Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

2022 Community Health Needs Assessment

Acknowledgments

This 2022 Community Health Needs Assessment report for Northeast Hospital Corporation (NHC) is the culmination of a collaborative process that began in September 2021. Under a single license, NHC, referred to throughout this report as Beverly and Addison Gilbert Hospitals (BH/AGH) operates two acute care campuses - Beverly Hospital in Beverly, Massachusetts and Addison Gilbert Hospital in Gloucester, Massachusetts; an acute psychiatric inpatient satellite, BayRidge Hospital in Lynn, Massachusetts; and an outpatient facility, Lahey Outpatient Center–Danvers in Danvers, Massachusetts. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key collaborators from throughout BH/AGH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

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

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

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Table of Contents

Introduction

Background

Northeast Hospital Corporation (NHC) consists of multiple entities organized to serve the needs of those in its communities. NHC, referred to as BH/AGH throughout this report, operates, under a single license, two acute-care campuses – Beverly Hospital in Beverly, Massachusetts, and Addison Gilbert Hospital in Gloucester, Massachusetts; an acute psychiatric inpatient satellite, BayRidge Hospital in Lynn, Massachusetts; and an outpatient facility, Lahey Outpatient Center–Danvers, in Danvers, Massachusetts.

Beverly Hospital (BH) is a full-service, 223-bed community hospital providing leading-edge, patient-centered care to North Shore and Cape Ann residents. The hospital provides a full range of state-of-the-art services including primary care, cardiovascular care, surgery, orthopedics, emergency care, maternity, and pediatrics, as well as many other specialties.

Addison Gilbert Hospital (AGH) is a full-service, 79-bed medical/surgical acute care facility. The hospital, founded in 1889, provides state-of-the-art inpatient and outpatient care to residents of the Cape Ann community in specialties such as pain management, wound care, cancer care, primary and pediatric care, cardiology, geriatric services, and emergency medicine.

BayRidge Hospital provides accessible and high-quality substance abuse and mental health treatment. This psychiatric hospital offers a continuum of chemical dependency and psychiatric services on an inpatient, partial hospitalization, and outpatient basis. Coordination of care between Beverly Hospital's psychiatric service, the Leland Unit, and BayRidge Hospital assures the provision of a range of acute inpatient services to individuals with psychiatric disabilities.

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

This 2022 Community Health Needs Assessment (CHNA) report is an integral part of BH/AGH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BH/AGH provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This CHNA, along with the associated prioritization and planning processes, also provides a critical opportunity for BH/AGH to engage residents and strengthen the community partnerships that are essential to BH/AGH's success now and in the future. The assessment engaged more than 1,000 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department and ambulance officials), faith leaders, other government officials, and community residents.

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

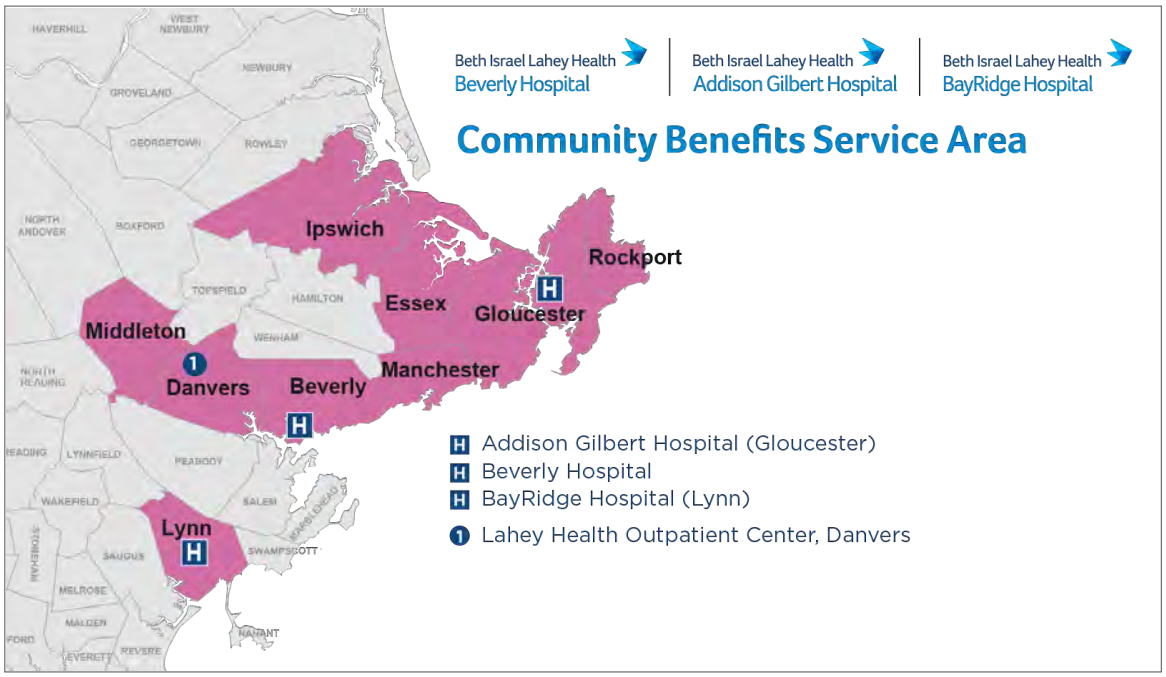
Purpose

The CHNA is at the heart of BH/AGH'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 inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BH/AGH serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and have been historically underserved.

Prior to this current CHNA, BH/AGH completed its last assessment in the summer of 2019 and the report, along with the associated 2020-2022 IS, was approved by the NHC Board of Trustees on September 5, 2019. The 2019 CHNA report was posted on the hospitals' websites before September 5, 2019 and, per federal compliance requirements, made available in paper copy, without charge, upon request. The assessment and planning work for this current report was conducted between September 2021 and September 2022 and NHC's Board of Trustees approved the 2022 report and adopted the 2023-2025 IS, included as Attachment E, on September 8, 2022.

Definition of Community Served

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



Description of Service Area

BH/AGH's CBSA includes the nine municipalities of Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester-by-the-Sea, Middleton, and Rockport in the northeast portion of Massachusetts. These municipalities are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban, and semi-rural). There is also diversity with respect to community needs. There are segments of the BH/AGH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. BH/AGH is committed to promoting health, enhancing access, and delivering the best care to all who live in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. BH/AGH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

BH/AGH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within the CBSA. The activities that will be implemented as a result of this assessment will support all of the people who live in the CBSA. However, in recognition of the health disparities that exist for some residents, BH/AGH 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. By prioritizing these cohorts, BH/AGH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

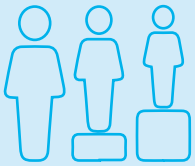
Assessment Approach & Methods

Approach

It would be difficult to overstate BH/AGH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BH/AGH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage BH/AGH's partners and community residents, and a thoughtful prioritization, planning, and reporting process.

Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, 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, collaboration, engagement, capacity building, and intentionality.

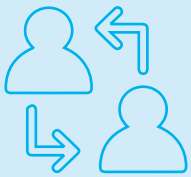


Equity:

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

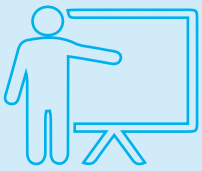
Collaboration:

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



Engagement:

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



Capacity Building:

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

Intentionality:

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

The assessment and planning process was conducted between September 2021 and September 2022 in three phases, which are detailed in the table below.

Phase I: Preliminary Assessment & Engagement	Phase II: Focused Engagement	Phase III: Strategic Planning & Reporting
Engagement of existing CBAC	Additional interviews	Presentation of findings and prioritization with CBAC and NHC 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 NHC leadership
Evaluation of community benefits activities	Facilitation of community listening sessions to present and prioritize findings	Presentation to NHC Boards of Trustees
Preliminary analysis of key themes	Compilation of resource inventory	Distribution of results via hospitals' websites

In July of 2021, BILH hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to assist BH/AGH and other BILH hospitals to conduct the CHNA. BH/AGH worked with JSI to ensure that the final BH/AGH 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 BH/AGH's assessment and planning activities. BH/AGH's CBAC was formed in 2018 and is made up of staff from BH/AGH's Community Benefits Department, other BH/AGH administrative and clinical staff, and members of NHC's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Local public health departments/boards of health
- Additional municipal staff (such as elected officials, planning, etc.)
- Education
- Housing (such as community development corporations, local public housing authority, etc.)
- Social services
- Regional planning and transportation agencies
- Private sectors
- Community health centers
- Community-based organizations.

These institutions are committed to serving residents throughout the region and are particularly focused on meeting the needs of those who are medically

Demographic, SES* & SDOH** Data	Commonwealth/National Health Status Data	Hospital Utilization Data	Municipal Data Sources
Age, SOGI***, race, ethnicity	Vital statistics	Inpatient discharges	Public school districts
Poverty, employment, education	Behavioral risk factors	Emergency department discharges	Local assessments and reports
Crime/violence	Disease registries		
Food access	Substance use data		
Housing/transportation	COVID-19 Community Impact Survey		

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

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

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, BH/AGH collected a wide range of quantitative data to characterize the communities in the CBSA. BH/AGH 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 also tested for statistical significance whenever possible, and was compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment, including data from the BH/AGH Community Health Survey, is included in Appendix B.

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 and evidence-informed IS. Accordingly, BH/AGH applied the Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1] To meet these standards, BH/AGH employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Between October 2021 and February 2022, BH/AGH conducted 18 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,300 residents, and organized two community listening sessions. In total, the assessment collected information from more than 1,400 community residents, clinical and social service providers, and other community partners. 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 materials.

18 interviews
with community leaders

1,341 survey respondents

3 focus groups

- Action, Inc.
- Lynn Shelter Association
- Youth in Danvers.

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 BH/AGH. Community Benefits staff reviewed BH/AGH's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which included a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify key partners who may or may not be already collaborating with BH/AGH. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

At the outset of the strategic planning and reporting phase of the project, community listening sessions were organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA. This was the first step in the prioritization process and allowed the community the opportunity to discuss the CHNA findings and formally identify the issues that they believed were most important, using an interactive and anonymous polling software. These sessions also allowed participants to share their ideas on existing community assets and strengths, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the community listening sessions, the CBAC was engaged. The CBAC was updated on assessment progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in their own prioritization process using the same set of interactive and anonymous polls, which allowed them to identify a set of community health priorities and the cohorts that they believed should be considered for prioritization as BH/AGH developed its IS.

After the prioritization process, a CHNA report was developed and BH/AGH's existing IS was augmented, revised, and tailored. In developing the IS, BH/AGH's Community Benefits staff took care to retain the community health initiatives that worked well and that aligned with the identified priorities from the 2022 CHNA, but also pose new strategies to address the newly identified priorities.

After drafts of the CHNA report and IS were developed, they were shared with BH/AGH's senior leadership team for input and comment. BH/AGH's Community Benefits staff reviewed these inputs and incorporated elements, as appropriate, before the final 2022 CHNA report and 2023-2025 IS were submitted to NHC's Board of Trustees for approval.

After the NHC Board of Trustees formally approved the 2022 CHNA report and adopted the 2023-2025 IS, these documents were posted on BH/AGH's websites, alongside the 2019 CHNA report and 2020-2022 IS, for easy viewing and download. As with all BH/AGH CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that BH/AGH'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 2022 assessment and planning process or past assessment processes should be directed to:

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Assessment Findings

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

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

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

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 BH/AGH's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, immigration status, 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 BH/AGH CBSA were issues related to age, race/ethnicity, language, disability status, and immigration status. Residents in the CBSA were predominantly white and born in the United States, but there were non-white, people of color, recent immigrants, non-English speakers, and foreign-born populations in all communities.

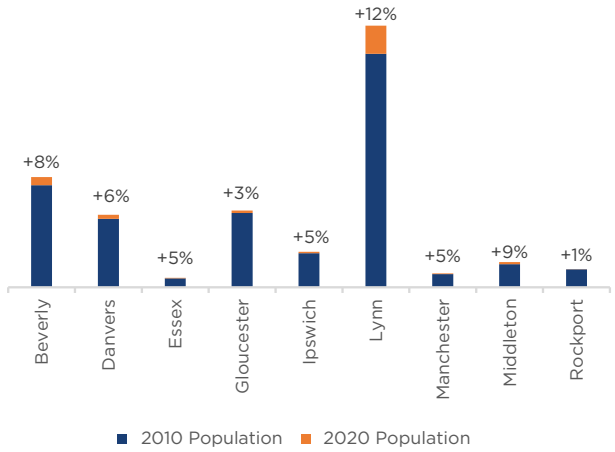
There was consensus among interviewees and focus group participants that older adults, people of color, individuals with disabilities, recent immigrants and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than young, white, English speakers who were born in the United States. While relatively small, these segments of the population were impacted by language barriers, cultural barriers, and stigma that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have lead to discrimination and disparities in access and health outcomes.

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

Population Growth

Between 2010 and 2020, the population in BH/AGH's CBSA increased by 8%, from 222,867 to 241,365 people. Lynn saw the greatest percentage increase (12%) and Rockport saw the lowest (1%).

Population Changes by Municipality, 2010 to 2020



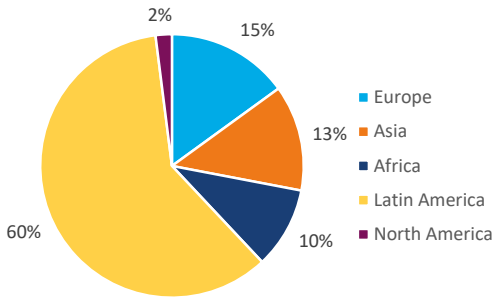
Source: US Census Bureau, 2010 and 2020 Decennial Census

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.[2]

20% of the BH/AGH CBSA population was foreign-born.

Region of Origin Among Foreign-Born Residents in the CBSA, 2016-2020



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

Language

Language barriers pose significant challenges to receiving and providing effective and high-quality health and social services. Studies show that health outcomes improve when patients and providers speak the same language.[3]

26% of BH/AGH CBSA residents 5 years of age and older spoke a language other than English at home and of those,

48% spoke English less than "very well."

Source: US Census Bureau American Community Survey 2016-2020

Age

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

18%

of residents in the BH/AGH CBSA were 65 years of age or older. The proportion of older adults is expected to increase by 2030, which may have implications for the provision of health and social services.

21%

of residents in the BH/AGH CBSA were under 18 years of age.

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

Gender Identity and Sexual Orientation

Massachusetts has the second largest lesbiand 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.

5%

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

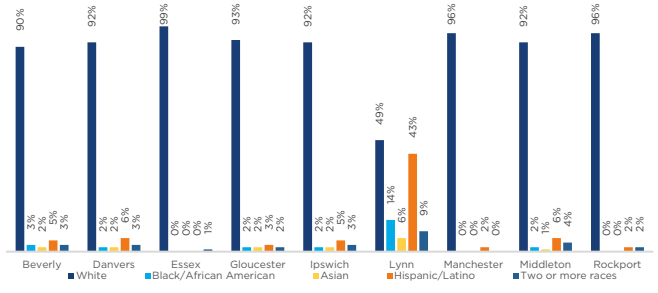
21% of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

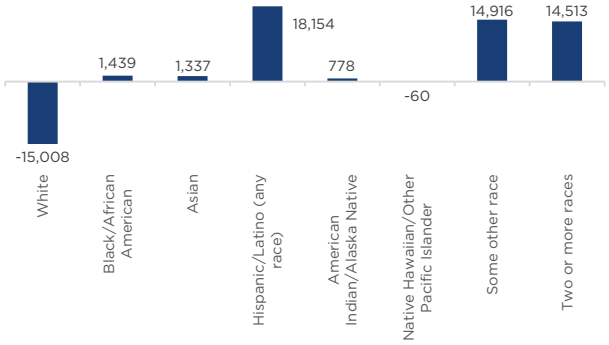
In the BH/AGH CBSA overall, the number of residents who identified as white and Native Hawaiian or other Pacific Islander has decreased since 2010, while there was an increase in other census categories. Interviewees, focus groups, and community listening session participants reported that they felt the CBSA was increasingly diverse, though the BH/AGH CBSA was predominantly white.

Race/Ethnicity by Municipality, 2016-2020



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

CBSA Population Changes by Race/Ethnicity, 2010 to 2020



Source: US Census Bureau, 2010 and 2020 Decennial Census

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

Household Composition

Household composition and family arrangements may have significant impacts on health and well-being, particularly as family members act as sources of emotional, social, financial, and material support.[4]

29% of BH/AGH CBSA households included one or more people under 18 years of age.

34% of BH/AGH CBSA households included one or more people over 65 years of age.

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

Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[5] These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, access to care/navigation issues, and other important social factors.[5]

There was limited quantitative data in the area of social determinants of health. Information gathered through interviews, focus groups, listening sessions, and the BH/AGH Community Health Survey reinforced that these issues had 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 groups, and community listening session participants shared that access to affordable housing was the most significant challenge for many residents in the CBSA. This was particularly true for older adults and those living on inadequate fixed incomes. Interviewees, focus groups, and listening session participants also noted that there were individuals who are homeless or unstably housed in the CBSA, particularly in Gloucester and Lynn.

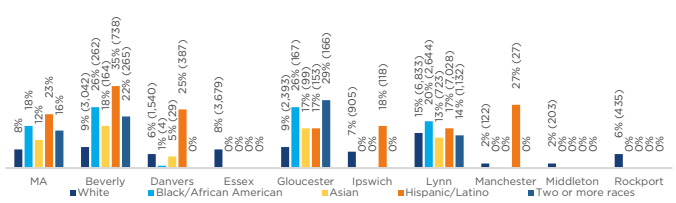
Interviewees, focus groups, listening session participants, and survey respondents also shared that transportation was a critical factor to maintaining one's health and accessing care, especially for those that did not have a personal vehicle or were without caregivers, family, or social support networks. Food insecurity, food scarcity, and hunger were also identified as significant 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 inadequate fixed incomes, which impacted the ability of individuals and families to eat a healthy diet. Other social factors that were highlighted in a more limited way during the assessment included lack of access to affordable childcare and domestic violence.

Economic Stability

Economic stability is affected by income/poverty, financial resources, employment and work environment, which allow people the ability to access the resources needed to lead a healthy life.[6] Lower-than-average life expectancy is highly correlated with low-income status.[7] Those who experience economic instability are also more likely to be uninsured or to have health insurance plans with very limited benefits. Research has shown that those who are uninsured or have limited health insurance benefits are substantially less likely to access health care services.[8]

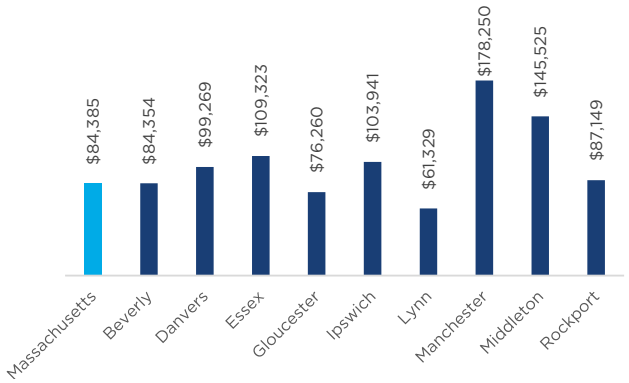
COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability.

Percentage of Residents Living Below the Poverty Level, 2016-2020



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

Median Household Income, 2016-2020

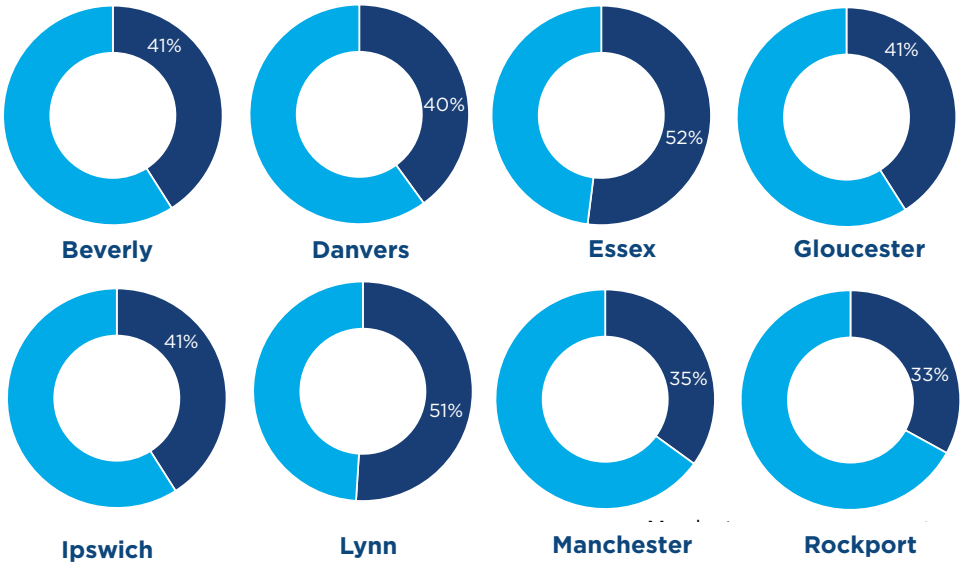


Source: US Census Bureau American Community Survey, 2016-2020

Across the BH/AGH CBSA, the percentage of individuals living below the poverty level tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of systemic racism, discrimination, and cumulative disadvantage over time.[9] Median household income is the total gross income before taxes, received within a one year period by all members of a household. Median household income was lower than the Commonwealth overall in Beverly, Gloucester, and Lynn.

The Massachusetts Department of Public Health (MDPH) conducted the COVID-19 Community Impact Survey in the fall of 2020 to assess emerging health needs, results of which indicated that community residents were concerned about their ability to pay their bills.

Percentage* Worried About Paying for One or More Type of Expenses/Bills in Coming Weeks (Fall 2020



Data for Middleton was suppressed.

***Unweighted percentages displayed**

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

Education

Research shows that those with more education live longer, healthier lives.[10] Patients with a higher level of educational attainment are able to better understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers.

88% of BH/AGH CBSA residents 25 years of age and older had a high school degree or higher.

37% of BH/AGH CBSA residents 25 years of age and older had a bachelor's degree or higher.

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

Social Determinants of Health

Food Insecurity and Nutrition

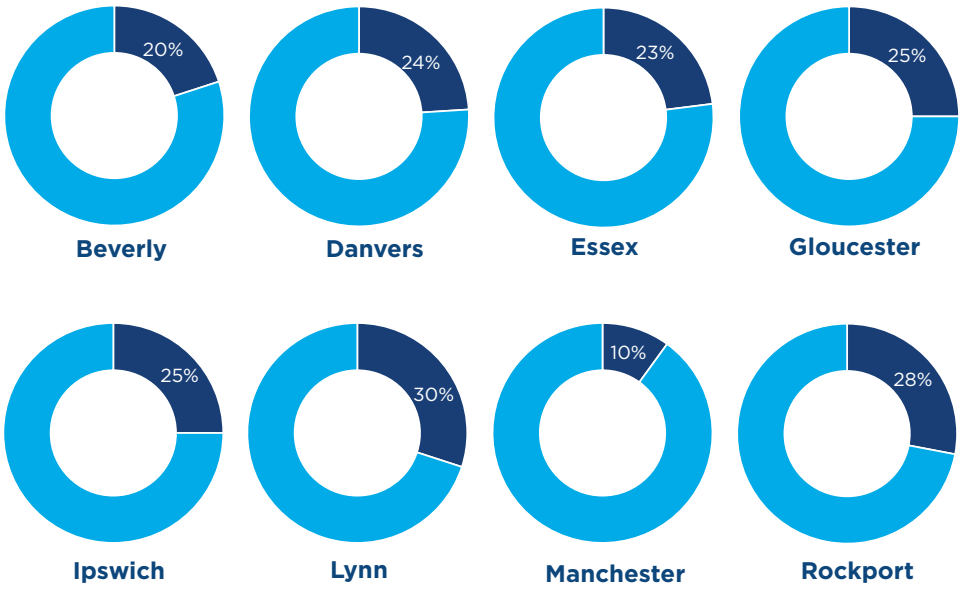
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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

15%

of BH/AGH CBSA households received SNAP benefits (formerly food stamps) within the past year. SNAP provides benefits to low-income families to help purchase healthy foods. In Gloucester, Ipswich, Lynn, and Rockport, at least 25% of respondents to MDPH's COVID-19 Community Impact Survey reported that they were worried about getting food or groceries in the fall of 2020.

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



Data for Middleton was suppressed.

***Unweighted percentages displayed**

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

Neighborhood and Built Environment

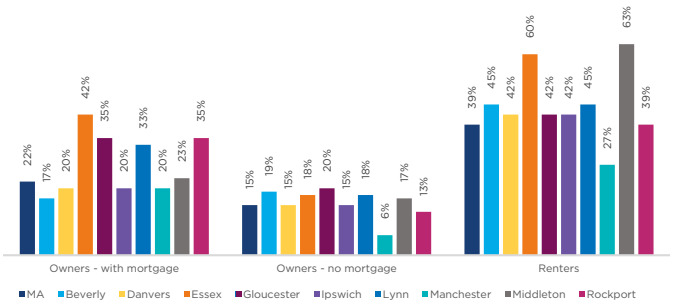
The conditions and environment in which one lives have significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks, and bike lanes improve health and quality of life.[10]

Housing

Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases, and poor mental health.[12] At the extreme are those without housing, including those who are unhoused or living in unstable or transient housing situations who are more likely to delay medical care and have mortality rates up to four times higher than those who have secure housing.[13]

Interviewees, focus groups, listening session participants, and BH/AGH Community Health Survey respondents expressed concern over the limited options for affordable housing throughout the CBSA. The percentage of housing units in the BH/AGH CBSA with owner and renter costs in excess of 35% of household income was lower or similar to the Commonwealth overall, with the exception of Essex, Gloucester, and Middleton, where the percentages were higher.

Percentage of Housing Units With Monthly Owner/ Renter Costs Over 35% of Household Income



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

When asked what they'd like to improve in their community:

54% of BH/AGH Community Health Survey respondents said "more affordable housing."

57% of BH/AGH Community Health Survey respondents said that housing in the community was not affordable for people with different income levels.

Transportation

Transportation was identified as a significant barrier to care and needed services, especially for older adults who no longer drove or who did not have family or caregivers nearby.

When asked what they'd like to improve in their community:

29% of BH/AGH Community Health Survey respondents wanted better access to public transportation.

12% of housing units in the BH/AGH CBSA did not have an available vehicle.

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

Roads/Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety and increased mobility. Sidewalks allow more space for people to walk or bike, which increases physical activity and reduces the need for vehicles on the road. Respondents to the BH/AGH Community Health Survey prioritized these improvements to the built environment.

37% of BH/AGH Community Health Survey respondents identified a need for better roads.

30% of BH/AGH Community Health Survey respondents identified a need for better sidewalks and trails.

Systemic Factors

In the context of the health care system, systemic factors include a broad range of considerations that influence a person's ability to access timely, equitable, and high-quality services. There is a growing appreciation for the importance of these factors as they are critical to ensuring that people are able to find, access, and engage in the services they need, communicate with clinical and social service providers, and transition seamlessly from one service setting to another. The assessment gathered information related to perceptions of service gaps, barriers to access (e.g., cost of care, health insurance status, language access, cultural competence, care coordination, and information sharing. The assessment also explored issues related to diversity, equity, and inclusion and the impacts of racism and discrimination.

Systemic barriers affect all segments of the population, but have a particularly significant impacts on people of color, non-English speakers, recent immigrants, individuals with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment highlighted the challenges that residents throughout the BH/AGH CBSA faced with respect to accessing care. The most common concerns were related to workforce shortages that led to long wait-times and service gaps, which impacted people's ability to access services in a timely manner. This was particularly true with respect to primary care, behavioral health, medical specialty care, and dental care services.

Interviewees, focus group and community listening session participants identified linguistic and cultural barriers to care, and the need to ensure access to interpreter services and bi-lingual/bi-cultural service providers. The assessment findings also reflected on how difficult it was for many residents to schedule appointments, coordinate care, and find the services they need. Interviewees, focus groups, and listening session participants discussed the need for tools to support these efforts, such as resource inventories, case managers, recovery coaches, and health care navigators.

Those participating in the interviews, focus groups, listening sessions also discussed the challenges that some segments of the population face with respect to accessing the internet, taking advantage of telehealth services, and technology resources more generally. This led to challenges navigating the health care system, coordinating care, and accessing services. Finally, participants reflected on the high costs of care, particularly for those who are uninsured or have inadequate health care coverage.

Racial Equity

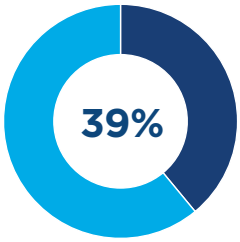
Racial equity is the condition where one's racial identity has no influence on how one fares in society.[14] Racism and discrimination influence the social, economic, and physical development of Black, Indigenous and People of Color (BIPOC), resulting in poorer social and physical conditions in those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

"My community is a warm and friendly place, but it lacks almost any racial diversity. Black people who do live in the area are mostly met with curiosity/ignorance that still makes them feel 'other,' but there is still a deeper racism and xenophobia that lingers here and does not get much opportunity to be exposed or removed."

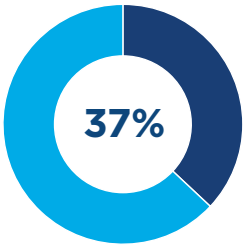
- BH/AGH Community Health Survey respondent

Interviewees, focus groups, and community listening session participants reported that their communities were increasingly diverse in terms of race, ethnicity, sexual orientation, and gender identity. This diversity was identified as a strength. However, these individuals also expressed concerns about racism, discrimination, and varying levels of acceptance and recognition of diversity in the community. Experiencing racism and discrimination contributes to trauma, chronic stress, and mental health issues that ultimately impact health outcomes.

Among BH/AGH Community Health Survey respondents:



reported that built, economic, and educational environments in the community were impacted by **systemic racism.**



reported that environments in the community were impacted by **individual racism.**

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 stem from the way in which the system does or does not function. System-level issues included providers not accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

There were also individual-level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.[16] Finally, transportation was also identified as a significant barrier, particularly for those who did not have a personal vehicle, or those with mobility issues who may have had challenges accessing public transportation.

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

"A lot of health professionals are unwilling to explain the health care system or US-based customs to people from outside of the country. This has routinely happened to me and other friends from outside of the country. [There is] lack of patience, clarification, and simple processes to navigate appointments, insurance, and extra costs."

- BH/AGH Community Health Survey respondent

Cohorts facing barriers and disparities:

- Individuals best served in a language other than English
- Older adults without caregivers
- Individuals with disabilities
- Individuals with limited economic means.

Community Connections and Information Sharing

A strength of BH/AGH's CBSA were the strong community collaboratives and task forces that convened to share information and resources. Interviewees described a strong sense of partnership and camaraderie among community-based organizations and clinical and social service providers, borne out of a shared mission to ensure that community members had access to the services and care that they needed.

Behavioral Factors

The nation, including the residents of Massachusetts and BH/AGH's CBSA, face a health crisis due to the increasing burden of chronic medical conditions. Underlying these health conditions are a series of behavioral risk factors that are known to help prevent illness and are the early signs or contributors of the leading causes of death (e.g., heart disease, cancer, stroke, and diabetes). According to the National Centers for Disease Control and Prevention, the leading behavioral risk factors include an unhealthy diet, physical inactivity, and tobacco, alcohol, and marijuana use. Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being, and reduces the risk of illness and death due to the chronic conditions mentioned above.[18]

When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use, and alcohol use. Those who participated in the assessment's community engagement activities were also asked to identify the health issues that they felt were most important. While these issues were ultimately not selected during BH/AGH's prioritization process, the information from the assessment supports the importance of incorporating these issues into BH/AGH'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.[19] Access to affordable healthy foods is essential to a healthy diet.

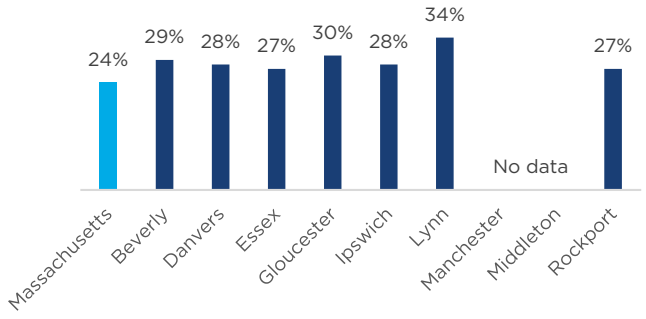
15% of BH/AGH Community Health Survey respondents said they would like their community to have better access to healthy food.

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the CBSA, though there was recognition that lack of physical fitness was a leading risk factor for obesity and a number of chronic health conditions.

The percentage of adults who were obese (with a body mass index over 30) was higher than the Commonwealth in all communities in the CBSA, except Manchester-by-the-Sea and Middleton, where there was no data available.

Percentage of Adults Who Were Obese, 2018



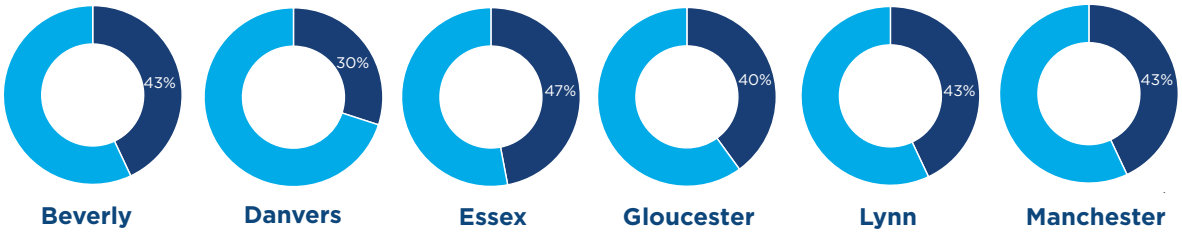
Source: Behavioral Risk Factor Surveillance System, 2018

Alcohol, Marijuana, and Tobacco Use

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

Among MDPH COVID-19 Community Impact Survey respondents in BH/AGH's CBSA communities who were current substance users, more than 30% reported that they used more substances in the fall of 2020 than before the pandemic.

Percentage* of Substance Users Who Said They Used More Substances Since the Start of the Pandemic, Fall 2020



Data for Ipswich, Middleton, and Rockport was suppressed.

***Unweighted percentages displayed**

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

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 complex medical conditions as well as mental health and substance use disorders. As discussed in the introductory sections of this report, the assessment gathered quantitative data to assess the extent that these issues were a concern in BH/AGH's CBSA.

To augment and clarify this information, the assessment efforts included community engagement activities that specifically asked 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 disorders. Given the limitations of the quantitative data, specifically that it was often old data and was not stratified by age, race, and ethnicity, the qualitative information from interviews, focus groups, listening sessions, and the BH/AGH Community Health Survey was of critical importance.

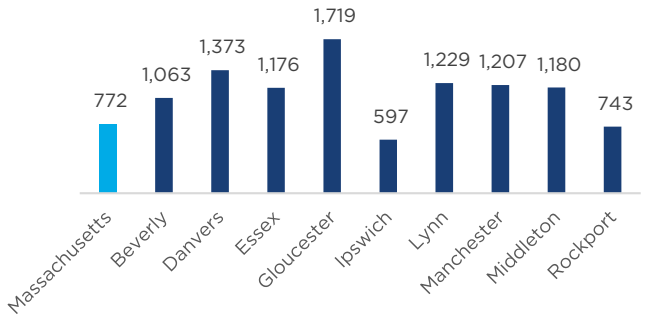
Mental Health

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues on youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, and peer support groups. Interviewees, focus groups, and listening session participants also reflected on mental health stigma and the shame and isolation that those with mental health challenges faced that limited their ability to access care and cope with their illness.

Youth mental health was a critical concern in BH/AGH's CBSA, including the significant prevalence of chronic stress, depression, anxiety, and behavioral issues. These conditions were exacerbated over the course of the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Inpatient Discharge Rates (per 100,000) for Mental Health Conditions Among Those Under 18 Years of Age, 2019

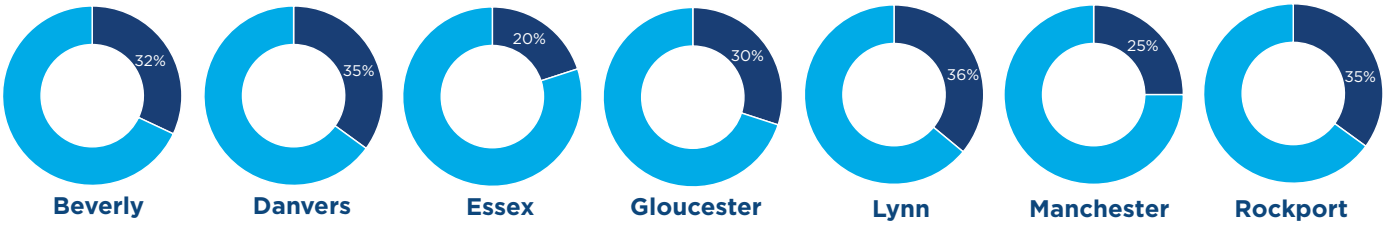


Source: Massachusetts Center for Health Information and Analysis, 2019

Inpatient discharge rates for mental health conditions among individuals under 18 years of age were higher than the Commonwealth in all CBSA communities except Ipswich and Rockport.

In Danvers, Lynn, and Rockport, over a third of residents who took MDPH's COVID-19 Community Impact Survey reported that they had 15 or more poor mental health days in the past month.

Percentage* of Individuals with 15 or More Poor Mental Health Days in the Past Month (Fall 2020)



Data for Ipswich and Middleton was suppressed.

***Unweighted percentages displayed**

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

Health Conditions

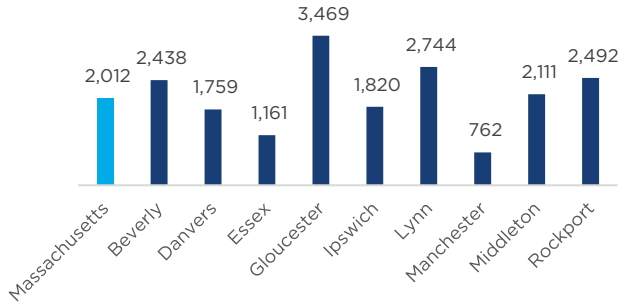
Substance Use

Substance use continued to have a major impact on the BH/AGH 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. Individuals engaged in the assessment 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). Interviewees, focus groups, and listening session participants also reflected on the need for transitional housing and other recovery support services.

"Two things that impact the health of the population is the drug epidemic, and also the mental health issues that many times go hand and hand."

-BH/AGH Community Health Survey respondent

Inpatient Discharge Rates (per 100,000) for Substance Use Disorder Among Those 18-44 Years of Age, 2019



Source: Center for Health Information and Analysis, 2019

Inpatient discharges for substance use disorders among individuals 18-44 years of age were higher than the Commonwealth in Beverly, Gloucester, Lynn, Middleton, and Rockport.

Chronic and Complex Conditions

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

Inpatient Discharge Rates (per 100,000) for Cancers Among Those 65 Years of Age and Older, 2019

	MA	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport
Breast	1,253	2,147	2,236	1,828	1,490	1,385	1,482	1,955	1,510	1,595
Colorectal	271	142	287	522	255	120	298	75	378	410
Lung	1,347	1,579	1,868	1,958	1,688	1,023	1,809	1,053	2,266	1,185
Prostate	1,270	1,527	1,501	1,175	1,802	1,505	1,571	1,203	1,762	1,230

Source: Center for Health Information and Analysis, 2019

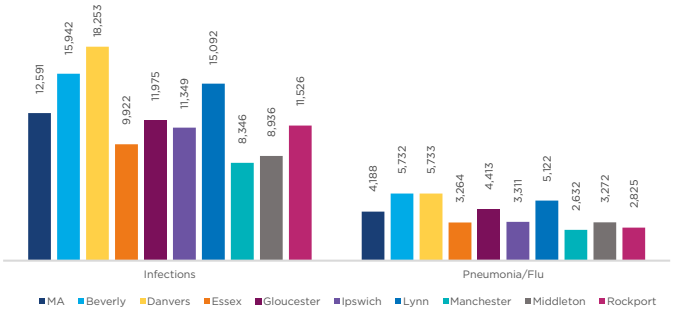
Looking across the four most common cancer types, inpatient discharge rates among those 65 years of age and older were higher than the Commonwealth in many communities, particularly Danvers, Lynn, and Middleton.

Communicable and Infectious Disease

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

Data from the Center for Health Information and Analysis indicated that older adults in Beverly, Danvers, and Lynn had higher inpatient discharge rates for infections and flu/pneumonia compared to the Commonwealth overall.

Inpatient Discharge Rates (per 100,000) Among Those 65 Years of Age and Older, 2019



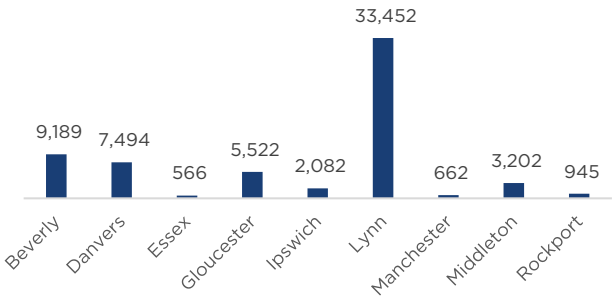
Source: Center for Health Information and Analysis, 2019

COVID-19

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

COVID-19 presented significant risks for older adults and those with underlying medical conditions because they faced a higher risk of complications from the virus. Several key informants described how COVID-19 exacerbated poor health outcomes, inequities, and health system deficiencies.

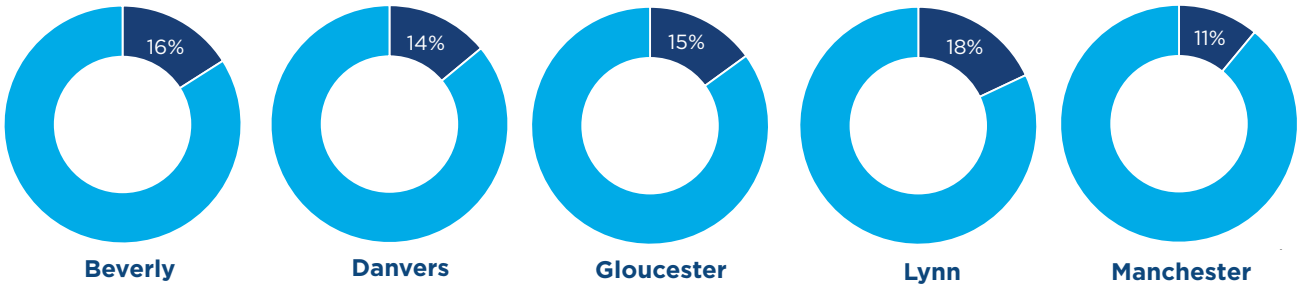
Total COVID-19 Case Counts Through May 12, 2022



Source: Massachusetts Department of Public Health, COVID-19 Data Dashboard

In Beverly, Danvers, Gloucester, Lynn, and Manchester, more than 10% of respondents to the MDPH COVID-19 Community Impact Survey reported that they had not gotten the medical health care they needed since July of 2020. Lapses in medical care may lead to increases in morbidity and mortality.

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



Data for Essex, Ipswich, Middleton, and Rockport was suppressed.

***Unweighted percentages displayed**

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

Priorities

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities or are disproportionately impacted by systemic racism or other forms of discrimination. Accordingly, using an interactivea and nonymous polling software, BH/AGH's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of BH/AGH's IS. This prioritization process helps to ensure that BH/AGH 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 BH/AGH's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

Massachusetts Community Health Priorities

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

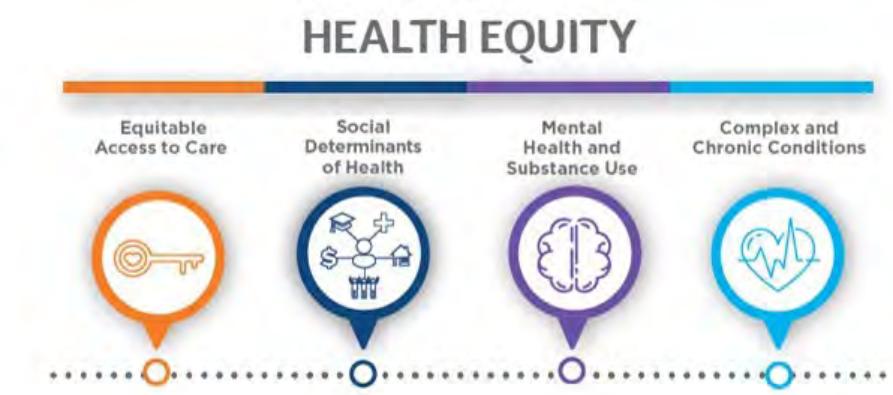
Community Health Priorities and Priority Cohorts

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

BH/AGH Community Health Needs Assessment: Priority Cohorts

- **Youth**
- **Low-Resourced Populations**
- **Older Adults**
- **Racially, Ethnically and Linguistically Diverse Populations**

BH/AGH Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BH/AGH

It is important to note that there are community health needs that were identified in the CHNA that were not prioritized for investment or included in BH/AGH's IS. Specifically, supporting education across the lifespan and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) and affordable childcare, were identified as community needs but were not included in BH/AGH's IS. While these issues are important, BH/AGH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, BH/AGH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. BH/AGH 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 BH/AGH's IS

The issues that were identified in the CHNA and are addressed in some way in the IS are housing, food insecurity, transportation, economic insecurity, workforce capacity, system navigation, digital divide/access to technology resources, diversifying the workforce, cost and insurance barriers to access, care giver support, youth mental health, stress/anxiety/depression, isolation, mental health stigma, racism/discrimination, supportive services for immigrants, ageism, diversifying leadership, homophobia/transphobia, linguistic access to community resources/services, treatment programs that address mental health and substance use disorders, and transitional housing.

Implementation Strategy

BH/AGH's current 2020-2022 IS was developed in 2019 and addressed the priority areas identified by the 2019 CHNA. The 2022 CHNA provides new guidance and invaluable insight on the characteristics of BH/AGH's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed BH/AGH to develop its 2023-2025 IS.

Included below, organized by priority area, are the core elements of BH/AGH's 2023-2025 IS. The 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).

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

Community Benefits Resources

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

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

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

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

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

Strategies to address the priority:

- Promote access to health care, health insurance, patient financial counselors, needed medications and other essentials for patients who are uninsured or underinsured .
- Support and/or provide initiatives that provide job readiness and career development opportunities to obtain employment or employment with higher wages.
- Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.
- Increase access to health services and screenings for homebound individuals by reducing barriers to care such as transportation, illness, etc.

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.

Strategies to address the priority:

- Organize/support impactful programs that stabilize or increase access to safe, affordable housing.
- Alleviate food insecurity and promote active living by advocating for system changes, increasing opportunities for physical activity, and providing healthy, low-cost food resources to communities.
- Advocate for policy, systems, programs, and environmental changes that address the 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:

- Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.
- Build the capacity of community members to understand the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.
- Implement/support evidence-based programs that promote healthy development, support children and families, and increase their resilience.
- Improve systems for management and control of substance use disorder through education, reducing access to substances, and multidisciplinary efforts.
- Participate in multi-sector community coalitions to convene collaborators to identify and advocate for policy, systems, and environmental changes to increase resiliency, promote mental health, reduce substance use, and prevent opioid overdoses and deaths.

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.

Strategies to address the priority:

- 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.

Evaluation of Impact of 2020-2022 Implementation Strategy

As part of the assessment, BH/AGH evaluated its current IS. This process allowed BH/AGH to better understand the effectiveness of their community benefits programming and to identify which programs should or should not continue. Moving forward with the 2023-2025 IS, BH/AGH and all BILH hospitals will review community benefit programs through an objective, consistent process using the BILH Program Evaluation and Assessment Tool. Created with Community Benefits staff across BILH hospitals, the tool scores each program using criteria focused on CHNA priority alignment, funding, impact, and equity to determine fit and inclusion in the IS.

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

For the 2020-2022 IS process, BH/AGH planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2019 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and charity care. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2020 and 2021. BH/AGH will continue to monitor efforts through FY 2022 to determine its impact in improving the health of the community and inform the next IS. A more detailed evaluation is included in Appendix D.

Priority Area	Summary of accomplishments and outcomes
Mental Health	NHC reported more than $7 million in community benefits expenditures in FY 2020 and 2021 for programs and services addressing mental health. • NHC awarded more than $3K in FY 2021 and 2021 to community organizations to support programs/initiatives to address mental health issues. Examples include Pathways to Children Nurturing Program (English and Spanish) and Greater Lynn Senior Services Project Uniper, reaching more than 100 community members. • NHC awarded $34,200 in one year grants for programs that address mental health including Gloucester Health Department YRBS Online Tool, North Shore YMCA SEAL program, and Greater Lynn Senior Services Project Uniper program continuation/expansion. Programs reached more than 300 community members.
Substance Dependency	NHC reported more than $4 million in community benefits expenditures in FY 2020 and 2021 for programs and services addressing substance dependency. • NHC awarded more than $1K in FY 2020 and 2021 to community organizations to support programs/initiatives to address substance Use disorder. This included Pathways to Children Youth at Risk Conference. • NHC awarded more than $50K in one year grants for programs that address substance dependency including Gloucester Health Department YRBS Online Tool, North Shore YMCA SEAL program, SeniorCare Mental Health First Aid for Adults, and Pathways to Children Youth at Risk Conference. Programs reached over 600 community members.
Chronic/ Complex Conditions and Risk Factors	NHC reported more than $15 million in community benefits expenditures for programs and services addressing chronic disease and chronic/complex conditions. • School Based Health Center at Gloucester High School provided counseling sessions and more than 40 outreach activities. Through a collaboration with The Open Door Food Pantry, a free “Food Locker” provided more than 800 free food orders to students and families experiencing food insecurity. • NHC provided more than $200 to community organizations to support programs/initiatives to address chronic/complex conditions. Examples include the North Shore YMCA Enhance Fitness and The Open Door Food is Medicine program. Programs reached more than 400 community members.

Social Determinants of Health and Access to Care	NHC reported more than $3 million in community benefits expenditures in FY 2020 and FY 2021 for programs and services addressing social determinants of health and access to care. Resources and funding was re-allocated to address the urgent and emerging social determinant of health needs in the community exasperated by the Covid pandemic, specifically housing, food access, digital divide/digital literacy, and career development programs. • SHINE Counseling: Served more than 7,000 community members. • During this time NHC provided more than $500 to community organizations to support programs/initiatives to address Social Determinants of Health & Access to care. Examples include the Action Inc. Welcome Home Program, Beverly Bootstraps Mobile Markets, Wellspring House Pathways to Jobs, Greater Lynn Senior Services Project Uniper, Center Board Project Hope and Gloucester Addressing the Digital Divide. • NHC awarded more than $54K in one year grants for programs that address social determinants of health and access to care including Wellspring House Pathways to Jobs program continuation/expansion and the Pathways Nurturing program. Programs reached 200 community members.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2020-2022 Implementation Strategy

Appendix E: 2023-2025 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

Beth Israel Lahey Health Community Health Assessment

Interview Guide

Please complete this section for each interview:

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

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

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

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

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

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

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

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

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

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

Interview Summary

Interviewees

- Beverly Municipal Leaders
- City of Beverly Health Subcommittee
- Danvers Municipal Leaders
- Essex Municipal Leaders
- Gloucester Municipal Leaders
- Lynn Municipal Leaders
- Nancy Hammond, Director of Senior Services/Council on Aging, Manchester by the Sea
- Eric Mitchell, President and CEO, Pathways for Children
- Susan Gabriel, Executive Director, Beverly Bootstraps
- Valerie Parker-Callahan, Director of Planning and Development, Greater Lynn Senior Services
- Peggy Hegarty-Steck, CEO, Action Inc.
- Kim Hopkins, Director of Innovation and Planning, Centerboard/Project Hope
- Chris Lovasco, CEO, YMCA of the North Shore
- Andrea Baez, Senior Executive Director, YMCA of Metro North
- Julia Lafontaine, President, The Open Door
- Dr. Kiame Mahaniah, CEO, Lynn Community Health Center
- Scott Trenti, CEO, SeniorCare Inc.
- Melissa Dimond, President and Executive Director, Wellspring House

Key Findings

Community characteristics

- Significant diversity between service area communities – by race, ethnicity, language, income, education
- Community residents are described as hard-working, civic minded, and engaged

Specific populations facing barriers

- Youth
- BIPOC
- Older adults
- Individuals with limited economic means
- LGBTQIA+
- Non English Speakers
- Immigrants

Social Determinants of Health

- Housing is a major concern – lack of affordable housing for both low income and increasingly, middle income population
- Economic insecurity – cost of living continues to rise; pandemic had significant impact on many people financially
- Childcare is unaffordable
- Food insecurity

- Some residents struggle with transportation. Poor connectivity to major service hubs (Boston, Lynn)

Mental health

- Significant prevalence of stress, anxiety, depression, isolation (especially among older adults) and behavioral issues that were exacerbated throughout the pandemic
    - Major emphasis on youth mental health
- Over the course of the pandemic, people reported that it was more difficult to find providers who were taking on new patients
    - "[Finding mental health services is] especially hard in this region. The number of providers is simply too low. [There are] long wait lists and insurance complications."
- Mental health care unaffordable for many, even for those who have insurance

Access to care

- People face difficulties navigating the health care system, including insurance
    - Even more difficult for those who don't speak English
- Barriers include cost/insurance barriers, difficulty accessing services because of long wait times and lack of providers (especially over COVID)
    - This affects all sectors of healthcare system – primary care, behavioral health, dental care, specialties

Diversity, Equity, Inclusion

- Need to recognize the economic diversity in the community and shape social services to reflect it – especially housing. Need more housing support
- Need more supportive services for immigrants
- Would like to see more diversity among leadership – municipal leadership, community organizations, individuals who sit on Boards/Committees. Leadership should be more representative of community

Substance use

- Need for more services that can support recovery – e.g., transitional and supportive housing
- Need treatment programs that address not just SUD but mental health (acknowledgement that there is often dual diagnosis)
- Stigma has impacts on peoples willingness to seek and accept treatment

Resources/Assets

- Schools
- Hospital
- Good collaboration between organizations and sectors – "people are very responsive and keen to problem solve."
- Many good resources and advocacy for seniors
- Culture of donation and giving

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

Opening Script (10 Minutes)

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

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

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

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

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

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

Does anyone have any questions before we begin?

Section One: Community Perceptions

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

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

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

If yes, move on to Section 2.

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

Let's talk more deeply about these concepts.

Section Two: Key Factors

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

For each issue they identified:

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

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

Section Three: Ideas and Recommendations

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

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

BH/AGH Focus Group Summary: Action, Inc.

Date: 10/27/21	Start Time: 3:00	End time: 4:00
Group Name and Location: Action, Inc. | 180 Main Street, Gloucester, MA		

What keeps you healthy?

- Housing (lack of housing is a challenge)
- Supportive services, like those offered by Action Inc.
- Food (it can be hard to eat healthy on limited income)
- Health insurance
- Employment (connected to exercise, mental health)
- Mental health (can challenge someone's ability to feel healthy)

What prevents you from staying healthy?

- Lack of housing
- Lack of holistic services
- Lack of behavioral health treatment
- Lack of employment
- Lack of access to healthy food/nutrition
- Stigma associated with seeking medical care as someone with SUD

4 Key Issues:

1. **Housing**
    - **a.** Affordable housing is hard to find; cost of housing is too high here
    - **b.** Long waitlist; issues embedded within the process
    - **c.** Documentation can be a challenge (i.e., meeting HUD's definition of homelessness)
    - **d.** Hard to be healthy without your own home; on a bad weather day like today, where do you go?
    - **e.** Housing with services (like at Action) helps
2. **Food/nutrition**
    - a. Did not seem to be as much of an issue upon further discussion; participants said good access to food at the shelter and good food bank
3. **Jobs**
    - **a.** Transportation makes it hard to find work
    - **b.** Shelter hours make it challenging (restricts potential work hours)
    - **c.** COVID has made it more challenging
    - **d.** Physical and mental health can be barriers to working
4. **Access to health care**
    - **a.** Lack of access to psychiatric care
    - **b.** Transportation to medical care is a challenge; participants referenced needing to go to Peabody, Beverly, etc. for medical care that is unavailable locally (i.e., hip replacement)
    - **c.** People without insurance need to go to Beverly Hospital for medical care
    - **d.** AGH is an ok hospital if you have insurance

e. Stigma associated with seeking medical care if you are homeless, have SUD; treated poorly by doctors

f. Good access to primary care through Gloucester Family Health Center and good access to dental care

What health conditions have the greatest impact/are most important to address?

- Mental health (depression, anxiety, serious mental illness, trauma)
- Substance use disorder, smoking

If you were BH/AGH, what would you do?

- Hire psychologists/psychiatrists; hire more mental health professionals
- Expand SUD services
- Provide more understanding, compassionate services (professionals who won't treat you with stigma if you have history of addiction)

BH/AGH Focus Group Summary: DanversCARES

Date: 11/23/21	Start Time: 2:00pm	End time: 3:30pm
Group Name and Location: DanversCARES High School Student Group		

Turn on the audio recorder if ALL have consented.

Section 1: Community Perceptions	
Healthy: To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?	• Physical health • Good health system, lots of doctors, access to health care is very strong • Athletic activities • Lots of extracurricular opportunities • Access to healthy food - farm town, plenty of places available
Unhealthy: What are some of the things that make it hard for you to be healthy?	• Financial insecurity – Leads to unhealthy food, poor access to health care, housing challenges • No health insurance • MH challenges • Isolation, lack of social interaction • Social media, too much screen time, bullying • Shortage of MH therapists • School pressure / too much work / Life Balance • Race, social justice, and Equity • Bullying in school • Lack of accountability for bullying, racism, homophobia, bad behavior

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

If yes, move on to Section 2.

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

Let’s talk more deeply about these concepts.</td><td>Top Factors
1. MH problems and limited access to services
2. Racism, social justice, and equity
3. Academic pressures / school-Life-social balance
4. Bullying in school
5. Substance use (Vaping especially)</td></tr>
<tr><td colspan="2"><u>Section 2: Exploring Key Factors</u>
In this section, ask participants to go more in depth about the factors they brought up in the previous section.</td></tr>
<tr><td>Are these (things that keep you healthy) available to everyone or just a few groups of people?</td><td></td></tr>
<tr><td>Why do you think they (things that make it hard to be healthy) exist?
- Why is this a challenge?</td><td></td></tr>
<tr><td>What are some examples of how these challenges impact someone's health?</td><td>MH problems and limited access to services
• Mental health problems a major problem in youth
o Depression and anxiety
▪ “More kids absolutely hate school than like it.” Leads to depression
o Stress
o Grief
o Not feeling understood</td></tr>
</table>

	o Peer pressure/bullying o Racism and discrimination o Not feeling well supported o Social media - Danvers specific pages. Hateful and spiteful. Spread horrible rumors, all made up - Input on a google form o COVID has been really hard. Isolation, Zoom classes o Now with being in school have to wear masks all day. Attendance is low. Lots of depression anxiety, acting as if everything is back to normal but the academic pressures are intensve, lots of people failed classes, seniors are having to do their applications…many colleges acting as if nothing has changed since pre-COVID. “It’s awful and really stressful”. o "Unable to motivate yourself to do schoolwork. It’s very difficult for some reason.” o “Needing to Relearning and getting back into the habits.” o “We were always on our phones and social media. So hard to focus on anything that isn’t a screen.” o School - did not do a really good job. Perception that teachers didn’t care. • Major shortages and/or lack of access to therapists and MH services o “Social workers are available - but really hard to get therapy o Poor communication about what is available and how to access it ▪ “We have good mental health services - but communication/awareness of services is bad” o Very limited sense of privacy, which is a problem for those who don’t want their parents to know ▪ “The fact that teachers are mandatory reporters is a problem, it prevents people from wanting to open up and share what is going on.” o “OK if you have a broken arm or need an ice pack, but MH services are not available.” o Middle School “nightmare” for mental health services.

	- General feeling was that students were not looking for ”full therapy” in school but someone to talk to and help them to talk things through, help them to cope and perhaps recommend or link them to therapy outside of school. - School should be the first “layer of support” and then go to more support in the community. - needed the personal connection...I couldn’t do it last year -- don’t know family situation - COVID “Exacerbated” problem. Isolation and quarantine had a major impact **Racism, social justice, and equity** - Racism and discrimination is a HUGE problem. So much racist and discriminatory talk, especially among some kids. It’s really hurtful and painful. - Jokes and other language re: racist, sexuality, trans -- etc. - If someone popular says it, they won’t lose any friends. - Don’t get in trouble. - Tremendous issue with the language - anything that’s offensive or edgy -- cool to say -- not ok! - Lack of diversity at school among teachers and admin staff - Lack of attention to stopping students from doing it. No accountability. Kids just get away with it. “When students reach out about it, they won’t talk about it -- they don’t care. They just let it happen “Some kids got in trouble for defending people against discrimination. “yelled at for speaking about it” - Perception that teachers don’t care and aren’t “brave enough” to say something to students” “Hear at least 2 racist jokes a day” “Teachers are afraid of backlash” - Lots of issues in “real time” at school and its even work online - Sexual harassment happens a lot at school

	• Hockey players were the victims • Helpful to have groups like this to be able to talk about things -- we've been hearing disgusting things for so long, we're desensitized. **Academic pressures / school-Life-social balance** • Lots of pressure to succeed and do well and it's just really hard and many people at school and at home/parents do not understand or just want everything to be back to normal • Need more emphasis on learning, less on grades • Lack of appreciation for how hard it is for some kids. • Need to adapt school to different learning styles o I do better writing stuff down -- being on a screen in school stresses me out. • It's hitting us all like a truck -- we are expected to go to college in 5 months • Self-worth and success is all based off of your grades. There is more to life than school and getting good grades • Hard for those who struggle with mental illness to attend school. Not fair to those struggling • Need flexibility, approach and balance between school, home, extracurricular and social life • Lots of emphasis is place on presentations and for many it's really hard to speak publicly o insensitive to make people do it; punishment; inconsiderate to make them; • School too intensive about absences o Mad at you for chronic absences. "Need to ask us WHY we are absent or late"? "Understand us, please!" o Horrible that they go to parents first instead of kids -- BAD • Social media a problem o It was easier to exist with no social media - you should be as ok as they were when they were younger. We shouldn't have all these issues.

	• Need more understanding and support from parents
	  o "Parents should see the 'realness' of our generation."
	  o "My mom doesn't believe in mental illness "
	• "Parents only see their own generation.
	
	Bullying in school
	• Lots of horrible language
	• Social media is a problem
	• No one is held accountable
	• (SEE ABOVE RE: RACE DISCUSSION)
	
	Substance Use - Vaping and Disciplinary
	• Vaping a problem
	• Other drugs are issues
	• Disciplinary system is ridiculous You get suspended and then you just stay alone at home, where you have more access to drugs.
	• PASS program…"you just hang out there" "so fun -- sat there and did nothing for 3 days"

<u>Section 3: Ideas and Priorities</u>	

Ideas:
- Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time?
- Based on what you shared in the beginning about the things that keep you healthy, what of the
	• ***Mental health***
	  ○ More education and awareness re: problem, destigmatize it, talk about it
	  ○ More education and workshops for parents
	  ○ More education, workshops, and training for teachers
	  ○ Increase access to treatment and counseling in school and outside of school
	  ○ More resources to let people know what to do and what services are available in school and in community
	  ○ Support navigating the system
	
	• ***Race, social justice and equity***
	  ○ *Need more diversity at school, people of color, gay/trans, etc.*
	  ○ *Need for opportunities to talk about what happened at the school with the*

things you mentioned would you like to see more of?	*"hockey team"* ○ More education and workshops for parents ○ More education, workshops, and training for teachers ○ Some administrators and teachers are trying but there needs to be more effort, more accountability, and more talking and processing ○ Stop this "Let's move on" dialogue. Need to talk, process, and learn from the past ○ Need to express that "we're not going to tolerate the bad behavior and horrible language anymore" ○ Great an anonymous reporting system – message box or google form ○ Develop real repercussions for those who go against the rules. ○ Higher expectations and hold people accountable • ***Substance Use - Vaping and Disciplinary*** o Need better, different disciplinary system. PASS program not working **Bullying in school** • Better rules and more accountability to following them • Education re: screen time and its impacts • Teachers need to be trained on how to intervene and hold students accountable for bad behavior
Priorities: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	● More discussion of issues of race and discrimination ● More awareness and understanding of mental health challenges in youth, academic pressure and need for life balance ● More MH services at school and in community ● Hold teachers and staff and students accountable for bad behavior
<u>Section 4: Final Remarks & Closing</u>	
Are there other factors that influence your health that we have not discussed tonight that you feel are important?	***None***

BH/AGH Focus Group Summary: Lynn Shelter Association

Date: November 17, 2021	Start Time: 7pm	End time: 8pm
Group Name and Location: Lynn Shelter Association; 95 Green St., Lynn, MA		

Health	
What does being healthy mean to you? - What does it look like? - What does it feel like?	● Managing health conditions, being around healthy people and environments, keeping up with doctor's appointments and immunizations ● Good mental health, lower stress, being surrounded by good people ● Healthy living - healthy foods, exercise, ability to partake in normal life activities Verbatim notetaking: - When you eat correct - Attend frequent doctor visits - Keep up with immunizations - Exercise - Normal things of life - Reducing stress - Everything "i have a rare autoimmune disease, had to have three heart surgeries in two months, escaped death twice. So access to nutritious foods and being able to get to my specialist. Making sure my blood pressure is where it needs to be at because I have low blood pressure. Making sure I'm around healthy people because I'm immunocompromised and high risk, more high risk because of the heart issues" - Being able to breathe because of CHF - Being around people that can make you feel happy, good positive energy, this can change stress and way of thinking for the day, health is physical and mental thing. People around you that can change your health

Healthy Factors	

What are some of the things that help you stay healthy?
- Are there things in your community that help you stay healthy?
	● Medical care - medications, communicating with providers
	● Healthy living - exercise, food
	● Positive mindsets and environments
	  ○ Support animals, pets
	  ○ Meditation
	● Community services and nature
	
	<u>Verbatim notetaking:</u>
	- Exercise
	- Medications
	  - "nothing I can do without my medication"
	- Taking a walk to the beach, enjoying the sky
	- Dogs, animals, support animals
	- Mindset
	- Communication with providers
	- Eating healthy
	- Meditation
	- Built a new part of the YMCA
	  - YMCA is not free
	- Library
	  - Library is free
	- Beach and parks are free
	- Outreach program in the city
	- "Not really anything around here"

Are the things that help you stay healthy available to everyone or just a few groups of people?	● Not many services for people who are low-income, fixed-income <u>Verbatim notetaking:</u> - Need more free services in the community, for people who don't have enough income

Of the things that you've named as helping to keep you healthy, which would you like to see more of?	● More services for young, old, homeless, at free/low costs, including ○ Fitness activities ○ Community-building ○ Transportation <u>Verbatim notetaking:</u> - More community centers for young, old, homeless, at free/low-costs - More activities that promote health, at free/low-costs - Some people that can provide activities - basketball, swim - Being around people for a better environment - Public transportation to make it easier to go to places, at free/low-costs - More public transportation for people are homeless, low-income - Mayor Wu is making buses free in Boston
<u>Unhealthy Factors</u>	
What are some of the things that make it hard for you to be healthy?	● Lack of affordable housing and shelters with available beds, especially for low-income or fixed-income folks ○ COVID-19 impacting shelter capacity and mobility of folks trying to move in/out of buildings ● Transitional housing/rooming houses lack of cleanliness in common areas ● COVID-19 impacted people financially - lost jobs, lost hours, unable to take care of things in timely way working at home ● Leisure time, people walking around streets with nothing to do ● Costs of dental care ● Unable to get reasonable accommodations for housing or social services <u>Verbatim notetaking:</u> - Affordable housing - Affordable low-income housing - Need another shelter, plenty of homeless people sleeping in tents because not enough beds - There's not enough room - Rooming houses/transitional housing that we have need to be a little more cleaner, they need to start cleaning the bathroom, hallways, common areas - Especially for those who are on fixed incomes

	- COVID-pandemic impacting housing issues, can only take a handful - COVID makes it hard to find housing, move out of their building, increased costs - COVID caused people to lose jobs, can't go back to work, monetary effects - COVID people working from home, can't take care of things in a timely function - "The more you build the more they come" - Having things to do, occupy time so you're not in the streets walking around - Dietary foods provided are very carb heavy, sodium heavy. Not getting fresh fruits and vegetables, that can worsen people's health, people gaining weight - Shelters dont allow people to bring in food or cook, against the rules and no access to other food options - Price of dental implants, and dental period. They're not seeing anyone, can't get an appointment for a dentist for at least three months unless it's life or death - ADA, disability and things like that, very difficult to get a reasonable accommodation through housing. "I have a lot mental disorders and things like that, told not eligible for social security, emotional support animal, reasonable accommodation. Screening behind disability needs to be more in depth, half of them don't need it they work full jobs" -

Do these things (that make it hard for you to be healthy) affect everyone or just a few groups of people?	• People with multiple identities face increased difficulties
	  ○ BIPOC folks
	  ○ LGBTQ folks
	  ○ Undocumented folks
	  ○ Folks with criminal history
	
	<u>Verbatim notetaking:</u>
	- Black and minorities
	- Black and hispanics
	- Minorities and homeless
	- Especially intersecting ideas
	- Criminal history and records
	- Undocumented, but not currently at their shelter
	- LGBTQ community, discrimination for liking another gender

Why do you think the things that make it hard for you to be healthy exist?	● Food access at shelters is limited to carb, sodium heavy diet, not able to bring in food or cook ● Focus on profits over people ● Reviving economy is not equitable, creating more hardships for low-income people to keep up ● Lasting U.S. history and systemic racism ○ Power is maintained by those with privilege and culturally-learned biases ○ Racial profiling ○ Police brutality and also police not showing up at all ○ Unequitable health outcomes ○ Discrimination ○ Directly impacts individual stress and health <u>Verbatim notetaking:</u> - People focused on making money than providing for the community - Not putting in time and effort to the community - Put the economy of the community up which makes it harder for low-income people to keep up - Expanding land to fill their pockets versus helping the community - This country was founded on systemic racism, it's ingrained in our history, this land was taken on indigenous people, built on the back of slaves, this country is how it was brought up, look at the risks of black women giving birth to children higher than other races or ethnicity, people are higher up in the 1% that do have power look down upon people who are black, brown, disabled, LQBTQ+ because that's what's been ingrained in them, that's what they've been taught, people who grew up in the jim crow era who still have power in this country - Cops that drive by the shelter on bicycles - Witness discrimination towards Black/Hispanics to pack up and leave, but they are not asked to leave (White speaker). Another instance where police racially profiled an individual stating they asked him to leave - Police racially profile individuals multiple times, so many different occasions, "warrants for my arrest but it wasn't even for me" - Disagreement with older White woman and called the police, but the 8 different cops listened to the White woman instead of the person calling the police - Calling the police but no one showed up, they didn't know he was

	Dominican but doesn't matter because they know 90% of people at the shelter are minorities - When situations occur, caucasion person could be guilty but police are hounding people of color and not paying attention to the perpetrator, seen it so many times - Racism causing stress, kills people - Showing your upset, hostility, and police can arrest, shoot, taze you, or shot in custody - Tazing someone while cuffed, person was trying to say that wasn't the right person - Extremely hard to find resources as a younger person without children for domestic violence, families are prioritized which makes sense but more resources needed
Section 3: Ideas and Priorities	
Thinking about all that we have talked about, what ideas do you have for ways that hospitals can work with other groups to help make your community healthier?	● Increased funding and resources for lower-income and minority groups in areas such as medical care, housing, healthy foods ● Equal opportunity for everyone, less discrimination and racism ● Quicker support that is patient-centered and sensitive from first-responders, emergency room staff, others ● Improving referral systems ● Helping youth from trouble homes ● Increase domestic violence resources for single individuals Verbatim notetaking: - Equal opportunity, across the board. Let's say there's three people in a dire situation they would have taken the White person over others even if they didn't come first - Funding needs to change. Funding for medical care, housing, better food, and in general for lower-income, minority people - Dietary foods provided are very carb heavy, sodium heavy. Not getting fresh fruits and vegetables, that can worsen people's health, people gaining weight - Shelters dont allow people to bring in food or cook, against the rules and no access to other food options

	- What you put into your body fuels your whole system, by overloading with sugar, carbs, processed foods, it impacts you physically but also psychologically. Scientific studies on food coloring, etc. and how that's related to ADHD. that's the foods we have access to - Quicker responses and stop prioritizing certain people, first responders, emergency room staff, everybody - Prioritize people who have higher income, housing, car over someone who is homeless - Nurse spoke to doctor entering room "clear as day, don't worry about her, she's homeless" - Having eye symptoms and fainting, focused on fainting rather than eye symptom concerns in relation to autoimmune disease, admitted to the hospital bc of special autoimmune disease. Admitting physician discharged her bc they said there was no reason and only focused on fainting, then had to uber to another hospital to be seen and confirmed worries about her connections between the autoimmune disease and eye symptoms. Increased time and costs to get care - Changing health insurance to get PCP after moving, but in that time period ran out of medications. Psychiatrist approved three months of medications to hold out until patient gets next PCP, but issues with insurance, nurse that was condescending about provider's responsibility to handle insurance and medication issues - Incarceration and reentry support for people - Helping youth from trouble homes - Extremely hard to find resources as a younger person without children for domestic violence, families are prioritized which makes sense but more resources needed
What do you think should be the top 3 issues that health service providers should focus on to make your community healthier?	● Improved delivery of services - including HIPAA compliance, speed, quality, and coordination of care ● Improving staff hiring or competency for working with individuals ● Incarceration and reentry support for people with criminal histories <u>Verbatim notetaking:</u> - Quicker response in general, everything, ambulance, doctors, nurses - Specialists coming together with hospitals, going to primary care doctor first than

	seeing a specialist, that can be done in an easier way - Who they hire, person's character and how they look at things is important because it's uncalled for to be treated bad because of the way you live or the color of your skin, it's just uncalled for. They should screen in a better way, not just about credentials - Actually following HIPAA - Contacting mother instead of fiance as the emergency contact
<u>Section 4: Final Remarks & Closing</u>	
Are there other factors that influence your health that we haven't talked about today that you feel are important?	<u>Verbatim notetaking:</u> - Price of dental implants, and dental period. They're not seeing anyone, can't get an appointment for a dentist for at least three months unless it's life or death - ADA, disability and things like that, very difficult to get a reasonable accommodation through housing. "I have a lot mental disorders and things like that, told not eligible for social security, emotional support animal, reasonable accommodation. Screening behind disability needs to be more in depth, half of them don't need it they work full jobs" - Incarceration and reentry support for people - Helping youth from trouble homes - Extremely hard to find resources as a younger person without children for domestic violence, families are prioritized which makes sense but more resources needed

Community Listening Sessions

- Presentation from Facilitation Training for community partners
- Listening session presentation
- Facilitation guide for listening sessions
- Priority vote results and notes from January 25, 2022 listening session
- Priority vote results and notes from February 9, 2022 listening session

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

AGENDA

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

WHAT IS FACILITATION?

Facilitation is a dance, an artform.

INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish community agreements

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

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Design for different learning and processing styles

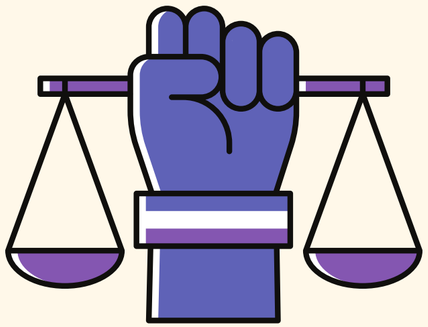
Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

Consider accessibility

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

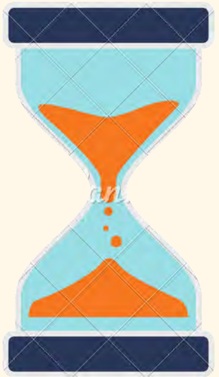
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

LET'S CONSIDER THE FOLLOWING

1

A participant seems to dominate the conversation.

2

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

3

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

THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

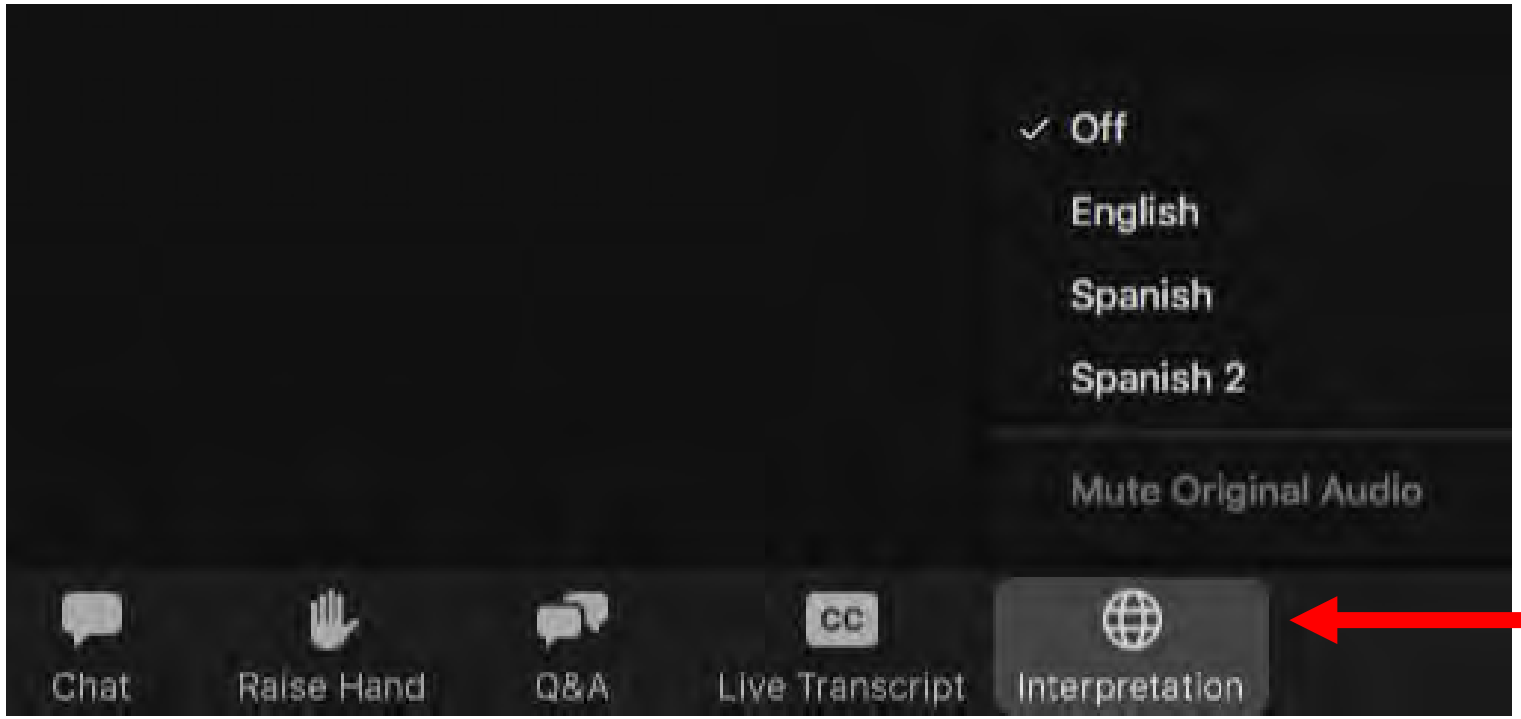
Feel free to send in any questions to **corina_pinto@jsi.com.**

BEVERLY HOSPITAL & ADDISON GILBERT HOSPITAL COMMUNITY LISTENING SESSION

January 25, 2022
February 9, 2022

Beth Israel Lahey Health

中文解釋



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BH-AGH Community Listening Session

Acknowledgements

BH-AGH Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
9:30-9:35	Opening remarks	JSI
9:35-9:45	Overview of assessment purpose, process, and guiding principles	Marylou Hardy, Regional Manager of Community Benefits/Community Relations, BH-AGH
9:45-9:55	Presentation of preliminary themes and data findings	JSI
9:55-10:50	Breakout Groups	Community Facilitators
10:50-10:55	Sharing back	JSI
10:55-11:00	Wrap up: Closing statements and next steps	Marylou Hardy

Assessment Purpose and Process

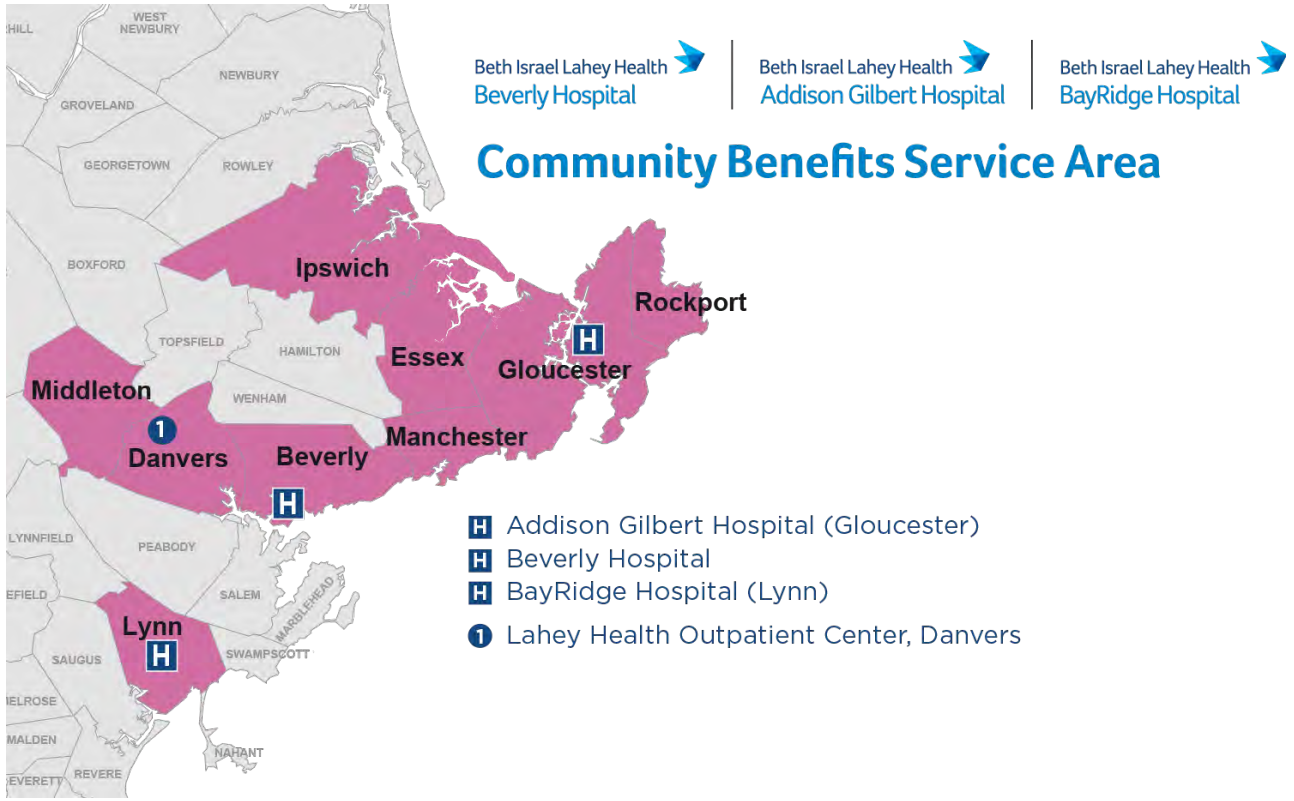
Assessment Purpose and Process

Purpose

Identify and prioritize the health-related and social 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 3 year 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



Assessment Purpose and Process

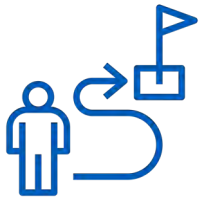
FY22 CHNA and Implementation Strategy Guiding Principles

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

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

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

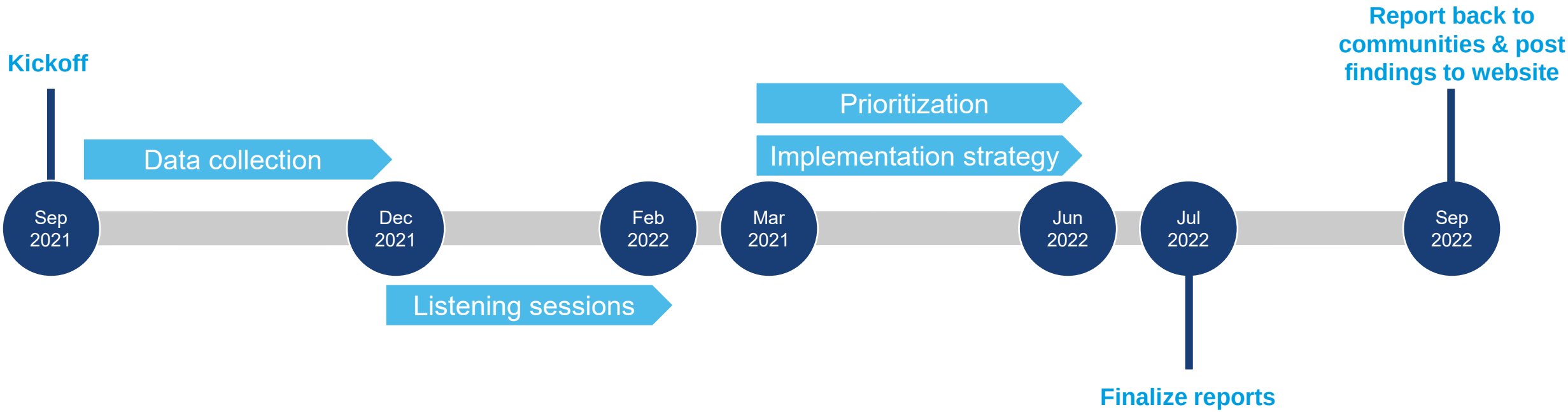
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



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

Assessment Purpose and Process

FY22 CHNA and Implementation Strategy Process

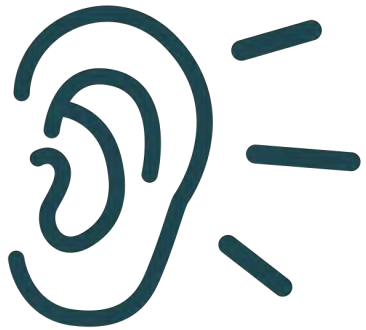


Assessment Purpose and Process

Meeting goals

Goals:

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



We want to hear from you.

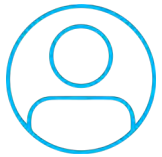
Please speak up, raise your hand, or use the chat when we get to Breakout Sessions

Preliminary Themes & Data Findings

CHNA Progress
Activities to date

Collection of secondary data, e.g.:

- ✓ Massachusetts Department of Public Health
- ✓ Center for Health Information and Analytics (CHIA)
- ✓ County Health Rankings
- ✓ Behavioral Risk Factor Surveillance Survey
- ✓ Youth Risk Behavior Survey
- ✓ US Census Bureau



18 **Key Informant Interviews**

1,341 **BILH Community Health Survey Respondents**

3 **Focus Groups**

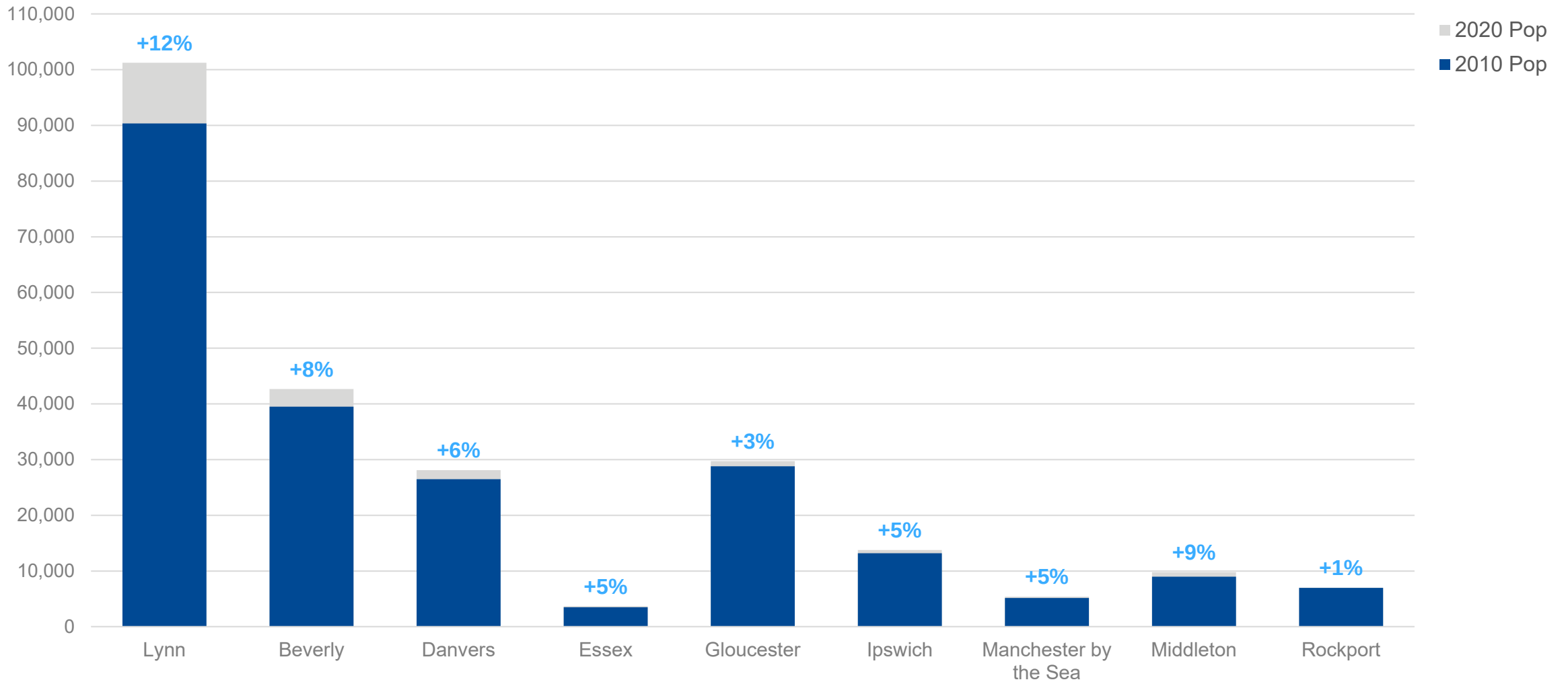
-Lynn Shelter Association

-Action, Inc.

-DanversCARES

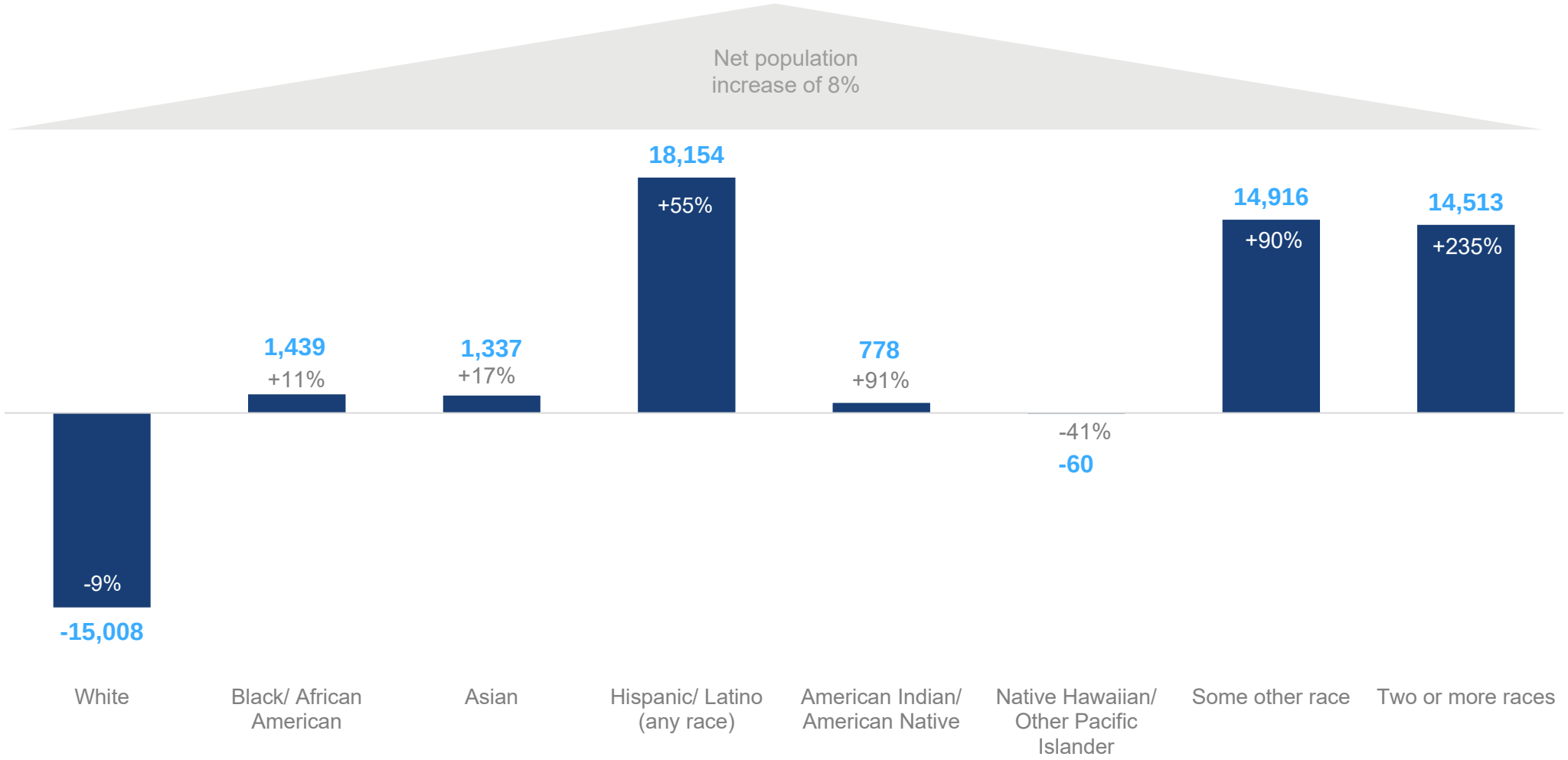
CHNA Progress

Population Change in Community Benefits Service Area 2010-2020



CHNA Progress

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

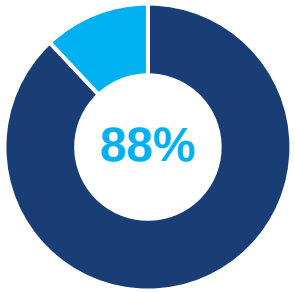


CHNA Progress
Service Area Strengths

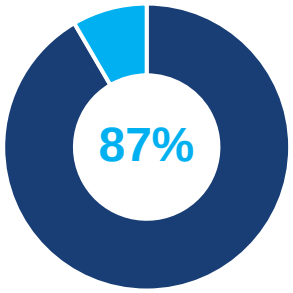
FROM INTERVIEWS & FOCUS GROUPS:

- Significant diversity between service area communities, in terms of income, race, ethnicity, education, language
- Engaged, hard-working, civic-minded communities

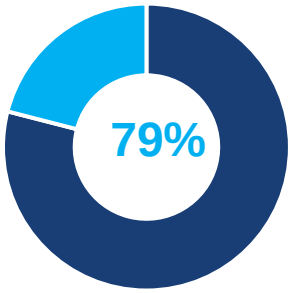
FROM BH-AGH COMMUNITY HEALTH SURVEY:



said they were **satisfied with the quality of life** in their community



said the community has **good access to resources**



said the community is a **good place to grow old**

CHNA Progress
Key themes

- **Mental health**
- **Social determinants of health**
- **Substance use**
- **Diversity, equity, inclusion**
- **Access to care**

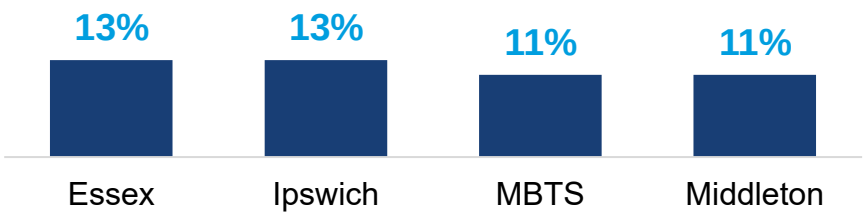
CHNA Progress
Key Themes: Mental Health (Youth)

Significant prevalence of stress, anxiety, behavioral issues

- Exacerbated by Covid

Difficulty finding providers with availability, and affording care (many providers don't take insurance)

Percentage High Schoolers Reporting Suicidal Ideation (2018)



Data from Youth Risk Behavior Survey; data in other communities available in previous years

"There is a critical lack of therapists who take health insurance and who have openings. Therapists for children are almost non-existent. Every clinician is full and/or charges a high fee and does not take any insurance."

– BH-AGH Community Health Survey Respondents

CHNA Progress
Key Themes: Mental Health (Adult)

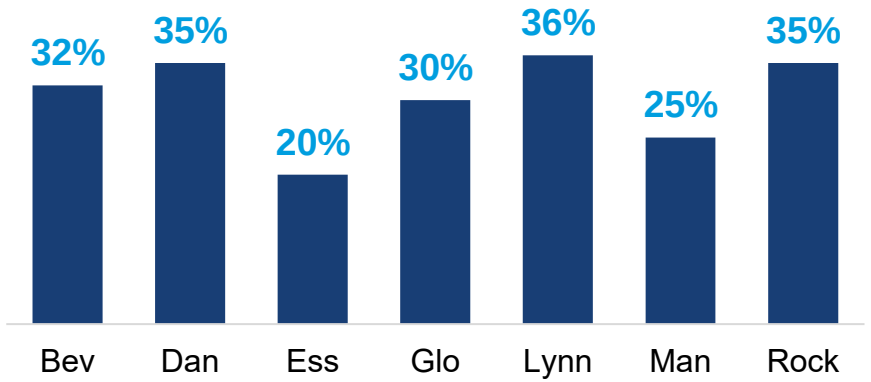
Mental health issues exacerbated by COVID – anxiety, stress, depression, isolation

17% of BH-AGH Community Health Survey respondents reported that, within the past year, they needed mental health care but were not able to access it. Many cited lack of providers taking new patients, long wait times, and lack of insurance coverage as barriers

[There are] no availability for in-person mental health services. Most local clinicians are not accepting new patients. Many only offer virtual visits since COVID, which doesn't work for me."

– BH-AGH Community Health Survey Respondents

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



Data source: COVID-19 Community Impact Survey, MDPH

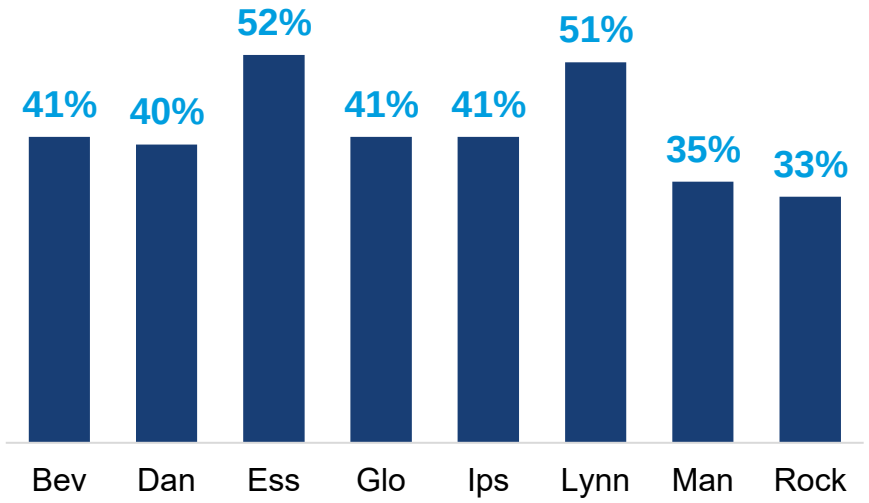
**Unweighted percentages displayed*

CHNA Progress
Key Themes: Social Determinants of Health

Primary concerns:

- Lack of affordable housing
- Economic insecurity/high cost of living
- Affordability/availability of childcare
- Food insecurity

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



When asked what they'd like to improve in their community, **54%** of BH-AGH Community Health Survey respondents reported

"more affordable housing"
(#1 response)

["Affordable housing is a critical need that is approaching a crisis point. It has become nearly impossible for lower income families with children to find housing that meets space and budget needs."

– BH-AGH Community Health Survey Respondents

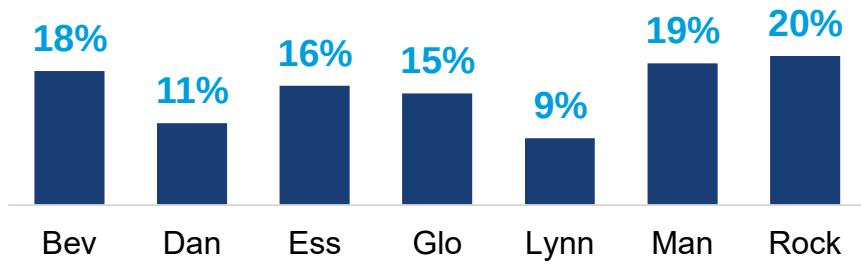
Beth Israel Lahey Health

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

CHNA Progress
Key Themes: Substance Use

- Stigma affects willingness to seek treatment
- Need for transitional housing for those in treatment
- Need for services that can address SUD/mental health dual diagnosis

Substance Use Among Newburyport 12th graders



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

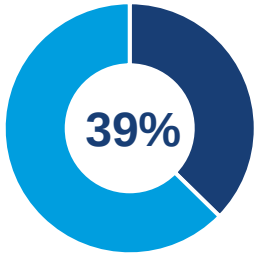
"Two things that impact the health of the population is the drug epidemic, and also the mental health issues that many times go hand and hand."

— BH-AGH Community Health Survey Respondents

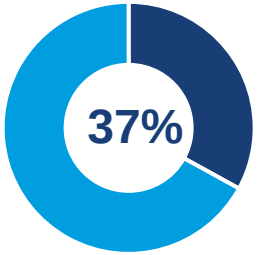
CHNA Progress
Key Themes: Diversity, Equity, and Inclusion

- Need housing supports and social services that reflect the economic diversity in the community
- Calls to see more diversity in leadership (municipal, organizations, Boards)

AMONG BH-AGH COMMUNITY HEALTH SURVEY RESPONDENTS:



39% agreed that the built, economic, and educational environments in the community are impacted by systemic racism



37% agreed that the community is impacted by individual racism

"My community is a warm and friendly place, but it lacks almost any racial diversity. Black people who do live in the area are mostly met with curiosity/ignorance that still makes them feel 'other,' but there is still a deeper racism and xenophobia that lingers here and does not get much opportunity to be exposed or removed."

– BH-AGH Community Health Survey respondent

CHNA Progress

Key Themes: Access to Care

Difficulty accessing care because of long wait times, lack of providers, cost/insurance barriers

- Primary care
- Behavioral health care
- Dental care
- Specialties

Difficulties understanding how to navigate the health care system and insurance

"A lot of health professionals are unwilling to explain the health care system or US-based customs to people from outside of the country. This has routinely happened to me and other friends from outside of the country. [This is due to] lack of patience, clarification, simple processes to navigate appointments, insurance, and extra costs."

– BH-AGH Community Health Survey respondent

Breakout Sessions

Reconvene

Wrap-up
BH-AGH Community Benefits

Marylou Hardy
Regional Manager, Community Benefits & Community Relations
Beverly Hospital & Addison Gilbert Hospital
978-381-7585
Marylou.hardy@bilh.org

Community Health Information on website:
https://www.beverlyhospital.org/about-us/community-health

Community Benefits information on website:
https://www.beverlyhospital.org/about-us/community-benefits-report

Community Benefits Annual Meeting in June (More info TBD)

Thank you!

BH/AGH Community Listening Session: Breakout Discussion Guide

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

Mentimeter link:
Jamboard link:

Ground rules and introductions (5 minutes)

Facilitator: "Thank you for joining the Community Listening Session today. We will be in this small breakout group for approximately 45 minutes. Let's start with brief introductions and some ground rules for our time together. I will call on each of you. If you're comfortable, please share your name, your community, and one word to describe how you're feeling today. If you don't want to share, just say pass. I'll start. I'm ____ from ____ and today I'm feeling _____."
(Facilitator calls on each participant)

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

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

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

Question 1 (5 minutes)

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

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

Notes:

Question 2 (15 minutes)

Part 1: 10 minutes

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

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

Notes on missing priority areas:

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

Part 2: 5 minutes

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

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

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

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

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

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

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

Question 3 (25 minutes)

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

Let's start with [Priority Area 1].

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

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

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

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

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

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

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

Notetakers will be taking notes within Jamboard.

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

Wrap Up (1 minute)

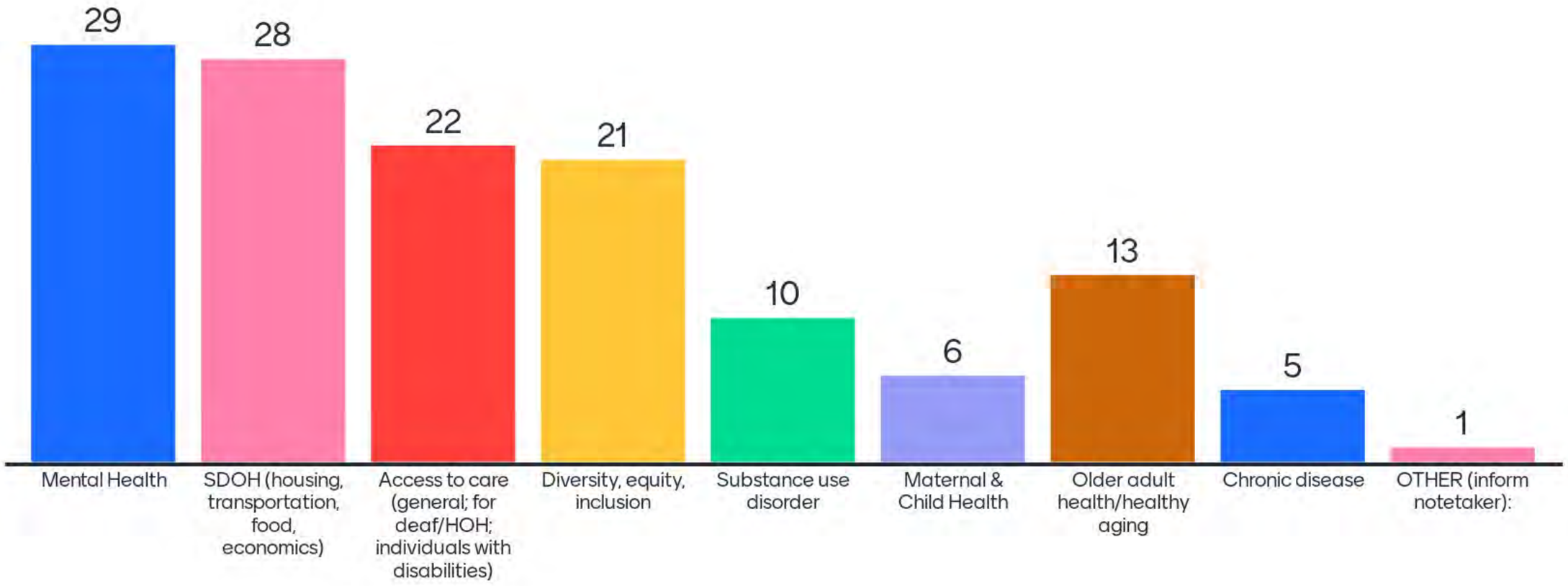
Facilitator: "I want to thank you all for sharing your experiences, perspectives, and knowledge. In a minute we're going to be moved back into the Main Zoom room to hear about some of the things discussed in the groups today, and to talk about the next steps in the Needs Assessment process. Is there anything else people would like to share before we're moved out of the breakout room?"

Notes:

Choose your top 4 priority areas.

Mentimeter

Priority voting results from January 25, 2022 Listening Session



Priority Area 1: Mental Health

Notes from January 25, 2022 Listening Session

Resources/Assets

Vets coming back with lots of MH issues; Cape Vets is a resource

NAMI North Shore - not utilized as much as it could be. Offer Individual and family support

Senior Care has mental health resources.

Positive Alternatives to School Suspension. Referrals through BH or MH issues. District and grant funded.

Importance of awareness of mental health amongst youth

Early intervention services available in the area. North East Arc. YMCAs.

Cape Ann Mental Health coalition is a loose organization that was developed through addison gilbert but it is no longer a formal group

Cape Ann Mental Health Crisis Team. Sandy Ronan, Claudia Schweitzer, Margaret Whittaker.

Children's Friends services; Cape Ann museum youth group; youth leadership model in each community; regional youth provider network; Be Healthy Beverly Coalition.

Task forces are growing, presence of this topic amongst Police

Community partnerships and collaborations

We can work with politicians and advocates to support more MH

Money

Caregiver and community education

Ability to provide Telehealth is a resource and a barrier (doesn't work well for everyone)

Peer recovery networks such as support groups (youth-specific, LGBTQ, caregivers, certified adult care specialists), beneficial for substance use communities. Focus outside of strictly medical resources

Internship program for MSW's to encourage pipeline - making this internship more possible/attainable should be a priority. ways to incentivize more mental health workers

24 hour help and online support lines

Gaps/Barriers

Paperwork required (especially for youth) keeps providers from offering services to Youth. Excessive paperwork for mental health claims.

Lack of access to services

Need better communication of organizations/ resources available, even within medical community

Not enough pediatric providers or high turnover. Kids sit in ERs. Continuous limitation.

Lack of linguistic access to MH services and providers for Spanish, Portuguese, non-English speakers

Still a lot of stigma around mental health.

Recovery Act, federal funding: providers have access to $$. State is not the best at getting the $$ to providers.

Address insurance issues which limit access to MH services and other barriers, ex. providers not taking insurance

Figure out how to recruit more MH professionals, address why there's not many available

Sense that there are more gaps than assets

School systems need to get on MH issues early in kids lives

Linkage with police use of force situations. Police don't have the resources to deal with it

Need for linkage of mental health and primary care practices. This is happening too slowly and not efficiently. Mental health care needs more of a boost from primary care

Health center is resource for supporting where to go for care, but not a lot of services - need more hospital beds. People are being treated in ER

Need in-home services for folks who can't leave the home; not always available.

Suicide prevention and treatment resources are a gap

Social isolation; particularly for seniors, those remote learning

training on cleaning hearing aids and other things for hard of hearing is needed

Substance use is a critical aspect of MH, lots of co-ocurring MH and SU. Self-medicating

LGBTQ resources needed

Money helps, but there is a lack of staff. Can make more money at Amazon.

Priority Area 2: Social Determinants of Health

Resources/Assets

Beverly city government focuses on housing

2 hospitals in the North Shore - can support the movement for supportive housing and other resources

Essex Housing Coalition

Foundation funded housing for hospital patients

Uber Health - helps with free transportation for patients

Harvard Community Partners re housing.

Essex and Middlesex County has support resources for cancer care, patients can get up to $750 year for cancer support from a community program

Salem has a fair amount of low income housing but it is still inadequate

Community Preservation Funds in different communities.

Affordability of housing on the North Shore

Volunteer drivers, grants for transportation

Access to the MBTA, new free fares

Counsels on aging and senior care are great resources for transportation, sometimes limited more demand than volunteers

Housing trust is being created to help address this issue in Essex

Harbor Light Community Partners - Housing and Community Development partner

Family Progress

Beverly Bootstraps - offers case management services, helps with clothing vouchers, food pantry, HS equiv classes and helps with SDOH

Pantries, also doing home deliveries, more pick up options. Pantries are knowledgeable about other resources, e.g., sign people up for SNAP. Open Door is Gloucester. Back Yard Growers in Gloucester.

VNA home care; made a huge difference in my life. We need to get word of this out more.

Education is an influencer of SDOH. Education in MA is among the best in the country.

Church programs that help the community

Government helped at the beginning of COVID when peop became unemployed.

Warm Friends - program that knit hats for people and lap blankets - more of this is needed

Gaps/Barriers

Money - people lost jobs during COVID, lack of income for family caregivers

Each resource takes a ton of paperwork; this is a barrier for families.

Access to affordable childcare - federal guidelines are so low that people working min. wage jobs is over the income guidelines for qualification - cyclical inability to work bc of this

Housing a national crisis and certainly in service area, almost no affordable housing. Some elder housing from 60s but nothing since then. More section 8 certificates. Demand > Availability. Long waits.

Need more volunteers to assist constituents including travel but COVID impacts that

English as a second language. See a lot of different types of languages come through for services, but people don't know that these services are available for them

Young people fleeing the region due to high cost of housing

Low income, affordable housing needs to be more equitably developed and placed so those marginalized have same opportunity for safe beautiful housing. Developers not building subsidized housing.

Food insecure older adults

Big SNAP gap between people eligible and people signed up.

measure of overall health of the community. There are hospitals that have put food pantries in the hospital/certain clinics. Joint ventures with other entities involved in housing/public housing. These are

No MBTA services on Cape Ann, even though they were having to contribute to the MBTA revenue through their budget

communication/collaboration needed with community based organizations as well as integrating them within hospital based programs. more coordination and promotion of work. facilitate community communications.

Climate change and transportation are linked. Sea level rise near causeway and apple street, woomdan's. Rt 133 is really important and vulnerable to flooding.

More transportation needed. referrals for transportation needed from PCP's. public transportation routed does not meet needs

Priority Area 3: Access to Care

Resources/Assets

Programs that are funded through the State and private grants that assist with access to care.

No Wrong Door program

Council on Aging is helpful, supports transportation

volunteer transportation program for local and out-of-town medical appointments for residents 60+ who are self mobile (Beverly, Essex, Gloucester, Hamilton, Ipswich, Manchester-by-the-Sea, Rockport, Topsfield

Beverly has a veteran representative to connect veterans to resource.

Mass Health PTI form needs a referral through PCP but can get transportation

Grant for resource navigator for North Shore out of Gloucester Health Dept. Staff at GHD left and they lost grant. Beverly wants to take over, but BHD didn't have capacity.

Barrier and Resource: Consolidation/ mergers of hospitals and practices over the last ten years. Hard to find solo practitioners. Access to more resources, but adds to cost of care.

Beverly School for the Deaf

People need to know about someone with a hearing concern, they should make a referral to a local provider for health

At Lahey every person with cancer is assigned a social worker

State is doing a good job with facilitating access for individuals with disabilities, but the providers are more hesitant to work with those individuals (don't know how to work with them)

Patient and family advisory council

When docs join larger group practices, have less time and flexibility to work with more complex patients.

Comfort baskets are available for people with cancer care in Essex and Middlesex County

Gaps/Barriers

Digital Divide - internet access as a crucial resource. Many public housing complexes do not have good, affordable internet access

The way BILH system operates it's practices is not affording the best access to care. Need to start thinking about access from a patients point of view.

Need to take an extra moment or two when providing services to do a little research on providing referral services that address other SDOH such as transportation

Need to remember how we are treating people when providing services. This is what is missing with services. Treat people like they are another number

Physical plans for access (non-ambulatory)

very low income get services, very wealthy but their own way, it's the people in middle income that struggle if they need health care when illness strikes or have job loss

Center for Medicaid/Medicare allocated money for assistance, CHW's, to help people to access services but nothing has become of it.

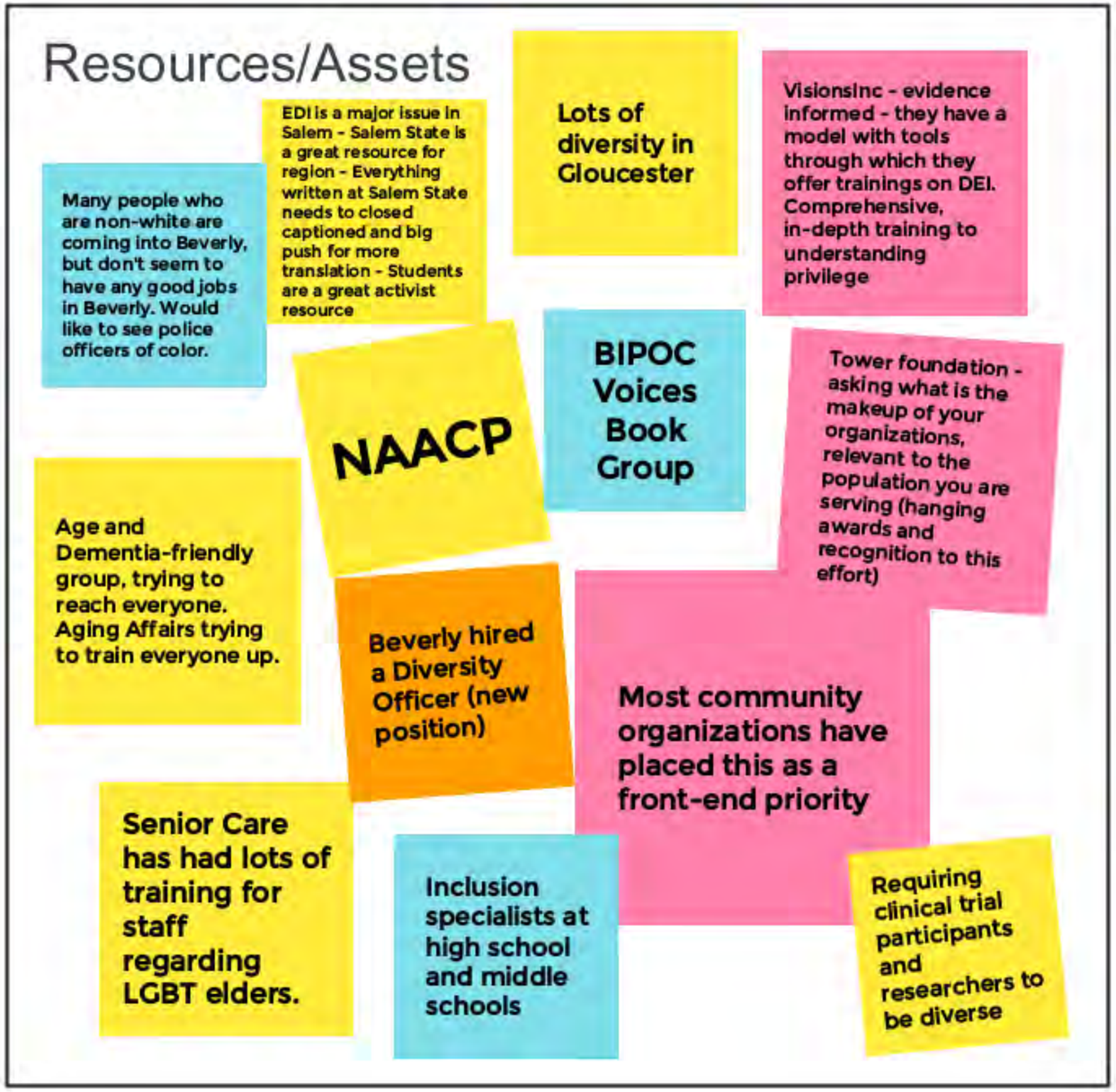
Language barriers - providing services in non-english languages is not prevalent at all

Navigation help and system is needed for finding services and accessing them. Including MassHealth support. Peer support systems. Otherwise an isolating process.

Need more specialists with training for older adults.

Not knowing what you don't know

Priority Area 4: Diversity/Equity/Inclusion



Multiple-choice poll (Multiple answers)

Priority voting results from February 9, 2022 Listening Session

(BHAG 2/9) What are the 4 priority areas that are most important to you.

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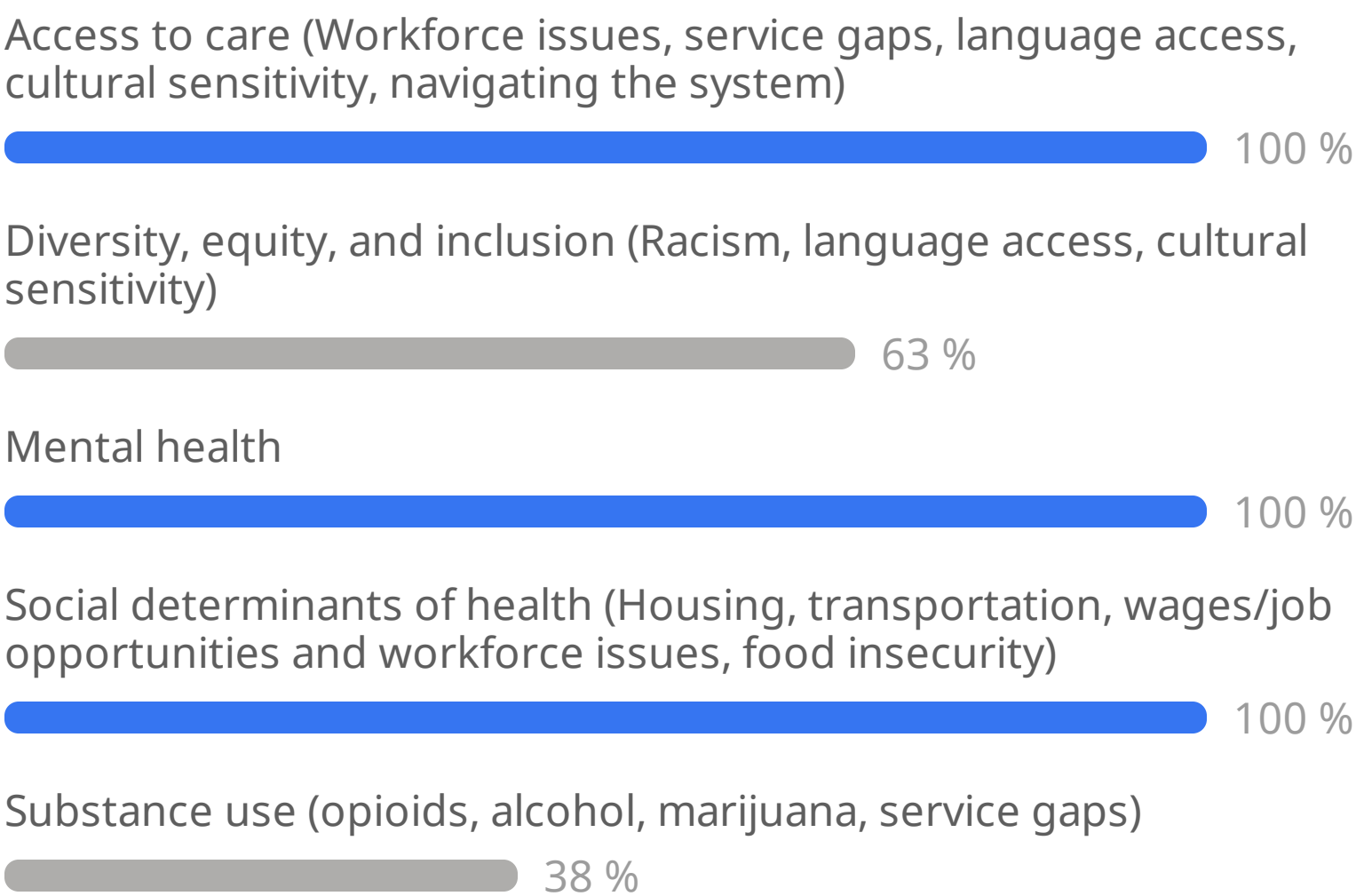

Priority Area 1: Access to care

Notes from February 9, 2022 Listening Session

Resources/Assets

Hopes for state to look at how to support new health care workforce

People are going into healtcare

Gaps/Barriers

Need to pay attention to cultural influences in understanding access to care

Workforce development - need to know what is done to improve it

There are best practices around access to care and it is not the standard

Workforce-There isn't enough faculty to teach new nurses

We need healthcare navigators

Health care is complex and insurance/MassHealth makes it more complex

Priority Area 2: Mental Health

Resources/Assets

There is a lot more awareness of mental health needs

Some funding for MH is coming out

Lynn has a lot of resources

Gaps/Barriers

Not enough therapists for young people

Mental health workforce for youth do not represent race/ethnicity/culture of populations in need

Lot of people not assessed as having MH issues due to cultural misunderstanding and stigma

Priority Area 3: Social Determinants of Health

Resources/Assets

Food security - we have food pantries and people can access food in Lynn

Can think about creating a community fridge to expand in communities

Gaps/Barriers

Crisis in housing

People are not safely housed

We are pricing people out of housing

Landlords cannot recoup their losses as a result of COVID - this will lead to lack of diversity

Need single person housing, not just families or elderly

Existing landlords can raise rents a lot if units are not protected by housing legislation

Priority Area 4: Diversity, Equity, Inclusion

Resources/Assets

DEI work is difficult, Centerboard has been doing it for a while

Funding from some sponsors have been found to help with EDI work - people need to be flexible

Gaps/Barriers

Are large orgs culturally welcoming?

Some organizations write the EDI work in a grant but don't really live it

People won't come back to agencies unless they are culturally sensitive

Legislators and business leaders need to address EDI and connect different communities

People/organozations need to be prepared for the long haul of DEI work

Language barriers - need to consider literacy levels and if people can read and write and at what levels

Need to consider the cultural foundations of communication, not just translation and interpretation

Need to pay attention to body language not just verbal language

People are isolated and it is more difficult with different ethnic groups - leaders need to engage cross groups

We are pricing people out of housing

Appendix B:
Data Book

Secondary Data

Key

Significantly low compared to the Commonwealth based on margin of error

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

			Community Benefits Service Area									
	MA	**Essex County**	**Beverly**	**Danvers**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester**	**Middleton**	**Rockport**	**Source**
Demographics												
Population												US Census Bureau, American Community Survey 2016-2020
Total Population	6,873,003	787,038	42,062	27,549	3,771	30,291	14,022	94,201	5,400	9,952	7,269	
Male	51.5%	48.2%	46.9%	46.7%	48.6%	49.6%	46.4%	50.3%	48.4%	54.6%	44.9%	
Female	48.5%	51.8%	53.1%	53.3%	51.4%	50.4%	53.6%	49.7%	51.6%	45.4%	55.1%	
Age Distribution												US Census Bureau, American Community Survey 2016-2020
Under 5 years (%)	5.2%	5.6%	5.3%	5.1%	7.8%	5.6%	4.4%	6.8%	4.0%	3.7%	3.8%	
5 to 9 years	5.3%	5.5%	5.0%	4.9%	5.9%	4.0%	4.6%	6.4%	3.4%	5.7%	3.1%	
10 to 14 years	5.7%	6.3%	6.1%	4.4%	10.1%	3.9%	7.0%	6.6%	11.9%	5.5%	3.9%	
15 to 19 years	6.6%	6.5%	6.5%	6.2%	7.2%	4.4%	5.9%	6.9%	7.3%	3.9%	5.5%	
20 to 24 years	7.1%	6.5%	8.6%	6.9%	1.8%	4.2%	6.0%	7.2%	3.1%	7.2%	2.2%	
25 to 34 years	14.3%	12.4%	12.4%	13.0%	9.3%	11.3%	8.4%	15.6%	5.5%	13.6%	7.5%	
35 to 44 years	12.2%	12.0%	10.8%	10.0%	9.6%	10.2%	10.3%	13.5%	10.2%	10.0%	8.1%	
45 to 54 years	13.3%	13.8%	13.5%	13.3%	16.5%	13.5%	16.3%	13.6%	17.6%	16.1%	10.7%	
55 to 59 years	7.1%	7.7%	6.8%	8.3%	9.2%	8.7%	10.2%	5.7%	8.2%	8.4%	9.2%	
60 to 64 years	6.5%	6.6%	7.4%	6.4%	7.5%	10.1%	5.8%	5.2%	6.4%	7.5%	9.9%	
65 to 74 years	9.5%	9.8%	9.7%	11.3%	10.5%	14.7%	11.8%	7.6%	15.4%	12.0%	22.6%	
75 to 84 years	4.6%	4.6%	4.7%	6.2%	2.8%	6.6%	6.2%	3.1%	4.7%	5.2%	8.7%	
85 years and over	2.4%	2.7%	3.2%	4.0%	1.9%	2.9%	3.1%	1.7%	2.2%	1.2%	4.8%	
Under 18 years of age	19.8%	21.3%	19.0%	18.4%	30.3%	16.3%	20.1%	24.0%	24.8%	17.7%	13.8%	
Over 65 years of age	16.5%	17.1%	17.7%	21.6%	15.2%	24.1%	21.1%	12.3%	22.4%	18.4%	36.2%	
Race/Ethnicity												US Census Bureau, American Community Survey 2016-2020
White alone (%)	76.6%	78.2%	90.3%	91.7%	99.1%	93.1%	91.7%	49.1%	96.4%	91.7%	96.3%	
Black or African American alone (%)	7.5%	4.3%	3.0%	1.9%	0.0%	2.2%	1.6%	14.4%	0.0%	2.3%	0.1%	
Asian alone (%)	6.8%	3.4%	2.3%	2.1%	0.0%	1.9%	2.2%	6.0%	0.4%	0.6%	0.2%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.4%	0.0%	0.1%	0.1%	
Some Other Race alone (%)	4.2%	9.1%	1.0%	1.3%	0.4%	0.8%	2.0%	21.1%	3.2%	1.1%	1.5%	
Two or More Races (%)	4.8%	4.7%	3.1%	3.0%	0.5%	1.9%	2.6%	8.9%	0.1%	4.3%	1.9%	
Hispanic or Latino of Any Race (%)	12.0%	21.4%	5.4%	5.8%	0.4%	2.9%	5.0%	43.0%	1.8%	5.6%	1.5%	
Race/Ethnicity of Students in Public Schools												School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021
African American (%)	9.3		3.6	2.4	0.4*	1.6	1.1	8.2	0.4*	1.3	0.7	*Note that Manchester and Essex are included in

			Community Benefits Service Area									
	MA	Essex County	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport	Source
Asian (%)	7.2		2.5	2.4	1.1*	1.3	1.3	7.6	1.1*	4.4	1.8	one regional school district
Hispanic (%)	22.3		15.0	8.8	1.3*	12.7	7.1	67.6	1.3*	5.8	3.7	
White (%)	56.7		74.8	83.8	96.7*	80.0	86.5	13.1	96.7*	84.1	90.7	
Native American (%)	0.2		0.1	0.1	0.0*	0.2	0.1	0.3	0.0*	0.6	-	
Native Hawaiian, Pacific Islander (%)	0.1		-	-	0.0*	0.4	-	-	0.0*	0.1	-	
Multi-Race, Non-Hispanic (%)	4.10		3.9	2.5	0.6*	3.8	3.9	3.2	0.6*	3.7	3.1	
Foreign-born	17.0%	17.5%	8.9%	9.9%	1.8%	8.4%	6.2%	36.7%	5.8%	8.6%	4.0%	US Census Bureau, American Community Survey 2016-2020
Naturalized U.S. Citizen	54.2%	56.6%	58.2%	70.3%	85.1%	56.2%	62.9%	48.3%	59.7%	72.2%	78.1%	
Not a U.S. Citizen	45.8%	43.4%	41.8%	29.7%	14.9%	43.8%	37.1%	51.7%	40.3%	27.8%	21.9%	
Region of birth: Europe	20.0%	15.0%	34.0%	34.7%	47.8%	35.8%	20.3%	7.5%	40.0%	50.5%	65.4%	
Region of birth: Asia	31.1%	16.0%	23.2%	14.8%	0.0%	19.4%	29.5%	10.8%	6.3%	19.1%	11.0%	
Region of birth: Africa	9.3%	5.3%	10.4%	14.1%	20.9%	14.3%	0.0%	9.7%	0.0%	1.8%	0.0%	
Region of birth: Oceania	0.3%	0.3%	2.0%	0.7%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	3.1%	
Region of birth: Latin America	36.7%	61.2%	24.6%	33.1%	0.0%	23.4%	43.4%	71.4%	21.9%	22.3%	15.1%	
Region of birth: Northern America	2.5%	2.2%	5.8%	2.7%	31.3%	7.1%	6.7%	0.4%	31.7%	6.3%	5.5%	
Language												US Census Bureau, American Community Survey 2016-2020
English only	76.1%	73.30%	88.8%	88.8%	97.7%	91.2%	92.2%	48.2%	95.1%	85.6%	96.3%	
Language other than English	23.9%	26.70%	11.2%	11.2%	2.3%	8.8%	7.8%	51.8%	4.9%	14.4%	3.7%	
Speak English less than "very well"	9.2%	11.20%	4.2%	3.6%	0.9%	3.5%	2.2%	26.8%	1.4%	3.7%	0.6%	
Spanish	9.1%	17.70%	3.0%	3.1%	0.3%	2.1%	3.0%	36.9%	2.6%	4.4%	1.0%	
Speak English less than "very well"	3.8%	8.00%	0.9%	1.1%	0.0%	1.1%	0.5%	19.8%	1.2%	1.7%	0.2%	
Other Indo-European languages	9.0%	5.90%	5.9%	5.8%	2.0%	4.9%	3.3%	8.0%	2.0%	5.5%	2.7%	
Speak English less than "very well"	3.0%	2.00%	2.1%	2.0%	0.9%	1.5%	1.2%	3.8%	0.3%	1.9%	0.4%	
Asian and Pacific Islander languages	4.4%	2.10%	1.2%	0.6%	0.0%	0.5%	1.4%	4.4%	0.0%	0.3%	0.0%	
Speak English less than "very well"	2.0%	0.90%	0.7%	0.1%	0.0%	0.0%	0.5%	2.3%	0.0%	0.0%	0.0%	
Other languages	1.4%	1.10%	1.1%	1.8%	0.0%	1.3%	0.0%	2.5%	0.3%	4.2%	0.0%	
Speak English less than "very well"	0.4%	0.30%	0.6%	0.4%	0.0%	0.8%	0.0%	0.9%	0.0%	0.2%	0.0%	
Percent of public school student population that are English language learners (%)	10.5		4.2	1.3	0.6*	7.9	2.3	56.0	0.6*	1.5	0.7	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations) * Note that Manchester and Essex are part of one combined district.
Employment												US Census Bureau, American Community Survey 2016-2020
Unemployment rate	5.1%	5.2%	2.6%	4.4%	1.9%	5.5%	2.8%	6.4%	3.8%	4.7%	7.7%	
Unemployment rate by race/ethnicity												
White alone	4.5%	4.4%	2.7%	4.5%	1.9%	5.8%	2.2%	4.1%	4.0%	4.9%	6.7%	
Black or African American alone	8.3%	5.4%	0.0%	0.0%	-	0.0%	47.1%	8.2%	-	0.0%	-	
American Indian and Alaska Native alone	10.7%	21.3%	0.0%	-	-	0.0%	-	0.0%	-	-	-	
Asian alone	4.2%	3.0%	3.2%	3.7%	-	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%	

			Community Benefits Service Area									
	MA	Essex County	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport	Source
Native Hawaiian and Other Pacific Islander alone	5.4%	0.0%	-	-	-	-	-	0.0%	-	-	-	
Some other race alone	8.3%	9.0%	0.0%	0.0%	-	0.0%	0.0%	9.7%	0.0%	0.0%	0.0%	
Two or more races	9.1%	13.2%	0.0%	6.3%	0.0%	7.3%	0.0%	11.8%	-	0.0%	54.1%	
Hispanic or Latino origin (of any race)	8.3%	9.2%	4.9%	12.7%	-	4.3%	2.6%	8.0%	30.3%	0.0%	60.9%	
Unemployment rate by educational attainment												
Less than high school graduate	9.7%	11.6%	0.0%	12.2%	0.0%	4.0%	0.6%	9.8%	-	0.0%	53.3%	
High school graduate (includes equivalency)	5.9%	5.6%	4.6%	4.9%	6.0%	10.2%	1.4%	4.7%	0.0%	1.0%	0.0%	
Some college or associate's degree	4.5%	4.3%	1.9%	4.4%	6.8%	5.5%	6.2%	3.9%	0.0%	2.6%	1.4%	
Bachelor's degree or higher	2.8%	2.9%	2.5%	3.8%	0.0%	3.0%	1.3%	3.3%	3.1%	4.0%	7.7%	
Income and Poverty												US Census Bureau, American Community Survey 2016-2020
Median household income (dollars)	84,385	82,225	84,354	99,269	109,323	76,260	103,941	61,329	178,250	145,525	87,149	
Population living below the federal poverty line in the last 12 months												
Individuals	9.8%	10.1%	10.3%	6.1%	8.3%	9.6%	7.1%	15.8%	2.3%	2.3%	6.9%	
Families	6.6%	7.3%	6.8%	4.2%	8.0%	5.7%	3.5%	12.5%	0.0%	1.9%	4.8%	
Individuals under 18 years of age	12.2%	13.6%	18.0%	5.1%	11.4%	15.0%	5.7%	20.6%	0.0%	1.3%	8.6%	
Individuals over 65 years of age	8.9%	9.7%	4.4%	7.2%	9.4%	6.1%	10.2%	19.3%	3.6%	3.7%	3.7%	
Female head of household, no spouse present	20.5%	21.3%	34.5%	14.0%	28.2%	21.8%	16.4%	25.9%	0.0%	0.0%	25.8%	
White alone	7.9%	8.1	8.7%	6.2%	8.3%	8.5%	7.1%	14.9%	2.3%	2.4%	6.3%	
Black or African American alone	17.6%	17.1	25.8%	0.8%	-	25.5%	0.4%	19.6%	-	0.0%	-	
American Indian and Alaska Native alone	23.3%	34.2	0.0%	0.0%	-	0.0%	-	40.1%	-	-	0.0%	
Asian alone	11.8%	9	17.7%	5.1%	-	17.1%	0.0%	12.7%	0.0%	0.0%	0.0%	
Native Hawaiian and Other Pacific Islander alone	11.9%	29.9	-	-	-	-	-	56.6%	-	-	-	
Some other race alone	22.2%	21.7	59.9%	26.7%	0.0%	24.5%	32.9%	16.4%	0.0%	0.0%	58.3%	
Two or more races	15.5%	14.7	21.6%	0.0%	0.0%	29.1%	0.0%	13.6%	-	0.0%	0.0%	
Hispanic or Latino origin (of any race)	23.0%	20.4	35.4%	24.7%	0.0%	17.4%	17.7%	17.4%	27.3%	0.0%	0.0%	
Less than high school graduate	23.2%	23.6%	22.9%	17.0%	0.0%	19.8%	16.7%	21.8%	-	23.7%	44.9%	
High school graduate (includes equivalency)	11.7%	12.5%	14.2%	10.3%	25.3%	12.6%	15.2%	15.6%	5.3%	3.3%	4.8%	
Some college, associate's degree	8.4%	8.1%	11.4%	6.6%	3.6%	9.9%	6.8%	11.4%	0.0%	1.2%	7.9%	
Bachelor's degree or higher	3.9%	3.5%	2.4%	3.6%	3.6%	3.0%	5.6%	7.4%	2.1%	0.7%	4.2%	
With Social Security	30.2%	31.8%	33.8%	32.8%	30.6%	39.4%	33.0%	27.2%	32.0%	34.7%	48.8%	
With retirement income	19.3%	19.2%	17.0%	26.0%	13.9%	21.0%	22.3%	13.1%	20.8%	25.8%	31.6%	
With Supplemental Security Income	5.9%	6.1%	5.7%	2.1%	5.2%	4.5%	3.4%	9.5%	1.0%	1.7%	2.8%	
With cash public assistance income	2.8%	3.8%	2.4%	1.6%	1.5%	3.4%	1.4%	5.3%	0.5%	6.1%	1.5%	

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With Food Stamp/SNAP benefits in the past 12 months	11.6%	13.6%	11.5%	5.5%	8.9%	10.3%	5.4%	26.1%	0.5%	2.9%	5.1%	
Public School Distric Students Who are Low Income (%)	36.6		23.8	20.7	11.2*	40.7	16.5	78.5	11.2*	9.1	20.7	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations) *Note that Manchester and Essex are part of one combined district.
Housing												US Census Bureau, American Community Survey 2016-2020
Occupied housing units	2,646,980	297,254	16,568	10,652	1,371	13,410	5,653	33,261	2,128	3,062	3,402	
Owner-occupied	62.5%	63.8%	60.4%	70.4%	82.3%	62.7%	73.6%	46.4%	75.9%	92.7%	68.2%	
Renter-occupied	37.5%	36.2%	39.6%	29.6%	17.7%	37.3%	26.4%	53.6%	24.1%	7.3%	31.8%	
Lacking complete plumbing facilities	0.3%	0.5%	0.2%	0.1%	0.8%	0.3%	0.0%	0.9%	0.0%	0.0%	0.0%	
Lacking complete kitchen facilities	0.8%	1.1%	2.0%	1.8%	0.8%	0.2%	0.8%	1.5%	0.0%	0.0%	0.2%	
No telephone service available	1.2%	1.4%	1.5%	4.3%	0.0%	1.5%	0.6%	1.8%	1.7%	1.1%	1.1%	
Monthly housing costs <35% of total household income												
Among owner-occupied housing units with a mortgage	22.0%	23.9%	17.1%	20.4%	41.7%	30.0%	20.1%	32.7%	19.7%	23.1%	35.3%	
Among owner-occupied units without a mortgage	15.2%	16.1%	18.5%	15.3%	17.7%	19.6%	15.4%	17.5%	6.0%	17.3%	13.2%	
Among occupied units paying rent	39.1%	44.2%	45.2%	41.9%	60.0%	41.8%	41.6%	45.2%	27.3%	62.6%	39.3%	
Number of eviction filings	37,500	6,200	197	172	1	152	5.00	945.00	No data	No data	12	Eviction Lab, 2018 Evictions
Access to Technology												US Census Bureau, American Community Survey 2016-2020
Among households												
Has smartphone	83.3%	82.8%	79.5%	78.7%	90.4%	78.0%	80.0%	79.0%	90.1%	86.8%	85.2%	
Has desktop or laptop	82.2%	79.8%	80.1%	81.7%	92.8%	77.8%	87.4%	68.7%	94.5%	90.4%	85.4%	
Has tablet or other portable wireless computer	64.8%	65.1%	65.0%	65.9%	71.1%	61.1%	66.8%	53.6%	75.0%	79.1%	55.1%	
No computer	7.4%	7.9%	10.0%	7.7%	0.5%	7.5%	7.3%	11.3%	0.6%	4.8%	6.8%	
With broadband internet	88.2%	87.6%	87.1%	89.0%	92.8%	89.2%	88.6%	82.3%	95.8%	96.7%	88.3%	
Transportation												US Census Bureau, American Community Survey 2016-2020
Mode of transportation to work for workers aged 16+												
Car, truck, or van -- drove alone	68.0%	73.7%	67.3%	81.0%	66.4%	77.3%	76.2%	65.9%	63.4%	84.6%	71.8%	
Car, truck, or van -- carpooled	7.3%	8.4%	6.2%	6.1%	9.7%	7.9%	3.8%	12.1%	5.8%	5.2%	6.8%	
Public transportation (excluding taxicab)	9.5%	5.2%	9.4%	2.7%	4.6%	2.9%	6.2%	10.2%	15.5%	1.2%	4.9%	
Walked	4.8%	3.1%	5.8%	0.8%	7.5%	5.1%	4.0%	3.6%	3.3%	0.6%	7.2%	
Other means	2.1%	2.0%	1.8%	0.8%	0.6%	1.4%	0.5%	3.7%	0.0%	0.6%	0.3%	
Worked from home	8.3%	7.6%	9.5%	8.6%	11.3%	5.4%	9.3%	4.4%	12.0%	7.7%	9.0%	
Mean travel time to work (minutes)	30	30.2	29	29	28	27	31	32	38	34	32	
Vehicles available among occupied housing units												
No vehicles available	12.2%	10.6%	13.2%	7.4%	2.1%	8.7%	5.6%	18.5%	1.8%	1.1%	6.5%	
1 vehicle available	35.1%	34.1%	36.0%	33.3%	26.5%	38.8%	35.1%	39.2%	27.5%	19.8%	43.8%	
2 vehicles available	36.1%	37.4%	35.9%	38.0%	51.5%	39.2%	35.9%	28.8%	47.1%	42.9%	37.1%	

			Community Benefits Service Area									
	MA	Essex County	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport	Source
3 or more vehicles available	16.5%	18.0%	14.9%	21.2%	19.8%	13.3%	23.4%	13.4%	23.6%	36.3%	12.7%	
Education												US Census Bureau, American Community Survey 2016-2020
Educational attainment of adults 25 years and older												
Less than 9th grade (%)	4.2%	5.5%	1.9%	1.8%	1.5%	2.8%	1.0%	14.8%	0.0%	2.6%	1.0%	
9th to 12th grade, no diploma (%)	4.7%	4.8%	2.7%	4.7%	2.9%	3.0%	1.7%	8.7%	0.0%	6.8%	2.7%	
High school graduate (includes equivalency) (%)	23.5%	24.5%	23.0%	24.0%	15.6%	26.5%	16.6%	31.8%	9.4%	30.5%	13.6%	
Some college, no degree (%)	15.3%	16.3%	13.4%	15.3%	14.6%	17.2%	15.8%	17.1%	9.9%	14.8%	16.2%	
Associate's degree (%)	7.7%	8.2%	9.7%	9.5%	6.2%	11.4%	8.7%	8.2%	6.2%	7.6%	7.3%	
Bachelor's degree (%)	24.5%	24.3%	30.9%	28.8%	29.2%	23.1%	30.8%	13.5%	41.5%	25.5%	30.9%	
Graduate or professional degree (%)	20.0%	16.4%	18.5%	15.9%	30.0%	16.1%	25.5%	6.0%	32.9%	12.1%	28.2%	
High school graduate or higher (%)	91.1%	89.7%	95.4%	93.5%	95.6%	94.3%	97.3%	76.5%	100.0%	90.5%	96.2%	
Bachelor's degree or higher (%)	44.5%	40.6%	49.4%	44.7%	59.2%	39.2%	56.3%	19.5%	74.4%	37.6%	59.1%	
Educational attainment by race/ethnicity												
White alone												
High school graduate or higher	93.3%	93.0%	96.3%	93.7%	96.3%	94.2%	97.6%	85.4%	100.0%	92.3%	96.2%	
Bachelor's degree or higher	46.3%	44.0%	49.9%	45.1%	59.9%	39.0%	56.6%	24.7%	73.9%	39.0%	59.3%	
Black alone												
High school graduate or higher	86.2%	85.8%	77.8%	91.4%	-	88.6%	100.0%	85.6%	-	74.9%	100.0%	
Bachelor's degree or higher	27.6%	26.5%	37.7%	32.3%	-	40.3%	52.2%	19.2%	-	0.0%	100.0%	
American Indian or Alaska Native alone												
High school graduate or higher	81.0%	66.3%	100.0%	-	-	100.0%	-	56.9%	-	100.0%	100.0%	
Bachelor's degree or higher	21.9%	23.0%	100.0%	-	-	0.0%	-	15.1%	-	100.0%	100.0%	
Asian alone												
High school graduate or higher	85.7%	85.1%	73.5%	80.1%	-	100.0%	100.0%	68.2%	100.0%	100.0%	100.0%	
Bachelor's degree or higher	61.8%	56.1%	48.9%	62.1%	-	52.7%	31.0%	17.9%	0.0%	100.0%	0.0%	
Native Hawaiian and Other Pacific Islander alone												
High school graduate or higher	89.1%	100.0%	-	-	-	-	-	100.0%	-	-	-	
Bachelor's degree or higher	36.4%	65.2%	-	-	-	-	-	43.4%	-	-	-	
Some other race alone												
High school graduate or higher	69.9%	62.9%	98.7%	86.0%	0.0%	90.7%	52.4%	49.5%	100.0%	79.1%	91.5%	
Bachelor's degree or higher	15.7%	9.1%	0.0%	25.0%	0.0%	19.6%	25.6%	4.7%	100.0%	0.0%	0.0%	
Two or more races												
High school graduate or higher	81.3%	78.8%	92.2%	100.0%	75.0%	100.0%	100.0%	64.8%	-	56.9%	100.0%	
Bachelor's degree or higher	34.9%	30.8%	51.6%	32.0%	0.0%	47.4%	96.0%	17.3%	-	21.2%	77.9%	
Hispanic or Latino Origin												
High school graduate or higher	72.4%	67.8%	90.2%	87.6%	0.0%	68.8%	72.6%	56.1%	100.0%	53.7%	92.0%	
Bachelor's degree or higher	20.9%	13.6%	22.9%	44.6%	0.0%	23.6%	62.1%	7.1%	100.0%	5.5%	46.0%	

			Community Benefits Service Area									
	MA	**Essex County**	**Beverly**	**Danvers**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester**	**Middleton**	**Rockport**	**Source**
4-Year Graduation Rate Among Public High School Students (%)	89.0		91.0	95.8	99.1*	83.7	90.8	79.0	99.1*	No data	94.9	Massachusetts Department of Elementary and Secondary Education, 2020 *Note that Manchester and Essex are part of one combined district.
Safety/Crime												Massachusetts Crime Statistics, 2021
Property Crimes Offenses (#)												
Burglary	9,592.0		13	19	1	24	18	138	3	6	4	
Larceny-theft	55,672.0		180	222	8	22	33	639	14	18	8	
Motor vehicle theft	7,045.0		15	17	0	145	7	140	2	2	0	
Arson	312.0		2	1	0	1	0	5	0	0	0	
Crimes Against Persons Offenses (#)												
Murder/non-negligent manslaughter	151		0	0	0	0	0	1	0	0	0	
Sex offenses	4,171		11	13	3	14	1	61	0	2	2	
Assaults	67,690		99	230	13	237	41	1,362	8	31	23	
Access to Care												
Ratio of population to primary care physicians	960 to 1	1380 to 1										County Health Rankings, 2019
Ratio of population to mental health providers	140 to 1	160 to 1										County Health Rankings, 2021
Ratio of population to dentists	930 to 1	1090 to 1										County Health Rankings, 2020
Health insurance coverage among civilian noninstitutionalized population (%)												American Community Survey (U.S. Census Bureau), 2016-2020
With health insurance coverage	97.3%	97.0%	98.7%	98.3%	98.4%	96.4%	99.0%	95.6%	99.4%	98.4%	98.8%	
With private health insurance	74.5%	71.9%	79.6%	83.3%	87.4%	70.1%	85.3%	52.0%	93.4%	88.1%	80.7%	
With public coverage	36.1%	39.3%	34.7%	33.4%	23.1%	43.2%	31.3%	53.2%	20.8%	29.3%	45.7%	
No health insurance coverage	2.7%	3.0%	1.3%	1.7%	1.6%	3.6%	1.0%	4.4%	0.6%	1.6%	1.2%	

Key

Significantly low compared to the Commonwealth based on margin of error

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

			Community Benefits Service Area									
	Massachusetts	**Essex County**	**Beverly**	**Danvers**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester**	**Middleton**	**Rockport**	Source
Overall Health												
Mortality rate (age-adjusted per 100,000)	654	671	810.5	778.1	776.7	717.3	614.9	755.9	443.1	524.9	693.5	Massachusetts Death Report, 2019
Premature mortality rate (per 100,000)	272.8	271.3	300.8	342.9	233.4	315.7	263	356.8	120.2	212.7	227.4	
Leading causes of death (counts)												
Cancer	12,584		91	69	9	87	20	164	8	24	24	
Heart Disease	11,779		83	89	4	63	33	148	5	11	17	
Chronic Lower Respiratory Disease	2,842		40	17	1	19	5	33	2	6	3	
Stroke	2,463		16	12	2	16	4	15	3	8	2	
Disability												US Census Bureau, American Community Survey 2016-2020
Percent of population with a disability	11.7%	12.0%	10.9%	11.9%	11.5%	10.3%	8.1%	14.3%	4.5%	9.1%	13.6%	
Under 18	4.7%	4.7%	2.6%	4.1%	3.9%	2.0%	3.2%	7.1%	0.0%	5.0%	4.2%	
18-64	8.9%	9.0%	8.0%	8.2%	10.0%	7.6%	4.3%	12.1%	0.5%	5.8%	5.8%	
65+	31.3%	32.4%	30.8%	29.7%	32.1%	22.8%	23.3%	40.7%	18.9%	22.3%	28.3%	
Healthy Living												
Adults over 18 with no leisure-time physical activity (age-adjusted)	26	30										Behavioral Risk Factor Surveillance System, 2019
Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%)	22.2											Behavioral Risk Factor Surveillance System, 2019
Population with adequate access to locations for physical activity	89	93										County Health Rankings, 2021
Adults who consumed fruit less than one time per day (%)	32.7											Behavioral Risk Factor Surveillance System, 2019
Adults who consumed vegetables less than one time per day (%)	15.5											Behavioral Risk Factor Surveillance System, 2019
Population with limited access to healthy foods (%)	4	4										USDA Food Environment Atlas, 2019
Total Population that Did Not Have Access to a Reliable Source of Food During Past Year (food insecurity rate) (%)	8.2											Feeding America, Map the Meal Gap, 2019
Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted) (%)	34	35										Behavioral Risk Factor Surveillance System, 2018
Mental Health												
Average number of mentally unhealthy days in past 30 days	4.2	4.4										County Health Rankings, 2019
Youth Risk Behavior Survey (YRBS)												Youth Risk Behavior Survey - Report years indicated
	2019		**2011 Middle School; 2010 High School**	**2016**	**2018***	**2015**	**2018**		**2018***	**2018**		*Note that Manchester and Essex are part of one regional school district.
% of students (grades 6-8) bullied on school property (%)	35.3		48.5 (ever)	34.0	28.0 (ever)	39.0	34.0		28.0 (ever)	20.8 (couple months)		
% of students (grades 6-8) bullied electronically (%)	15.2		28.8 (ever)	23.0	17.0 (ever)	24.0	15.0		17.0 (ever)	14.4 (couple months)		
% of students (grades 9-12) bullied on school property (%)	19.0		26.3	19.0	12.0	24.0	23.0		12.0	15.1		
% of students (grades 9-12) bullied electronically (%)	14.9		--	15.0	9.8	20.0	18.0		9.8	10.0		
% of students (grades 6-8) reporting self harm (%)	21		--	13.0	--	10.0	12.0		--	7.5		
% of students (grades 6-8) reporting suicide ideation (%)	11.3		82.0	13.0	13.0 (ever)	10.0	16.0		13.0 (ever)	5.9		
% of students (grades 6-8) reporting suicide attempt (%)	5.0		5.0	3.0	3.0 (ever)	3.0	3.0		3.0 (ever)	1.2		
% of students (grades 9-12) reporting self harm (%)	--		19.1	18.0	--	18.0	16.0		--	8.8		
% of students (grades 9-12) reporting suicide ideation (%)	17.2		16.2	18.0	11.3	13.0	13.0		11.3	10.7		
% of students (grades 9-12) reporting suicide attempt (%)	7.4		9.8	6.0	10.3	5.0	3.0		10.3	1.7		

			Community Benefits Service Area									
	Massachusetts	Essex County	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport	Source
Substance Use												
Admissions to DPH-funded treatment programs (count)	98944		597	287	0-100	484	158	2077	0-100	0-100	0-100	MA DPH, Bureau of Substance Abuse Services, 2017
Rate of injection drug user admissions to DPH-funded treatment	52.4		33.5	37.6	-	36.8	41.1	49.3	-	36.4	17.8	MA DPH, Bureau of Substance Abuse Services, 2017
Primary substance of use when entering treatment												MA DPH, Bureau of Substance Abuse Services, 2017
Alcohol (%)	32.8		47.6	39.4	52.2	37.4	38.6	31.4	60	48.1	71.1	
Crack/Cocaine (%)	4.1		2.5	-	-	3.3	-	4.8	-	-	-	
Heroin (%)	52.8		36.9	47	30.4	45.7	48.1	53.5	32	36.4	20	
Marijuana (%)	3.5		5.4	3.5	-	3.7	5.1	3.6	-	-	-	
Other Opioids (%)	4.6		4.2	5.2	-	5.8	5.1	4.9	-	-	-	
Other Sedatives/Hypnotics (%)	1.5		2	-	-	2.7	-	1.5	-	-	-	
Other Stimulants (%)	0.5		-	-	-	-	-	-	-	-	-	
Other (%)	0.3		-	-	-	-	-	-	-	-	-	
Adults who are current smokers (age-adjusted) (%)	12	14										Behavioral Risk Factor Surveillance System, 2019
Adults who report excessive drinking (binge or heavy drinking) (%)	22	23										Behavioral Risk Factor Surveillance System, 2019
Youth Risk Behavior Survey (YRBS)												Youth Risk Behavior Survey - Report years indicated
	2019		2011 Middle School; 2010 High School	2016	2018*	2015	2018		2018*	2018		
Students (grades 6-8) reporting lifetime alcohol use (%)	13.6		15.5	10.0	15.0	15.0	10.0		15.0	7.7		*Note that Manchester and Essex are part of one regional school district.
Students (grades 6-8) reporting current alcohol use (%)	4.4		--	2.0	--	5.0	4.0		--	2.9		
Students (grades 9-12) reporting lifetime alcohol use (%)	--		68.9	57.0	--	63.0	45.0		--	45.7		
Students (grades 9-12) reporting current alcohol use (%)	29.8		43.2	35.0	42.8	39.0	26.0		42.8	23.4		
Students (grades 6-8) reporting current binge alcohol use (%)	0.9		--	1.0	--	1.0	0.0		--	0.2		
Students (grades 9-12) reporting current binge alcohol use (%)	13.5		27.4	21.0	23.9	25.0	24.0		23.9	8.0		
Students (grades 6-8) reporting lifetime cigarette use (%)	5.2		8	3.0	5.0	4.0	2.0		5.0	0.0		
Students (grades 6-8) reporting current cigarette use (%)	--		1.7	0.0	--	0.9	0.0		--	0.0		
Students (grades 9-12) reporting lifetime cigarette use (%)	28.9		35.9	22.0	--	20.0	9.0		--	6.7		
Students (grades 9-12) reporting current cigarette use (%)	8.8		15.3	9.0	7.5	9.0	5.0		7.5	2.7		
Students (grades 6-8) reporting lifetime marijuana use (%)	7.0		7.6	3.0	3.0	8.0	2.0		3.0	0.6		
Students (grades 6-8) reporting current marijuana use (%)	3.0		--	1.0	--	5.0	1.0		--	0.6		
Students (grades 9-12) reporting lifetime marijuana use (%)	35.6		46.7	38.0	42.0	51.0	29.0		42.0	25.0		
Students (grades 9-12) reporting current marijuana use (%)	19.8		31.2	24.5	26.5	31.0	16.0		26.5	20.1		
Students (grades 6-8) reporting lifetime electronic tobacco use (%)	14.7		--	--	13.0	--	12.0		13.0	--		
Students (grades 6-8) reporting current electronic tobacco use (%)	--		--	2.0	--	--	5.0		--	2.4		
Students (grades 9-12) reporting lifetime electronic tobacco use (%)	42.2		--	--	40.0	--	36.0		40.0	--		
Students (grades 9-12) reporting current electronic tobacco use (%)	13.2		--	6.0	--	--	21.0		--	27.7		
Chronic Disease (more data on CHIA data tabs)												
Cancer mortality (all types, age-adjusted rate per 100,000)	149.92	143.41										Massachusetts Cancer Registry, 2014-2018
Cancer incidence (age-adjusted per 100,000)												
All sites	498.16	509.23										
Breast Cancer	176.35	178.01										
Cervical Cancer	5.5	5.8										
Coloretal Cancer	35.96	34.59										
Lung and Bronchus Cancer	61.41	62.27										
Prostate Cancer	108.84	109.42										
Risk factors												
Percent of Adults who are Obese (%)	24		28.8	28	27	29.5	28.4	33.9	-	-	27	Behavioral Risk Factor Surveillance System, 2018
Diagnosed diabetes among adults aged >=18 years (%)	8.6		7.1	6.9	6.4	7.5	7.1	10.9	-	-	6.4	Behavioral Risk Factor Surveillance System, 2018
Age-adjusted mortality due to heart disease per 100,000 population (%)	138.7											Massachusetts Department of Public Health, Population Health Information Tool, 2015
Adults ever told by doctor that they had angina or coronary heart disease (%)	4.7											Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high blood pressure	26.8											Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high cholesterol (age-	33.1											Behavioral Risk Factor Surveillance System, 2017

			Community Benefits Service Area									
	Massachusetts	Essex County	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport	Source
Reproductive Health												
Infant Mortality Rate (per 1,000 live births)	3.7	4.6										March of Dimes, 2019
Low birth weight (%)	7.4	6.8										March of Dimes, 2020
Mothers with late or no prenatal care (%)	3.9%	3.7										March of Dimes, 2020
Births to adolescent mothers (per 1,000 females ages 15-19)	8	11										National Center for Health Statistics, 2014-2020
Percent of mothers receiving publicly funded prenatal care 2016	38.60%											Massachusetts Births 2016
Women screened for postpartum depression within 6 months after delivery (%)												MDPH January 2016-December 2016
White (non-Hispanic)	13.60%											
Black (non-Hispanic)	9.70%											
Asian or Pacific Islander (non-Hispanic)	14.60%											
American Indian/Alaska Native (non-Hispanic)	10.30%											
Other race (non-Hispanic)	13.30%											
Unknown race	12.40%											
Less than a high school diploma	8.00%											
With a high school diploma or GED	9.30%											
Some College/Associate Degree	11.40%											
Bachelor Degree	14.10%											
Graduate Degrees	15.20%											
Among individuals who had a full-term birth	12.10%											
Among individuals who had a pre-term birth	11.50%											
Among individuals who are not married	9.70%											
Among individuals who are married	13.70%											
Frequency of self-reported postpartum depressive symptoms 2017												MDPH 2019. CY18 Summary of Activities Related to Screening for Postpartum Depression
Rarely/Never	61.4%											
Often/Always	10.7%											
Sometimes	27.9%											
Communicable and Infectious Disease												
HIV prevalence	355	291										National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention, 2019
STI infection cases (per 100,000)												Massachusetts Population Health Information Tool, 2018
Syphillis (case count)	1,164		Less than 5	Less than 5	0	Less than 5	0	21	Less than 5	Less than 5	0	
Gonorrhea (case count)	7,629		23	10	0	7	Less than 5	160	Less than 5	6	Less than 5	
Chlamydia	30,297		87	55	5	63	28	652	9	37	12	
Confirmed and probable Hepatitis B cases (per 100,000 population)	25.1											Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Hepatitis B Virus Infection 2020 Surveillance Report. https://www.mass.gov/lists/infectious-disease- data-reports-and-requests. Published February 2021
Rate of Hepatitis C (per 100,000)	97.9		53.5	56.4	0	83.5	37.2	147.7	No data	225.9	No data	Massachusetts Population Health Information Tool, 2018
Tuberculosis (case count)	204		0	0	0	Less than 5	0	7	0	0	0	Massachusetts Population Health Information Tool, 2018
Medicare enrollees that had annual flu vaccination (%)	56%	56										Mapping Medicare Disparities, 2019

*Suppressed

	Massachusetts	Essex County	Community Benefits Service Area: Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport	Source
COVID-19 Community Impact Survey												MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole.
% very worried about getting infected with COVID-19		34%	30%	32%	25%	32%	25%	37%	27%	*	26%	
% ever been tested for COVID		48%	31%	50%	24%	44%	33%	55%	30%	*	29%	
% who have not gotten the medical care they needed since July 2020		14%	16%	14%	*	15%	*	18%	11%	*	*	
% with 15 or more of poor mental health days in the past 30 days		33%	32%	35%	20%	30%	*	36%	25%	*	35%	
% of substance users who said they are now using more substances than before the pandemic		42%	43%	30%	47%	40%	*	43%	43%	*	*	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks		43%	41%	40%	52%	41%	41%	51%	35%	*	33%	
% Worried about getting food or groceries in the coming weeks		26%	20%	24%	23%	25%	25%	30%	10%	*	28%	
% Worried about getting face masks in the coming weeks		13%	9%	10%	10%	11%	*	22%	*	*	13%	
% Worried about getting medication in the coming weeks		12%	9%	12%	*	11%	*	13%	*	*	13%	
% Worried about getting broadband in the coming weeks		13%	14%	17%	10%	11%	*	15%	*	*	13%	
% of Employed residents who experienced job loss		8%	7%	7%	21%	12%	23%	5%	*	*	*	
% of employed residents who experienced reduced work hours		12%	12%	13%	*	11%	*	11%	*	*	*	
% Worried about paying mortgage, rent, or utilities related expenses		33%	29%	24%	40%	28%	19%	40%	15%	*	23%	
% Worried they may have to move out of where they live in the next few months		19%	17%	*	*	21%	*	15%	*	*	*	
Boston Indicators: COVID Community Data Lab												Boston Indicators
Unemployment claims (#) reported on 10/30/21	5,901											
Unemplyment rate as of 10/21/21	5.3%											
COVID-19 Layoff												Metropolitian Area Planning Council, The COVID-19 Layoff Housing Gap (October 2020)
Estimated number of households in need of assistance with no government aid (without any unmployment benefits)			424	330	29	355	124	1,982	31	73	61	
Unemployment claims (#)			1,846	1,434	126	1,442	543	7,603	149	389	275	

Community Health Needs Assessment - Beverly & Addison Gilbert Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 0-17, Beverly & Addison Gilbert Hospital Community Benefits Service Area defined by BILH Community Benefits

		Beverly & Addison Gilbert Hospital Community Benefits Service Area								
	MA	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport
All Cause										
FY19 Inpatient Discharges (all cause) rate per 100,000	1,735	2,190	2,216	1,438	2,299	1,752	2,008	1,710	2,033	1,952
Change in Inpatient Discharge Rate FY17 to FY19	-7%	4%	32%	-45%	2%	0%	-23%	-11%	11%	40%
FY19 ED Volume (all cause) rate per 100,000	19,530	20,977	16,023	10,588	23,486	11,624	34,748	10,765	14,033	16,357
Change in ED Volume Rate FY17 to FY19	-1%	1%	-1%	-21%	6%	-21%	37%	-23%	-1%	21%
Chronic Disease										
Asthma										
FY19 Inpatient Discharges rate per 100,000	333	582	476	131	500	478	372	302	393	186
Change in Inpatient Discharge Rate FY17 to FY19	-12%	10%	-7%	-75%	-4%	9%	-46%	0%	50%	-60%
FY19 ED Volume rate per 100,000	2,481	2,848	2,051	784	3,838	1,274	3,963	604	1,246	2,788
Change in ED Volume Rate FY17 to FY19	2%	-7%	-18%	-63%	10%	-38%	59%	-68%	0%	-3%
Diabetes Mellitus										
FY19 Inpatient Discharges rate per 100,000	53	25	92	0	80	40	39	0	0	93
Change in Inpatient Discharge Rate FY17 to FY19	7%	-71%	150%	0%	33%	0%	29%	-100%	0%	0%
FY19 ED Volume rate per 100,000	117	165	92	131	180	80	166	101	197	0
Change in ED Volume Rate FY17 to FY19	-2%	18%	150%	0%	0%	-33%	81%	0%	50%	0%
Obesity										
FY19 Inpatient Discharges rate per 100,000	61	25	18	0	40	80	92	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	6%	-60%	0%	0%	-60%	0%	-30%	0%	-100%	0%
FY19 ED Volume rate per 100,000	81	38	18	0	60	0	26	0	0	0
Change in ED Volume Rate FY17 to FY19	0%	-25%	0%	0%	-50%	-100%	-68%	0%	-100%	0%
Injuries and Infections										
Allergy										
FY19 Inpatient Discharges rate per 100,000	125	190	293	0	140	159	206	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	2%	67%	100%	-100%	75%	100%	81%	-100%	-100%	-100%
FY19 ED Volume rate per 100,000	1,874	3,064	2,655	654	2,898	1,115	6,058	1,509	2,295	1,487
Change in ED Volume Rate FY17 to FY19	-1%	48%	69%	0%	21%	-20%	192%	-6%	59%	45%
HIV Infection										
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0	0	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	18%	0%	0%	0%	0%	0%	-100%	0%	0%	0%
FY19 ED Volume rate per 100,000	1	0	0	0	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	-23%	0%	0%	0%	0%	0%	-100%	0%	0%	0%
Infections										
FY19 Inpatient Discharges rate per 100,000	767	962	1,117	915	899	518	814	805	1,049	743
Change in Inpatient Discharge Rate FY17 to FY19	-2%	27%	69%	-22%	-10%	-35%	-17%	700%	60%	300%
FY19 ED Volume rate per 100,000	7,457	7,849	5,310	3,791	8,055	4,021	18,205	2,515	3,738	5,390
Change in ED Volume Rate FY17 to FY19	4%	12%	10%	16%	3%	-9%	60%	-7%	-2%	41%
Injuries										
FY19 Inpatient Discharges rate per 100,000	345	253	293	654	380	199	451	101	197	279
Change in Inpatient Discharge Rate FY17 to FY19	-4%	18%	23%	0%	0%	0%	0%	-80%	-57%	50%
FY19 ED Volume rate per 100,000	7,024	7,368	6,043	4,575	8,535	4,777	8,879	5,634	6,689	5,297
Change in ED Volume Rate FY17 to FY19	-8%	-15%	-25%	-47%	-8%	-37%	6%	-24%	2%	-20%
Poisonings										
FY19 Inpatient Discharges rate per 100,000	85	114	110	131	120	40	105	0	262	0
Change in Inpatient Discharge Rate FY17 to FY19	-30%	125%	200%	-50%	-33%	-50%	-31%	0%	0%	0%
FY19 ED Volume rate per 100,000	501	1,355	1,062	392	1,339	239	3,749	503	787	651
Change in ED Volume Rate FY17 to FY19	32%	133%	107%	0%	24%	100%	416%	25%	140%	-30%

Pneumonia/Influenza										
FY19 Inpatient Discharges rate per 100,000	213	544	348	131	460	398	236	101	262	372
Change in Inpatient Discharge Rate FY17 to FY19	3%	54%	0%	-50%	77%	25%	-31%	-50%	33%	300%
FY19 ED Volume rate per 100,000	1,098	1,190	714	392	1,839	557	1,925	503	721	836
Change in ED Volume Rate FY17 to FY19	38%	45%	11%	-50%	197%	8%	40%	-38%	120%	350%
Sexually Transmitted Diseases										
FY19 Inpatient Discharges rate per 100,000	4	0	0	0	0	0	4	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	-100%	0%	0%	0%	-75%	0%	0%	0%
FY19 ED Volume rate per 100,000	35	0	37	0	0	0	66	0	0	0
Change in ED Volume Rate FY17 to FY19	15%	0%	0%	0%	0%	0%	7%	0%	0%	0%
Other										
Attention Deficit Hyperactivity Disorder										
FY19 Inpatient Discharges rate per 100,000	141	215	311	392	300	80	136	604	131	93
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-11%	240%	0%	15%	-60%	-16%	50%	-67%	-50%
FY19 ED Volume rate per 100,000	588	1,620	751	261	2,918	756	367	1,107	1,049	1,859
Change in ED Volume Rate FY17 to FY19	17%	-7%	-18%	-78%	66%	-30%	-2%	0%	23%	82%
Learning Disorders										
FY19 Inpatient Discharges rate per 100,000	135	127	92	0	80	40	122	201	66	0
Change in Inpatient Discharge Rate FY17 to FY19	12%	67%	-55%	-100%	33%	0%	-3%	100%	-67%	-100%
FY19 ED Volume rate per 100,000	103	89	37	0	80	0	44	0	66	372
Change in ED Volume Rate FY17 to FY19	84%	0%	-60%	-100%	-33%	-100%	-38%	-100%	0%	0%
Mental Health										
FY19 Inpatient Discharges rate per 100,000	772	1,063	1,373	1,176	1,719	597	1,229	1,207	1,180	743
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-26%	70%	50%	19%	-35%	-12%	-29%	-31%	-67%
FY19 ED Volume rate per 100,000	2,592	3,760	2,783	1,176	5,297	2,826	1,737	1,811	2,164	5,762
Change in ED Volume Rate FY17 to FY19	5%	0%	52%	13%	26%	-17%	8%	-5%	-11%	107%
Substance Use Disorders										
FY19 Inpatient Discharges rate per 100,000	53	114	92	131	160	80	79	0	131	93
Change in Inpatient Discharge Rate FY17 to FY19	-8%	50%	400%	0%	167%	0%	-53%	-100%	-33%	-50%
FY19 ED Volume rate per 100,000	343	722	366	261	600	358	385	503	656	1,394
Change in ED Volume Rate FY17 to FY19	-5%	90%	100%	100%	20%	350%	5%	400%	11%	200%
Complication of Medical Care										
FY19 Inpatient Discharges rate per 100,000	229	215	220	131	100	199	267	101	131	93
Change in Inpatient Discharge Rate FY17 to FY19	-4%	6%	200%	-86%	-38%	150%	-16%	0%	-33%	-50%
FY19 ED Volume rate per 100,000	208	241	165	131	180	199	289	0	66	372
Change in ED Volume Rate FY17 to FY19	3%	58%	0%	0%	-47%	150%	25%	-100%	0%	300%

Community Health Needs Assessment - Beverly & Addison Gilbert Hospital

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

		Beverly & Addison Gilbert Hospital Community Benefits Service Area								
	MA	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport
All Cause										
FY19 Inpatient Discharges (all cause) rate per 100,000	6,072	6,607	6,058	4,107	7,618	5,384	8,894	3,188	5,248	5,192
Change in Inpatient Discharge Rate FY17 to FY19	0%	-2%	-2%	18%	5%	-12%	2%	2%	-1%	28%
FY19 ED Volume (all cause) rate per 100,000	25,053	22,452	18,636	12,500	34,174	16,750	40,377	9,841	13,251	18,224
Change in ED Volume Rate FY17 to FY19	-1%	-1%	3%	-14%	-6%	-4%	14%	4%	-17%	10%
Cancer										
Breast Cancer										
FY19 Inpatient Discharges rate per 100,000	32	67	43	0	56	0	46	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-10%	233%	-33%	0%	150%	-100%	45%	0%	-100%	0%
FY19 ED Volume rate per 100,000	27	53	0	0	33	0	43	0	0	0
Change in ED Volume Rate FY17 to FY19	25%	700%	-100%	0%	-25%	0%	15%	0%	0%	0%
Colorectal Cancer										
FY19 Inpatient Discharges rate per 100,000	15	40	0	0	0	0	26	0	117	0
Change in Inpatient Discharge Rate FY17 to FY19	17%	500%	0%	0%	-100%	0%	350%	0%	100%	0%
FY19 ED Volume rate per 100,000	4	13	0	0	0	0	3	0	0	0
Change in ED Volume Rate FY17 to FY19	21%	100%	0%	0%	0%	0%	0%	0%	-100%	0%
GYN Cancer										
FY19 Inpatient Discharges rate per 100,000	41	53	11	0	45	25	63	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	11%	60%	0%	0%	300%	0%	-21%	0%	0%	0%
FY19 ED Volume rate per 100,000	30	40	0	0	11	0	37	0	0	0
Change in ED Volume Rate FY17 to FY19	23%	-33%	-100%	0%	0%	0%	-7%	0%	0%	0%
Lung Cancer										
FY19 Inpatient Discharges rate per 100,000	26	40	21	0	0	50	52	0	322	0
Change in Inpatient Discharge Rate FY17 to FY19	3%	-14%	-50%	0%	-100%	100%	100%	0%	267%	0%
FY19 ED Volume rate per 100,000	7	7	0	0	22	25	6	0	0	0
Change in ED Volume Rate FY17 to FY19	47%	-50%	0%	0%	100%	-83%	100%	0%	0%	0%
Prostate Cancer										
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0	0	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-15%	0%	0%	0%	0%	0%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000	0	0	0	0	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	150%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other Cancer										
FY19 Inpatient Discharges rate per 100,000	304	401	354	179	335	224	445	139	1,114	0
Change in Inpatient Discharge Rate FY17 to FY19	2%	-29%	6%	0%	58%	-36%	65%	-33%	245%	0%
FY19 ED Volume rate per 100,000	142	274	182	179	279	150	178	69	88	0
Change in ED Volume Rate FY17 to FY19	29%	28%	42%	100%	4%	100%	68%	-50%	50%	0%
Chronic Disease										
Asthma										
FY19 Inpatient Discharges rate per 100,000	745	902	826	179	1,227	947	1,197	277	469	519
Change in Inpatient Discharge Rate FY17 to FY19	-5%	2%	10%	-67%	34%	9%	8%	-20%	7%	25%
FY19 ED Volume rate per 100,000	2,649	3,226	2,230	1,250	6,803	2,468	4,276	1,386	880	2,181
Change in ED Volume Rate FY17 to FY19	3%	-2%	-13%	-22%	1%	-8%	45%	186%	-38%	24%
Congestive Heart Failure										
FY19 Inpatient Discharges rate per 100,000	124	114	75	0	134	100	235	0	59	52
Change in Inpatient Discharge Rate FY17 to FY19	14%	31%	75%	0%	-70%	-50%	78%	0%	0%	0%
FY19 ED Volume rate per 100,000	56	40	21	0	100	75	121	0	176	0
Change in ED Volume Rate FY17 to FY19	42%	0%	-33%	0%	-57%	-67%	425%	0%	0%	0%

COPD and Lung Disease										
FY19 Inpatient Discharges rate per 100,000	136	167	86	0	379	349	166	139	117	363
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-7%	-20%	0%	42%	600%	-2%	0%	0%	-30%
FY19 ED Volume rate per 100,000	127	140	21	0	290	174	210	0	0	415
Change in ED Volume Rate FY17 to FY19	16%	-43%	-71%	0%	-35%	250%	92%	0%	0%	300%
Diabetes Mellitus										
FY19 Inpatient Discharges rate per 100,000	478	381	558	89	535	499	855	69	352	935
Change in Inpatient Discharge Rate FY17 to FY19	5%	-2%	53%	0%	-28%	-20%	17%	-75%	140%	1700%
FY19 ED Volume rate per 100,000	1,167	1,082	708	179	1,372	598	2,454	416	293	779
Change in ED Volume Rate FY17 to FY19	7%	-5%	-23%	-33%	-13%	-50%	38%	-14%	-23%	15%
Heart Disease										
FY19 Inpatient Discharges rate per 100,000	445	387	354	357	491	174	726	416	469	467
Change in Inpatient Discharge Rate FY17 to FY19	6%	-6%	38%	300%	-59%	-59%	27%	0%	167%	-36%
FY19 ED Volume rate per 100,000	375	481	279	89	770	374	1,004	485	176	52
Change in ED Volume Rate FY17 to FY19	31%	29%	8%	-67%	-21%	36%	141%	250%	-40%	-89%
Hypertension										
FY19 Inpatient Discharges rate per 100,000	606	715	665	357	781	623	910	0	557	883
Change in Inpatient Discharge Rate FY17 to FY19	1%	-5%	0%	300%	-14%	14%	11%	-100%	58%	13%
FY19 ED Volume rate per 100,000	1,838	1,383	1,244	893	3,591	1,570	3,045	0	498	1,038
Change in ED Volume Rate FY17 to FY19	8%	-9%	-17%	25%	-4%	9%	41%	-100%	-55%	5%
Liver Disease										
FY19 Inpatient Discharges rate per 100,000	427	367	761	268	513	474	608	69	440	312
Change in Inpatient Discharge Rate FY17 to FY19	15%	-18%	294%	50%	-16%	58%	-1%	0%	275%	-60%
FY19 ED Volume rate per 100,000	185	381	161	0	535	324	270	139	293	156
Change in ED Volume Rate FY17 to FY19	25%	68%	25%	0%	60%	225%	57%	100%	400%	-40%
Obesity										
FY19 Inpatient Discharges rate per 100,000	919	855	1,104	804	1,316	947	1,564	277	469	467
Change in Inpatient Discharge Rate FY17 to FY19	6%	-2%	32%	13%	-7%	41%	-4%	-20%	-6%	-44%
FY19 ED Volume rate per 100,000	530	668	450	446	1,573	299	511	208	88	779
Change in ED Volume Rate FY17 to FY19	11%	-17%	-18%	25%	-16%	-29%	-37%	50%	-63%	150%
Stroke and Other Neurovascular Diseases										
FY19 Inpatient Discharges rate per 100,000	71	53	0	0	67	50	129	69	0	0
Change in Inpatient Discharge Rate FY17 to FY19	9%	-27%	-100%	0%	-40%	-50%	32%	0%	0%	-100%
FY19 ED Volume rate per 100,000	28	13	32	0	89	25	32	0	0	0
Change in ED Volume Rate FY17 to FY19	11%	-67%	-25%	-100%	60%	0%	22%	-100%	0%	-100%
Injuries and Infections										
Allergy										
FY19 Inpatient Discharges rate per 100,000	553	748	729	268	725	449	895	208	469	260
Change in Inpatient Discharge Rate FY17 to FY19	13%	47%	66%	-57%	10%	-14%	94%	50%	-6%	25%
FY19 ED Volume rate per 100,000	3,482	5,237	5,329	3,482	7,885	4,711	13,446	1,733	2,873	4,206
Change in ED Volume Rate FY17 to FY19	44%	206%	328%	117%	80%	130%	658%	108%	145%	138%
Hepatitis										
FY19 Inpatient Discharges rate per 100,000	344	347	365	89	424	249	674	0	645	208
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-25%	62%	0%	-25%	-9%	10%	0%	-4%	33%
FY19 ED Volume rate per 100,000	195	401	193	179	937	150	86	0	469	208
Change in ED Volume Rate FY17 to FY19	1%	-39%	6%	0%	-13%	-57%	-52%	-100%	0%	33%
HIV Infection										
FY19 Inpatient Discharges rate per 100,000	44	7	32	0	0	0	69	0	59	0
Change in Inpatient Discharge Rate FY17 to FY19	2%	0%	0%	-100%	-100%	0%	0%	0%	100%	0%
FY19 ED Volume rate per 100,000	102	7	21	0	56	0	175	0	29	52
Change in ED Volume Rate FY17 to FY19	11%	-75%	-33%	-100%	0%	0%	-3%	0%	0%	0%
Infections										
FY19 Inpatient Discharges rate per 100,000	1,534	1,890	2,091	625	1,640	1,321	2,838	347	1,876	1,142
Change in Inpatient Discharge Rate FY17 to FY19	2%	25%	44%	-36%	0%	0%	28%	-50%	0%	-19%
FY19 ED Volume rate per 100,000	5,547	4,248	3,549	2,232	7,205	2,767	8,750	1,871	2,228	3,790
Change in ED Volume Rate FY17 to FY19	-6%	-5%	-9%	-31%	-17%	5%	6%	23%	-28%	14%

Injuries										
FY19 Inpatient Discharges rate per 100,000	1,103	1,409	1,115	1,071	1,550	1,171	1,507	347	1,055	1,610
Change in Inpatient Discharge Rate FY17 to FY19	5%	12%	-8%	300%	23%	38%	18%	-62%	-45%	63%
FY19 ED Volume rate per 100,000	7,762	6,426	5,201	3,571	9,045	5,035	11,586	2,079	5,101	4,933
Change in ED Volume Rate FY17 to FY19	-4%	-15%	-17%	-20%	-14%	-20%	-3%	-40%	-31%	2%
Poisonings										
FY19 Inpatient Discharges rate per 100,000	189	347	161	0	390	249	235	139	381	208
Change in Inpatient Discharge Rate FY17 to FY19	-7%	0%	-12%	-100%	3%	-33%	-38%	0%	333%	0%
FY19 ED Volume rate per 100,000	693	561	547	89	1,249	523	1,027	347	880	519
Change in ED Volume Rate FY17 to FY19	-8%	-36%	-12%	-83%	33%	-19%	1%	150%	43%	-23%
Pneumonia/Influenza										
FY19 Inpatient Discharges rate per 100,000	286	401	268	268	457	449	408	69	293	467
Change in Inpatient Discharge Rate FY17 to FY19	8%	62%	-14%	-25%	17%	200%	8%	-50%	-44%	50%
FY19 ED Volume rate per 100,000	588	588	429	179	625	224	1,045	277	176	156
Change in ED Volume Rate FY17 to FY19	27%	42%	21%	-50%	-20%	-31%	58%	100%	-50%	0%
Sexually Transmitted Diseases										
FY19 Inpatient Discharges rate per 100,000	80	114	75	0	100	75	98	69	88	52
Change in Inpatient Discharge Rate FY17 to FY19	-9%	42%	0%	-100%	200%	200%	-23%	0%	0%	0%
FY19 ED Volume rate per 100,000	262	60	32	0	123	25	364	0	0	156
Change in ED Volume Rate FY17 to FY19	15%	-18%	-63%	-100%	10%	-50%	18%	0%	-100%	200%
Tuberculosis										
FY19 Inpatient Discharges rate per 100,000	9	0	0	0	11	0	14	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	-100%	0%	0%	0%	25%	0%	-100%	0%
FY19 ED Volume rate per 100,000	5	13	0	0	0	0	9	0	29	0
Change in ED Volume Rate FY17 to FY19	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%
Other										
Dementia and Cognitive Disorders										
FY19 Inpatient Discharges rate per 100,000	177	234	247	0	212	324	290	69	176	312
Change in Inpatient Discharge Rate FY17 to FY19	9%	25%	53%	0%	46%	117%	74%	0%	-25%	200%
FY19 ED Volume rate per 100,000	201	160	129	89	290	125	175	0	176	208
Change in ED Volume Rate FY17 to FY19	-11%	-45%	-52%	0%	-16%	0%	-43%	-100%	-40%	33%
Mental Health										
FY19 Inpatient Discharges rate per 100,000	4,382	5,625	4,825	2,411	6,034	4,786	6,383	2,633	4,749	3,167
Change in Inpatient Discharge Rate FY17 to FY19	5%	-6%	7%	8%	25%	-4%	15%	81%	64%	56%
FY19 ED Volume rate per 100,000	7,907	13,153	8,310	7,054	22,150	8,774	10,280	6,376	5,189	11,630
Change in ED Volume Rate FY17 to FY19	16%	12%	16%	18%	11%	-10%	30%	8%	4%	24%
Parkinsons and Movement Disorders										
FY19 Inpatient Discharges rate per 100,000	41	53	54	89	78	75	26	0	29	0
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-11%	25%	0%	40%	50%	-25%	0%	0%	0%
FY19 ED Volume rate per 100,000	95	94	118	0	145	150	92	69	29	104
Change in ED Volume Rate FY17 to FY19	-4%	100%	175%	0%	30%	200%	-26%	0%	0%	100%
Substance Use Disorders										
FY19 Inpatient Discharges rate per 100,000	2,012	2,438	1,759	1,161	3,469	1,820	2,744	762	2,111	2,492
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-8%	-1%	30%	6%	-12%	-3%	-15%	18%	60%
FY19 ED Volume rate per 100,000	8,347	9,232	5,951	3,661	16,529	5,708	14,795	2,772	4,749	7,996
Change in ED Volume Rate FY17 to FY19	0%	-7%	-5%	-25%	-6%	-15%	11%	-9%	-16%	32%
Complication of Medical Care										
FY19 Inpatient Discharges rate per 100,000	2,698	2,879	2,681	1,964	2,911	2,293	4,319	1,663	1,906	2,233
Change in Inpatient Discharge Rate FY17 to FY19	5%	6%	-8%	5%	23%	-12%	8%	20%	-10%	65%
FY19 ED Volume rate per 100,000	582	421	686	89	524	224	1,002	139	235	260
Change in ED Volume Rate FY17 to FY19	14%	-9%	42%	0%	0%	-18%	34%	-50%	0%	-38%

Community Health Needs Assessment - Beverly & Addison Gilbert Hospital

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

		Beverly & Addison Gilbert Hospital Community Benefits Service Area								
	MA	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport
All Cause										
FY19 Inpatient Discharges (all cause) rate per 100,000	9,762	12,315	10,707	6,387	11,730	8,659	13,203	6,350	9,632	9,252
Change in Inpatient Discharge Rate FY17 to FY19	0%	-16%	-1%	6%	-7%	-3%	-1%	14%	0%	6%
FY19 ED Volume (all cause) rate per 100,000	24,003	25,291	17,594	13,123	27,096	13,707	36,973	12,251	13,280	18,594
Change in ED Volume Rate FY17 to FY19	2%	3%	2%	-12%	-10%	0%	11%	11%	-2%	-3%
Cancer										
Breast Cancer										
FY19 Inpatient Discharges rate per 100,000	258	596	131	612	167	417	236	64	401	272
Change in Inpatient Discharge Rate FY17 to FY19	-5%	83%	-59%	250%	-62%	13%	-18%	-75%	120%	-33%
FY19 ED Volume rate per 100,000	195	373	131	87	456	232	360	192	255	181
Change in ED Volume Rate FY17 to FY19	18%	3%	-21%	0%	0%	43%	65%	0%	0%	-43%
Colorectal Cancer										
FY19 Inpatient Discharges rate per 100,000	116	75	84	0	156	93	107	321	219	136
Change in Inpatient Discharge Rate FY17 to FY19	0%	-43%	-36%	0%	75%	300%	-14%	150%	20%	200%
FY19 ED Volume rate per 100,000	27	28	12	0	44	0	13	0	36	91
Change in ED Volume Rate FY17 to FY19	12%	50%	-67%	0%	300%	-100%	-40%	0%	-50%	100%
GYN Cancer										
FY19 Inpatient Discharges rate per 100,000	182	261	95	175	245	324	298	192	0	227
Change in Inpatient Discharge Rate FY17 to FY19	-3%	12%	-33%	0%	-21%	75%	-22%	0%	-100%	0%
FY19 ED Volume rate per 100,000	82	121	84	87	211	46	129	64	0	181
Change in ED Volume Rate FY17 to FY19	21%	-38%	40%	0%	-41%	-33%	142%	0%	-100%	-43%
Lung Cancer										
FY19 Inpatient Discharges rate per 100,000	358	438	370	787	200	232	467	770	547	227
Change in Inpatient Discharge Rate FY17 to FY19	5%	4%	-3%	200%	-54%	-23%	12%	0%	50%	67%
FY19 ED Volume rate per 100,000	97	28	143	87	145	116	142	257	36	181
Change in ED Volume Rate FY17 to FY19	21%	-79%	300%	0%	-24%	150%	28%	300%	0%	0%
Prostate Cancer										
FY19 Inpatient Discharges rate per 100,000	133	121	119	0	133	69	173	257	182	91
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-28%	67%	0%	-33%	-25%	34%	33%	0%	0%
FY19 ED Volume rate per 100,000	60	56	12	350	78	23	116	192	73	136
Change in ED Volume Rate FY17 to FY19	30%	-50%	-80%	300%	-13%	0%	117%	50%	0%	200%
Other Cancer										
FY19 Inpatient Discharges rate per 100,000	1,984	2,012	2,089	2,012	2,335	2,107	2,524	3,079	2,080	1,769
Change in Inpatient Discharge Rate FY17 to FY19	3%	-28%	-6%	156%	-2%	30%	28%	300%	21%	179%
FY19 ED Volume rate per 100,000	597	885	788	700	1,434	926	827	1,411	438	635
Change in ED Volume Rate FY17 to FY19	27%	-14%	38%	-53%	6%	18%	74%	83%	33%	-33%
Chronic Disease										
Asthma										
FY19 Inpatient Discharges rate per 100,000	1,051	1,565	1,110	612	1,134	1,042	1,760	706	547	1,270
Change in Inpatient Discharge Rate FY17 to FY19	-17%	-30%	-24%	0%	-18%	-24%	0%	38%	-59%	65%
FY19 ED Volume rate per 100,000	1,944	3,027	1,695	1,225	3,247	1,528	3,542	898	803	2,358
Change in ED Volume Rate FY17 to FY19	0%	-1%	5%	-44%	-16%	32%	89%	0%	-24%	-15%
Congestive Heart Failure										
FY19 Inpatient Discharges rate per 100,000	1,292	1,714	1,707	525	1,468	810	1,964	321	1,350	862
Change in Inpatient Discharge Rate FY17 to FY19	10%	0%	35%	500%	6%	13%	14%	-38%	76%	-14%
FY19 ED Volume rate per 100,000	396	456	346	0	500	255	880	64	292	408
Change in ED Volume Rate FY17 to FY19	41%	36%	12%	-100%	10%	57%	90%	-50%	60%	0%

COPD and Lung Disease										
FY19 Inpatient Discharges rate per 100,000	1,994	3,232	2,423	1,050	2,991	1,621	3,173	257	1,678	1,587
Change in Inpatient Discharge Rate FY17 to FY19	1%	9%	29%	50%	1%	13%	11%	33%	-4%	-29%
FY19 ED Volume rate per 100,000	1,388	2,972	1,098	875	3,625	857	2,173	192	766	1,497
Change in ED Volume Rate FY17 to FY19	10%	41%	8%	43%	18%	12%	35%	0%	-25%	22%
Diabetes Mellitus										
FY19 Inpatient Discharges rate per 100,000	2,808	3,586	2,948	1,137	2,980	2,408	4,742	962	2,481	2,041
Change in Inpatient Discharge Rate FY17 to FY19	3%	-3%	6%	8%	-12%	11%	5%	88%	48%	7%
FY19 ED Volume rate per 100,000	4,109	4,816	2,877	1,400	4,158	1,297	8,532	641	1,715	1,859
Change in ED Volume Rate FY17 to FY19	10%	11%	16%	-20%	-4%	-19%	43%	-38%	2%	-15%
Heart Disease										
FY19 Inpatient Discharges rate per 100,000	3,609	5,254	4,739	1,925	5,126	3,334	5,293	1,860	3,393	3,583
Change in Inpatient Discharge Rate FY17 to FY19	4%	-11%	30%	0%	8%	21%	8%	-3%	19%	22%
FY19 ED Volume rate per 100,000	1,448	2,059	1,420	962	2,969	903	2,964	1,155	730	1,542
Change in ED Volume Rate FY17 to FY19	17%	15%	-15%	-61%	0%	-32%	83%	38%	-17%	-23%
Hypertension										
FY19 Inpatient Discharges rate per 100,000	4,045	5,738	4,213	2,712	5,370	3,265	5,715	2,566	3,393	4,354
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-11%	1%	11%	-8%	-22%	1%	21%	-19%	12%
FY19 ED Volume rate per 100,000	7,878	8,971	5,658	4,024	10,140	4,445	13,380	3,207	4,341	6,213
Change in ED Volume Rate FY17 to FY19	10%	-1%	-2%	-8%	-8%	-4%	27%	0%	-3%	-1%
Liver Disease										
FY19 Inpatient Discharges rate per 100,000	1,562	2,571	1,922	1,312	1,890	1,227	2,177	1,860	1,350	1,678
Change in Inpatient Discharge Rate FY17 to FY19	5%	-19%	30%	-12%	-6%	-44%	8%	38%	-51%	147%
FY19 ED Volume rate per 100,000	404	1,006	418	700	1,123	324	284	513	657	952
Change in ED Volume Rate FY17 to FY19	19%	3%	6%	167%	23%	0%	-12%	60%	38%	-16%
Obesity										
FY19 Inpatient Discharges rate per 100,000	2,410	3,335	2,542	962	2,735	2,130	3,493	834	2,444	2,041
Change in Inpatient Discharge Rate FY17 to FY19	5%	1%	7%	-8%	-12%	16%	11%	-28%	26%	13%
FY19 ED Volume rate per 100,000	675	1,127	633	262	2,024	486	480	321	182	726
Change in ED Volume Rate FY17 to FY19	17%	12%	-24%	-73%	3%	-16%	-48%	0%	-55%	-43%
Stroke and Other Neurovascular Diseases										
FY19 Inpatient Discharges rate per 100,000	443	484	477	262	322	417	635	128	511	499
Change in Inpatient Discharge Rate FY17 to FY19	2%	-4%	3%	0%	-42%	-14%	13%	-60%	40%	-15%
FY19 ED Volume rate per 100,000	119	205	131	350	133	93	120	64	36	91
Change in ED Volume Rate FY17 to FY19	6%	83%	22%	-20%	-25%	-20%	-4%	0%	-86%	-60%
Injuries and Infections										
Allergy										
FY19 Inpatient Discharges rate per 100,000	1,314	1,816	1,850	1,137	1,701	1,065	2,533	706	2,043	1,859
Change in Inpatient Discharge Rate FY17 to FY19	20%	34%	63%	333%	1%	-2%	104%	-15%	115%	32%
FY19 ED Volume rate per 100,000	4,000	5,952	6,111	3,850	7,160	4,006	16,158	3,335	4,305	6,259
Change in ED Volume Rate FY17 to FY19	59%	190%	433%	159%	74%	92%	982%	225%	307%	55%
Hepatitis										
FY19 Inpatient Discharges rate per 100,000	492	736	513	175	878	69	1,169	641	547	136
Change in Inpatient Discharge Rate FY17 to FY19	-19%	-14%	8%	-60%	-15%	-63%	-1%	0%	-40%	-70%
FY19 ED Volume rate per 100,000	211	717	239	262	1,090	139	76	192	109	91
Change in ED Volume Rate FY17 to FY19	-11%	79%	11%	0%	-25%	-40%	-70%	0%	-57%	-82%
HIV Infection										
FY19 Inpatient Discharges rate per 100,000	157	47	24	0	178	0	262	0	36	0
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-58%	-67%	0%	33%	-100%	-14%	-100%	0%	-100%
FY19 ED Volume rate per 100,000	236	112	12	0	89	46	400	0	0	45
Change in ED Volume Rate FY17 to FY19	-3%	-14%	-80%	0%	-73%	0%	14%	0%	-100%	-50%
Infections										
FY19 Inpatient Discharges rate per 100,000	3,824	5,384	4,786	2,012	4,659	4,052	5,693	2,437	3,283	3,039
Change in Inpatient Discharge Rate FY17 to FY19	3%	7%	-2%	0%	9%	38%	11%	81%	-4%	18%
FY19 ED Volume rate per 100,000	3,618	3,018	2,196	2,275	4,058	2,848	4,999	1,283	1,715	3,039
Change in ED Volume Rate FY17 to FY19	-4%	-19%	6%	-21%	-19%	31%	-1%	-20%	-13%	5%

Injuries										
FY19 Inpatient Discharges rate per 100,000	3,425	4,583	4,452	2,712	4,136	3,450	4,897	2,373	4,451	3,719
Change in Inpatient Discharge Rate FY17 to FY19	6%	-4%	-1%	11%	-10%	16%	18%	85%	51%	17%
FY19 ED Volume rate per 100,000	7,959	8,803	6,386	6,124	9,506	4,191	11,212	5,516	5,837	6,531
Change in ED Volume Rate FY17 to FY19	-2%	4%	-2%	-5%	-12%	-34%	-6%	12%	3%	-12%
Poisonings										
FY19 Inpatient Discharges rate per 100,000	232	373	310	350	389	208	316	128	182	363
Change in Inpatient Discharge Rate FY17 to FY19	-7%	54%	-21%	300%	13%	-10%	-30%	100%	67%	33%
FY19 ED Volume rate per 100,000	395	298	418	262	612	301	573	385	146	227
Change in ED Volume Rate FY17 to FY19	5%	-27%	25%	50%	31%	8%	0%	200%	0%	-17%
Pneumonia/Influenza										
FY19 Inpatient Discharges rate per 100,000	1,135	1,472	1,420	875	1,368	1,158	1,569	449	1,204	590
Change in Inpatient Discharge Rate FY17 to FY19	8%	-5%	-2%	67%	-3%	61%	11%	0%	94%	8%
FY19 ED Volume rate per 100,000	555	661	382	787	523	301	1,035	385	109	227
Change in ED Volume Rate FY17 to FY19	11%	45%	28%	125%	21%	8%	68%	50%	-63%	-50%
Sexually Transmitted Diseases										
FY19 Inpatient Discharges rate per 100,000	24	19	60	0	0	23	44	192	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-50%	150%	0%	-100%	-50%	67%	0%	0%	0%
FY19 ED Volume rate per 100,000	38	37	0	0	0	0	67	0	73	0
Change in ED Volume Rate FY17 to FY19	5%	300%	-100%	0%	-100%	-100%	50%	0%	0%	0%
Tuberculosis										
FY19 Inpatient Discharges rate per 100,000	18	19	0	0	22	0	53	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	0%	0%	0%	0%	71%	0%	0%	0%
FY19 ED Volume rate per 100,000	6	0	0	0	0	0	9	0	0	0
Change in ED Volume Rate FY17 to FY19	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other										
Dementia and Cognitive Disorders										
FY19 Inpatient Discharges rate per 100,000	868	1,425	1,504	700	934	764	1,289	706	730	363
Change in Inpatient Discharge Rate FY17 to FY19	10%	20%	45%	100%	8%	65%	41%	38%	-13%	-43%
FY19 ED Volume rate per 100,000	325	345	442	175	300	116	298	64	73	272
Change in ED Volume Rate FY17 to FY19	-5%	12%	48%	-33%	-33%	-55%	-14%	0%	-60%	-54%
Mental Health										
FY19 Inpatient Discharges rate per 100,000	7,268	11,020	8,797	4,112	9,017	6,390	14,256	5,196	5,910	5,442
Change in Inpatient Discharge Rate FY17 to FY19	4%	-6%	1%	7%	1%	15%	35%	125%	12%	-10%
FY19 ED Volume rate per 100,000	6,209	13,945	6,613	6,212	16,366	5,256	10,434	3,464	3,831	11,111
Change in ED Volume Rate FY17 to FY19	17%	32%	8%	-16%	-1%	19%	74%	-7%	44%	7%
Parkinsons and Movement Disorders										
FY19 Inpatient Discharges rate per 100,000	252	363	346	175	245	324	244	128	219	227
Change in Inpatient Discharge Rate FY17 to FY19	8%	63%	7%	0%	-35%	40%	4%	-50%	0%	-44%
FY19 ED Volume rate per 100,000	185	242	131	175	167	185	160	192	109	317
Change in ED Volume Rate FY17 to FY19	5%	13%	0%	100%	-38%	167%	-12%	200%	-50%	40%
Substance Use Disorders										
FY19 Inpatient Discharges rate per 100,000	3,820	5,673	3,426	2,712	5,682	3,404	5,813	2,053	2,627	3,129
Change in Inpatient Discharge Rate FY17 to FY19	0%	-17%	0%	19%	-2%	4%	-8%	19%	-14%	-3%
FY19 ED Volume rate per 100,000	7,619	10,964	4,715	3,937	12,041	4,584	13,114	1,604	3,502	5,351
Change in ED Volume Rate FY17 to FY19	3%	14%	-9%	-24%	-9%	15%	3%	-38%	-8%	26%
Complication of Medical Care										
FY19 Inpatient Discharges rate per 100,000	1,870	2,906	2,745	1,400	1,979	1,922	2,733	706	2,481	1,587
Change in Inpatient Discharge Rate FY17 to FY19	7%	41%	23%	78%	6%	15%	13%	0%	31%	25%
FY19 ED Volume rate per 100,000	472	466	537	175	445	278	587	449	584	317
Change in ED Volume Rate FY17 to FY19	8%	-4%	36%	-33%	-2%	-8%	9%	600%	167%	40%

Community Health Needs Assessment - Beverly & Addison Gilbert Hospital

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

		Beverly & Addison Gilbert Hospital Community Benefits Service Area								
	MA	Beverly	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Middleton	Rockport
All Cause										
FY19 Inpatient Discharges (all cause) rate per 100,000	25,473	31,211	32,162	23,238	27,171	23,600	28,561	21,429	25,299	25,604
Change in Inpatient Discharge Rate FY17 to FY19	5%	-10%	-3%	13%	4%	3%	10%	-19%	15%	5%
FY19 ED Volume (all cause) rate per 100,000	26,010	27,497	27,052	16,188	28,788	19,898	30,169	17,744	23,474	26,925
Change in ED Volume Rate FY17 to FY19	10%	-3%	13%	15%	13%	2%	20%	-5%	16%	8%
Cancer										
Breast Cancer										
FY19 Inpatient Discharges rate per 100,000	1,253	2,174	2,236	1,828	1,490	1,385	1,482	1,955	1,510	1,595
Change in Inpatient Discharge Rate FY17 to FY19	6%	11%	40%	100%	48%	44%	35%	-19%	26%	84%
FY19 ED Volume rate per 100,000	480	1,139	655	653	1,362	662	700	1,278	378	911
Change in ED Volume Rate FY17 to FY19	42%	69%	32%	67%	57%	38%	194%	143%	-33%	-33%
Colorectal Cancer										
FY19 Inpatient Discharges rate per 100,000	271	142	287	522	255	120	298	75	378	410
Change in Inpatient Discharge Rate FY17 to FY19	2%	-27%	38%	0%	-10%	100%	11%	-67%	50%	-25%
FY19 ED Volume rate per 100,000	42	39	0	0	57	60	30	75	0	46
Change in ED Volume Rate FY17 to FY19	9%	0%	0%	-100%	300%	100%	-43%	0%	-100%	-50%
GYN Cancer										
FY19 Inpatient Discharges rate per 100,000	508	1,087	830	522	738	692	536	977	126	1,093
Change in Inpatient Discharge Rate FY17 to FY19	6%	83%	21%	33%	21%	156%	33%	225%	-60%	140%
FY19 ED Volume rate per 100,000	145	518	112	131	525	271	179	526	189	410
Change in ED Volume Rate FY17 to FY19	47%	67%	-50%	0%	28%	50%	300%	250%	-25%	-10%
Lung Cancer										
FY19 Inpatient Discharges rate per 100,000	1,347	1,579	1,868	1,958	1,688	1,023	1,809	1,053	2,266	1,185
Change in Inpatient Discharge Rate FY17 to FY19	9%	11%	38%	25%	12%	-11%	8%	27%	29%	0%
FY19 ED Volume rate per 100,000	282	336	240	653	610	241	328	301	629	273
Change in ED Volume Rate FY17 to FY19	26%	8%	-21%	400%	79%	100%	-10%	33%	67%	-57%
Prostate Cancer										
FY19 Inpatient Discharges rate per 100,000	1,270	1,527	1,501	1,175	1,802	1,505	1,571	1,203	1,762	1,230
Change in Inpatient Discharge Rate FY17 to FY19	6%	16%	-6%	-25%	32%	16%	20%	-24%	27%	-4%
FY19 ED Volume rate per 100,000	434	621	639	261	1,121	391	834	752	503	1,002
Change in ED Volume Rate FY17 to FY19	36%	17%	11%	-50%	13%	-24%	138%	-9%	-38%	0%
Other Cancer										
FY19 Inpatient Discharges rate per 100,000	7,146	9,860	9,709	5,875	8,740	7,556	9,322	7,293	7,804	11,526
Change in Inpatient Discharge Rate FY17 to FY19	13%	4%	19%	-24%	13%	13%	40%	-16%	3%	35%
FY19 ED Volume rate per 100,000	1,519	3,533	3,066	1,697	3,661	2,137	2,606	3,083	1,322	4,738
Change in ED Volume Rate FY17 to FY19	33%	8%	71%	8%	-2%	-3%	167%	21%	-13%	9%
Chronic Disease										
Asthma										
FY19 Inpatient Discharges rate per 100,000	1,596	2,549	2,363	1,958	1,632	1,957	2,546	2,256	1,825	2,050
Change in Inpatient Discharge Rate FY17 to FY19	-16%	-26%	-19%	36%	-29%	7%	9%	-25%	81%	-8%
FY19 ED Volume rate per 100,000	1,257	2,057	1,405	522	1,816	1,535	1,690	1,053	1,510	1,822
Change in ED Volume Rate FY17 to FY19	8%	-6%	-18%	-60%	4%	34%	77%	-22%	20%	-35%
Congestive Heart Failure										
FY19 Inpatient Discharges rate per 100,000	8,161	10,223	11,450	7,572	7,889	7,134	10,297	4,586	6,797	6,014
Change in Inpatient Discharge Rate FY17 to FY19	9%	-7%	8%	32%	15%	40%	30%	-37%	2%	10%
FY19 ED Volume rate per 100,000	1,705	2,329	2,938	1,305	2,043	1,204	3,626	1,203	1,510	1,959
Change in ED Volume Rate FY17 to FY19	34%	21%	32%	43%	-7%	-7%	195%	7%	20%	19%

COPD and Lung Disease										
FY19 Inpatient Discharges rate per 100,000	7,130	10,831	8,879	6,658	10,216	5,599	10,223	4,662	7,678	6,788
Change in Inpatient Discharge Rate FY17 to FY19	5%	4%	-6%	38%	12%	18%	23%	-29%	15%	17%
FY19 ED Volume rate per 100,000	2,422	4,244	2,827	3,133	4,299	1,445	3,127	1,429	2,140	2,551
Change in ED Volume Rate FY17 to FY19	18%	-5%	7%	118%	-2%	-38%	28%	-14%	10%	12%
Diabetes Mellitus										
FY19 Inpatient Discharges rate per 100,000	8,376	9,821	10,172	6,527	8,116	6,291	12,456	4,511	9,062	6,014
Change in Inpatient Discharge Rate FY17 to FY19	5%	-12%	7%	32%	1%	14%	24%	-31%	37%	33%
FY19 ED Volume rate per 100,000	5,867	5,836	5,541	3,133	5,732	3,251	9,925	2,481	4,657	4,784
Change in ED Volume Rate FY17 to FY19	18%	-10%	-1%	-11%	14%	-11%	37%	-15%	21%	57%
Heart Disease										
FY19 Inpatient Discharges rate per 100,000	18,344	24,521	26,190	19,321	23,851	19,597	23,394	13,835	19,320	20,866
Change in Inpatient Discharge Rate FY17 to FY19	6%	0%	13%	32%	10%	39%	24%	-27%	29%	9%
FY19 ED Volume rate per 100,000	3,975	7,169	6,883	3,264	9,506	3,763	5,703	3,759	4,594	8,109
Change in ED Volume Rate FY17 to FY19	16%	-10%	11%	0%	10%	-13%	43%	-21%	-20%	12%
Hypertension										
FY19 Inpatient Discharges rate per 100,000	10,397	12,526	11,865	8,355	11,365	9,151	11,347	9,248	11,768	11,800
Change in Inpatient Discharge Rate FY17 to FY19	-1%	-14%	-12%	-3%	-2%	-20%	3%	-19%	18%	0%
FY19 ED Volume rate per 100,000	12,665	13,238	13,111	8,355	14,586	9,753	14,965	8,872	11,454	15,216
Change in ED Volume Rate FY17 to FY19	14%	-12%	0%	23%	1%	5%	17%	-6%	-4%	11%
Liver Disease										
FY19 Inpatient Discharges rate per 100,000	1,956	2,264	2,443	1,567	1,816	2,107	2,338	1,504	1,573	1,686
Change in Inpatient Discharge Rate FY17 to FY19	16%	-15%	25%	9%	6%	8%	15%	-44%	-17%	-35%
FY19 ED Volume rate per 100,000	258	932	383	261	766	271	171	602	252	774
Change in ED Volume Rate FY17 to FY19	36%	13%	100%	-33%	54%	-10%	28%	14%	-20%	6%
Obesity										
FY19 Inpatient Discharges rate per 100,000	3,869	4,749	4,455	2,480	4,441	2,679	5,510	2,406	3,839	2,870
Change in Inpatient Discharge Rate FY17 to FY19	14%	-5%	2%	58%	11%	24%	26%	-20%	39%	24%
FY19 ED Volume rate per 100,000	367	556	447	261	1,334	211	253	75	629	866
Change in ED Volume Rate FY17 to FY19	26%	-37%	8%	0%	-9%	-42%	-44%	-75%	0%	138%
Stroke and Other Neurovascular Diseases										
FY19 Inpatient Discharges rate per 100,000	2,064	2,057	2,395	522	1,986	1,204	2,040	2,180	2,014	2,187
Change in Inpatient Discharge Rate FY17 to FY19	5%	-16%	-9%	-56%	-7%	-47%	1%	45%	-6%	14%
FY19 ED Volume rate per 100,000	380	634	607	131	355	421	253	677	252	866
Change in ED Volume Rate FY17 to FY19	10%	58%	36%	-67%	-29%	-7%	-26%	0%	-50%	111%
Injuries and Infections										
Allergy										
FY19 Inpatient Discharges rate per 100,000	3,711	5,538	6,324	3,264	5,136	3,462	6,827	3,985	4,091	5,604
Change in Inpatient Discharge Rate FY17 to FY19	32%	29%	88%	67%	34%	21%	195%	56%	117%	98%
FY19 ED Volume rate per 100,000	5,138	7,039	9,965	4,439	9,109	6,261	16,648	3,609	9,188	8,838
Change in ED Volume Rate FY17 to FY19	88%	179%	634%	209%	185%	160%	2136%	167%	943%	126%
Hepatitis										
FY19 Inpatient Discharges rate per 100,000	273	362	208	0	170	452	685	226	126	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	18%	0%	-14%	88%	30%	-73%	-67%	-100%
FY19 ED Volume rate per 100,000	70	349	0	131	312	30	22	150	0	46
Change in ED Volume Rate FY17 to FY19	36%	-44%	-100%	0%	0%	-50%	-25%	-33%	-100%	0%
HIV Infection										
FY19 Inpatient Discharges rate per 100,000	53	65	0	0	43	30	60	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	2%	-17%	-100%	-100%	-50%	0%	-50%	0%	0%	0%
FY19 ED Volume rate per 100,000	47	0	16	131	99	30	156	0	0	0
Change in ED Volume Rate FY17 to FY19	34%	-100%	0%	0%	0%	0%	320%	0%	-100%	0%
Infections										
FY19 Inpatient Discharges rate per 100,000	12,591	15,942	18,253	9,922	11,975	11,349	15,092	8,346	8,936	11,526
Change in Inpatient Discharge Rate FY17 to FY19	6%	-9%	9%	31%	9%	16%	26%	-22%	-5%	32%
FY19 ED Volume rate per 100,000	4,213	4,361	3,897	3,264	5,746	2,890	4,147	2,481	3,902	6,697
Change in ED Volume Rate FY17 to FY19	3%	-1%	7%	25%	13%	10%	19%	-13%	41%	37%

Injuries										
FY19 Inpatient Discharges rate per 100,000	11,877	16,369	19,690	13,446	13,663	13,727	18,450	9,925	11,517	13,485
Change in Inpatient Discharge Rate FY17 to FY19	15%	-8%	13%	34%	6%	5%	54%	-21%	3%	10%
FY19 ED Volume rate per 100,000	10,393	13,833	15,474	8,094	16,075	10,325	10,409	8,346	9,125	14,897
Change in ED Volume Rate FY17 to FY19	11%	-6%	18%	22%	27%	10%	5%	-23%	5%	18%
Poisonings										
FY19 Inpatient Discharges rate per 100,000	281	336	367	131	582	90	357	150	315	273
Change in Inpatient Discharge Rate FY17 to FY19	7%	-7%	-23%	0%	64%	-63%	-4%	-82%	150%	-40%
FY19 ED Volume rate per 100,000	185	272	128	131	156	271	253	75	315	137
Change in ED Volume Rate FY17 to FY19	27%	110%	-20%	0%	57%	350%	17%	0%	67%	-25%
Pneumonia/Influenza										
FY19 Inpatient Discharges rate per 100,000	4,188	5,732	5,733	3,264	4,413	3,311	5,122	2,632	3,272	2,825
Change in Inpatient Discharge Rate FY17 to FY19	0%	0%	-13%	9%	16%	7%	16%	-22%	-9%	-23%
FY19 ED Volume rate per 100,000	569	466	383	131	582	211	730	827	315	547
Change in ED Volume Rate FY17 to FY19	1%	-14%	-25%	0%	64%	-22%	26%	120%	-44%	-8%
Sexually Transmitted Diseases										
FY19 Inpatient Discharges rate per 100,000	30	39	16	0	28	0	52	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	9%	-25%	-50%	0%	100%	-100%	17%	0%	0%	0%
FY19 ED Volume rate per 100,000	5	0	0	0	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	0%	0%	0%	-100%	0%	0%	0%
Tuberculosis										
FY19 Inpatient Discharges rate per 100,000	52	129	48	131	28	30	127	0	0	46
Change in Inpatient Discharge Rate FY17 to FY19	-11%	43%	50%	0%	0%	-50%	21%	0%	0%	0%
FY19 ED Volume rate per 100,000	6	13	0	0	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	13%	0%	0%	0%	-100%	0%	-100%	0%	0%	0%
Other										
Dementia and Cognitive Disorders										
FY19 Inpatient Discharges rate per 100,000	6,264	7,790	9,661	5,091	6,002	4,756	6,686	4,060	3,335	4,875
Change in Inpatient Discharge Rate FY17 to FY19	6%	-13%	-13%	50%	14%	-18%	29%	-4%	-32%	-4%
FY19 ED Volume rate per 100,000	2,053	2,252	5,318	653	2,171	2,077	1,787	1,203	1,322	2,278
Change in ED Volume Rate FY17 to FY19	11%	-32%	17%	-17%	16%	10%	52%	14%	-13%	-4%
Mental Health										
FY19 Inpatient Discharges rate per 100,000	10,900	15,606	16,225	9,138	12,883	9,241	18,055	8,797	10,132	12,118
Change in Inpatient Discharge Rate FY17 to FY19	15%	-7%	1%	46%	10%	1%	65%	-17%	16%	2%
FY19 ED Volume rate per 100,000	3,500	10,210	6,867	3,916	10,570	4,726	4,996	6,165	2,769	8,656
Change in ED Volume Rate FY17 to FY19	35%	21%	31%	67%	31%	26%	131%	26%	-15%	24%
Parkinsons and Movement Disorders										
FY19 Inpatient Discharges rate per 100,000	1,523	1,630	1,980	2,089	2,341	1,325	1,325	2,030	1,196	2,597
Change in Inpatient Discharge Rate FY17 to FY19	10%	-26%	-31%	78%	6%	-2%	27%	29%	-44%	78%
FY19 ED Volume rate per 100,000	602	712	1,006	1,044	568	602	432	376	315	1,230
Change in ED Volume Rate FY17 to FY19	11%	-23%	5%	0%	-7%	5%	-8%	-64%	-44%	8%
Substance Use Disorders										
FY19 Inpatient Discharges rate per 100,000	2,956	4,309	3,258	2,742	4,100	2,739	4,393	2,857	2,958	2,232
Change in Inpatient Discharge Rate FY17 to FY19	13%	-5%	0%	50%	4%	0%	16%	-21%	24%	-25%
FY19 ED Volume rate per 100,000	2,258	3,675	2,044	2,219	3,859	1,385	3,872	1,880	2,077	1,458
Change in ED Volume Rate FY17 to FY19	22%	0%	52%	55%	33%	-16%	33%	4%	50%	-16%
Complication of Medical Care										
FY19 Inpatient Discharges rate per 100,000	4,867	6,755	6,308	3,525	5,675	4,816	6,619	4,135	5,538	5,194
Change in Inpatient Discharge Rate FY17 to FY19	13%	25%	23%	13%	44%	14%	38%	8%	24%	48%
FY19 ED Volume rate per 100,000	835	867	910	653	1,192	783	819	752	755	1,093
Change in ED Volume Rate FY17 to FY19	9%	-17%	-5%	150%	14%	-13%	45%	0%	-25%	-11%

Notes:

Population counts: Sg2 Claritas Demographic Data, 2021.

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

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

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

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

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

Community Health Survey

- BH/AGH Community Health Survey
  - Survey output
- Survey Distribution Channels

Beth Israel Lahey Health

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

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

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

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

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

Time in Community

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

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

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

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

Your Community

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
I feel like I belong in my community.	☐	☐	☐	☐	☐
Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.)	☐	☐	☐	☐	☐
My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play)	☐	☐	☐	☐	☐
My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support)	☐	☐	☐	☐	☐
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.).	☐	☐	☐	☐	☐

5. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

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

Social + Cultural Environment

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

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

Natural + Built Environment

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

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

Economic + Educational Environment

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

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

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

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

Health + Access to care

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

	True	Somewhat true	Not at all true	I don't know
Health care in my community meets the physical health needs of people like me.	☐	☐	☐	☐
Health care in my community meets the mental health needs of people like me.	☐	☐	☐	☐

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

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

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

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

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

_____

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

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

Experiences with Discrimination

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

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

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

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

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

_____

_____

_____

About You

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

17. What is your age?

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

18. What is your current gender identity?

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

19. What is your sexual orientation?

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

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

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

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

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

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

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

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

24. Are you currently:
- ☐ Employed full-time (40 hours or more per week)
- ☐ Employed part-time (Less than 40 hours per week)
- ☐ Self-employed (Full- or part-time)
- ☐ A stay at home parent
- ☐ A student (Full- or part-time)
- ☐ Unemployed
- ☐ Unable to work for health reasons
- ☐ Retired
- ☐ Other (specify_____)
- ☐ Prefer not to answer

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

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

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

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

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

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

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

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

First Name and Email or Phone:

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

Email:

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

Next
Back
Done

BH/AGH Community Health Survey Output

Response Counts

Completion Rate:	**100%**	
	Complete	1,339

Totals: 1,339

Note that two responses were removed in the data cleaning process.

1. Select a language.

Value	Percent	Responses
Take the survey in English	99.7%	1,326
参加简体中文调查	0.1%	1
Responda la encuesta en español	0.2%	3

Totals: 1,330

2. Please enter the zip code of the community in which you spend the most time.

Response
01930
01915
01966
01923
01938
01902
01929
01944
01904
01905
01949
01901
01965

3. How many years have you lived in the selected community?

Value	Percent	Responses
Less than 1 year	2.5%	33
1-5 years	18.7%	249
6-10 years	12.2%	162
Over 10 years but not all my life	45.1%	601
I have lived here all my life	19.3%	257
I used to live here, but not anymore	0.8%	11
I have never lived here	1.5%	20

Totals: 1,333

4. How many years have you worked in the selected community?

Value	Percent	Responses
Less than 1 year	3.6%	48
1-5 years	16.2%	213
6-10 years	10.5%	138
Over 10 years	33.2%	437
I do not work here	36.6%	482

Totals: 1,318

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
I feel like I belong in my community. Count Row %	35 2.6%	76 5.7%	645 48.8%	540 40.8%	26 2.0%	1,322
Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.) Count Row %	31 2.3%	112 8.5%	669 50.5%	500 37.8%	12 0.9%	1,324
My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play) Count Row %	25 1.9%	104 7.9%	556 42.2%	524 39.8%	109 8.3%	1,318
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 %	40 3.0%	183 13.8%	650 49.1%	389 29.4%	62 4.7%	1,324
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). Count Row %	20 1.5%	114 8.6%	697 52.9%	446 33.8%	41 3.1%	1,318
Totals Total Responses						1324

7. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

Value	Percent	Responses
Better access to good jobs	21.5%	285
Better access to health care	17.0%	226
Better access to healthy food	15.2%	202
Better access to internet	12.0%	159
Better access to public transportation	28.6%	380
Better parks and recreation	15.1%	201
Better roads	37.2%	494
Better schools	21.9%	291
Better sidewalks and trails	30.2%	401
Cleaner environment	17.4%	231
Lower crime and violence	8.9%	118
More affordable childcare	21.2%	281
More affordable housing	54.4%	722
More arts and cultural events	14.3%	190
More effective city services (like water, trash, fire department, and police)	11.1%	147
More inclusion for diverse members of the community	27.9%	370
Stronger community leadership	14.2%	189
Stronger sense of community	12.4%	165
Other	5.5%	73

8. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
There are people and/or organizations in my community that support me during times of stress and need. Count Row %	27 2.0%	150 11.3%	682 51.2%	252 18.9%	221 16.6%	1,332
I believe that all residents, including myself, can make the community a better place to live. Count Row %	10 0.7%	24 1.8%	619 46.4%	671 50.3%	10 0.7%	1,334
During COVID-19, information I need to stay healthy and safe has been readily available in my community. Count Row %	24 1.8%	64 4.8%	632 47.4%	584 43.8%	28 2.1%	1,332
During COVID-19, resources I need to stay healthy and safe have been readily available in my community. Count Row %	19 1.4%	109 8.2%	647 48.7%	507 38.1%	47 3.5%	1,329
Totals Total Responses						1334

9. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat True	Not At All True	Don't Know	Responses
My community feels safe. Count Row %	979 73.4%	324 24.3%	28 2.1%	2 0.2%	1,333
People like me have access to safe, clean parks and open spaces. Count Row %	985 73.9%	287 21.5%	45 3.4%	15 1.1%	1,332
People like me have access to reliable transportation. Count Row %	637 47.9%	507 38.1%	111 8.3%	75 5.6%	1,330
People like me have housing that is safe and good quality. Count Row %	788 59.4%	416 31.4%	82 6.2%	40 3.0%	1,326
The air in my community is healthy to breathe. Count Row %	963 72.2%	293 22.0%	26 1.9%	52 3.9%	1,334
The water in my community is safe to drink. Count Row %	759 57.2%	383 28.9%	89 6.7%	96 7.2%	1,327
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards. Count Row %	431 32.4%	532 40.0%	107 8.0%	260 19.5%	1,330
During extreme heat, people like me have access to options for staying cool. Count Row %	714 53.5%	390 29.2%	74 5.5%	156 11.7%	1,334
Totals Total Responses					1334

10. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat True	Not At All True	Don't Know	Responses
People like me have access to good local jobs with living wages and benefits. Count Row %	383 29.0%	561 42.4%	205 15.5%	173 13.1%	1,322
People like me have access to local investment opportunities, such as owning homes or businesses. Count Row %	387 29.2%	521 39.3%	320 24.1%	99 7.5%	1,327
Housing in my community is affordable for people with different income levels. Count Row %	100 7.5%	380 28.5%	761 57.2%	90 6.8%	1,331
People like me have access to affordable childcare services. Count Row %	117 8.9%	399 30.3%	320 24.3%	480 36.5%	1,316
People like me have access to good education for their children. Count Row %	628 47.8%	430 32.7%	69 5.3%	187 14.2%	1,314
Totals Total Responses					1331

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

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Responses
The built, economic, and educational environments in my community are impacted by **systemic racism.** This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row %	154 11.7%	219 16.6%	436 33.1%	344 26.1%	164 12.5%	1,317
The built, economic, and educational environments in my community are impacted by **individual racism.** This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row %	140 10.7%	248 18.9%	436 33.2%	386 29.4%	102 7.8%	1,312
Totals Total Responses						1317

12. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat True	Not at all True	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	706 53.2%	489 36.9%	78 5.9%	53 4.0%	1,326
Health care in my community meets the mental health needs of people like me. Count Row %	356 26.9%	442 33.5%	296 22.4%	227 17.2%	1,321
Totals Total Responses					1326

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

	I needed this type of care and was able to access it.	I needed this type of care but was not able to access it.	I did not need this type of care.	Responses
Routine medical care Count Row %	1,176 88.6%	62 4.7%	90 6.8%	1,328
Dental (mouth) care Count Row %	1,075 81.1%	124 9.4%	127 9.6%	1,326
Mental health care Count Row %	333 25.3%	219 16.6%	764 58.1%	1,316
Reproductive health care Count Row %	239 18.2%	36 2.7%	1,039 79.1%	1,314
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	60 4.6%	51 3.9%	1,204 91.6%	1,315
Treatment for a substance use disorder Count Row %	35 2.7%	21 1.6%	1,255 95.7%	1,311
Vision care Count Row %	847 64.2%	76 5.8%	397 30.1%	1,320
Medication for a chronic illness Count Row %	520 39.6%	44 3.4%	749 57.0%	1,313
Totals Total Responses				1328

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

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed	Responses
Routine medical care Count Row %	132 31.5%	68 16.2%	14 3.3%	61 14.6%	11 2.6%	1 0.2%	132 31.5%	419
Dental care Count Row %	116 26.9%	121 28.0%	10 2.3%	37 8.6%	10 2.3%	1 0.2%	137 31.7%	432
Mental health care Count Row %	32 7.6%	54 12.8%	11 2.6%	39 9.2%	19 4.5%	3 0.7%	264 62.6%	422
Reproductive health care Count Row %	28 9.5%	14 4.7%	9 3.0%	24 8.1%	10 3.4%	1 0.3%	210 70.9%	296
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	25 8.4%	28 9.5%	5 1.7%	13 4.4%	21 7.1%	4 1.4%	200 67.6%	296
Treatment for a substance use disorder Count Row %	25 9.3%	17 6.3%	6 2.2%	9 3.4%	11 4.1%	4 1.5%	196 73.1%	268
Vision care Count Row %	63 19.1%	54 16.4%	7 2.1%	22 6.7%	5 1.5%	0 0.0%	179 54.2%	330
Medication for a chronic illness Count Row %	39 13.5%	40 13.9%	4 1.4%	12 4.2%	8 2.8%	0 0.0%	185 64.2%	288

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed	Responses
Totals								
Total Responses								432

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

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Responses
Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row %	239 18.4%	255 19.6%	489 37.7%	213 16.4%	102 7.9%	1,298
Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row %	226 17.4%	275 21.2%	517 39.9%	224 17.3%	55 4.2%	1,297
Totals Total Responses						1298

17. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Responses
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise. Count Row %	1,055 84.6%	140 11.2%	37 3.0%	6 0.5%	2 0.2%	7 0.6%	1,247
You are unfairly stopped, searched, questioned, threatened, or abused by the police. Count Row %	1,213 94.6%	54 4.2%	12 0.9%	1 0.1%	0 0.0%	2 0.2%	1,282
You receive worse service than other people at stores, restaurants, or service providers. Count Row %	1,075 83.9%	106 8.3%	87 6.8%	7 0.5%	4 0.3%	3 0.2%	1,282
Landlords or realtors refused to rent or sell you an apartment or house. Count Row %	1,190 94.1%	50 4.0%	16 1.3%	3 0.2%	1 0.1%	4 0.3%	1,264
Healthcare providers treat you with less respect or provide worse services to you compared to other people. Count Row %	1,113 87.6%	96 7.6%	51 4.0%	5 0.4%	2 0.2%	4 0.3%	1,271
Totals Total Responses							1282

18. What do you think is the main reason for these experiences? You may select more than one.

Value	Percent	Responses
Ableism (discrimination on the basis of disability)	11.8%	20
Ageism (discrimination on the basis of age)	39.1%	66
Discrimination based on income or education level	24.3%	41
Discrimination based on the basis of religion	4.7%	8
Discrimination based on the basis of weight or body size	27.2%	46
Homophobia (discrimination against gay, lesbian, bisexual, or queer people)	5.3%	9
Racism (discrimination on the basis of racial or ethnic group identity)	15.4%	26
Sexism (discrimination on the basis of sex)	34.9%	59
Transphobia (discrimination against transgender or gender non-binary people)	1.2%	2
Xenophobia (discrimination against people born in another country)	4.1%	7
Don't know	19.5%	33
Prefer not to answer	6.5%	11

20. What is your age?

Value	Percent	Responses
Under 18	0.6%	8
18-24	3.2%	42
25-44	30.6%	407
45-64	35.3%	469
65-74	19.6%	261
75-84	9.0%	119
85 and over	1.1%	14
Prefer not to answer	0.7%	9

Totals: 1,329

21. What is your current gender identity?

Value	Percent	Responses
Genderqueer or gender non-conforming	0.6%	8
Man	20.8%	275
Transgender	0.1%	1
Woman	78.1%	1,033
Prefer to self-describe:	0.5%	6

Totals: 1,323

22. What is your sexual orientation?

Value	Percent	Responses
Bisexual	3.9%	52
Gay or lesbian	3.3%	44
Straight/heterosexual	85.3%	1,123
Prefer to self-describe:	0.9%	12
Prefer not to answer	6.5%	86

Totals: 1,317

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

Value	Percent	Responses
American Indian or Alaska Native	0.6%	8
Asian	1.1%	15
Black or African American	1.9%	25
Hispanic/Latino	2.5%	33
White	89.0%	1,182
Not listed above/Other:	1.5%	20
Prefer not to answer	5.7%	76

24. What is your ethnicity? Please select all that apply.

Value	Percent	Responses
American	62.4%	771
European (specify):	27.6%	341
Other (specify):	5.5%	68
Unknown/Not specified	5.3%	65
African (specify):	0.3%	4
African American	1.1%	13
Brazilian	0.2%	3
Cape Verdean	0.2%	3
Caribbean Islander (specify):	0.4%	5
Chinese	0.4%	5
Colombian	0.4%	5
Cuban	0.1%	1
Dominican	0.6%	8
Filipino	0.1%	1
Haitian	0.2%	2
Indian	0.1%	1
Japanese	0.2%	3
Korean	0.2%	3
Mexican, Mexican-American, Chicano	0.7%	9
Middle Eastern (specify):	0.6%	7
Portuguese	2.4%	30
Puerto Rican	0.2%	3
Russian	0.8%	10
Salvadoran	0.2%	3

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

Value	Percent	Responses
Armenian	3.3%	43
Chinese (including Mandarin and Cantonese)	0.4%	5
English	94.6%	1,244
Portuguese	0.3%	4
Russian	0.2%	2
Spanish	1.6%	21
Other (specify):	1.5%	20
Prefer not to answer	1.0%	13

26. What is the highest grade or level of school that you have completed?

Value	Percent	Responses
Grades 1 through 8	0.4%	5
Grades 9 through 11/ Some high school	1.0%	13
Grade 12/Completed high school or GED	6.5%	87
Some college, Associates Degree, or Technical Degree	21.9%	292
Bachelor's Degree	28.9%	384
Any post graduate studies	40.2%	535
Prefer not to answer	1.1%	15

Totals: 1,331

27. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	44.1%	585
Employed part-time (Less than 40 hours per week)	15.4%	205
Self-employed (Full- or part-time)	6.6%	88
A stay at home parent	3.8%	50
A student (Full- or part-time)	1.4%	18
Unemployed	2.1%	28
Unable to work for health reasons	1.4%	19
Retired	22.5%	299
Other (specify):	1.7%	22
Prefer not to answer	1.0%	13

Totals: 1,327

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

Value	Percent	Responses
1 to 3 years	0.4%	5
4 to 6 years	0.4%	5
More than 6 years, but not my whole life	5.5%	73
I have always lived in the United States	93.2%	1,237
Prefer not to answer	0.5%	7

Totals: 1,327

29. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?

Value	Percent	Responses
Never served in the military	94.0%	1,237
On active duty now (in any branch)	0.1%	1
On active duty in the past, but not now (includes retirement from any branch)	4.4%	58
Prefer not to answer	1.5%	20

Totals: 1,316

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

Value	Percent	Responses
Yes	10.8%	143
No	85.5%	1,130
Prefer not to answer	3.6%	48

Totals: 1,321

31. How would you describe your current housing situation?

Value	Percent	Responses
I rent my home	24.5%	325
I own my home	65.0%	863
I am staying with another household	3.6%	48
I am experiencing homelessness or staying in a shelter	0.3%	4
Other (specify):	4.1%	54
Prefer not to answer	2.5%	33

Totals: 1,327

32. Are you the parent or caregiver of a child under the age of 18?

Value	Percent	Responses
Yes	35.4%	466
No	63.3%	834
Prefer not to answer	1.3%	17

Totals: 1,317

33. Please indicate the age(s) of the child(ren) you care for. Please select all that apply.

Value	Percent	Responses
0-3 years	23.6%	109
4-5 years	21.5%	99
6-10 years	47.1%	217
11-14 years	33.0%	152
15-17 years	25.2%	116

34. Which of the following communities do you feel you belong to? Please select all that apply.

Value	Percent	Responses
My neighborhood or building	67.0%	847
Faith community (such as a church, mosque, temple, or faith-based organization)	25.5%	322
School community (such as a college or education program that you attend, or a school that you child attends)	26.1%	330
Work community (such as your place of employment, or a professional association)	50.6%	640
A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)	10.9%	138
A shared interest group (such as a club, sports team, political group, or advocacy group)	43.4%	549
Another city or town where I do not live	15.7%	198
Other (Feel free to share):	6.5%	82

Beth Israel Lahey Health

Survey Distribution Channels: Global View Communications (GVC)

Engaging with Diverse Communities

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

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

Our Approach

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

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

Channels

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

1. Print

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

A. El Mundo – Spanish Translation

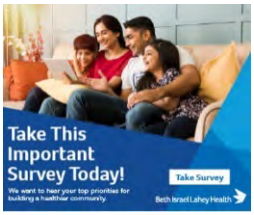
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

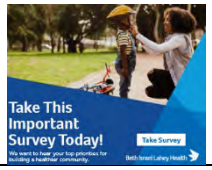
D. Bay State Banner – Black/African American, Cape Verdean/English

E. Chelsea Record – Hispanic/English

F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



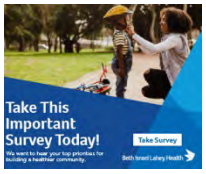
For the printed newspapers the publish dates are as follows:

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

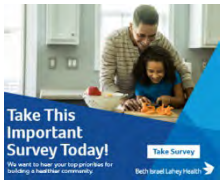
2. Digital Advertising

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

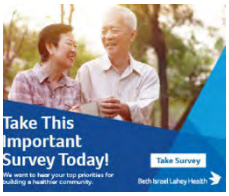
A. African American/Black, Haitian, Cape Verdean



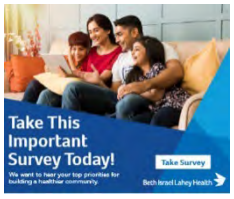
B. Hispanic



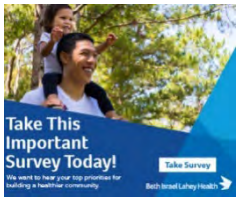
C. Chinese



D. Indian



E. Vietnamese



C. Precision Audio

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

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

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

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

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

Survey Distribution Channels: BH/AGH Community Partners

Organization	Promotion other than flyers or print (e.g., Social Media, Newsletter, other Electronic Publication, etc.)	Contact Person/Name	Title
Accord Food Pantry		Stacey Verge	Regional Director
Action Inc.	Social Media	Peggy Hegarty-Steck	Founder & Executive Director
Alzheimers Association MA Chapter		Autumn Hotaling	Director of Community Programs
Backyard Growers		Lara Lepionka	Executive Director
Be Healthy Beverly		Rebecca Jackson	Task Force Member
Beauport Ambulance		John Morris	Owner
Beverly Bootstraps		Susan Gabriele	Director
Beverly Council on Aging		Mary Ann Holak	COA Director
Beverly Diversity, Equity and Inclusion (DEI) Task Force		Abu Toppin, DEI Director	Diversity, Equity, & Inclusion Director
Beverly Health Department		William Burke	Health Agent
Beverly Housing Authority		Deborah Roy	Executive Director
Beverly Main Streets		Heather Wolsey	Marketing Director
Boys & Girls Club of Lynn		Brian Theirrien	Executive Director
Cape Ann Chamber of Commerce	Social Media	Ken Riehl	Executive Director
Cape Ann Mass in Motion		Jennifer Donnelly	Grant Coordinator
Community Access to the Arts (CATA)	Posters on vans	Felicia Webb	Direct0or
Catholic Charities North			
Centerboard	Social Media	Mark DeJoie, Esq.	CEO
The North Shore Community Health Network (CHNA) 13/14		Bernadette Orr	Director
Coordinating Council for Community Transportation		Valerie Parker Callahan	Executive Director
Creative Action Institute			
DanverCARES	Social Media	Whitney McNeilly	Director
Danvers Council on Aging (COA)		Pam Parkinson	COA Director
Danvers Food Council		Maureen Howlett	Assistant Director
Danvers Health Department		Mark Carleo	Director of Public Health
Danvers Housing		Cindy Dunn	Executive Director
Danvers YMCA		John Sommes	CEO
East Coast International Church		Kurt & Jen Lange	Lead Pastor
Elder Services of Merrimac valley and North Shore		Joan Hatem-Roy	CEO
Essex Council on Aging (COA)		Kristin Crockett	Director
Essex County Community Foundation		Beth Francis	President & CEO
Essex County Foundation		Beth Francis	Executive Director
Essex County Habitat for Humanity		Meegan O'Neil	
Essex Cultural Council		Robyn Canter	BOH Administrator
Essex Health Department		Erin Kirchner	Executive Director
Essex Housing Authority		Irene frontierro	Executive Director
Girls Inc. of Lynn		Deb Ansourlian	
Gloucester Council on Aging (COA)		Elise Sinagra	Director of Elder Services
Gloucester Community Health Center		TBD	Board Member of Gloucester EDIC
Gloucester Council on Aging (COA)		Elise Sinagra	Public Health Director
Gloucester Economic Development & Industrial Corp		Mike DiLascio	Principal
Gloucester Health Department		TBD, Karin Left	Community Health Worker
Gloucester High School		James Cook	Principal
Gloucester High School Health Center		Karen Hurst	School Based Health Director
Gloucester Housing Authority		David Houlden	Executive Director
Gloucester Racial Justice Team			Executive Director
Gloucester Unitarian Universalist Church		Janet Parsons Minister	Executive Director
Grace Center		Stephen Voysey	President
Greater Beverly Chamber of Commerce	Social Media	Leslie Gould	Executive Director
Greater Lynn Senior Services		Valerie Parker Callahan	Executive Director
Gregg House		Gregory Ambrose	Executive Director
Harborlight Community Partners		Andrew DeDranza	Executive Director
Haven Project		Tracey Scherrer	Director of Senior Services
Healing Abuse Working for Change		Sara Stanley, Esq.	Director of Public Health
Ipswich Aware		Ilia Stacy	Wraparound Director
Ipswich Council on Aging (COA)		Sheila Taylor	COA Director
Ipswich Health Department	Social Media	Colleen Fermon	Director
Ipswich Housing Authority		Kate McGuire	Program Director
JRI YOUnity Drop-In Center		Kate Wise	
Kakrona			CEO
Latino Support Network		Carolina Trujillo	Program Director
Lynn Community Health Center		Dr. Kiame Mahaniah	Chief Executive Officer
Lynn Council on Aging (COA)		Erica Brown	Director
Lynn Economic Opportunity		Birgitta Damon	
Lynn Health Department		Michelle Desmarais	Executive Director
Lynn Housing Authority		Charles Gaita	Executive Director

Lynn Main Streets		Carolina Trujillo	
Lynn Shelter Association		Mark Evans	Executive Director
Lynn United for Change			Director
MA Coalition for the Homeless		Robyn Frost	Public Health Nurse
Manchester Council on Aging (COA)		Nancy Hammond	
Manchester Health Department		Pam Ciccone	Health Director
Marquis Health		Deb Donovan	Marketing Director
Metro North YMCA		Andrea Baez	Director
Middleton Council on Aging (COA)		Jillian Smith	
Middleton Health Department	Social Media	Derek Fullerton	Executive Director
Middleton Housing Authority		Cynthia Dunn	Executive Director
Micro Support Group, Inc		Bruce Billingham	Board President
Mutual Aid Lynn			
My Brothers Table		Dianne Kuzia-Hills	Executive Director
National Alliance on Mental Health (NAMI) of Cape Ann		Dori Prescott	Executive Director
Needy Meds		Rich Sagall, MD	President
New Lynn Coalition		Jeff Crosby	Executive Director
North Shore Alliance of LGBTQ (Nagly)		James Giessler	
North Shore Chamber		Erik Smith	President
North Shore Health Project		Susan Coviello	Executive Director
North Shore Juneteenth Association		Nicole McCain	Executive Director
North Shore Pride		Hope Watt-Bucci	CEO
North Shore Veterans Services		Lynn Pellino	Director of Innovation & Strategy
North Shore YMCA		Chris Lovasco	Managing Director
Northeast Arc		Jo Ann Simons	President/CEO
Northeast Justice Center-Lawrence Location		Ethan Horowitz	President and Chief Executive Officer
Pathways for Children		Eric D. Mitchell	CEO
Peer Health Exchange			Executive Director
RAW Artworks		Kit Jenkins	Director
Rockport Council on Aging (COA)		Diane Bertolino	Health Agent
Rockport Health Department		Leslie Whelan	Health Director
Rockport Housing Authority		Leigh Perry Duda	Executive Director
Rockport Library	Social Media		Executive Director
School of Nursing @ Endicott College		Bethany Nasser	
Senior Care Inc.		Scott Trenti	Executive Director
The Open Door	Social Media, flyers in shopping bags	Julie LaFontaine	CEO
Town Leaders Beverly		Michael Cahill	Mayor
Town Leaders Danvers		Steve Bartha	Public Health Director
Town Leaders Essex		Brendhan Zubricki	Town Administrator
Town Leaders Gloucester		Sefatia Romeo Thekan	Mayor
Town Leaders Ipswich		Anthony Marino	Town Manager
Town Leaders Lynn		Thomas McGee	Mayor
Town Leaders Manchester by-the-Sea		Gregory Federspiel	Town Administrator
Town Leaders Middleton		Andrew Sheehan	Town Administrator
Town Leaders Rockport		Mitchell Vieira	Town Administrator
Veterans Services of the North Shore		Lynn Pellino	Director
Wellspring House		Melissa Diamond	President & Executive Director

Appendix C:
Resource Inventory

Northeast Hospital Corporation Community Resource List					
Community Benefits Service Area includes: Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester, Middleton, and Rockport					
Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Statewide Resources	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.			www.handholdma.org
	Executive Office of Elder Affairs	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 5th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-elder-affairs
	MA 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 5th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-elder-affairs
	MA Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program
	MassOptions	Provides connection to services for older adults and persons with disabilities.		800.243.4636	www.massoptions.org
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for finding substance use treatment and recovery services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		800.273.8255	www.suicidepreventionlifeline.org
	Network of Care Massachusetts	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.			www.massachusetts.networkofcare.org

Northeast Hospital Corporation Community Resource List

Community Benefits Service Area includes: Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester, Middleton, and Rockport

Health Issue	Organization	Brief Description	Address	Phone	Website
Statewide Resources	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	www.projectbread.org/get-help
	SafeLink	Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence.		877.785.2020	www.casamyrna.org/get-support/safelink
	SAMHSA's National Helpline	Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders.		800.662.HELP (4357)	www.samhsa.gov/find-help/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		800.273.8255	www.veteranscrisisline.net
Domestic Violence	Healing Abuse Working for Change	Provides support in Survivor Services, including advocacy, counseling, legal assistance, support groups and 24/7 Confidential Hotline.	27 Congress St Salem	978.744.8552 24/7 Hotline 800-547-1649	www.hawcdv.org
Food Assistance	Acord Food Pantry	Provides food assistance to residents of Essex, Hamilton, Ipswich, Manchester, Topsfield and Wenham.	69 Willow St South Hamilton	978.468.7424	www.acordfoodpantry.org
	Action Inc.	Offers emergency SNAP assistance and help applying for food assistance benefits.	370 Main St	978.282.1000	www.actioninc.org

Northeast Hospital Corporation Community Resource List

Community Benefits Service Area includes: Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester, Middleton, and Rockport

Health Issue	Organization	Brief Description	Address	Phone	Website
Food Assistance	Beverly Bootstraps	Offer emergency and long-term assistance including: access to food, housing stability, adult and youth programs, education, counseling and advocacy.	35 Park St Beverly	978.927.1561	www.beverlybootstraps.org
	Danvers People to People Food Pantry	Provides food assistance to residents of Danvers.	12 Sylvan St Danvers	978.739.4188	www.danverscommunitycouncil.com/danvers-people-to-people-food-pantry
	MA Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program
	Middleton Food Pantry	Provides food assistance to residents of Middleton.	38 Maple St Middleton	978.766.1402	www.middletonma.gov/176/Food-Pantry
	My Brother's Table	Provides food assistance to residents of Lynn.	98 Willow St Lynn	781.595.3224	www.mybrotherstable.org
	Open Door-Gloucester Food Pantry	Provides food assistance to residents of Gloucester, Rockport, Ipswich, Manchester, and Essex.	28 Emerson Ave Gloucester	978.283.6776	www.foodpantry.org
	Open Door-Ipswich Community Food Pantry	Provides food assistance to residents of Topsfield, Rowley, Ipswich, Boxford, Hamilton, and Wenham.	00 Southern Heights Ipswich	978.283.6776	www.foodpantry.org
	Project Bread Foodsource Hotline	Provides information about resources in your community as well as assist with SNAP applications over the phone.		800.645.8333	www.projectbread.org/get-help
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps
	St. Stephen's Food Pantry	Provides food assistance to residents of Lynn.	74 South Common St Lynn	781.599.4220	www.ststephenslynn.org/get-involved/serve-the-community
Housing Support	Action Inc. – Emergency Homeless Shelter	Temporary shelter providing advocacy, emergency food and clothing for persons who are unhoused.	370 Main St Gloucester	978.282.1000	www.actioninc.org/client-housing-services/emergency-shelter

Northeast Hospital Corporation Community Resource List

Community Benefits Service Area includes: Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester, Middleton, and Rockport

Health Issue	Organization	Brief Description	Address	Phone	Website
Housing Support	Beverly Housing Authority	Provides housing assistance programs to low-resource individuals and families.	137R Bridge St Beverly	978.922.3100	www.beverlyhousing.net
	Community Action, Inc.	Provides social service programs and housing resource assistance.	3 Washington Square Haverhill	978.388.2570	www.communityactioninc.org
	Danvers Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	14 Stone St Danvers	978.777.0909	www.danvershousing.org
	Essex Housing Authority	Provides affordable, subsidized rental housing for low-resource older adults and persons with disabilities.	Chebacco Terrace Essex	978.768.6821	www.essexha.org
	Family Promise North Shore Boston	Provides shelter, meals, job support and case management for people without housing.	330 Rantoul St Beverly	978.922.0787	www.familypromisensb.org
	Gloucester Housing Authority	Provides affordable, subsidized rental housing for residents of Gloucester.	259 Washington St Gloucester	978.281.4770	www.ghama.com
	The Grace Center	Offers a safe, free day resource center for individuals without housing, older adults, people with disabilities by connecting them to critical services, including transportation, health screenings, showers, food, and legal services.	10 Church St Gloucester	978.675.6240	www.lifebridgenorthshore.org/gracecenter
	Harborlight Community Partners	Provides information and resources for low and moderate resource families and individuals.	283 Elliott St Beverly	978.922.1305	www.harborlightcp.org
	The Haven Project	Provides direct services to youth aged 17-24 without housing.	57 Munroe St Lynn	781.913.5738	www.havenproject.net
	Ipswich Housing Authority	Provides affordable, subsidized rental housing for low-resource older adults and persons with disabilities.	1 Agawam Village Ipswich	978.356.2860	www.ipswichhousing.com
	Lynn Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	10 Church St Lynn	781.581.8600	www.lhand.org
	Lynn Shelter Association	Temporary shelter providing services for persons who are unhoused.	91 Liberty St Lynn	781.581.0739	www.lsahome.org

Northeast Hospital Corporation Community Resource List

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Health Issue	Organization	Brief Description	Address	Phone	Website
Housing Support	Manchester Housing Authority	Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities.	10 Central St Manchester	978.525.6436	www.manchesterhousing.org
	Middleton Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	Orchard Circle Middleton	978.774.4333	www.middletonhousing.org
	River House, Inc.	Provides emergency-shelter services for individuals without housing in the greater Beverly and North Shore area.	56 River St Beverly	978.921.1304	www.riverhousebeverly.org
	Rockport Housing Authority	Provides affordable, subsidized rental housing for low-resource families.	13 Millbrook Park Rockport	978.546.3181	www.rockportma.gov/housing-authority
	Wellspring House Inc.	Provides services and programs that assist with families and individuals, finances, education and job training.	302 Essex Ave Gloucester	978.281.3558	www.wellspringhouse.org
Mental Health and Substance Use	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.nebhealth.org
	Danvers Treatment Center	Offers medication-assisted treatment and counseling for adults with substance use disorders by offering 3 types of medication-assisted treatments.	111 Middleton Rd Danvers		www.nebhealth.org

Northeast Hospital Corporation Community Resource List

Community Benefits Service Area includes: Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester, Middleton, and Rockport

Health Issue	Organization	Brief Description	Address	Phone	Website
Mental Health and Substance Use	Eliot Community Human Services	Provides services for people of all ages throughout Massachusetts through a continuum of services includes diagnostic evaluation, 24-hour emergency services, and crisis stabilization, outpatient and court-mandated substance-use prevention services; individual, group and family outpatient counseling, early intervention, specialized psychological testing; day, residential, social and vocational programs for individuals with developmental disabilities, outreach and support services for people experiencing homelessness.	125 Hartwell Ave Lexington	781.861.0890	www.eliotchs.org
	Family Continuity	Provides evidence-based, best practice therapies for individuals and families.	9 Centennial Dr Ste 202 Peabody	978.927.9410	www.familycontinuity.org
	North Shore Counseling Center (NSCC)	Provides evidence-based, best practice therapies for individuals, couples, and families.	900 Cummings Center Ste 324-S Beverly	978.922.2280	www.nscc-inc.com
	North Shore Veterans Counseling Services Inc.	Provides counseling services to Veterans.	45 Broadway St Beverly	978.921.4851	www.northshoreveterans.com
	Ryan House	Provides treatment focused halfway house for those seeking recovery from substance abuse disorders and co-occurring disorders for adult men and women.	100-110 Green St Lynn	781.593.9434	www.nebhealth.org
	Triumph Center	Provides counseling, social skills groups, summer programming and psychological evaluation services for children, adolescents, young adults and families, as well as consultation and evaluations for schools and other institutions.	100 Cummings Center Ste 207-L Beverly	781.942.9277	www.triumphcenter.net

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Senior Services	Beverly Council on Aging	Provides services for older adults in Beverly including fitness, education, social services, recreation, and transportation.	90 Colon St Beverly	978.921.6017	www.beverlyma.gov/172/Council-on-Aging
	Danvers Council on Aging	Provides services for older adults in Danvers including fitness, education, social services, recreation, and transportation.	25 Stone St Danvers	978.762.0208	www.danversma.gov/departments/council-on-aging
	Elder Services of the Merrimack Valley & North Shore	Provides programs and services which are available and accessible to meet the diverse needs and changing lifestyles of older adults.	300 Rosewood Dr Ste 200 Danvers	978.683.7747	www.esmv.org
	Essex Council on Aging	Provides services for older adults in Essex including fitness, education, social services, recreation, and transportation.	17 Pickering St Essex	978.768.7932	www.essexma.org/essex-senior-centercouncil-aging
	Gloucester Council on Aging	Provides services for older adults in Gloucester including fitness, education, social services, recreation, and transportation.	6 Manuel F. Lewis St Gloucester	978.281.9765	www.gloucester-ma.gov/291/Council-on-Aging
	Greater Lynn Senior Services	Provides a broad range of services, including: information and referral; home care services; nutrition programs; transportation assistance; housing supports; clinical and protective services; programs designed to promote consumer engagement and better health and well-being.	8 Silsbee St Lynn	781.586.8687	ww.glss.net
	Ipswich Council on Aging	Provides services for older adults in Ipswich including fitness, education, social services, recreation, and transportation.	25 Green St Ipswich	978.356.6650	www.ipswichma.gov/335/Council-on-Aging
	Manchester-by-the-Sea Council on Aging	Provides services for older adults in Manchester including fitness, education, social services, recreation, and transportation.	10 Central St Manchester	978.526.7500	www.manchester.ma.us/371/Council-On-Aging
	Middleton Council on Aging	Provides services for older adults in Middleton including fitness, education, social services, recreation, and transportation.	38 Maple St Middleton	978.777.4067	www.middletonma.gov/179/Council-on-Aging

Northeast Hospital Corporation Community Resource List

Community Benefits Service Area includes: Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester, Middleton, and Rockport

Health Issue	Organization	Brief Description	Address	Phone	Website
Senior Services	Rockport Council on Aging	Provides services for older adults in Rockport including fitness, education, social services, recreation, and transportation.	58 Broadway Rockport	978.546.2573	www.rockportma.gov/rockport-council-aging
	SeniorCare	Provide supportive services for older adults.	49 Blackburn Center Gloucester	978.281.1750	www.seniorcareinc.org
Transportation	Cape Ann Transportation Authority (CATA)	Provides public transportation to the Cape Ann area, which includes Gloucester, Essex, Ipswich and Rockport.	3 Pond Rd Gloucester	978.283.1886	www.canntran.com
	MBTA Commuter Rail Service	Provides service to the Cape Ann region.			www.mbta.com
Additional Resources	Boys & Girls Club of Lynn	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	25 North Common St Lynn	781.593.1772	www.bgcl.org
	Cape Ann YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	71 Middle St Gloucester	978.283.0470	www.northshoreymca.org
	Danvers Community YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	34 Pickering St Danvers	978.774.2055	www.danversymca.org
	Girls Incorporated of Lynn	Provides programs and experiences that advocates on behalf of girls.	50 High St Lynn	781.592.9744	www.girlsinclynn.org
	Greater Beverly YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	254 Essex St Beverly	978.927.6855	www.northshoreymca.org
	Ipswich Family YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	110 County Rd Ipswich	978.356.9622	www.northshoreymca.org

Northeast Hospital Corporation Community Resource List					
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Health Issue	Organization	Brief Description	Address	Phone	Website
Additional Resources	Pathways for Children-Beverly office	Provides programming for children from birth to 13; robust social support services for families throughout Essex County; and professional development initiatives designed to inspire the next generation of teachers and youth/family services workers.	292 Cabot St Beverly	978.236.4101	www.pw4c.org
	Pathways for Children-Gloucester office	Provides programming for children from birth to 13; robust social support services for families throughout Essex County; and professional development initiatives designed to inspire the next generation of teachers and youth/family services workers.	29 Emerson Ave Gloucester	978.281.2400	www.pw4c.org
	Pathways for Children-Salem office	Provides programming for children from birth to 13; robust social support services for families throughout Essex County; and professional development initiatives designed to inspire the next generation of teachers and youth/family services workers.	79 Willson St Salem	978.515.5400	www.pw4c.org
	Tri-Town Council	Provides parent education, youth programs, professional development, prevention services, after-school enrichment to residents of Middleton, Topsfield and Boxford.	7 Grove St Unit 202 Topsfield	978.887.6512	www.tritowncouncil.org

Appendix D:

Evaluation of 2020-2022 Implementation Strategy

Northeast Hospital Corporation (NHC)
Evaluation of 2020-2022 Implementation Strategy

Below are highlights of the work that has been accomplished since the last Implementation Strategy. For full reports, please see submissions to the Massachusetts Attorney General Community Benefits office (https://massago.onbaseonline.com/massago/1801CBS/annualreport.aspx).

Priority: Mental Health

Goal 1: Support mental health outreach, education, and prevention programs, and improve access to treatment and services			
Population	Objectives	Activities	Progress, Outcomes, and Impact (From AG reports)
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	• Increase the number of individuals who are screened and referred to appropriate mental health treatment and support services • Increase the number of individuals and families educated on the risks, protective factors, and impacts of mental health issues	• High-Risk Intervention Team (HRIT) • Compass/Moms Do Care program • Pathways Nurturing Families program • Support counseling and/or referral resources in community-based settings • Provide Mental Health First Aid training(s) in community-based settings	• Over the past three years, the HRIT provided mental health and addiction consults, medication management assistance, and/or recovery coach referrals to an average of 430 patients per month. • The BH/AGH Compass Moms do Care Program provided prenatal and postnatal care to more than 115 women with a history of substance use. • Provided $18K to Pathways for Children to implement the Nurturing Families program to improve parenting skills and prevent child abuse and neglect. Two sessions were held in Gloucester (one in English and 2 in Spanish) reaching more than 60 people. In FY22 BH/AGH awarded Pathways $18K to implement the program in Beverly. • BILH Behavioral Services provided more than 30,000 individual and group mental health counseling sessions in the community serving approximately 5,000 children and adults with mental health issues over the past two years. • Provided financial support to SeniorCare Inc. in FY22 to implement Mental Health First Aid Training for adults in Gloucester and surrounding cities/towns. • Awarded $16,200 in FY22 to develop an online YRBS tool.
	Reduce structural barriers to mental health treatment	Support Bay Ridge Transportation and Taxi Voucher program	BH/AGH provided more than $75K annually in staffing costs and taxi vouchers to provide free transportation to patients travelling to and from BayRidge Hospital for mental health treatment.
	Increase the number of primary care practices with integrated behavioral health services	Enhance and promote integrated behavioral health in primary care clinics	Behavior Health clinicians have been integrated into more than ten primary care sites (called the Collaborative Care Model) in the BH/AGH CBSA, providing convenient access to mental health services to more than 2,000 patients per year.

• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Explore opportunities to reduce social isolation and depression	Organize and support initiatives that increase opportunities for social engagement (i.e. support groups, Senior Dine & Learn	• BH/AGH awarded a $27,500 to Greater Lynn Senior Services for Project Uniper to reduce social isolation and improve social emotional wellbeing for 50 residents in the BH/AGH CBSA by installing a device on their televisions allowing them to access telehealth, education programs, and information about community resources. An additional $18,200 grant was awarded in FY22 for continuation and expansion of the program. • BH/AGH provided two Senior Dine & Learn programs onsite at Beverly and Addison Gilbert Hospital in FY20 reaching 240 area seniors. In FY20-FY22 the program was suspended due to Covid restrictions and funds were reallocated to local senior centers to address urgent/emerging needs. • In person support groups were suspended from FY20 – FY22 due to Covid restrictions.

Priority: Substance Dependency

Goal 1: Address the impact(s) of substance dependency			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Promote collaboration, share knowledge, and increase awareness around the impacts and risk factors for developing substance misuse issues	Support and/or participate in task forces and community collaborations that offer education on the risks, protective factors, and impacts of substance misuse	• Supported the Pathways to Children Annual Youth at Risk Conference each year. In FY20 and FY21 more than 1,000 individuals who care for or work with youth in a variety of settings including schools, healthcare, and community service agencies were reached. • Awarded $14,878. In FY22 to the Gloucester Police Department to provide the "Teach to Reach" recovery Coach Training program for staff of local social services agencies.
Goal 2: Improve access to substance misuse treatment and support services			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Individuals and families of low resource • Older adults • Children and families	Increase the number of individuals who are screened and are referred to appropriate mental health treatment and support services	• Provide recovery coaches in the emergency departments at BH-AGH; provide Suboxone kits, medication-assisted treatment.	• BILH Behavioral Services provided community based counseling, treatment, and support services for adults and children recovering from substance use disorder. • With support from the HEAL Grant, the High Risk Intervention team (HRIT) provided inpatient addiction consults, medication assistance, and/or referrals to a recovery coach for more than 500 patients with Opioid Use Disorder.

• Individuals with chronic/complex conditions		• Compass/Moms Do Care Program offering counseling, group therapy, and connections to services and peer moms	• The Compass Moms do Care Program provided prenatal and postnatal care to more than 115 women, with a history of substance use over the past three years.

Priority: Chronic/Complex Conditions and Risk Factors

Goal 1: Prevent, detect and manage chronic disease and complex conditions, and enhance access to treatment and support services			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Create awareness/educate community members about the preventable risk factors associated with chronic and complex health conditions	Organize/ support programs and activities in clinical or community-based settings to provide education and prevention efforts	• Provided $25K to support The Open Door's "Food is Medicine" Program to provide workshops and nutrition counseling to individuals who are, or at at-risk for developing chronic illness. More than 28 different workshops conducted by a registered dietitian were conducted reaching approximately 300 community members in Gloucester and surrounding cities/towns • Participated in more than ten community health fairs to distribute information and create awareness about preventing and detecting chronic disease. Topics included sun safety/skin cancer, hypertension, breast cancer, and more. • BILH created an online newsletter called Healthy State to influence personal health choices, inform people about ways to enhance health and help them avoid health risks by increasing knowledge and awareness of health issues. In FY20 there were 72,205 page views, 8,700 return users, and an average view of 1.14 seconds per session. The publication was not provided in FY21.
	Provide opportunities for people to be screened for chronic and complex health conditions, and provide linkages to associated services	Organize/ support health screenings in clinical or non-clinical settings to detect chronic/complex conditions and refer to and/or coordinate care (e.g., skin cancer, blood pressure screening, breast cancer risk screening, health fairs)	BH/AGH provided free Breast Cancer Risk Assessment (BCRA) screenings to identify persons who may have a higher lifetime risk of developing breast cancer, and provided follow-up with all participants' physicians. More than 6,350 women were screened between FY21-FY22, and more than 600 were identifies at risk.

• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Support individuals and their caregivers who are engaged in evidence-based support and chronic disease management programs	Organize/ support programs and activities that refer, educate, or support individuals around better managing their chronic/complex conditions	• Provided financial support to the YMCA of the North Shore to implement the Enhance Fitness program. Due to Covid, the program was offered virtually to more than 70 people. In FY20 and FY22, and will resume in person classes at three locations in the community in FY22. • Oncology Nurse Navigators at BH/AGH assisted more than 1600 patients by guiding them through the complexities of the disease, directing them to health care services for timely treatment and survivorship, and addressing barriers to care that might prevent them from receiving timely and appropriate treatment.
	Increase access to supportive services that reduce stress among individuals with chronic/complex conditions and their caregivers	Provide support to alleviate burden(s) associated with chronic conditions to individuals/ family members (support groups, cancer navigators)	Provided financial support to the North Shore YMCA to implement the Cornerstone program, a collaborative health and wellness program that provided essential daily living support to 2,134 cancer patients, survivors, and their families.
	Increase access to affordable, healthy foods and affordable physical activity.	Organize and/or support programs that provide access to free or low-cost healthy foods and physical activity (e.g., Emergency Food Bag Program, Senior Nutrition Program, etc.)	Provided $25K to support The Open Door's "Food is Medicine" Program to provide workshops and nutrition counseling to individuals who are, or at at-risk for developing chronic illness. More than 28 different workshops conducted by a registered dietitian were conducted reaching approximately 300 community members in Gloucester and surrounding cities/towns.

Priority: Social Determinants of Health and Access to Care

Goal 1: Address barriers to social determinants of health and access to care			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Educate providers and community members about BH/AGH or public assistance programs to help them identify/ enroll in appropriate health insurance plans and/or reduce their	Provide counseling, support, and referral services to community members to enroll and remain in appropriate programs (e.g., financial counseling, SHINE program)	• Financial counselors from BH/AGH conducted 127,000 free counseling sessions for community members and patients to assess their eligibility for state and/or hospital-based financial assistance programs. • SHINE counseling was provided by staff at BH/AGH to more than 7,000 community members. In FY21 due to Covid restrictions, all sessions were conducted via telephone.

• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	financial burden		
	Increase access to appropriate primary care and specialty care services	Support programs that provide clinical services in community-based settings (e.g., Health Center at Gloucester High School, Mobile Phlebotomy)	• The School Based Health center at Gloucester High School provided high-quality, comprehensive health care onsite to more than students, including visits with a nurse practitioner or social worker. In FY20 and FY21 visits were conducted via telehealth due to Covid restrictions. In addition, more than 40 outreach activities were conducted including social skills work groups, reproductive health classes, and a walking group. Through a collaboration with The Open Door Food Pantry, a free "Food Locker" was implemented to provide more than 800 free food orders to students and families experiencing food • BH/AGH phlebotomy staff conducted more than 15,000 free home blood draws for homebound patients.
	Increase access to affordable and nutritious foods	Provide mini grants to community partners that address issues associated with food insecurity	In FY20, in response to Covid, BH/AGH provided funding to Beverly Bootstraps for home delivery of more than 2,350 bags of food to 520 low income older adults in ten different housing facilities. In FY21, additional funding was awarded to Beverly Bootstraps to provide 9,456 pounds of free fresh produce at 26 mobile markets at the Beverly Senior Center, serving 183 households.
	Increase mentorship, training, and employment opportunities	Explore employment and workforce development issues, including existing community resources and programs. Identify opportunities to strengthen the workforce, including education and job training	• BH/AGH awarded $ in FY21 to support Wellspring House's Pathways to Jobs program, which provided job training and career readiness programs to a diverse group of 150 young adults. Of the 150 participants, 6 transitioned to a job with higher wages, and 50 earned a degree or certificate. In FY22 an $18K grant was awarded for continuation of the program. • BH/AGH supported to the Lynn Shelter in providing career readiness training and resources to 64 homeless individuals.
	Increase awareness about creating a healthy, safe environment for babies and families, and promote healthy child development	Organize and/or support programs that promote a healthy, safe environment and/or that foster healthy growth and development for infants and babies and their families	Staff from Beverly Hospital Social Services and the Parent Education Department provided childbirth preparation and parenting education classes, connection to community resources and ongoing support to approximately 25 moms or moms to be and 20 fathers with limited resources and little emotional and social support.

• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions		(Compass/Moms Do Care Program, Connecting Young Moms, BH Parent Education, etc.)	
	Increase access to affordable and free opportunities for physical activity	Support community-based initiatives to offer free or low-cost physical activity (Enhance Fitness)	Provided financial support to the YMCA of the North Shore to implement the Enhance Fitness program. Due to Covid, the program was offered virtually to more than 70 people. In FY20 and FY22, and will resume in person classes at three locations in the community in FY22.
	**In FY20-FY22, resources were re-allocated to address the urgent needs that arose as a result of the Covid-10 pandemic.*	Support community-based initiatives to help individuals/families secure safe and affordable housing	• Provided financial support to Action Inc. to support the Welcome Home Program which secured permanent housing for 11 chronically homeless individuals in FY21. • With support from BH/AH, Centerboard's Project Hope diverted 42 community members from entering the shelter system.
	**In FY20-FY22, resources were re-allocated to address the urgent needs that arose as a result of the Covid-10 pandemic*	Support community-based initiatives to help address the digital divide by increasing digital literacy and access to virtual programming.	• BH/AGH awarded $25K to the Metro North YMCA for development of a new technology center called The Herring Community Technology Center, which helped bridge the digital divide by making internet services accessible for 200 residents in the City of Lynn. • BH/AGH awarded a $24,800 grant to Cape Ann Mass in Motion/Seniors on the Go to partner with the Gloucester Housing Authority, Council on Aging, and long term care facilities to assist 77 older adults expand their technological infrastructure by providing equipment, internet access, and education to increase their technology skills and help them access affordable, healthy food, fitness classes and medical appointments via telehealth.

• ***Not included in original IS, added as a result of urgent/emerging Covid needs.***

Appendix E:
2023-2025 Implementation Strategy

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

2022 Implementation Strategy

Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Northeast Hospital Corporation (NHC), part of Beth Israel Lahey Health (BILH) consists of multiple entities organized to service the needs of those in its communities. NHC, referred to as BH/AGH throughout this report, operates, under a single license, two acute care campuses – Beverly Hospital in Beverly, Massachusetts and Addison Gilbert Hospital in Gloucester, Massachusetts; an acute psychiatric inpatient satellite, BayRidge Hospital in Lynn, Massachusetts; and an outpatient facility, Lahey Outpatient Center – Danvers, in Danvers, Massachusetts.

Beverly Hospital (BH) is a full-service, 223-bed community hospital providing leading-edge, patient-centered care to North Shore and Cape Ann residents. The hospital provides a full range of state-of-the-art care and services including primary care, cardiovascular care, surgery, orthopedics, emergency care, maternity, and pediatrics, as well as many other specialties.

Addison Gilbert Hospital (AGH) is a full-service, 79-bed medical/surgical acute care facility. The hospital, founded in 1889, provides state-of-the-art inpatient and outpatient care to residents of the Cape Ann community in specialties such as pain management, wound care, cancer care, primary and pediatric care, cardiology, geriatric services, and emergency medicine.

BayRidge Hospital provides accessible, high-quality substance abuse and mental health treatment. This psychiatric hospital offers a continuum of chemical dependency and psychiatric services on an inpatient, partial hospitalization, and outpatient basis. Coordination of care between Beverly Hospital's psychiatric service, the Leland Unit, and BayRidge Hospital assures the provision of a range of acute inpatient services to individuals suffering from psychiatric disabilities.

The 2022 Community Health Needs Assessment (CHNA) and planning work for this 2022 report was conducted between September 2021 and September 2022. It would be difficult to overstate BH/AGH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BH/AGH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage BH/AGH's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, 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.

BH/AGH collected a wide range of quantitative data to characterize the communities served across the hospitals Community Benefits Service Area (CBSA). BH/AGH 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. 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 Implementation Strategy (IS). Between October 2021 and February 2022, BH/AGH conducted 18 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,300 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 1,400 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities or are disproportionately impacted by

systemic racism or other forms of discrimination. Accordingly, using an interactive, anonymous polling software, BH/AGH's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of BH/AGH's IS. This prioritization process helps to ensure that BH/AGH 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 BH/AGH'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.

BH/AGH'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).

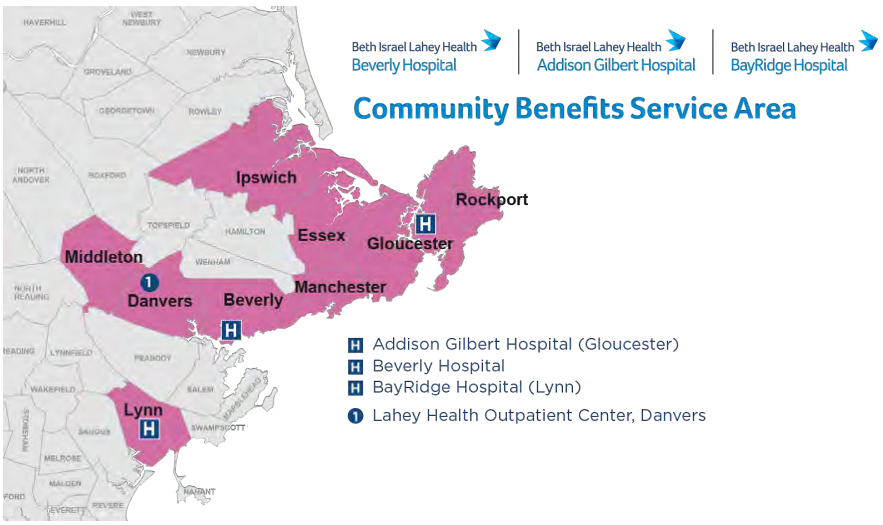
The following goals and strategies were developed so that they:

- Address the prioritized community health needs and/or populations in BH/AGH's Community Benefits Service Area (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.
- Could be scaled to other BILH hospitals.
- Are flexible to respond to emerging community needs.

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

Community Benefits Service Area

BH/AGH's CBSA includes the nine municipalities of Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester-by-the-Sea, Middleton, and Rockport in the northeast portion of Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban, and semi-rural). There is also diversity with respect to community needs. There are segments of the BH/AGH's CBSA population that are extremely healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. BH/AGH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. BH/AGH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.



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

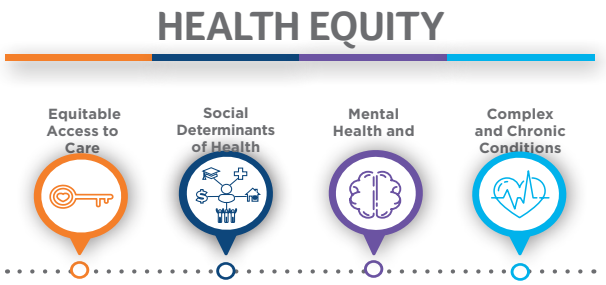
Prioritized Community Health Needs and Cohorts

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

BH/AGH Priority Cohorts

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations

BH/AGH Community Health Priority Areas



Community Health Needs Not Prioritized by BH/AGH

It is important to note that there are community health needs that were identified by BH/AGH's CHNA that were not prioritized for investment or included in BH/AGH's IS. Specifically, supporting education across the lifespan and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) and affordable childcare, were identified as community needs but were not included in BH/AGH's IS. While these issues are important, BH/AGH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, BH/AGH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. BH/AGH 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 BH/AGH's IS

The issues that were identified in BH/AGH's CHNA and are addressed in some way in the IS are housing, food insecurity, transportation, economic insecurity, workforce capacity, system navigation, digital divide/access to technology resources, diversifying the workforce, cost and insurance barriers to access, care giver support, youth mental health, stress/anxiety/depression, isolation, mental health stigma, racism/discrimination, supportive services for immigrants, ageism, diversifying leadership, homophobia/transphobia, linguistic access to community resources/services, treatment programs that address mental health and substance use disorders, and transitional housing.

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 are at the system level, and stem from the way in which the system does or does not function. System-level issues include providers not accepting new patients, long wait lists, and an inherently complicated health care system that is difficult for many to navigate.

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

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

Goal: Provide equitable and comprehensive access to high-quality health care services 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	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote access to health care, health insurance, patient financial counselors, needed medications and other essentials for patients who are uninsured or underinsured.	• Low-resourced populations • Youth • Older adults	• Financial Counseling • Serving the Health Insurance Needs of Everyone (SHINE) Program • Primary Care Support • School-Based Health Center • Provide community grants to address need	• # people assisted • # people referred for services • # of patients and their demographics	• BH/AGH Financial Services • BILH Primary Care • Greater Lynn Senior Services • Gloucester Health Dept. • MIM/Seniors on the Go • Gloucester High School	• Social Determinants of Health • Chronic/ Complex Conditions • Mental Health

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	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support and/or provide initiatives that provide job readiness and career development opportunities to obtain employment or employment with higher wages.	Racially, ethnically, and linguistically diverse populations	• Accelerating Access to Higher Education career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes • Diverse talent promotion and acquisition • Career Pipeline Programs • Provide community grants to address need	• # of participants and their demographics • # of employees who participated • # of staff hired or promoted	• Wellspring House • Endicott College • North Shore Community College • Community Colleges • BILH Workforce Development	Social Determinants of Health
Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.	Racially, ethnically, and linguistically diverse populations	• Interpreter Services • BH/AGH Diversity, Equity and Inclusion (DEI) Committee	• # of patients assisted • # of languages provided • # of DEI trainings	BH/AGH Interpreters	Not Applicable
Increase access to health services and screenings for homebound individuals by reducing barriers to care such as transportation, illness, etc.	• Older adults • Individuals with disabilities	• Home Blood Draw Program • Transportation support • Provide community grants to address needs	• # of patients assisted • # of rides provided	• BH/AGH Lab Services • BH/AGH Drivers	Chronic/ Complex Conditions

Priority: Social Determinants of Health

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Organize/support impactful programs that stabilize or increase access to safe, affordable housing.	Low-resourced populations	• Welcome Home Program • Provide community grants to address need	• # of participants and their demographics • # of families prevented from homelessness	• Action, Inc. • Harborlights	Not Applicable
Alleviate food insecurity and promote active living by advocating for system changes, increasing opportunities for physical activity, and providing healthy, low-cost food resources to communities.	• Youth • Older adults • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Senior Mobile Markets • Medically Tailored Groceries program • Council on Aging Exercise Classes • Provide community grants to address need	• Pounds of food distributed • # of individuals provided food and their demographics • Decreased food insecurity • # of individuals participating in physical activity and their demographics	• Beverly Bootstraps • The Open Door • North Shore YMCA • Local Councils on Aging	Chronic/ Complex Conditions

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Advocate for policy, systems, programs, and environmental changes that address the social determinants of health.	• Youth • Older adults • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Work with BILH Diversity, Equity, and Inclusion Council to expand contracts with diverse suppliers and vendors • Support relevant policies when proposed	• Supplier diversity spend • # policies reviewed • # of policies supported	• BILH Government Relations • BILH Diversity, Equity, and Inclusion Council	Equitable Access to Care

Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation are leading community health concerns. There were specific concerns about the impact of mental health issues on youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

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

Substance use continued to have a major impact on the CBSA; the opioid epidemic 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. Individuals engaged in the assessment 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). Those participating in interviews, focus groups, and listening sessions also reflected on the need for transitional housing and other recovery support services.

State Priority Area: Mental Health/Substance Use Disorder

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	• Older adults • Low-resourced populations • Youth • Racially, ethnically, and linguistically Diverse Populations	• Collaborative Care Model • Centralized Bed Management. • Community Clinics/ Counseling	• # of patients served • # of therapy sessions • # of integrated BH consultations • # of practices	• BILH Behavioral Health Services (BILHBS) • BH/AGH Emergency Department	Not Applicable
Build the capacity of community members to understand the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.	• Adults • Low-resourced populations • Youth • Racially, ethnically, and linguistically diverse populations	• Mental Health First Aid • Provide community grants to address need	• # of community members trained/ educated • Increased skills • Increased confidence in ability to use skills • Decreased isolation	• Senior Care Inc.	Not Applicable

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Implement/support evidence-based programs that promote healthy development, support children and families, and increase their resilience.	• Adults • Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Nurturing Parents Program • Moms Do Care program • Connecting Young Moms • Provide community grants to address need	• # of participants and their demographics • Grant specific metrics	• Pathways for Children • BH/AGH High-Risk Intervention Team (HRIT)	Not Applicable
Improve systems for management and control of substance use disorder through education, reducing access to substances, and multidisciplinary efforts.	• Youth • Adults	• Teach to Reach Recovery Coaches • Ryan Recovery House • BILH Behavioral Services (BILHBS) Detox/Opiate Treatment Services • Medication Boxes • NeedyMeds program	• # of patients and their demographics • Pounds of medication and sharps collected	• Gloucester Police Dept. • BILH Behavioral Services (BILHBS) • NeedyMeds • BH/AGH Emergency Dept.	Not Applicable
Participate in multi-sector community coalitions to convene collaborators to identify and advocate for policy, systems, and environmental changes to increase resiliency, promote mental health, reduce substance use, and prevent opioid overdoses and deaths.	Youth	• DanversCares • Be Healthy Beverly • Ipswich Aware	• Sectors represented • Amount of resources obtained • # of new partnerships developed • Skill building/education shared • # new policies/protocols implemented	• BILHBS • DanversCares • Be Healthy Beverly • Ipswich Aware • BILH Government Relations	Social Determinants of Health

Priority: Chronic and Complex Conditions

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

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

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions 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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide preventative 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.	• Youth • Adults	• Enhance fitness • Breast Cancer Risk Assessment • Health Screenings • High-Risk Intervention Team (HRIT) • Oncology Nurse Navigator • Provide community grants to address need	• # of patients served and their demographics • Reduced time between finding and treatment	• Gloucester High School • Beverly Bootstraps • The Open Door • Backyard Growers • North Shore YMCA • Local Councils on Aging • BH/AGH Breast Health Center • BH/AGH High-Risk Intervention Team (HRIT) • BH/AGH Cancer Team	• Social Determinants of Health • Mental Health

General Regulatory Information

Contact Person:	Marylou Hardy
Date of written plan:	June 30, 2022
Date written plan was adopted by authorized governing body:	September 8, 2022
Date written plan was required to be adopted	February 15, 2023
Authorized governing body that adopted the written plan:	Northeast Hospital Corporation 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 5, 2019
Name and EIN of hospital organization operating hospital facility:	Northeast Hospital Corporation (NHC) 04-2121317
Address of hospital organization:	85 Herrick Street Beverly, MA 01915

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital