9%	8.4%	17.9%	42.7%	8.6%	4.6%

							Areas of Interes	t
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham
Demographics								
Spanish	9.6%	18.8%	6.4%	3.5%	19.2%	59.3%	2.2%	2.8%
Speak English less than "very well"	4.1%	8.8%	2.4%	0.9%	9.8%	36.4%	0.5%	0.4%
Other Indo-European languages	9.2%	6.4%	12.2%	9.0%	10.1%	5.3%	14.1%	9.4%
Speak English less than "very well"	3.2%	2.2%	4.1%	2.8%	3.9%	3.2%	1.7%	1.9%
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	8.6%	6.5%	2.2%	21.2%	5.1%
Speak English less than "very well"	1.9%	0.9%	2.9%	4.3%	3.5%	1.2%	6.3%	1.7%
Other languages	1.6%	1.2%	2.0%	1.9%	2.6%	3.6%	2.6%	2.9%
Speak English less than "very well"	0.4%	0.4%	0.5%	0.4%	0.8%	1.9%	0.1%	0.6%
Employment								
Unemployment rate	5.1%	5.1%	4.2%	4.9%	6.2%	8.8%	3.0%	4.5%
Unemployment rate by race/ethnicity								
White alone	4.5%	4.3%	4.0%	4.6%	4.4%	4.3%	2.8%	4.4%
Black or African American alone	7.9%	4.6%	6.4%	8.0%	8.6%	3.5%	0.0%	13.4%
American Indian and Alaska Native alone	6.9%	1.8%	5.5%	16.0%	7.6%	0.0%	-	0.0%
Asian alone	4.0%	3.3%	3.5%	4.1%	4.7%	1.7%	3.7%	3.6%
Native Hawaiian and Other Pacific								
Islander alone	4.8%	0.0%	10.9%	0.0%	0.0%	-	-	-
Some other race alone	8.0%	7.9%	6.4%	6.1%	10.4%	15.2%	4.2%	0.0%
Two or more races	7.9%	8.6%	5.4%	6.2%	8.9%	11.2%	1.1%	6.2%
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	5.5%	9.6%	12.1%	1.9%	5.7%
Unemployment rate by educational attainm	nent							
Less than high school graduate	9.1%	10.0%	8.1%	7.5%	10.6%	14.8%	11.5%	0.0%
High school graduate (includes								
equivalency)	6.4%	5.3%	5.9%	7.1%	8.7%	8.1%	5.4%	0.5%
Some college or associate's degree	5.2%	4.8%	4.9%	5.1%	7.6%	7.9%	9.7%	5.6%
Bachelor's degree or higher	2.7%	3.1%	2.7%	2.6%	2.9%	1.6%	2.2%	3.8%

							Areas of Interes	t
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham
Demographics								
Income and Poverty								
Median household income (dollars)	101,341	99,431	126,779	126,497	92,859	72,220	219,402	212,241
Population living below the federal poverty	y line in the last 12							
months								
Individuals	10.0%	9.4%	7.5%	6.6%	16.5%	20.6%	4.3%	3.8%
Families	6.6%	4.4%	6.7%	4.7%	4.6%	11.7%	7.2%	1.8%
Individuals under 18 years of age	11.8%	12.1%	7.4%	5.8%	21.2%	27.0%	3.9%	2.5%
Individuals over 65 years of age	10.2%	10.8%	8.6%	8.7%	20.3%	24.5%	7.7%	6.4%
Female head of household, no spouse	19.1%	18.2%	15.4%	14.9%	23.3%	33.1%	29.9%	11.1%
White alone	7.6%	7.2%	6.0%	5.6%	11.6%	14.5%	3.5%	3.1%
Black or African American alone	17.1%	14.1%	15.4%	11.7%	19.7%	18.6%	17.6%	1.8%
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	11.1%	13.1%	10.3%	-	0.0%
Asian alone	11.0%	9.3%	8.6%	8.1%	23.5%	7.7%	3.8%	4.8%
Native Hawaiian and Other Pacific								
Islander alone	21.7%	0.0%	4.7%	40.9%	35.2%	-	-	57.7%
Some other race alone	20.1%	19.0%	14.2%	12.3%	20.9%	23.2%	12.2%	0.0%
Two or more races	15.7%	11.1%	10.5%	7.4%	20.9%	24.3%	7.2%	10.1%
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	9.4%	22.6%	23.2%	18.0%	7.0%
Less than high school graduate	24.4%	22.8%	20.4%	19.5%	30.3%	26.5%	26.5%	8.2%
High school graduate (includes								
equivalency)	12.7%	11.8%	12.1%	10.4%	19.0%	18.6%	18.7%	6.9%
Some college, associate's degree	9.2%	8.6%	8.2%	8.2%	14.8%	15.6%	9.7%	5.3%
Bachelor's degree or higher	4.0%	3.5%	3.4%	3.2%	6.7%	7.7%	2.6%	3.0%
With Social Security	29.8%	31.4%	25.8%	28.6%	20.9%	24.3%	29.9%	26.6%
With retirement income	22.9%	22.5%	20.9%	22.7%	13.7%	9.7%	22.3%	22.1%
With Supplemental Security Income	5.6%	5.8%	3.9%	3.8%	6.5%	8.9%	1.8%	3.1%
With cash public assistance income	3.5%	4.6%	2.8%	2.5%	3.8%	7.0%	2.8%	2.2%
With Food Stamp/SNAP benefits in the								
past 12 months	13.8%	16.0%	8.6%	8.7%	18.7%	23.9%	3.1%	3.0%

							Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham		
Demographics										
Housing										
Occupied housing units	91.6%	94.9%	95.5%	95.9%	91.0%	95.5%	97.4%	97.0%		
Owner-occupied	62.6%	64.0%	61.6%	68.5%	36.6%	29.2%	81.0%	84.3%		
Renter-occupied	37.4%	36.0%	38.4%	31.5%	63.4%	70.8%	19.0%	15.7%		
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.3%	0.4%	1.1%	0.6%	0.8%		
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.7%	1.0%	1.1%	1.5%	1.0%		
No telephone service available	0.8%	0.8%	0.6%	0.5%	1.2%	1.0%	0.4%	1.1%		
Monthly housing costs <35% of total household income										
Among owner-occupied units with a mortgage	22.7%	24.6%	20.7%	21.6%	25.6%	36.0%	16.9%	21.5%		
Among owner-occupied units without a	22.770	24.070	20.770	21.070	25.070	30.070	10.970	21.5/0		
mortgage	15.4%	16.6%	15.2%	16.9%	15.0%	10.6%	16.9%	11.1%		
Among occupied units paying rent	41.3%	46.3%	37.4%	40.7%	41.7%	45.6%	43.7%	52.5%		
Access to Technology										
Among households										
Has smartphone	89.2%	88.7%	91.5%	90.7%	90.5%	89.3%	93.6%	91.6%		
Has desktop or laptop	83.2%	81.0%	88.4%	87.7%	81.9%	67.6%	96.0%	90.4%		
With a computer	95.1%	94.8%	96.5%	96.5%	94.6%	92.2%	97.8%	97.3%		
With a broadband Internet subscription	91.8%	91.4%	94.2%	94.2%	90.3%	85.2%	97.3%	94.8%		
Transportation										
Car, truck, or van drove alone	62.7%	69.3%	56.0%	59.0%	36.6%	46.4%	54.1%	57.5%		
Car, truck, or van carpooled	6.9%	7.0%	6.4%	5.6%	6.2%	15.2%	4.7%	3.8%		
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	9.5%	23.6%	20.3%	5.7%	7.6%		
Walked	4.2%	2.8%	4.2%	3.2%	12.3%	5.7%	2.2%	1.9%		
Other means	2.5%	2.6%	3.2%	2.1%	3.8%	2.9%	1.7%	0.3%		
Worked from home	16.7%	14.6%	22.2%	20.6%	17.5%	9.6%	31.6%	28.8%		
Mean travel time to work (minutes)	29.3	28.9	30.0	32.9	30.9	33.5	30.5	28.6		

						Areas of Interest		
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham
Demographics								
Vehicles available among occupied								
housing units								
No vehicles available	11.8%	9.6%	10.4%	8.9%	31.8%	27.9%	4.8%	6.7%
1 vehicle available	35.8%	34.6%	36.5%	35.4%	43.5%	47.2%	27.1%	23.1%
2 vehicles available	35.8%	37.4%	37.8%	39.1%	18.9%	19.4%	52.6%	54.5%
3 or more vehicles available	16.6%	18.4%	15.3%	16.6%	5.9%	5.5%	15.5%	15.7%
Education								
Educational attainment of adults 25 years								
and older								
Less than 9th grade	4.2%	5.2%	3.3%	3.0%	7.4%	21.1%	1.0%	1.1%
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	2.7%	5.0%	9.8%	1.5%	1.5%
High school graduate (includes								
equivalency)	22.8%	24.4%	17.5%	17.4%	20.5%	30.8%	4.5%	7.0%
Some college, no degree	14.4%	15.2%	11.2%	12.4%	12.1%	11.9%	5.0%	6.5%
Associate's degree	7.5%	8.2%	5.7%	7.0%	5.1%	4.5%	3.0%	3.0%
Bachelor's degree	25.3%	24.9%	28.8%	30.0%	26.8%	14.2%	26.2%	29.7%
Graduate or professional degree	21.4%	17.5%	30.2%	27.7%	23.1%	7.7%	58.8%	51.2%
High school graduate or higher	91.4%	90.1%	93.4%	94.4%	87.6%	69.1%	97.5%	97.3%
Bachelor's degree or higher	46.6%	42.3%	59.0%	57.6%	49.9%	22.0%	85.0%	80.8%
Educational attainment by race/ethnicity								
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	94.7%	96.0%	97.0%	95.5%	85.2%	98.3%	98.2%
Bachelor's degree or higher	49.4%	47.7%	60.9%	59.3%	66.0%	36.3%	84.6%	81.2%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	85.3%	89.6%	90.0%	86.4%	85.0%	89.2%	78.5%
Bachelor's degree or higher	30.7%	31.0%	40.0%	39.4%	27.4%	32.8%	51.5%	43.3%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	85.2%	69.1%	78.6%	73.3%	68.8%	-	100.0%
Bachelor's degree or higher	24.4%	19.7%	31.3%	41.8%	30.2%	15.1%	-	0.0%

							Areas of Interest	t
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Chelsea	Lexington	Needham
Demographics								
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	83.9%	90.3%	84.2%	80.8%	73.6%	97.0%	93.8%
Bachelor's degree or higher	64.0%	55.0%	71.3%	61.0%	57.0%	41.5%	89.1%	84.0%
Native Hawaiian and Other Pacific								
Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	100.0%	98.5%	65.9%	100.0%	-	-	100.0%
Bachelor's degree or higher	40.0%	95.2%	20.9%	44.5%	63.0%	-	-	100.0%
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	67.5%	73.6%	81.9%	71.5%	70.9%	85.6%	100.0%
Bachelor's degree or higher	20.0%	12.9%	27.1%	40.3%	22.2%	15.6%	54.6%	100.0%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	81.1%	85.6%	92.3%	72.7%	53.8%	96.2%	97.3%
Bachelor's degree or higher	33.6%	29.6%	46.1%	57.3%	30.3%	9.9%	80.1%	82.2%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	71.1%	77.6%	90.0%	70.6%	57.4%	91.5%	96.8%
Bachelor's degree or higher	23.3%	16.9%	34.9%	53.2%	22.5%	11.3%	63.7%	88.0%
Health insurance coverage among civilian noninstitutionalized population (%)								
With health insurance coverage	97.4%	97.2%	97.6%	98.1%	96.7%	96.0%	99.2%	98.8%
With private health insurance	73.8%	71.0%	80.0%	82.0%	67.5%	40.0%	90.0%	91.1%
With public coverage	37.1%	39.9%	29.9%	29.1%	38.1%	61.4%	23.2%	19.5%
No health insurance coverage	2.6%	2.8%	2.4%	1.9%	3.3%	4.0%	0.8%	1.2%
Disability								
Percent of population with a disability	12.1%	12.1%	9.8%	9.7%	12.3%	14.8%	7.2%	7.0%
Under 18 with a disability	4.9%	5.0%	4.1%	3.6%	6.0%	8.3%	2.3%	1.8%
18-64	9.4%	9.1%	7.1%	6.9%	9.2%	10.9%	3.9%	3.2%
65+	30.2%	31.0%	27.9%	27.3%	38.1%	53.5%	22.2%	27.8%

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

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

							Areas of Intere	st
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Newton	Peabody	Winchester
Demographics								
Population								
Total population	6992395	807258	1622896	724540	782172	88504	54180	22862
Male	48.9%	48.6%	49.4%	48.5%	48.3%	48.6%	47.6%	47.5%
Female	51.1%	51.4%	50.6%	51.5%	51.7%	51.4%	52.4%	52.5%
Age Distribution								
Under 5 years (%)	5.0%	5.4%	5.1%	5.2%	4.9%	4.1%	5.7%	5.4%
5 to 9 years	5.2%	5.6%	5.4%	5.5%	4.1%	5.6%	4.8%	8.6%
10 to 14 years	5.7%	6.2%	5.6%	6.1%	4.6%	6.6%	4.2%	8.4%
15 to 19 years	6.5%	6.4%	6.3%	6.4%	6.9%	9.6%	5.0%	7.8%
20 to 24 years	6.8%	6.2%	6.8%	6.1%	9.1%	6.8%	5.3%	2.8%
25 to 34 years	14.1%	12.5%	15.1%	12.9%	22.5%	9.9%	12.6%	6.2%
35 to 44 years	12.9%	12.6%	13.8%	13.2%	13.6%	11.6%	11.4%	13.4%
45 to 54 years	12.6%	12.8%	12.8%	13.3%	10.7%	14.0%	12.1%	16.6%
55 to 59 years	7.0%	7.3%	6.8%	7.3%	5.5%	6.2%	7.9%	8.0%
60 to 64 years	6.8%	7.0%	6.2%	6.7%	5.2%	6.5%	6.8%	5.0%
65 to 74 years	10.3%	10.7%	9.3%	10.0%	7.7%	11.1%	12.0%	9.1%
75 to 84 years	4.9%	5.0%	4.6%	4.9%	3.5%	5.5%	6.8%	5.6%
85 years and over	2.2%	2.4%	2.1%	2.4%	1.8%	2.5%	5.5%	3.0%
Under 18 years of age	19.6%	21.0%	19.6%	20.7%	16.2%	20.8%	17.5%	28.3%
Over 65 years of age	17.5%	18.0%	16.0%	17.4%	13.0%	19.1%	24.3%	17.7%

Demographics: Newton – Winchester

						Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Newton	Peabody	Winchester	
Demographics									
Race/Ethnicity									
White alone (%)	70.70%	70.3%	69.0%	71.4%	48.1%	71.1%	79.9%	72.4%	
Black or African American alone (%)	7.0%	4.1%	5.0%	7.2%	19.1%	2.2%	3.6%	3.0%	
American Indian and Alaska Native (%) alone	0.2%	0.3%	0.2%	0.1%	0.4%	0.4%	0.5%	0.3%	
Asian alone (%)	7.1%	3.5%	13.2%	12.1%	9.0%	16.6%	2.0%	15.7%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	12.1%	4.2%	2.3%	7.8%	2.4%	4.3%	1.5%	
Two or More Races (%)	9.5%	9.7%	8.4%	6.8%	15.5%	7.3%	9.7%	7.1%	
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	5.5%	22.8%	4.8%	12.4%	3.2%	
Foreign-born									
Foreign-born population	1,236,518	151,560	366,954	138,392	230,245	20,831	9,306	4,624	
Naturalized U.S. citizen	54.5%	56.4%	51.0%	60.1%	50.3%	65.8%	63.8%	68.0%	
Not a U.S. citizen	45.5%	43.6%	49.0%	39.9%	49.7%	34.2%	36.2%	32.0%	
Region of birth: Europe	18.1%	13.4%	16.9%	20.0%	10.9%	31.4%	33.3%	30.5%	
Region of birth: Asia	30.5%	14.5%	42.9%	47.6%	23.9%	50.3%	9.7%	53.3%	
Region of birth: Africa	9.5%	5.5%	7.6%	7.3%	10.4%	4.3%	2.5%	4.2%	
Region of birth: Oceania	0.3%	0.2%	0.5%	0.3%	0.2%	0.6%	0.0%	0.0%	
Region of birth: Latin America	39.4%	64.4%	29.7%	22.8%	53.1%	10.0%	52.8%	10.6%	
Region of birth: Northern America	2.2%	2.0%	2.4%	2.0%	1.4%	3.5%	1.7%	1.4%	
Language									
English only	75.2%	71.6%	71.7%	77.0%	61.6%	72.5%	76.2%	73.1%	
Language other than English	24.8%	28.4%	28.3%	23.0%	38.4%	27.5%	23.8%	26.9%	
Speak English less than "very well"	9.7%	12.2%	9.9%	8.4%	17.9%	7.9%	10.0%	6.0%	

Demographics: Newton – Winchester

							Areas of Intere	st
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Newton	Peabody	Winchester
Demographics								
Spanish	9.6%	18.8%	6.4%	3.5%	19.2%	3.2%	8.1%	2.4%
Speak English less than "very well"	4.1%	8.8%	2.4%	0.9%	9.8%	0.7%	4.1%	0.2%
Other Indo-European languages	9.2%	6.4%	12.2%	9.0%	10.1%	11.2%	13.5%	13.5%
Speak English less than "very well"	3.2%	2.2%	4.1%	2.8%	3.9%	3.1%	5.1%	2.3%
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	8.6%	6.5%	10.2%	1.5%	10.5%
Speak English less than "very well"	1.9%	0.9%	2.9%	4.3%	3.5%	3.5%	0.6%	3.4%
Other languages	1.6%	1.2%	2.0%	1.9%	2.6%	2.8%	0.7%	0.4%
Speak English less than "very well"	0.4%	0.4%	0.5%	0.4%	0.8%	0.5%	0.2%	0.0%
Employment								
Unemployment rate	5.1%	5.1%	4.2%	4.9%	6.2%	3.3%	4.8%	3.0%
Unemployment rate by race/ethnicity								
White alone	4.5%	4.3%	4.0%	4.6%	4.4%	3.5%	5.3%	3.5%
Black or African American alone	7.9%	4.6%	6.4%	8.0%	8.6%	3.6%	3.1%	0.0%
American Indian and Alaska Native alone	6.9%	1.8%	5.5%	16.0%	7.6%	0.0%	0.0%	46.5%
Asian alone	4.0%	3.3%	3.5%	4.1%	4.7%	3.1%	1.4%	1.5%
Native Hawaiian and Other Pacific								
Islander alone	4.8%	0.0%	10.9%	0.0%	0.0%	0.0%	-	-
Some other race alone	8.0%	7.9%	6.4%	6.1%	10.4%	1.5%	1.4%	0.0%
Two or more races	7.9%	8.6%	5.4%	6.2%	8.9%	2.1%	4.8%	1.8%
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	5.5%	9.6%	2.0%	4.6%	0.0%
Unemployment rate by educational attainn	nent							
Less than high school graduate	9.1%	10.0%	8.1%	7.5%	10.6%	1.1%	5.0%	0.0%
High school graduate (includes								
equivalency)	6.4%	5.3%	5.9%	7.1%	8.7%	2.7%	3.6%	1.5%
Some college or associate's degree	5.2%	4.8%	4.9%	5.1%	7.6%	8.2%	4.2%	9.8%
Bachelor's degree or higher	2.7%	3.1%	2.7%	2.6%	2.9%	2.5%	2.7%	1.8%

							Areas of Interes	st
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Newton	Peabody	Winchester
Demographics								
Income and Poverty								
Median household income (dollars)	101,341	99,431	126,779	126,497	92,859	184,989	95,278	218,176
Population living below the federal poverty line in the last 12 months								
Individuals	10.0%	9.4%	7.5%	6.6%	16.5%	4.7%	6.5%	3.9%
Families	6.6%	4.4%	6.7%	4.7%	4.6%	3.0%	4.0%	2.0%
Individuals under 18 years of age	11.8%	12.1%	7.4%	5.8%	21.2%	2.4%	3.9%	2.6%
Individuals over 65 years of age	10.2%	10.8%	8.6%	8.7%	20.3%	6.1%	8.0%	7.6%
Female head of household, no spouse	19.1%	18.2%	15.4%	14.9%	23.3%	14.7%	14.6%	19.8%
White alone	7.6%	7.2%	6.0%	5.6%	11.6%	3.9%	6.0%	3.7%
Black or African American alone	17.1%	14.1%	15.4%	11.7%	19.7%	14.6%	5.6%	0.1%
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	11.1%	13.1%	14.0%	40.8%	27.4%
Asian alone	11.0%	9.3%	8.6%	8.1%	23.5%	6.9%	0.3%	2.0%
Native Hawaiian and Other Pacific Islander alone	21.7%	0.0%	4.7%	40.9%	35.2%	-	-	-
Some other race alone	20.1%	19.0%	14.2%	12.3%	20.9%	5.0%	17.2%	44.9%
Two or more races	15.7%	11.1%	10.5%	7.4%	20.9%	4.6%	5.9%	3.2%
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	9.4%	22.6%	8.6%	13.7%	20.8%
Less than high school graduate	24.4%	22.8%	20.4%	19.5%	30.3%	22.0%	13.0%	38.6%
High school graduate (includes equivalency)	12.7%	11.8%	12.1%	10.4%	19.0%	13.2%	10.8%	14.1%
Some college, associate's degree	9.2%	8.6%	8.2%	8.2%	14.8%	6.0%	6.4%	1.6%
Bachelor's degree or higher	4.0%	3.5%	3.4%	3.2%	6.7%	3.4%	2.6%	2.6%
With Social Security	29.8%	31.4%	25.8%	28.6%	20.9%	27.3%	40.0%	28.5%
With retirement income	22.9%	22.5%	20.9%	22.7%	13.7%	22.4%	29.7%	24.8%
With Supplemental Security Income	5.6%	5.8%	3.9%	3.8%	6.5%	2.5%	5.5%	2.0%
With cash public assistance income	3.5%	4.6%	2.8%	2.5%	3.8%	2.1%	3.3%	1.6%
With Food Stamp/SNAP benefits in the past 12 months	13.8%	16.0%	8.6%	8.7%	18.7%	4.4%	10.4%	1.7%

							Areas of Interes	st
	Massachusetts	Essex	Middlesex	Norfolk	Suffolk	Newton	Peabody	Winchester
	Widssachusetts	County	County	County	County	Newton	1 cabouy	Willenester
Demographics								
Housing								
Occupied housing units	91.6%	94.9%	95.5%	95.9%	91.0%	94.6%	96.6%	97.2%
Owner-occupied	62.6%	64.0%	61.6%	68.5%	36.6%	71.0%	65.6%	83.4%
Renter-occupied	37.4%	36.0%	38.4%	31.5%	63.4%	29.0%	34.4%	16.6%
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.3%	0.4%	0.2%	0.3%	0.2%
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.7%	1.0%	0.5%	1.7%	0.6%
No telephone service available	0.8%	0.8%	0.6%	0.5%	1.2%	0.2%	1.1%	0.4%
Monthly housing costs <35% of total household income								
Among owner-occupied units with a mortgage	22.7%	24.6%	20.7%	21.6%	25.6%	23.4%	22.3%	16.7%
Among owner-occupied units without a	22.770	24.070	20.770	21.0/0	25.070	25.470	22.370	10.770
mortgage	15.4%	16.6%	15.2%	16.9%	15.0%	15.4%	16.2%	18.7%
Among occupied units paying rent	41.3%	46.3%	37.4%	40.7%	41.7%	33.5%	51.3%	30.6%
Access to Technology								
Among households								
Has smartphone	89.2%	88.7%	91.5%	90.7%	90.5%	93.9%	85.5%	90.5%
Has desktop or laptop	83.2%	81.0%	88.4%	87.7%	81.9%	94.0%	79.3%	93.2%
With a computer	95.1%	94.8%	96.5%	96.5%	94.6%	97.8%	93.1%	96.0%
With a broadband Internet subscription	91.8%	91.4%	94.2%	94.2%	90.3%	96.9%	91.0%	95.2%
Transportation								
Car, truck, or van drove alone	62.7%	69.3%	56.0%	59.0%	36.6%	49.6%	79.6%	52.3%
Car, truck, or van carpooled	6.9%	7.0%	6.4%	5.6%	6.2%	5.6%	6.6%	4.4%
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	9.5%	23.6%	8.7%	2.5%	7.1%
Walked	4.2%	2.8%	4.2%	3.2%	12.3%	5.4%	0.9%	2.7%
Other means	2.5%	2.6%	3.2%	2.1%	3.8%	1.9%	1.5%	1.9%
Worked from home	16.7%	14.6%	22.2%	20.6%	17.5%	28.7%	8.8%	31.6%
Mean travel time to work (minutes)	29.3	28.9	30.0	32.9	30.9	26.7	27.2	30.8

							Areas of Intere	st
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Newton	Peabody	Winchester
Demographics								
Vehicles available among occupied housing units								
No vehicles available	11.8%	9.6%	10.4%	8.9%	31.8%	5.7%	9.5%	5.7%
1 vehicle available	35.8%	34.6%	36.5%	35.4%	43.5%	35.2%	34.7%	26.3%
2 vehicles available	35.8%	37.4%	37.8%	39.1%	18.9%	45.3%	36.9%	52.0%
3 or more vehicles available	16.6%	18.4%	15.3%	16.6%	5.9%	13.8%	18.8%	16.0%
Education								
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	5.2%	3.3%	3.0%	7.4%	1.4%	5.8%	1.4%
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	2.7%	5.0%	1.3%	3.6%	1.3%
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	17.4%	20.5%	6.6%	29.6%	9.0%
Some college, no degree	14.4%	15.2%	11.2%	12.4%	12.1%	5.9%	16.1%	6.9%
Associate's degree	7.5%	8.2%	5.7%	7.0%	5.1%	4.2%	11.0%	2.9%
Bachelor's degree	25.3%	24.9%	28.8%	30.0%	26.8%	28.2%	22.3%	27.6%
Graduate or professional degree	21.4%	17.5%	30.2%	27.7%	23.1%	52.4%	11.5%	50.8%
High school graduate or higher	91.4%	90.1%	93.4%	94.4%	87.6%	97.3%	90.6%	97.3%
Bachelor's degree or higher	46.6%	42.3%	59.0%	57.6%	49.9%	80.7%	33.9%	78.4%
Educational attainment by race/ethnicity								
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	94.7%	96.0%	97.0%	95.5%	98.4%	93.1%	97.8%
Bachelor's degree or higher	49.4%	47.7%	60.9%	59.3%	66.0%	81.9%	35.4%	78.1%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	85.3%	89.6%	90.0%	86.4%	94.2%	92.2%	89.5%
Bachelor's degree or higher	30.7%	31.0%	40.0%	39.4%	27.4%	60.4%	28.5%	63.1%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	85.2%	69.1%	78.6%	73.3%	72.8%	78.6%	87.0%
Bachelor's degree or higher	24.4%	19.7%	31.3%	41.8%	30.2%	66.1%	0.0%	43.5%

Demographics: Newton – Winchester

							Areas of Intere	st
	Massachusetts	Essex County	Middlesex County	Norfolk County	Suffolk County	Newton	Peabody	Winchester
Demographics								
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	83.9%	90.3%	84.2%	80.8%	95.2%	73.8%	96.9%
Bachelor's degree or higher	64.0%	55.0%	71.3%	61.0%	57.0%	79.9%	43.6%	86.2%
Native Hawaiian and Other Pacific								
Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	100.0%	98.5%	65.9%	100.0%	-	-	-
Bachelor's degree or higher	40.0%	95.2%	20.9%	44.5%	63.0%	-	-	-
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	67.5%	73.6%	81.9%	71.5%	89.9%	72.5%	91.3%
Bachelor's degree or higher	20.0%	12.9%	27.1%	40.3%	22.2%	55.2%	15.9%	62.5%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	81.1%	85.6%	92.3%	72.7%	95.1%	78.4%	97.1%
Bachelor's degree or higher	33.6%	29.6%	46.1%	57.3%	30.3%	83.5%	29.1%	73.0%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	71.1%	77.6%	90.0%	70.6%	91.0%	70.3%	91.6%
Bachelor's degree or higher	23.3%	16.9%	34.9%	53.2%	22.5%	73.5%	18.1%	72.0%
Health insurance coverage among civilian noninstitutionalized population (%)								
With health insurance coverage	97.4%	97.2%	97.6%	98.1%	96.7%	98.6%	97.1%	98.4%
With private health insurance	73.8%	71.0%	80.0%	82.0%	67.5%	88.6%	74.7%	89.5%
With public coverage	37.1%	39.9%	29.9%	29.1%	38.1%	22.3%	40.7%	19.9%
No health insurance coverage	2.6%	2.8%	2.4%	1.9%	3.3%	1.4%	2.9%	1.6%
Disability								
Percent of population with a disability	12.1%	12.1%	9.8%	9.7%	12.3%	7.3%	16.5%	6.7%
Under 18 with a disability	4.9%	5.0%	4.1%	3.6%	6.0%	3.4%	4.7%	3.2%
18-64	9.4%	9.1%	7.1%	6.9%	9.2%	4.5%	11.3%	3.1%
65+	30.2%	31.0%	27.9%	27.3%	38.1%	20.6%	38.2%	24.4%

Health Status

						Areas of			
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Boston	Brookline	Burlington	Chelsea	Source
Access to Care									
Ratio of population to primary care									County Health Rankings,
physicians	103.5	128.3	125.7	150.0	150.0	125.7	128.3	150.0	2021
Ratio of population to mental									County Health Rankings,
health providers	135.7	145.3	145.1	94.3	94.2	145.3	145.2	94.2	2023
Addiction and substance abuse									CMS- National Plan and
providers (rate per 100,000									Provider Enumeration
population)	31.3	18.0	16.4	47.3	50.0	7.9	11.4	90.7	System (NPPES), 2024
Overall Health									
Adults age 18+ with self-reported									
fair or poor general health (%), age-		Data	Data	Data					Behavioral Risk Factor
adjusted	13.8	unavailable	unavailable	unavailable	16.4	8.9	10.9	24.4	Surveillance System, 2022
Mortality rate (crude rate per									CDC-National Vital Statistics
100,000)	900.2	764.9	871.1	645.8					System, 2018-2021
Premature mortality rate (per									Massachusetts Death
100,000)	308.1	188.0	233.2	180.6					Report, 2021
Risk Factors									
Farmers Markets Accepting SNAP,									
Rate per 100,00 low-income									USDA - Agriculture
population	1.8	4.8	2.2	1.3	1.6	10.9	0.0	0.0	Marketing Service, 2023
SNAP-Authorized Retailers, Rate									USDA - SNAP Retailer
per 10,000 population	9.6	7.6	8.1	11.1	10.6	5.1	15.7	18.1	Locator, 2024
Population with low food access (%)									USDA - Food Access
	27.8	24.6	35.7	1.0	0.6	3.8	19.9	0.0	Research Atlas, 2019
Obesity (adults) (%), age-adjusted		Data	Data	Data					
prevalence	27.2	unavailable	unavailable	unavailable	27.3	24.4	21.5	31.4	BRFSS, 2022
High blood pressure (adults) (%)		Data	Data	Data					
age-adjusted prevalence	No data	unavailable	unavailable	unavailable	28.2	22.6	23.4	28.8	BRFSS, 2021
High cholesterol among adults who		Data	Data	Data					
have been screened (%)	No data	unavailable	unavailable	unavailable	29.5	31.1	29.8	30.9	BRFSS, 2021
Adults with no leisure time physical		Data	Data	Data					
activity (%), age-adjusted	21.3	unavailable	unavailable	unavailable	23.3	14.3	15.9	32.2	BRFSS, 2022

						Areas o	f interest		
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Boston	Brookline	Burlington	Chelsea	Source
Chronic Conditions									
Current asthma (adults) (%) age-		Data	Data	Data					
adjusted prevalence	11.3	unavailable	unavailable	unavailable	11.7	10.3	10.6	11.8	BRFSS, 2022
Diagnosed diabetes among adults (%),		Data	Data	Data					
age-adjusted	10.5	unavailable	unavailable	unavailable	10.1	7.1	7.1	12.5	BRFSS, 2022
Chronic obstructive pulmonary disease		Data	Data	Data					
among adults (%), age-adjusted	5.7	unavailable	unavailable	unavailable	5.5	3.4	4.3	6.7	BRFSS, 2022
Coronary heart disease among adults		Data	Data	Data					
(%), age-adjusted	6.2	unavailable	unavailable	unavailable	5.5	4.4	4.8	6.7	BRFSS, 2022
		Data	Data	Data					
Stroke among adults (%), age-adjusted	3.6	unavailable	unavailable	unavailable	3.2	2	2.3	3.7	BRFSS, 2022
Cancer									
Mammography screening among		Data	Data	Data					
women 50-74 (%), age-adjusted	84.9	unavailable	unavailable	unavailable	83.4	86.1	83.7	80	BRFSS, 2022
Colorectal cancer screening among		Data	Data	Data					
adults 45-75 (%), age-adjusted	71.5	unavailable	unavailable	unavailable	60.8	66	66.9	53.2	BRFSS, 2022
Cancer incidence (age-adjusted per									
100,000)									
All sites									State Cancer Profiles,
	449.4	426.6	462.7	408.9	408.9	463.3	428.1	408.7	2016-2020
Lung and Bronchus Cancer									State Cancer Profiles,
	59.2	52.1	56.3	54.9	54.8	56.1	51.1	55.2	2016-2020
Prostate Cancer									State Cancer Profiles,
	113.2	108.6	117.7	111.7	111.8	116.6	106.6	111.4	2016-2020
Prevention and Screening									
Adults age 18+ with routine checkup in									Behavioral Risk Factor
Past 1 year (%) (age-adjusted)		Data	Data	Data					Surveillance System,
	81.0	unavailable	unavailable	unavailable	77.4	79.7	76.2	74.8	2022
Cholesterol screening within past 5									Behavioral Risk Factor
years (%) (adults)		Data	Data	Data					Surveillance System,
	No data	unavailable	unavailable	unavailable	86.1	90.3	88	83	2021

						Areas			
		Middlesex	Norfolk	Suffolk	_	_			_
	Massachusetts	County	County	County	Boston	Brookline	Burlington	Chelsea	Source
Communicable and Infectious									
Disease									
STI infection cases (per 100,000)									
Chlamydia									National Center for
									HIV/AIDS, Viral
									Hepatitis, STD, and
	385.8	264.0	358.2	264.0	807.8	264.0	293.2	807.8	TB Prevention. 2021
									National Center for
									HIV/AIDS, Viral
									Hepatitis, STD, and
Syphilis	10.6	9.8	6.9	25.8	25.8	6.9	9.9	25.8	TB Prevention. 2021
									National Center for
									HIV/AIDS, Viral
	2440	0.4.2	64.0	200.0	200.0	64.0	04.3	200.0	Hepatitis, STD, and
Gonorrhea	214.0	84.2	64.0	298.0	298.0	64.0	84.2	298.0	TB Prevention. 2021
									National Center for
									HIV/AIDS, Viral
HIV prevalence	385.8	288.2	234.1	832.2	832.2	234.1	288.2	832.2	Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	234.1	832.2	832.2	234.1	200.2	832.2	National Center for
									HIV/AIDS, Viral
									Hepatitis, STD, and
Tuberculosis (per 100,000)	2.2	2.7	1.7	4.6	4.6	1.7	2.7	4.6	TB Prevention. 2022
COVID-19	2.2	2.7	1.7	4.0	4.0	1.7	2.7	4.0	TBTTEVENTION. 2022
COVID-13									CDC - GRASP, 2018 -
Percent of Adults Fully Vaccinated	78.1	87.7	87.8	81.3	83.3	85.8	87.0	83.3	2022
Estimated Percent of Adults Hesitant	70.1	57.7	07.0	01.3	03.3	05.8	57.0	00.0	2022
About Receiving COVID-19									
Vaccination	4.5	4.0	3.8	4.4	4.4	3.8	4.0	4.4	
Vaccine Coverage Index	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.1	

		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Boston	Brookline	Burlington	Chelsea	Source
Substance Use									
		Data	Data	Data					
Current cigarette smoking (%), age-adjusted	10.4	unavailable	unavailable	unavailable	11.8	6.9	8.9	14.8	BRFSS, 2021
		Data	Data	Data					
Binge drinking % (adults), age-adjusted	17.2	unavailable	unavailable	unavailable	19	19.9	18.4	18.4	BRFSS, 2022
									CDC- National
									Vital Statistics
Drug overdose (age-adjusted per 100,000									System, 2016-
population)	32.7	22.2	26.0	32.6	32.6	26.0	22.2	32.6	2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6	38.5	51.0					
Female Drug Overdose Mortality Rate (per									
100,000)	17.6	12.0	14.2	15.2					
Substance-related deaths (Age-adjusted rate per									
100k)									
Any substance	61.9	41.1	40.3	74.2	74.3	16.1	41.0	96.0	
Opioid-related deaths	33.7	20.1	21.8	45.0	45.4	10.9	*	59.7	
Alcohol-related deaths	29.1	20.4	18.6	30.2	29.6	*	29.9	32.4	
Stimulant-related deaths	23.0	13.6	13.6	35.3	37.6	*	*	38.0	
Substance-related ER visits (age-adjusted rate per									
100K)									
Any substance-related ER visits	1605.7	1246.4	1182.2	2674.7	2862.5	700.0	597.7	3038.4	
Opioid-related ER visits	169.3	102.9	89.8	253.0	278.4	18.6	29.5	178.1	
Opioid-related EMS Incidents	248.8	176.3	138.6	379.2	395.9	87.0	87.2	404.5	
Alcohol-related ER visits	1235.6	962.1	929.9	2156.4	2312.2	529.2	433.5	2566.0	
Stimulant-related ER visits	15.7	13.6	9.9	29.2	34.5	*	*	*	
Substance Addiction Services									
Individuals admitted to BSAS services (crude rate									
per 100k)	588.4	340.3	352.4	932.9	966.6	80.7	193.4	821.3	
Number of BSAS providers		201.0	88.0	231.0	217.0	5.0	1.0	10.0	
Number of clients of BSAS services (residents)		3702.0	1540.0	4681.0	4225.0	38.0	31.0	204.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	19.0	11.0	11.0	17.0	20.0	15.0	

					Areas of interest				
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Boston	Brookline	Burlington	Chelsea	Source
Buprenorphine RX's filled	9982.0	6002.1	7796.8	7972.3	7412.3	1487.6	5774.0	8137.4	
Individuals who received									
buprenorphine RX's		508.3	668.1	764.1	744.2	150.3	466.3	787.0	
Naloxone kits received		35323.0	16008.0	34809.0	33510.0	551.0	140.0	590.0	
Naloxone kids: Opioid deaths Ratio		78.0	55.0	97.0	113.0	56.0	*	16.0	
Fentanyl test strips received		50130.0	21900.0	69000.0	66100.0	1600.0	600.0	1800.0	
Environmental Health									
Environmental Justice (%) (Centers for									
Disease Control and Prevention, CDC -									Population in Neighborhoods Meeting
Agency for Toxic Substances and									Environmental Justice Health Criteria,
Disease Registry. Accessed via CDC									Centers for Disease Control and
National Environmental Public Health									Prevention, CDC - Agency for Toxic
Tracking. 2022.)	56.6	72.4	55.9	97.8	98.3	100.0	56.5	100.0	Substances and Disease Registry, 2022
									MDPH BCEH Childhood Lead Poisoning
									Prevention Program (CLPPP),
									2021Percentage of children age 9-47
Lead screening %	68.0				67.0	54.0	70.0	65.0	months screened for lead in 2021
									UMass Donahue Institute (UMDI),
									2017 population estimates, 2021 5-
									year annual average rate (2017-2021)
									for children age 9-47 months with an
Prevalence of Blood Lead Levels (per									estimated confirmed blood lead level
1,000)	13.6				14.8	5.3	5.4	15.3	≥ 5 µg/dL
									ACS 5-year estimates for housing,
% of houses built before 1978	67.0				75.0	83.0	58.0	70.0	2017 - 2021
Asthma Emergency Department Visits						_			Massachusetts Center for Health
(Age-adjusted rate)	28.6				42.2	8.1	8.7	36.1	Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8									
Students (%) (per 100 K-8 students)	9.9				14.4	6.9	10.1	10.4	MDPH BCEH, 2022-2023 school year

						Areas of			
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Boston	Brookline	Burlington	Chelsea	Source
Age Adjusted Rates of Emergency									
Department Visit for Heat Stress per 100,00									Center for Health
people for males and females combined by									Information and
county	7.6	5.5	7.0	5.2	5.0	0.0	0.0	NS	Analysis, 2020
Air Quality Respiratory Hazard Index (EPA -									EPA - National Air Toxics
National Air Toxics Assessment, 2018)	0.3	0.3	0.3	0.4					Assessment, 2018
Mental Health									
Suicide mortality rate (age-adjusted death									CDC-National Vital
rate per 100,000)									Statistics System, 2016-
	50.7	36.9	41.2	47.8	47.8	41.2	36.9	47.8	2021
Depression among adults (%), age-adjusted									Behavioral Risk Factor
		Data	Data	Data					Surveillance System,
	21.6	unavailable	unavailable	unavailable	22.9	20	22.9	23.5	2022
Adults feeling socially isolated (%), age-									Behavioral Risk Factor
adjusted		Data	Data	Data					Surveillance System,
	No data	unavailable	unavailable	unavailable	35.1	28.9	33.2	37.9	2022
Adults reporting a lack of social and									Behavioral Risk Factor
emotional support (%), age-adjusted		Data	Data	Data					Surveillance System,
	No data	unavailable	unavailable	unavailable	25.6	18.9	23	29.8	2023
Adults experiencing frequent mental									Behavioral Risk Factor
distress (%), age-adjusted		Data	Data	Data					Surveillance System,
	13.6	unavailable	unavailable	unavailable	17	13	14.3	19	2022
Youth experiences of harassment or									U.S. Department of
bullying (allegations, rate per 1,000)									Education - Civil Rights
									Data Collection, 2020-
	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	2021
Maternal and Child Health/Reproductive							_		
Health									
Infant Mortality Rate (per 1,000 live births)									County Health Rankings,
	4.0	3.0	3.0	5.0	5.0	3.0	3.0	5.0	2015-2021
Low birth weight (%)									County Health Rankings,
	7.6	7.0	7.0	8.0	8.4	6.9	7.1	8.4	2016-2022

						Areas of			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Chelsea	Source
Safety/Crime									
Property Crimes Offenses (#)									Massachusetts Crime Statistics, 2023
Burglary	10028.0				1265.0	45.0	19.0	84.0	
Larceny-theft	60647.0				9359.0	500.0	401.0	528.0	
Motor vehicle theft	7224.0				1200.0	35.0	27.0	76.0	
Arson	377.0				32.0	0.0	3.0	4.0	
Crimes Against Persons Offenses (#)									
Murder/non-negligent manslaughter	162.0				51.0	0.0		0.0	
Sex offenses	4365.0				372.0	9.0	11.0	69.0	
Assaults	72086.0				15157.0	173.0	118.0	877.0	
Human trafficking	0.0				9.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)									
Race/Ethnicity/Ancestry Bias	222.0				82.0	1.0		0.0	
Religious Bias	88.0				23.0	1.0		1.0	
Sexual Orientation Bias	80.0				36.0	1.0		1.0	
Gender Identity Bias	22.0				9.0	1.0		0.0	
Gender Bias	2.0				0.0	0.0		0.0	
Disability Bias	0.0				0.0	0.0		0.0	

Health Status: Lexington – Peabody

						Areas of			
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Lexington	Needham	Newton	Peabody	Source
Access to Care									
Ratio of population to primary care									County Health Rankings,
physicians	103.5	128.3	125.7	150.0	128.3	125.7	128.3	73.3	2021
Ratio of population to mental health									County Health Rankings,
providers	135.7	145.3	145.1	94.3	145.2	145.2	145.4	151.7	2023
									CMS- National Plan and
Addiction and substance abuse providers									Provider Enumeration
(rate per 100,000 population)	31.3	18.0	16.4	47.3	0.0	12.5	3.4	22.0	System (NPPES), 2024
Overall Health									
Adults age 18+ with self-reported fair or		Data	Data	Data					Behavioral Risk Factor
poor general health (%), age-adjusted	13.8	unavailable	unavailable	unavailable	7.8	8.2	8.6	13.9	Surveillance System, 2022
									CDC-National Vital
									Statistics System, 2018-
Mortality rate (crude rate per 100,000)	900.2	764.9	871.1	645.8					2021
									Massachusetts Death
Premature mortality rate (per 100,000)	308.1	188.0	233.2	180.6					Report, 2021
Risk Factors									
Farmers Markets Accepting SNAP, Rate									USDA - Agriculture
per 100,00 low-income population	1.8	4.8	2.2	1.3	53.3	0.0	0.0	0.0	Marketing Service, 2023
SNAP-Authorized Retailers, Rate per									USDA - SNAP Retailer
10,000 population	9.6	7.6	8.1	11.1	3.3	4.2	3.2	10.7	Locator, 2024
Population with low food access (%)									USDA - Food Access
	27.8	24.6	35.7	1.0	28.3	21.8	9.9	31.6	Research Atlas, 2019
Obesity (adults) (%), age-adjusted		Data	Data	Data					
prevalence	27.2	unavailable	unavailable	unavailable	17.6	24.2	20.4	29.9	BRFSS, 2022
High blood pressure (adults) (%) age-		Data	Data	Data					
adjusted prevalence	No data	unavailable	unavailable	unavailable	20.9	21.6	22.2	26.6	BRFSS, 2021
High cholesterol among adults who have		Data	Data	Data					
been screened (%)	No data	unavailable	unavailable	unavailable	29.6	30.5	29.5	30.6	BRFSS, 2021
Adults with no leisure time physical	_	Data	Data	Data					
activity (%), age-adjusted	21.3	unavailable	unavailable	unavailable	12.5	13.1	12.9	19	BRFSS, 2022

Health Status: Lexington – Peabody

						Areas of i	nterest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Lexington	Needham	Newton	Peabody	Source
Chronic Conditions		-	-	_	_			-	
Current asthma (adults) (%) age-		Data	Data	Data					
adjusted prevalence	11.3	unavailable	unavailable	unavailable	9.3	10.3	10.3	11.8	BRFSS, 2022
Diagnosed diabetes among adults		Data	Data	Data					
(%), age-adjusted	10.5	unavailable	unavailable	unavailable	6.5	6.2	6.3	7.9	BRFSS, 2022
Chronic obstructive pulmonary									
disease among adults (%), age-		Data	Data	Data					
adjusted	5.7	unavailable	unavailable	unavailable	2.9	3.4	3.3	5.6	BRFSS, 2022
Coronary heart disease among		Data	Data	Data					
adults (%), age-adjusted	6.2	unavailable	unavailable	unavailable	4	4.4	4.2	5.7	BRFSS, 2022
Stroke among adults (%), age-		Data	Data	Data					
adjusted	3.6	unavailable	unavailable	unavailable	1.8	1.9	1.9	2.6	BRFSS, 2022
Cancer									
Mammography screening among		Data	Data	Data					
women 50-74 (%), age-adjusted	84.9	unavailable	unavailable	unavailable	85.1	86.7	85	83.2	BRFSS, 2022
Colorectal cancer screening among		Data	Data	Data					
adults 45-75 (%), age-adjusted	71.5	unavailable	unavailable	unavailable	68.2	68.1	68.8	64.6	BRFSS, 2022
Cancer incidence (age-adjusted per									
100,000)									
All sites	449.4	426.6	462.7	408.9	427.2	463.6	426.3	452.9	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	56.3	54.9	51.4	55.3	52.2	58.7	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	117.7	111.7	108.0	117.2	108.5	111.2	State Cancer Profiles, 2016-2020
Prevention and Screening									
Adults age 18+ with routine									
checkup in Past 1 year (%) (age-		Data	Data	Data					Behavioral Risk Factor
adjusted)	81.0	unavailable	unavailable	unavailable	77.4	78.8	77	78.9	Surveillance System, 2022
Cholesterol screening within past 5		Data	Data	Data					Behavioral Risk Factor
years (%) (adults)	No data	unavailable	unavailable	unavailable	90.1	90.2	89	87.8	Surveillance System, 2021

Health Status: Lexington – Peabody

						Areas of i			
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Lexington	Needham	Newton	Peabody	Source
Communicable and Infectious Disease									
STI infection cases (per 100,000)									
Chlamydia									National Center for HIV/AIDS,
									Viral Hepatitis, STD, and TB
	385.8	264.0	358.2	264.0	293.2	264.0	293.2	424.5	Prevention. 2021
									National Center for HIV/AIDS,
									Viral Hepatitis, STD, and TB
Syphilis	10.6	9.8	6.9	25.8	9.9	6.9	9.9	6.7	Prevention. 2021
									National Center for HIV/AIDS,
									Viral Hepatitis, STD, and TB
Gonorrhea	214.0	84.2	64.0	298.0	84.2	64.0	84.2	90.7	Prevention. 2021
									National Center for HIV/AIDS,
									Viral Hepatitis, STD, and TB
HIV prevalence	385.8	288.2	234.1	832.2	288.2	234.1	288.2	289.6	Prevention. 2021
									National Center for HIV/AIDS,
									Viral Hepatitis, STD, and TB
Tuberculosis (per 100,000)	2.2	2.7	1.7	4.6	2.7	1.7	2.7	2.9	Prevention. 2022
COVID-19									
Percent of Adults Fully Vaccinated	78.1	87.7	87.8	81.3	87.0	85.8	87.0	82.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant									
About Receiving COVID-19 Vaccination	4.5	4.0	3.8	4.4	4.0	3.8	4.0	4.5	
Vaccine Coverage Index	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	
Substance Use									
Current cigarette smoking (%), age-		Data	Data	Data					
adjusted	10.4	unavailable	unavailable	unavailable	5.5	7	6.7	12.1	BRFSS, 2021
		Data	Data	Data					
Binge drinking % (adults), age-adjusted	17.2	unavailable	unavailable	unavailable	17.4	22.4	18.9	20.1	BRFSS, 2022

		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Lexington	Needham	Newton	Peabody	Source
									CDC- National Vital
									Statistics System,
Drug overdose (age-adjusted per 100,000 population)	32.7	22.2	26.0	32.6	22.2	26.0	22.2	39.3	2016-2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6	38.5	51.0					
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0	14.2	15.2					
Substance-related deaths (Age-adjusted rate per 100k)									
Any substance	61.9	41.1	40.3	74.2	*	23.4	15.4	65.3	
Opioid-related deaths	33.7	20.1	21.8	45.0	*	*	*	30.0	
Alcohol-related deaths	29.1	20.4	18.6	30.2	0.0	*	7.5	30.6	
Stimulant-related deaths	23.0	13.6	13.6	35.3	*	0.0	*	15.7	
Substance-related ER visits (age-adjusted rate per 100K)									
Any substance-related ER visits	1605.7	1246.4	1182.2	2674.7	482.2	754.1	665.7	1151.6	
Opioid-related ER visits	169.3	102.9	89.8	253.0	*	32.0	24.9	107.5	
Opioid-related EMS Incidents	248.8	176.3	138.6	379.2	29.0	37.4	59.6	200.1	
Alcohol-related ER visits	1235.6	962.1	929.9	2156.4	307.9	628.6	459.5	864.5	
Stimulant-related ER visits	15.7	13.6	9.9	29.2	0.0	*	*	*	
Substance Addiction Services									
Individuals admitted to BSAS services (crude rate per									
100k)	588.4	340.3	352.4	932.9	84.2	93.5	115.8	596.5	
Number of BSAS providers		201.0	88.0	231.0	1.0	3.0	3.0	6.0	
Number of clients of BSAS services (residents)		3702.0	1540.0	4681.0	21.0	16.0	59.0	196.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	19.0	11.0	24.0	30.0	23.0	17.0	
Buprenorphine RX's filled	9982.0	6002.1	7796.8	7972.3	1558.6	1339.9	2170.4	11136.0	
Individuals who received buprenorphine RX's		508.3	668.1	764.1	148.0	121.5	275.5	985.7	
Naloxone kits received		35323.0	16008.0	34809.0	307.0	135.0	335.0	1230.0	
Naloxone kids: Opioid deaths Ratio		78.0	55.0	97.0	*	*	*	62.0	
Fentanyl test strips received		50130.0	21900.0	69000.0	3200.0	300.0	1430.0	1400.0	

				Areas of interest olk Suffolk					
		Middlesex	Norfolk	Suffolk					
	Massachusetts	County	County	County	Lexington	Needham	Newton	Peabody	Source
Environmental Health									
Environmental Justice (%)									
(Centers for Disease Control and									
Prevention, CDC - Agency for									Population in Neighborhoods Meeting
Toxic Substances and Disease									Environmental Justice Health Criteria,
Registry. Accessed via CDC									Centers for Disease Control and
National Environmental Public									Prevention, CDC - Agency for Toxic
Health Tracking. 2022.)	56.6	72.4	55.9	97.8	66.8	44.5	91.4	77.4	Substances and Disease Registry, 2022
									MDPH BCEH Childhood Lead Poisoning
									Prevention Program (CLPPP),
									2021Percentage of children age 9-47
Lead screening %	68.0				50.0	76.0	62.0	81.0	months screened for lead in 2021
									UMass Donahue Institute (UMDI), 2017
									population estimates, 2021 5-year annual
									average rate (2017-2021) for children age
Prevalence of Blood Lead Levels									9-47 months with an estimated confirmed
(per 1,000)	13.6				5.0	2.6	5.4	6.4	1 5,
									ACS 5-year estimates for housing, 2017 -
% of houses built before 1978	67.0				67.0	67.0	81.0	64.0	2021
Asthma Emergency Department									Massachusetts Center for Health
Visits (Age-adjusted rate)	28.6				9.0	8.4	9.8	23.1	Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in									
K-8 Students (%) (per 100 K-8									
students)	9.9				-	6.2	7.2	5.1	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of									
Emergency Department Visit for									
Heat Stress per 100,00 people									
for males and females combined									Center for Health Information and
by county	7.6	5.5	7.0	5.2	NS	NS	NS	NS	Analysis, 2020
Air Quality Respiratory Hazard									
Index (EPA - National Air Toxics									
Assessment, 2018)	0.3	0.3	0.3	0.4					EPA - National Air Toxics Assessment, 2018

						Areas of in	terest		
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Lexington	Needham	Newton	Peabody	Source
Mental Health									
A. Suicide mortality rate (age-adjusted									CDC-National Vital
death rate per 100,000)									Statistics System, 2016-
	50.7	36.9	41.2	47.8	36.9	41.2	36.9	57.4	2021
Depression among adults (%), age-		Data	Data	Data					Behavioral Risk Factor
adjusted	21.6	unavailable	unavailable	unavailable	20	20.8	22.6	24.5	Surveillance System, 2022
Adults feeling socially isolated (%), age-		Data	Data	Data					Behavioral Risk Factor
adjusted	No data	unavailable	unavailable	unavailable	31.9	29	32.3	34.5	Surveillance System, 2022
Adults reporting a lack of social and		Data	Data	Data					Debaggional Diale Footon
emotional support (%), age-adjusted	No data	Data unavailable	Data	Data	22.4	18.3	21.1	22.6	Behavioral Risk Factor
Adulta and discontinuity of the second of th	No data	unavanable	unavailable	unavailable	22.1	18.3	21.1	22.6	Surveillance System, 2023
Adults experiencing frequent mental		Data	Data	Data					Behavioral Risk Factor
distress (%), age-adjusted	13.6	unavailable	unavailable	unavailable	11.6	12.9	13.2	17.5	Surveillance System, 2022
Youth experiences of harassment or									U.S. Department of
bullying (allegations, rate per 1,000)									Education - Civil Rights
I									Data Collection, 2020-
I	0.1	0.1	0.1	0.0	0.0	0.2	0.0	0.0	2021
Maternal and Child									
Health/Reproductive Health									
Infant Mortality Rate (per 1,000 live									County Health Rankings,
births)	4.0	3.0	3.0	5.0	3.0	3.0	3.0	4.0	2015-2021
Low birth weight (%)									County Health Rankings,
I	7.6	7.0	7.0	8.0	7.1	6.9	7.1	7.4	2016-2022

						Areas o			
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Lexington	Needham	Newton	Peabody	Source
Safety/Crime									
Property Crimes Offenses (#)									Massachusetts Crime Statistics, 2023
Burglary	10028.0				20.0	21.0	62.0	49.0	
Larceny-theft	60647.0				81.0	142.0	502.0	385.0	
Motor vehicle theft	7224.0				8.0	7.0	11.0	22.0	
Arson	377.0				0.0	0.0	2.0	2.0	
Crimes Against Persons Offenses (#)									
Murder/non-negligent manslaughter	162.0				0.0	0.0	1.0	0.0	
Sex offenses	4365.0				6.0	17.0	16.0	23.0	
Assaults	72086.0				67.0	80.0	214.0	363.0	
Human trafficking	0.0				0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)									
Race/Ethnicity/Ancestry Bias	222.0						9.0		
Religious Bias	88.0						6.0		
Sexual Orientation Bias	80.0						1.0		
Gender Identity Bias	22.0						1.0		
Gender Bias	2.0						0.0		
Disability Bias	0.0						0.0		

Community Health Equity Survey (CHES) – Youth

CHES Youth: Boston - Brookline

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

			Massa	chusetts	Middles	sex County	Norfoll	County	В	oston	Bro	okline
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
		No steady place	1908	1.30%	528	1.10%	*	*	*	*	*	*
		Worried about losing	1908	2.60%	528	2.70%	163	3.70%	*	*	*	*
Housing	Current living situation	Steady place	1908	95.10%	528	95.80%	163	95.70%	70	98.60%	40	95.00%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	510	22.00%	155	15.50%	68	36.80%	37	24.30%
		Never	1963	87.80%	546	90.80%	164	93.90%	72	83.30%	40	90.00%
		Sometimes	1963	9.90%	546	7.00%	164	4.30%	72	11.10%	*	*
Basic Needs	Food insecurity, past month	A lot	1963	2.30%	546	2.20%	*	*	*	*	*	*
		No internet	1938	1.30%	538	0.90%	*	*	*	*	*	*
		Does not work well	1938	6.60%	538	5.20%	*	*	71	8.50%	*	*
Basic Needs	Current internet access	Works well	1938	92.20%	538	93.90%	164	98.20%	71	90.10%	40	95.00%
		Somewhat or strongly disagree	1864	2.50%	516	1.60%	*	*	*	*	*	*
		Somewhat agree	1864	14.60%	516	10.30%	160	6.30%	69	21.70%	39	12.80%
Neighborhood	Able to get where you need to go	Strongly agree	1864	82.80%	516	88.20%	160	93.10%	69	76.80%	39	87.20%
		Never	1833	65.00%	504	73.80%	159	79.20%	68	35.30%	39	74.40%
		Rarely	1833	22.80%	504	19.20%	159	16.40%	68	36.80%	39	20.50%
	Experienced neighborhood	Somewhat often	1833	8.50%	504	4.60%	159	3.80%	68	19.10%	*	*
Neighborhood	violence, lifetime	Very often	1833	3.70%	504	2.40%	*	*	68	8.80%	*	*

CHES Youth: Boston - Brookline

			Massac	husotts		dlesex	Norfol	k County	D.	oston	Bro	ookline
Topic	Question	Response	N	%	N CO	%	N	%	N	% %	N	% %
Торіс	Question	No	1739	3.90%	469	3.20%	*	*	*	*	*	*
		Yes, adult in home	1739	80.50%	469	83.80%	152	86.80%	66	71.20%	38	84.20%
		Yes, adult in Home	1733	00.5070	403	05.0070	132	00.0070	00	71.2070	30	04.2070
		home	1739	37.30%	469	36.20%	152	35.50%	66	33.30%	38	50.00%
Safety &		Yes, friend or non-	1,00	37.3070	103	30.2070	132	33.3070	- 00	33.3070	- 50	30.0070
Support	Have someone to talk to if needed help	adult family	1739	43.00%	469	44.80%	152	39.50%	66	39.40%	38	44.70%
- ' '		Not at all	1768	1.00%	473	1.70%	*	*	*	*	*	*
Safety &		Somewhat	1768	7.70%	473	6.80%	155	4.50%	66	7.60%	*	*
Support	Feel safe with my family/caregivers	Very much	1768	91.30%	473	91.50%	155	94.80%	66	90.90%	38	92.10%
	7 77	Not at all	1760	5.90%	472	5.50%	*	*	66	10.60%	*	*
Safety &		Somewhat	1760	29.10%	472	28.60%	155	21.90%	66	34.80%	38	28.90%
Support	Feel I belong at school	Very much	1760	65.00%	472	65.90%	155	76.80%	66	54.50%	38	65.80%
		Not at all	1745	2.40%	467	3.20%	*	*	*	*	*	*
Safety &	Feel my family/caregivers support my	Somewhat	1745	17.10%	467	15.40%	153	12.40%	66	27.30%	37	24.30%
Support	interests	Very much	1745	80.50%	467	81.40%	153	86.90%	66	71.20%	37	73.00%
Safety &	Did errands/chores for family, past	,										1
Support	month	Yes	1761	68.20%	471	66.50%	155	63.20%	66	57.60%	38	71.10%
Safety &												
Support	Helped family financially, past month	Yes	1761	7.20%	471	5.30%	155	3.90%	66	18.20%	*	*
Safety &	Provided emotional support to caregiver,											
Support	past month	Yes	1761	21.20%	471	18.30%	155	20.00%	66	24.20%	38	39.50%
Safety &	Dealt with fights in the family, past											
Support	month	Yes	1761	11.90%	471	13.40%	155	10.30%	66	9.10%	38	13.20%
Safety &	Took care of a sick/disabled family											
Support	member, past month	Yes	1761	7.50%	471	6.40%	155	5.80%	*	*	*	*
Safety &	Took care of children in family, past										41.	
Support	month	Yes	1761	14.20%	471	13.00%	155	9.70%	66	18.20%	*	*
Safety &	Holmod family in ANV way much recent	Vos	1761	75 100/	474	72 200/	155	60.400/	cc	66.700/	20	04.300/
Support	Helped family in ANY way, past month	Yes	1761	75.10%	471	72.20%	155	68.40%	66	66.70%	38	84.20%

CHES Youth: Boston - Brookline

					Mid	dlesex	No	orfolk				
			Massac	chusetts	Co	unty	Co	ounty	Вс	oston	Bro	okline
Topic	Question	Response	N	%	N	%	N	%	Ν	%	N	%
Safety &	Experienced intimate partner	Ever	1589	13.10%	442	8.60%	122	9.00%	59	8.50%	35	17.10%
Support	violence (a)	In past year	1567	7.80%	440	5.20%	122	4.10%	*	*	*	*
Safety &	Experienced household violence	Ever	1536	14.20%	420	11.00%	118	7.60%	58	10.30%	*	*
Support	(b)	In past year	1519	5.50%	417	5.30%	118	4.20%	*	*	*	*
Safety &		Ever	1558	9.20%	430	7.70%	121	6.60%	*	*	*	*
Support	Experienced sexual violence (c)	In past year	1551	3.10%	428	2.10%	*	*	*	*	*	*
Safety &		Ever	1674	45.20%	446	44.80%	152	35.50%	61	47.50%	37	56.80%
Support	Experienced discrimination	In past year	1674	19.60%	446	19.50%	152	15.80%	61	21.30%	37	27.00%
		No	1652	51.50%	433	56.10%	149	62.40%	62	66.10%	37	40.50%
		Yes, <10 hours per week	1652	18.10%	433	21.70%	149	22.80%	62	11.30%	37	24.30%
		Yes, 11-19 hours per week	1652	13.30%	433	12.20%	149	7.40%	62	8.10%	37	16.20%
		Yes, 20-34 hours per week	1652	10.30%	433	6.50%	*	*	62	12.90%	*	*
Employment	Worked for pay, past year	Yes, >35 hours per week	1652	6.80%	433	3.50%	149	4.70%	*	*	*	*
		None of these	1484	66.80%	386	67.60%	142	77.50%	56	73.20%	36	66.70%
		Frequent absences	1484	7.60%	386	8.30%	*	*	*	*	*	*
		Needed more support in school	1484	7.00%	386	6.50%	142	3.50%	*	*	*	*
		Needed more support outside										
		school	1484	6.30%	386	8.00%	*	*	*	*	*	*
	Educational challenges, past	Safety concerns	1484	5.10%	386	5.20%	*	*	*	*	*	*
Education	year	Temperature in classroom	1484	18.50%	386	16.60%	142	18.30%	56	16.10%	36	25.00%
		Never	1503	87.70%	391	90.50%	143	93.00%	56	89.30%	37	86.50%
		Once or twice	1503	9.10%	391	6.90%	143	6.30%	*	*	*	*
	Hurt or harrassed by school	Monthly	1503	1.60%	391	1.30%	*	*	*	*	*	*
Education	staff, past year	Daily	1503	1.60%	391	1.30%	*	*	*	*	*	*

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

CHES Youth: Boston - Brookline

			Massa	chusetts	Middle	esex County	Norfo	olk County	E	Boston	Bro	okline
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
		College-preparation	1459	57.90%	382	61.30%	142	64.10%	54	50.00%	37	73.00%
 		Extracurricular activities	1459	74.40%	382	82.20%	142	83.10%	54	63.00%	37	89.20%
 		Guidance counselor	1459	58.80%	382	59.40%	142	66.90%	54	59.30%	37	70.30%
 		Programs to reduce										
Education	Helpful school resources provided	bullying, violence, racism	1459	19.10%	382	24.30%	142	19.00%	54	24.10%	*	*
Healthcare	Unmet need for short-term illness care											
Access	(among those needing care)	Yes	473	3.50%	139	5.00%	*	*	*	*	*	*
Healthcare	Unmet need for injury care (among those											
Access	needing care)	Yes	320	3.70%	106	5.70%	*	*	*	*	*	*
Healthcare	Unmet need for ongoing health condition											
Access	(among those needing care)	Yes	125	10.70%	*	*	*	*	*	*	*	*
Healthcare	Unmet need for home and community-											
Access	based services (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*
Healthcare	Unmet need for mental health care											
Access	(among those needing care)	Yes	278	16.50%	72	20.80%	*	*	*	*	*	*
Healthcare	Unmet need for sexual and reproductive											
Access	health care (among those needing care)	Yes	102	10.10%	*	*	*	*	*	*	*	*
 	Unmet need for substance use or											
Healthcare	addiction treatment (among those needing											
Access	care)	Yes	*	*	*	*	*	*	*	*	*	*
Healthcare	Unmet need for other type of care (among											
Access	those needing care)	Yes	62	7.90%	*	*	*	*	*	*	*	*
Healthcare	ANY unmet heath care need, past year											
Access	(among those needing any care)	Yes	857	10.30%	234	10.70%	67	7.50%	*	*	*	*
 		Low	1376	22.10%	362	22.10%	101	22.80%	48	29.20%	34	20.60%
 		Medium	1376	33.00%	362	34.00%	101	38.60%	48	39.60%	34	41.20%
Mental		High	1376	18.40%	362	20.20%	101	21.80%	48	12.50%	34	23.50%
Health	Psychological distress, past month	Very high	1376	26.60%	362	23.80%	101	16.80%	48	18.80%	34	14.70%
Mental												
Health	Feel isolated from others	Usually or always	1517	14.80%	394	14.70%	136	6.60%	56	16.10%	*	*
Mental												
Health	Suicide ideation, past year (d)	Yes	1338	14.60%	352	12.80%	104	13.50%	*	*	*	*

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

CHES Youth: Boston - Brookline

			Massac	husetts		dlesex		rfolk unty	R _C	oston	Brook	kline
Topic	Question	Response	N	%	N	%	N CO.	%	N D	%	N	%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	390	6.70%	136	3.70%	58	8.60%	*	*
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	382	8.40%	134	8.20%	*	*	*	*
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	382	7.30%	134	5.20%	55	9.10%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	383	9.40%	134	7.50%	56	14.30%	*	*
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*	*	*	*	*

CHES Youth: Boston - Brookline

					Mido	llesex						
			Massac	husetts	Cou	unty	Norfol	k County	Во	ston	Brool	kline
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
Emerging		Yes	1445	7.30%	376	8.00%	*	*	*	*	*	*
Issues	Someone close died from COVID-19	Not sure	1445	5.70%	376	6.40%	128	5.50%	*	*	*	*
Emerging	Felt unwell due to poor air quality/heat/allergies,											
Issues	past 5 years (1)	Yes	767	25.40%	190	22.10%	70	21.40%	36	19.40%	*	*
Emerging Issues	Flooding in home or on street, past 5 years (1)	Yes	767	5.50%	190	7.40%	70	7.10%	*	*	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (1)	Yes	767	20.20%	190	20.50%	70	22.90%	*	*	*	*
Emerging	D		767	25 400/	100	26.000/	70	20.000/	26	22.200/	*	*
Issues	Power outages, past 5 years (1)	Yes	767	25.40%	190	26.80%	70	20.00%	36	33.30%	4	*
Emerging Issues	School cancellation due to weather, past 5 years (1)	Yes	767	39.40%	190	38.90%	70	21.40%	36	36.10%	*	*
Emerging Issues	Unable to work due to weather, past 5 years (1)	Yes	767	7.60%	190	6.80%	*	*	*	*	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (1)	Yes	767	33.30%	190	28.90%	70	31.40%	36	27.80%	*	*
Emerging Issues	Other climate impact, past 5 years (1)	Yes	767	0.90%	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (1)	Yes	767	59.70%	190	56.30%	70	48.60%	36	52.80%	*	*

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

CHES Youth: Chelsea - Needham

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

			Massa	chusetts	Middle	sex County	Norfol	k County	Ch	elsea	Nee	dham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
		No steady place	1908	1.30%	528	1.10%	*	*	*	*	*	*
		Worried about losing	1908	2.60%	528	2.70%	163	3.70%	116	7.80%	*	*
Housing	Current living situation	Steady place	1908	95.10%	528	95.80%	163	95.70%	116	88.80%	109	96.30%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	510	22.00%	155	15.50%	112	55.40%	106	11.30%
		Never	1963	87.80%	546	90.80%	164	93.90%	120	62.50%	110	94.50%
		Sometimes	1963	9.90%	546	7.00%	164	4.30%	120	33.30%	*	*
Basic Needs	Food insecurity, past month	A lot	1963	2.30%	546	2.20%	*	*	120	4.20%	*	*
		No internet	1938	1.30%	538	0.90%	*	*	118	4.20%	*	*
		Does not work well	1938	6.60%	538	5.20%	*	*	118	18.60%	*	*
Basic Needs	Current internet access	Works well	1938	92.20%	538	93.90%	164	98.20%	118	77.10%	110	99.10%
		Somewhat or strongly disagree	1864	2.50%	516	1.60%	*	*	115	5.20%	*	*
		Somewhat agree	1864	14.60%	516	10.30%	160	6.30%	115	33.90%	*	*
Neighborhood	Able to get where you need to go	Strongly agree	1864	82.80%	516	88.20%	160	93.10%	115	60.90%	108	97.20%
		Never	1833	65.00%	504	73.80%	159	79.20%	114	27.20%	107	81.30%
		Rarely	1833	22.80%	504	19.20%	159	16.40%	114	28.90%	107	15.00%
	Experienced neighborhood violence,	Somewhat often	1833	8.50%	504	4.60%	159	3.80%	114	37.70%	*	*
Neighborhood	lifetime	Very often	1833	3.70%	504	2.40%	*	*	114	6.10%	*	*

CHES Youth: Chelsea - Needham

						ldlesex		orfolk				
			Massa	chusetts	Co	ounty	C	ounty	Che	elsea	Nee	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
		No	1739	3.90%	469	3.20%	*	*	*	*	*	*
		Yes, adult in home	1739	80.50%	469	83.80%	152	86.80%	111	69.40%	101	91.10%
Safety &		Yes, adult outside home	1739	37.30%	469	36.20%	152	35.50%	111	42.30%	101	28.70%
Support	Have someone to talk to if needed help	Yes, friend or non-adult family	1739	43.00%	469	44.80%	152	39.50%	111	38.70%	101	34.70%
		Not at all	1768	1.00%	473	1.70%	*	*	*	*	*	*
Safety &		Somewhat	1768	7.70%	473	6.80%	155	4.50%	112	13.40%	*	*
Support	Feel safe with my family/caregivers	Very much	1768	91.30%	473	91.50%	155	94.80%	112	85.70%	104	99.00%
		Not at all	1760	5.90%	472	5.50%	*	*	*	*	*	*
Safety &		Somewhat	1760	29.10%	472	28.60%	155	21.90%	113	36.30%	104	16.30%
Support	Feel I belong at school	Very much	1760	65.00%	472	65.90%	155	76.80%	113	62.80%	104	83.70%
		Not at all	1745	2.40%	467	3.20%	*	*	*	*	*	*
Safety &	Feel my family/caregivers support my	Somewhat	1745	17.10%	467	15.40%	153	12.40%	112	26.80%	103	6.80%
Support	interests	Very much	1745	80.50%	467	81.40%	153	86.90%	112	69.60%	103	93.20%
Safety &												
Support	Did errands/chores for family, past month	Yes	1761	68.20%	471	66.50%	155	63.20%	113	77.90%	104	58.70%
Safety &	Helmad family financially mask manth	V	1761	7.200/	474	F 200/	455	2.000/	442	24.000/	*	*
Support Safety &	Helped family financially, past month Provided emotional support to caregiver,	Yes	1761	7.20%	471	5.30%	155	3.90%	113	24.80%	-	-
Support	past month	Yes	1761	21.20%	471	18.30%	155	20.00%	113	24.80%	104	12.50%
Safety &	past month.					20.0070		20.0070		2 110070		12.0070
Support	Dealt with fights in the family, past month	Yes	1761	11.90%	471	13.40%	155	10.30%	113	12.40%	104	8.70%
Safety &	Took care of a sick/disabled family											
Support	member, past month	Yes	1761	7.50%	471	6.40%	155	5.80%	113	9.70%	104	4.80%
Safety &	Took care of children in family, past											
Support	month	Yes	1761	14.20%	471	13.00%	155	9.70%	113	27.40%	104	9.60%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	471	72.20%	155	68.40%	113	87.60%	104	60.60%

CHES Youth: Chelsea - Needham

					Mid	dlesex						
			Massa	achusetts	Co	unty	Norfol	k County	Cl	nelsea	Nee	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
Safety &	Experienced intimate partner	Ever	1589	13.10%	442	8.60%	122	9.00%	98	19.40%	*	*
Support	violence (a)	In past year	1567	7.80%	440	5.20%	122	4.10%	95	11.60%	*	*
Safety &	Experienced household violence	Ever	1536	14.20%	420	11.00%	118	7.60%	94	13.80%	72	8.30%
Support	(b)	In past year	1519	5.50%	417	5.30%	118	4.20%	*	*	*	*
Safety &		Ever	1558	9.20%	430	7.70%	121	6.60%	90	12.20%	*	*
Support	Experienced sexual violence (c)	In past year	1551	3.10%	428	2.10%	*	*	*	*	*	*
Safety &		Ever	1674	45.20%	446	44.80%	152	35.50%	110	59.10%	102	25.50%
Support	Experienced discrimination	In past year	1674	19.60%	446	19.50%	152	15.80%	110	12.70%	102	7.80%
		No	1652	51.50%	433	56.10%	149	62.40%	108	42.60%	99	68.70%
		Yes, <10 hours per week	1652	18.10%	433	21.70%	149	22.80%	108	13.90%	99	23.20%
		Yes, 11-19 hours per week	1652	13.30%	433	12.20%	149	7.40%	108	17.60%	*	*
		Yes, 20-34 hours per week	1652	10.30%	433	6.50%	*	*	108	18.50%	*	*
Employment	Worked for pay, past year	Yes, >35 hours per week	1652	6.80%	433	3.50%	149	4.70%	108	7.40%	*	*
		None of these	1484	66.80%	386	67.60%	142	77.50%	103	65.00%	94	84.00%
		Frequent absences	1484	7.60%	386	8.30%	*	*	103	9.70%	*	*
		Needed more support in school	1484	7.00%	386	6.50%	142	3.50%	103	10.70%	*	*
		Needed more support outside school	1484	6.30%	386	8.00%	*	*	103	11.70%	*	*
		Safety concerns	1484	5.10%	386	5.20%	*	*	*	*	*	*
Education	Educational challenges, past year	Temperature in classroom	1484	18.50%	386	16.60%	142	18.30%	103	18.40%	94	13.80%
		Never	1503	87.70%	391	90.50%	143	93.00%	104	87.50%	94	94.70%
		Once or twice	1503	9.10%	391	6.90%	143	6.30%	104	8.70%	94	5.30%
	Hurt or harrassed by school staff,	Monthly	1503	1.60%	391	1.30%	*	*	*	*	*	*
Education	past year	Daily	1503	1.60%	391	1.30%	*	*	*	*	*	*

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

CHES Youth: Chelsea - Needham

					Mic	ddlesex	No	orfolk				
			Massac	husetts	C	ounty	Co	unty	Ch	elsea	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
		College-preparation	1459	57.90%	382	61.30%	142	64.10%	102	58.80%	93	64.50%
		Extracurricular activities	1459	74.40%	382	82.20%	142	83.10%	102	58.80%	93	79.60%
		Guidance counselor	1459	58.80%	382	59.40%	142	66.90%	102	64.70%	93	63.40%
		Programs to reduce										
Education	Helpful school resources provided	bullying, violence, racism	1459	19.10%	382	24.30%	142	19.00%	102	7.80%	93	21.50%
Healthcare	Unmet need for short-term illness care											
Access	(among those needing care)	Yes	473	3.50%	139	5.00%	*	*	*	*	*	*
Healthcare	Unmet need for injury care (among those											
Access	needing care)	Yes	320	3.70%	106	5.70%	*	*	*	*	*	*
Healthcare	Unmet need for ongoing health condition											
Access	(among those needing care)	Yes	125	10.70%	*	*	*	*	*	*	*	*
Healthcare	Unmet need for home and community-											
Access	based services (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*
Healthcare	Unmet need for mental health care											
Access	(among those needing care)	Yes	278	16.50%	72	20.80%	*	*	*	*	*	*
Healthcare	Unmet need for sexual and reproductive											
Access	health care (among those needing care)	Yes	102	10.10%	*	*	*	*	*	*	*	*
Healthcare	Unmet need for substance use or addiction											
Access	treatment (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*
Healthcare	Unmet need for other type of care (among											
Access	those needing care)	Yes	62	7.90%	*	*	*	*	*	*	*	*
Healthcare	ANY unmet heath care need, past year											*
Access	(among those needing any care)	Yes	857	10.30%	234	10.70%	67	7.50%	48	14.60%	*	·
		Low	1376	22.10%	362	22.10%	101	22.80%	83	19.30%	57	21.10%
		Medium	1376	33.00%	362	34.00%	101	38.60%	83	37.30%	57	40.40%
		High	1376	18.40%	362	20.20%	101	21.80%	83	16.90%	57	22.80%
Mental Health	Psychological distress, past month	Very high	1376	26.60%	362	23.80%	101	16.80%	83	26.50%	57	15.80%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	394	14.70%	136	6.60%	105	19.00%	*	*
Mental Health	Suicide ideation, past year (d)	Yes	1338	14.60%	352	12.80%	104	13.50%	89	9.00%	61	11.50%

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

CHES Youth: Chelsea - Needham

			Massa	chusetts		dlesex unty		rfolk unty	Cł	nelsea	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	390	6.70%	136	3.70%	105	13.30%	*	*
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	382	8.40%	134	8.20%	104	6.70%	89	6.70%
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	382	7.30%	134	5.20%	104	9.60%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	383	9.40%	134	7.50%	104	15.40%	89	5.60%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*	*	*	*	*

CHES Youth: Chelsea - Needham

			Massa	chusetts	Middlese	x County	Norfoll	k County	Ch	elsea	Nee	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%
Emerging		Yes	1445	7.30%	376	8.00%	*	*	103	12.60%	*	*
Issues	Someone close died from COVID-19	Not sure	1445	5.70%	376	6.40%	128	5.50%	103	14.60%	82	8.50%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (1)	Yes	767	25.40%	190	22.10%	70	21.40%	58	32.80%	50	24.00%
Emerging Issues	Flooding in home or on street, past 5 years (1)	Yes	767	5.50%	190	7.40%	70	7.10%	*	*	50	10.00%
Emerging Issues	More ticks or mosquitoes, past 5 years (1)	Yes	767	20.20%	190	20.50%	70	22.90%	58	15.50%	50	22.00%
Emerging Issues	Power outages, past 5 years (1)	Yes	767	25.40%	190	26.80%	70	20.00%	58	17.20%	50	20.00%
Emerging Issues	School cancellation due to weather, past 5 years (1)	Yes	767	39.40%	190	38.90%	70	21.40%	58	17.20%	50	22.00%
Emerging Issues	Unable to work due to weather, past 5 years (1)	Yes	767	7.60%	190	6.80%	*	*	58	8.60%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (1)	Yes	767	33.30%	190	28.90%	70	31.40%	58	41.40%	50	26.00%
Emerging Issues	Other climate impact, past 5 years (1)	Yes	767	0.90%	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (1)	Yes	767	59.70%	190	56.30%	70	48.60%	58	58.60%	50	48.00%

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

Community Health Equity Survey (CHES) – Adult

CHES Adult: Boston – Burlington

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

						llesex					_		_		_	
			Massac	husetts	Cou	inty	Norfol	k County	Suffol	k County	Вс	oston	Bro	okline	Bu	rlington
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
		No steady place	14888	2.50%	3353	1.70%	1313	1.10%	1279	5.70%	1124	5.50%	468	1.10%	*	*
		Worried about losing	14888	8.00%	3353	6.50%	1313	6.60%	1279	9.30%	1124	9.10%	468	8.10%	*	*
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	1313	92.10%	1279	84.50%	1124	84.90%	468	90.60%	90	92.20%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	1006	31.70%	965	45.10%	845	43.70%	361	38.00%	68	41.20%
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	630	4.00%	665	5.00%	583	5.00%	216	3.70%	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	630	11.70%	665	21.20%	583	19.90%	216	10.60%	*	*
Basic	Trouble paying for health	163	7400	10.0070	1003	12.20/0	030	11.70/0	003	21.20/0	363	19.90/0	210	10.0070		
Needs	care (1)	Yes	7486	15.00%	1689	13.30%	630	10.30%	665	16.10%	583	16.00%	216	7.40%	*	*
Basic	Trouble paying for		7.100	20.0070		20.0070		20.0070		20.2070	300	20.0070		71.1070		
Needs	housing (1)	Yes	7486	19.40%	1689	15.60%	630	11.10%	665	22.70%	583	22.00%	216	8.80%	42	11.90%
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	630	4.90%	665	9.30%	583	8.90%	216	4.20%	*	*
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	630	7.60%	665	14.60%	583	14.10%	216	5.10%	*	*
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	630	9.40%	665	16.10%	583	14.80%	216	5.10%	42	11.90%
Basic	Trouble paying for ANY	162	7400	17.20/0	1003	11.50%	030	3.40/0	003	10.10%	363	14.00%	210	3.10/0	42	11.50/0
Needs	basic needs (1)	Yes	7486	35.20%	1689	27.10%	630	24.90%	665	40.50%	583	37.90%	216	19.00%	42	21.40%
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	3366	12.40%	1317	13.40%	1278	34.30%	1122	34.40%	461	10.20%	*	*

CHES Adult: Boston – Burlington

					Mid	dlesex	No	rfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Вс	ston	Bro	ookline	Bui	rlington
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
		Not enough														
		money	13814	16.50%	3141	11.00%	1201	11.00%	1191	19.80%	1054	18.90%	429	9.10%	80	7.50%
		Just enough														
		money	13814	31.10%	3141	24.90%	1201	28.10%	1191	40.00%	1054	40.30%	429	21.40%	80	28.80%
	End of month	Money left														
Basic Needs	finances	over	13814	52.40%	3141	64.10%	1201	60.90%	1191	40.20%	1054	40.80%	429	69.50%	80	63.80%
		No internet	11425	3.00%	2514	1.60%	1030	0.90%	981	5.50%	861	4.90%	*	*	*	*
		Does not														
_	Current internet	work well	11425	9.30%	2514	7.00%	1030	6.10%	981	9.00%	861	8.10%	368	6.00%	*	*
Basic Needs	access (2)	Works well	11425	87.70%	2514	91.50%	1030	93.00%	981	85.50%	861	87.00%	368	92.90%	69	97.10%
		Somewhat or														
		strongly	11064	7.000/	2524	F F00/	060	4.000/	965	C 200/	840	C 200/	326	2.100/	*	*
		disagree Somewhat	11064	7.00%	2521	5.50%	968	4.90%	965	6.30%	840	6.30%	326	3.10%		
		agree	11064	22.00%	2521	21.70%	968	17.30%	965	19.50%	840	18.10%	326	10.70%	73	28.80%
	Able to get where	Strongly	11004	22.0070	2321	21.7070	308	17.3070	303	19.5070	840	10.1070	320	10.7070	/3	28.8070
Neighborhood	you need to go (2)	agree	11064	71.00%	2521	72.80%	968	77.90%	965	74.20%	840	75.60%	326	86.20%	73	65.80%
	7 ou meet to 80 (=)	Never	11008	58.60%	2509	63.50%	967	64.60%	960	43.90%	835	46.90%	327	67.90%	73	67.10%
		Rarely	11008	28.90%	2509	28.60%	967	28.70%	960	31.90%	835	31.70%	327	29.10%	73	28.80%
	Experienced	Somewhat	11000	20.3070	2303	20.0070	307	20.7070	300	32.3070	000	31.7070	J2,	23.2070		20.0070
	neighborhood	often	11008	9.10%	2509	5.80%	967	5.50%	960	15.00%	835	12.80%	327	2.80%	*	*
Neighborhood	violence, lifetime (2)	Very often	11008	3.40%	2509	2.10%	967	1.10%	960	9.30%	835	8.50%	*	*	*	*
Safety &	Can count on	Yes	14393	80.60%	3236	83.50%	1285	84.10%	1256	75.20%	1103	75.60%	461	84.60%	90	84.40%
Support	someone for favors	Not sure	14393	6.50%	3236	6.60%	1285	5.60%	1256	5.80%	1103	5.40%	461	5.00%	90	6.70%
	Can count on	Yes	14366	73.20%	3233	75.50%	1281	75.40%	1252	68.20%	1098	68.50%	459	73.20%	90	68.90%
Safety &	someone to care for															
Support	you if sick	Not sure	14366	10.20%	3233	10.80%	1281	9.90%	1252	10.10%	1098	9.70%	459	11.10%	90	15.60%
	Can count on	Yes	14325	64.60%	3226	72.50%	1281	73.00%	1242	60.00%	1091	61.70%	460	76.30%	89	68.50%
Safety &	someone to lend															
Support	money	Not sure	14325	12.90%	3226	11.60%	1281	10.80%	1242	12.50%	1091	12.20%	460	8.30%	89	14.60%

CHES Adult: Boston – Burlington

					Mid	dlesex	No	orfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Вс	ston	Bro	okline	Bu	rlington
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Safety &	Can count on someone for	Yes	14336	79.20%	3222	82.70%	1277	83.60%	1250	77.20%	1099	77.40%	458	84.70%	89	77.50%
Support	support with family trouble	Not sure	14336	7.00%	3222	6.80%	1277	6.10%	1250	6.10%	1099	5.90%	458	6.10%	89	10.10%
Safety &	Can count on someone to	Yes	14247	62.30%	3212	66.10%	1266	66.70%	1247	60.40%	1093	62.10%	451	66.70%	89	57.30%
Support	help find housing	Not sure	14247	16.30%	3212	17.40%	1266	16.40%	1247	13.30%	1093	13.10%	451	16.90%	89	19.10%
Safety &	Experienced intimate	Ever	13621	29.70%	3068	26.50%	1207	23.80%	1174	26.90%	1036	25.80%	431	21.60%	84	27.40%
Support	partner violence (a)	In past year	13359	4.50%	3029	3.20%	1195	3.20%	1152	5.20%	1018	4.70%	430	2.10%	*	*
Safety &	Experienced sexual violence	Ever	13628	21.00%	3073	22.60%	1211	18.10%	1194	21.30%	1049	22.00%	432	16.40%	86	22.10%
Support	(b)	In past year	13593	1.40%	3070	1.20%	1210	0.40%	1190	2.20%	1046	2.20%	*	*	*	*
Safety &		Ever	14130	55.20%	3160	59.10%	1256	57.60%	1235	59.20%	1084	57.80%	452	61.90%	86	58.10%
Support	Experienced discrimination	In past year	14130	18.00%	3160	17.20%	1256	16.80%	1235	22.00%	1084	21.30%	452	12.60%	86	18.60%
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	563	21.00%	600	20.50%	536	20.00%	182	20.90%	37	16.20%
		At home only	9173	7.50%	2091	10.40%	771	10.00%	762	6.60%	678	6.60%	238	14.70%	52	13.50%
		Outside home only	9173	54.60%	2091	42.40%	771	43.70%	762	50.10%	678	49.70%	238	29.00%	52	51.90%
	Location of work (among all	Both at home/outside														
Employment	workers)	home	9173	37.40%	2091	46.60%	771	46.00%	762	42.90%	678	43.20%	238	55.50%	52	34.60%
	Paid sick leave at work	Yes	6903	75.30%	1543	76.80%	564	74.30%	599	75.60%	534	75.80%	182	64.80%	37	78.40%
Employment	(among all workers) (2)	Not sure	6903	4.20%	1543	3.60%	564	4.40%	599	4.00%	534	3.60%	182	5.50%	*	*

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

CHES Adult: Boston – Burlington

		Massa	chusotts							D.	oston	Bre	ooklina	P	rlington
Question	Pasnansa		1		· ·			i e	1		1		1		%
Question	Response	IN	70	IN	70	IN	70	IN	70	IN	70	IN	70	IN	70
Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	635	65.00%	578	64.50%	510	64.50%	229	63.80%	43	60.50%
		0011	00.2070		00.0075		00.0070	0.0	0 110070	525	0 110 0 70		00.0070		
needed this care) (2)	Yes	3455	7.60%	849	5.90%	331	6.00%	281	11.00%	253	11.10%	135	5.20%	*	*
Unmet need for injury care															
(among those who needed this															
care) (2)	Yes	1674	9.00%	443	7.70%	152	4.60%	116	7.80%	103	7.80%	*	*	*	*
Unmet need for ongoing health															
condition (among those who															
, , ,	Yes	3052	9.00%	713	6.60%	275	8.70%	290	6.90%	270	6.70%	94	6.40%	*	*
·															
· =															
	Yes	334	25.40%	69	34.80%	40	27.50%	48	16.70%	44	18.20%	*	*	*	*
	l														*
	Yes	2441	21.10%	596	17.40%	222	21.60%	220	21.80%	198	21.20%	85	16.50%	*	*
·															
1 '	V	000	7.000/	242	C C00/	77	10 100/	116	6.000/	101	F 000/	*	4	*	*
, , ,	Yes	998	7.00%	243	6.60%	//	10.40%	116	6.90%	104	5.80%	**	T	*	+
, ,	Voc	100	12 00%	*	*	*	*	*	*	*	*	*	*	*	*
, , ,	163	109	13.90/0												
7.															
_	Yes	760	12 80%	174	11 50%	72	11 10%	53	24 50%	41	17 10%	*	*	*	*
, , ,	103	, 55	12.0070	1,7	11.50/0	, ,	11.10/0	- 55	24.50/0	71	17.10/0				+
•															
1	Yes	6941	15.20%	1655	12.60%	635	13.70%	634	15.80%	567	15.20%	237	11.40%	41	22.00%
	Unmet need for injury care (among those who needed this care) (2) Unmet need for ongoing health	Reported chronic condition (1) Unmet need for short-term illness care (among those who needed this care) (2) Unmet need for injury care (among those who needed this care) (2) Unmet need for ongoing health condition (among those who needed this care) (2) Unmet need for home and community-based services (among those who needed this care) (2) Unmet need for mental health care (among those who needed this care) (2) Ves Unmet need for sexual and reproductive health care (among those who needed this care) (2) Unmet need for substance use or addiction treatment (among those who needed this care) (2) Ves Unmet need for other type of care (among those who needed this care) (2) Yes ANY unmet health care need, past year (among those who	QuestionResponseNReported chronic condition (1)Yes6821Unmet need for short-term illness care (among those who needed this care) (2)Yes3455Unmet need for injury care (among those who needed this care) (2)Yes1674Unmet need for ongoing health condition (among those who needed this care) (2)Yes3052Unmet need for home and community-based services (among those who needed this care) (2)Yes334Unmet need for mental health care (among those who needed this care) (2)Yes2441Unmet need for sexual and reproductive health care (among those who needed this care) (2)Yes998Unmet need for substance use or addiction treatment (among those who needed this care) (2)Yes109Unmet need for other type of care (among those who needed this care) (2)Yes760ANY unmet health care need, past year (among those who	Reported chronic condition (1) Unmet need for short-term illness care (among those who needed this care) (2) Unmet need for injury care (among those who needed this care) (2) Unmet need for ongoing health condition (among those who needed this care) (2) Unmet need for home and community-based services (among those who needed this care) (2) Unmet need for mental health 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CHES Adult: Boston – Burlington

			Massa	chusetts	-	dlesex unty	_	rfolk unty	Suffoll	k County	Вс	ston	Bro	ookline	Bur	rlington
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
		One or more														
		visit	6747	51.20%	1504	58.80%	636	56.10%	579	51.60%	511	52.10%	233	62.20%	42	57.10%
		Offered, didn't														
		have	6747	7.00%	1504	7.60%	636	6.90%	579	7.80%	511	8.00%	233	6.90%	*	*
		Not offered	6747	22.10%	1504	19.00%	636	20.80%	579	20.60%	511	20.70%	233	16.70%	42	26.20%
Healthcare	Telehealth visit, past year	No healthcare														
Access	(1)	visits	6747	20.30%	1504	14.80%	636	16.70%	579	20.60%	511	19.80%	233	14.60%	42	14.30%
	Child had unmet mental	Yes	4184	20.20%	1016	19.20%	394	18.80%	259	18.10%	219	18.30%	138	17.40%	*	*
Healthcare	health care need (among															
Access	parents)	Not sure	4184	3.80%	1016	3.60%	394	4.60%	259	5.00%	219	5.00%	138	5.10%	*	*
		Low	13267	36.80%	3024	38.70%	1183	40.20%	1146	34.80%	1014	36.50%	428	40.40%	82	42.70%
		Medium	13267	32.00%	3024	34.30%	1183	35.20%	1146	29.50%	1014	28.60%	428	41.10%	82	37.80%
Mental	Psychological distress, past	High	13267	13.90%	3024	13.70%	1183	11.70%	1146	15.80%	1014	15.50%	428	10.00%	82	8.50%
Health	month	Very high	13267	17.30%	3024	13.40%	1183	12.80%	1146	19.90%	1014	19.40%	428	8.40%	82	11.00%
Mental		Usually or														
Health	Feel isolated from others	always	10237	13.00%	2311	10.90%	906	9.70%	905	11.60%	789	11.00%	312	7.70%	68	7.40%
Mental	Suicide ideation, past year															
Health	(c)	Yes	13036	7.40%	2981	7.00%	1168	4.70%	1119	6.80%	985	7.00%	423	2.80%	80	8.80%

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

CHES Adult: Boston – Burlington

				_	_	dlesex	_	rfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Вс	oston	Bro	okline	Bu	rlington
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Substance																
Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	908	6.30%	915	15.00%	808	14.20%	339	2.90%	*	*
Substance		Yes, past														
Use	Alcohol use, past month	month	13463	49.60%	3027	56.30%	1209	52.10%	1187	40.20%	1042	41.00%	438	55.00%	81	58.00%
Substance		Yes, past														
Use	Medical cannabis use, past month	month	13607	6.40%	3057	4.40%	1221	4.40%	1192	3.90%	1047	3.20%	441	3.40%	*	*
Substance		Yes, past														
Use	Medical cannabis use, past year	year	13626	7.40%	3061	5.40%	1224	5.00%	1195	4.80%	1049	4.00%	442	4.10%	*	*
Substance	Non-medical cannabis use, past	Yes, past														
Use	month	month	13612	13.80%	3058	11.20%	1223	10.80%	1195	14.90%	1049	15.40%	442	9.70%	84	6.00%
Substance	Non-medical cannabis use, past	Yes, past														
Use	year	year	13626	18.00%	3061	16.60%	1224	13.20%	1195	20.60%	1049	21.50%	442	13.60%	85	12.90%
Substance	Amphetamine/methamphetamine															
Use	use, past year	Yes	13626	0.50%	3061	0.40%	*	*	1195	0.70%	1049	0.70%	*	*	*	*
Substance																
Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	1195	1.10%	1049	0.90%	*	*	*	*
Substance	Ecstasy/MDMA/LSD/Ketamine															
Use	use, past year	Yes	13626	0.80%	3061	0.80%	1224	0.40%	1195	1.50%	1049	1.30%	*	*	*	*
Substance																
Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	1195	0.50%	1049	0.50%	*	*	*	*
Substance																
Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*	*	*
Substance	Opioid use, not prescribed, past															
Use	year	Yes	13626	0.80%	3061	0.30%	*	*	1195	0.70%	1049	0.80%	*	*	*	*
Substance	Opioid use, not used as															
Use	prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	1195	0.80%	1049	0.90%	*	*	*	*
Substance	Prescription drugs use, non-															
Use	medical, past year	Yes	13626	1.70%	3061	1.20%	1224	1.30%	1195	1.30%	1049	1.10%	442	1.40%	*	*
Substance	OCT drug use, non-medical, past															
Use	year	Yes	13626	0.80%	3061	0.60%	1224	0.70%	*	*	*	*	*	*	*	*
Substance																
Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	1224	1.10%	1195	2.40%	1049	2.40%	442	1.60%	*	*

CHES Adult: Boston – Burlington

					Mid	dlesex	N	orfolk	S	uffolk						
			Massa	chusetts	Co	unty	C	ounty	C	ounty	В	oston	Bro	okline	Bu	rlington
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
	COV(ID 40	Yes	6729	67.80%	1506	76.40%	636	78.50%	568	68.10%	501	69.90%	239	90.40%	44	68.20%
Emerging Issues	COVID-19 vaccination, past year (1)	Not sure	6729	3.60%	1506	3.30%	636	2.50%	568	3.70%	501	3.00%	239	2.50%	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	554	15.50%	475	21.70%	413	20.80%	186	12.40%	42	11.90%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	902	38.50%	938	38.90%	827	39.90%	337	40.90%	58	34.50%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	902	10.90%	938	9.80%	827	9.80%	337	11.60%	58	10.30%
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	902	23.90%	938	16.70%	827	17.30%	337	22.30%	58	34.50%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	902	20.40%	938	14.10%	827	14.30%	337	18.40%	58	25.90%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	902	15.20%	938	12.00%	827	12.20%	337	16.30%	58	17.20%
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	902	10.90%	938	13.10%	827	13.50%	337	9.80%	58	15.50%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	902	24.50%	938	29.20%	827	29.70%	337	29.10%	58	25.90%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	902	1.90%	938	1.50%	827	1.50%	337	1.50%	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	902	63.30%	938	59.30%	827	59.30%	337	64.10%	58	70.70%

CHES Adult: Chelsea - Needham

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

					Mid	dlesex	No	orfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Cł	nelsea	Le	xington	N	eedham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
		No steady														
		place	14888	2.50%	3353	1.70%	1313	1.10%	1279	5.70%	100	9.00%	*	*	*	*
		Worried about														
		losing	14888	8.00%	3353	6.50%	1313	6.60%	1279	9.30%	100	11.00%	*	*	*	*
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	1313	92.10%	1279	84.50%	100	80.00%	60	95.00%	75	98.70%
		Yes, at least														
Housing	Issues in current housing (2)	one	11103	37.00%	2437	39.10%	1006	31.70%	965	45.10%	78	55.10%	46	23.90%	55	30.90%
Basic	Trouble paying for															
Needs	childcare/school (1)	Yes	7486	4.60%	1689	4.70%	630	4.00%	665	5.00%	*	*	*	*	*	*
	Trouble paying for food or															
Basic	groceries (including formula or															
Needs	baby food) (1)	Yes	7486	18.80%	1689	12.20%	630	11.70%	665	21.20%	56	35.70%	*	*	*	*
Basic	Trouble paying for health care															
Needs	(1)	Yes	7486	15.00%	1689	13.30%	630	10.30%	665	16.10%	56	14.30%	*	*	*	*
Basic																
Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	630	11.10%	665	22.70%	56	33.90%	*	*	*	*
Basic	Trouble paying for technology															
Needs	(1)	Yes	7486	8.40%	1689	6.00%	630	4.90%	665	9.30%	56	8.90%	*	*	*	*
Basic	Trouble paying for															
Needs	transportation (1)	Yes	7486	12.60%	1689	9.40%	630	7.60%	665	14.60%	56	16.10%	*	*	*	*
Basic																
Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	630	9.40%	665	16.10%	56	23.20%	*	*	*	*
Basic	Trouble paying for ANY basic															
Needs	needs (1)	Yes	7486	35.20%	1689	27.10%	630	24.90%	665	40.50%	56	66.10%	*	*	*	*

CHES Adult: Chelsea – Needham

					Mid	dlesex	No	rfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Cl	nelsea	Le	xington	N	eedham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
	Applied for/received															
Basic Needs	economic assistance	Yes	14928	20.30%	3366	12.40%	1317	13.40%	1278	34.30%	102	41.20%	60	10.00%	75	6.70%
		Not enough														
		money	13814	16.50%	3141	11.00%	1201	11.00%	1191	19.80%	91	28.60%	*	*	*	*
		Just enough														
		money	13814	31.10%	3141	24.90%	1201	28.10%	1191	40.00%	91	40.70%	51	21.60%	64	14.10%
		Money left														
Basic Needs	End of month finances	over	13814	52.40%	3141	64.10%	1201	60.90%	1191	40.20%	91	30.80%	51	74.50%	64	81.30%
		No internet	11425	3.00%	2514	1.60%	1030	0.90%	981	5.50%	78	11.50%	*	*	*	*
		Does not														
		work well	11425	9.30%	2514	7.00%	1030	6.10%	981	9.00%	78	17.90%	*	*	*	*
Basic Needs	Current internet access (2)	Works well	11425	87.70%	2514	91.50%	1030	93.00%	981	85.50%	78	70.50%	47	93.60%	57	100.00%
		Somewhat or														
		strongly														
		disagree	11064	7.00%	2521	5.50%	968	4.90%	965	6.30%	83	6.00%	*	*	*	*
		Somewhat														
		agree	11064	22.00%	2521	21.70%	968	17.30%	965	19.50%	83	30.10%	39	28.20%	51	19.60%
	Able to get where you	Strongly														
Neighborhood	need to go (2)	agree	11064	71.00%	2521	72.80%	968	77.90%	965	74.20%	83	63.90%	39	66.70%	51	72.50%
		Never	11008	58.60%	2509	63.50%	967	64.60%	960	43.90%	83	18.10%	38	81.60%	51	70.60%
		Rarely	11008	28.90%	2509	28.60%	967	28.70%	960	31.90%	83	32.50%	38	15.80%	51	27.50%
	Experienced	Somewhat														
	neighborhood violence,	often	11008	9.10%	2509	5.80%	967	5.50%	960	15.00%	83	34.90%	*	*	*	*
Neighborhood	lifetime (2)	Very often	11008	3.40%	2509	2.10%	967	1.10%	960	9.30%	83	14.50%	*		*	*
Safety &	Can count on someone for	Yes	14393	80.60%	3236	83.50%	1285	84.10%	1256	75.20%	100	72.00%	56	91.10%	72	83.30%
Support	favors	Not sure	14393	6.50%	3236	6.60%	1285	5.60%	1256	5.80%	100	8.00%	*	*	72	8.30%
Safety &	Can count on someone to	Yes	14366	73.20%	3233	75.50%	1281	75.40%	1252	68.20%	101	65.30%	56	76.80%	71	76.10%
Support	care for you if sick	Not sure	14366	10.20%	3233	10.80%	1281	9.90%	1252	10.10%	101	12.90%	56	8.90%	71	12.70%
Safety &	Can count on someone to	Yes	14325	64.60%	3226	72.50%	1281	73.00%	1242	60.00%	98	37.80%	56	76.80%	71	80.30%
Support	lend money	Not sure	14325	12.90%	3226	11.60%	1281	10.80%	1242	12.50%	98	18.40%	56	8.90%	71	7.00%

CHES Adult: Chelsea - Needham

					Mid	dlesex	No	rfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Ch	nelsea	Lex	ington	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
_	Can count on someone for	Yes	14336	79.20%	3222	82.70%	1277	83.60%	1250	77.20%	98	73.50%	55	87.30%	71	84.50%
Safety & Support	support with family trouble	Not sure	14336	7.00%	3222	6.80%	1277	6.10%	1250	6.10%	98	8.20%	*	*	71	8.50%
Safety &	Can count on someone to	Yes	14247	62.30%	3212	66.10%	1266	66.70%	1247	60.40%	101	42.60%	54	74.10%	69	59.40%
Support	help find housing	Not sure	14247	16.30%	3212	17.40%	1266	16.40%	1247	13.30%	101	19.80%	54	14.80%	69	24.60%
Safety &	Experienced intimate	Ever	13621	29.70%	3068	26.50%	1207	23.80%	1174	26.90%	88	27.30%	54	18.50%	70	18.60%
Support	partner violence (a)	In past year	13359	4.50%	3029	3.20%	1195	3.20%	1152	5.20%	85	7.10%	*	*	*	*
Safety &	Experienced sexual	Ever	13628	21.00%	3073	22.60%	1211	18.10%	1194	21.30%	96	15.60%	54	14.80%	66	12.10%
Support	violence (b)	In past year	13593	1.40%	3070	1.20%	1210	0.40%	1190	2.20%	*	*	*	*	*	*
Safety &		Ever	14130	55.20%	3160	59.10%	1256	57.60%	1235	59.20%	99	69.70%	55	70.90%	71	50.70%
Support	Experienced discrimination	In past year	14130	18.00%	3160	17.20%	1256	16.80%	1235	22.00%	99	31.30%	55	30.90%	71	16.90%
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	563	21.00%	600	20.50%	37	35.10%	32	18.80%	*	*
		At home only	9173	7.50%	2091	10.40%	771	10.00%	762	6.60%	*	*	38	13.20%	39	12.80%
		Outside home only	9173	54.60%	2091	42.40%	771	43.70%	762	50.10%	52	57.70%	38	31.60%	39	35.90%
	Location of work (among	Both at home/outside														
Employment	all workers)	home	9173	37.40%	2091	46.60%	771	46.00%	762	42.90%	52	34.60%	38	55.30%	39	51.30%
	Paid sick leave at work	Yes	6903	75.30%	1543	76.80%	564	74.30%	599	75.60%	38	65.80%	32	71.90%	*	*
Employment	(among all workers) (2)	Not sure	6903	4.20%	1543	3.60%	564	4.40%	599	4.00%	*	*	*	*	*	*

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

CHES Adult: Chelsea – Needham

					Mid	dlesex	N	orfolk	S	uffolk						
			Massa	chusetts	Co	unty	C	ounty	C	ounty	C	helsea	Lexin	gton	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Healthcare																
Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	635	65.00%	578	64.50%	43	67.40%	*	*	37	62.20%
	Unmet need for short-term illness															
Healthcare	care (among those who needed this															
Access	care) (2)	Yes	3455	7.60%	849	5.90%	331	6.00%	281	11.00%	*	*	*	*	*	*
Healthcare	Unmet need for injury care (among															
Access	those who needed this care) (2)	Yes	1674	9.00%	443	7.70%	152	4.60%	116	7.80%	*	*	*	*	*	*
	Unmet need for ongoing health															
Healthcare	condition (among those who needed															
Access	this care) (2)	Yes	3052	9.00%	713	6.60%	275	8.70%	290	6.90%	*	*	*	*	*	*
	Unmet need for home and															
Healthcare	community-based services (among															
Access	those who needed this care) (2)	Yes	334	25.40%	69	34.80%	40	27.50%	48	16.70%	*	*	*	*	*	*
	Unmet need for mental health care															
Healthcare	(among those who needed this care)															
Access	(2)	Yes	2441	21.10%	596	17.40%	222	21.60%	220	21.80%	*	*	*	*	*	*
	Unmet need for sexual and															
Healthcare	reproductive health care (among															
Access	those who needed this care) (2)	Yes	998	7.00%	243	6.60%	77	10.40%	116	6.90%	*	*	*	*	*	*
	Unmet need for substance use or															
Healthcare	addiction treatment (among those															
Access	who needed this care) (2)	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*	*	*
	Unmet need for other type of care															
Healthcare	(among those who needed this care)															
Access	(2)	Yes	760	12.80%	174	11.50%	72	11.10%	53	24.50%	*	*	*	*	*	*
	ANY unmet health care need, past															
Healthcare	year (among those who needed any															
Access	care) (2)	Yes	6941	15.20%	1655	12.60%	635	13.70%	634	15.80%	40	20.00%	*	*	*	*

CHES Adult: Chelsea – Needham

					Mid	dlesex	No	rfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	С	helsea	Le	xington	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
		One or more														
		visit	6747	51.20%	1504	58.80%	636	56.10%	579	51.60%	42	40.50%	*	*	39	61.50%
		Offered, didn't														
		have	6747	7.00%	1504	7.60%	636	6.90%	579	7.80%	*	*	*	*	*	*
		Not offered	6747	22.10%	1504	19.00%	636	20.80%	579	20.60%	42	19.00%	*	*	39	20.50%
Healthcare	Telehealth visit, past year	No healthcare														
Access	(1)	visits	6747	20.30%	1504	14.80%	636	16.70%	579	20.60%	42	35.70%	*	*	39	12.80%
	Child had unmet mental	Yes	4184	20.20%	1016	19.20%	394	18.80%	259	18.10%	*	*	*	*	*	*
Healthcare	health care need (among															
Access	parents)	Not sure	4184	3.80%	1016	3.60%	394	4.60%	259	5.00%	*	*	*	*	*	*
		Low	13267	36.80%	3024	38.70%	1183	40.20%	1146	34.80%	86	18.60%	53	41.50%	67	43.30%
		Medium	13267	32.00%	3024	34.30%	1183	35.20%	1146	29.50%	86	37.20%	53	41.50%	67	44.80%
Mental	Psychological distress, past	High	13267	13.90%	3024	13.70%	1183	11.70%	1146	15.80%	86	20.90%	53	15.10%	*	*
Health	month	Very high	13267	17.30%	3024	13.40%	1183	12.80%	1146	19.90%	86	23.30%	*	*	*	*
Mental		Usually or														
Health	Feel isolated from others	always	10237	13.00%	2311	10.90%	906	9.70%	905	11.60%	77	14.30%	*	*	*	*
Mental	Suicide ideation, past year															
Health	(c)	Yes	13036	7.40%	2981	7.00%	1168	4.70%	1119	6.80%	*	*	*	*	*	*

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

CHES Adult: Chelsea – Needham

						dlesex		rfolk								
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Cl	helsea	Le	xington	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Substance																
Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	908	6.30%	915	15.00%	70	22.90%	*	*	*	*
Substance		Yes, past														
Use	Alcohol use, past month	month	13463	49.60%	3027	56.30%	1209	52.10%	1187	40.20%	95	20.00%	55	49.10%	70	62.90%
Substance		Yes, past														
Use	Medical cannabis use, past month	month	13607	6.40%	3057	4.40%	1221	4.40%	1192	3.90%	95	7.40%	*	*	*	*
Substance		Yes, past														
Use	Medical cannabis use, past year	year	13626	7.40%	3061	5.40%	1224	5.00%	1195	4.80%	96	8.30%	*	*	*	*
Substance	Non-medical cannabis use, past	Yes, past														
Use	month	month	13612	13.80%	3058	11.20%	1223	10.80%	1195	14.90%	96	12.50%	*	*	70	10.00%
Substance	Non-medical cannabis use, past	Yes, past														
Use	year	year	13626	18.00%	3061	16.60%	1224	13.20%	1195	20.60%	96	13.50%	*	*	70	14.30%
Substance	Amphetamine/methamphetamine															
Use	use, past year	Yes	13626	0.50%	3061	0.40%	*	*	1195	0.70%	*	*	*	*	*	*
Substance																
Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	1195	1.10%	*	*	*	*	*	*
Substance	Ecstasy/MDMA/LSD/Ketamine															
Use	use, past year	Yes	13626	0.80%	3061	0.80%	1224	0.40%	1195	1.50%	*	*	*	*	*	*
Substance																
Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	1195	0.50%	*	*	*	*	*	*
Substance																
Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*	*	*
Substance	Opioid use, not prescribed, past															
Use	year	Yes	13626	0.80%	3061	0.30%	*	*	1195	0.70%	*	*	*	*	*	*
Substance	Opioid use, not used as															
Use	prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	1195	0.80%	*	*	*	*	*	*
Substance	Prescription drugs use, non-															
Use	medical, past year	Yes	13626	1.70%	3061	1.20%	1224	1.30%	1195	1.30%	*	*	*	*	*	*
Substance	OCT drug use, non-medical, past															
Use	year	Yes	13626	0.80%	3061	0.60%	1224	0.70%	*	*	*	*	*	*	*	*
Substance																
Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	1224	1.10%	1195	2.40%	*	*	*	*	*	*

CHES Adult: Chelsea – Needham

					Mid	dlesex	No	orfolk	Sı	uffolk						
			Massa	chusetts	Co	unty	Co	ounty	Co	ounty	С	helsea	Lex	kington	Ne	edham
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
		Yes	6729	67.80%	1506	76.40%	636	78.50%	568	68.10%	42	54.80%	*	*	38	84.20%
Emerging Issues	COVID-19 vaccination, past year (1)	Not sure	6729	3.60%	1506	3.30%	636	2.50%	568	3.70%	42	11.90%	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	554	15.50%	475	21.70%	38	28.90%	*	*	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	902	38.50%	938	38.90%	73	23.30%	44	38.60%	52	34.60%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	902	10.90%	938	9.80%	73	8.20%	*	*	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	902	23.90%	938	16.70%	*	*	44	50.00%	52	28.80%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	902	20.40%	938	14.10%	73	12.30%	44	40.90%	52	15.40%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	902	15.20%	938	12.00%	73	13.70%	44	18.20%	52	19.20%
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	902	10.90%	938	13.10%	73	9.60%	44	11.40%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	902	24.50%	938	29.20%	73	24.70%	44	20.50%	52	21.20%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	902	1.90%	938	1.50%	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	902	63.30%	938	59.30%	73	50.70%	44	75.00%	52	63.50%

CHES Adult: Newton – Peabody

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

					Mid	ldlesex	No	orfolk						
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Ne	ewton	Pe	eabody
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%
		No steady place	14888	2.50%	3353	1.70%	1313	1.10%	1279	5.70%	*	*	*	*
		Worried about losing	14888	8.00%	3353	6.50%	1313	6.60%	1279	9.30%	310	3.90%	*	*
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	1313	92.10%	1279	84.50%	310	95.50%	37	89.20%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	1006	31.70%	965	45.10%	229	34.10%	*	*
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	630	4.00%	665	5.00%	156	3.80%	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	630	11.70%	665	21.20%	156	5.10%	*	*
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	1689	13.30%	630	10.30%	665	16.10%	156	6.40%	*	*
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	630	11.10%	665	22.70%	156	8.30%	*	*
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	630	4.90%	665	9.30%	156	3.80%	*	*
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	630	7.60%	665	14.60%	156	3.80%	*	*
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	630	9.40%	665	16.10%	156	5.10%	*	*
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	1689	27.10%	630	24.90%	665	40.50%	156	12.20%	*	*
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	3366	12.40%	1317	13.40%	1278	34.30%	313	5.80%	*	*
		Not enough money	13814	16.50%	3141	11.00%	1201	11.00%	1191	19.80%	282	7.40%	*	*
		Just enough money	13814	31.10%	3141	24.90%	1201	28.10%	1191	40.00%	282	17.40%	36	27.80%
Basic Needs	End of month finances	Money left over	13814	52.40%	3141	64.10%	1201	60.90%	1191	40.20%	282	75.20%	36	61.10%
		No internet	11425	3.00%	2514	1.60%	1030	0.90%	981	5.50%	*	*	*	*
		Does not work well	11425	9.30%	2514	7.00%	1030	6.10%	981	9.00%	239	2.10%	*	*
Basic Needs	Current internet access (2)	Works well	11425	87.70%	2514	91.50%	1030	93.00%	981	85.50%	239	97.50%	*	*

CHES Adult: Newton – Peabody

					Mid	dlesex	No	rfolk						
			Massa	chusetts	Co	unty	Co	unty	Suffol	k County	Ne	wton	Pe	abody
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%
		Somewhat or												
		strongly disagree	11064	7.00%	2521	5.50%	968	4.90%	965	6.30%	226	5.80%	*	*
	Able to get where you need to	Somewhat agree	11064	22.00%	2521	21.70%	968	17.30%	965	19.50%	226	17.30%	*	*
Neighborhood	go (2)	Strongly agree	11064	71.00%	2521	72.80%	968	77.90%	965	74.20%	226	77.00%	*	*
		Never	11008	58.60%	2509	63.50%	967	64.60%	960	43.90%	225	69.80%	*	*
		Rarely	11008	28.90%	2509	28.60%	967	28.70%	960	31.90%	225	27.10%	*	*
	Experienced neighborhood	Somewhat often	11008	9.10%	2509	5.80%	967	5.50%	960	15.00%	225	2.20%	*	*
Neighborhood	violence, lifetime (2)	Very often	11008	3.40%	2509	2.10%	967	1.10%	960	9.30%	*	*	*	*
Safety &		Yes	14393	80.60%	3236	83.50%	1285	84.10%	1256	75.20%	294	90.80%	37	81.10%
Support	Can count on someone for favors	Not sure	14393	6.50%	3236	6.60%	1285	5.60%	1256	5.80%	294	5.40%	*	*
Safety &	Can count on someone to care	Yes	14366	73.20%	3233	75.50%	1281	75.40%	1252	68.20%	293	80.50%	37	70.30%
Support	for you if sick	Not sure	14366	10.20%	3233	10.80%	1281	9.90%	1252	10.10%	293	9.90%	37	13.50%
Safety &	Can count on someone to lend	Yes	14325	64.60%	3226	72.50%	1281	73.00%	1242	60.00%	293	84.30%	36	72.20%
Support	money	Not sure	14325	12.90%	3226	11.60%	1281	10.80%	1242	12.50%	293	7.20%	*	*
Safety &	Can count on someone for	Yes	14336	79.20%	3222	82.70%	1277	83.60%	1250	77.20%	292	90.80%	37	83.80%
Support	support with family trouble	Not sure	14336	7.00%	3222	6.80%	1277	6.10%	1250	6.10%	292	4.10%	*	*
Safety &	Can count on someone to help	Yes	14247	62.30%	3212	66.10%	1266	66.70%	1247	60.40%	291	69.40%	36	55.60%
Support	find housing	Not sure	14247	16.30%	3212	17.40%	1266	16.40%	1247	13.30%	291	20.60%	*	*
Safety &	Experienced intimate partner	Ever	13621	29.70%	3068	26.50%	1207	23.80%	1174	26.90%	284	22.50%	36	19.40%
Support	violence (a)	In past year	13359	4.50%	3029	3.20%	1195	3.20%	1152	5.20%	283	2.10%	*	*
Safety &		Ever	13628	21.00%	3073	22.60%	1211	18.10%	1194	21.30%	283	23.30%	36	13.90%
Support	Experienced sexual violence (b)	In past year	13593	1.40%	3070	1.20%	1210	0.40%	1190	2.20%	283	1.80%	*	*
Safety &		Ever	14130	55.20%	3160	59.10%	1256	57.60%	1235	59.20%	287	60.60%	37	64.90%
Support	Experienced discrimination	In past year	14130	18.00%	3160	17.20%	1256	16.80%	1235	22.00%	287	14.30%	37	24.30%

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

CHES Adult: Newton – Peabody

						ldlesex		orfolk		ıffolk				
			Massa	chusetts	Co	unty	C	ounty	Co	ounty	N	ewton	Pea	body
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	563	21.00%	600	20.50%	144	19.40%	*	*
		At home only	9173	7.50%	2091	10.40%	771	10.00%	762	6.60%	180	16.10%	*	*
		Outside home												
		only	9173	54.60%	2091	42.40%	771	43.70%	762	50.10%	180	32.80%	*	*
		Both at												
		home/outside												
Employment	Location of work (among all workers)	home	9173	37.40%	2091	46.60%	771	46.00%	762	42.90%	180	51.10%	*	*
	Paid sick leave at work (among all workers)	Yes	6903	75.30%	1543	76.80%	564	74.30%	599	75.60%	142	76.10%	*	*
Employment	(2)	Not sure	6903	4.20%	1543	3.60%	564	4.40%	599	4.00%	*	*	*	*
Healthcare														
Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	635	65.00%	578	64.50%	131	55.70%	*	*
Healthcare	Unmet need for short-term illness care													
Access	(among those who needed this care) (2)	Yes	3455	7.60%	849	5.90%	331	6.00%	281	11.00%	*	*	*	*
Healthcare	Unmet need for injury care (among those													
Access	who needed this care) (2)	Yes	1674	9.00%	443	7.70%	152	4.60%	116	7.80%	*	*	*	*
Healthcare	Unmet need for ongoing health condition													
Access	(among those who needed this care) (2)	Yes	3052	9.00%	713	6.60%	275	8.70%	290	6.90%	55	9.10%	*	*
	Unmet need for home and community-based													
Healthcare	services (among those who needed this care)													
Access	(2)	Yes	334	25.40%	69	34.80%	40	27.50%	48	16.70%	*	*	*	*
Healthcare	Unmet need for mental health care (among													
Access	those who needed this care) (2)	Yes	2441	21.10%	596	17.40%	222	21.60%	220	21.80%	*	*	*	*
	Unmet need for sexual and reproductive													
Healthcare	health care (among those who needed this													
Access	care) (2)	Yes	998	7.00%	243	6.60%	77	10.40%	116	6.90%	*	*	*	*
	Unmet need for substance use or addiction													
Healthcare	treatment (among those who needed this													
Access	care) (2)	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*
Healthcare	Unmet need for other type of care (among													
Access	those who needed this care) (2)	Yes	760	12.80%	174	11.50%	72	11.10%	53	24.50%	*	*	*	*
Healthcare	ANY unmet health care need, past year													
Access	(among those who needed any care) (2)	Yes	6941	15.20%	1655	12.60%	635	13.70%	634	15.80%	145	7.60%	*	*

CHES Adult: Newton – Peabody

				_		dlesex		rfolk						
			Massa	chusetts	Со	unty	Co	unty	Suffol	k County	Ne	ewton	Pe	abody
Topic	Question	Response	N	%	N	%	N	%	N	%	N	%	N	%
		One or more												
		visit	6747	51.20%	1504	58.80%	636	56.10%	579	51.60%	129	62.00%	*	*
		Offered, didn't												
		have	6747	7.00%	1504	7.60%	636	6.90%	579	7.80%	129	8.50%	*	*
		Not offered	6747	22.10%	1504	19.00%	636	20.80%	579	20.60%	129	17.80%	*	*
Healthcare		No healthcare												
Access	Telehealth visit, past year (1)	visits	6747	20.30%	1504	14.80%	636	16.70%	579	20.60%	129	11.60%	*	*
Healthcare	Child had unmet mental health care	Yes	4184	20.20%	1016	19.20%	394	18.80%	259	18.10%	115	22.60%	*	*
Access	need (among parents)	Not sure	4184	3.80%	1016	3.60%	394	4.60%	259	5.00%	115	4.30%	*	*
		Low	13267	36.80%	3024	38.70%	1183	40.20%	1146	34.80%	271	42.80%	36	36.10%
		Medium	13267	32.00%	3024	34.30%	1183	35.20%	1146	29.50%	271	35.80%	36	47.20%
		High	13267	13.90%	3024	13.70%	1183	11.70%	1146	15.80%	271	10.70%	*	*
Mental Health	Psychological distress, past month	Very high	13267	17.30%	3024	13.40%	1183	12.80%	1146	19.90%	271	10.70%	*	*
		Usually or												
Mental Health	Feel isolated from others	always	10237	13.00%	2311	10.90%	906	9.70%	905	11.60%	208	7.20%	*	*
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	2981	7.00%	1168	4.70%	1119	6.80%	266	6.80%	*	*
Substance														
Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	908	6.30%	915	15.00%	219	5.00%	*	*
Substance														
Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	1209	52.10%	1187	40.20%	276	62.00%	37	45.90%
Substance														
Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	1221	4.40%	1192	3.90%	277	5.10%	*	*
Substance														
Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	1224	5.00%	1195	4.80%	277	6.10%	*	*
Substance														
Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	1223	10.80%	1195	14.90%	277	8.70%	*	*
Substance														
Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	1224	13.20%	1195	20.60%	277	13.00%	*	*

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

CHES Adult: Newton – Peabody

			Massa	chusetts	_	dlesex		orfolk	Suffall	k County	N	ewton	Pool	bodv
Tonic	Question	Posnonso	N	%	N	%	N	%	N	%	N	%	N	%
Topic	Amphetamine/methamphetamine use, past	Response	IN	70	IN	70	IN	70	IN	70	IN	70	IN	70
Substance Use	vear	Yes	13626	0.50%	3061	0.40%	*	*	1195	0.70%	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	1195	1.10%	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	3061	0.80%	1224	0.40%	1195	1.50%	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	1195	0.50%	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	3061	0.30%	*	*	1195	0.70%	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	1195	0.80%	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	1224	1.30%	1195	1.30%	277	2.20%	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	1224	0.70%	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	1224	1.10%	1195	2.40%	277	1.80%	*	*
		Yes	6729	67.80%	1506	76.40%	636	78.50%	568	68.10%	126	85.70%	*	*
Emerging Issues	COVID-19 vaccination, past year (1)	Not sure	6729	3.60%	1506	3.30%	636	2.50%	568	3.70%	*	*	*	*
	Ever had long COVID (among those who had													
Emerging Issues	COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	554	15.50%	475	21.70%	141	11.30%	*	*
	Felt unwell due to poor air													
Emerging Issues	quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	902	38.50%	938	38.90%	218	41.30%	*	*
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	902	10.90%	938	9.80%	218	17.00%	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	902	23.90%	938	16.70%	218	26.60%	*	*
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	902	20.40%	938	14.10%	218	22.00%	*	*
	School cancellation due to weather, past 5													
Emerging Issues	years (2)	Yes	10422	17.60%	2312	19.20%	902	15.20%	938	12.00%	218	24.80%	*	*
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	902	10.90%	938	13.10%	218	11.90%	*	*
	Extreme temperatures at home, work, school,													
Emerging Issues	past 5 years (2)	Yes	10422	28.30%	2312	32.40%	902	24.50%	938	29.20%	218	33.00%	*	*
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	902	1.90%	938	1.50%	218	2.30%	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	902	63.30%	938	59.30%	218	71.10%	*	*

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

CHIA Ages 0-17: Boston (Allston) – Boston (Fenway)

		BIDMC Community Benefits Service Area								
	Massachusetts	Allston - Brighton	Boston - ALL	Boston - Bowdoin/Geneva	Boston - Chinatown	Boston - Fenway/Kenmore				
All Causes										
FY24 ED Volume (all cause) rate per 100,000	4923	323	1297	627	33	37				
FY24 Inpatient Discharges (all cause) rate per										
100,000	1396	89	322	136	14	34				
Allergy										
FY24 ED Volume rate per 100,000	293	16	78	35	3	1				
FY24 Inpatient Discharges rate per 100,000	29	1	10	4	0	1				
Asthma										
FY24 ED Volume rate per 100,000	347	25	146	77	1	1				
FY24 Inpatient Discharges rate per 100,000	67	4	25	12	0	1				
Attention Deficit Hyperactivity Disorder										
FY24 ED Volume rate per 100,000	77	4	22	8	0	0				
FY24 Inpatient Discharges rate per 100,000	27	1	8	3	0	0				
Complication of Medical Care										
FY24 ED Volume rate per 100,000	33	2	8	2	0	1				
FY24 Inpatient Discharges rate per 100,000	49	1	21	6	0	5				
Diabetes										
FY24 ED Volume rate per 100,000	21	0	6	3	0	0				
FY24 Inpatient Discharges rate per 100,000	8	0	4	2	0					
HIV/AIDS										
FY24 ED Volume rate per 100,000	0									
FY24 Inpatient Discharges rate per 100,000	0									
Infection										
FY24 ED Volume rate per 100,000	1314	79	352	167	8	10				
FY24 Inpatient Discharges rate per 100,000	131	6	49	20	1	6				

CHIA Ages 0-17: Boston (Allston) – Boston (Fenway)

		BIDMC Community Benefits Service Area								
	Massachusetts	Allston - Brighton	Boston - ALL	Boston - Bowdoin/Geneva	Boston - Chinatown	Boston - Fenway/Kenmore				
Injuries										
FY24 ED Volume rate per 100,000	922	52	222	114	6	4				
FY24 Inpatient Discharges rate per 100,000	49	1	16	6	0	2				
Learning Disorders										
FY24 ED Volume rate per 100,000	22	3	18	5	0	2				
FY24 Inpatient Discharges rate per 100,000	24	1	11	4	0	2				
Mental Health										
FY24 ED Volume rate per 100,000	292	10	57	28	2	1				
FY24 Inpatient Discharges rate per 100,000	75	4	18	8	0	0				
Obesity										
FY24 ED Volume rate per 100,000	7	0	2	1						
FY24 Inpatient Discharges rate per 100,000	12	1	5	2						
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	150	7	28	15	0	0				
FY24 Inpatient Discharges rate per 100,000	32	0	8	3	0	1				
Poisonings										
FY24 ED Volume rate per 100,000	59	1	10	5	0	0				
FY24 Inpatient Discharges rate per 100,000	6	0	1	0						
STIs										
FY24 ED Volume rate per 100,000	4	0	2	1		0				
FY24 Inpatient Discharges rate per 100,000	1		0	0						
Substance Use										
FY24 ED Volume rate per 100,000	48	2	8	5	0	0				
FY24 Inpatient Discharges rate per 100,000	11	0	1	0						
Age 0-17 Total	4923	323	1297	627	33	37				

CHIA Ages 0-17: Boston (Roxbury) – Chelsea

		BIDMC Commi	unity Benefit	s Service Area	1	
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea
All Causes						
FY24 ED Volume (all cause) rate per 100,000	4923	511	1923	3148	2481	7124
FY24 Inpatient Discharges (all cause) rate per						
100,000	1396	99	885	1417	1066	1987
Allergy						
FY24 ED Volume rate per 100,000	293	31	143	416	168	443
FY24 Inpatient Discharges rate per 100,000	29	2	11	30	19	37
Asthma						
FY24 ED Volume rate per 100,000	347	56	157	187	143	431
FY24 Inpatient Discharges rate per 100,000	67	9	14	106	34	142
Attention Deficit Hyperactivity Disorder						
FY24 ED Volume rate per 100,000	77	10	52	49	20	57
FY24 Inpatient Discharges rate per 100,000	27	2	6	30	19	47
Complication of Medical Care						
FY24 ED Volume rate per 100,000	33	3	15	45	22	42
FY24 Inpatient Discharges rate per 100,000	49	3	35	22	18	30
Diabetes						
FY24 ED Volume rate per 100,000	21	2	3	7	4	15
FY24 Inpatient Discharges rate per 100,000	8	0	1	7	7	5
HIV/AIDS						
FY24 ED Volume rate per 100,000	0					
FY24 Inpatient Discharges rate per 100,000	0					
Infection						
FY24 ED Volume rate per 100,000	1314	147	320	748	629	2572
FY24 Inpatient Discharges rate per 100,000	131	12	59	95	65	208

CHIA Ages 0-17: Boston (Roxbury) – Chelsea

		BIDMC Commu	unity Benefit	s Service Area	3	
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea
Injuries						
FY24 ED Volume rate per 100,000	922	84	483	756	500	859
FY24 Inpatient Discharges rate per 100,000	49	4	23	19	22	62
Learning Disorders						
FY24 ED Volume rate per 100,000	22	8	20	19	18	35
FY24 Inpatient Discharges rate per 100,000	24	3	9	22	15	35
Mental Health						
FY24 ED Volume rate per 100,000	292	22	76	213	92	433
FY24 Inpatient Discharges rate per 100,000	75	6	51	64	60	167
Obesity						
FY24 ED Volume rate per 100,000	7	1	1			15
FY24 Inpatient Discharges rate per 100,000	12	2	6	7	12	52
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	150	9	30	103	31	235
FY24 Inpatient Discharges rate per 100,000	32	1	4	26	13	55
Poisonings						
FY24 ED Volume rate per 100,000	59	3	17	38	21	67
FY24 Inpatient Discharges rate per 100,000	6	0		3	1	10
STIs						
FY24 ED Volume rate per 100,000	4	1			7	2
FY24 Inpatient Discharges rate per 100,000	1	13				5
Substance Use						
FY24 ED Volume rate per 100,000	48	2	12	11	17	60
FY24 Inpatient Discharges rate per 100,000	11	6	1		5	30
Age 0-17 Total	4923	511	1923	3148	2481	7124

CHIA Ages 0-17: Dorchester – Winchester

		BIDMC Community Benefits Service Area									
	Massachusetts	Dorchester	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester				
All Causes											
FY24 ED Volume (all cause) rate per 100,000	4923	265	2127	3285	561	5529	3888				
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	65	745	1107	221	1357	1214				
Allergy											
FY24 ED Volume rate per 100,000	293	12	280	463	50	745	587				
FY24 Inpatient Discharges rate per 100,000	29	1	23	9	3	46	26				
Asthma											
FY24 ED Volume rate per 100,000	347	24	134	265	44	350	306				
FY24 Inpatient Discharges rate per 100,000	67	3	43	40	7	90	78				
Attention Deficit Hyperactivity Disorder											
FY24 ED Volume rate per 100,000	77	4	70	87	10	55	96				
FY24 Inpatient Discharges rate per 100,000	27	0	35	31	4	49	56				
Complication of Medical Care											
FY24 ED Volume rate per 100,000	33	0	29	28	7	36	17				
FY24 Inpatient Discharges rate per 100,000	49	2	32	21	14	33	26				
Diabetes											
FY24 ED Volume rate per 100,000	21	0	8	21		14	4				
FY24 Inpatient Discharges rate per 100,000	8	0	20	12		3					
HIV/AIDS											
FY24 ED Volume rate per 100,000	0	0									
FY24 Inpatient Discharges rate per 100,000	0										
Infection											
FY24 ED Volume rate per 100,000	1314	74	365	578	127	2057	727				
FY24 Inpatient Discharges rate per 100,000	131	5	46	78	20	125	78				

CHIA Ages 0-17: Dorchester – Winchester

			BIDMC Community Benefits Service Area							
	Massachusetts	Dorchester	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester			
Injuries										
FY24 ED Volume rate per 100,000	922	45	794	1004	148	964	1201			
FY24 Inpatient Discharges rate per 100,000	49	1	35	28	6	27	30			
Learning Disorders										
FY24 ED Volume rate per 100,000	22	1	20	3	15	16	13			
FY24 Inpatient Discharges rate per 100,000	24	1	17	6	11	29	13			
Mental Health										
FY24 ED Volume rate per 100,000	292	13	189	256	26	241	355			
FY24 Inpatient Discharges rate per 100,000	75	3	96	81	12	95	131			
Obesity										
FY24 ED Volume rate per 100,000	7	0				1				
FY24 Inpatient Discharges rate per 100,000	12	0	8	6	2	16				
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	150	4	55	25	11	284	78			
FY24 Inpatient Discharges rate per 100,000	32	1	26	15	2	53	26			
Poisonings										
FY24 ED Volume rate per 100,000	59	2	43	34	2	182	35			
FY24 Inpatient Discharges rate per 100,000	6	0	5	3	2	1	4			
STIs										
FY24 ED Volume rate per 100,000	4	1	2				4			
FY24 Inpatient Discharges rate per 100,000	1	0				5				
Substance Use										
FY24 ED Volume rate per 100,000	48	1	26	40	5	23	70			
FY24 Inpatient Discharges rate per 100,000	11	0	2	3		5	13			
Age 0-17 Total	4923	265	2127	3285	561	5529	3888			

CHIA Ages 18-44: Boston (Allston) – Boston (Fenway)

		BIDMC Community Benefits Service Area									
		Allston -	Boston -	Boston -	Boston -	Boston -					
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore					
All Causes											
FY24 ED Volume (all cause) rate per 100,000	11106	1318	3977	1609	287	298					
FY24 Inpatient Discharges (all cause) rate per											
100,000	2251	195	544	238	36	40					
Allergy											
FY24 ED Volume rate per 100,000	952	124	455	146	35	32					
FY24 Inpatient Discharges rate per 100,000	206	23	44	18	2	2					
Asthma											
FY24 ED Volume rate per 100,000	552	43	198	116	13	4					
FY24 Inpatient Discharges rate per 100,000	266	18	99	44	3	3					
Breast Cancer											
FY24 ED Volume rate per 100,000	7	0	1	0	0	0					
FY24 Inpatient Discharges rate per 100,000	9	0	1	0	0	0					
CHF											
FY24 ED Volume rate per 100,000	14	0	4	2		0					
FY24 Inpatient Discharges rate per 100,000	50	1	17	8	0	0					
Complication of Medical Care											
FY24 ED Volume rate per 100,000	120	13	36	14	1	3					
FY24 Inpatient Discharges rate per 100,000	645	48	156	69	7	12					
COPD and Lung Disease											
FY24 ED Volume rate per 100,000	30	1	5	2	1						
FY24 Inpatient Discharges rate per 100,000	40	0	8	1	0	0					
Diabetes											
FY24 ED Volume rate per 100,000	309	24	95	44	10	3					
FY24 Inpatient Discharges rate per 100,000	173	14	50	23	1	2					

CHIA Ages 18-44: Boston (Allston) – Boston (Fenway)

		BIDMC Community Benefits Service Area								
		Allston -	Boston -	Boston -	Boston -	Boston -				
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore				
GYN Cancer										
FY24 ED Volume rate per 100,000	2		0			0				
FY24 Inpatient Discharges rate per 100,000	4	0								
Heart Disease										
FY24 ED Volume rate per 100,000	12	1	3	1	0					
FY24 Inpatient Discharges rate per 100,000	56	2	19	8	0	0				
Hepatitis										
FY24 ED Volume rate per 100,000	26	2	11	6	1					
FY24 Inpatient Discharges rate per 100,000	70	1	27	7	5	1				
HIV/AIDS										
FY24 ED Volume rate per 100,000	24	5	17	8	3	0				
FY24 Inpatient Discharges rate per 100,000	14	1	12	6	1	0				
Hypertension										
FY24 ED Volume rate per 100,000	447	29	116	60	10	2				
FY24 Inpatient Discharges rate per 100,000	210	13	59	27	2	2				
Infection										
FY24 ED Volume rate per 100,000	1595	184	624	228	48	52				
FY24 Inpatient Discharges rate per 100,000	338	24	103	43	7	7				
Injuries										
FY24 ED Volume rate per 100,000	1775	219	645	273	41	46				
FY24 Inpatient Discharges rate per 100,000	237	22	73	28	6	4				
Liver Disease										
FY24 ED Volume rate per 100,000	99	8	22	9	1	1				
FY24 Inpatient Discharges rate per 100,000	191	16	49	22	2	1				
Mental Health										
FY24 ED Volume rate per 100,000	1310	159	511	195	78	33				
FY24 Inpatient Discharges rate per 100,000	834	84	225	91	18	16				
Obesity										
FY24 ED Volume rate per 100,000	135	7	26	15	1	0				
FY24 Inpatient Discharges rate per 100,000	324	26	78	40	1	2				

CHIA Ages 18-44: Boston (Allston) – Boston (Fenway)

		BIDMC Community Benefits Service Area								
		Allston -	Boston -	Boston -	Boston -	Boston -				
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore				
Other Cancer										
FY24 ED Volume rate per 100,000	12	0	1	0	0	0				
FY24 Inpatient Discharges rate per 100,000	23	1	3	1	0	0				
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	122	14	42	14	4	3				
FY24 Inpatient Discharges rate per 100,000	85	5	19	7	1	0				
Poisonings										
FY24 ED Volume rate per 100,000	182	15	43	14	5	4				
FY24 Inpatient Discharges rate per 100,000	33	2	10	3	0	0				
Prostate Cancer										
FY24 ED Volume rate per 100,000	0									
FY24 Inpatient Discharges rate per 100,000	0									
STIs										
FY24 ED Volume rate per 100,000	77	11	73	33	4	3				
FY24 Inpatient Discharges rate per 100,000	37	2	11	5	0	0				
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	8	0	1	0		0				
FY24 Inpatient Discharges rate per 100,000	19	1	3	1	0	0				
Substance Use										
FY24 ED Volume rate per 100,000	2079	179	839	344	125	43				
FY24 Inpatient Discharges rate per 100,000	588	60	159	68	19	6				
Tuberculosis										
FY24 ED Volume rate per 100,000	2	0	0	0	0					
FY24 Inpatient Discharges rate per 100,000	8	0	3	1	0					
Age 18-44 Total	11106	1318	3977	1609	287	298				

CHIA Ages 18-44: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area									
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester				
All Causes											
FY24 ED Volume (all cause) rate per 100,000	11106	1315	4089	6939	8094	14136	591				
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	185	1205	2059	1586	3121	111				
Allergy											
FY24 ED Volume rate per 100,000	952	166	650	1532	685	1250	49				
FY24 Inpatient Discharges rate per 100,000	206	18	89	126	96	243	10				
Asthma											
FY24 ED Volume rate per 100,000	552	52	102	152	143	463	28				
FY24 Inpatient Discharges rate per 100,000	266	43	114	175	152	323	18				
Breast Cancer											
FY24 ED Volume rate per 100,000	7				3	5	0				
FY24 Inpatient Discharges rate per 100,000	9	0	1	3	11	2	0				
CHF											
FY24 ED Volume rate per 100,000	14	1	7		2	17	1				
FY24 Inpatient Discharges rate per 100,000	50	7	14	15	33	90	5				
Complication of Medical Care											
FY24 ED Volume rate per 100,000	120	11	33	84	80	117	5				
FY24 Inpatient Discharges rate per 100,000	645	54	400	691	512	977	38				
COPD and Lung Disease											
FY24 ED Volume rate per 100,000	30	1	1	11	8	20	0				
FY24 Inpatient Discharges rate per 100,000	40	4	3	11	24	70	1				
Diabetes											
FY24 ED Volume rate per 100,000	309	27	59	171	61	358	9				
FY24 Inpatient Discharges rate per 100,000	173	19	44	141	83	381	10				

CHIA Ages 18-44: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area									
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester				
GYN Cancer											
FY24 ED Volume rate per 100,000	2				0						
FY24 Inpatient Discharges rate per 100,000	4				4	5	0				
Heart Disease											
FY24 ED Volume rate per 100,000	12	0	1		3	5	0				
FY24 Inpatient Discharges rate per 100,000	56	7	9	61	54	70	3				
Hepatitis											
FY24 ED Volume rate per 100,000	26	2	4	7	9	12	3				
FY24 Inpatient Discharges rate per 100,000	70	9	7	26	39	97	3				
HIV/AIDS											
FY24 ED Volume rate per 100,000	24	3	3	7	16	17	1				
FY24 Inpatient Discharges rate per 100,000	14	3		7	11	50	1				
Hypertension											
FY24 ED Volume rate per 100,000	447	33	66	103	128	273	15				
FY24 Inpatient Discharges rate per 100,000	210	22	51	129	98	318	9				
Infection											
FY24 ED Volume rate per 100,000	1595	212	582	886	1180	2170	84				
FY24 Inpatient Discharges rate per 100,000	338	35	119	248	178	471	19				
Injuries											
FY24 ED Volume rate per 100,000	1775	217	661	1058	1392	1995	104				
FY24 Inpatient Discharges rate per 100,000	237	27	105	198	141	318	11				
Liver Disease											
FY24 ED Volume rate per 100,000	99	6	28	22	44	140	3				
FY24 Inpatient Discharges rate per 100,000	191	18	66	145	89	438	10				
Mental Health											
FY24 ED Volume rate per 100,000	1310	145	387	638	887	1383	73				
FY24 Inpatient Discharges rate per 100,000	834	77	413	527	591	1178	39				
Obesity											
FY24 ED Volume rate per 100,000	135	7	17	11	11	67	3				
FY24 Inpatient Discharges rate per 100,000	324	30	98	198	121	513	17				

CHIA Ages 18-44: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area							
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester		
Other Cancer									
FY24 ED Volume rate per 100,000	12	0	1	3	1	2	0		
FY24 Inpatient Discharges rate per 100,000	23	0	7	15	15	25	1		
Pneumonia/Influenza									
FY24 ED Volume rate per 100,000	122	13	39	68	73	160	4		
FY24 Inpatient Discharges rate per 100,000	85	7	20	84	36	110	3		
Poisonings									
FY24 ED Volume rate per 100,000	182	12	73	95	103	195	9		
FY24 Inpatient Discharges rate per 100,000	33	4	7	30	13	50	1		
Prostate Cancer									
FY24 ED Volume rate per 100,000	0								
FY24 Inpatient Discharges rate per 100,000	0								
STIs									
FY24 ED Volume rate per 100,000	77	25	22	38	57	112	9		
FY24 Inpatient Discharges rate per 100,000	37	5	19	11	25	80	3		
Stroke and Other Neurovascular Diseases									
FY24 ED Volume rate per 100,000	8	0	3	3	7	17	0		
FY24 Inpatient Discharges rate per 100,000	19	0	6	22	14	32	0		
Substance Use									
FY24 ED Volume rate per 100,000	2079	246	446	1001	975	2125	126		
FY24 Inpatient Discharges rate per 100,000	588	52	141	347	286	757	28		
Tuberculosis									
FY24 ED Volume rate per 100,000	2	0		3	0	7	0		
FY24 Inpatient Discharges rate per 100,000	8	1	1	3	11	42	0		
Age 18-44 Total	11106	1315	4089	6939	8094	14136	591		

CHIA Ages 18-44: Lexington – Winchester

			BIDI	MC Community Benefits Service	Area	
	Massachusetts	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester
All Causes						
FY24 ED Volume (all cause) rate per 100,000	11106	2916	3745	931	10215	4734
FY24 Inpatient Discharges (all cause) rate per						
100,000	2251	788	1336	287	2097	1315
Allergy						
FY24 ED Volume rate per 100,000	952	625	472	171	2985	828
FY24 Inpatient Discharges rate per 100,000	206	61	56	16	191	87
Asthma						
FY24 ED Volume rate per 100,000	552	67	215	30	306	153
FY24 Inpatient Discharges rate per 100,000	266	64	134	14	295	70
Breast Cancer						
FY24 ED Volume rate per 100,000	7	2	9	1	1	
FY24 Inpatient Discharges rate per 100,000	9	8	9		3	
CHF						
FY24 ED Volume rate per 100,000	14	2			5	8
FY24 Inpatient Discharges rate per 100,000	50	17	12	1	38	26
Complication of Medical Care						
FY24 ED Volume rate per 100,000	120	26	93	10	101	52
FY24 Inpatient Discharges rate per 100,000	645	268	441	111	568	451
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	30	14		1	14	17
FY24 Inpatient Discharges rate per 100,000	40	11	9	3	36	8
Diabetes						
FY24 ED Volume rate per 100,000	309	40	59	14	339	96
FY24 Inpatient Discharges rate per 100,000	173	26	75	6	166	65

CHIA Ages 18-44: Lexington – Winchester

			BIDM	C Community Benefits Servi	ce Area	
	Massachusetts	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester
GYN Cancer						
FY24 ED Volume rate per 100,000	2				5	
FY24 Inpatient Discharges rate per 100,000	4	2		3		17
Heart Disease						
FY24 ED Volume rate per 100,000	12		3		9	8
FY24 Inpatient Discharges rate per 100,000	56	26	15	5	57	21
Hepatitis						
FY24 ED Volume rate per 100,000	26	2		2	9	8
FY24 Inpatient Discharges rate per 100,000	70	14	21	5	46	4
HIV/AIDS						
FY24 ED Volume rate per 100,000	24	5		5		
FY24 Inpatient Discharges rate per 100,000	14		3	1	1	
Hypertension						
FY24 ED Volume rate per 100,000	447	58	125	16	352	214
FY24 Inpatient Discharges rate per 100,000	210	37	37	9	219	70
Infection						
FY24 ED Volume rate per 100,000	1595	412	513	139	1523	727
FY24 Inpatient Discharges rate per 100,000	338	87	147	31	315	149
Injuries						
FY24 ED Volume rate per 100,000	1775	435	751	133	1654	758
FY24 Inpatient Discharges rate per 100,000	237	52	100	24	217	118
Liver Disease						
FY24 ED Volume rate per 100,000	99	17	37	9	127	61
FY24 Inpatient Discharges rate per 100,000	191	61	84	11	158	35
Mental Health						
FY24 ED Volume rate per 100,000	1310	359	341	102	994	719
FY24 Inpatient Discharges rate per 100,000	834	271	416	88	809	407
Obesity						
FY24 ED Volume rate per 100,000	135	2	34	7	108	48
FY24 Inpatient Discharges rate per 100,000	324	37	93	35	372	61

CHIA Ages 18-44: Lexington – Winchester

		BIDMC Community Benefits Service Area						
	Massachusetts	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester		
Other Cancer								
FY24 ED Volume rate per 100,000	12	2	12	2	9	8		
FY24 Inpatient Discharges rate per 100,000	23	17	12	15	23	17		
Pneumonia/Influenza								
FY24 ED Volume rate per 100,000	122	17	53	7	164	96		
FY24 Inpatient Discharges rate per 100,000	85	23	40	5	59	48		
Poisonings								
FY24 ED Volume rate per 100,000	182	49	37	6	214	100		
FY24 Inpatient Discharges rate per 100,000	33	8	9	1	36	8		
Prostate Cancer								
FY24 ED Volume rate per 100,000	0							
FY24 Inpatient Discharges rate per 100,000	0							
STIs								
FY24 ED Volume rate per 100,000	77		6	5	31	17		
FY24 Inpatient Discharges rate per 100,000	37	8	12	3	23	13		
Stroke and Other Neurovascular Diseases								
FY24 ED Volume rate per 100,000	8		3		1	4		
FY24 Inpatient Discharges rate per 100,000	19	2	6	3	31			
Substance Use								
FY24 ED Volume rate per 100,000	2079	306	362	111	2110	771		
FY24 Inpatient Discharges rate per 100,000	588	90	103	21	547	192		
Tuberculosis								
FY24 ED Volume rate per 100,000	2				3			
FY24 Inpatient Discharges rate per 100,000	8				5			
Age 18-44 Total	11106	2916	3745	931	10215	4734		

CHIA Ages 45-64: Boston (Allston) – Boston (Fenway)

				BIDMC Community Bene	fits Service Area	
	Massachusetts	Allston - Brighton	Boston - ALL	Boston - Bowdoin/Geneva	Boston - Chinatown	Boston - Fenway/Kenmore
All Causes						
FY24 ED Volume (all cause) rate per 100,000	6844	397	1947	885	168	55
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	93	529	240	30	18
Allergy						
FY24 ED Volume rate per 100,000	797	41	288	97	20	10
FY24 Inpatient Discharges rate per 100,000	330	18	79	32	3	2
Asthma						
FY24 ED Volume rate per 100,000	299	11	88	57	3	1
FY24 Inpatient Discharges rate per 100,000	254	8	89	36	2	2
Breast Cancer						
FY24 ED Volume rate per 100,000	40	1	6	2	0	0
FY24 Inpatient Discharges rate per 100,000	57	2	11	4	0	0
CHF						
FY24 ED Volume rate per 100,000	78	3	22	10	2	0
FY24 Inpatient Discharges rate per 100,000	344	11	127	54	5	3
Complication of Medical Care						
FY24 ED Volume rate per 100,000	100	4	27	12	1	0
FY24 Inpatient Discharges rate per 100,000	428	16	111	51	4	3
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	239	10	34	16	8	0
FY24 Inpatient Discharges rate per 100,000	415	14	86	37	7	2
Diabetes						
FY24 ED Volume rate per 100,000	759	36	202	98	19	3
FY24 Inpatient Discharges rate per 100,000	688	24	195	92	6	5

CHIA Ages 45-64: Boston (Allston) – Boston (Fenway)

				BIDMC Community Bene	fits Service Area	
		Allston -	Boston -	Boston -	Boston -	Boston -
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore
GYN Cancer						
FY24 ED Volume rate per 100,000	4	0	1	0		
FY24 Inpatient Discharges rate per 100,000	16	0	2	1		
Heart Disease						
FY24 ED Volume rate per 100,000	37	1	3	1	0	
FY24 Inpatient Discharges rate per 100,000	280	9	85	39	3	1
Hepatitis						
FY24 ED Volume rate per 100,000	23	3	7	4	1	
FY24 Inpatient Discharges rate per 100,000	83	4	52	16	5	1
HIV/AIDS						
FY24 ED Volume rate per 100,000	34	4	28	9	9	1
FY24 Inpatient Discharges rate per 100,000	34	3	30	5	1	3
Hypertension						
FY24 ED Volume rate per 100,000	1377	66	321	171	24	6
FY24 Inpatient Discharges rate per 100,000	918	38	207	90	11	6
Infection						
FY24 ED Volume rate per 100,000	813	47	231	101	17	7
FY24 Inpatient Discharges rate per 100,000	627	20	154	68	8	5
Injuries						
FY24 ED Volume rate per 100,000	1351	79	399	184	36	8
FY24 Inpatient Discharges rate per 100,000	534	25	145	61	8	5
Liver Disease						
FY24 ED Volume rate per 100,000	113	4	20	9	2	0
FY24 Inpatient Discharges rate per 100,000	383	15	99	34	5	3
Mental Health						
FY24 ED Volume rate per 100,000	703	40	213	96	39	4
FY24 Inpatient Discharges rate per 100,000	1042	49	262	99	16	10
Obesity						
FY24 ED Volume rate per 100,000	138	4	16	10	0	0
FY24 Inpatient Discharges rate per 100,000	619	27	133	69	2	3

CHIA Ages 45-64: Boston (Allston) – Boston (Fenway)

				BIDMC Community Benef	fits Service Area	
		Allston -	Boston -	Boston -	Boston -	Boston -
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore
Other Cancer						
FY24 ED Volume rate per 100,000	30	0	3	1	0	0
FY24 Inpatient Discharges rate per 100,000	100	3	16	8	0	1
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	73	2	17	7	1	0
FY24 Inpatient Discharges rate per 100,000	228	7	52	24	2	2
Poisonings						
FY24 ED Volume rate per 100,000	82	3	23	10	1	0
FY24 Inpatient Discharges rate per 100,000	36	1	14	4	1	0
Prostate Cancer						
FY24 ED Volume rate per 100,000	12	0	2	1	0	0
FY24 Inpatient Discharges rate per 100,000	28	1	8	4	0	0
STIs						
FY24 ED Volume rate per 100,000	10	1	9	4	1	
FY24 Inpatient Discharges rate per 100,000	6	0	2	1	0	
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	24	0	3	1	0	
FY24 Inpatient Discharges rate per 100,000	92	4	21	10	0	0
Substance Use						
FY24 ED Volume rate per 100,000	1492	87	624	244	112	11
FY24 Inpatient Discharges rate per 100,000	858	43	248	90	18	7
Tuberculosis						
FY24 ED Volume rate per 100,000	1	0	0	0	0	
FY24 Inpatient Discharges rate per 100,000	11	0	5	2	0	0
Age 45-64 Total	6844	397	1947	885	168	55

CHIA Ages 45-64: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area							
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester		
All Causes									
FY24 ED Volume (all cause) rate per 100,000	6844	678	2014	4868	4186	7362	279		
FY24 Inpatient Discharges (all cause) rate per									
100,000	2291	192	642	1830	1044	2138	71		
Allergy									
FY24 ED Volume rate per 100,000	797	118	468	1769	463	925	24		
FY24 Inpatient Discharges rate per 100,000	330	32	87	233	105	270	7		
Asthma									
FY24 ED Volume rate per 100,000	299	21	33	106	80	127	15		
FY24 Inpatient Discharges rate per 100,000	254	41	65	252	122	238	8		
Breast Cancer									
FY24 ED Volume rate per 100,000	40	2	11	22	8	7	1		
FY24 Inpatient Discharges rate per 100,000	57	5	17	49	32	57	1		
CHF									
FY24 ED Volume rate per 100,000	78	7	7	15	15	35	2		
FY24 Inpatient Discharges rate per 100,000	344	55	54	256	145	333	14		
Complication of Medical Care									
FY24 ED Volume rate per 100,000	100	10	38	145	70	117	3		
FY24 Inpatient Discharges rate per 100,000	428	43	137	416	167	423	14		
COPD and Lung Disease									
FY24 ED Volume rate per 100,000	239	8	27	15	55	90	3		
FY24 Inpatient Discharges rate per 100,000	415	32	49	187	169	313	13		
Diabetes									
FY24 ED Volume rate per 100,000	759	65	169	481	154	701	27		
FY24 Inpatient Discharges rate per 100,000	688	73	145	504	281	759	23		

CHIA Ages 45-64: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area								
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester			
GYN Cancer										
FY24 ED Volume rate per 100,000	4	0	1		2					
FY24 Inpatient Discharges rate per 100,000	16	0	20	45		20	0			
Heart Disease										
FY24 ED Volume rate per 100,000	37	1	7	19	5	37	0			
FY24 Inpatient Discharges rate per 100,000	280	33	62	286	119	280	9			
Hepatitis										
FY24 ED Volume rate per 100,000	23	1		3	7	20	2			
FY24 Inpatient Discharges rate per 100,000	83	19	23	26	77	152	4			
HIV/AIDS										
FY24 ED Volume rate per 100,000	34	4	28	3	39	35	2			
FY24 Inpatient Discharges rate per 100,000	34	13	15	11	33	52	2			
Hypertension										
FY24 ED Volume rate per 100,000	1377	94	272	393	314	686	46			
FY24 Inpatient Discharges rate per 100,000	918	81	207	737	361	859	25			
Infection										
FY24 ED Volume rate per 100,000	813	84	258	473	561	917	34			
FY24 Inpatient Discharges rate per 100,000	627	57	162	485	263	676	21			
Injuries										
FY24 ED Volume rate per 100,000	1351	132	408	985	811	1265	58			
FY24 Inpatient Discharges rate per 100,000	534	57	126	462	267	468	18			
Liver Disease										
FY24 ED Volume rate per 100,000	113	6	28	53	37	115	2			
FY24 Inpatient Discharges rate per 100,000	383	42	114	317	174	471	8			
Mental Health										
FY24 ED Volume rate per 100,000	703	54	167	301	384	518	21			
FY24 Inpatient Discharges rate per 100,000	1042	105	323	699	540	1057	30			
Obesity										
FY24 ED Volume rate per 100,000	138	4	15	22	11	35	2			
FY24 Inpatient Discharges rate per 100,000	619	46	116	420	173	491	17			

CHIA Ages 45-64: Boston (Roxbury) – Dorchester

		ВІДМС	Community	Benefits Servi	ce Area		
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester
Other Cancer							
FY24 ED Volume rate per 100,000	30	0	14	11	16	15	1
FY24 Inpatient Discharges rate per 100,000	100	4	59	126	33	77	2
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	73	6	12	49	33	95	2
FY24 Inpatient Discharges rate per 100,000	228	18	33	164	83	195	8
Poisonings							
FY24 ED Volume rate per 100,000	82	8	19	38	55	92	4
FY24 Inpatient Discharges rate per 100,000	36	7	6	30	16	40	1
Prostate Cancer							
FY24 ED Volume rate per 100,000	12	0	1	3	1	2	1
FY24 Inpatient Discharges rate per 100,000	28	2	14	11	16	5	1
STIs							
FY24 ED Volume rate per 100,000	10	3	1		7	12	1
FY24 Inpatient Discharges rate per 100,000	6	0	1		9	12	0
Stroke and Other Neurovascular Diseases							
FY24 ED Volume rate per 100,000	24	1	3	30	8	32	0
FY24 Inpatient Discharges rate per 100,000	92	7	25	68	35	85	3
Substance Use							
FY24 ED Volume rate per 100,000	1492	205	234	657	1005	1466	65
FY24 Inpatient Discharges rate per 100,000	858	106	173	512	431	877	26
Tuberculosis							
FY24 ED Volume rate per 100,000	1				1	2	0
FY24 Inpatient Discharges rate per 100,000	11	2	1	7	18	17	1
Age 45-64 Total	6844	678	2014	4868	4186	7362	279

CHIA Ages 45-64: Lexington – Winchester

			BID	MC Community Benefits Service	Area	
	Massachusetts	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester
All Causes						
FY24 ED Volume (all cause) rate per 100,000	6844	2773	3288	591	6730	3520
FY24 Inpatient Discharges (all cause) rate per						
100,000	2291	929	985	142	2263	1201
Allergy						
FY24 ED Volume rate per 100,000	797	838	325	188	2809	732
FY24 Inpatient Discharges rate per 100,000	330	105	143	32	302	162
Asthma						
FY24 ED Volume rate per 100,000	299	23	209	19	125	166
FY24 Inpatient Discharges rate per 100,000	254	93	103	13	260	105
Breast Cancer						
FY24 ED Volume rate per 100,000	40	20	62	4	46	21
FY24 Inpatient Discharges rate per 100,000	57	70	68	5	94	52
CHF						
FY24 ED Volume rate per 100,000	78	8	28	2	51	
FY24 Inpatient Discharges rate per 100,000	344	113	128	14	363	74
Complication of Medical Care						
FY24 ED Volume rate per 100,000	100	11	46	12	114	35
FY24 Inpatient Discharges rate per 100,000	428	216	225	24	488	206
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	239	11	37		129	26
FY24 Inpatient Discharges rate per 100,000	415	81	90	9	400	105
Diabetes						
FY24 ED Volume rate per 100,000	759	128	244	31	765	153
FY24 Inpatient Discharges rate per 100,000	688	172	209	27	671	219

CHIA Ages 45-64: Lexington – Winchester

			BID	MC Community Benefits Service	Area	
	Massachusetts	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester
GYN Cancer						
FY24 ED Volume rate per 100,000	4	2	6	2	5	4
FY24 Inpatient Discharges rate per 100,000	16	8	21	5	9	
Heart Disease						
FY24 ED Volume rate per 100,000	37	11	18	4	25	26
FY24 Inpatient Discharges rate per 100,000	280	160	87	21	273	153
Hepatitis						
FY24 ED Volume rate per 100,000	23		3		9	
FY24 Inpatient Discharges rate per 100,000	83	5	6	3	66	30
HIV/AIDS						
FY24 ED Volume rate per 100,000	34	2	6	3	3	
FY24 Inpatient Discharges rate per 100,000	34	2	6		14	4
Hypertension						
FY24 ED Volume rate per 100,000	1377	195	619	81	948	482
FY24 Inpatient Discharges rate per 100,000	918	300	312	50	940	420
Infection						
FY24 ED Volume rate per 100,000	813	321	362	74	773	337
FY24 Inpatient Discharges rate per 100,000	627	195	206	31	594	324
Injuries						
FY24 ED Volume rate per 100,000	1351	639	757	118	1402	806
FY24 Inpatient Discharges rate per 100,000	534	195	212	48	566	236
Liver Disease						
FY24 ED Volume rate per 100,000	113	40	53	2	116	74
FY24 Inpatient Discharges rate per 100,000	383	119	184	16	385	179
Mental Health						
FY24 ED Volume rate per 100,000	703	178	162	28	560	306
FY24 Inpatient Discharges rate per 100,000	1042	350	469	65	1138	381
Obesity						
FY24 ED Volume rate per 100,000	138	17	25	4	121	65
FY24 Inpatient Discharges rate per 100,000	619	140	165	30	684	201

CHIA Ages 45-64: Lexington – Winchester

		BIDMC Community Benefits Service Area					
	Massachusetts	Lexington	Needham	Newton - Chestnut Hill	Peabody	Winchester	
Other Cancer							
FY24 ED Volume rate per 100,000	30	5	50	1	11	8	
FY24 Inpatient Discharges rate per 100,000	100	40	93	11	97	61	
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	73	29	28	5	83	35	
FY24 Inpatient Discharges rate per 100,000	228	61	59	10	269	43	
Poisonings							
FY24 ED Volume rate per 100,000	82	32	40	5	86	30	
FY24 Inpatient Discharges rate per 100,000	36	11	6	1	35	13	
Prostate Cancer							
FY24 ED Volume rate per 100,000	12	8	15	1	1	4	
FY24 Inpatient Discharges rate per 100,000	28	37	28	1	27	21	
STIs							
FY24 ED Volume rate per 100,000	10	23			11		
FY24 Inpatient Discharges rate per 100,000	6		3	1	12		
Stroke and Other Neurovascular Diseases							
FY24 ED Volume rate per 100,000	24	14	9	1	22	21	
FY24 Inpatient Discharges rate per 100,000	92	26	34	9	95	30	
Substance Use							
FY24 ED Volume rate per 100,000	1492	219	140	24	1485	377	
FY24 Inpatient Discharges rate per 100,000	858	181	153	19	815	249	
Tuberculosis							
FY24 ED Volume rate per 100,000	1						
FY24 Inpatient Discharges rate per 100,000	11	8	9		7		
Age 45-64 Total	6844	2773	3288	591	6730	3520	

CHIA Ages 65+: Boston (Allston) – Boston (Fenway)

	BIDMC Community Benefits Service Area								
		Allston -	Boston -	Boston -	Boston -	Boston -			
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore			
All Causes									
FY24 ED Volume (all cause) rate per 100,000	5485	330	1027	412	62	53			
FY24 Inpatient Discharges (all cause) rate per									
100,000	4476	240	710	294	45	34			
Allergy									
FY24 ED Volume rate per 100,000	798	41	179	56	7	11			
FY24 Inpatient Discharges rate per 100,000	671	46	99	38	3	4			
Asthma									
FY24 ED Volume rate per 100,000	155	5	19	9	0	0			
FY24 Inpatient Discharges rate per 100,000	314	21	91	34	2	3			
Breast Cancer									
FY24 ED Volume rate per 100,000	69	3	3	2	0	0			
FY24 Inpatient Discharges rate per 100,000	216	13	30	13	1	1			
CHF									
FY24 ED Volume rate per 100,000	270	13	30	13	1	1			
FY24 Inpatient Discharges rate per 100,000	1445	81	249	99	11	11			
Complication of Medical Care									
FY24 ED Volume rate per 100,000	158	11	30	12	1	2			
FY24 Inpatient Discharges rate per 100,000	809	45	155	64	4	9			
COPD and Lung Disease									
FY24 ED Volume rate per 100,000	350	12	31	18	1	1			
FY24 Inpatient Discharges rate per 100,000	1111	45	153	54	7	5			
Diabetes									
FY24 ED Volume rate per 100,000	860	54	165	75	9	6			
FY24 Inpatient Discharges rate per 100,000	1509	92	336	145	16	12			

CHIA Ages 65+: Boston (Allston) – Boston (Fenway)

	BIDMC Community Benefits Service Area							
		Allston -	Boston -	Boston -	Boston -	Boston -		
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore		
GYN Cancer								
FY24 ED Volume rate per 100,000	7	0	0	0				
FY24 Inpatient Discharges rate per 100,000	27	2	4	3				
Heart Disease								
FY24 ED Volume rate per 100,000	90	2	5	3	0	0		
FY24 Inpatient Discharges rate per 100,000	1079	57	168	66	10	8		
Hepatitis								
FY24 ED Volume rate per 100,000	7	2	2	1	0			
FY24 Inpatient Discharges rate per 100,000	51	5	36	10	1	0		
HIV/AIDS								
FY24 ED Volume rate per 100,000	7	0	4	1	0	0		
FY24 Inpatient Discharges rate per 100,000	14	1	16	3	0	1		
Hypertension								
FY24 ED Volume rate per 100,000	1774	105	266	125	23	13		
FY24 Inpatient Discharges rate per 100,000	1758	90	280	116	19	15		
Infection								
FY24 ED Volume rate per 100,000	718	44	138	55	7	6		
FY24 Inpatient Discharges rate per 100,000	1455	83	238	98	12	11		
Injuries								
FY24 ED Volume rate per 100,000	1257	69	212	78	14	11		
FY24 Inpatient Discharges rate per 100,000	1365	93	234	85	15	14		
Liver Disease								
FY24 ED Volume rate per 100,000	65	3	10	3	1	0		
FY24 Inpatient Discharges rate per 100,000	421	30	91	37	4	4		
Mental Health								
FY24 ED Volume rate per 100,000	347	19	46	21	5	1		
FY24 Inpatient Discharges rate per 100,000	1456	87	219	75	10	11		
Obesity								
FY24 ED Volume rate per 100,000	72	2	4	1	0	0		
FY24 Inpatient Discharges rate per 100,000	764	53	120	53	1	3		

CHIA Ages 65+: Boston (Allston) – Boston (Fenway)

		BIDMC Community Benefits Service Area							
		Allston -	Boston -	Boston -	Boston -	Boston -			
	Massachusetts	Brighton	ALL	Bowdoin/Geneva	Chinatown	Fenway/Kenmore			
Other Cancer									
FY24 ED Volume rate per 100,000	58	2	5	3	0	0			
FY24 Inpatient Discharges rate per 100,000	285	16	40	16	2	2			
Pneumonia/Influenza									
FY24 ED Volume rate per 100,000	79	3	9	3		0			
FY24 Inpatient Discharges rate per 100,000	627	33	78	31	5	2			
Poisonings									
FY24 ED Volume rate per 100,000	30	0	6	3	0	0			
FY24 Inpatient Discharges rate per 100,000	44	2	8	3	0	0			
Prostate Cancer									
FY24 ED Volume rate per 100,000	62	2	9	5	1	0			
FY24 Inpatient Discharges rate per 100,000	221	11	52	22	1	2			
STIs									
FY24 ED Volume rate per 100,000	1	0	1	0					
FY24 Inpatient Discharges rate per 100,000	7	0	4	2	0	0			
Stroke and Other Neurovascular Diseases									
FY24 ED Volume rate per 100,000	63	3	5	1	0	0			
FY24 Inpatient Discharges rate per 100,000	290	15	50	22	1	3			
Substance Use									
FY24 ED Volume rate per 100,000	391	20	122	39	18	5			
FY24 Inpatient Discharges rate per 100,000	552	23	124	46	7	3			
Tuberculosis									
FY24 ED Volume rate per 100,000	1		1	0	0				
FY24 Inpatient Discharges rate per 100,000	15	1	13	4	0	0			
Age 65+ Total	5485	330	1027	412	62	53			

CHIA Ages 65+: Boston (Roxbury) – Dorchester

		BIDMC	Community	Benefits Servi	ce Area		
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester
All Causes							
FY24 ED Volume (all cause) rate per 100,000	5485	376	2912	5785	3139	4036	139
FY24 Inpatient Discharges (all cause) rate per							
100,000	4476	245	2209	5510	2300	2938	113
Allergy							
FY24 ED Volume rate per 100,000	798	73	933	2663	387	601	13
FY24 Inpatient Discharges rate per 100,000	671	37	315	691	222	526	13
Asthma							
FY24 ED Volume rate per 100,000	155	8	36	26	50	47	5
FY24 Inpatient Discharges rate per 100,000	314	41	151	389	205	278	8
Breast Cancer							
FY24 ED Volume rate per 100,000	69	0	30	11	7	12	0
FY24 Inpatient Discharges rate per 100,000	216	9	141	343	133	165	5
CHF							
FY24 ED Volume rate per 100,000	270	11	94	114	44	77	4
FY24 Inpatient Discharges rate per 100,000	1445	101	644	1750	690	1098	39
Complication of Medical Care							
FY24 ED Volume rate per 100,000	158	11	73	183	107	100	3
FY24 Inpatient Discharges rate per 100,000	809	57	553	1230	376	554	22
COPD and Lung Disease							
FY24 ED Volume rate per 100,000	350	8	98	80	50	140	5
FY24 Inpatient Discharges rate per 100,000	1111	70	344	1069	463	889	28
Diabetes							
FY24 ED Volume rate per 100,000	860	59	296	733	160	604	20
FY24 Inpatient Discharges rate per 100,000	1509	125	585	1918	695	1579	51

CHIA Ages 65+: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area							
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester		
GYN Cancer									
FY24 ED Volume rate per 100,000	7	0	4	3	4	2			
FY24 Inpatient Discharges rate per 100,000	27	0	22	30	27	12	0		
Heart Disease									
FY24 ED Volume rate per 100,000	90	0	23	45	14	42	0		
FY24 Inpatient Discharges rate per 100,000	1079	62	588	1467	625	769	26		
Hepatitis									
FY24 ED Volume rate per 100,000	7	0	1	3	1		0		
FY24 Inpatient Discharges rate per 100,000	51	20	17	30	42	120	3		
HIV/AIDS									
FY24 ED Volume rate per 100,000	7	1	1	3	10	2			
FY24 Inpatient Discharges rate per 100,000	14	9	4		11	20	1		
Hypertension									
FY24 ED Volume rate per 100,000	1774	73	763	512	343	734	41		
FY24 Inpatient Discharges rate per 100,000	1758	89	866	2166	798	1100	43		
Infection									
FY24 ED Volume rate per 100,000	718	52	341	726	394	554	21		
FY24 Inpatient Discharges rate per 100,000	1455	85	760	1631	698	1057	40		
Injuries									
FY24 ED Volume rate per 100,000	1257	81	650	1253	716	802	27		
FY24 Inpatient Discharges rate per 100,000	1365	84	912	1734	792	1000	36		
Liver Disease									
FY24 ED Volume rate per 100,000	65	2	39	42	12	55	0		
FY24 Inpatient Discharges rate per 100,000	421	36	234	401	221	423	14		
Mental Health									
FY24 ED Volume rate per 100,000	347	12	145	129	133	210	6		
FY24 Inpatient Discharges rate per 100,000	1456	85	934	1658	887	1263	37		
Obesity									
FY24 ED Volume rate per 100,000	72	2	15	22	6	10	0		
FY24 Inpatient Discharges rate per 100,000	764	47	275	565	265	536	16		

CHIA Ages 65+: Boston (Roxbury) – Dorchester

		BIDMC Community Benefits Service Area						
	Massachusetts	Boston - Roxbury/Mission Hill	Brookline	Burlington	Cambridge	Chelsea	Dorchester	
Other Cancer								
FY24 ED Volume rate per 100,000	58	1	9	19	14	12	0	
FY24 Inpatient Discharges rate per 100,000	285	11	207	405	144	142	6	
Pneumonia/Influenza								
FY24 ED Volume rate per 100,000	79	3	38	99	33	55	1	
FY24 Inpatient Discharges rate per 100,000	627	29	291	596	263	503	16	
Poisonings								
FY24 ED Volume rate per 100,000	30	1	12	53	16	22	0	
FY24 Inpatient Discharges rate per 100,000	44	3	25	68	15	32	0	
Prostate Cancer								
FY24 ED Volume rate per 100,000	62	1	20	26	15	25	1	
FY24 Inpatient Discharges rate per 100,000	221	19	118	278	105	97	6	
STIs								
FY24 ED Volume rate per 100,000	1	0		3	0			
FY24 Inpatient Discharges rate per 100,000	7	1	4	7	11	20	0	
Stroke and Other Neurovascular Diseases								
FY24 ED Volume rate per 100,000	63	1	35	68	25	45	1	
FY24 Inpatient Discharges rate per 100,000	290	15	90	408	133	160	9	
Substance Use								
FY24 ED Volume rate per 100,000	391	49	157	221	222	265	14	
FY24 Inpatient Discharges rate per 100,000	552	57	181	439	278	476	18	
Tuberculosis								
FY24 ED Volume rate per 100,000	1	0			3	2	0	
FY24 Inpatient Discharges rate per 100,000	15	5	12	38	23	32	1	
Age 65+ Total	5485	376	2912	5785	3139	4036	139	

CHIA Ages 65+: Lexington – Winchester

		BIDMC Community Benefits Service Area							
	Massachusetts	Lexington	Mass	Needham	Newton - Chestnut Hill	Peabody	Winchester		
All Causes									
FY24 ED Volume (all cause) rate per 100,000	5485	3804	5485	5438	835	7003	4485		
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	3655	4476	3961	708	7348	4191		
Allergy									
FY24 ED Volume rate per 100,000	798	1423	798	538	274	3590	1223		
FY24 Inpatient Discharges rate per 100,000	671	450	671	366	140	1027	683		
Asthma									
FY24 ED Volume rate per 100,000	155	49	155	200	20	125	109		
FY24 Inpatient Discharges rate per 100,000	314	271	314	291	66	664	227		
Breast Cancer									
FY24 ED Volume rate per 100,000	69	43	69	150	20	51	74		
FY24 Inpatient Discharges rate per 100,000	216	268	216	253	66	488	311		
CHF									
FY24 ED Volume rate per 100,000	270	55	270	312	30	324	210		
FY24 Inpatient Discharges rate per 100,000	1445	935	1445	1248	183	2608	1131		
Complication of Medical Care									
FY24 ED Volume rate per 100,000	158	128	158	190	22	206	135		
FY24 Inpatient Discharges rate per 100,000	809	707	809	732	168	1391	749		
COPD and Lung Disease									
FY24 ED Volume rate per 100,000	350	46	350	281	13	202	118		
FY24 Inpatient Discharges rate per 100,000	1111	511	1111	635	106	1717	613		
Diabetes									
FY24 ED Volume rate per 100,000	860	189	860	660	89	1082	416		
FY24 Inpatient Discharges rate per 100,000	1509	876	1509	848	186	2420	1153		

CHIA Ages 65+: Lexington – Winchester

		BIDMC Community Benefits Service Area					
	Massachusetts	Lexington	Mass	Needham	Newton - Chestnut Hill	Peabody	Winchester
GYN Cancer							
FY24 ED Volume rate per 100,000	7	5	7	12	6	5	4
FY24 Inpatient Discharges rate per 100,000	27	29	27	12	6	59	48
Heart Disease							
FY24 ED Volume rate per 100,000	90	17	90	97	7	84	56
FY24 Inpatient Discharges rate per 100,000	1079	812	1079	1217	202	2060	797
Hepatitis							
FY24 ED Volume rate per 100,000	7		7		1		4
FY24 Inpatient Discharges rate per 100,000	51	11	51	15	1	60	8
HIV/AIDS							
FY24 ED Volume rate per 100,000	7	2	7	3			
FY24 Inpatient Discharges rate per 100,000	14	14	14			12	
Hypertension							
FY24 ED Volume rate per 100,000	1774	409	1774	2343	230	1379	1148
FY24 Inpatient Discharges rate per 100,000	1758	1461	1758	1448	288	2597	1801
Infection							
FY24 ED Volume rate per 100,000	718	371	718	713	82	811	618
FY24 Inpatient Discharges rate per 100,000	1455	1151	1455	1511	227	2414	1385
Injuries							
FY24 ED Volume rate per 100,000	1257	1040	1257	1605	214	1791	1174
FY24 Inpatient Discharges rate per 100,000	1365	1326	1365	1426	299	2783	1275
Liver Disease							
FY24 ED Volume rate per 100,000	65	32	65	53	3	95	48
FY24 Inpatient Discharges rate per 100,000	421	210	421	381	55	693	263
Mental Health							
FY24 ED Volume rate per 100,000	347	134	347	159	27	321	403
FY24 Inpatient Discharges rate per 100,000	1456	1122	1456	1257	265	2918	1030
Obesity							
FY24 ED Volume rate per 100,000	72	2	72	28	3	71	56
FY24 Inpatient Discharges rate per 100,000	764	274	764	316	76	1374	460

CHIA Ages 65+: Lexington – Winchester

		BIDMC Community Benefits Service Area					
	Massachusetts	Lexington	Mass	Needham	Newton - Chestnut Hill	Peabody	Winchester
Other Cancer							
FY24 ED Volume rate per 100,000	58	26	58	147	22	33	48
FY24 Inpatient Discharges rate per 100,000	285	295	285	306	70	507	206
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	79	49	79	71	4	71	39
FY24 Inpatient Discharges rate per 100,000	627	438	627	597	59	913	569
Poisonings							
FY24 ED Volume rate per 100,000	30	37	30	31	3	57	17
FY24 Inpatient Discharges rate per 100,000	44	32	44	28	6	66	39
Prostate Cancer							
FY24 ED Volume rate per 100,000	62	14	62	194	6	44	83
FY24 Inpatient Discharges rate per 100,000	221	265	221	409	56	387	179
STIs							
FY24 ED Volume rate per 100,000	1		1	3			
FY24 Inpatient Discharges rate per 100,000	7	8	7	6		7	
Stroke and Other Neurovascular Diseases							
FY24 ED Volume rate per 100,000	63	23	63	46	18	202	35
FY24 Inpatient Discharges rate per 100,000	290	271	290	253	39	418	267
Substance Use							
FY24 ED Volume rate per 100,000	391	96	391	56	11	428	162
FY24 Inpatient Discharges rate per 100,000	552	195	552	222	24	756	241
Tuberculosis							
FY24 ED Volume rate per 100,000	1		1				
FY24 Inpatient Discharges rate per 100,000	15	14	15	9	1	23	8
Age 65+ Total	5485	3804	5485	5438	835	7348	4485

Community Health Survey

- FY25 BIDMC Community Health Survey
 - Survey output



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

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

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

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

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

Select a language

About Your Community

1. We want to know about you live, work, play, pray or wors	our experiences in the community where you spend the most time. This may be where you hip, or learn.
Please enter the zip	code of the community where you spend the most time.
Zip code:	
2. Please select the response	e(s) that best describes your relationship to the community:
☐ I live in this commun	ity
☐ I work in this commu	ınity
☐ Other (specify:)

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

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



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 abou	it 🗆						
organizations, agencies, healthcare, etc.).					_		
My community feels safe.							
My community has housing that is safe and of good qualit							
My community is prepared for climate disasters like							
flooding, hurricanes, or blizzards.							
My community offers people options for staying cool duri	ing 🗆						
extreme heat.							
My community has services that support people during							
times of stress and need.		_					
I believe that all residents, including myself, can make the							
community a better place to live.							
4. What are the things you want to improve about yo ☐ Better access to good jobs ☐ Better road	,	Please select	up to 5 iten				
☐ Better access to health care ☐ Better scho	ols			•	artment, and		
☐ Better access to healthy food ☐ Better side	walks and trails		police)	,	,		
☐ Better access to internet ☐ Cleaner env	/ironment		More inclu	sion for div	/erse		
☐ Better access to public ☐ Lower crime	e and violence		members o	of the comr	munity		
•	dable childcare				•		
·	dable housing		_				
☐ More arts a	nd cultural event	ts 🗆	Other (
Health and Access to care 5. Please check the response that best describes how much you agree or disagree with each statement about your access							
to health care in your community.							
	Strongly Agree	Agree	Dis		Strongly Disagree		
Health care in my community meets the physical health needs of people like me.							
Health care in my community meets the mental health needs of people like me.							
6. Where do you primarily receive your routine healt ☐ A doctor's or nurse's office ☐ A public health clinic or community health ce ☐ Urgent care provider ☐ A hospital emergency room ☐ No usual place ☐ Other, please specify:		hoose one.					



7. Wha	at barriers, if any, keep you from getting	nee	ded health care? Ple	eas	se select all that appl	y.
	Fear or distrust of the health care syst	em			Cost	
	Not enough time				Concern about COV	D or other disease exposure
	Insurance problems				Transportation	
	No providers or staff speak my langua	ge	_		Other, please specif	v:
	, , ,	60			No barriers	,
8. Wha	at health issues matter the most in your	com	nmunity? Please sele	ect	up to 5 issues from t	he list below.
	arthritis, falls, hearing/vision loss) Alcohol or drug misuse Asthma Cancer Child abuse/neglect Diabetes Domestic violence		Homelessness Housing Infant death Mental health (anx depression, etc.) Obesity Poor diet/inactivity Poverty	on kiet	:y,	Suicide Teenage pregnancy Trauma
About	t You					
	llowing questions help us better unders erent experiences in the community. Yo					
9. Wha	at is the highest grade or school year yo	u ha	ve finished?			
	school) Started college but not finished		h E E ter E			or example, BA, BS, AB) or example, master's, ate) v)
10. WI	nat is your race or ethnicity? Select all th	at a	pply.			
	Black or African American Hispanic or Latine/a/o				White Other (specify below Not sure Prefer not to answe Other:	r



11. Wh	at is your sexual orientation?		
	Asexual Bisexual and/or Pansexual Gay or Lesbian Straight (Heterosexual) Queer		Questioning/I am not sure of my sexuality I use a different term (specify:) I do not understand what this question is asking I prefer not to answer
12. Wh	at is your current gender identity?		
	Female, Woman Male, Man Nonbinary, Genderqueer, not exclusively male or female Questioning/I am not sure of my gender identity I use a different term (specify:) I do not understand what this question is asking I prefer not to answer		
13. In t	he past 12 months, did you have trouble paying for any of th	e fo	llowing? Select all that apply.
	Childcare or school Food or groceries Formula or baby food Health care (appointments, medicine, insurance) Housing (rent, mortgage, taxes, insurance)		Technology (computer, phone, internet) Transportation (car payment, gas, public transit) Utilities (electricity, water, gas) Other (specify:) None of the above
14. W	hat is your age?		
	Under 18 18-24 25-44 45-64		65-74 75-84 85 and over Prefer not to answer
15. W	hat is the primary language(s) spoken in your home? (Please c	heck	c all that apply.)
	Armenian Cape Verdean Creole Chinese (including Mandarin and Cantonese) English Haitian Creole Hindi Khmer		Portuguese Russian Spanish Vietnamese Other (specify) Prefer not to answer
16. <i>A</i>	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	☐ Prefer not to answer
	Other (specify)	
17. Do	you identify as a person with a disability?	
	Yes	
	Prefer not to answer	
18. I d	currently:	
	Rent my home	
	Own my home (with or without a mortgage)	
	Live with parent or other caretakers who pay f	or my housing
	Live with family or roommates and share costs	
	Live in a shelter, halfway house, or other tempo	rary housing
	Live in senior housing or assisted living	
	I do not currently have permanent housing	
	Other	
19. H	ow long have you lived in the United States?	
	I have always lived in the United States	
	More than 6 years, but not my whole life	
	Prefer not to answer	
20. M	any people feel a sense of belonging to commu	nities other than the city or town where they spend the most
	Which of the following communities do you fee	you belong to? (Select all that apply)
	My neighborhood or building	
	Faith community (such as a church, mosque, tem	•
		n program that you attend or a school that your child attends)
	Work community (such as your place of employn	, ,
		of people who share an immigration experience, a racial or
	hnic identity, a cultural heritage, or a gender identi	
	A shared interest group (such as a club, sports to	am, political group, or advocacy group)
	Another city or town where I do not live	
Ш	Other ()



Enter to Win a \$100.00 Gift Card!

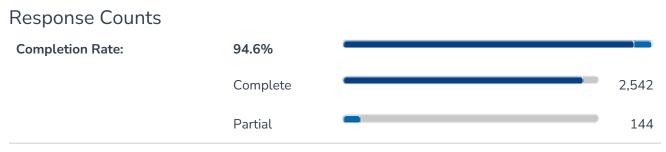
To enter the drawing to win a \$100 gift card, please:

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

1.	Please enter your first name and the best way to contact you. This information will not be used to identify your answers to the survey in any way. First Name:
	Email:
	Daytime Phone #:
2.	Would you like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities? \square Yes \square No (If yes, please be sure you have listed your email address above).

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

FY25 BILH CHNA Survey - BIDMC



1. Select a language.

Value	Percent	Responses
Take the survey in English	84.5%	1,607
شارك في الاستطلاع باللغة العربية	0.2%	4
参加简体中文调查	10.2%	194
參加繁體中文調查	0.2%	3
Reponn sondaj la nan lang kreyòl ayisyen	0.2%	3
हिंदी में सर्वेक्षण में भाग लें	0.6%	12
Participe da pesquisa em português	1.5%	28
Пройдите анкету на русском языке	1.4%	27
Responda la encuesta en español	1.2%	23

Totals: 1,901

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

Value	Percent	Responses
I live in this community	90.7%	2,144
I work in this community	26.7%	632
Other, please specify:	2.3%	54

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

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
I feel like I belong in my community. Count Row %	760 33.7%	1,240 55.0%	152 6.7%	41 1.8%	63 2.8%	2,256
Overall, I am satisfied with the quality of life in my community. (Think about health care, raising children, getting older, job opportunities, safety, and support.) Count Row %	710 31.9%	1,190 53.4%	212 9.5%	74 3.3%	41 1.8%	2,227
My community is a good place to raise children. (Think about things like schools, daycare, after-school programs, housing, and places to play) Count Row %	786 35.2%	1,023 45.8%	201 9.0%	68 3.0%	158 7.1%	2,236
My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support) Count Row %	640 28.4%	1,075 47.7%	311 13.8%	94 4.2%	133 5.9%	2,253
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.) Count Row %	761 30.5%	1,380 55.4%	213 8.5%	63 2.5%	75 3.0%	2,492
My community feels safe. Count Row %	848 33.2%	1,241 48.6%	316 12.4%	105 4.1%	42 1.6%	2,552

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	751 29.2%	1,308 50.9%	296 11.5%	106 4.1%	109 4.2%	2,570
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	329 17.0%	810 41.9%	236 12.2%	75 3.9%	484 25.0%	1,934
My community offers people options for staying cool during extreme heat. Count Row %	531 24.0%	1,032 46.6%	245 11.1%	78 3.5%	327 14.8%	2,213
My community has services that support people during times of stress and need. Count Row %	450 19.6%	1,148 49.9%	260 11.3%	83 3.6%	359 15.6%	2,300
I believe that all residents, including myself, can make the community a better place to live. Count Row %	1,081 42.5%	1,262 49.6%	93 3.7%	51 2.0%	58 2.3%	2,545
Totals Total Responses						2570

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

Value	Percent	Responses
Better access to good jobs	23.3%	596
Better access to health care	23.5%	602
Better access to healthy food	27.0%	690
Better access to internet	10.7%	275
Better access to public transportation	31.1%	795
Better parks and recreation	14.8%	379
Better roads	22.0%	562
Better schools	22.0%	563
Better sidewalks and trails	27.4%	702
Cleaner environment	17.2%	440
Lower crime and violence	21.5%	550
More affordable childcare	23.3%	597
More affordable housing	50.0%	1,281
More arts and cultural events	17.7%	452
More effective city services (like water, trash, fire department, and police)	14.1%	361
More inclusion for diverse members of the community	17.9%	458

Value	Percent	Responses
Stronger community leadership	11.8%	302
Stronger sense of community	10.9%	280
Other, please specify:	4.6%	117

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
Health care in my community meets the <u>physical</u> health needs of people like me. Count Row %	216 9.8%	450 20.3%	1,026 46.4%	453 20.5%	67 3.0%	2,212
Health care in my community meets the mental health needs of people like me. Count Row %	174 8.1%	528 24.5%	907 42.0%	243 11.3%	306 14.2%	2,158

Totals

Total Responses 2212

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

Value	Percent	Responses
A doctor's or nurse's office	70.1%	1,634
A public health clinic or community health center	14.7%	343
Urgent care provider	4.6%	107
A hospital emergency room	4.0%	94
No usual place	3.6%	83
Other, please specify:	3.0%	70

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

Value	Percent	Responses
Fear or distrust of the health care system	10.9%	222
Not enough time	18.6%	378
Insurance problems	18.0%	366
No providers or staff speak my language	5.8%	118
Can't get an appointment	26.2%	531
Cost	25.5%	518
Concern about COVID or other disease exposure	8.3%	169
Transportation	10.8%	220
Other, please specify:	5.1%	103
No barriers	33.3%	676

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

Value	Percent	Responses
Aging problems (like arthritis, falls, hearing/vision loss)	41.9%	983
Alcohol or drug misuse	26.7%	626
Asthma	10.4%	244
Cancer	18.4%	432
Child abuse/neglect	7.0%	165
Diabetes	17.3%	405
Domestic violence	11.6%	273
Environment (like air quality, traffic, noise)	24.4%	572
Heart disease and stroke	16.8%	393
Hunger/malnutrition	9.8%	230
Homelessness	18.2%	427
Housing	31.8%	745
Mental health (anxiety, depression, etc.)	48.1%	1,128
Obesity	16.1%	378
Poor diet/inactivity	13.1%	307
Poverty	10.9%	256

Value	Percent	Responses
Rape/sexual assault	4.7%	109
Sexually transmitted infections (STIs)	4.4%	102
Smoking	11.1%	260
Suicide	6.6%	155
Teenage pregnancy	3.9%	92
Trauma	7.2%	169
Underage drinking	9.7%	227
Vaping/E-cigarettes	12.4%	290
Violence	10.5%	246
Youth use of social media	21.0%	493
Infant death		2.4%

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

Value	Percent	Responses
12th grade or lower (no diploma)	11.2%	276
High school (including GED, vocational high school)	8.4%	208
Started college but not finished	8.0%	198
Vocational, trade, or technical program after high school	4.4%	108
Associate degree (for example, AA, AS)	7.3%	181
Bachelor's degree (for example, BA, BS, AB)	27.2%	671
Graduate degree (for example, master's, professional, doctorate)	29.9%	738
Other, please specify:	1.2%	29
Prefer not to answer	2.5%	61

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

Value	Percent	Responses
American Indian or Alaska Native	1.3%	31
Asian	16.2%	390
Black or African American	10.9%	264
Hispanic or Latine/a/o	15.5%	373
Middle Eastern or North African	1.0%	24
Native Hawaiian or Pacific Islander	0.5%	13
White	54.8%	1,322
Other, please specify:	1.6%	38
Not sure	0.4%	10
Prefer not to answer	3.5%	85

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.5%	36
Bisexual and/or Pansexual	4.0%	95
Gay or Lesbian	2.8%	67
Straight (Heterosexual)	81.1%	1,932
Queer	1.3%	32
Questioning/I am not sure of my sexuality	0.5%	13
I use a different term, please specify:	0.5%	11
I do not understand what this question is asking	2.0%	47
I prefer not to answer	6.2%	148

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	71.9%	1,765
Male, Man	24.4%	599
Nonbinary, Genderqueer, not exclusively male or female	1.2%	29
Questioning/I am not sure of my gender identity	0.2%	5
I use a different term, please specify:	0.1%	3
I do not understand what this question is asking	0.4%	9
I prefer not to answer	1.9%	46

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

Value	Percent	Responses
Childcare or school	4.5%	104
Food or groceries	18.4%	425
Formula or baby food	2.0%	47
Health care (appointments, medicine, insurance)	16.8%	389
Housing (rent, mortgage, taxes, insurance)	23.4%	541
Technology (computer, phone, internet)	8.7%	201
Transportation (car payment, gas, public transit)	12.7%	293
Utilities (electricity, water, gas)	14.8%	343
Other, please specify:	1.4%	32
None of the above	54.1%	1,252

14. What is your age?

Value	Percent	Responses
Under 18	5.3%	132
18-24	6.2%	155
25-44	33.1%	828
45-64	26.3%	659
65-74	12.8%	320
75-84	11.3%	282
85 and over	3.8%	95
Prefer not to answer	1.4%	34

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

Value	Percent	Responses
Armenian	1.5%	36
Cape Verdean Creole	0.7%	17
Chinese (including Mandarin and Cantonese)	7.7%	188
English	76.7%	1,872
Haitian Creole	2.0%	49
Hindi	1.2%	29
Khmer	0.0%	1
Portuguese	2.5%	62
Russian	1.6%	40
Spanish	12.7%	310
Vietnamese	1.0%	24
Other, please specify:	4.2%	103
Prefer not to answer	1.3%	31

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	38.6%	860
Employed part-time (Less than 40 hours per week)	15.8%	353
Self-employed (Full- or part-time)	4.4%	99
A stay-at-home parent	3.8%	84
A student (Full- or part-time)	3.5%	79
Unemployed	4.1%	91
Unable to work for health reasons	3.0%	67
Retired	22.8%	509
Other, please specify:	1.6%	35
Prefer not to answer	2.4%	53

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

Value	Percent	Responses
Yes	15.3%	367
No	80.9%	1,946
Prefer not to answer	3.9%	93

18. I currently:

Value	Percent	Responses
Rent my home	32.0%	777
Own my home (with or without a mortgage)	46.6%	1,133
Live with parent or other caretakers who pay for my housing	8.4%	203
Live with family or roommates and share costs	5.0%	121
Live in a shelter, halfway house, or other temporary housing	0.8%	19
Live in senior housing or assisted living	2.7%	65
I do not currently have permanent housing	1.9%	47
Other	2.7%	66

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

Value	Percent	Responses
I have always lived in the United States	67.1%	1,670
Less than one year	2.0%	50
1 to 3 years	2.9%	73
4 to 6 years	3.9%	96
More than 6 years, but not my whole life	22.9%	569
Prefer not to answer	1.2%	30

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

Value	Percent	Responses
My neighborhood or building	53.9%	1,126
Faith community (such as a church, mosque, temple, or faith-based organization)	26.8%	559
School community (such as a college or education program that you attend or a school that your child attends)	22.0%	460
Work community (such as your place of employment or a professional association)	36.1%	754
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)	16.9%	352
A shared interest group (such as a club, sports team, political group, or advocacy group)	28.7%	599
Another city or town where I do not live	10.2%	212
Other, please feel free to share:	5.5%	114

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

Value	Percent	Responses
Yes	36.8%	368
No	63.2%	633

Totals: 1,001

Appendix C: Resource Inventory

Beth Israel Deaconess Medical Center Community Resource List

Community Benefits Service Area includes: Brookline, Burlington, Chestnut Hill, Lexington, Peabody, and Needham, and the City of Boston Neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, and Roxbury/Mission Hill

		on/Brighton, Bowdoin/Geneva, Chinatown, Fenw	ray/Kenmore, and Rox	bury/Mission Hill	
Health Best Organization Brief Description Reduces Propre Interest					
, Y	nikat	asscrift	Addres	5 PH	The Delite
Healt	Organ	Provides tips, tools, and resources to help	Adv	- Pri	Me
		Provides ties to also and recovered to help		022 772 2445	handhalduna ava
	Department of Mental Health-	Trovides tips, tools, and resources to help		833.773.2445	www.handholdma.org
	Handhold program	families navigate children's mental health journey.			
	Executive Office of	Provides access to the resources for older	1 Ashburton Place	617.727.7750	www.mass.gov/orgs/execut
	Aging &	adults to live healthy in every community in	10th Floor Boston	017.727.7730	ve-office-of-aging-
	Independence	the Commonwealth.	TOUT FIOOT BOSTOTI		independence
	Mass 211	Available 24 hours a day, 7 days a week,		211 or	www.mass211.org
	141033 211	Mass 211 is an easy way to find or give help		877.211.6277	WWW.IIId55211.016
		in your community.		07712210277	
	Massachusetts	Hotline is available 24 hours a day or by	1 Ashburton Place	800.922.2275	www.mass.gov/orgs/execut
		phone. Older adult abuse includes:	10th Floor Boston	000.522.2270	ve-office-of-aging-
	2.46.7.24567.666	physical, sexual, and emotional abuse,	2000110011200001		independence
		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.			
	Women, Infants	Provides free nutrition, health education		800.942.1007	www.mass.gov/orgs/wome
	and Children (WIC)	and other services to families who qualify.			infants-children-nutrition-
	Nutrition Program	. ,			program?
	MassOptions	Provides connection to services for older		800.243.4636	www.massoptions.org
		adults and persons with disabilities.			
	Massachusetts	Provides a searchable directory of over		833.773.2445	www.masshelpline.com/MA
	Behavioral Health	5,000 Behavioral Health service providers in			BHHLTreatmentConnection
	Help Line (BHHL)	Massachusetts.			esourceDirectory
	Treatment				
	Connection				
Statewide	Massachusetts	24/7 Free and confidential public resource		800.327.5050	www.helplinema.org
Resources	Substance Use	for substance use treatment, recovery, and			
nesources	Helpline	problem gambling services.			
	National Suicide	Provides 24/7, free and confidential		988	www.suicidepreventionlifel
	Prevention Lifeline	support.			e.org
	Project Bread	Provides information about food resources		1.800.645.8333	www.projectbread.org/food
	Foodsource Hotline	in the community and assistance with SNAP			ource-hotline
		applications by phone.			
	0.5.1.1				
	SafeLink	Massachusetts' statewide 24/7 toll-free		877.785.2020	www.casamyrna.org/get-
		domestic violence hotline and a resource for			support/safelink
		anyone affected by domestic or dating			
	SAMHSA's National	violence. Provides a free, confidential, 24/7, 365-day-		800.662.HELP	www.samhsa.gov/find-
	Helpline	a-year treatment referral and information		(4357)	help/helplines/national-
	Петрине	service (in English and Spanish) for		(4337)	helpline
		individuals and families in need of mental			петрине
		health resources and/or information for			
		those with substance use disorders.			
		unose with substance use disorders.			
	Supplemental	Provides nutrition benefits to individuals		877.382.2363	www.mass.gov/snap-
	Nutritional	and families to help subsidize food costs.		077.302.2303	benefits-formerly-food-
	Assistance Program				stamps?
	(SNAP)				otamps:
	Veteran Crisis	Free, every day, 24/7 confidential support		988	www.veteranscrisisline.net
	Hotline	for Veterans and their families who may be			
		experiencing challenges.			
		experiencing challenges.			

	DIDMC Courter for	Donalds and south and to a to a set	220 Bas aldia a Assa	C17 CC7 01 41	
	BIDMC Center for	Provides outreach and treatment	330 Brookline Ave	617.667.8141	www.bidmc.org/centers-and-
	Violence Prevention	interventions to respond to victims of	Boston		departments/social-
		interpersonal, sexual, community violence,			work/center-for-violence-
		and homicide bereavement.			prevention-and-
					recovery/programs-and-
					services
	Boston Area Rape	Provides free, confidential support and	99 Bishop Allen Dr	617.492.8306	www.barcc.org
	Crisis Center-Family	services to survivors of sexual violence.	Cambridge	24/7 Hotline:	
	Justice Center			800.841.8371	
	Casa Myrna	Provides domestic violence awareness	451 Blue Hill Ave	617.521.0100	www.casamyrna.org
	,	efforts, shelter and supportive services to	Boston		
		survivors.			
	Cory Johnson	Offers a peer-centered approach to	328 Warren St	617.945.6629	www.rpcsocialimpactctr.org/
	Program	addressing post-traumatic stress in urban	Roxbury	0	about
		neighborhoods.	110/12/11/		assat
Domestic	The Flizaheth Stone	Provides support to survivors of domestic	1 Westminster Ave	Mainline	www.stonehouseinc.org
Violence	House	violence in four areas of intervention: safety		617.427.9801	www.stonenousemc.org
Violence	nouse	•	ROXDUIY		
		and shelter; advocacy; education and		Intake line:	
		prevention; community engagement.		781.400.0770	
	The Network/La	Survivor-led, social justice organization that		Office:	www.tnlr.org/en
	Red	works to end partner abuse in lesbian, gay,	Boston	617.695.0877	
		bisexual, transgender, SM, polyamorous,		24/7 Hotline:	
		and queer communities.		800.832.1901	
	REACH Beyond	Provides support to survivors of domestic	PO Box 540024	Office:	www.reachma.org
	Domestic Violence	violence in four areas of intervention: safety	Waltham	781.891.0724	
		and shelter; advocacy; education and		Hotline:	
		prevention; community engagement.		800.899.4000	
	ABCD Food Pantry	Provides food assistance to residents of	178 Tremont St	617.348.6000	www.bostonabcd.org/servic
		Boston.	Boston		e/food-pantries/
	Community	Provides meals to chronically and critically	179 Amory St	617.522.7777	www.servings.org
	Servings	ill individuals and their families.	Jamaica Plain		
	Daily Table	Provides food assistance to residents of	2201 Washington	617.516.8174	www.dailytable.org
		Greater Boston.	St Roxbury		
	Dorchester	An initiative to build a community and	195 Bowdoin St		www.dorchesterfoodcoop.co
	Community Food	worker-owned grocery store(opening in	Dorchester		m
	Co-Op	2023) that provides healthy food			
		accessibility and advances economic			
		opportunity through neighborhood			
		engagement.			
	Fair Foods	Provides food assistance to residents of	PO Box 220168	617.288.6185	www.fairfoods.org
		Greater Boston for \$2.	Dorchester		g .
Food Assistance	Fenway Cares	Provides food assistance to residents of	1282 Boylston St	857.246.9053	www.fenwaycommunitycent
	,	Fenway/Kenmore community residents.	Boston		er.org/fenwaycares
	Food for Free	Provides access to healthy food through	59 Inner Belt Rd	617.802.9880	www.foodforfree.org
	. 354.511166	establishing innovative programming and	Somerville	27.302.3000	The state of the s
		partnerships to overcome barriers and	Some vine		
		strengthen the community food system.			
	Froch Truck	Provides food assistance to residents of		617 207 7695	www.aboutfresh.org
	Fresh Truck	Greater Boston via mobile markets.	69 Shirley St Boston	617.297.7685	www.aboutilesii.org
	Greater Posts:		70 Courth Day Ave	617 427 5200	ununu ahfh ara
	Greater Boston	Provides healthy food and resources to	70 South Bay Ave	617.427.5200	www.gbfb.org
	Food Bank	agencies and direct distribution programs	Boston		
		across Eastern Massachusetts.	4.6% 11.11.6	C47 C25 C7:	
		Provides food assistance to residents of	1 City Hall Sq Room	617.635.3717	www.boston.gov/departmen
1	Mayor's Office of			the state of the s	
	Food Access	Boston.	804 Boston		ts/food-access
	Food Access				
	Food Access Allston Brighton	Leads initiatives that create and preserve	18R Shepard St Ste	617.787.3874	ts/food-access www.allstonbrightoncdc.org
	Food Access	Leads initiatives that create and preserve affordable homes, foster community		617.787.3874	
	Food Access Allston Brighton	Leads initiatives that create and preserve	18R Shepard St Ste	617.787.3874	

	Asian CDC	Works in underserved and immigrant Asian American communities to create and	38 Oak St Boston	617.482.2380	www.asiancdc.org
		preserve affordable, sustainable, and healthy neighborhoods.			
	Boston Housing	Provides affordable, subsidized rental housing for low-resource individuals.	52 Chauncy St	617.988.4000	www.bostonhousing.org
	Authority		Boston	647 422 0600	
	Boston Tenant Coalition	Promotes affordable housing in Boston, organized to defend and expand the rights of tenants, and to push city, state and federal government, as well as private	11 Beacon St Ste 510 Boston	617.423.8609	www.bostontenant.org
		industry to address the needs of low-resources tenants.			
	Bridge Over Troubled Waters	Provides services for youth without housing, runaway and at risk youth.	47 West St Boston	617.423.9575	www.bridgeotw.org
	Chelsea Housing	Provides affordable, subsidized rental	54 Locke St Chelsea	617 409 5310	www.chelseaha.com
	U	housing for low-resource individuals and families, older adults and persons with disabilities.	154 LOURE ST CHEISEA	017.403.3310	www.citeiseana.com
	Empath	Disrupts poverty through direct services, advocacy, research, and a global learning network. Helps individuals move out of poverty and provide other institutions with the tools to systematically do the same.	10 Perthshire Rd Brighton	857.559.2100	www.empathways.org
	ESAC Boston	Provides innovative programs in home ownership, education, and community service focusing on children and older adults.	434 Jamaicaway Jamaica Plain	617.524.2555	www.esacboston.org
	Family Aid Boston	Empowers parents and caregivers facing homelessness to secure and sustain housing and build strong foundations for their children's futures.	3815 Washington St Boston	617.542.7286	www.familyaidboston.org
	Fenway CDC	Provides affordable, subsidized rental housing for low-resource individuals and families.	70 Burbank St Boston	617.267.4637	www.fenwaycdc.org
	Greater Boston Legal Services	Provides free legal assistance to low- resource families to assist them in securing basic necessities.	197 Friend St Boston	617.371.1234	www.gbls.org
Housing Support	Homestart	Provides information and resources for low and moderate resource individuals.	105 Chauncy St Ste 502 Boston	617.542.0338	www.homestart.org
	Hospitality Homes	Provides short-term housing for families/friends of patients receiving medical care in the Boston area.	PO Box 15265 Boston	888.595.4678	www.hosp.org
	Inquilinos Boricuas Accion (IBA)	Provides affordable, subsidized rental housing, education, and arts programs.	2 San Juan St Boston	617.927.1707	www.ibaboston.org
	Mayor's Office of Housing Stability	Helps residents find and maintain stable, safe, and affordable housing.	2 Center Plaza Boston	617.635.4200	www.boston.gov/departmen ts/housing/office-housing- stability
	MetroHousing Boston	Provides information and resources for low and moderate resource families and individuals.	1411 Tremont St Boston	617.859.0400	www.MetroHousingBoston.o
	_	Promotes economic diversity, opportunity, and quality of life in the communities of Chelsea, Revere, and Everett.	4 Gerrish Ave #2 Chelsea	617.889.1375	www.theneighborhooddevel opers.org
	Development Corporation	Works to revitalize communities and assure that all families have affordable homes by transforming vacant and abandoned lots and buildings into housing.	2565 Washington St 2nd Floor Roxbury	617.427.3599	www.nuestracdc.org
	Pine Street Inn	Provides temporary shelter to unhoused individuals.	444 Harrison Ave Boston	617.892.9100	www.pinestreetinn.org

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	Rosie's Place	A multi-service community center that	889 Harrison Ave	617.442.9322	www.rosiesplace.org
		offers women emergency shelter and meals,			
		a food pantry, ESOL classes, legal assistance,			
		wellness care, one-on-one support, housing			
		and job search services, and community			
		outreach.			
	Urban Edge	Provides affordable, subsidized rental	1542 Columbus Ave	617.989.9300	www.urbanedge.org
	_	housing.	Roxbury		
	Y2Y	Employs a youth-to-youth model to provide	955 Massachusetts	617.864.0795	www.y2ynetwork.org
		a safe and environment for young adults 18-			
		24 experiencing homelessness.	Cambridge		
		24 experiencing nomelessitess.	Cambridge		
	Advocates	Provides routine appointments, same-day	675 Main St	781.893.5110	www.advocates.org/services
	Community	access for urgent issues, and 24/7 crisis	Waltham	702103010120	/cbhc
	Behavioral Health	intervention for people of all ages.			, 65.1.6
	Centers	intervention for people of all ages.			
	centers				
	Doth loro ol Labar	Drovides high quality grounds beath and		070 060 1700	ununu hilbhohaviaral ara
	Beth Israel Lahey	Provides high-quality mental health and		978.968.1700	www.bilhbehavioral.org
	Health (BILH)	addiction treatment for children and adults			
	Behavioral Services				
		services.			
	Boston Medical	Provides a comprehensive and highly	850 Harrison Ave	617.414.5470	www.bmc.org/emergency-
	Center CBHC	integrated system of crisis evaluation,	Boston		services-program
		intervention, and treatment.			
		,			
	Children's Services	Provides culturally responsive wraparound	520 Dudley St	617.445.6655	www.csrox.org
	of Roxbury	services for children, young adults, and	Roxbury		
	or noxbury	families.	NOXBUT Y		
Mental Health	The Family Van	Educates, counsels and assists community	200 Longwood Ave	617.442.3200	www.familyvan.org
and Substance	The raining van	members in strengthening and protecting	Boston	017.442.3200	www.nammyvam.org
			BOSTOII		
Use	E 11 11 1161	their bodies, minds and communities.	42.6 11 4	647 700 0070	6 11 116
	Fathers Uplift	Provides mental health counseling,	12 Southern Ave	617.708.0870	www.fathersuplift.org
		coaching, advocacy, and resource support	Dorchester		
		to assist fathers with overcoming barriers			
		that prevent them from remaining engaged			
		in their children's lives.			
	Mayors Health Line	Works to ensure Boston residents' ability to	1010	617.534.5050	https://www.boston.gov/gov
		access services and programs that promote	Massachusetts Ave		ernment/cabinets/boston-
		health and wellness. The MHL staff is	2nd Floor Boston		public-health-
		available to help residents with a variety of			commission/about-health-
		services including, answering questions			commission/mayors-health-
		about health insurance eligibility, enrolling			line
		in health insurance, finding primary care			
		providers, finding social services, locating			
		free clinics.			
	North Suffolk	Provides a wide variety of behavioral health	301 Broadway	617.889.4860	www.northsuffolk.org
	Mental Health	treatment and rehabilitation services.	Chelsea	017.005.4000	
		treatment and renabilitation services.	Cilcised		
	Association	Provides treatment for mental health	190 Loney St	781.769.8670	www.rivorsidoss.cra/adult
	Riverside	Provides treatment for mental health,	190 Lenox St	701.709.8070	www.riversidecc.org/adult-
	Community	substance use, and co-occurring disorders.	Norwood		services/mental-health-
	Behavioral Health				substance-use-
	Center				adults/community-
					behavioral-health-centers-
					adults/
	Samaritans	Provides lifesaving suicide prevention	41 West St. 4th	617.536.2460	www.samaritanshope.org
		services in Massachusetts.	Floor Boston		
	I				
	2Life Communities	Creating vibrant communities that invite	30 Wallingford Rd	617.912.8400	www.2lifecommunities.org
		senior adults of all income levels to live,	Brighton		
		thrive and grow.			
	•				

	BCYF Grove Hall	Provides services for older adults in Boston	51 Geneva Ave	617.635.1484	www.boston.gov/departmen
	Senior Center	including fitness, education, social services,	Boston	017.055.1464	ts/boston-centers-youth-
	Semor center	and recreation.	Doston		families/bcyf-grove-hall-
		una recreation.			senior-center
	Boston Age Strong	Provides access to resources and programs	1 City Hall Sq. Room	617.635.4366	www.boston.gov/departmen
	Commission	for older adults in Boston.	271 Boston		ts/age-strong-commission
	Boston Elder INFO	Provides resources for older adults and	89 South St Boston	617.292.6211	www.elderinfo.org
		person with disabilities who are residents of			
		Boston.			
	Central Boston	Provide supportive services for older adults	2315 Washington	617.277.7416	www.centralboston.org
	Elder Services	and persons with disabilities.	St Boston		
	Chelsea Senior		10 Riley Way	617.466.4370	www.chelseama.gov/depart
	Center	including fitness, education, social services,	Chelsea		ments/elder_services/index.
	ETLIOC	and recreation. Provides programs and services which are	FFF A	617.522.6700	php www.ethocare.org
	ETHOS	available and accessible to meet the diverse	555 Amory St	017.322.0700	www.ethocare.org
		needs and changing lifestyles of older	Januariani		
Senior Services		adults.			
	FriendshipWorks	Works to reduce social isolation in older	105 Chauncy St 8th	617.482.1510	www.fw4elders.org
	, p	adults residing in Boston.	Floor Boston		
	Greater Boston	Offers a network of programs that serve the		617.357.0226	www.gbcgac.org
	Chinese Golden Age	needs of the older adult Chinese population.			
	Center				
	Lexington Senior	Provides services for older adults in	39 Marrett Rd	781.698.4840	www.lexingtonma.gov/354/S
	Center	Lexington including fitness, education,	Lexington		enior-Services
		social services, recreation, and			
		transportation.			
	Veronica B. Smith	Provides services for older adults in Boston	20 Chestnut Hill	617.635.6120	www.boston.gov/departmen
	Senior Center	including fitness, education, social services,	Ave Boston		ts/age-strong-
		recreation, and transportation.			commission/veronica-b-
					smith-senior-center
	Boston Cyclist	Campaign for better bike infrastructure and	1419 Tremont St	617.516.8877	www.bostoncyclistsunion.or
	Union	safer streets throughout Metro Boston.	Boston	017.510.0077	g/
	Omon	Engages with policymakers and elected	503(011		ы
		officials, organize residents, and mobilize			
		membership to influence projects.			
	Age Strong Shuttle	Provides Boston residents age 60 and older	1 City Hall Sq Room	617.635.4366	www.boston.gov/departmen
		with free transportation within the City of	271 Boston		ts/age-strong-
		Boston to non-emergency medical			commission/age-strong-
		appointments, with advance notice.			shuttle
	MBTA	Provides transportation throughout Boston			www.mbta.com
	Too or side As it	and surrounding communities.	62.6		
	TransitMatters	Dedicated to improving transit in and	62 Summer St		www.transitmatters.org
		around Boston by offering new perspectives, uniting transit advocates, and	Boston		
Transportation		informing the public.			
	WalkBoston	Helps people evaluate the walking	50 Milk St 16th	617.367.9255	www.walkboston.org
		environment, develop plans to improve	Floor Boston	27.1507.15255	
		walking conditions, and encourage walking	22. 200.0.1		
		activities.			
	African Community	Helps African refugees and immigrants in	48 John Eliot Sq.	617.708.0754	www.acedone.org
	Economic	Boston develop a self-sufficient and vital	Roxbury		
	Development of	community by providing our youth with the	89 South St Ste 2A		
	New England	education and life experience to thrive	Boston		
	(ACEDONE)	socially, professionally, and economically.			

	BAGLY (Boston	Provides community-based leadership	28 Court Sq. Boston	617.227.4313	www.bagly.org
-		development, health promotion, and social			
	Lesbian, Bisexual and Transgender	support programs for Massachusetts LGBTQ youth communities.			
	Youth)	youth communities.			
-	Boston Chinatown	Provides a broad range of innovative	38 Ash St Boston	617.635.5129	www.bcnc.net
	Neighborhood	programs and services centered around			
	Center	education, workforce development, family			
		support, and arts and culture.			
	Boston Public	Provides a wide-range of services in child,	1010	617.534.5395	www.bphc.org
	Health Commission	adolescent and family health; community health initiatives; homeless services;	Massachusetts Ave 6th Floor Boston		
		infectious disease; recovery services; and	oth floor boston		
		emergency medical services.			
	Center for Working	Provides financial education and	7 Palmer St	617.541.2670	www.boston.gov/departmen
	Families	employment services including: one-on-one	Roxbury		ts/center-working-families
		coaching, credit and asset building, and			
		workforce development.			
	English for New	Provides English language learning	185 Devonshire St	617.982.6860	www.englishfornewbostonia
	Bostonians	programs to non-English speaking residents.	Ste 700 Boston		ns.org
	Jewish Vocational	Provides adult education and workforce	75 Federal St 3rd	617.399.3131	www.jvs-boston.org
	Services	development services, serving a diverse	Floor Boston		,
		clientele and helping people secure financial			
		independence through educational and			
		employment services.	45.01	547.005.4047	1.11
	Louis D Brown	Serves as a center of healing, teaching, and	15 Christopher St Dorchester	617.825.1917	www.ldbpeaceinstitute.org
	Peace Institute	learning for families and communities impacted by murder, trauma, grief, and loss.			
		impacted by murder, tradina, grier, and ioss.			
	MassHire Metro	Provides customer centered job search	186 Alewife Brook	617.661.7867	www.masshiremncareers.co
	North Career	assistance to enable individuals to meet	Parkway Ste 310		m
	Center-Cambridge	their training and employment goals.	Cambridge		
	Oak Square YMCA	Offers a wide range of youth development	615 Washington St	617.782.3535	www.ymcaboston.org
		programs, healthy living and fitness classes, and social responsibility outreach	Brighton		
		opportunities.			
	Sociedad Latina	Provides high-quality, comprehensive, and	1530 Tremont St	617.442.4299	www.sociedadlatina.org
		holistic out-of-school time programming in	Roxbury		
		four key areas that meet the needs and			
		interests of the community: Education,			
		Workforce Development, Civic Engagement,			
		and Arts and Culture.			
	Tech Goes Home	Provides access to digital devices, network	131 Dartmouth St	617.398.7831	www.techgoeshome.org
Additional		connectivity, and robust training in how to	3rd Floor Boston		
Resources		utilize digital resources.			
	United Way of	Work to create positive and lasting change	9 Channel Center St	617.624.8000	www.unitedwaymassbay.org
	Massachusetts Bay	for people through financial opportunity	Ste 500 Boston		
	& Merrimack Valley	and educational success.			
	Victory Programs	Offers hope, recovery, and community for	404 S. Huntington	617.541.0222	www.vpi.org
	,	individuals and families facing	Ave Boston		,
		homelessness, addiction, or other chronic			
		health conditions.			
	Wang VMCA of	Offers a wide range of wouth development	9 Oak St. March	617.426.2237	www.vmcahoston.org
	Wang YMCA of Chinatown	Offers a wide range of youth development programs, healthy living and fitness classes,	8 Oak St West Boston	017.420.2237	www.ymcaboston.org
	Cimiacowii	and social responsibility outreach	DOSCOTI		
		opportunities.			

West	t End House	Offers programs in Five Core Program Areas:	105 Allston St	617.787.4044	www.westendhouse.org
Boys	and Girls Club	The Arts, Health & Life Skills, Character &	Allston		
	ı	Leadership Development, Education &			
		Career Development and Sports, Fitness and			
		Recreation.			

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Beth Israel Deaconess Medical Center

Evaluation of 2023-2025 Implementation Strategy

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

Priority: Equitable Access to Care

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

Priority Cohorts	Strategies	Initiatives to address the priority	Progress, Outcome, Impacts
 Youth Racially, ethnically and linguistically diverse populations Older adults Low-resourced populations LGBTQIA+ 	Promote equitable care, health equity, and health literacy for patients across BIDMC and BILH's licensed and/or affiliated health centers, especially those who face cultural and linguistic barriers.	• Interpreter Services	 Progress, Outcome, Impacts # of patients assisted with interpreter services FY23: 53,442 FY24: 40,783 (data capture was affected by EMR transition) # of interpreter services provided FY23: 298,022 FY24: 311,031 # of languages provided FY23: 72 FY24: 84

 Youth Racially, ethnically and linguistically diverse populations Older adults Low-resourced populations LGBTQIA+ 	Increase access to primary care and specialty care services, including OB/GYN and maternal child health services.	 Community Care Alliance (CCA) and support for Community-based Primary and Specialty Care Network/IT Integration and Access for CCA Health Centers Care Connection Residency Training Program 	 # of BIDMC specialists at affiliated FQHCs FY23: 33 FY24: 23 # of specialists at CCA health centers FY23: 36 FY24: 26 # of patients seen at affiliated FQHCs FY23: 95,934 FY24: 111,128 # of visits provided at affiliated FQHCs FY23: 305,353 FY24: 355,374 # of patients without insurance served at FQHC CCA health centers FY23: 5,977 FY24: 6,716
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Low-resourced populations	Address the health-related social needs (HRSN) of patients in order to support access to care.	 Community Health Worker Program BIDMC Social Work Department Services 	 # of patients assisted with Health-Related Social Need (HRSN) # of patients provided with housing support (FY23, FY24: data not available) # of patients provided emergency food or gift cards (FY23, FY24: data not available) # of patients provided clothing (FY23, FY24: data not available)
BIDMC employees	Provide and promote career support services and career mobility programs to hospital employees.	 Pipeline programs Career and academic advising Hospital-sponsored community college courses Hospital-sponsored English Speakers of Other Languages (ESOL) classes 	 # of employees who participated in career support and career mobility programs: FY23: 111 FY24: 1,044 across BILH system # of employees who were promoted (FY23: data not available)

Low-resourced	Promote access to health	Financial Counseling	# of patients screened for
populations	insurance, patient financial	Pharmacy Programs	eligibility
populations	counselors, and needed	- marmaey regrams	,
	medications for patients who are		o FY23: 315,578
	uninsured or underinsured.		o FY24: 296,437*
			# of patients enrolled into
			entitlement programs
			o FY23: 31,251
			o FY24: 39,032*
			 # of patients enrolled in
			MassHealth
			o FY23: 15,703
			o FY24: 22,213*
			# of patients enrolled in Health
			Safety Net (HSN):
			o FY23: 6,639
			o FY24: 9,044*
			*The BIDMC Epic EHR
			'
			implementation in June of 2024
			resulted in FY 24 data reported
			from two distinct and
			autonomous systems. Future
			data will be only be captured and
			reported from Epic
 Community residents 	Advocate for and support policies	• TBD	# of policies reviewed and
	and programs that address		supported (FY23: BILH conducted
	healthcare access.		direct advocacy for six policies:
			An Act relative to emergency
			response and preparedness in
			the event of a surge in pediatric
			· ·
			or adult hospitalizations, An Act

BIDMC patients and community residents	Support research aimed at providing more equitable care for patients and community members.	• TBD	expanding coverage of dental procedures, An Act establishing a task force to study the sustainability of emergency medical services, An Act relative to pharmaceutical access, costs and transparency, An Act relative to reducing administrative burden, and An Act improving healthcare delivery for underserved residents of the Commonwealth) • Amount of funding dedicated to disparities research • FY23: \$4,860,470 • FY24: \$4,716,868
BIDMC patients and Commonwealth residents	Provide and support residents with transportation access, public safety, emergency care, public health and emergency preparedness.	 Medical and Critical Care Transportation Trauma, Emergency Management, and Public Health Surveillance Public Safety 	 # of patients assisted with transportation (data not available) # taxi or ride-sharing vouchers provided FY23: 5,660 FY24: 7,059

Priority: Social Determinants of Health

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

Priority Cohorts	Strategies	Initiatives to address the priority	Progress, Outcome, Impacts
 Youth Racially, ethnically and linguistically diverse populations Older adults Low-resourced populations LGBTQIA+ Families affected by violence and/or incarceration 	Support evidence-based programs and strategies to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families.	Investments in housing programs to stabilize or create access to affordable housing	 # of participants and their demographics 1,814 total participants reached (184 in evaluation sample) # of housing policies passed Achieved milestones such as: committee hearings on all three state level policies; budgetary increase on one initiative; and mayoral ratification of two new city-wide regulations. *Based on data collected between April 1, 2024 and Sept 30, 2024 *Housing: A new cohort of housing grantees received 3-year grants that began January 2024. Data collection began April 2024 and is ongoing.

	 Housing stability
	 Housing instability
	 Housing control
	using (Based on data collected between July
	1 and Sept 30, 2023) Note: funding for this
	t of grantees ended December 2023.
Metri	cs and outcomes are below.
0	Housing satisfaction: (FY23: On average,
	participants reported higher levels of
	satisfaction with their housing situation
	at endpoint compared to when they
	enrolled; this result was statistically
	significant. The overall average level of
	housing satisfaction increased
	significantly from 2.9 at baseline to 3.2 at
	endpoint.)
0	Housing control: (FY23: On average,
	participants reported a higher level of
	control of their housing situation at
	endpoint compared to when they
	enrolled; this result was statistically
	significant. The average level of housing
	control increased from 2.8 at baseline to
	3.1 at endpoint.)
0	Housing situation: (FY23: The majority of
	participants (85.0%) did not have any
	change in their housing situation
	between baseline and endpoint). Note:
	Given that the Boston housing market is
	one of the most expensive in the US, this
	one of the most expensive in the os, this

 Youth Racially, ethnically and linguistically diverse populations Older adults Low-resourced populations LGBTQIA+ Families affected by violence and/or incarceration Support evidence-based programs, strategies, and partnerships to increase employment and earnings and increase financial security. 	 Investments in jobs and financial security programs to strengthen the local workforce and address underemployment Community hiring 	stability in description of housing situation can be interpreted as a positive result. Advocacy: (FY23: 2,689 advocacy efforts among four grantees for policy change related to housing affordability) # of youths housed: (FY23: 24) *Jobs and financial security: A new cohort of jobs and financial security grantees received 3-year grants that began January 2024. Data collection began April 2024 and is ongoing. Outcome data will be shared in future reports on the measures below. Awareness and utilization of skills and resources Financial goal orientation Financial well-being Program successes 334 participants from six grantees achieved a positive increase in financial habits and significant improvements in financial capability (FY23) 1.7% increase in the proportion of participants reporting they had a personal budget, spending plan, or financial plan (Adult Hope Scale) (FY23)
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 Youth Racially, Ethnically and Linguistically Diverse Populations Older Adults Low-resourced Populations Families Affected by Violence and/or Incarceration 	Promote thriving neighborhoods and enhance community cohesion and resilience.	 Healthy Neighborhoods Initiative The Wellness Center at Bowdoin Street Health Center Village in Progress (VIP) Neighborhood Trauma Team Placemaking activities and neighborhood improvement 	 Across four collectives, an average of 78% of collective members reported that they have strengthened their relationships with other members (FY24) Neighborhood Trauma Team 12 incidents of level 4 or 5 neighborhood incidents responded to (FY23) 11 incidents of level 4 or 5 neighborhood incidents responded to (FY24) 534 therapeutic sessions provided (FY23)
 Youth (including youth with physical and cognitive disabilities) Racially, ethnically and linguistically diverse populations Low-resourced populations 	Increase mentorship, leadership, training, and employment opportunities for youth and young adults residing in the communities BIDMC serves.	 Youth summer jobs program BIDMC Youth Advisors 	 34 youth involved (FY23) 26 youth involved (FY24)

Community residents	Advocate for and support policies and programs that address the social determinants of health.	• TBD	BILH conducted direct advocacy for two policies: An Act providing affordable and accessible high-quality early education and care to promote child development and well-being and support the economy in the Commonwealth and An Act to advance health equity (FY23)
 BIDMC patients and employees Community residents 	Conserve natural resources, reduce carbon emissions, and foster a culture of sustainability to create a healthy environment for residents.	Environmental Sustainability	 Greenhouse gas emissions FY23: BIDMC reduced organizational emissions by 11.9% FY24: BIDMC reduced organizational emissions by 14.6% % Local Food and Beverage Spend FY23: Purchased 17.3% sustainable and local food & beverage FY24: Purchased 17.0% sustainable and local food & beverage Waste diversion FY23: Achieved 56.8% diversion FY24: Achieved 55.8% diversion

Families Affected by Violence and/or Incarceration	Build community awareness, advocate for policy change, and provide supportive care for victims of violence and trauma.	The Center for Violence Prevention and Recovery (CVPR)	 # sexual assault victims receiving services FY23: 702 FY24: 626 # of services provided to sexual assault victims in the Emergency Department (ED) FY23: 66 FY24: 63 # of education and outreach services to employees in health centers, colleges and universities, and other community groups around sexual assault, interpersonal violence, community violence, secondary traumatic stress, and human trafficking FY23: provided 27 trainings to 662 employees; FY24: hosted 12 trainings to 489 employees FY23: provided two groups with 8 sessions of service to community groups around secondary traumatic stress # of safe bed overnight stays FY23: 6 FY24: 14 # of healing circles FY23: 32 and 390 total attendees FY24: 24, and 92 total attendees
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 Youth Racially, ethnically and linguistically diverse populations Low-resourced populations Older adults 	Promote healthy eating and active living by increasing opportunities for physical activity and providing healthy food resources to patients and community residents.	 The Wellness Center at Bowdoin Street Health Center Grocery store gift card distribution program Fitness in the City Explore installation of Freight Farms 	 # of participants in Healthy in the City (fka Fitness in the City) FY23: 43 FY24: 144 of which 63 were new enrollments # of units of food distributed FY23: 1590 bags through Fair Foods were distributed for free to patients and community members and 276 meals were donated to Food for Free FY24: 958 bags through Fair Foods were distributed for free, 573 grocery store vouchers were distributed to patients, and 314 meals were donated to Food for Free # of Farmer's Market Coupons BPHC provided that could be used at any City of Boston Farmer's Market to patients and community members FY23: 609 FY24: 387
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Priority: Mental Health and Substance Use

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

Dui anita a Cala ant (a)	Strategies		Program Outsons Invasts
Priority Cohort(s) Youth Racially, ethnically and linguistically diverse populations Low-resourced populations Older adults LGBTQIA+ Families affected by violence and/or incarceration	Support and implement evidence-based programs that increase access to high-quality and culturally and linguistically appropriate mental health and substance use services.	 Initiatives to address the priority Investments in community behavioral health services through screening, monitoring, counseling, navigation, and treatment Community-based Primary and Specialty Care (Support for licensed and/or affiliated community health centers) Screening, Brief Intervention, and Referral to Treatment Integrative Care Model Collaborative Care Model Opioid Care Committee The Dimock Center substance use clinical stabilization services 	 ◆ # of Behavioral Health patients reached FY23: 748 FY24: 104 ◆ # of behavioral health counseling sessions FY23: 1,603 FY24: 372 ◆ Mental health symptoms (Using PHQ-8; PHQ-9; PSYCHLOPS scale): FY23: More than 3 of every 5 participants experienced improvement in their mental health symptoms between baseline and endpoint (61.9%) FY24: Data not available ◆ Stigma (Recovery Assessment Scale (RAS-DS): FY23: On average, there was a statistically significant increase in participant confidence and selfefficacy related to managing life stressors and mental health from baseline to endpoint. The average RAS-DS score increased from 2.9 at baseline to 3.2 at endpoint FY24: Data not yet available ◆ *General Help-Seeking Questionnaire (GHSQ):

			 FY23: On average, participants reported a statistically significant increase in likelihood of seeking help at endpoint compared to baseline. These increased likelihoods were statistically significant for each of the listed individuals, with the exception of an intimate partner FY24: Data not yet available # of Integrated Behavioral Health Consultations provided in BSHC Primary Care Clinic FY23: 399 # of practices using the Collaborative Care/Integrative Care model FY23: 5
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• Community residents	Advocate for and support policies and programs that address mental health and substance use.	• TBD	# of policies reviewed and supported: (FY23: data not available; FY24: BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for 8 bills supporting access to mental health and substance use services for all Massachusetts residents)
 Racially, ethnically and linguistically diverse populations LGBTQIA+ Families affected by violence and/or incarceration 	Implement trauma-informed care (TIC) principles and other prevention strategies to improve care for all, especially those with a history of adversity.	Expansion of Trauma- informed care (TIC) training across hospital	 # of medical professionals and trainees who received training on trauma-informed care FY23 and FY24: 340 # of community partners/collaborators that received training on trauma-informed care FY23 and FY24: 191

Priority: Complex and Chronic Conditions

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

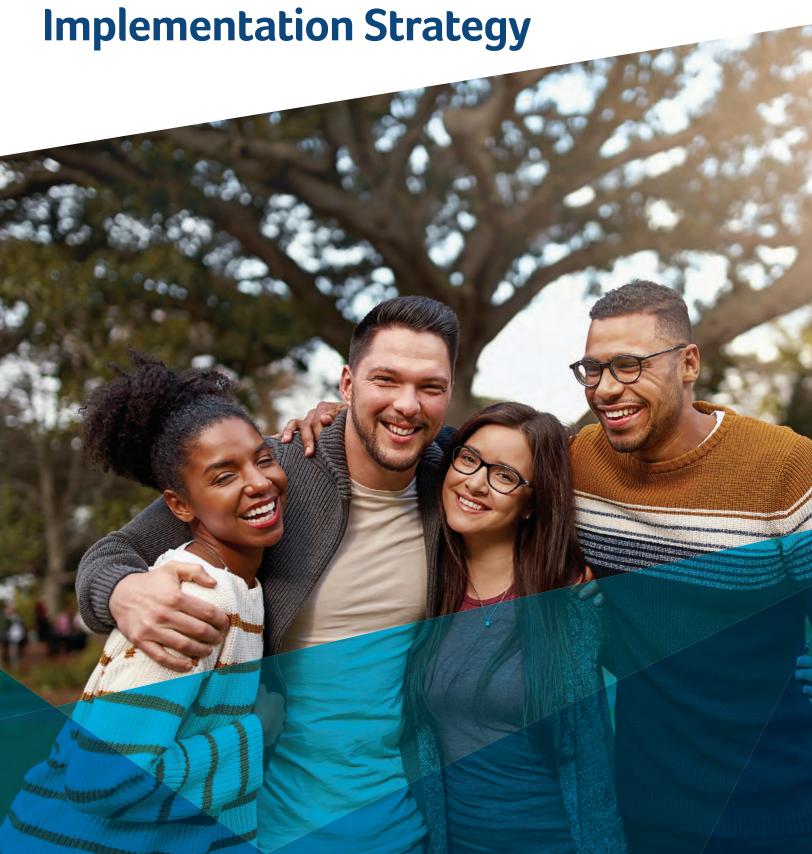
Priority Cohort(s)	Strategies	Initiatives to address the priority	Progress, Outcome, Impacts
 Racially, ethnically and linguistically diverse populations Low-resourced populations Older adults LGBTQIA+ 	Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.	 The Wellness Center at Bowdoin Street Health Center BILH Pharmacy Assistance Programs Community-based Diabetes Prevention and Treatment Programs Cancer Patient Navigators Support Groups Lung Cancer Early Detection Screening Implement BILH Diabetes Disparities initiative strategies, as appropriate 	 # of patients served at CCA health centers, affiliated FQHC's and Outer Cape Health Services FY23: 122,800 FY24: 119,994 # of medical care service visits (including virtual) provided at CCA health centers and Outer Cape Health Services FY23: 386,100 FY24: 355,374 Percentage of CCA Federally Qualified Health Center (FQHC) and Outer Cape Health Services patients with diabetes with HbA1c < 9 controlled FY23: 75% FY24: 75% Percentage of CCA FQHC and Outer Cape Health Services patients with hypertension who had a blood pressure < 140/90 [controlled]

	 FY23: average of 6 patients attended
	each support group meeting
	 FY24: about 63 patients attended
	support groups
	 # of patients receiving early detection lung
	cancer screening
	o FY23: 1,250
	o FY24: 1,364





FY26-FY28



Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Medical Center (BIDMC) is one of the nation's premier academic medical centers and a primary teaching hospital and research affiliate of Harvard Medical School. The medical center has 766 licensed inpatient beds, with more than 10,000 employees and over 3,000 clinicians on active medical staff. BIDMC is devoted to advancing the science and practice of medicine through groundbreaking research and education, taking particular pride in centers of excellence, including in cardiovascular, cancer, neuroscience, digestive health and obstetrics and gynecology.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. In conducting this assessment and planning process, it would be difficult to overstate BIDMC's commitment to community engagement and a comprehensive, data-driven, collaborative and transparent assessment and planning process. Altogether, this approach involved extensive data collection activities, substantial efforts to engage the medical center's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been historically underserved, such as those are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, or other personal characteristics.

BIDMC collects a wide range of quantitative data to characterize the communities served across its Community Benefits Service Area (CBSA). BIDMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national level to support analysis

and the prioritization process. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing segments of the population most at-risk, and crafting a collaborative, evidence-informed IS. BIDMC employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Across all three components, the assessment included 35 one-on-one interviews with key collaborators in the community, 17 focus groups with segments of the population facing the greatest health-related disparities, 5 sector-based focus groups with community partners, and 1 community listening session that engaged about 40 participants.

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 Implementation Strategy (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 are faced with health-related disparities. Accordingly, using an interactive, anonymous polling software, BIDMC's CBAC and community residents, through a community listening session, formally prioritized the community health issues and cohorts that they believed should be the focus of BIDMC's IS. This prioritization process helps to ensure that BIDMC 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.

BIDMC's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary

prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

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

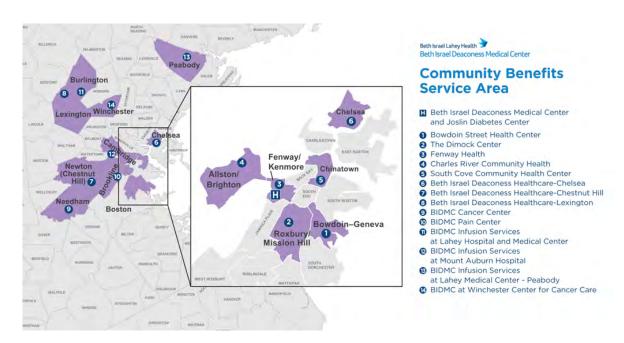
Recognizing that community benefits planning is ongoing and will change with continued community input, BIDMC's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change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

Community Benefits Service Area

BIDMC's CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns that are part of the Community Care Alliance and/or where BIDMC operates licensed facilities. BIDMC's CHNA focused on identifying the leading community health needs and priority cohorts living

and/or working within its CBSA. In recognition of the considerable health disparities that exist in some communities in its CBSA, BIDMC 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 city of Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/ Kenmore, Mission Hill and Roxbury.

While there are segments of the populations in Brookline, Burlington, Cambridge, Chestnut Hill, Lexington, Needham, Peabody and Winchester who are underresourced and have limited access to the care they need, the greatest disparities exist for those who live in Chelsea and the Boston neighborhoods specified above. By prioritizing these cohorts, BIDMC can promote health and well-being, address health disparities, and maximize the impact of its community benefits resources. Further, while BIDMC operates licensed facilities in Burlington, Cambridge, Needham, Peabody, and Winchester. These service locations are in other BILH CBSAs. The Town of Burlington and the City of Peabody are located within Lahey Hospital and Medical Center's (LHMC's) CBSA, the Town of Needham is located within Beth Israel Deaconess Needham's (BID Needham) CBSA, the City of Cambridge is located within Mount Auburn Hospital's (MAH) CBSA, and the Town of Winchester is located within Winchester Hospital's (WH's) CBSA. As a result, the community benefits activities for these municipalities have been delegated to LHMC, BID Needham, MAH, and WH. This helps to ensure that activities are properly coordinated and address the identified needs.



Prioritized Community Health Needs and Cohorts

BIDMC is committed to promoting health, enhancing access and delivering the best care for those in its CBSA. Over the next three years, the medical center will work with its community partners, with a focus on Chelsea and the Boston neighborhoods in its CBSA, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. 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 and community health priority areas.

BIDMC Priority Cohorts



Youth



Low-resourced Populations



Families Affected by Violence or Incarceration



Older adults



LGBTQIA+



Racially, Ethnically, and Linguistically Diverse Populations

Community Health Needs Not Prioritized by BIDMC

It is important to note that there are community health needs that were identified by BIDMC's assessment that were not prioritized for investment or included in BIDMC's IS. Specifically, addressing issues related to the built environment (e.g., improving sidewalks and roads) were identified as community needs but were not included in BIDMC's IS. While these issues are important, BIDMC's CBAC and senior leadership team decided that these issues were outside of the medical center's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. As a result, BIDMC recognized that other public and private organizations in its CBSA, Boston, and the Commonwealth were better positioned to focus on these issues. BIDMC 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 BIDMC's IS

The issues that were identified in the BIDMC CHNA and are addressed in the hospital IS are housing issues, food insecurity, transportation, environmental justice/climate, economic insecurity, community safety, workforce development, language and cultural barriers to care, long wait times for care, navigating a complex health care system, health insurance and cost barriers, youth mental health, depression/anxiety/stress, support for individuals with substance use disorder, social isolation among older adults, navigating the behavioral health system, trauma, conditions associated with aging, education and prevention around chronic disease risk factors, emergency preparedness, and care navigation and management.

BIDMC Community Health Priority Areas HEALTH EQUITY









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 full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	Low-resourced populations Racially, ethnically, and linguistically diverse populations LGBTQIA+	 Health insurance eligibility and enrollment assistance activities Financial counseling activities Programs and activities to support culturally/ linguistically competent care and interpreter services Expanded access to primary care, medical specialty care, and other clinical services for Medicaid covered, uninsured, and underinsured populations Emergency medical services training, leadership, and community preparedness activities Intensive case management, care navigation, and referral programs Education, wellness, navigation, and peer support programs and activities 	• # of sessions conducted • # of people assisted • # of referrals made • # of interpreter services provided • # of languages • # of medical residents placed at health centers • # of specialists at health centers • # of patients seen • Financial assistance provided • # of support groups	Colleges and universities Community health centers Private, non-profit, health-related agencies Hospital-based activities
Advocate for and support policies and systems that improve access to care.	All priority populations	Advocacy activities	• # of policies supported	 Local, state, and federal governmental agencies and advocacy organizations

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.

Information gathered through interviews, focus groups, the listening session, and surveys reinforced that these issues have considerable impacts 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: BIDMC 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 BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, or leveraged 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 outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	 Youth Low-resourced populations Racially, ethnically, and linguistically diverse populations 	 Food access, nutrition support, and education programs and activities Fitness and education programs and activities 	 # of people served Units distributed # of community education events 	 Private, non-profit, health-related agencies Hospital-based activities Community health centers
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	All priority populations	 Community investment and affordable housing initiatives Housing assistance, navigation, and resident support activities 	Metrics pertaining to housing stability	Housing support and community development agencies

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.	All priority populations	Career advancement and mobility programs Youth employment and internship programs	 # of youth participating # hired by hospital # of programs # of participants # of employees served 	 Local primary and secondary schools Cultural, linguistic, and community advocacy programs Hospital- based activities
Support programs and activities that increase employment, earnings, and financial security.	Youth Low-resourced populations Racially, ethnically, and linguistically diverse populations Families affected by violence and/or incarceration	Career advancement and mobility programs	Awareness/ utilization of skills and resources Financial well- being Amount invested	Private, non- profit, and health-related agencies
Support programs and activities that foster social connections, strengthen community cohesion and resilience, and address public safety and causes and impacts of violence.	• All priority populations	 Community connection, social engagement, and beautification activities Community healing, violence prevention, and community safety activities 	 # of people served # of classes, activities, sessions, or units of service organized # of safe bed overnight stays # of incidents responded to 	 Private, non-profit, and health-related agencies Hospital-based activities
Advance environmental sustainability and climate resilience by reducing carbon emissions, conserving natural resources, strengthening community and infrastructure preparedness for climate-related disruptions, and addressing the health impacts of climate change, with a focus on support for those most affected.	All priority populations	Sustainability and environmental health activities	 % reductions in greenhouse gas emissions % local food and beverage spend % waste diversion 	• Hospital- based activities

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Advocate for and support policies and systems that address social determinants of health.	All priority populations	Advocacy activities	• # of policies supported	Hospital-based activities

Priority: Mental Health and Substance Use

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

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

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

Resources/Financial Investment: BIDMC 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 BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, or leveraged 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	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	 Racially, ethnically, and linguistically diverse populations Low-resourced populations Older adults Youth LGBTQIA+ Families affected by violence and/or incarceration 	Health education, awareness, and wellness activities for all age groups	 # of classes # of attendees Changes in knowledge 	Hospital-based activities
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	Racially, ethnically, and linguistically diverse populations Low-resourced populations Older adults Youth LGBTQIA+ Families affected by violence and/or incarceration	 Substance use and mental health screening, monitoring, counseling, and referral programs Expand access to mental health and substance use services for individuals and families Patient care navigator programs Primary care and behavioral health integration and collaborative care programs Crisis intervention and early response programs and activities Workforce development activities 	 # of people served # of people screened # of patients referred # of counseling sessions Improvement in mental health literacy Stigma reduction # of locations/ practices # of professionals receiving training 	Community health centers Children and family services agencies Cultural, linguistic, and community advocacy programs Local primary and secondary schools Hospital-based activities

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Advocate for and support policies and programs that address mental health and substance use.	All priority populations	Advocacy activities	# of policies supported	 Hospital based activities

Priority: Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than \$41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.¹

Resources/Financial Investment: BIDMC expends substantial resources 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 BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, inkind, or leveraged 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 and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	All priority populations	 Fitness, nutrition, and healthy living programs and activities Chronic disease management, treatment, and self-care support programs Cancer education, wellness, navigation, and survivorship support programs Support groups (peer- and professional-led) HIV/AIDS care, education, and support programs Research to foster health equity 	• # of people served • # of federally qualified health center (FQHC) patients whose diabetes is is controlled • % of FQHC patients whose hypertension is controlled • % HIV+ patients screened for HCV • # of visits by infectious disease physicians	Community health centers Private, non-profit, health-related agencies Hospital-based activities
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	Advocacy activities	• # of policies supported	Hospital-based activities

¹ Massachusetts Executive Office of Health and Human Services. State Health Improvement Plan - Chronic Disease. Retrieved from https://www.mass.gov/info-details/ship-chronic-disease

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.	 Racially, ethnically, and linguistically diverse populations Low-resourced populations Youth 	Culturally responsive prenatal/postnatal case management and care coordination programs	• # of patients served	Community health centers

General Regulatory Information

Contact Person:	Anna Spier, Community Benefits/Community Relations Manager	
Date of written report:	June 30, 2025	
Date written report was approved by authorized governing body:	September 3, 2025	
Date of written plan:	June 30, 2025	
Date written plan was adopted by authorized governing body:	September 3, 2025	
Date written plan was required to be adopted	February 15, 2026	
Authorized governing body that adopted the written plan:	Beth Israel Deaconess Medical Center Board of Trustees	
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No	
Date facility's prior written plan was adopted by organization's governing body:	September 21, 2022	
Name and EIN of hospital organization operating hospital facility:	Beth Israel Deaconess Medical Center: 04-2103881	
Address of hospital organization:	330 Brookline Ave. Boston, MA 02215	

Beth Israel Lahey Health Beth Israel Deaconess Medical Center