Beth Israel Lahey Health
Beth Israel Deaconess Needham

2022 Community Health Needs Assessment

Acknowledgments

This 2022 Community Health Needs Assessment report for Beth Israel Deaconess Hospital-Needham (BID Needham) is the culmination of a collaborative process that began in September 2021. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key collaborators from throughout BID Needham'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.

BID Needham 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.

BID Needham thanks the BID Needham Community Benefits Advisory Committee and the residents who contributed to this process. Hundreds of residents throughout the hospital'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.

Beth Israel Deaconess Hospital-Needham Community Benefits 2022 Senior Leadership Team

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Nancy Hoffman, Chief Financial Officer

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Kathy Davidson, Chief Nursing Officer

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Beth Israel Deaconess Hospital-Needham 2022 Community Benefits Advisory Committee

Lina Arena DeRosa, Director, Westwood Council on Aging

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Carol Burak, Trustee, Dedham Food Pantry

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Janet Claypoole, Director, Dover Council on Aging

Sue Crossley, Executive Director, Family Promise MetroWest

Kathy Davidson, Chief Nursing Officer, BID Needham

Lise Elcock, Membership Director, Charles River Regional Chamber

Frank Fleming, Associate Director of Integrated Behavioral Health Service, Fenway Health

Jeanne Goldberg, Regional Practice Director, Beth Israel Deaconess Healthcare

Alyssa Kence, Director of Community Benefits, BID Needham

Wanita Kennedy, Advisor, BID Needham Board of Advisors

Matthew Kuklentz, Assistant Principal, Thurston Middle School

Valerie Lin, Board Member, Dover Parks and Recreation

Cyndi Locke, Director of Clinical Operations, Fenway Health

Tim McDonald, Director, Needham Public Health

Leslie Medalie, Trustee, BID Needham Board of Trustees

Manny Oppong, Assistant Vice President of Behavioral Health Services, Riverside Community Care

Sheila Pransky, Director, Dedham Council on Aging

Sandra Robinson, Director, Needham Community Council

Susan Shaver, Director, Needham Community Farm

Nicole Stewart, Advisor, BID Needham Board of Advisors

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Introduction

Background

Beth Israel Deaconess Hospital-Needham (BID Needham) is a 58-bed acute care community hospital in Needham, Massachusetts that has been nationally recognized for quality and safety. BID Needham's mission is to provide safe, high-quality, community-based health care and access to tertiary care in close collaboration with Beth Israel Deaconess Medical Center. BID Needham commits to its mission by providing the highest quality care focused on patient safety and has been fulfilling this vision for more than 100 years. The entire BID Needham team, including employees, physicians, volunteers, and students, is dedicated to exceeding the expectations of patients, families, the community, and each other. BID Needham has been recognized by several organizations for quality and safety, including the Gold Seal of Approval® from The Joint Commission and a first-place Accountable Care Compass Award from the Massachusetts Health & Hospital Association.

BID Needham 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, BID Needham 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 our patients, our communities, and one another. BID Needham, 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 BID Needham's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BID Needham provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This assessment, along with the associated prioritization and planning processes, also provides a critical opportunity for BID Needham to engage the community and strengthen the community partnerships that are essential to BID Needham's success now and in the future. The assessment engaged more than 600 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, 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 BID Needham's mission. Finally, this report allows BID Needham 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 BID Needham's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BID Needham serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

Prior to this current CHNA, BID Needham completed its last assessment in the summer of 2019 and the report, along with the associated 2020-2022 IS, was approved by the BID Needham Board of Trustees on September 5, 2019. The 2019 CHNA report was posted on BID Needham's website before September 30, 2019 and, per federal compliance requirements, made available in paper copy without charge upon request.

The assessment and planning work for this current report was conducted between September 2021 and September 2022 and BID Needham'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 BID Needham's CBSA. Understanding the geographic and demographic characteristics of BID Needham's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

Description of Community Benefits Service Area

BID Needham's CBSA includes the four municipalities of Dedham, Needham, Norwood, and Westwood, located in the Metrowest area to the south and west of Boston, 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). There is also diversity with respect to community needs. There are segments of the BID Needham'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. BID Needham is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in the CBSA, regardless of race, ethnicity, language

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Community Benefits Service Area

Beth Israel Deaconess Hospital-Needham

spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. BID Needham is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

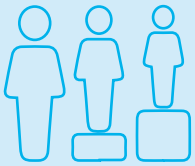
BID Needham's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within the CBSA. The activities that will be implemented as a result of this assessment will support all of the people who live in the CBSA. However, in recognition of the health disparities that exist for some residents, BID Needham focuses most of its community benefits activities to improve the health status of those who face health disparities, experience poverty, or have been historically underserved. By prioritizing these cohorts, BID Needham 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 BID Needham's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BID Needham'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 the hospital's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, 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.

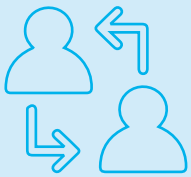


Equity:

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

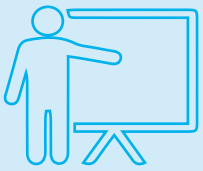
Collaboration:

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:

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

In July of 2021, BILH hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to assist BID Needham and other BILH hospitals to conduct the CHNA. BID Needham worked with JSI to ensure that the final BID Needham CHNA engaged the necessary community constituents, incorporated comprehensive quantitative information for all communities in its CBSA, and fulfilled federal and Commonwealth community benefits guidelines.

Methods

Oversight and Advisory Structures

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

- 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 addressing the needs of those who are medically underserved, those experiencing poverty, and those who face inequities due to their race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, age, or other personal characteristics.

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

The involvement of BID Needham's staff in the CBAC promotes transparency and communication as well as ensures that there is a direct link between the hospital and many of the community's leading health and social service community-based organizations. The CBAC meets quarterly to support BID Needham's community benefits work and met five times during the course of the assessment. 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, BID Needham collected a wide range of quantitative data to characterize the communities in the hospital's CBSA. BID Needham 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 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 the BID Needham 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, BID Needham applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, BID Needham 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, BID Needham conducted 18 one-on-one interviews with collaborators in the community, facilitated four focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 480 residents and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers, and other key 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 related materials.

18 interviews

with community leaders

488 survey respondents

4 focus groups

- Youth
- Older adults
- English language learners
- Parents of youth with mental health needs.

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across a 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 BID Needham. Community Benefits staff reviewed BID Needham's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which includes 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 collaborating with BID Needham. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

At the outset of the strategic planning and reporting phase of the project, community listening sessions were organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA. This was the first step in the prioritization process and allowed the community to discuss the assessment's findings and formally 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 BID Needham 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 anonymous polls, which allowed them to identify a set of community health priorities and population cohorts that they believed should be considered for prioritization as BID Needham developed its IS.

After the prioritization process, a CHNA report was developed and BID Needham's existing IS was augmented, revised, and tailored. When developing the IS, BID Needham's Community Benefits staff retained community health initiatives that worked well and aligned with the priorities from the 2022 CHNA.

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

After the Board of Trustees formally approved the 2022 CHNA report and adopted 2023-2025 IS, these documents were posted on BID Needham's website, alongside the 2019 CHNA report and 2020-2022 IS, for easy viewing and download. As with all BID Needham CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that the hospital's Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

Questions regarding the 2022 assessment and planning process or past assessment processes should be directed to:

Alyssa Kence
Director of Community Benefits
Beth Israel Deaconess Hospital-Needham
148 Chestnut St.
Needham, MA 02492
akence@bilh.org
781-453-5460

Michele Craig
Director, Community Benefits and Community Relations
South Region
Beth Israel Lahey Health
330 Brookline Ave.
Boston, MA 02115
michele.craig@bilh.org

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 BID Needham'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 BID Needham's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status, and other characteristics.

Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the BID Needham CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were non-white, people of color, 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, recent immigrants, and non-English speakers faced systemic challenges that limited their ability to access health care services. Some segments of the population were impacted by language and cultural barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may lead to discrimination and disparities in access and health outcomes.

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

Population Growth

Between 2010 and 2020, the population in BID Needham's CBSA increased by 9%, from 96,835 to 105,332 people. Westwood saw the greatest percentage increase (11%) and Dedham saw the lowest (3%).

Population Changes by, Municipality, 2010 to 2020

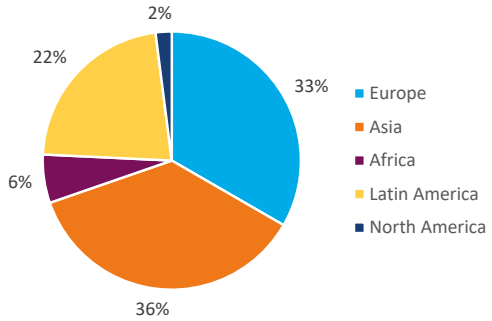
Source: US Census Bureau, 2010 and 2020 Decennial Census'

Nation of Origin

Immigration status is linked to health in many ways; individuals who are foreign-born are less likely to have access to health care and are more likely to forgo needed care due to fear of interacting with public agencies.[2]

15% of the BID Needham 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]

19% of BID Needham CBSA residents 5 years of age and older spoke a language other than English at home and of those,

34% 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 BID Needham 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.

23%
of residents in the 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 lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA+) population of any state in the nation. LGBTQIA+ individuals face issues of disproportionate violence and discrimination, socioeconomic inequality and health disparities.

5%
of adults in Massachusetts identified as LGBTQIA+. Data was unavailable at the municipal level.

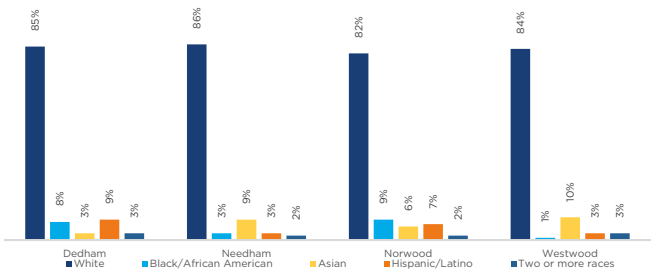
21%
of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

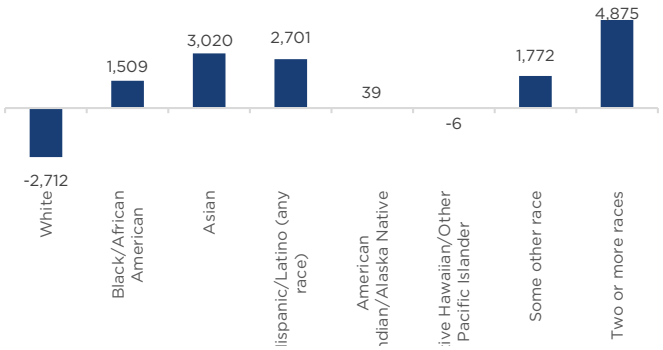
In the BID Needham CBSA overall, the number of residents who identified as white and Native Hawaiian or other Pacific Islander has decreased since 2010, while there was an increase in other census categories. Interviewees reported that they felt the BID Needham CBSA was increasingly diverse, though the 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, 2010and 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 the white, Non-Hispanic white, and Asian populations.

Household Composition

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

33% of BID Needham CBSA households included one or more people under 18 years of age.

34% of BID Needham 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." These conditions influence and define quality of life for many segments of the population in BID Needham's 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. economic insecurity, access to care/navigation issues, and other important social factors.[5]

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

Interviewees, focus groups, and listening session participants shared that access to affordable housing was the most significant challenge for many residents in the BID Needham CBSA. This was particularly true for older adults and those living on fixed incomes. Interviewees, focus groups, and listening session participants shared that there are segments of the CBSA population who are resource insecure, and that even for individuals and families who were in middle and upper-middle income brackets, housing costs were so high that they faced financial insecurity.

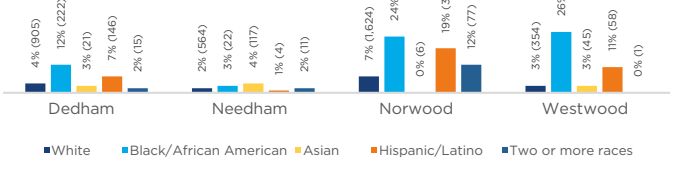
Food insecurity, food scarcity, and hunger were identified as significant challenges, particularly for individuals and families experiencing economic insecurity. These issues were driven by issues related to job loss, the inability to find employment that paid a livable wage, or living on an inadequate, fixed income, which impacted the ability of individuals and families to eat healthy diets. Interviewees, focus groups, listening session participants, and BID Needham Community Health Survey respondents shared that transportation was a critical factor in maintaining one's health and accessing care, especially for those that did not have a personal vehicle or were without caregivers, family, and social support networks. 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 shows that those who are uninsured or have limited health insurance benefits are less likely to access health care services than those who are adequately insured.[8]

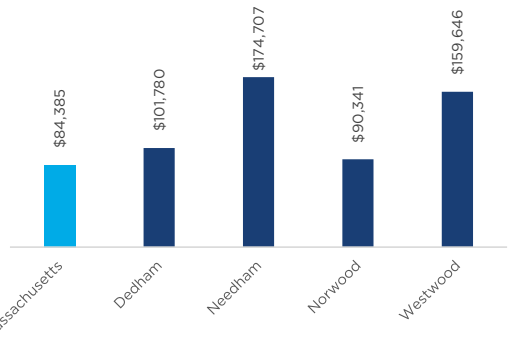
COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, which led to issues of financial hardship, food insecurity, and housing instability.

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



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

Median Household Income, 2016-2020

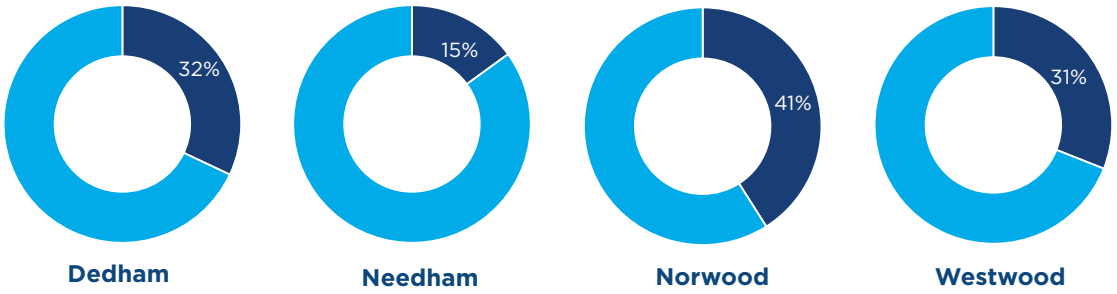


Source: US Census Bureau American Community Survey, 2016-2020

Across the BID Needham 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 higher than the Commonwealth overall in all BID Needham CBSA municipalities.

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)



***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.

96% of BID Needham CBSA residents 25 years of age and older had a high school degree or higher.

63% of BID Needham 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

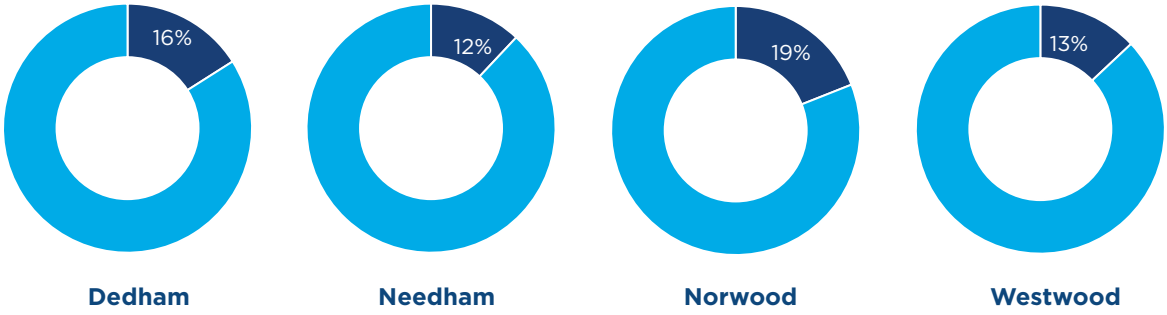
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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, older adults living on fixed incomes, and people living with disabilities and/or chronic health conditions.

5%

of BID Needham CBSA households received SNAP benefits (formerly food stamps) within the past year. SNAP provides benefits to low-income families to help purchase healthy foods.

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



***Unweighted percentages displayed**

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

Neighborhood and Built Environment

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

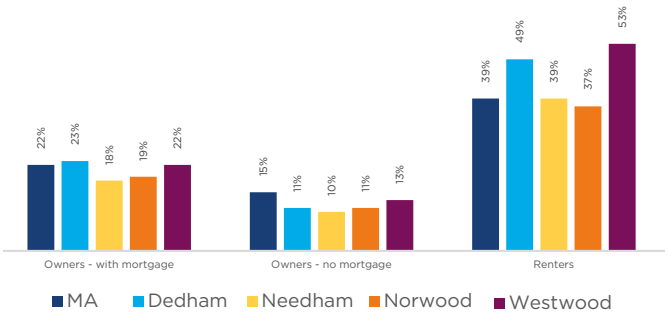
Housing

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

Interviewees, focus groups, and BID Needham Community Health Survey respondents expressed concern over the limited options for affordable housing throughout the CBSA.

The percentage of housing units in the CBSA with owner and renter costs in excess of 35% of household income was lower or similar to the Commonwealth overall in most communities, with the exception of Dedham, where the percentages were higher than the Commonwealth among owners with mortgages and among renters; and Westwood, where the percentage was higher among renters.

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:

57% of BID Needham Community Health Survey respondents said "more affordable housing."

65% of BID Needham Community Health Survey respondents said that housing in the community was not affordable for people with different income levels.

Transportation

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

Transportation was identified as a significant barrier to care and needed services, especially for older adults who may no longer drive or who don't have family or caregivers nearby.

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

34% of BID Needham Survey Community Health Survey respondents wanted more access to public transportation.

7% of housing units in the BID Needham 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 BID Needham Community Health Survey prioritized these improvements to the built environment.

19% of BID Needham Community Health Survey respondents identified a need for better roads.

36% of BID Needham 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 different considerations that influence a person's ability to access timely, equitable, accessible, and high quality services. There is a growing appreciation for the importance of these factors as they are seen as critical to ensuring that people 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 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 reinforced the challenges that residents throughout the BID Needham CBSA faced with respect to long wait-times, provider/workforce shortages, and service gaps which impacted people's ability to access services in a timely manner. This was true with respect to primary care, behavioral health, medical specialty care, and dental care services.

Interviewees, focus groups, and listening session participants also reflected on the high costs of care, including prescription medications, particularly for those who were uninsured or who had limited health insurance benefits. It can be challenging for low-resourced individuals and families to access the services they need to live a happy, productive, and fulfilling life.

Interviewees, focus groups, and listening session participants also discussed the challenges that some segments of the population faced with respect to accessing the internet, taking advantage of telehealth services, and technological resources more generally. These issues were particularly challenging for older adults and non-English speakers and led to challenges navigating the health care system, coordinating care, and accessing services.

Racial Equity

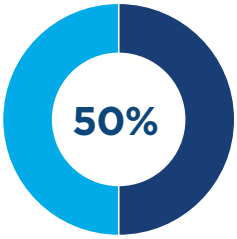
Racial equity is the condition where one's racial identity has no influence on how one fares in society.[14] Racism and discrimination influence the social, economic, and physical environments of Black, Indigenous and People Of Color (BIPOC), resulting in poorer social and physical conditions in those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

Interviewees 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, interviewees expressed concerns about racism, discrimination, and varying levels of acceptance and recognition of diversity in the community.

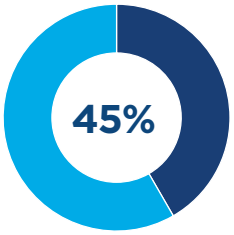
"Despite a strong effort by the town to create a welcoming environment, there is still a strong undercurrent of racism and anti-LGBT sentiment (especially anti-trans) in the town that makes it feel scary to be a person of color and/or a member of the LGBT community. I think the efforts of the town, schools, and community groups are helping to be more inclusive, but those rare yet shocking instances of overt bigotry stick in our minds and leave us wondering whether we'll be the next victim of hate speech, or worse."

- BID Needham Community Health Survey respondent

Among BID Needham 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 stemmed from the ways in which the system did or did 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]

Populations 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.

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 lacked technical resources or technical savvy to take advantage of such programs.[17]

Community Connections and Information Sharing

A great strength of BID Needham's CBSA were the strong community-based organizations and task forces that worked to meet the needs of CBSA residents. However, interviewees, focus groups, and listening session participants reported that community-based organizations often worked in silos, and there was a need for more partnership, information sharing, and leveraging of resources between organizations. Interviewees and focus group participants also reported that it was difficult for many community members to know what resources were available to them, and how to access them.

"We [community organizations] need to develop truly collaborative and collective solutions that conserve resources and do things more efficiently."

– BID Needham interviewee

Behavioral Factors

The nation, including the residents of Massachusetts and BID Needham's CBSA, faces 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 previously.[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 the community's prioritization process, the information from the assessment supports the importance of incorporating these issues into BID Needham'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.

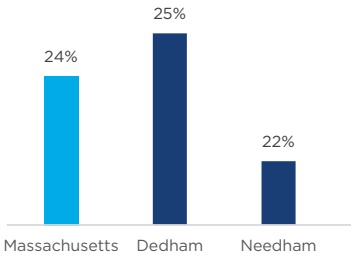
10% of BID Needham Community Health Survey respondents said they would like their community to have better access to healthy food.

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the BID Needham CBSA, though there was recognition that lack of physical fitness is 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 Dedham; data was unavailable in Norwood and Westwood.

Percentage of Adults Who Were Obese, 2018



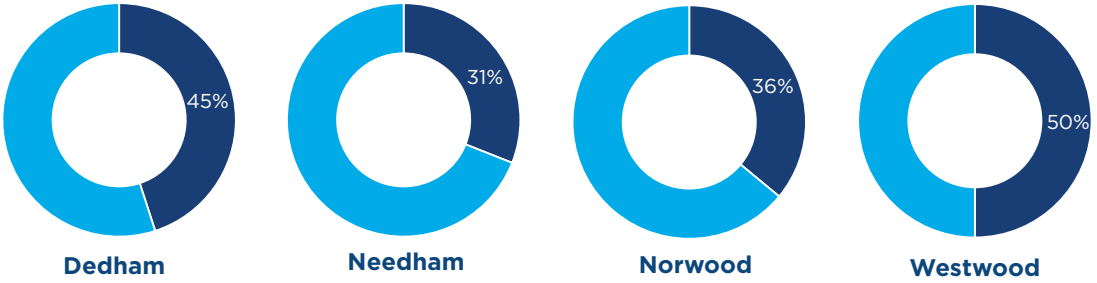
Source: Behavioral Risk Factor Surveillance System, 2018

Alcohol, Marijuana and Tobacco Use

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

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

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



***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 BID Needham's CBSA.

To augment and clarify this information, the assessment efforts included community engagement activities and specific requests for participants to reflect on the issues that they felt had the greatest impact on community health. Efforts were made to ensure that participants reflected on a broad range of issues, including chronic and communicable medical conditions and behavioral health issues.

Given the limitations of the quantitative data, specifically that it was often old data and was not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, listening sessions, and the BID Needham 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 for youth and young adults and social isolation among older adults. These difficulties were exacerbated by COVID-19.

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

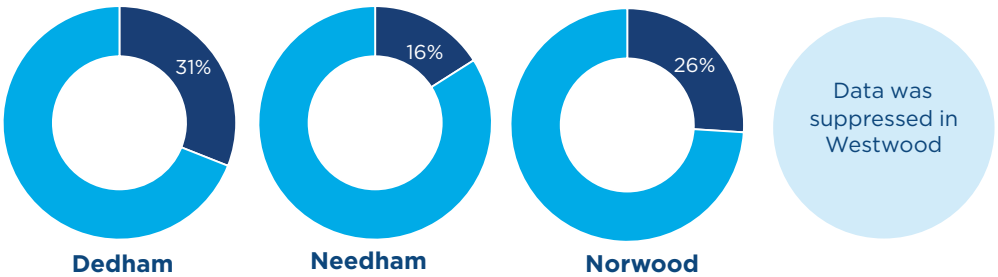
Youth mental health was a critical concern in the BID Needham CBSA, including the significant prevalence of chronic stress, depression, anxiety, and behavioral issues. These conditions were exacerbated over the course of the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

46% of high school students in Needham reported that the greatest barrier to seeking help at school for emotional challenges was that "they wouldn't have time or wouldn't want to miss class." (Needham Youth Risk Behavior Survey, 2018)

12% of 12th graders in Needham reported having seriously considered suicide in the past year. (Needham Youth Risk Behavior Survey, 2018)

In Dedham, Needham, and Norwood, over 15% of residents who took MDPH's COVID-19 Community Impact Survey reported they had 15 or more poor mental health days in the past month. Data was suppressed in Westwood.

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



***Unweighted percentages displayed**

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

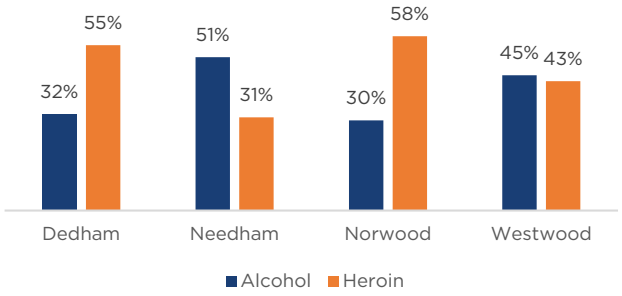
Health Conditions

Substance Use

Substance use continued to have a major impact on the 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 and economic insecurity. Interviewees, focus group and listening session participants reported that alcohol use was normalized, and use was prevalent among both adults and youth.

Among those who were admitted to Massachusetts Department of Public Health treatment facilities, alcohol was the most common primary substance of use in Needham and Westwood, while heroin was the most common in Dedham and Norwood.

Common Substances of Use Among Those Admitted to DPH Treatment Centers, 2017



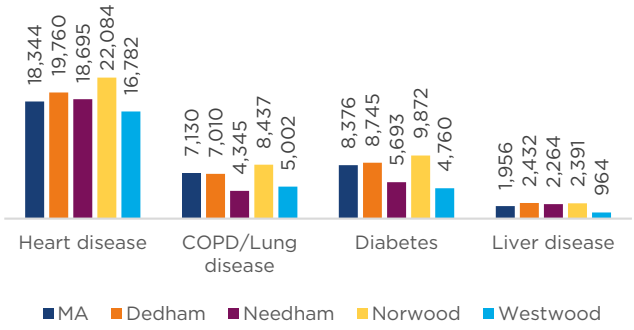
Source: MDPH Bureau of Substance Abuse Services, 2017

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.[20]

Looking across four of the more common chronic/complex conditions, inpatient discharge rates among adults 65 years of age and older were similar to or higher than the Commonwealth in Dedham, Needham, and Norwood. Rates were consistently lower than the Commonwealth in Westwood.

Inpatient Discharge Rates (per 100,000) for Chronic/Complex Conditions Among Those 65 Years of Age and Older, 2019



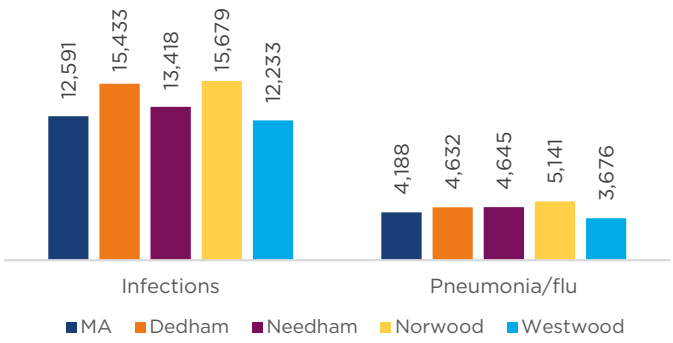
Source: Center for Health Information and Analysis, 2019

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 at listening sessions 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 BID Needham's CBSA had higher inpatient discharge rates for infections and pneumonia/flu compared to the Commonwealth, with the exception of Westwood, where rates were lower.

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



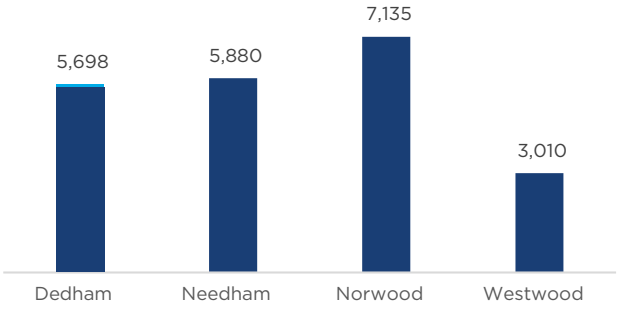
Source: Center for Health Information and Analysis, 2019

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 continues to directly impact nearly all facets of life, including economic stability, food insecurity, mental health (stress, depression, isolation, anxiety), substance use (opioids, marijuana, alcohol), and one's ability to access health care and social services.

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 interviewees described how COVID-19 exacerbated poor health outcomes, inequities, and health system deficiencies.

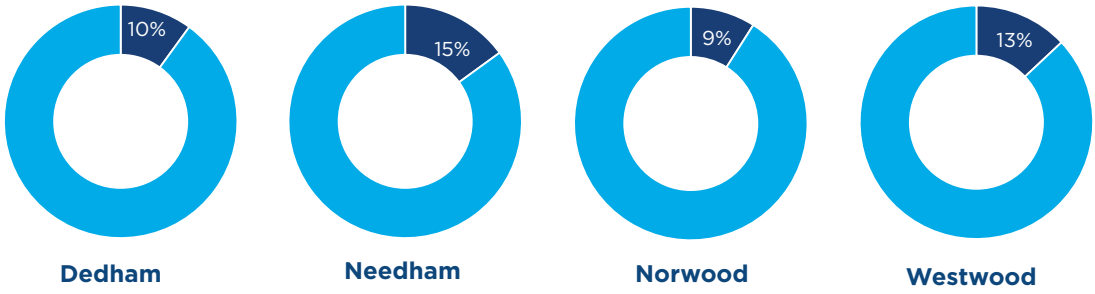
Total COVID-19 Case Counts Through June 23, 2022



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

In all of BID Needham's CBSA communities except Norwood, at least 10% of respondents to the COVID-19 Community Impact Survey reported that they had not gotten the 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)



***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 interactive, anonymous polling software, BID Needham's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and the cohorts that they believed should be the focus of BID Needham's IS. This prioritization process helps to ensure that BID Needham maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

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

Massachusetts Community Health Priorities

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

Community Health Priorities and Priority Cohorts

BID Needham is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, BID Needham 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 cohorts within the community health priority areas.

BID Needham Community Health Needs Assessment: Priority Cohorts

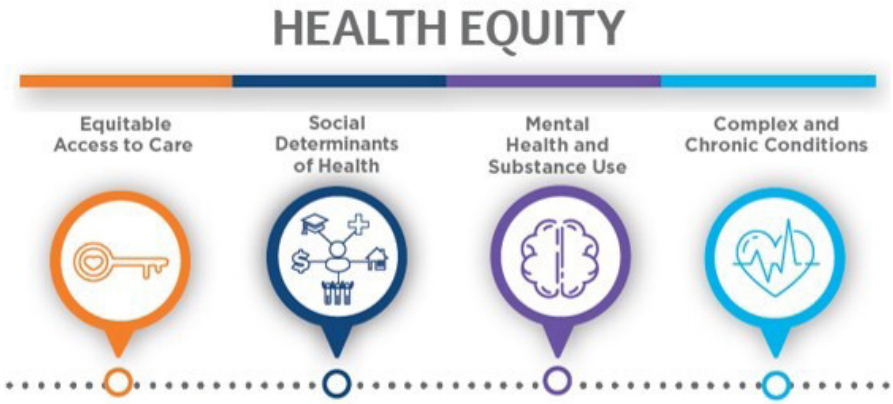
Youth

Older Adults

Low-Resourced Populations

Racially, Ethnically and Linguistically Diverse Populations

BID Needham Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BID Needham

It is important to note that there are community health needs that were identified by BID Needham's assessment that were not prioritized for investment or included in BID Needham's IS. Specifically, supporting education across the lifespan, affordability of childcare, digital divide, tackling misinformation, connections between police and community, and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in BID Needham's IS. While these issues are important, BID Needham'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, BID Needham recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. BID Needham 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 BID Needham's IS

The issues that were identified in the BID Needham CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, transportation, economic insecurity, build capacity of workforce, navigation of healthcare system, linguistic access barriers, diversify provider workforce, affirming care for LGBTQIA+, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, racism/discrimination, culturally appropriate/competent health and community services, cross sector partnerships/collaboration/responses, linguistic access/barriers to community resources/services, alcohol use prevention/treatment, vaping, marijuana use, opioid use, health education and awareness of risk factors and resources, resource inventory, fostering sense of community and belonging, and cross sector collaboration/partnerships/information sharing/referrals.

Implementation Strategy

BID Needham'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 BID Needham's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed BID Needham to develop its 2023-2025 IS.

Included below, organized by priority area, are the core elements of BID Needham's 2023-2025 IS. The content of the strategy is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention), and disease management and treatment (tertiary prevention).

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

Community Benefits Resources

BID Needham 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 BID Needham and/or its partners to improve the health of those living in its CBSA. Finally, BID Needham supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and are unable to pay for care and services. Moving forward, BID Needham 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, BID Needham'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. BID Needham 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 BID Needham 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:

- Provide and promote career support services and career mobility programs to hospital employees and support job-training programs that strengthen the local workforce and address underemployment.
- Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.
- Promote access to health care, health insurance, patient financial counselors, needed medications and other essentials for patients who are uninsured or underinsured.

SOCIAL DETERMINANTS OF HEALTH

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

Strategies to address the priority:

- Support impactful programs that address issues associated with the social determinants of health.
- Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.
- Promote collaboration, share knowledge and coordinate activities with internal colleagues and external partners.
- Support impactful programs that stabilize or create access to affordable housing.
- Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

- Enhance relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills.
- 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.
- Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.
- Support impactful programs that address issues associated with mental health and substance use.

COMPLEX AND CHRONIC CONDITIONS

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions 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.
- Ensure older adults and those with complex/chronic conditions have access to coordinated healthcare, supportive services, and resources to support overall health and age in place.

Evaluation of Impact of 2020-2022 Implementation Strategy

As part of the assessment, BID Needham evaluated its current IS. This process allowed BID Needham to better understand the effectiveness of it's ommunity benefits programming and to identify which programs should or should not continue. Moving forward with the 2023-2025 IS, BID Needham 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, BID Needham 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. BID Needham 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	Summary of Accomplishments and Outcomes
Mental Health and Substance Use	The closure of Norwood Hospital, along with the aftermath of COVID-19, has caused an increase in acuity and frequency of mental health needs at BID Needham. The hospital has responded by investing in the continued integration of behavioral healthcare at the hospital. A Director of Clinical Psychiatry was hired in FY20 to offer consults on inpatients, and in FY21 the hospital added a Director of Behavioral Health and embedded a social worker in the Emergency Department to help with placement and navigation. BID Needham also continued to contract with Riverside to manage the bed search and placement process for all patients requiring inpatient level of care. In addition to the clinical staff, BID Needham continued internal programs focused on substance use, such as the Opioid Taskforce and a medication and sharps disposal kiosk in the lobby. Realizing the importance of having access to behavioral health providers in the primary care setting, BID Needham supports the Beth Israel Deaconess Healthcare Collaborative Care model, which places social workers in PCP offices as a resource for patients and consult for physicians. Within the community, BID Needham has awarded grants to several organizations to address these needs. The hospital supports the Interface Mental Health Hotline in Needham and Medfield, the Substance Prevention Alliance of Needham (SPAN), Plugged-In Band Program, Walker and Riverside school. Grants from the hospital have also supported training and education on behavioral health topics within the community, such as QPR training, talks for parents and caregivers, and Narcan training. BID Needham has also offered Mental Health First Aid Training to staff and board members. Finally, the hospital works collaboratively on taskforces and coalitions focused on mental health and substance use, to assist with the identification and resolution of chronic needs. Examples include the Community Crisis Intervention Teams in Needham and Norwood, the Youth Resource Network, the Charles River Opioid Taskforce, and SPAN.
Chronic and Complex Conditions and their Risk Factors	Chronic conditions continue to be a health priority for the hospital's service area, and BID Needham works toward the prevention and management of these conditions within the hospital and community. Within the hospital, BID Needham has a Utilization Review Committee focused on preventing readmissions and helping those patients with chronic conditions to manage their illnesses. The hospital subsidizes a CHF nurse to focus solely on helping these patients manage their conditions. Bridging care into the community, BID Needham partners with local EMT's on a stroke prevention program, and also restocks ambulances with medications to ensure patients have the life-saving medication needed.

Chronic and Complex Conditions and their Risk Factors (continued)	Epi-pens and syringes are donated to schools and public health to ensure access to this medication and to vaccines, such as flu shots. BID Needham provides financial support to Beth Israel Deaconess Healthcare Primary Care Offices within the community benefits service area to ensure access to care for local residents. Within the community, BID Needham continues to partner with BIDMC and the Boston JCC to provide an annual series of health-related talks to the community, free of charge. In addition, the hospital has provided grants focused on the management and prevention of chronic disease, including the Livestrong Program at the Charles River YMCA, a Medical Nutrition Therapy pilot program at the Westwood Council on Aging, for outdoor exercise equipment at Gonzalez Park in Dedham, and to Charles River Center to purchase medical supplies and equipment for their residents.
Social Determinants of Health and Access to Care	BID Needham saw a large increase in need for housing and food access during the pandemic, and supported local organizations that were addressing these needs. The hospital also continued to focus on health equity. In the area of housing, BIDN supported Family Promise Metrowest with a grant for their LIFE program, a homelessness prevention program that supports families who are at risk of eviction but not yet homeless. To support the basic needs of patients and residents, the hospital provided grants and partnership to local organizations addressing these needs. BID Needham and Circle of Hope partnered to create an "ED Essentials" closet, providing clothing, shoes, coats and hygiene products to patients in need. The Concord Prison Outreach's WELCOMEBACKpack program provided essentials to incarcerated men and women who were recently released from prison; and Circle of Hope's health and dignity program provided hygiene products at the Dedham Food Pantry. In the area of food access, BID Needham awarded grants to several local organizations addressing food insecurity, including Dedham Food Pantry, Needham Community Farm, Needham Farmer's Market, Mass Bay Community College and Three Squares New England. The hospital also continued to partner with Needham Public Health on the traveling meals program for homebound residents. The pandemic provided a huge struggle for older adults in the community, both in terms of social interaction/ isolation, and with food and technology access. BID Needham provided grants to the local Councils on Aging to address these needs through creative food distribution and social programming. The hospital also continued the ongoing partnership with Needham Public Health and Needham Council on Aging to address the social and physical needs of older adults through a Healthy Aging Initiative, offering fitness, balance and social programming. Finally, in the area of health equity, BID Needham supported the Needham Community Council's medical transportation program, Neighbor Brigade and their efforts to provide assistance to chronically ill residents, and VNA Care for their employee training on community resources. Within the hospital, Certified Application Counselors provide insurance enrollment assistance and the hospital continues to improve culturally and linguistically-appropriate care.

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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 BID Needham [and any collaborators] are conducting a community health needs assessment and creating an implementation plan to address the prioritized needs identified. For the first time, all 10 hospitals in the BILH system are conducting this needs assessment together. Our hope is that we will create a plan at the individual hospital level as well as the system level that will span across the hospitals.

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

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

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

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

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

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

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

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

BID Needham Interview Summary

Interviewees

- Lina Arena-DeRosa, Director, Westwood Council on Aging
- Anne Marie Bajwa, President and CEO, The Charles River Center
- Pam Chubet, Senior Resident Services Coordinator, Norwood Housing Authority
- Aubrey Ciol, Program Director, Impact Norwood Prevention Coalition
- Susan Crossley, Executive Director, Family Promise MetroWest
- Marcy Eckel, Executive Director, Neighbor Brigade
- Representative Denise Garlick, State Representative
- Kristina King, Program Director, Dedham Drug Free Communities
- Matthew Kuklentz, Assistant Principal, Westwood Public Schools
- Sheryl Leary, Director of Planning and Community Development, HESSCO Elder Services
- Christina Matthews, Member, Needham Human Rights Committee
- Tim McDonald, Director of Public Health, Town of Needham
- Carrie Moore, Executive Director, Dedham Housing Authority
- Manny Oppong, Vice President of Service Integration, Riverside Community Care
- Sigalle Reiss, Public Health Director, Town of Norwood
- Sandra Robinson, Executive Director, Needham Community Council
- Jenn Scheck-Kahn, Consultant, Special Education Services
- Kylee Sullivan, Health Director, Town of Dedham

Key Findings

Community characteristics

- Residents are civic-minded; eager to be involved in community
    - "High degree of volunteer spirit."
- Strong public school systems – draws people to these communities
- Increasingly diverse in terms of race, ethnicity, household composition, etc. but still overwhelmingly white and affluent

Specific populations facing barriers

- Older adults – isolation and living on limited incomes
- Youth - specifically mental health concerns
- LGBTQIA – can be a marginalized population
- BIPOC individuals facing racism/discrimination – may not feel comfortable in largely white community
- Non-English speakers – Asian languages, Russian, Hindi
- Low-income individuals

Social Determinants of Health

- Significant concerns around housing
    - Lack of truly affordable housing for low-income and middle class families and older adults
    - High taxes – "Taxes are extreme. When your taxes are as high as they are here, and you're on a limited income, people struggle."

- Though communities in the service area are considered 'affluent,' there are many individuals struggling with economic insecurity
- Lack of affordable childcare

- Food insecurity
- Transportation an issue for some – especially those who need transport into Boston to see specialists.

Mental health

- High prevalence of anxiety, chronic stress, depression, isolation
    - Existed prior to, but were certainly exacerbated by COVID
    - "People's filters are gone. People are angrier. Many people in this community aren't used to difficult times."
- Youth mental health is critical concern – contributing factors include pressure to succeed in academics and extracurriculars; social issues; impacts of COVID (including stress within the home, remote learning, isolation from peers)
- Barriers to care are numerous – long wait times, providers not accepting insurance (out of pocket costs very expensive), stigma of seeking care and discussing mental health issues
    - Specifically in need of more options for inpatient psychiatric treatment, especially for youth

Access to care

- Across all sectors – long wait times
- Lack of capacity in specific areas – inpatient psychiatric care, mental health counseling
- Limited safety net providers in the service area
- Cost and insurance are significant barriers for those who are uninsured and underinsured
- Language and cultural barriers

Community connections/info sharing

- Though community resources exist, they aren't well-known to all community members
- Community organizations working in silos can lead to fragmentation of services – need better communication and collaboration
    - "[Community organizations] need to develop truly collaborative and collective solutions that conserve resources and do things more efficiently."

Diversity, Equity, Inclusion

- Over past two years, many communities have formed new coalitions and task forces to address racism and inequities in communities
- Need more conversations in the community around unconscious bias
- Racism has impact on mental health
- Biggest challenges to addressing these issues is ignorance and denial
    - "[The biggest challenge to addressing impacts of racism] is the fact that people don't think it exists."
- Lack of diversity among community leaders

Substance Use

- Among youth, marijuana and vaping are being used to cope with stress and mental health issues
- Alcohol use increasingly normalized and prevalent among adults and youth
- Opioid crisis persists
- Since pandemic, providers report an uptick in drug/alcohol relapse

Resources/Assets

- Engaged community members – "people that care about improving their community
- Educational systems
- Hospital

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

Beth Israel Lahey Health Community Health Assessment

Focus Group Guide

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

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

Summary of Focus Group with Parents of Teens with Mental Health Issues

Date: 10/19/21 Start Time: 7 pm End time: 8pm

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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?**

- Access to kids with similar challenges in non-institutional settings
- Being part of a group- sports, clubs at school, etc
    - Finding your group, a place that will celebrate who you are
- Adults who actually care and take them seriously

2. **What are some of the things that make it hard for your child/adolescent to be healthy?**

- Isolation, feeling like not part of a group
- Devices, screen time, specifically social media
- Fear, especially among LGBTQ population
- Lack of training in schools around the LGBTQ experience
- Shame

Recommendations:

- Non labeled, open ended, informal space for adolescents to connect with peers
    - With a nominal fee
- Volunteer opportunities
    - An easier way to access volunteer opportunities (a method or system)
- Connection with an elder/a mentor
- Animal of the day
    - Local vets could have volunteer opportunities
- Resources to help parents speak with their kids
    - Dr. Ross Greene (https://drrossgreene.com/): Collaborative Problem Solving
    - parent training/counseling etc is really key
    - Asking your kid to recommend movies, shows and books that would help you understand their experience / perspective
    - https://livesinthebalance.org/

Summary of English Language-Learner Focus Group

Date: 11/16/2021 Start Time: 10am End time: 11am

Health	
What does being healthy mean to you? • What does it look like? • What does it feel like?	• Physical health ○ No pain, feeling good in your body • Mental health • Oral health • OBGYN/women's 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?	• Regular check-ups, routine visits • Eating healthy, good nutrition • Good hygiene: keeping your environment clean, keeping self clean • Regular exercise: sports, walking • Herbal, traditional medicine
Are the things that help you stay healthy available to everyone or just a few groups of people?	Note: participant mentioned difficulty speaking for a community, not connected • Exercise is available to most people without disabilities • Personal choices around eating choices, exercise frequency • Herbal medicines from Haiti, asking friends or network to bring some over
Of the things that you've named as helping to keep you healthy, which would you like to see more of?	• More healthy food choices, less fast-food ○ More health education, knowing what's good for your body and organs • More exercise options
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?	**Top Factors** 1. Access to doctors/regular care 2. Healthy eating 3. Good hygiene 4. Exercise
Unhealthy Factors	

What are some of the things that make it hard for you to be healthy?	• Insurance access and coverage, affordability of healthcare
	  ○ Lack of continuity of care, e.g. being unable to finish treatments because of loss of insurance
	  ○ Not seeking care despite health concerns, e.g. waiting for health insurance coverage
	• Navigating insurance/health information and systems
	  ○ Knowing what is **and** is not covered
	  ○ Knowing what health services are available for self and children
	• Access to healthy choices i.e. fruits and vegetables
	• Mental health/stress

	○ Leading stressors include taking care of kids, finding a job, adult education, grief from familial issues and deaths (including COVID-19 related deaths)
Do these things (that make it hard for you to be healthy) affect everyone or just a few groups of people?	• Information for non-English speaking residents • Different access to private healthcare and private doctors
Why do you think the things that make it hard for you to be healthy exist?	Did not ask this question
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?	Note: participant mentioned difficulty since they have not received care at hospitals • Increased information access ○ List of available services, doctors, locations, associated costs • Prioritizing caring for people outside of monetary value/profit, e.g. going to front desk and just being seen as someone without insurance instead of someone needing assistance
What do you think should be the top 3 issues that health service providers should focus on to make your community healthier?	Costs of taking care of family and health
Section 4: Final Remarks & Closing	
Are there any other ideas you wanted to share before we leave today?	

Summary of Focus Group with Older Adults at Dedham Council on Aging

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

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

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

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

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

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

Summary of Focus Group with Needham High School Students

Date: 12/16/2021 Start Time: 2:45pm End time: 4:00pm

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?	• Exercise for physical and emotional health
	  ○ Needham High School offers sports 5-6 days/ week
	• Healthy foods
	  ○ Many dietary options for breakfast and lunch
	• Supportive community for mental health
	  ○ School counselors
	  ○ "Own Your Peace" club that addresses mental health
	• Numerous school groups to address issues of health, race, and equity
	  ○ SALSA (Students Advocating Life without Substance Abuse) to increase awareness and connect students with resources
	  ○ CCOR class (Courageous Conversations on Race) that addresses racism and racial inequities
	  ○ Racial Literacy programs that have started at Needham elementary schools.
	• Numerous Community groups / organizations that address issues of health
	  ○ SPAN Coalition (Substance Prevention Alliance of Needham)
	  ○ Needham Youth & Family Services
	  ▪ Peer Tutoring programs & High School Mentor programs for ES and MS students
	  ○ Community Council
	  ▪ Food Pantry
	  ▪ Thrift Store
	  ▪ Medical Equipment
	  ▪ Transportation
	  ▪ English Language Learning
	  ▪ Tablets & Tutors

Unhealthy: What are some of the things that make it hard for you to be healthy?	• Too much academic stress • Mental Health challenges (Anxiety, depression, isolation/ lack of socialization) • Poor School / Life / Friend Balance • Substance use issues • Poor / stressful home life / parental conflict • Lack of healthy foods • Financial Concerns • Eating disorders • Lack of sleep • Outdated school health curriculum • Bullying / peer pressure • Racial Equity

	• LGBTQIA+ discrimination • "Mansplaining"
Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly? *If yes, move on to Section 2.* *If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)* Let's talk more deeply about these concepts.	Top Factors 1. Mental Health 2. Substance Use 3. Racial Equity 4. Special Ed stigma
<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.*	
Explore Key Factors	**Mental Health / Academic Pressure / Life Balance** • **Mental Health** o Often mental health not taken seriously by staff/ other students o Lack of availability and awareness regarding mental health services available o Teachers don't want to address individual mental health issues or make allowances. o Social Media causes a lot of stress (Instagram/Snapchat) o Home life can be stressful w/parental conflict o Some students feel that they don't belong or are not well understood, don't appreciate the pressure and stresses that they have to deal with • **Academic pressure** o Challenging courses + excessive homework = high stress o Pressure to take the "Blast" classes and join many clubs/extracurricular activities, which leads to stress, limited social / down time, and affects school performance o Sense that school must come before health, fun, and social activities o Teachers don't help students with mental health problems by shifting workloads/deadlines

- Teachers don't reach out to help. Students must ask for help and some don't feel comfortable asking for help (or their parents don't want them to get help)
- Peer pressure related to academic achievement
  - Pressure to take the most challenging classes
  - Students are stereotyped based on the classes they take
  - Lots of competition academically among peers
  - Bullying / peer pressure

Substance use

- "Substance use is casual at NHS. It's normalized and that can be dangerous."
- "We need to increase awareness that it can be cool not to use"
- Drinking and driving is taboo, but marijuana use and driving is not a big concern. "We don't hear much about the dangers of marijuana and driving".
- Need to think more about the underlying causes of substance use. The focus is on risks and harm but not necessarily on the underlying issues that might have led to the substance use
- "Needs to be more discussion of Harm reduction and addressing / understanding root causes"

Racial Equity / LGBTQIA Discrimination

- **Racial Equity**
  - There is increased awareness about racial inequities, but no change happens.
  - Stereotypes and micro aggressions against Asian, Black and Female students (by staff and peers)
  - Black students in a predominantly white school must talk/act in a specific way with their white peers (need to change)
  - Some teachers let racial/gender equity issues go in the classroom. They hear inappropriate racist comments but don't do anything. Students not held accountable for their actions
  - There are no school policies regarding discrimination

- **LGBTQIA+ Discrimination**
  - There is increased awareness about racial and gender inequities, but no change happens.
    - Some students have been forced to leave class after being targeted with disrespectful gender pronouns (respondent seemed to suggest that was not fair)

	○ Assumptions are made regarding gender. Staff has been educated/made aware of gender pronouns, but they continue to disrespect students. They don't change their behaviors. ○ Incidences of disrespect, micro aggressions, and racist innuendo are not entirely uncommon by students and teachers ▪ "Lack of respect in the classroom by teachers and administration staff" ○ Students file reports with counselors or administrators re: disrespectful gender or racial issues but nothing seems to change. ○ Students believe that some of the ways that LGBTQIA+ issues are "performative". "They use the "He/she/They" pronouns and think that makes them an ally but it really doesn't. This is disrespectful. Need more concrete, sincere action" • **Gender Discrimination** ○ Teachers at NHS get more respect by students if they are male vs. female ○ "Mansplaining"- boys assume they are better at Math/Science **Other Issues** • Home life can be stressful w/parental conflict • Financial pressure ○ "It's hard to have a healthy diet when I'm busy and need to buy lunch. My parents don't always have time to buy healthy food to have at home."" • Lack of healthy foods ○ Food policies in the school cafeteria (payment/portions) ○ School starts very early each day- I'm starving but there aren't any options at home/school • Eating disorders ○ Sometimes teachers don't realize it but trigger students by emphasizing diets and calorie counting during Wellness classes ○ The curriculum needs updating (ex: Calorie counting in Wellness classes and BMI calculations in science classes) • Lack of sleep • Outdated school health curriculum
Are these **(things that keep you healthy)** available to	• Clear sense that some groups were much more affected by these issues than others, particularly those

everyone or just a few groups of people?	who experience material poverty, Black/African Americans, and Asians across the spectrum (e.g., Korean, Chinese, people from India, etc.) • A great deal of discussion regarding cultural stereotypes and racism and the trauma, injustice, and harm that can occur by reinforcing or "buying-in" to these stereotypes and racist ideas.
Why do you think they **(things that make it hard to be healthy)** exist? • Why is this a challenge?	• ***See above***
What are some examples of how these challenges impact someone's health?	• ***See above***
Section 3: Ideas and Priorities	
Ideas: • Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time? • Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?	**Mental Health / Academic Pressure / Life Balance** • Need to develop policies and procedures norms re: homework and workload that lead to better life balance and reduce stress • Need to develop and conduct better education and awareness campaigns, policies and programs that increase understanding of the burden of mental health and encourage school community to take it more seriously • Need to increase awareness and work to link students to mental health resources • Increase programs related to prevention and reduction of stress behaviors • Programs, educational interventions that reduce negative impacts of Social Media (Instagram/Snapchat) • Develop programs that engaged parents, family members, and caregivers that raise awareness and work to address family stress and reduce parental conflict • Teachers and parents need to be more proactive about reaching out to students about stress, academic burdens, depression, etc. • Need more clear and effective policies and programs to address mental health stress and reduce academic pressure. The school and teachers need to be held accountable • Educate staff about how to identify a student in need and connect them with resources (what to look for). • Increased awareness for students regarding available resources in/outside school (some students not comfortable sharing w/school counselor) • Reduce the cost of school sports (barrier for some students) • Need to be able to see a counselor outside the school day (after school)

	• High School Counselors should work w/Middle School Counselors to understand the needs of rising 9th graders • Counselors should not share so much info. with parents • Allow students to change guidance counselors if there is not a good fit (some students want/need help but counselor is not helpful or is too busy) • Allow students to see counselor at school without parental approval (some parents do not want their child to see a counselor) **Substance use** • More and better education re: substance use, focusing on harm reduction and addressing underlying causes of substance use • Address normalization of marijuana **Racial Equity / LGBTQIA Discrimination** • **Racial Equity** o More better education, awareness, and sensitivity training around race and gender identity o Need policies and programs that reduce impacts of racism and discrimination and hold teachers and students and administrators accountable o Need to develop plans that lead to real change and to monitor the efforts to ensure that there is improvement. Need to track incidences of micro aggressions against Asian, Black and female o Education for staff re: how to engage with students in ways that do not trigger them re: race, gender
Priorities: • What do you think should be the top 3 issues service providers should focus on to make your community healthier?	***See above***
<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***

Community Listening Sessions

- Presentation from Facilitation Training for community partners
- Facilitation guide for listening sessions
- Listening Session presentation
- Priority vote results and notes from February 2, 2022 listening session
- Priority vote results and notes from February 8, 2022 listening session

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

AGENDA

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

WHAT IS FACILITATION?

Facilitation is a dance, an artform.

INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish community agreements

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

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Design for different learning and processing styles

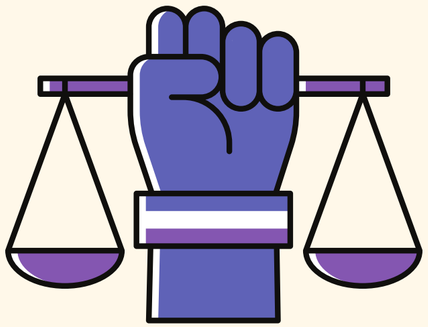
Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

Consider accessibility

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

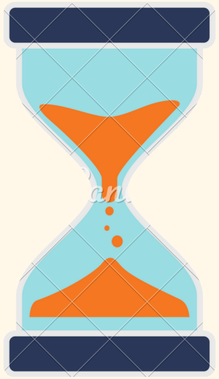
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

LET'S CONSIDER THE FOLLOWING

1

A participant seems to dominate the conversation.

2

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

3

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

THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

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

BILH Community Listening Session: Breakout Discussion Guide

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

Mentimeter link:
Jamboard link:

Ground rules and introductions (5 minutes)

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

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

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

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

Question 1 (5 minutes)

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

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

Notes:

Question 2 (15 minutes)

Part 1: 10 minutes

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

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

Notes on missing priority areas:

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

Part 2: 5 minutes

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

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

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

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

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

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

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

Question 3 (25 minutes)

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

Let's start with [Priority Area 1].

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

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

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

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

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

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

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

Notetakers will be taking notes within Jamboard.

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

Wrap Up (1 minute)

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

Notes:

BID NEEDHAM
COMMUNITY LISTENING SESSION

February 2, 2022 9:30-11:00
February 8, 2022 7:30-9:00

Beth Israel Lahey Health

BID Needham Community Listening Session

Acknowledgments

BID Needham Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
9:30-9:35	Opening remarks and Zoom overview	JSI
9:35-9:45	Overview of assessment purpose, process, and guiding principles	Alyssa Kence, Community Benefits Director, BID Needham
9:45-9:55	Presentation of preliminary themes and data findings	JSI
9:55-10:55	Breakout Groups	Community Facilitators
10:55-11:00	Wrap up: Closing statements and next steps	Alyssa Kence

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** identifies key health needs and issues through data collection and analysis.
- An **Implementation Strategy** is a plan to address public health problems collaboratively with municipalities, organizations, and residents.

All non-profit hospitals are required to conduct a Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) every 3 years

Beth Israel Lahey Health
Beth Israel Deaconess Needham

Community Benefits Service Area

Beth Israel Deaconess Hospital-Needham

Assessment Purpose and Process

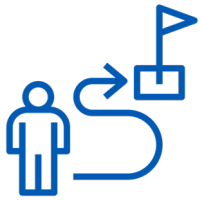
FY22 CHNA and Implementation Strategy Guiding Principles

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

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

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

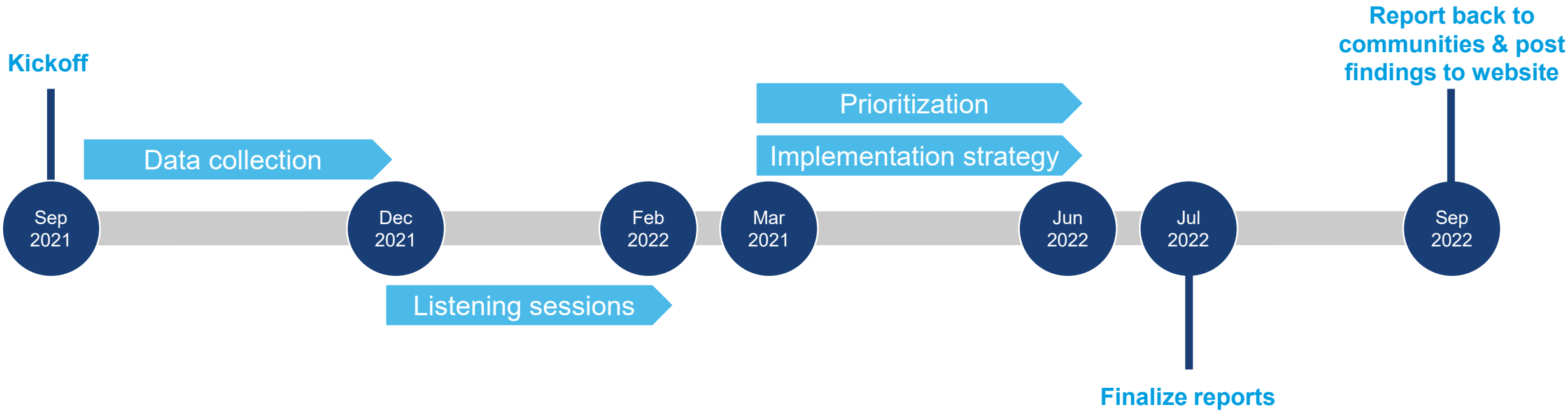
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



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

Assessment Purpose and Process

FY22 CHNA and Implementation Strategy Process

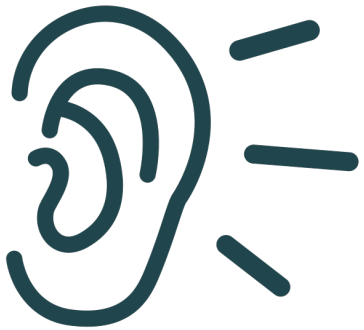


Assessment Purpose and Process

Meeting goals

Goals:

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



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

Key Themes & Data Findings

CHNA Progress
Activities to date

Gathered Publicly Available 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 **Interviews with Community Leaders**

488 **Survey Respondents**

4 **Small Group Discussions**

-Needham Youth

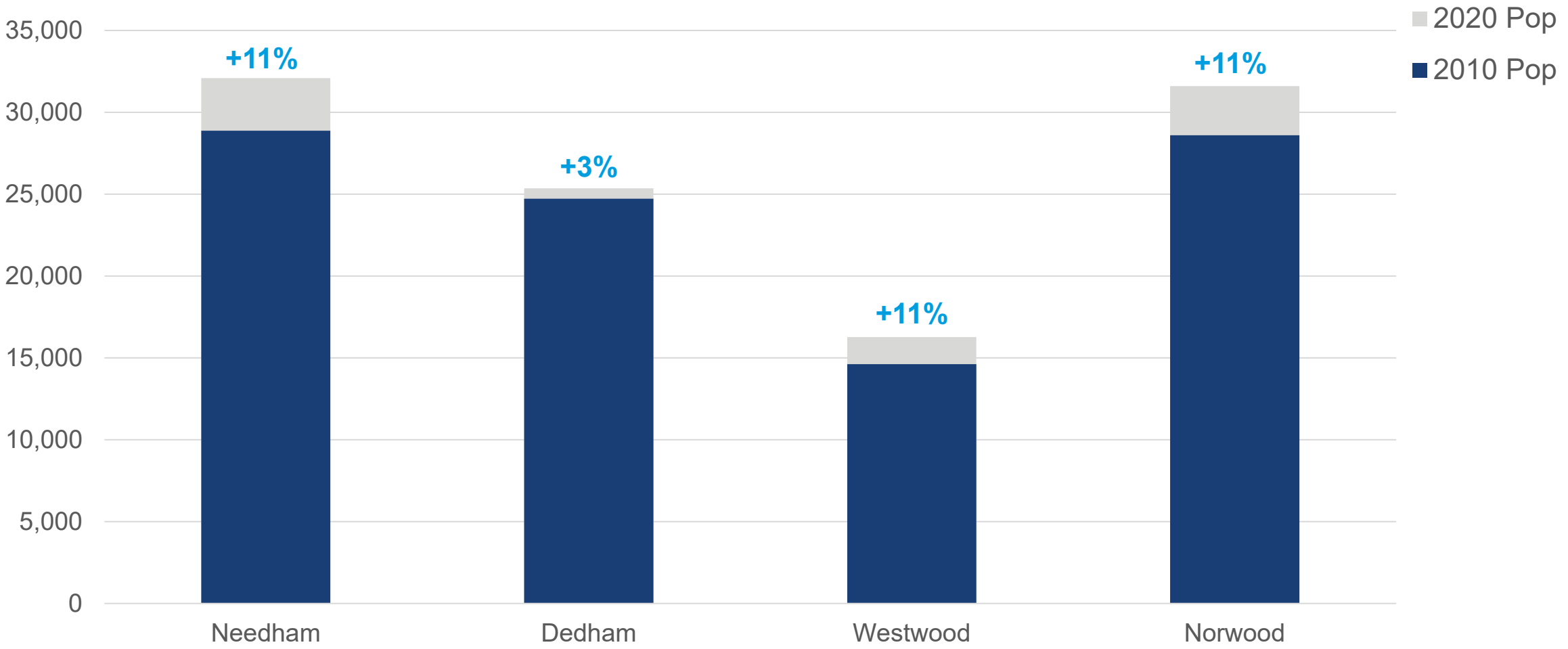
-Older adults

-Needham Parent Al-Anon

-English language learners

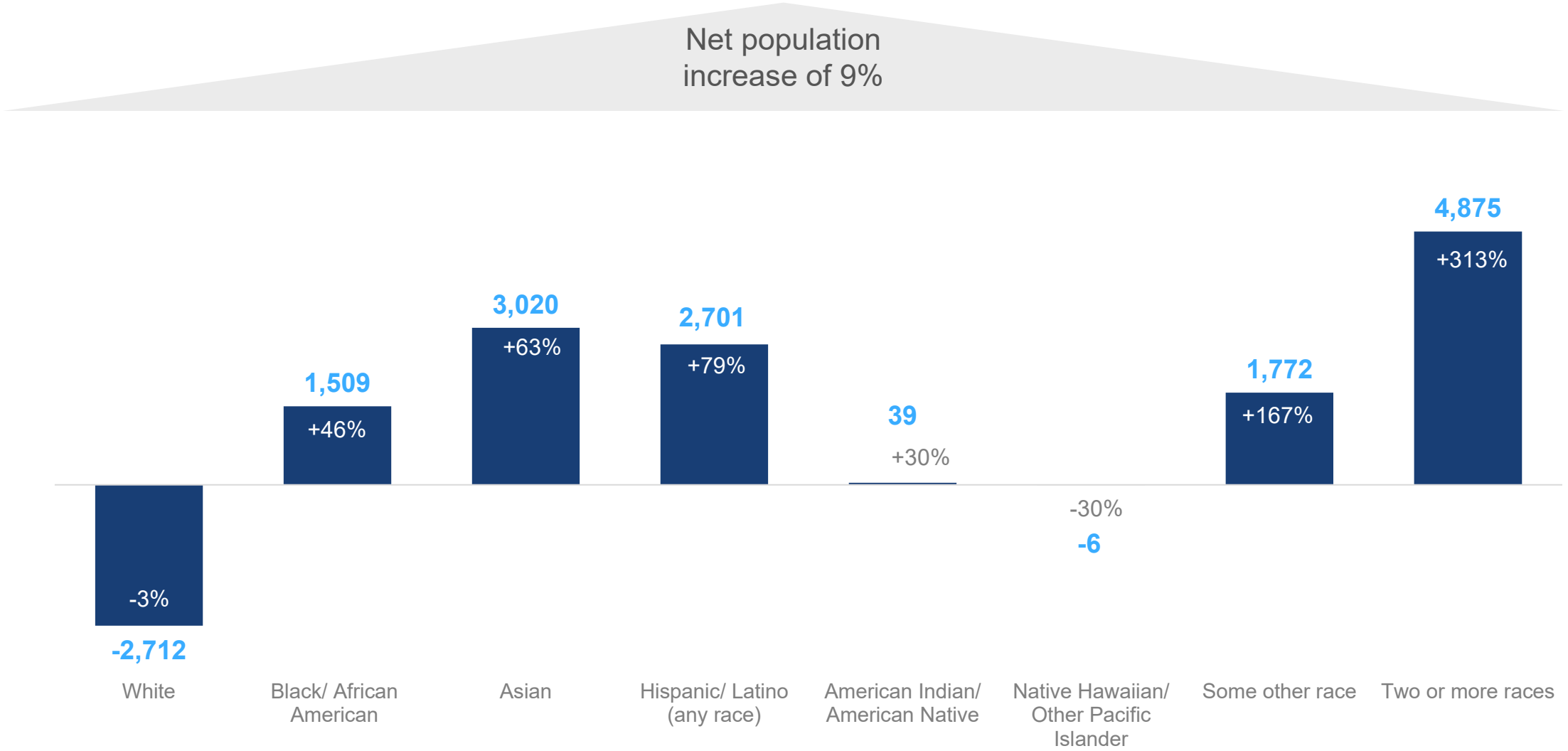
CHNA Progress

Population Change in Community Benefits Service Area 2010-2020



CHNA Progress

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



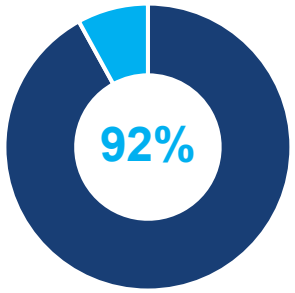
Data source: US Census Bureau American Community Survey 5-Year Estimates, 2015-2019

CHNA Progress
Service Area Strengths

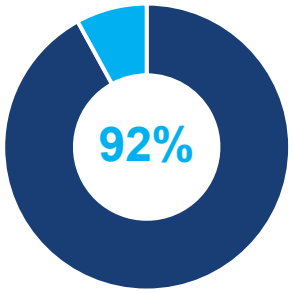
FROM INTERVIEWS & FOCUS GROUPS:

- Civic-minded
- Strong educational system
- Increasingly diverse

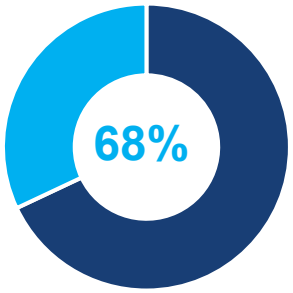
FROM BILH COMMUNITY HEALTH SURVEY:



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**

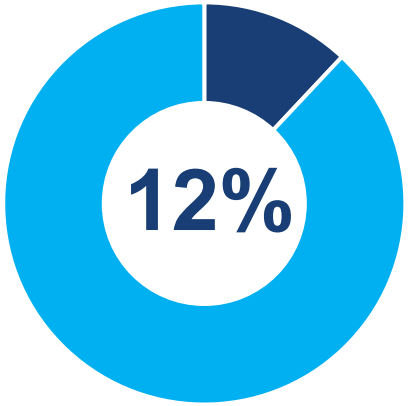
CHNA Progress
Key Themes

- Mental health
- Social determinants of health
- Diversity, equity, inclusion
- Substance use
- Access to care
- Community connections and information sharing

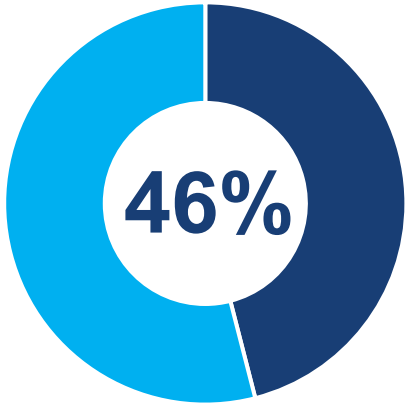
CHNA Progress
Key Themes: Mental Health (Youth)

There is significant prevalence of anxiety, depression, and chronic stress among youth

- Contributing factors include pressure to succeed and other school issues, social issues, impacts of COVID (remote learning, stress at home)
- Barriers to care include long wait times, providers don't accept insurance, stigma, insufficient inpatient psychiatric treatment



12% of 12th graders in Needham reported having seriously considered suicide in the past 12 months (Needham YRBS, 2018).



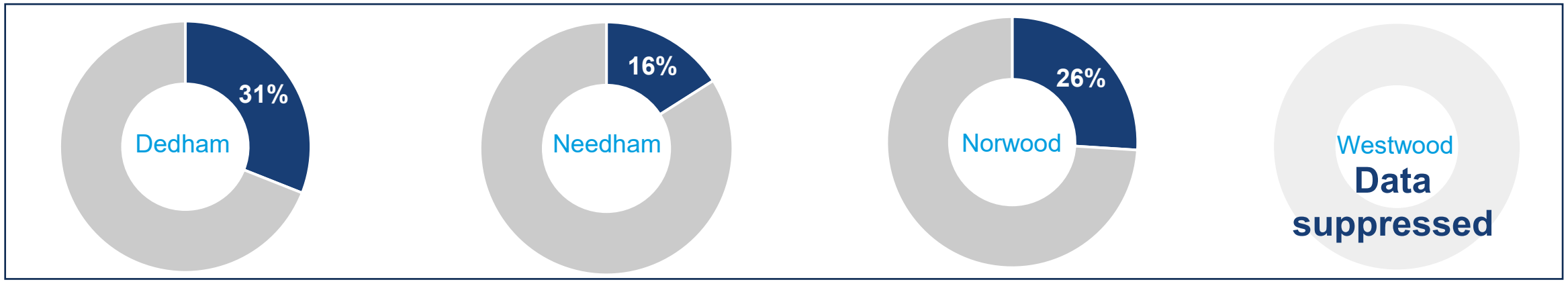
46% of high school students reported that the greatest barrier to seeking help at school for emotional challenges was that *"they wouldn't have time or wouldn't want to miss class"* (Needham YRBS, 2018)

CHNA Progress
Key Themes: Mental Health (Adult)

Mental health issues, including anxiety, stress, depression and feelings of isolation were exacerbated by COVID.

10% of BILN 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 and long wait times

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



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

Beth Israel Lahey Health

CHNA Progress
Key Themes: Social Determinants of Health

Primary concerns:

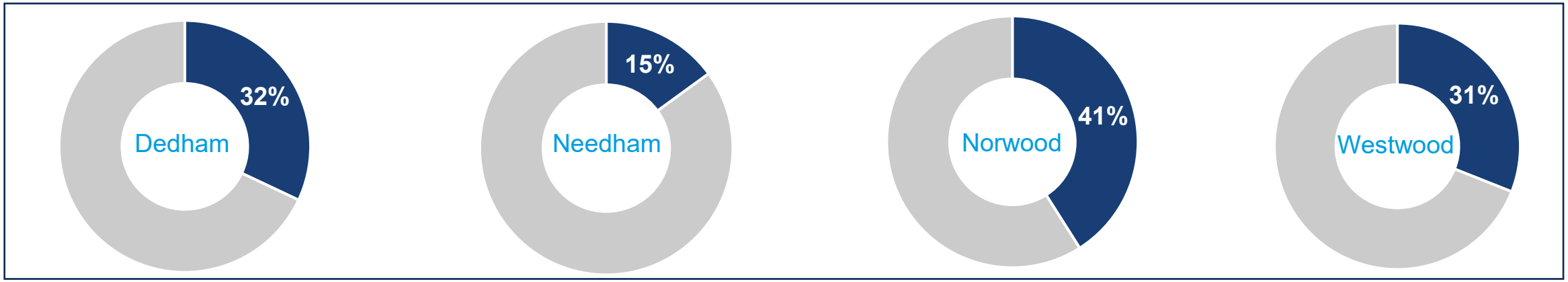
- Lack of affordable housing
- Pockets of economic insecurity in service area
- Cost of childcare
- Food insecurity

(All issues existed pre-pandemic, but were exacerbated by COVID)

When asked what they'd like to improve in their community, **57%** of BILN Community Health Survey respondents reported

"more affordable housing"
(#1 response)

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



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

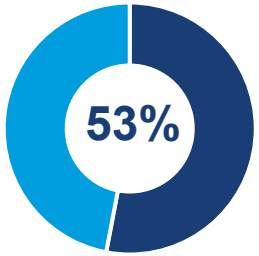
CHNA Progress
Key Themes: Diversity, Equity, and Inclusion

When asked what they'd like to improve in their community, **42%** of BILN Community Health Survey respondents reported

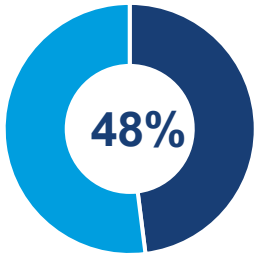
"more inclusion for diverse community members"
(#2 response)

Key informants and focus group participants discussed new organizations, task forces, and committees formed to address racism and inequities in the community

AMONG BILN COMMUNITY HEALTH SURVEY RESPONDENTS:



53% reported that built, economic, and educational environments in the community are impacted by **systemic** racism



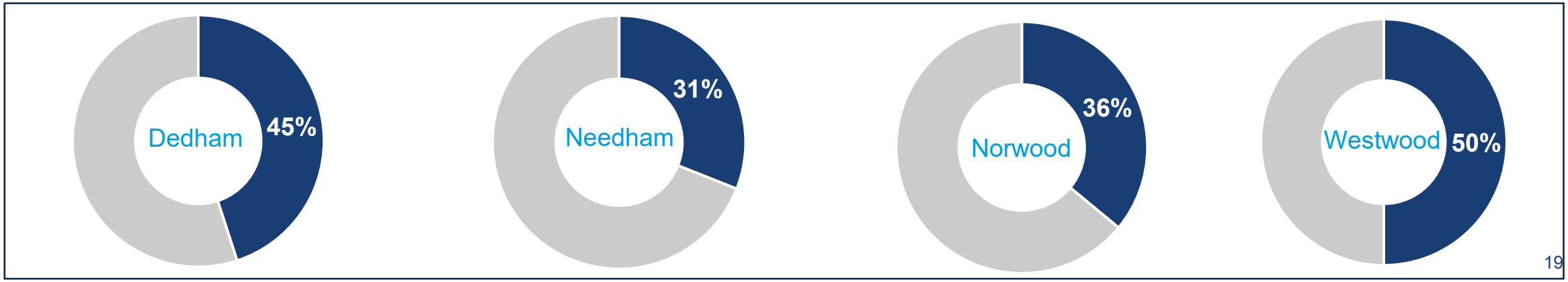
48% reported that environments in the community are impacted by **individual** racism

"…the efforts of the town, schools, and community groups are helping to change the current to be more inclusive, but those rare yet shocking instances of overt bigotry stick in our minds and leave us wondering if we'll be the next victim of hate speech or worse."- BILH Community Health Survey Respondent

CHNA Progress
Key Themes: Substance Use

- Marijuana/vaping tobacco prevalent among youth as coping mechanism for stress & mental health issues
- Alcohol use normalized & prevalent among adults & youth
- Opioid crisis persists
- Noticeable uptick in relapses of drug/alcohol use during pandemic

Percentage* of substance users who said they are using more substances than before the pandemic (Fall 2020)



Unweighted percentages displayed

Data source: COVID-19 Community Impact Survey, MDPH

CHNA Progress
Key Themes: Access to Care

Key themes from interviews/focus groups

- Long wait times and lack of specific services (e.g., inpatient psychiatric care; mental health counseling; limited safety net providers)
- Out of pocket healthcare costs for uninsured and underinsured
- Language and cultural barriers

CHNA Progress
Preliminary Themes: Community Connections & Information Sharing

- **Community resources not well known to community members**
- **Fragmentation of services**
- **Organizations not working together as they should; lack of communication and collaboration**

"We [community organizations] need to develop truly collaborative and collective solutions that conserve resources and do things more efficiently." – Key informant

Breakout Sessions

Reconvene

Wrap-up
BID Needham Community Benefits

Alyssa Kence
Community Benefits Director, BID Needham
781-453-5460
akence@bilh.org

Community Benefits Information on website:
BIDneedham.org

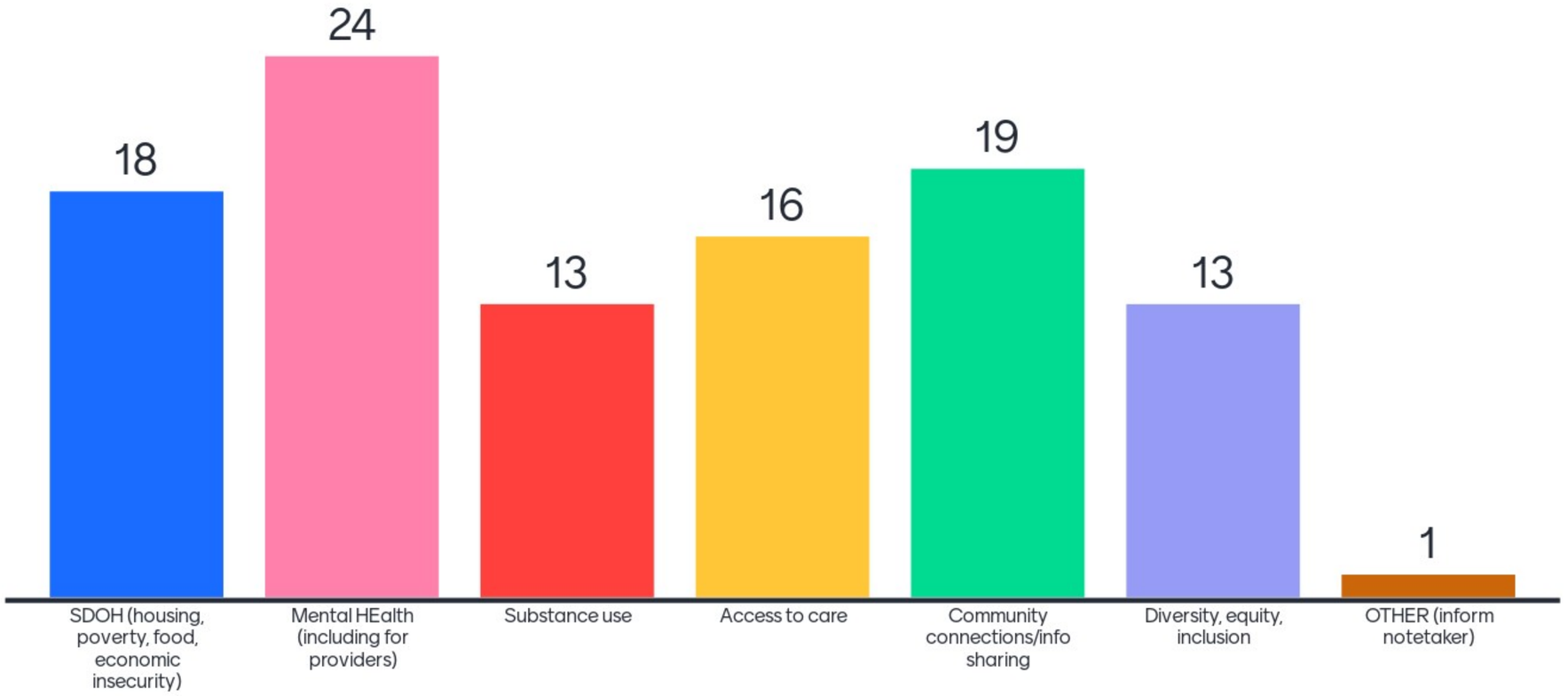
Community Benefits Annual Meeting: June 16, 9:00 AM

Thank you!

Multiple Choice

Polling results from Community Listening Session - February 2, 2022

Mentimeter



Priority Area 1: Mental Health

Notes from Listening Session on February 2, 2022

Resources/Assets

- bereavement groups
- telehealth has been helpful in connection people
- Schools in Needham: students use school nurses, personal counselor
- counselors at school, youth departments, police departments (currently unfilled)
- Needham did a suicide prevention coalition to raise awareness
- seekinghelp that is a search engine/database for open beds https://mabhaccess.com/CBHI.aspx
- William James interface, you can call them if you need resources
- Police department; two officers in particular have a large presence in the community
- Youth - The Lighthouse Initiative provides resources for youth having difficulties and identify high risk youth
- Westwood: youth and family services
- trevor project and other hotlines
- 2-1-1 number for resources
- Riverside counseling, emergency and outpatient services, facilities for after-care and long-term residents, crisis support, on-site responding, family assistance
- Needham housing authority works closely with CBOs like council on aging, center of the heights. Residents welcome to provider collaboration
- council on aging have social workers

Gaps/Barriers

- gap between ages 18-60
- Light House Initiaitve and Riverside works for some not all
- not enough resources for services across board
- Some insurance companies don't take everybody, services have to apply to get reimbursed
- There is lack of mental health providers available to people
- Need greater coordination of services that ARE available
- Riverside cannot actively assess suicidal or homicidal youth. They have to wait and it could be too late
- health departments provide referrals but do not have providers giving ongoing mental health services
- Insurance changes disrupt services
- long waiting times
- Lack of knowledge of William James interface resource
- Cannot therapy groups right now at Light House
- educating people on how MH services can be helpful and addressing stigma
- There is a gap for services AFTER crises
- HUGE gap in service provision: providers from different races and/or ethnicities with various linguistic capacity
- Slow turnaround times for clinician access
- People in public housing - there is something missing like a patient/resident centered approach
- What is the process at BID if you need services?
- Youth need more can than the need
- Equal justice, restorative justice, punitive justice need to be considered for their impact on MH
- Finding a bed for those that need hospitalization

Priority Area 2: Community Connections/Info Sharing

Resources/Assets

- veterans office
- if you're affiliated with a church, you may feel well-connected
- community councils efforts with folks who speak english as a second-language. valuable human connections.
- Needham devoted to social justice issues: NEEDHAM HUMAN RIGHTS COMMITTEE, NEEDHAM DIVERSITY INITIATIVE, AT MY NEIGHBOR'S TABLE, EQUAL JUSTICE NEEDHAM, IMMIGRATION JUSTICE TASK FORCE, - check on google for
- institutional work needed to support connections. currently people-centered and people in current roles supporting connections
- Having service providers augment hospital services is essential
- Over the age of 60 may not know about the referral services available to them
- Needham has a public information officer that could be repurposed to share resources available
- social workers at the police department, could use more and permanent funding outside of a grant, but step in right direction
- The Needham Town Website has a guide, Get Connected Needham, which lists many different resources
- Needham facebook page has resources
- Needham Public Schools signed on with MGH Center for Addiction Medicine - with a clinical psychologist. Program for SU treatment services brought on-site to schools
- BID advisory board (case consultation)
- youth resource network - collaborative of churches, housing, schools, mental health, big brothers/big sisters.

Gaps/Barriers

- there are no places in Norwood for seniors to go
- isolation
- more support and training to police department for mental health and community connections
- police departments responding to mental health. disconnect on how connections should be made. would like more time and effort the human/community aspect of policing
- Needham website is not well organized, still needs updating
- Navigating support services and health care process is so difficult
- individuals without social capital
- communication between police departments with other CBOs
- non-traditional communication channels should be used more (like TikTok and other social media channels) especially for youth
- parents may not be supportive of youth seeking help
- no central place for all resources (central repository)
- Workers who go to patient's homes know more of the issues but have difficulty finding referrals for ALL needs. Can only address some issues because demand outweighs need.
- youth feel more comfortable asking for help for a friend then for themselves
- support and resources for older individuals. deliver services and offering smoother transitions for getting information

Priority Area 3: Social Determinants of Health

Resources/Assets

Public Housing - networking through PH helped to reach the services that are needed (1 individual reports)

Housing: people can donate to tax relief funds

Housing: assistance for rent and mortgage payments, but very little

Organizations connect with Mayor of Boston to increase housing budgets

Westwood food pantry

Housing: section 8, public housing vouchers

Housing: Needham has exceeded the level of affordable housing

Housing: MCO housing, first-time homebuyer programs

deliveries and outreach for those who can't get to senior center (includes food, medication support, test kits, etc)

JCC has food and support for people

Economic insecurity: dept. of public health has funds (from donations) to help pay for utilities/heating

Students have missed socialization as a result of in person school experience - and networking through informal channels help especially for children with special needs

support for food pantry

raised bed gardens and farm community support

grab and go lunches with Hesco

school department meals

Gaps/Barriers

There is an acute need for shelter for homeless, those experiencing DV and other issues

Zoning has been a point of contention - there is potential to build more housing units but permits are given for less than what's available

anchor institution models (example, westside united in chicago), work with other institutions in the town

Long waits to receive assistance and services

Housing authority is not maintaining the property due to a lack of caring. Need to introduce ways to care better for people.

Housing: aging in place has been difficult

Informal networking works but doesn't meet EDI needs always

Misinformation on income brackets - need for more awareness and support

Govt School lunch program works but additional food supports are needed

Lack of knowledge on how to cook affordably

hospitals are good at healthcare, not so great with SDOH

Priority Area 4: Access to Care

Resources/Assets

Facebook groups are key community platforms for resource sharing

Needham was a pilot town for interface referral service that people can call for MH support and medication referral

SU helpline for treatment is helpful

Human Rights Committee - open meetings every month invites the public to share ideas, concerns etc.

delivering services at schools from reputable hospitals, folks don't need to go into Boston

Gaps/Barriers

System navigation especially in a health care episode is difficult and lacks coordination

BID is currently the only hospital servicing these towns

making sure veterans know they can apply to VA healthcare, education is very powerful

Who are people referred to? Especially for MassHealth patients.

communities that are less comfortable with the medical system

There are longer waits due to workforce stress

Understanding the differences between limited mass health and complete mass health

People on limited insurance are being billed high amounts without prior awareness of costs

Interface referral service is EXPENSIVE

Need for coverage for behavioral health concerns - not just physical

having health insurance

Need for training, support and awareness on available service care for immigrants and non-english speakers

Transportation options, availability and affordable access for all at convenient times, evening bus services end early inhibiting people who need to commute after 530pm

getting people who do qualify for healthcare, into healthcare

helping people to get into preventative care

Social workers should be available for contextual needs - not just grouping people into broad categories

knowing where to find care

OTHER

Housing authority is not maintaining the property due to a lack of caring. Need to introduce ways to care better for people.

SUD and support treatment - outside of Boston people have to travel due to regional limitations. NWH SU services have helped.

Resource: In Needham and Dedham - an asset that people don't realize is the SW'ers and Nurses that work for the town are great resources

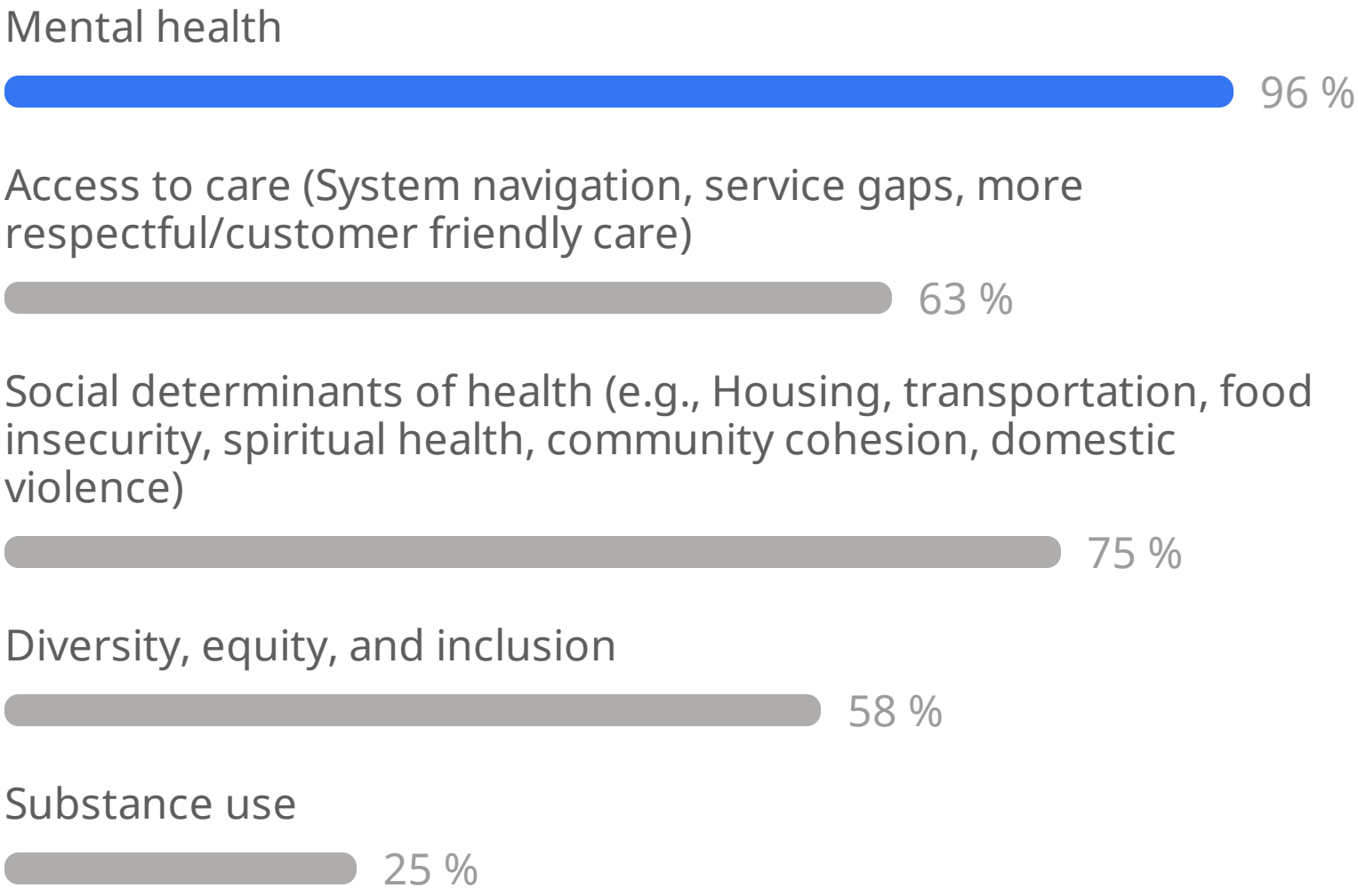
Multiple-choice poll (Multiple answers)

Poling results from Community Listening Session February 8, 2022

(Needham 2/8) Choose the 4 priority areas that are most important to you.

0 2 4

(1/2)



(Needham 2/8) Choose the 4 priority areas that are most important to you.

0 2 4

(2/2)

Community connections/info sharing

58 %

Chronic disease and their risk factors (nutrition, fitness, and nutrition)

25 %

Priority Area 1: Mental Health

Notes from Listening Session on February 8, 2022

Resources/Assets

Family members are usually the first point of contact. Social service areas; hospitals, HMOs.

When police are called they help with emergencies

needham community council has information about interface

Conversations on policing with the PD; lots of discussion of MH and how strategies need to shift.

William James Referral Service

hotlines and emergency services like BI, Riverside

School, all students have personal guidance counselors that are there for them and there are clubs in school that talk about mental health and where you can get help. SALSA has many meetings where they talk about

employee assistance programs

schools

Support hotlines - calling anumber

Full page for DANA Group, for MH services (but surprising that they would need to advertise for clients).

parents, friends, coaches, and teachers offer support that's more personable

consortiums and groups that came together to support individuals ex. Project Interface (currently not taking referrals until the end of the month)

having access to the internet and the resources made available online.

Gaps/Barriers

MH services needed for someone who still hasn't been able to get services for 6 MONTHS

Need more collaboration among MH providers re available spaces, so as to cut down on long wait list; don't be so proprietary.

Complete backlog on services and referrals - february 22nd is currently the first availability

Lack of long-term (non emergency) care

long waiting lists

Hard to actually connect to a person.

Very few worthwhile services support MH

Police staffing for MH strategies will be a challenge.

Even if you telehealth with a psychiatric nurse practitioner - they will try to get rid of you and close the case

MH services are now by telehealth and not enough residential care is available as needed. Providers not equipped to handle serious MH

Some people can't wait (to come up on a waiting list).

Priority Area 2: Social Determinants of Health

Resources/Assets

- Needham Community has clothing shop for used clothing
- Needham facebook page (info on things like community councils, religious gatherings, etc)
- Some Churches provide assistance with paying bills (St. Joseph's)
- COVID 19 Relief Fund (United Way of Mass Bay); financial assistance for housing, food, childcare, etc.; Dedham area.
- Meals on Wheels program; really bridges the gap for those seniors who can't shop or prepare meals.
- **MBTA The Ride**
- Needham Community Education publishes a booklet with resources that can be affordable
- Food pantries are seemingly a good resource
- Free meals at the HS's are ongoing; snacks, however, are not free. Not much variety; and extras can be expensive.
- Needham Community Council, people may not be aware of but they offer a lot
- Traveling Meals program (different than Meals on Wheels), through town of Needham. But takes some digging to find it. And town website is not easy to navigate.

Gaps/Barriers

- Unaffordable Housing
- **Very few rental properties**
- physical activity and recreational opportunities (limited by costs, high competitiveness)
- Not enough day care providers and too expensive
- need for more awareness of resources
- **fragmented access**
- People don't know about all these great programs we have. People who need them the most, know about them the least.
- Transportation for those experiencing disability (particularly youth)
- transportation. specifically for seniors. consider how students and employees can get to needham in the hours they need
- Zoning laws work against development of affordable units

Priority Area 3: Access to care

Resources/Assets

Having senior center being a centralized source of info is very helpful.

Newsletter goes to seniors, which tells of lots of resources.

Personable, friendly, committed, kind hospital workers; from cleaning staff to nurses to doctors

MBTA The Ride

Gaps/Barriers

maintain awareness of technology gaps -- example = vaccine process

Burnt out hospital workers/ healthcare providers

A critical shortage of paraprofessionals--car etakers, etc.--to meet needs of seniors and communities. Extreme staffing shortages.

Health care providers have left the profession'

Deep impact of Norwood Hosp closing

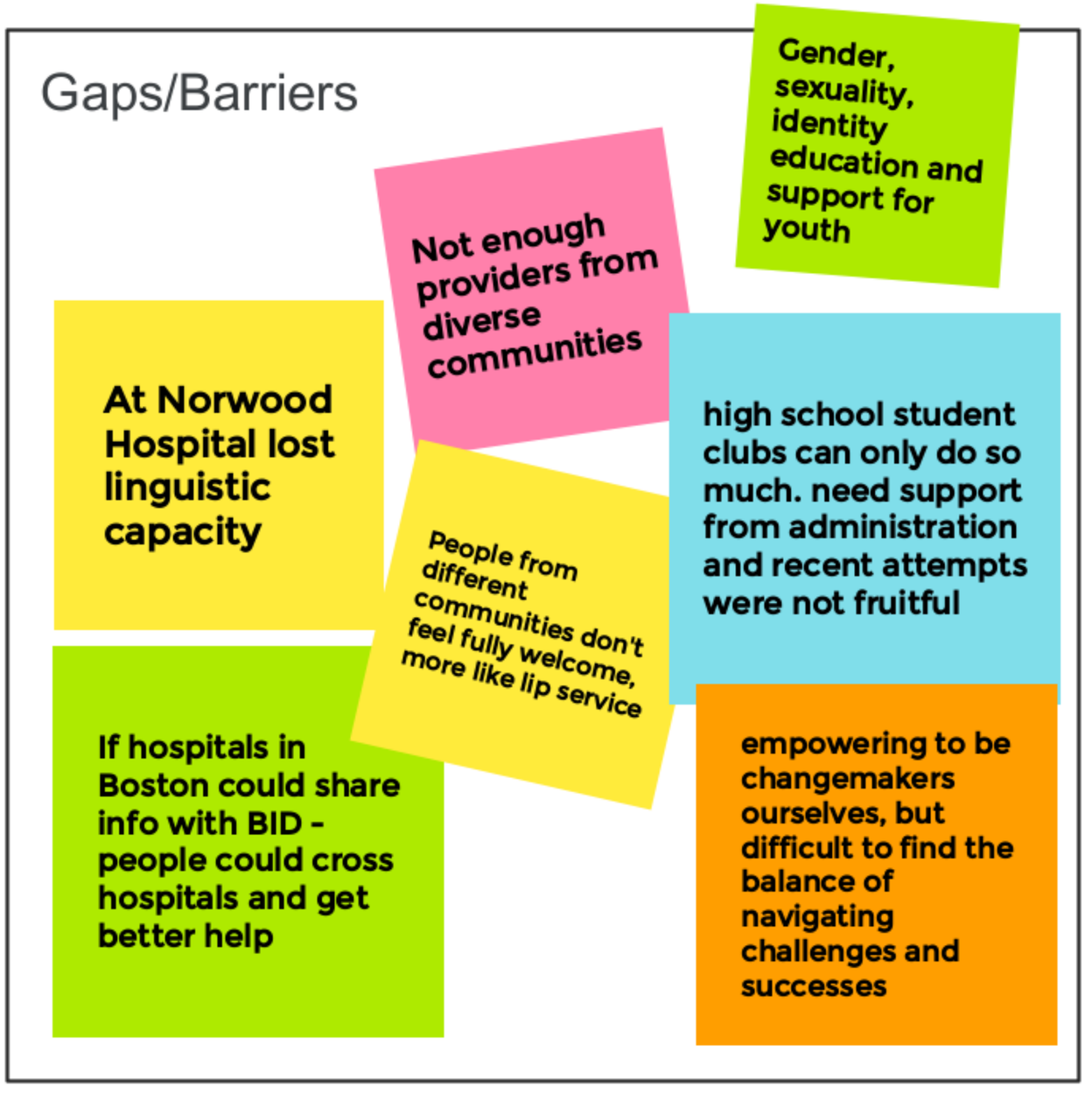
MH issues have been exasperated

Need PCP to link you to other types of care. BID Needham is overwhelmed due to Norwood Hosp closing.

Need for strong focus on youth healthcare (outside of school)

transportation. specifically for seniors. consider how students and employees can get to needham in the hours they need

Priority Area 4: Diversity, Equity, Inclusion



Priority Area 5: Community connection/information sharing

Resources/Assets

Needham community council offers 10 rides a month to help get people to the hospital outside of Dedham

Livable Deham and Womens Club are resources

Hesco in Sharon - provides information on phone

spiritual health and faith communities support resilience

social and community belonging is a protective factor

Social Worker t Needham Senior Center was helpful with connecting with Natick patient advocate - cross towns

BOH might also be helpful if people need info

Needham has an email listserve that announces info

Evacuees from hurricane 4 years ago - 50+ people to Dedham and the town helped based on personal networking

email newsletters

Needham Facebook Page

Gaps/Barriers

Strong need for community hope and healing in a time of racial hate

Board of Health used to have contract MH and other services available, need to know if still available

being mindful of technology gaps

centralized information otherwise overload to sift through everything

Before pandemic had volunteer drivers, not much now

Connection between generations - there is a lot of generational misinformation/difference

Need to have Patient advocates that do home visits and connect with patients in hospitals

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

			Areas of interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Population							US Census Bureau, American Community Survey 2016-2020
Total Population	6,873,003	703,740	25,330	31,177	29,446	16,215	
Male	51.5%	48.1%	46.6%	47.7%	48.9%	47.4%	
Female	48.5%	51.9%	53.4%	52.3%	51.1%	52.6%	
Age Distribution							US Census Bureau, American Community Survey 2016-2020
Under 5 years (%)	5.2%	5.3%	6.7%	4.8%	5.6%	5.1%	
5 to 9 years	5.3%	5.5%	3.8%	8.1%	5.6%	8.2%	
10 to 14 years	5.7%	6.2%	5.4%	8.9%	5.2%	6.6%	
15 to 19 years	6.6%	6.4%	3.8%	7.9%	4.8%	7.3%	
20 to 24 years	7.1%	6.2%	7.0%	4.1%	5.1%	5.3%	
25 to 34 years	14.3%	12.9%	13.6%	4.9%	17.4%	8.5%	
35 to 44 years	12.2%	12.6%	11.1%	12.9%	11.9%	9.4%	
45 to 54 years	13.3%	14.1%	15.9%	14.8%	12.9%	15.3%	
55 to 59 years	7.1%	7.4%	6.2%	8.2%	7.1%	9.2%	
60 to 64 years	6.5%	6.5%	7.2%	5.8%	7.6%	6.7%	
65 to 74 years	9.5%	9.4%	8.9%	10.2%	7.7%	7.1%	
75 to 84 years	4.6%	4.8%	5.8%	5.1%	5.4%	6.8%	
85 years and over	2.4%	2.6%	4.6%	4.2%	3.7%	4.4%	
Under 18 years of age	19.8%	20.9%	18.5%	27.3%	19.6%	25.4%	
Over 65 years of age	16.5%	16.8%	19.4%	19.5%	16.7%	18.3%	
Race/Ethnicity							US Census Bureau, American Community Survey 2016-2020
White alone (%)	76.6%	76.1%	84.6%	86.1%	81.7%	84.0%	
Black or African American alone (%)	7.5%	7.2%	7.6%	2.8%	8.5%	1.2%	
Asian alone (%)	6.8%	11.3%	2.9%	8.7%	5.5%	10.3%	
Native Hawaiian and Other Pacific Islander (%)	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	
American Indian and Alaska Native (%) alone	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%	

			Areas of interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Some Other Race alone (%)	4.2%	1.7%	1.5%	0.4%	2.1%	1.4%	
Two or More Races (%)	4.8%	3.5%	3.2%	1.9%	2.2%	3.0%	
Hispanic or Latino of Any Race (%)	12.0%	4.7%	9.3%	2.6%	6.6%	3.3%	
Race/Ethnicity of Students in Public Schools							School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021
African American (%)	9.3		29.3	6.2	4.5	3.9	
Asian (%)	7.2		9.1	20	0.1	41.8	
Hispanic (%)	22.3		42.4	10.8	87.7	4.8	
White (%)	56.7		15.3	52.2	6.2	42.2	
Native American (%)	0.2		0.3	-	0.2	0.1	
Native Hawaiian, Pacific Islander (%)	0.1		0.2	0.1	-	-	
Multii-Race, Non-Hispanic (%)	4.10		3.4	10.8	1.3	7.3	
Foreign-born	17.0%	18.5%	12.2%	13.8%	19.0%	14.6%	US Census Bureau, American Community Survey 2016-2020
Naturalized U.S. Citizen	54.2%	60.6%	65.9%	70.6%	55.4%	69.1%	
Not a U.S. Citizen	45.8%	39.4%	34.1%	29.4%	44.6%	30.9%	
Region of birth: Europe	20.0%	23.0%	42.6%	36.2%	29.6%	25.5%	
Region of birth: Asia	31.1%	47.0%	21.9%	43.8%	29.2%	58.5%	
Region of birth: Africa	9.3%	7.3%	7.1%	5.6%	8.0%	1.9%	
Region of birth: Oceania	0.3%	0.3%	0.4%	0.7%	0.0%	1.2%	
Region of birth: Latin America	36.7%	20.1%	26.8%	10.2%	32.4%	10.3%	
Region of birth: Northern America	2.5%	2.3%	1.2%	3.4%	0.8%	2.5%	
Language							US Census Bureau, American Community Survey 2016-2020
English only	76.1%	77.8%	82.8%	83.4%	78.4%	81.2%	
Language other than English	23.9%	22.2%	17.2%	16.6%	21.6%	18.8%	
Speak English less than "very well"	9.2%	8.2%	4.5%	5.0%	9.4%	5.6%	
Spanish	9.1%	3.1%	5.7%	2.2%	4.7%	0.9%	
Speak English less than "very well"	3.8%	0.6%	0.9%	0.3%	0.9%	0.1%	
Other Indo-European languages	9.0%	9.1%	7.4%	7.0%	12.4%	7.5%	
Speak English less than "very well"	3.0%	2.8%	2.1%	2.3%	6.6%	1.6%	
Asian and Pacific Islander languages	4.4%	8.3%	2.5%	4.8%	2.8%	8.8%	
Speak English less than "very well"	2.0%	4.3%	0.5%	2.0%	1.3%	3.5%	
Other languages	1.4%	1.7%	1.6%	2.5%	1.7%	1.6%	

			Areas of interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Speak English less than "very well"	0.4%	0.5%	1.0%	0.5%	0.6%	0.4%	
Percent of public school student population that are English language learners (%)	10.5		5.5	3.2	12.8	0.8	Massachusetts Department of Elementary and Secondary Education, 2021
Employment							US Census Bureau, American Community Survey 2016-2020
Unemployment rate	5.1%	4.5%	3.7%	4.4%	2.9%	4.2%	
Unemployment rate by race/ethnicity							
White alone	4.5%	4.1%	2.7%	4.3%	2.5%	4.7%	
Black or African American alone	8.3%	8.2%	11.7%	9.1%	6.1%	0.0%	
American Indian and Alaska Native alone	10.7%	0.0%	0.0%	0.0%	-	-	
Asian alone	4.2%	3.4%	6.4%	4.5%	2.6%	1.0%	
alone	5.4%	0.0%	0.0%	-	-	-	
Some other race alone	8.3%	5.8%	12.1%	0.0%	5.8%	0.0%	
Two or more races	9.1%	7.7%	0.0%	3.5%	0.0%	0.0%	
Hispanic or Latino origin (of any race)	8.3%	6.3%	1.8%	11.5%	5.9%	0.0%	
Unemployment rate by educational attainment							
Less than high school graduate	9.7%	8.2%	0.0%	1.6%	0.0%	0.0%	
High school graduate (includes equivalency)	5.9%	6.6%	1.9%	0.0%	6.4%	5.9%	
Some college or associate's degree	4.5%	3.6%	2.2%	5.0%	3.9%	4.8%	
Bachelor's degree or higher	2.8%	2.6%	3.4%	3.2%	1.7%	2.5%	
Income and Poverty							US Census Bureau, American Community Survey 2016-2020
Median household income (dollars)	84,385	105,320	101,780	174,707	90,341	159,646	
Population living below the federal poverty line in the last 12 months							
Individuals	9.8%	6.0%	4.8%	2.4%	8.1%	2.8%	
Families	6.6%	4.0%	2.7%	1.9%	6.3%	1.5%	
Individuals under 18 years of age	12.2%	5.4%	5.3%	0.5%	15.4%	2.2%	
Individuals over 65 years of age	8.9%	7.2%	5.7%	5.8%	7.3%	3.1%	
Female head of household, no spouse prese	20.5%	14.4%	13.7%	4.6%	29.4%	0.0%	
White alone	7.9%	5.1	4.4%	2.1%	6.9%	2.6%	
Black or African American alone	17.6%	11.2	12.4%	2.7%	23.8%	25.8%	
American Indian and Alaska Native alone	23.3%	7.4	0.0%	0.0%	-	-	
Asian alone	11.8%	7.7	2.9%	4.4%	0.4%	2.7%	

			Areas of interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Native Hawaiian and Other Pacific Islander a	11.9%	2.6	31.6%	-	-	-	
Some other race alone	22.2%	10.9	0.0%	1.7%	8.4%	7.3%	
Two or more races	15.5%	7.7	1.9%	2.2%	12.1%	0.2%	
Hispanic or Latino origin (of any race)	23.0%	11.5	6.5%	0.5%	19.4%	10.9%	
Less than high school graduate	23.2%	15.8	11.8%	6.7%	20.7%	4.6%	
High school graduate (includes equivalency)	11.7%	9.2	8.3%	4.2%	9.8%	7.2%	
Some college, associate's degree	8.4%	6.6	4.6%	3.8%	8.1%	2.6%	
Bachelor's degree or higher	3.9%	3.1	2.9%	2.3%	1.8%	1.7%	
With Social Security	30.2%	29.5%	30.9%	32.6%	28.5%	33.5%	
With retirement income	19.3%	19.7%	20.3%	22.4%	19.2%	22.1%	
With Supplemental Security Income	5.9%	3.5%	2.3%	3.1%	4.7%	4.4%	
With cash public assistance income	2.8%	1.9%	2.8%	1.9%	1.6%	1.2%	
12 months	11.6%	6.7%	5.7%	2.7%	7.6%	2.0%	
Public School Distric Students Who are Low Income (%)	36.6		24.8	6.4	29.4	6.2	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Housing							US Census Bureau, American Community Survey 2016-2020
Occupied housing units							
Owner-occupied	62.5%	68.8%	71.3%	84.5%	55.2%	86.2%	
Renter-occupied	37.5%	31.2%	28.7%	15.5%	44.8%	13.8%	
Lacking complete plumbing facilities	0.3%	0.2%	0.5%	0.4%	0.2%	0.0%	
Lacking complete kitchen facilities	0.8%	0.7%	1.7%	0.8%	0.9%	0.4%	
No telephone service available	1.2%	1.0%	1.5%	1.2%	2.3%	0.9%	
Monthly housing costs <35% of total household income							
Among owner-occupied housing units with a mortgage	22.0%	21.2%	21.4%	18.2%	18.8%	21.6%	
Among owner-occupied units without a mortgage	15.2%	16.4%	23.0%	9.8%	10.7%	13.1%	
Among occupied units paying rent	39.1%	37.5%	48.5%	39.3%	36.6%	52.8%	
Eviction rate (%)	1.52	1.72	1.3	0.74	2.26	0.5	Eviction Lab, 2018
Access to Technology							US Census Bureau, American Community Survey 2016-2020
Among households							
Has smartphone	83.3%	85.4%	81.1%	84.4%	82.2%	84.4%	

			Areas of interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Has desktop or laptop	82.2%	87.1%	83.8%	91.7%	83.1%	91.6%	
Has tablet or other portable wireless compu	64.8%	70.3%	69.7%	76.0%	69.0%	79.9%	
No computer	7.4%	5.4%	6.6%	4.4%	7.9%	4.0%	
With broadband internet	88.2%	91.5%	91.4%	93.6%	90.9%	94.3%	
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%	65.0%	71.7%	66.7%	70.4%	69.7%	
Car, truck, or van -- carpooled	7.3%	6.3%	6.5%	3.9%	8.2%	5.1%	
Public transportation (excluding taxicab)	9.5%	13.5%	9.6%	12.8%	9.6%	13.8%	
Walked	4.8%	3.6%	2.3%	2.9%	2.1%	0.4%	
Other means	2.1%	1.7%	3.1%	1.0%	2.0%	0.3%	
Worked from home	8.3%	9.9%	6.7%	12.7%	7.7%	10.7%	
Mean travel time to work (minutes)	30	34.6	32.6	32.5	33.1	34.4	
Vehicles available among occupied housing units							
No vehicles available	12.2%	9.3%	7.1%	6.4%	8.2%	3.3%	
1 vehicle available	35.1%	33.5%	36.3%	21.7%	37.3%	24.5%	
2 vehicles available	36.1%	40.5%	42.1%	53.7%	38.4%	46.2%	
3 or more vehicles available	16.5%	16.7%	14.5%	18.3%	16.0%	25.9%	
Education							US Census Bureau, American Community Survey 2016-2020
Educational attainment of adults 25 years and older							
Less than 9th grade (%)	4.2%	2.6%	1.7%	0.9%	2.6%	0.1%	
9th to 12th grade, no diploma (%)	4.7%	3.3%	3.3%	1.2%	3.7%	3.3%	
High school graduate (includes equivalency)	23.5%	18.7%	20.1%	8.4%	20.0%	10.0%	
Some college, no degree (%)	15.3%	13.5%	14.3%	7.3%	15.8%	9.2%	
Associate's degree (%)	7.7%	7.3%	5.2%	4.1%	7.9%	7.3%	
Bachelor's degree (%)	24.5%	28.8%	30.1%	31.1%	31.7%	37.1%	
Graduate or professional degree (%)	20.0%	25.8%	25.3%	47.1%	18.4%	33.0%	
High school graduate or higher (%)	91.1%	94.1%	94.9%	97.9%	93.7%	96.6%	
Bachelor's degree or higher (%)	44.5%	54.6%	55.4%	78.1%	50.1%	70.1%	
Educational attainment by race/ethnicity							
White alone							
High school graduate or higher	93.3%	96.4%	95.6%	98.3%	94.6%	98.0%	

			Areas of interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Bachelor's degree or higher	46.3%	55.9%	56.5%	78.7%	48.6%	69.6%	
Black alone							
High school graduate or higher	86.2%	88.9%	94.9%	93.2%	92.3%	100.0%	
Bachelor's degree or higher	27.6%	36.9%	39.5%	50.2%	47.1%	100.0%	
American Indian or Alaska Native alone							
High school graduate or higher	81.0%	81.3%	82.1%	100.0%	-	-	
Bachelor's degree or higher	21.9%	28.6%	32.1%	100.0%	-	-	
Asian alone							
High school graduate or higher	85.7%	83.3%	98.5%	95.9%	90.7%	86.2%	
Bachelor's degree or higher	61.8%	57.9%	78.9%	81.6%	80.2%	71.0%	
Native Hawaiian and Other Pacific Islander alone							
High school graduate or higher	89.1%	76.3%	68.4%	-	-	-	
Bachelor's degree or higher	36.4%	52.6%	68.4%	-	-	-	
Some other race alone							
High school graduate or higher	69.9%	83.7%	74.9%	100.0%	64.1%	91.5%	
Bachelor's degree or higher	15.7%	33.0%	39.9%	38.8%	36.8%	65.0%	
Two or more races							
High school graduate or higher	81.3%	91.6%	85.2%	88.4%	99.1%	100.0%	
Bachelor's degree or higher	34.9%	61.1%	39.9%	79.3%	61.5%	100.0%	
Hispanic or Latino Origin							
High school graduate or higher	72.4%	91.3%	89.5%	98.5%	90.1%	92.4%	
Bachelor's degree or higher	20.9%	46.8%	45.7%	73.4%	34.6%	82.6%	
4-Year Graduation Rate Among Public High School Students (%)	89		93.2	98.5	94.8	97.1	Massachusetts Department of Elementary and Secondary Education, 2020
Safety/Crime							Massachusetts Crime Statistics, 2021
Property Crimes Offenses (#)							
Burglary	9,592.0		15	21	17	5	
Larceny-theft	55,672.0		270	99	223	114	
Motor vehicle theft	7,045.0		18	5	31	5	
Arson	312.0		0	1	1		
Crimes Against Persons Offenses (#)							
Murder/non-negligent manslaughter	151		0	0	1	0	
Sex offenses	4,171		0	6	11	3	

			Areas of interest				
	MA	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Assaults	67,690		67	65	149	39	
Human trafficking	41		0	0	0	1	
Access to Care							
Ratio of population to primary care physicians	960 to 1	780 to 1					County Health Rankings, 2019
Ratio of population to mental health providers	140 to 1	150 to 1					County Health Rankings, 2021
Ratio of population to dentists	930 to 1	800 to 1					County Health Rankings, 2020
Health insurance coverage among civilian noninstitutionalized population (%)							American Community Survey (U.S. Census Bureau), 2016-2020, S2301
With health insurance coverage	97.3%	98.2%	98.1%	98.7%	98.5%	98.1%	
With private health insurance	74.5%	82.9%	86.3%	89.3%	81.0%	89.8%	
With public coverage	36.1%	28.4%	30.0%	24.8%	31.6%	22.1%	
No health insurance coverage	2.7%	1.8%	1.9%	1.3%	1.5%	1.9%	

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	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	Source
Overall Health							Massachusetts Deaths, 2017
Mortality rate (age-adjusted per 100,000)	675.7	623.3	661.3	532.3	683.2	467.4	
Premature mortality rate (per 100,000)	282.6	242.2	268.5	164.8	293.6	116	
Leading causes of death (counts)							
Cancer	12,937	1314	75	49	72	27	
Heart Disease	12,165	1247	81	67	68	24	
Chronic Lower Respiratory Disease	2,843	243	19	10	13	6	
Stroke	2,370	244	14	13	15	8	
Disability							US Census Bureau, American Community Survey 2016-2020
Percent of population with a disability	11.7%	9.5%	10.8%	7.4%	11.2%	8.9%	
Under 18	4.7%	3.2%	4.6%	2.0%	4.5%	1.3%	
18-64	8.9%	6.8%	7.4%	3.9%	7.4%	4.5%	
65+	31.3%	27.8%	28.7%	25.0%	35.1%	32.9%	
Healthy Living							
Adult population with fruit intake of 5 or more per day (%)	14.2						CDC Adults Meeting Fruit and Vegetable Intake Recommendations — United States, 2013
Adult population with vegetable intake of 5 or more per day (%)	9.4						CDC Adults Meeting Fruit and Vegetable Intake Recommendations — United States, 2013
Adults who consumed vegetables at least one time per day (%)	84.5						Behavioral Risk Factor Surveillance System, 2019
Adults who consumed fruits at least one time per day (%)	67.3						Behavioral Risk Factor Surveillance System, 2019
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						County Health Rankings, 2015
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
Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%)	22.2						Behavioral Risk Factor Surveillance System, 2019
Mental Health							
Average number of mentally unhealthy days in past 30 days (adults)	4.3	4.1					County Health Rankings, 2018
Youth Behavioral Risk Survey (YRBS)	**2019**		**2018**	**2016 MS/2018 HS**	**2015**	**Not available**	Youth Risk Behavior Surveys (see years in column)
% of students (grades 6-8) bullied on school property (%)	35.3		--	9.7	20.0		
% of students (grades 6-8) bullied electronically (%)	15.2		--	14.2	18.0		
% of students (grades 9-12) bullied on school property (%)	19.0		--	11.3	11.0		
% of students (grades 9-12) bullied electronically (%)	14.9		20.5 (ever)	15.1	10.0		
% of students (grades 6-8) reporting self harm (%)	21		11.2	4.9	11.0		
% of students (grades 6-8) reporting suicide ideation (%)	11.3		13.1	7.6	10.0		
% of students (grades 6-8) reporting suicide attempt (%)	5.0		2.3	1.1	2.0		
% of students (grades 9-12) reporting self harm (%)	--		10.6	9.1	12.0		
% of students (grades 9-12) reporting suicide ideation (%)	17.2		13.2	6.7	12.0		
% of students (grades 9-12) reporting suicide attempt (%)	7.4		3.7	2.2	3.0		
Substance Use							
Admissions to DPH-funded treatment programs (count)	98944		233	0-100	251	0-100	MA DPH, Bureau of Substance Abuse Services, 2017
Rate of injection drug user admissions to DPH-funded treatment program (%)	52.4		48.1	27.	44.2	36.7	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		32.2	50.8	30.3	45.0	
Crack/Cocaine (%)	4.1		3.0	-	-	-	
Heroin (%)	52.8		54.5	30.5	57.8	43.3	
Marijuana (%)	3.5		3	-	4.4	-	
Other Opioids (%)	4.6		5.6	-	4.0	-	

			Community Benefits Service Area				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	Source
Other Sedatives/Hypnotics (%)	1.5		-	-	-	-	
Other Stimulants (%)	0.5		-	-	-	-	
Other (%)	0.3		54.5	30.5	57.8	43.3	
Adults who report current smoking status (%)	11.1						Behavioral Risk Factor Surveillance System, 2019
Adults who report excessive drinking (binge or heavy drinking) (%)	24						County Health Rankings, 2018
Youth Risk Behavior Survey (YRBS) - report year indicated	**2019**		**2013**	**2016 MS/2018 HS**	**2015**	**Not available**	Massachusetts Youth Health Risk Report, 2015; Local Youth Risk Behavior Survey (YRBS)
Students (grades 6-8) reporting lifetime alcohol use (%)	13.6		16.0	6.2	16.0		
Students (grades 6-8) reporting current alcohol use (%)	4.4		6.0	1.9	3.0		
Students (grades 9-12) reporting lifetime alcohol use (%)	--		66.0	49.0	55.0		
Students (grades 9-12) reporting current alcohol use (%)	29.8		41.0	29.2	29.0		
Students (grades 6-8) reporting current binge alcohol use (%)	0.9		2.0	0.5	0.2		
Students (grades 9-12) reporting current binge alcohol use (%)	13.5		26.0	18.5	15.0		
Students (grades 6-8) reporting lifetime cigarette use (%)	5.2		4.0	1.3	4.0		
Students (grades 6-8) reporting current cigarette use (%)	--		1.0	0.5	0.0		
Students (grades 9-12) reporting lifetime cigarette use (%)	28.9		37.0	10.8	17.0		
Students (grades 9-12) reporting current cigarette use (%)	8.8		19.0	2.4	5.0		
Students (grades 6-8) reporting lifetime marijuana use (%)	7.0		4.0	0.8	4.0		
Students (grades 6-8) reporting current marijuana use (%)	3.0		3.0	0.7	2.0		
Students (grades 9-12) reporting lifetime marijuana use (%)	35.6		41.0	28.6	31.0		
Students (grades 9-12) reporting current marijuana use (%)	19.8		27.0	19.6	20.0		
Students (grades 6-8) reporting lifetime electronic tobacco use (%)	14.7		--	2.8	13.0		
Students (grades 6-8) reporting current electronic tobacco use (%)	--		--	1.4	5.0		
Students (grades 9-12) reporting lifetime electronic tobacco use (%)	42.2		--	34.6	42.0		
Students (grades 9-12) reporting current electronic tobacco use (%)	13.2		--	22.5	23.0		
Chronic Disease (more data on CHIA data tabs)							
Cancer mortality (all types, age-adjusted rate per 100,000)	149.92	144.67					Massachusetts Cancer Registry, 2014-2018
Cancer incidence (age-adjusted per 100,000)							
All sites, invasive	498.16	478.46					
Breast Cancer	176.35	196.7					
Cervical Cancer	5.5	4.17					
Coloretal Cancer	35.96	36.22					
Lung and Bronchus Cancer	61.41	60.42					
Prostate Cancer	108.84	113.74					
Risk factors							
Percent of Adults who are Obese (%)	24.4		24.7	21.5			Behavioral Risk Factor Surveillance System, 2018
Diagnosed diabetes among adults aged >=18 years (%)	8.6		6.7	5.6			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 (%)	33.1						Behavioral Risk Factor Surveillance System, 2017
Reproductive Health							
Infant Mortality Rate (per 1,000 live births)	3.7	2.9					March of Dimes, 2019
Low birth weight (%)	7.4	7.2					March of Dimes, 2020
Mothers with late or no prenatal care (%)	3.9%	3					March of Dimes, 2020
Births to adolescent mothers (per 1,000 females ages 15-19)	8.5						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%						

			Community Benefits Service Area				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	Source
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 incidence - Case Count	611		No data	0	Less than 5	Less than 5	Massachusetts Population Health Information Tool, 2017
Rate of population living with a diagnosis of HIV 2018	349						Sullivan PS, Woodyatt C, Koski C, Pembleton E, McGuinness P, Taussig J, Ricca A, Luisi N, Mokotoff E, Benbow N, Castel AD. A data visualization and dissemination
Rate of STI infection cases (per 100,000)							Massachusetts Population Health Information Tool, 2018
Syphillis	16.8		No data	No data	0	0	
Gonorrhea	110.3		85.8	20.5	16	No data	
Chlamydia	438		350.6	163.9	324.4	176.4	
Confirmed and probable Hepatitis B cases (per 100,000 population)	25.1	36.2					Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Hepatitis B Virus Infection 2020 Surveillance Report. Published February 2021
Rate of Hepatitis C (per 100,000)	97.9						MA DPH PHIT 2018
Count of Tuberculosis	2.9						MA DPH PHIT 2018
Medicare enrollees that had annual flu vaccination (%)	56%						NIS-Flu for children 6 months-17 years, BRFSS for Adults 18+

			Community Benefits Service Area				
	Massachusetts	Norfolk County	Dedham	Needham	Norwood	Westwood	*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		27%	27%	10%	22%	20%	
% ever been tested for COVID		42%	56%	38%	35%	40%	
% who have not gotten the medical care they needed since July 2020		14%	10%	15%	9%	13%	
% with 15 or more of poor mental health days in the past 30 days		29%	31%	16%	26%	*	
% of substance users who said they are now using more substances than before the pandemic		39%	45%	31%	36%	50%	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks		34%	32%	15%	41%	31%	
% Worried about getting food or groceries in the coming weeks		19%	16%	12%	12%	12%	
% Worried about getting face masks in the coming weeks		11%	11%	4%	10%	12%	
% Worried about getting medication in the coming weeks		10%	10%	6%	8%	11%	
% Worried about getting broadband in the coming weeks		8%	6%	4%	7%	11%	
% of Employed residents who experienced job loss		8%	7%	8%	7%	10%	
% of employed residents who experienced reduced work hours		11%	11%	15%	14%	*	
% Worried about paying mortgage, rent, or utilities related expenses		24%	21%	11%	30%	17%	
% Worried they may have to move out of where they live in the next few months		14%	7%	15%	18%	*	
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 Layoffs							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)			249	156	352	91	
Unemployment claims (#)			1,157	811	1,596	469	

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Needham

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

Patients aged 0-17

		BID Needham Community Benefits Service Area			
	MA	Dedham	Needham	Norwood	Westwood
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,00(	1,735	1,684	1,403	1,717	902
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-13%	20%	11%	-44%
FY19 ED Volume (all cause) rate per 100,000	19,530	12,175	12,933	16,017	9,890
Change in ED Volume Rate FY17 to FY19	-1%	-25%	-6%	-7%	-21%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	333	223	249	241	141
Change in Inpatient Discharge Rate FY17 to FY19	-12%	-45%	46%	15%	-55%
FY19 ED Volume rate per 100,000	2,481	1,705	1,403	1,541	1,043
Change in ED Volume Rate FY17 to FY19	2%	-24%	-4%	5%	-21%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	53	41	39	64	28
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	0%	100%	0%
FY19 ED Volume rate per 100,000	117	81	105	80	28
Change in ED Volume Rate FY17 to FY19	-2%	-20%	14%	-44%	-67%
Obesity					
FY19 Inpatient Discharges rate per 100,000	61	20	13	48	0
Change in Inpatient Discharge Rate FY17 to FY19	6%	0%	0%	-25%	-100%
FY19 ED Volume rate per 100,000	81	61	26	16	0
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	-80%	0%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	125	81	52	96	28
Change in Inpatient Discharge Rate FY17 to FY19	2%	-43%	-43%	50%	-50%
FY19 ED Volume rate per 100,000	1,874	1,400	1,902	1,236	1,268
Change in ED Volume Rate FY17 to FY19	-1%	-25%	11%	-15%	-35%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	18%	-100%	0%	0%	0%
FY19 ED Volume rate per 100,000	1	0	0	0	0
Change in ED Volume Rate FY17 to FY19	-23%	0%	0%	0%	0%
Infections					
FY19 Inpatient Discharges rate per 100,000	767	690	538	530	479
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-8%	3%	-31%	-15%
FY19 ED Volume rate per 100,000	7,457	3,571	2,518	5,842	2,085
Change in ED Volume Rate FY17 to FY19	4%	-16%	-9%	-1%	-5%
Injuries					
FY19 Inpatient Discharges rate per 100,000	345	284	262	225	225
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-7%	-13%	17%	-27%
FY19 ED Volume rate per 100,000	7,024	4,485	6,663	5,874	5,128
Change in ED Volume Rate FY17 to FY19	-8%	-37%	-3%	-17%	-20%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	85	41	13	128	0
Change in Inpatient Discharge Rate FY17 to FY19	-30%	-60%	-67%	100%	-100%
FY19 ED Volume rate per 100,000	501	264	210	289	113
Change in ED Volume Rate FY17 to FY19	32%	-35%	-16%	-5%	-43%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	213	203	157	112	169
Change in Inpatient Discharge Rate FY17 to FY19	3%	25%	0%	0%	20%
FY19 ED Volume rate per 100,000	1,098	690	590	915	479
Change in ED Volume Rate FY17 to FY19	38%	31%	88%	0%	55%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	4	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	0%	0%	-100%
FY19 ED Volume rate per 100,000	35	0	0	0	0
Change in ED Volume Rate FY17 to FY19	15%	-100%	0%	-100%	-100%

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Needham

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

Patients aged 0-17

		BID Needham Community Benefits Service Area			
	MA	Dedham	Needham	Norwood	Westwood
Other					
Attention Deficit Hyperactivity Disorder					
FY19 Inpatient Discharges rate per 100,000	141	142	223	193	85
Change in Inpatient Discharge Rate FY17 to FY19	-3%	17%	89%	200%	50%
FY19 ED Volume rate per 100,000	588	710	564	498	366
Change in ED Volume Rate FY17 to FY19	17%	-22%	-27%	19%	-13%
Learning Disorders					
FY19 Inpatient Discharges rate per 100,000	135	203	197	48	141
Change in Inpatient Discharge Rate FY17 to FY19	12%	67%	200%	50%	0%
FY19 ED Volume rate per 100,000	103	61	0	209	56
Change in ED Volume Rate FY17 to FY19	84%	200%	-100%	225%	0%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	772	832	1,312	1,332	310
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-11%	156%	38%	-54%
FY19 ED Volume rate per 100,000	2,592	2,009	2,151	2,889	1,747
Change in ED Volume Rate FY17 to FY19	5%	-32%	-12%	55%	-5%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	53	0	26	112	0
Change in Inpatient Discharge Rate FY17 to FY19	-8%	-100%	100%	600%	-100%
FY19 ED Volume rate per 100,000	343	304	157	128	169
Change in ED Volume Rate FY17 to FY19	-5%	36%	-43%	-27%	-14%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	229	223	105	160	85
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-31%	0%	25%	-57%
FY19 ED Volume rate per 100,000	208	122	249	177	28
Change in ED Volume Rate FY17 to FY19	3%	-14%	58%	10%	-93%

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

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

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

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Needham

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

Patients aged 18-44

		BID Needham Community Benefits Service Area			
	MA	Dedham	Needham	Norwood	Westwood
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,00(	6,072	6,525	5,157	8,005	4,511
Change in Inpatient Discharge Rate FY17 to FY19	0%	-5%	1%	-3%	-14%
FY19 ED Volume (all cause) rate per 100,000	25,053	18,317	10,301	22,013	9,386
Change in ED Volume Rate FY17 to FY19	-1%	0%	-12%	-1%	-20%
Cancer					
Breast Cancer					
FY19 Inpatient Discharges rate per 100,000	32	12	61	38	0
Change in Inpatient Discharge Rate FY17 to FY19	-10%	0%	0%	300%	-100%
FY19 ED Volume rate per 100,000	27	12	49	19	0
Change in ED Volume Rate FY17 to FY19	25%	0%	300%	0%	-100%
Colorectal Cancer					
FY19 Inpatient Discharges rate per 100,000	15	36	0	29	0
Change in Inpatient Discharge Rate FY17 to FY19	17%	-25%	0%	0%	0%
FY19 ED Volume rate per 100,000	4	0	0	10	0
Change in ED Volume Rate FY17 to FY19	21%	0%	0%	0%	0%
GYN Cancer					
FY19 Inpatient Discharges rate per 100,000	41	48	12	57	23
Change in Inpatient Discharge Rate FY17 to FY19	11%	100%	-50%	200%	0%
FY19 ED Volume rate per 100,000	30	0	0	48	0
Change in ED Volume Rate FY17 to FY19	23%	-100%	-100%	400%	-100%
Lung Cancer					
FY19 Inpatient Discharges rate per 100,000	26	84	12	0	68
Change in Inpatient Discharge Rate FY17 to FY19	3%	-13%	0%	-100%	0%
FY19 ED Volume rate per 100,000	7	12	12	19	0
Change in ED Volume Rate FY17 to FY19	47%	0%	0%	0%	0%
Prostate Cancer					
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-15%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	150%	0%	0%	0%	0%
Other Cancer					
FY19 Inpatient Discharges rate per 100,000	304	371	146	152	204
Change in Inpatient Discharge Rate FY17 to FY19	2%	-23%	-40%	14%	13%
FY19 ED Volume rate per 100,000	142	84	97	200	45
Change in ED Volume Rate FY17 to FY19	29%	17%	14%	75%	-33%

	BID Needham Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	745	611	510	877	499
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-18%	-5%	-21%	-24%
FY19 ED Volume rate per 100,000	2,649	1,975	1,262	2,935	703
Change in ED Volume Rate FY17 to FY19	3%	-20%	-4%	50%	-28%
Congestive Heart Failure					
FY19 Inpatient Discharges rate per 100,000	124	12	49	95	0
Change in Inpatient Discharge Rate FY17 to FY19	14%	0%	100%	67%	-100%
FY19 ED Volume rate per 100,000	56	24	0	10	0
Change in ED Volume Rate FY17 to FY19	42%	0%	-100%	0%	-100%
COPD and Lung Disease					
FY19 Inpatient Discharges rate per 100,000	136	144	61	124	45
Change in Inpatient Discharge Rate FY17 to FY19	-5%	71%	67%	8%	-50%
FY19 ED Volume rate per 100,000	127	144	12	48	0
Change in ED Volume Rate FY17 to FY19	16%	50%	0%	-69%	0%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	478	323	376	553	91
Change in Inpatient Discharge Rate FY17 to FY19	5%	17%	63%	29%	-84%
FY19 ED Volume rate per 100,000	1,167	635	376	1,296	204
Change in ED Volume Rate FY17 to FY19	7%	39%	29%	64%	-79%
Heart Disease					
FY19 Inpatient Discharges rate per 100,000	445	323	194	295	136
Change in Inpatient Discharge Rate FY17 to FY19	6%	69%	14%	-23%	-57%
FY19 ED Volume rate per 100,000	375	419	182	305	181
Change in ED Volume Rate FY17 to FY19	31%	218%	-21%	39%	-11%
Hypertension					
FY19 Inpatient Discharges rate per 100,000	606	527	194	886	227
Change in Inpatient Discharge Rate FY17 to FY19	1%	-14%	0%	18%	-44%
FY19 ED Volume rate per 100,000	1,838	1,065	558	1,963	771
Change in ED Volume Rate FY17 to FY19	8%	-13%	-18%	49%	-15%
Liver Disease					
FY19 Inpatient Discharges rate per 100,000	427	551	206	600	23
Change in Inpatient Discharge Rate FY17 to FY19	15%	64%	-23%	54%	-89%
FY19 ED Volume rate per 100,000	185	287	85	172	113
Change in ED Volume Rate FY17 to FY19	25%	700%	75%	200%	0%
Obesity					
FY19 Inpatient Discharges rate per 100,000	919	802	437	1,325	317
Change in Inpatient Discharge Rate FY17 to FY19	6%	-11%	9%	6%	-48%
FY19 ED Volume rate per 100,000	530	335	206	476	113
Change in ED Volume Rate FY17 to FY19	11%	-10%	6%	35%	-50%
Stroke and Other Neurovascular Diseases					
FY19 Inpatient Discharges rate per 100,000	71	108	24	10	68
Change in Inpatient Discharge Rate FY17 to FY19	9%	50%	-67%	-92%	200%
FY19 ED Volume rate per 100,000	28	24	12	48	23
Change in ED Volume Rate FY17 to FY19	11%	0%	-83%	0%	0%

	BID Needham Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	553	539	328	610	385
Change in Inpatient Discharge Rate FY17 to FY19	13%	15%	69%	14%	31%
FY19 ED Volume rate per 100,000	3,482	3,184	1,274	1,791	1,700
Change in ED Volume Rate FY17 to FY19	44%	131%	38%	63%	108%
Hepatitis					
FY19 Inpatient Discharges rate per 100,000	344	180	12	400	363
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-38%	-50%	-42%	433%
FY19 ED Volume rate per 100,000	195	251	0	295	136
Change in ED Volume Rate FY17 to FY19	1%	24%	-100%	-44%	50%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	44	12	12	38	23
Change in Inpatient Discharge Rate FY17 to FY19	2%	-75%	0%	33%	0%
FY19 ED Volume rate per 100,000	102	72	0	38	91
Change in ED Volume Rate FY17 to FY19	11%	20%	-100%	-75%	0%
Infections					
FY19 Inpatient Discharges rate per 100,000	1,534	1,604	570	1,915	861
Change in Inpatient Discharge Rate FY17 to FY19	2%	25%	-48%	1%	-31%
FY19 ED Volume rate per 100,000	5,547	3,807	2,063	4,279	2,176
Change in ED Volume Rate FY17 to FY19	-6%	19%	-10%	-16%	25%
Injuries					
FY19 Inpatient Discharges rate per 100,000	1,103	1,125	437	1,353	657
Change in Inpatient Discharge Rate FY17 to FY19	5%	4%	-22%	4%	7%
FY19 ED Volume rate per 100,000	7,762	6,082	3,603	7,147	3,061
Change in ED Volume Rate FY17 to FY19	-4%	0%	-14%	-4%	-31%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	189	72	73	181	204
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-67%	0%	-21%	200%
FY19 ED Volume rate per 100,000	693	563	206	658	181
Change in ED Volume Rate FY17 to FY19	-8%	-10%	-11%	-14%	-65%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	286	335	73	429	136
Change in Inpatient Discharge Rate FY17 to FY19	8%	100%	-63%	105%	100%
FY19 ED Volume rate per 100,000	588	419	413	572	181
Change in ED Volume Rate FY17 to FY19	27%	52%	62%	25%	33%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	80	60	24	105	45
Change in Inpatient Discharge Rate FY17 to FY19	-9%	-55%	-67%	-27%	-33%
FY19 ED Volume rate per 100,000	262	120	85	324	45
Change in ED Volume Rate FY17 to FY19	15%	-23%	75%	143%	0%
Tuberculosis					
FY19 Inpatient Discharges rate per 100,000	9	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000	5	0	0	0	0
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	0%	0%

	BID Needham Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Other					
Dementia and Cognitive Disorders					
FY19 Inpatient Discharges rate per 100,000	177	192	61	238	91
Change in Inpatient Discharge Rate FY17 to FY19	9%	33%	-55%	56%	0%
FY19 ED Volume rate per 100,000	201	108	85	162	68
Change in ED Volume Rate FY17 to FY19	-11%	29%	40%	21%	-25%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	4,382	4,465	3,142	5,965	2,993
Change in Inpatient Discharge Rate FY17 to FY19	5%	-13%	19%	-10%	8%
FY19 ED Volume rate per 100,000	7,907	5,830	2,706	9,215	3,106
Change in ED Volume Rate FY17 to FY19	16%	-12%	-21%	39%	-33%
Parkinsons and Movement Disorders					
FY19 Inpatient Discharges rate per 100,000	41	24	0	19	0
Change in Inpatient Discharge Rate FY17 to FY19	-2%	100%	-100%	100%	0%
FY19 ED Volume rate per 100,000	95	84	61	114	23
Change in ED Volume Rate FY17 to FY19	-4%	40%	-17%	50%	-50%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	2,012	1,712	485	2,506	725
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-28%	-18%	-17%	-27%
FY19 ED Volume rate per 100,000	8,347	4,585	1,080	5,984	1,950
Change in ED Volume Rate FY17 to FY19	0%	-19%	-51%	-1%	-15%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	2,698	3,125	3,264	3,726	2,766
Change in Inpatient Discharge Rate FY17 to FY19	5%	1%	10%	8%	-2%
FY19 ED Volume rate per 100,000	582	371	231	572	227
Change in ED Volume Rate FY17 to FY19	14%	-14%	-55%	22%	-17%

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 Needs Assessment - Beth Israel Deaconess Hospital - Needham

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

Patients aged 45-64

		BID-Needham Community Benefits Service Area			
	MA	Dedham	Needham	Norwood	Westwood
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,00(	9,762	9,327	5,138	13,010	5,767
Change in Inpatient Discharge Rate FY17 to FY19	0%	-8%	-2%	12%	-3%
FY19 ED Volume (all cause) rate per 100,000	24,003	18,231	10,336	21,289	11,420
Change in ED Volume Rate FY17 to FY19	2%	-2%	-17%	6%	2%
Cancer					
Breast Cancer					
FY19 Inpatient Discharges rate per 100,000	258	325	460	400	294
Change in Inpatient Discharge Rate FY17 to FY19	-5%	53%	39%	68%	333%
FY19 ED Volume rate per 100,000	195	339	259	262	181
Change in ED Volume Rate FY17 to FY19	18%	14%	0%	17%	-50%
Colorectal Cancer					
FY19 Inpatient Discharges rate per 100,000	116	99	71	137	113
Change in Inpatient Discharge Rate FY17 to FY19	0%	-36%	-45%	-15%	67%
FY19 ED Volume rate per 100,000	27	0	0	50	23
Change in ED Volume Rate FY17 to FY19	12%	-100%	-100%	-20%	0%
GYN Cancer					
FY19 Inpatient Discharges rate per 100,000	182	254	189	300	113
Change in Inpatient Discharge Rate FY17 to FY19	-3%	80%	-16%	50%	-29%
FY19 ED Volume rate per 100,000	82	14	94	100	23
Change in ED Volume Rate FY17 to FY19	21%	-83%	-11%	0%	0%
Lung Cancer					
FY19 Inpatient Discharges rate per 100,000	358	452	271	599	113
Change in Inpatient Discharge Rate FY17 to FY19	5%	10%	-12%	109%	-69%
FY19 ED Volume rate per 100,000	97	170	82	200	0
Change in ED Volume Rate FY17 to FY19	21%	100%	17%	60%	-100%
Prostate Cancer					
FY19 Inpatient Discharges rate per 100,000	133	141	106	112	249
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-38%	-31%	13%	175%
FY19 ED Volume rate per 100,000	60	42	141	50	136
Change in ED Volume Rate FY17 to FY19	30%	-25%	71%	-43%	200%
Other Cancer					
FY19 Inpatient Discharges rate per 100,000	1,984	2,643	1,674	3,958	1,402
Change in Inpatient Discharge Rate FY17 to FY19	3%	32%	-11%	61%	-36%
FY19 ED Volume rate per 100,000	597	636	566	1,024	475
Change in ED Volume Rate FY17 to FY19	27%	-22%	-16%	61%	-9%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	1,051	961	577	1,473	317
Change in Inpatient Discharge Rate FY17 to FY19	-17%	8%	17%	8%	-53%
FY19 ED Volume rate per 100,000	1,944	1,300	884	1,536	565
Change in ED Volume Rate FY17 to FY19	0%	-17%	-23%	18%	-55%
Congestive Heart Failure					
FY19 Inpatient Discharges rate per 100,000	1,292	1,088	483	1,698	90
Change in Inpatient Discharge Rate FY17 to FY19	10%	-21%	24%	15%	-43%
FY19 ED Volume rate per 100,000	396	452	189	300	113
Change in ED Volume Rate FY17 to FY19	41%	129%	-20%	26%	67%
COPD and Lung Disease					
FY19 Inpatient Discharges rate per 100,000	1,994	1,865	695	2,497	588
Change in Inpatient Discharge Rate FY17 to FY19	1%	-18%	5%	22%	8%
FY19 ED Volume rate per 100,000	1,388	975	271	1,536	294
Change in ED Volume Rate FY17 to FY19	10%	-18%	-43%	7%	-32%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	2,808	2,318	1,155	3,746	701
Change in Inpatient Discharge Rate FY17 to FY19	3%	-7%	17%	29%	-47%
FY19 ED Volume rate per 100,000	4,109	3,038	1,308	3,446	837
Change in ED Volume Rate FY17 to FY19	10%	-4%	-4%	8%	-26%

	BID Needham Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Heart Disease					
FY19 Inpatient Discharges rate per 100,000	3,609	3,081	1,626	3,996	1,334
Change in Inpatient Discharge Rate FY17 to FY19	4%	-9%	6%	6%	-28%
FY19 ED Volume rate per 100,000	1,448	1,837	660	1,598	769
Change in ED Volume Rate FY17 to FY19	17%	29%	-33%	8%	-26%
Hypertension					
FY19 Inpatient Discharges rate per 100,000	4,045	3,618	1,662	4,982	2,239
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-20%	-7%	-1%	-9%
FY19 ED Volume rate per 100,000	7,878	6,897	3,288	6,867	3,370
Change in ED Volume Rate FY17 to FY19	10%	1%	-14%	1%	6%
Liver Disease					
FY19 Inpatient Discharges rate per 100,000	1,562	2,077	860	1,873	633
Change in Inpatient Discharge Rate FY17 to FY19	5%	1%	83%	15%	-10%
FY19 ED Volume rate per 100,000	404	283	130	412	181
Change in ED Volume Rate FY17 to FY19	19%	-23%	10%	57%	33%
Obesity					
FY19 Inpatient Discharges rate per 100,000	2,410	2,643	919	3,883	1,425
Change in Inpatient Discharge Rate FY17 to FY19	5%	9%	18%	21%	24%
FY19 ED Volume rate per 100,000	675	523	330	649	520
Change in ED Volume Rate FY17 to FY19	17%	-36%	115%	18%	15%
Stroke and Other Neurovascular Diseases					
FY19 Inpatient Discharges rate per 100,000	443	565	247	662	271
Change in Inpatient Discharge Rate FY17 to FY19	2%	18%	-5%	18%	-29%
FY19 ED Volume rate per 100,000	119	170	71	125	45
Change in ED Volume Rate FY17 to FY19	6%	20%	-57%	-23%	-60%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	1,314	1,427	471	1,548	814
Change in Inpatient Discharge Rate FY17 to FY19	20%	80%	33%	39%	44%
FY19 ED Volume rate per 100,000	4,000	3,985	1,226	1,736	1,922
Change in ED Volume Rate FY17 to FY19	59%	228%	93%	96%	158%
Hepatitis					
FY19 Inpatient Discharges rate per 100,000	492	537	59	312	90
Change in Inpatient Discharge Rate FY17 to FY19	-19%	6%	-69%	-22%	-20%
FY19 ED Volume rate per 100,000	211	28	0	300	0
Change in ED Volume Rate FY17 to FY19	-11%	-87%	-100%	60%	-100%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	157	42	35	162	0
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-25%	200%	550%	-100%
FY19 ED Volume rate per 100,000	236	155	12	112	90
Change in ED Volume Rate FY17 to FY19	-3%	0%	-50%	350%	33%
Infections					
FY19 Inpatient Discharges rate per 100,000	3,824	3,915	2,381	5,369	2,058
Change in Inpatient Discharge Rate FY17 to FY19	3%	0%	0%	17%	-24%
FY19 ED Volume rate per 100,000	3,618	2,261	1,249	2,959	2,148
Change in ED Volume Rate FY17 to FY19	-4%	-4%	-36%	7%	61%
Injuries					
FY19 Inpatient Discharges rate per 100,000	3,425	3,151	1,567	4,120	1,854
Change in Inpatient Discharge Rate FY17 to FY19	6%	-7%	-1%	6%	24%
FY19 ED Volume rate per 100,000	7,959	6,020	4,160	7,641	4,274
Change in ED Volume Rate FY17 to FY19	-2%	-20%	-24%	2%	-14%
Poisonings					
FY19 Inpatient Discharges rate per 100,000	232	240	71	325	136
Change in Inpatient Discharge Rate FY17 to FY19	-7%	21%	-40%	8%	50%
FY19 ED Volume rate per 100,000	395	184	153	375	204
Change in ED Volume Rate FY17 to FY19	5%	-19%	18%	-27%	29%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	1,135	947	589	1,311	452
Change in Inpatient Discharge Rate FY17 to FY19	8%	-9%	2%	4%	-20%
FY19 ED Volume rate per 100,000	555	396	236	524	249
Change in ED Volume Rate FY17 to FY19	11%	22%	-33%	17%	38%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	24	0	0	50	23
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	-100%	300%	0%
FY19 ED Volume rate per 100,000	38	0	12	25	23
Change in ED Volume Rate FY17 to FY19	5%	-100%	0%	0%	0%

Tuberculosis					
FY19 Inpatient Discharges rate per 100,000	18	28	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	100%	0%	-100%	-100%
FY19 ED Volume rate per 100,000	6	0	0	12	0
Change in ED Volume Rate FY17 to FY19	7%	0%	0%	-50%	0%
Other					
Dementia and Cognitive Disorders					
FY19 Inpatient Discharges rate per 100,000	868	975	471	1,261	317
Change in Inpatient Discharge Rate FY17 to FY19	10%	-16%	-7%	49%	-7%
FY19 ED Volume rate per 100,000	325	198	177	325	113
Change in ED Volume Rate FY17 to FY19	-5%	-46%	7%	18%	0%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	7,268	7,137	3,512	10,526	3,573
Change in Inpatient Discharge Rate FY17 to FY19	4%	-3%	12%	24%	-2%
FY19 ED Volume rate per 100,000	6,209	4,353	1,591	8,116	2,307
Change in ED Volume Rate FY17 to FY19	17%	-18%	-46%	88%	-30%
Parkinsons and Movement Disorders					
FY19 Inpatient Discharges rate per 100,000	252	339	177	337	68
Change in Inpatient Discharge Rate FY17 to FY19	8%	4%	200%	13%	0%
FY19 ED Volume rate per 100,000	185	141	47	175	68
Change in ED Volume Rate FY17 to FY19	5%	-47%	0%	-18%	50%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	3,820	3,674	1,072	4,520	1,289
Change in Inpatient Discharge Rate FY17 to FY19	0%	-19%	8%	3%	-14%
FY19 ED Volume rate per 100,000	7,619	4,268	955	4,907	1,560
Change in ED Volume Rate FY17 to FY19	3%	-16%	-43%	5%	-8%
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	1,870	2,304	1,167	2,747	1,131
Change in Inpatient Discharge Rate FY17 to FY19	7%	28%	2%	40%	-15%
FY19 ED Volume rate per 100,000	472	424	295	537	317
Change in ED Volume Rate FY17 to FY19	8%	3%	-40%	19%	-13%

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

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

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

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Needham

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

Patients aged 65+

		BID Needham Community Benefits Service Area			
	MA	Dedham	Needham	Norwood	Westwood
All Cause					
FY19 Inpatient Discharges (all cause) rate per 100,00(	25,473	27,933	24,588	32,348	25,218
Change in Inpatient Discharge Rate FY17 to FY19	5%	3%	1%	0%	-5%
FY19 ED Volume (all cause) rate per 100,000	26,010	25,393	27,485	26,729	24,104
Change in ED Volume Rate FY17 to FY19	10%	-5%	-1%	6%	-4%
Cancer					
Breast Cancer					
FY19 Inpatient Discharges rate per 100,000	1,253	1,860	1,448	1,349	1,928
Change in Inpatient Discharge Rate FY17 to FY19	6%	-8%	-4%	-10%	0%
FY19 ED Volume rate per 100,000	480	751	766	649	934
Change in ED Volume Rate FY17 to FY19	42%	-18%	-18%	58%	-11%
Colorectal Cancer					
FY19 Inpatient Discharges rate per 100,000	271	143	200	359	241
Change in Inpatient Discharge Rate FY17 to FY19	2%	-47%	33%	-19%	-50%
FY19 ED Volume rate per 100,000	42	18	17	68	30
Change in ED Volume Rate FY17 to FY19	9%	-75%	-75%	100%	0%
GYN Cancer					
FY19 Inpatient Discharges rate per 100,000	508	590	366	786	271
Change in Inpatient Discharge Rate FY17 to FY19	6%	57%	29%	-10%	-40%
FY19 ED Volume rate per 100,000	145	161	150	120	30
Change in ED Volume Rate FY17 to FY19	47%	-36%	-25%	-36%	-80%
Lung Cancer					
FY19 Inpatient Discharges rate per 100,000	1,347	1,574	1,315	1,486	964
Change in Inpatient Discharge Rate FY17 to FY19	9%	13%	3%	-11%	-38%
FY19 ED Volume rate per 100,000	282	429	400	683	211
Change in ED Volume Rate FY17 to FY19	26%	-11%	14%	14%	-30%

	BID NeedhamCommunity Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Prostate Cancer					
FY19 Inpatient Discharges rate per 100,000	1,270	1,717	2,031	1,315	1,958
Change in Inpatient Discharge Rate FY17 to FY19	6%	10%	1%	8%	20%
FY19 ED Volume rate per 100,000	434	733	666	632	994
Change in ED Volume Rate FY17 to FY19	36%	-2%	-33%	236%	50%
Other Cancer					
FY19 Inpatient Discharges rate per 100,000	7,146	9,317	9,389	7,805	8,225
Change in Inpatient Discharge Rate FY17 to FY19	13%	18%	15%	-12%	9%
FY19 ED Volume rate per 100,000	1,519	2,361	2,647	1,998	2,410
Change in ED Volume Rate FY17 to FY19	33%	-7%	-6%	24%	8%
Chronic Disease					
Asthma					
FY19 Inpatient Discharges rate per 100,000	1,596	1,913	1,815	1,640	1,567
Change in Inpatient Discharge Rate FY17 to FY19	-16%	-26%	11%	-25%	-13%
FY19 ED Volume rate per 100,000	1,257	1,234	1,365	1,213	1,627
Change in ED Volume Rate FY17 to FY19	8%	-17%	1%	11%	8%
Congestive Heart Failure					
FY19 Inpatient Discharges rate per 100,000	8,161	8,995	7,808	10,179	8,255
Change in Inpatient Discharge Rate FY17 to FY19	9%	-3%	-5%	5%	1%
FY19 ED Volume rate per 100,000	1,705	2,289	2,231	2,015	2,109
Change in ED Volume Rate FY17 to FY19	34%	-4%	-6%	48%	8%
COPD and Lung Disease					
FY19 Inpatient Discharges rate per 100,000	7,130	7,010	4,345	8,437	5,002
Change in Inpatient Discharge Rate FY17 to FY19	5%	-9%	-21%	6%	-24%
FY19 ED Volume rate per 100,000	2,422	2,682	1,931	2,818	1,838
Change in ED Volume Rate FY17 to FY19	18%	-7%	-9%	-7%	-22%
Diabetes Mellitus					
FY19 Inpatient Discharges rate per 100,000	8,376	8,745	5,693	9,872	4,760
Change in Inpatient Discharge Rate FY17 to FY19	5%	16%	8%	10%	-7%
FY19 ED Volume rate per 100,000	5,867	5,186	4,412	5,944	3,284
Change in ED Volume Rate FY17 to FY19	18%	2%	3%	15%	-20%
Heart Disease					
FY19 Inpatient Discharges rate per 100,000	18,344	19,760	18,695	22,084	16,782
Change in Inpatient Discharge Rate FY17 to FY19	6%	-7%	-1%	2%	-15%
FY19 ED Volume rate per 100,000	3,975	5,508	5,044	5,346	4,550
Change in ED Volume Rate FY17 to FY19	16%	-20%	-20%	10%	-15%
Hypertension					
FY19 Inpatient Discharges rate per 100,000	10,397	11,016	9,472	13,664	9,852
Change in Inpatient Discharge Rate FY17 to FY19	-1%	-10%	-2%	-13%	-14%
FY19 ED Volume rate per 100,000	12,665	13,197	14,999	13,356	12,594
Change in ED Volume Rate FY17 to FY19	14%	-11%	1%	-4%	-10%
Liver Disease					
FY19 Inpatient Discharges rate per 100,000	1,956	2,432	2,264	2,391	964
Change in Inpatient Discharge Rate FY17 to FY19	16%	43%	70%	4%	-24%
FY19 ED Volume rate per 100,000	258	215	200	222	151
Change in ED Volume Rate FY17 to FY19	36%	-43%	9%	8%	67%
Obesity					
FY19 Inpatient Discharges rate per 100,000	3,869	3,809	2,297	5,961	3,133
Change in Inpatient Discharge Rate FY17 to FY19	14%	30%	31%	26%	35%
FY19 ED Volume rate per 100,000	367	340	216	427	271
Change in ED Volume Rate FY17 to FY19	26%	-21%	117%	56%	125%
Stroke and Other Neurovascular Diseases					
FY19 Inpatient Discharges rate per 100,000	2,064	2,504	1,864	2,630	1,989
Change in Inpatient Discharge Rate FY17 to FY19	5%	0%	-8%	3%	-26%
FY19 ED Volume rate per 100,000	380	501	466	786	603
Change in ED Volume Rate FY17 to FY19	10%	-33%	-47%	28%	0%
Injuries and Infections					
Allergy					
FY19 Inpatient Discharges rate per 100,000	3,711	4,238	2,397	4,236	3,073
Change in Inpatient Discharge Rate FY17 to FY19	32%	106%	100%	40%	34%
FY19 ED Volume rate per 100,000	5,138	4,345	2,880	1,896	2,983
Change in ED Volume Rate FY17 to FY19	88%	119%	184%	152%	161%

	BID Needham Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Hepatitis					
FY19 Inpatient Discharges rate per 100,000	273	429	133	188	151
Change in Inpatient Discharge Rate FY17 to FY19	-3%	41%	-27%	-21%	-38%
FY19 ED Volume rate per 100,000	70	36	0	51	0
Change in ED Volume Rate FY17 to FY19	36%	100%	-100%	-25%	0%
HIV Infection					
FY19 Inpatient Discharges rate per 100,000	53	0	0	17	0
Change in Inpatient Discharge Rate FY17 to FY19	2%	-100%	-100%	-50%	0%
FY19 ED Volume rate per 100,000	47	0	83	0	0
Change in ED Volume Rate FY17 to FY19	34%	-100%	67%	0%	0%
Infections					
FY19 Inpatient Discharges rate per 100,000	12,591	15,433	13,418	15,679	12,233
Change in Inpatient Discharge Rate FY17 to FY19	6%	6%	-10%	-5%	0%
FY19 ED Volume rate per 100,000	4,213	3,362	3,762	3,484	3,435
Change in ED Volume Rate FY17 to FY19	3%	-5%	-14%	-6%	-10%
Injuries					
FY19 Inpatient Discharges rate per 100,000	11,877	15,612	12,502	15,269	12,956
Change in Inpatient Discharge Rate FY17 to FY19	15%	21%	-1%	12%	5%
FY19 ED Volume rate per 100,000	10,393	12,965	13,235	12,178	10,967
Change in ED Volume Rate FY17 to FY19	11%	-7%	-13%	30%	-7%
Injuries					
FY19 Inpatient Discharges rate per 100,000	281	215	133	290	90
Change in Inpatient Discharge Rate FY17 to FY19	7%	-25%	-11%	143%	-67%
FY19 ED Volume rate per 100,000	185	125	117	256	151
Change in ED Volume Rate FY17 to FY19	27%	133%	-22%	50%	150%
Pneumonia/Influenza					
FY19 Inpatient Discharges rate per 100,000	4,188	4,632	4,645	5,141	3,676
Change in Inpatient Discharge Rate FY17 to FY19	0%	-5%	-13%	12%	-25%
FY19 ED Volume rate per 100,000	569	644	566	478	422
Change in ED Volume Rate FY17 to FY19	1%	29%	10%	-26%	-22%
Sexually Transmitted Diseases					
FY19 Inpatient Discharges rate per 100,000	30	89	17	17	30
Change in Inpatient Discharge Rate FY17 to FY19	9%	150%	0%	-50%	0%
FY19 ED Volume rate per 100,000	5	0	0	0	0
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	0%	0%
Tuberculosis					
FY19 Inpatient Discharges rate per 100,000	52	54	17	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-11%	50%	-75%	-100%	0%
FY19 ED Volume rate per 100,000	6	0	0	34	0
Change in ED Volume Rate FY17 to FY19	13%	-100%	-100%	0%	0%
Other					
Dementia and Cognitive Disorders					
FY19 Inpatient Discharges rate per 100,000	6,264	7,493	7,158	8,642	6,448
Change in Inpatient Discharge Rate FY17 to FY19	6%	-13%	-7%	-11%	-12%
FY19 ED Volume rate per 100,000	2,053	3,201	3,629	3,535	3,465
Change in ED Volume Rate FY17 to FY19	11%	-19%	-13%	0%	5%
Mental Health					
FY19 Inpatient Discharges rate per 100,000	10,900	14,360	9,772	13,134	10,304
Change in Inpatient Discharge Rate FY17 to FY19	15%	24%	-3%	2%	26%
FY19 ED Volume rate per 100,000	3,500	3,183	2,331	5,346	2,230
Change in ED Volume Rate FY17 to FY19	35%	-2%	-16%	127%	-5%
Parkinsons and Movement Disorders					
FY19 Inpatient Discharges rate per 100,000	1,523	2,325	1,931	2,306	1,748
Change in Inpatient Discharge Rate FY17 to FY19	10%	37%	21%	14%	-18%
FY19 ED Volume rate per 100,000	602	769	899	888	844
Change in ED Volume Rate FY17 to FY19	11%	-37%	20%	24%	-7%
Substance Use Disorders					
FY19 Inpatient Discharges rate per 100,000	2,956	3,094	1,165	3,587	1,356
Change in Inpatient Discharge Rate FY17 to FY19	13%	9%	-13%	1%	-12%
FY19 ED Volume rate per 100,000	2,258	1,359	383	1,469	723
Change in ED Volume Rate FY17 to FY19	22%	7%	-41%	-25%	-11%

	BID Needham Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
Complication of Medical Care					
FY19 Inpatient Discharges rate per 100,000	4,867	5,436	5,177	5,500	4,369
Change in Inpatient Discharge Rate FY17 to FY19	13%	8%	3%	12%	-4%
FY19 ED Volume rate per 100,000	835	966	1,032	939	1,416
Change in ED Volume Rate FY17 to FY19	9%	-36%	-19%	20%	104%

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

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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

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Community Health Survey

- BID Needham 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.

_____

_____

_____

Beth Israel Lahey Health

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

BID Needham Community Health Survey Output

Response Counts

Completion Rate:	**100%**	
	Complete	488

Totals: 488

1. Select a language.

Value	Percent	Responses
Take the survey in English	99.0%	479
参加简体中文调查	0.2%	1
Participe da pesquisa em português	0.2%	1
Пройдите анкету на русском языке	0.2%	1
Responda la encuesta en español	0.4%	2

Totals: 484

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

Response
02492
02494
02026
02090
02062

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

Value	Percent	Responses
Less than 1 year	2.3%	11
1-5 years	11.7%	57
6-10 years	11.7%	57
Over 10 years but not all my life	62.0%	302
I have lived here all my life	9.9%	48
I used to live here, but not anymore	0.6%	3
I have never lived here	1.8%	9

Totals: 487

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

Value	Percent	Responses
Less than 1 year	3.3%	16
1-5 years	14.9%	72
6-10 years	10.1%	49
Over 10 years	25.5%	123
I do not work here	46.2%	223

Totals: 483

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 %	12 2.5%	26 5.4%	226 47.2%	203 42.4%	12 2.5%	479
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 %	6 1.2%	27 5.6%	219 45.4%	224 46.5%	6 1.2%	482
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 %	6 1.3%	12 2.5%	152 32.0%	274 57.7%	31 6.5%	475
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 %	23 4.8%	93 19.5%	198 41.6%	133 27.9%	29 6.1%	476
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). Count Row %	4 0.8%	16 3.4%	241 51.0%	196 41.4%	16 3.4%	473
Totals Total Responses						482

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	7.5%	36
Better access to health care	7.7%	37
Better access to healthy food	9.8%	47
Better access to internet	4.4%	21
Better access to public transportation	33.8%	162
Better parks and recreation	19.6%	94
Better roads	18.8%	90
Better schools	11.3%	54
Better sidewalks and trails	36.3%	174
Cleaner environment	12.7%	61
Lower crime and violence	3.8%	18
More affordable childcare	21.9%	105
More affordable housing	57.4%	275
More arts and cultural events	26.7%	128
More effective city services (like water, trash, fire department, and police)	12.9%	62
More inclusion for diverse members of the community	39.7%	190
Stronger community leadership	9.8%	47
Stronger sense of community	16.1%	77
Other	10.0%	48

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 %	6 1.3%	50 10.4%	234 48.8%	125 26.0%	65 13.5%	480
I believe that all residents, including myself, can make the community a better place to live. Count Row %	4 0.8%	7 1.5%	218 45.3%	241 50.1%	11 2.3%	481
During COVID-19, information I need to stay healthy and safe has been readily available in my community. Count Row %	3 0.6%	27 5.6%	242 50.0%	198 40.9%	14 2.9%	484
During COVID-19, resources I need to stay healthy and safe have been readily available in my community. Count Row %	5 1.0%	37 7.7%	241 50.0%	174 36.1%	25 5.2%	482
Totals Total Responses						484

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 %	388 80.3%	88 18.2%	6 1.2%	1 0.2%	483
People like me have access to safe, clean parks and open spaces. Count Row %	356 73.7%	107 22.2%	13 2.7%	7 1.4%	483
People like me have access to reliable transportation. Count Row %	232 47.9%	191 39.5%	43 8.9%	18 3.7%	484
People like me have housing that is safe and good quality. Count Row %	337 69.6%	127 26.2%	16 3.3%	4 0.8%	484
The air in my community is healthy to breathe. Count Row %	342 70.7%	108 22.3%	10 2.1%	24 5.0%	484
The water in my community is safe to drink. Count Row %	342 70.5%	97 20.0%	18 3.7%	28 5.8%	485
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards. Count Row %	184 38.1%	134 27.7%	26 5.4%	139 28.8%	483
During extreme heat, people like me have access to options for staying cool. Count Row %	279 57.9%	118 24.5%	27 5.6%	58 12.0%	482
Totals Total Responses					485

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 %	177 37.2%	166 34.9%	29 6.1%	104 21.8%	476
People like me have access to local investment opportunities, such as owning homes or businesses. Count Row %	207 43.6%	163 34.3%	61 12.8%	44 9.3%	475
Housing in my community is affordable for people with different income levels. Count Row %	21 4.4%	117 24.4%	309 64.5%	32 6.7%	479
People like me have access to affordable childcare services. Count Row %	45 9.6%	150 31.8%	107 22.7%	169 35.9%	471
People like me have access to good education for their children. Count Row %	321 68.2%	100 21.2%	7 1.5%	43 9.1%	471
Totals Total Responses					479

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 %	47 9.9%	63 13.3%	127 26.7%	167 35.2%	71 14.9%	475
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 %	44 9.3%	72 15.2%	143 30.2%	162 34.2%	53 11.2%	474
Totals Total Responses						475

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 %	310 64.6%	139 29.0%	14 2.9%	17 3.5%	480
Health care in my community meets the mental health needs of people like me. Count Row %	123 25.7%	180 37.7%	59 12.3%	116 24.3%	478
Totals Total Responses					480

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 %	432 90.0%	20 4.2%	28 5.8%	480
Dental (mouth) care Count Row %	419 87.7%	22 4.6%	37 7.7%	478
Mental health care Count Row %	106 22.3%	44 9.3%	325 68.4%	475
Reproductive health care Count Row %	66 13.9%	7 1.5%	402 84.6%	475
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	15 3.2%	8 1.7%	451 95.1%	474
Treatment for a substance use disorder Count Row %	4 0.8%	1 0.2%	468 98.9%	473
Vision care Count Row %	343 72.1%	25 5.3%	108 22.7%	476
Medication for a chronic illness Count Row %	223 46.8%	15 3.1%	239 50.1%	477
Totals Total Responses				480

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 %	45 37.5%	6 5.0%	8 6.7%	13 10.8%	2 1.7%	2 1.7%	44 36.7%	120
Dental care Count Row %	51 43.2%	21 17.8%	4 3.4%	6 5.1%	2 1.7%	1 0.8%	33 28.0%	118
Mental health care Count Row %	10 9.7%	9 8.7%	1 1.0%	8 7.8%	5 4.9%	0 0.0%	70 68.0%	103
Reproductive health care Count Row %	7 9.6%	2 2.7%	0 0.0%	5 6.8%	1 1.4%	0 0.0%	58 79.5%	73
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	4 5.5%	3 4.1%	1 1.4%	3 4.1%	1 1.4%	0 0.0%	61 83.6%	73
Treatment for a substance use disorder Count Row %	2 3.1%	2 3.1%	1 1.5%	2 3.1%	1 1.5%	0 0.0%	57 87.7%	65
Vision care Count Row %	31 32.3%	7 7.3%	3 3.1%	10 10.4%	0 0.0%	0 0.0%	45 46.9%	96
Medication for a chronic illness Count Row %	10 13.3%	10 13.3%	4 5.3%	1 1.3%	0 0.0%	1 1.3%	49 65.3%	75

	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								120

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 %	82 17.6%	88 18.9%	172 36.9%	86 18.5%	38 8.2%	466
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 %	71 15.2%	105 22.5%	184 39.5%	89 19.1%	17 3.6%	466
Totals Total Responses						466

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 %	363 83.3%	56 12.8%	14 3.2%	0 0.0%	1 0.2%	2 0.5%	436
You are unfairly stopped, searched, questioned, threatened, or abused by the police. Count Row %	430 95.1%	14 3.1%	7 1.5%	1 0.2%	0 0.0%	0 0.0%	452
You receive worse service than other people at stores, restaurants, or service providers. Count Row %	368 81.1%	45 9.9%	36 7.9%	4 0.9%	1 0.2%	0 0.0%	454
Landlords or realtors refused to rent or sell you an apartment or house. Count Row %	431 96.6%	13 2.9%	2 0.4%	0 0.0%	0 0.0%	0 0.0%	446
Healthcare providers treat you with less respect or provide worse services to you compared to other people. Count Row %	394 87.4%	39 8.6%	12 2.7%	6 1.3%	0 0.0%	0 0.0%	451
Totals Total Responses							454

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)	14.5%	8
Ageism (discrimination on the basis of age)	52.7%	29
Discrimination based on income or education level	10.9%	6
Discrimination based on the basis of religion	7.3%	4
Discrimination based on the basis of weight or body size	20.0%	11
Homophobia (discrimination against gay, lesbian, bisexual, or queer people)	3.6%	2
Racism (discrimination on the basis of racial or ethnic group identity)	38.2%	21
Sexism (discrimination on the basis of sex)	36.4%	20
Xenophobia (discrimination against people born in another country)	3.6%	2
Don't know	7.3%	4

20. What is your age?

Value	Percent	Responses
Under 18	1.0%	5
18-24	1.2%	6
25-44	17.9%	87
45-64	38.8%	188
65-74	20.6%	100
75-84	14.6%	71
85 and over	4.3%	21
Prefer not to answer	1.4%	7

Totals: 485

21. What is your current gender identity?

Value	Percent	Responses
Genderqueer or gender non-conforming	0.4%	2
Man	13.3%	64
Woman	85.7%	412
Prefer to self-describe:	0.6%	3

Totals: 481

22. What is your sexual orientation?

Value	Percent	Responses
Bisexual	2.7%	13
Gay or lesbian	2.1%	10
Straight/heterosexual	89.6%	432
Prefer to self-describe:	0.2%	1
Prefer not to answer	5.4%	26

Totals: 482

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	0.4%	2
Asian	3.9%	19
Black or African American	1.5%	7
Hispanic/Latino	3.9%	19
Native Hawaiian or Other Pacific Islander	0.2%	1
White	87.6%	422
Not listed above/Other:	1.0%	5
Prefer not to answer	3.1%	15

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

Value	Percent	Responses
American	57.3%	264
European (specify):	27.8%	128
Other (specify):	5.6%	26
Unknown/Not specified	5.4%	25
African American	1.3%	6
Brazilian	0.7%	3
Cape Verdean	0.2%	1
Chinese	2.0%	9
Colombian	0.7%	3
Cuban	0.2%	1
Dominican	0.4%	2
Filipino	0.9%	4
Haitian	0.2%	1
Indian	0.7%	3
Korean	0.2%	1
Mexican, Mexican-American, Chicano	0.9%	4
Middle Eastern (specify):	1.3%	6
Puerto Rican	0.9%	4
Russian	2.6%	12

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

Value	Percent	Responses
Armenian	1.9%	9
Chinese (including Mandarin and Cantonese)	0.8%	4
English	93.7%	447
Hindi	0.2%	1
Portuguese	0.4%	2
Russian	0.8%	4
Spanish	2.3%	11
Other (specify):	1.0%	5
Prefer not to answer	1.0%	5

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

Value	Percent	Responses
Grades 1 through 8	0.2%	1
Grades 9 through 11/ Some high school	1.0%	5
Grade 12/Completed high school or GED	4.8%	23
Some college, Associates Degree, or Technical Degree	11.6%	56
Bachelor's Degree	28.7%	138
Any post graduate studies	52.0%	250
Prefer not to answer	1.7%	8

Totals: 481

27. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	32.8%	157
Employed part-time (Less than 40 hours per week)	14.9%	71
Self-employed (Full- or part-time)	6.1%	29
A stay at home parent	5.2%	25
A student (Full- or part-time)	1.3%	6
Unemployed	2.5%	12
Unable to work for health reasons	1.7%	8
Retired	33.5%	160
Other (specify):	1.0%	5
Prefer not to answer	1.0%	5

Totals: 478

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

Value	Percent	Responses
Less than one year	0.2%	1
4 to 6 years	0.4%	2
More than 6 years, but not my whole life	10.2%	49
I have always lived in the United States	88.2%	425
Prefer not to answer	1.0%	5

Totals: 482

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	93.9%	448
On active duty in the past, but not now (includes retirement from any branch)	3.6%	17
Prefer not to answer	2.5%	12

Totals: 477

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

Value	Percent	Responses
Yes	12.3%	59
No	84.3%	404
Prefer not to answer	3.3%	16

Totals: 479

31. How would you describe your current housing situation?

Value	Percent	Responses
I rent my home	13.1%	63
I own my home	79.6%	382
I am staying with another household	3.3%	16
Other (specify):	1.9%	9
Prefer not to answer	2.1%	10

Totals: 480

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

Value	Percent	Responses
Yes	33.9%	162
No	64.9%	310
Prefer not to answer	1.3%	6

Totals: 478

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

Value	Percent	Responses
0-3 years	16.9%	27
4-5 years	8.1%	13
6-10 years	33.1%	53
11-14 years	43.1%	69
15-17 years	46.9%	75

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

Value	Percent	Responses
My neighborhood or building	68.7%	318
Faith community (such as a church, mosque, temple, or faith-based organization)	38.4%	178
School community (such as a college or education program that you attend, or a school that you child attends)	25.1%	116
Work community (such as your place of employment, or a professional association)	39.3%	182
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)	13.4%	62
A shared interest group (such as a club, sports team, political group, or advocacy group)	42.1%	195
Another city or town where I do not live	13.4%	62
Other (Feel free to share):	6.0%	28

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

Channels

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

1. Print

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

A. El Mundo – Spanish Translation

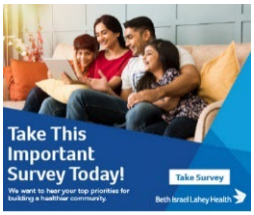
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

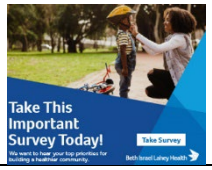
D. Bay State Banner – Black/African American, Cape Verdean/English

E. Chelsea Record – Hispanic/English

F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



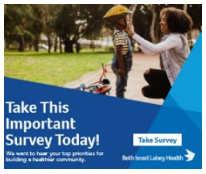
For the printed newspapers the publish dates are as follows:

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

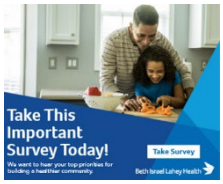
2. Digital Advertising

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

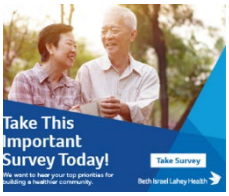
A. African American/Black, Haitian, Cape Verdean



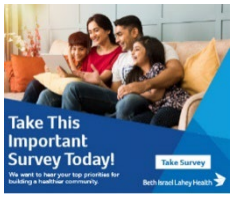
B. Hispanic



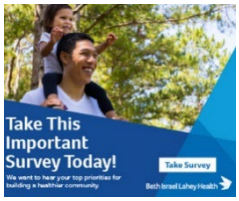
C. Chinese



D. Indian



E. Vietnamese



C. Precision Audio

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

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

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

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

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

Survey Distribution Channels: BID Needham Community Partners

Organization	Surveys	Promotion other than flyers or print (e.g., Social Media, Newsletter, other Electronic Publication, etc.)	Contact Person/Name	Title (if Applicable)
Avita of Needham	x		Mary Jane McGill	Sales Director
Baby Basics	x		Alicia Stedman	Director
Beth Israel Deaconess Healthcare (Dedham/Westwood)	x		Nancy Trask	Practic Manager
Beth Israel Deaconess Healthcare (PCP Manager)	x		Jeanne Goldberg	Regional Practice Manager
BID Needham Board of Advisors	x	social media	Janet Barrett	Board Member
BID Needham Cancer Center			Anna Marinilli	Administrator
BID Needham Cancer Center			Andrea Goldberg	Social Worker
BID Needham Case Management	x		Marea Pickette	Case Manager
Blue Hills Regional Technical School	x		Tammy Macdonald	ESOL Instructor
Briarwood	x		Carly Ring	Sales
Charles River Center	x		Hillary Ryan	Director of Development
Charles River YMCA	x		Paula Jacobson	Director of Development
Christ Church Needham	x		Nick Morris-Kliment	Rector
Circle of Hope	x		Barbara Waterhouse	Director of Development
Concord Prison Outreach	x		Jennifer Albanese	N/A
Dedham Council on Aging	x		Sheila Pransky	Director
Dedham Disability commission			John Tocci	Member
Dedham Food Pantry	x		Carol Burak	Board Member
Dedham Housing Authority	x		Carrie Moore	Director
Dedham Organization for Substance Awareness (DOSA)	x		Kristina King	Director
Dedham Public Health Department	x		Kylee Sullivan	Director
Dedham Youth Commission	x		Angela Osei-Mensah	Counselor
Dover Church	x		Beth Benjamin	Administrator
Dover Council on Aging	x		Janet Claypoole	Director
Dover Parks & Recreation	x		Valerie Lin	Board Member
Family ACCESS Community Connections	x		Jodi Levin	Community Outreach
Family Promise MetroWest	x		Sue Crossley	Director
Great Hall Performance Foundation	x		Michael Niden	Board Member
Hebrew Senior Life	x		Lisa Relich	Community Outreach
Human Rights Commission - Dedham	x		Joseph Borsellino	Director
Impact Norwood	x		Aubrey Ciol	Substance Prevention Director
Jewish Community Centers of Greater Boston	x		Heidi White	Health Coordinator
Liberty Veteran's House	x		Michael Boucher	Development
Livable Dedham	x		Diane Barry Preston	Member
Mass Bay Community College	x		Karen Britton	Development
Medfield Schools	x		Kathy Thompson	School Nurse
Medfield Schools, Nurse	x		Kathy Thompson	School Nurse
Medfield Suicide Coalition	x		Chelsea Goldstein-Walsh	Member
Medfield Suicide Prevention Committee	x		Andreea Cazacu	Board Member
Needham Area Al Anon	x		Sandra Rizkallah	Director
Needham Boosters	x		Jeff Greene	Board Member
Needham Community Council	x		Sandy Robinson	Director
Needham Community Education	x		Amy Goldman	Director
Needham Community Farm	x		Mary Helen McCollister	Development
Needham Council on Aging	x		LaTanya Steele, Aicha Kelley	Director
Needham Council on Aging	x		Jessica Moss	Social Worker
Needham Education Foundation	x		Sarah Winig	Board Member
Needham Exchange Club	x		John Terry	Board Member
Needham Farmers Market	x		Jeff Friedman	President
Needham Fire Department	x		Eddie Sullivan	Community Representative
Needham Housing Authority	x		Deb Tambeau	Housing Services
Needham Human Rights Committee			Marcus Nelson	Member
Needham Interfaith Group	x		Reverend Catie and Reverend Ryan	Chairs
Needham Park & Recreation	x		Stacey Mulroy	Director
Needham Police Department	x		David Forte	Community Representative
Needham Public Health	x		Hanna Burnett	Public Health Nurse
Needham Public Health	x		Tiffany Zike	Public Health Nurse
Needham Public Health Department	x		Tim McDonald	Director
Needham Public Health/Substance Prevention Alliance of Needham (SPAN)	x		Karen Shannon	Director
Needham Public Health/Substance Prevention Alliance of Needham (SPAN)/Students Advocating Life without Substance Abuse (SALSA)	x		Karen Mullen	Student Director
Needham Public Schools	x		Tom Denton, Corinne McDonald	Director Of Guidance
Needham Public Schools Director of Nursing	x		Susannah Hann	School Nurse
Needham SEPAC, Equal Justice Needham	x		Jenn Scheck Kahn	Member
Needham State Representative & Newsletter	x		Denise Garlick	State Legislator
Needham Veterans	x		Tom Keating	Chair
Needham Youth & Family Services	x		Sara Shine	Director
Neighbor Brigade	x		Mark Murphy	Board Member

Neponset River Regional Chamber	x		Tom O'Rourke	Director
New England Veteran Liberty House	x		Sean O'Donnelly	Development
New Year's Needham	x		Artie Crocker	Board Member
Newton Community Farm	x		Sue Bottino	Development
North Hill	x		Kathy Souza	Events Coordinator
Norwood Council on Aging	x		Kerri McCarthy	Director
Norwood Housing Authority	x		Stephen Merritt	Board Chair
Norwood Public Health Department	x		Sigalle Reiss	Director
Norwood State Representative			John Rogers	State Legislator
Needham Unite Against Racism Initiative (NUARI)			Marianne Cooley	Member
Plugged In Band	x		Sandra Rizkallah	Director
Ripples of Hope	x		Marcia Robinson	Director
Riverside Community Care	x		Manny Opping	Vice President
Riverside Community Cares	x		Amanda Rutherford	Social Worker
Substance Abuse Prevention Collaborative (SAPC)	x		Carol Read	Chair
Three Squares New England	x		Marcia Robinson	Director
Town of Needham "News"	x		Cyndi Roy Gonzalez	Communications Manager
Tribute Home Health Care	x		Jen Kulig	Sales
VNA Care	x		Laura Wise	Development
Walker Therapeutic & Educational Programs	x		Amy Perna	Development
Westwood & Dedham State Representative			Paul McMurtry	State Legislator
Westwood Council on Aging	x		Lina Arena-DeRosa	Director
Westwood Director of Youth & Family Services	x		Danielle Sutton	Director
Westwood Food Pantry	x		Trish Tucke	Board Member
Westwood Food Pantry	x		Trish Tucke	Board Member
Westwood Public Health	x		Margaret Sullivan	Public Health Nurse
Westwood Public Health Department	x		Margaret Sullivan	Public Health Nurse
Westwood Schools	x		Matthew Kuklentz	Principal
Westwood Youth & Family Services	x		Katy Colthart	Director
Wingate	x		Jill Bosa	Sales Director

Appendix C:
Resource Inventory

Beth Israel Deaconess Needham Community Resource List

Community Benefits Service Area includes: Dedham, Needham, Norwood and Westwood

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

Beth Israel Deaconess Needham Community Resource List

Community Benefits Service Area includes: Dedham, Needham, Norwood and Westwood

Health Issue	Organization	Brief Description	Address	Phone	Website
Statewide Resources	Network of Care Massachusetts	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.			www.massachusetts.networkofcare.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		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	Boston Area Rape Crisis Center	Provides free, confidential support and services to survivors of sexual violence.	989 Commonwealth Ave Boston	24/7 Hotline:	www.barcc.org

Beth Israel Deaconess Needham Community Resource List

Community Benefits Service Area includes: Dedham, Needham, Norwood and Westwood

Health Issue	Organization	Brief Description	Address	Phone	Website
Domestic Violence	DOVE, Inc.	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 690267 Quincy	2	www.dovema.org
	REACH Beyond Domestic Violence	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 540024 Waltham	781.891.0724 Hotline: 800.899.4000	www.reachma.org
Food Assistance	Centre Street Food Pantry	Provides food assistance to residents of Needham.	11 Homer St Newton	617.340.9554	www.centrestfoodpantry.org
	Dedham Food Pantry	Provides food assistance to residents of Dedham.	797 Providence Highway Dedham	781.269.1541	www.dedhamfoodpantry.org
	Needham Community Council	Provides food assistance to residents of Needham.	570 Hillside Ave Needham	781.444.2415	www.needhamcommunitycouncil.org/food-pantry
	Westwood Food Pantry	Provides food assistance to residents of Westwood.	60 Nahatan St Westwood	781.269.2008	www.westwoodfoodpantry.org
Housing Support	Dedham Housing Authority	Provides affordable, subsidized rental housing for low-resource residents in Dedham.	163 Dedham Blvd Dedham	781.326.3543	www.dedhamhousing.org
	Family Promise MetroWest	Provides shelter, education and comprehensive support to families with children without housing.	6 Mulligan St Natick	508.318.4820	www.familypromisemetrowest.org/
	Father Bill's & Mainspring	Provides shelter, job support and case management for people without housing.	38 Broad St Quincy	617.770.3314	www.helpfbms.org
	Needham Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	28 Captain Robert Cook Dr Needham	781.444.3011	www.needhamhousing.org

Beth Israel Deaconess Needham Community Resource List

Community Benefits Service Area includes: Dedham, Needham, Norwood and Westwood

Health Issue	Organization	Brief Description	Address	Phone	Website
Housing Support	Norwood Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals.	40 William Shyne Circle Norwood	781.762.8115	www.norwoodha.org
	Westwood Housing Authority	Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities.	580 High St Westwood	781.320.1031	www.townhall.westwood.ma.us/government/boards-committees/westwood-housing-authority
Mental Health and Substance Use	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.nebhealth.org
	Boston Treatment Center	Provides inpatient detoxification and treatment service for men and women who need to be medically detoxified from alcohol, opiates and benzodiazepines.	784 Massachusetts Ave Boston	617.247.1001	www.nebhealth.org
	Dana Group	Provides psychology, psychiatry, and medication management.	220 Reservoir St Ste 21 & 28 Needham	781.429.7755 ext. 2222	www.dana-group.com
	Riverside Community Care	Offers comprehensive mental health services for children and families.	270 Bridge St. Ste 301 Dedham	781.329.0909	www.riversidecc.org
	Walker Counseling Services	Provides therapeutic and educational programming for children in the areas of behavioral health and special education.	1968 Central Ave Needham	781.449.4500	www.walkercares.org
	William James INTERFACE Referral Service	Provides free, confidential, mental health and wellness referral service for residents of Newton.	One Wells Ave Newton	888.244.6843	www.interface.williamjames.edu

Beth Israel Deaconess Needham Community Resource List

Community Benefits Service Area includes: Dedham, Needham, Norwood and Westwood

Health Issue	Organization	Brief Description	Address	Phone	Website
Senior Services	Dedham Council on Aging	Provides services for older adults in Dedham including fitness, education, social services, and recreation.	450 Washington St Dedham	781.751.9495	www.dedham-ma.gov/departments/council-on-aging
	HESSCO	Provide supportive services for older adults.	1 Merchant St Sharon	781.784.4944	www.hessco.org
	Needham Council on Aging	Provides services for older adults in Needham including fitness, education, social services, and recreation.	300 Hillside Ave Needham	781.455.7555	www.needhamma.gov/519/Council-on-Aging
	Norwood Council on Aging	Provides services for older adults in Norwood including fitness, education, social services, and recreation.	275 Prospect St Norwood	781.762.1201	www.norwoodma.gov/departments/council_on_aging/index.php
	Springwell Elder Services	Provide supportive services for older adults and persons with disabilities.	307 Waverley Oaks Rd Ste 205 Waltham	617.926.4100	www.springwell.com
	Westwood Council on Aging	Provides services for older adults in Norwood including fitness, education, social services, transportation, and recreation.	60 Nahatan St Westwood	781.329.8799	www.townhall.westwood.ma.us/government/boards-committees/council-on-aging
Transportation	MBTA	Provides transportation thru out Boston and surrounding communities.			www.mbta.com
Additional Resources	Neighbor Brigade	Provides temporary, non-monetary assistance with day-to-day needs such as transportation, meal delivery, and household needs.	PO Box 735 Maynard	855.241.HELP (4357)	www.neighborbrigade.org
	YMCA of Greater Boston, Charles River Branch	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	380 Chestnut St Needham	781.444.6400	www.ymcaboston.org/charlesriver

Appendix D:

Evaluation of 2020-2022 Implementation Strategy

BID Needham

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 Area 1: Mental Health and Substance Use

Goal 1: Educate about and reduce stigma associated with mental health and substance use issues				
Strategy	**Population**	**Objectives**	**Activities**	**Progress, Outcomes and Impact**
Educate about and reduce stigma associated with mental health and substance use Issues	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health • Reduce the stigma associated with mental illness/ mental health and substance use/misuse, and addiction	• Support **Mental Health First Aid** trainings in targeted community-based settings to raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use	• A $600 grant to CHNA 18 provided mental health QPR training for local librarians. The event was hosted at Dedham Public Library and was attended by 40 staff members from area libraries (FY20). • BID Needham promoted free Youth MHFA training (offered by Needham Public Health) to employees and community members (FY21-22). The hospital also hosted a training in May 2022 for Emergency Department staff.
			• Provide **Community Health Mini Grants** to local departments of Health or other community-based partners to support evidence-based programs that promote mental health and substance use education and prevention	• BID Needham offered community grants to several organizations. Programs are listed throughout this document (FY20-22).
			• Support **Mental Health and Substance Use Support Groups** for those with or in recovery from mental health or substance use and their family/friends/caregivers to raise awareness, reduce stigma, educate, and promote coping/recovery	• The hospital hosted an AA group in FY20 but the group began meeting virtually during the pandemic. • BID Needham promoted the Needham Parent Al Anon group to employees and community members (FY21-22).

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Educate about and reduce stigma associated with mental health and substance use Issues	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health • Reduce the stigma associated with mental illness/ mental health and substance use/misuse, and addiction	• Support **Community-based Health Education Events** and programming with community partners to raise awareness, and educate on risk/protective factors, and services available in the community.	• The hospital partnered with the Substance Prevention Alliance of Needham to offer "The Family Dinner Project" to Needham families. The evening included a catered dinner for the families, guided conversation during dinner, and a parent workshop while kids made dessert. More than 50 family members attended the event (FY20). • Prior to "The Family Dinner Project," the keynote speaker provided a workshop for teachers and youth leaders in the community. Thirteen community members attended the workshop (FY20). • BID Needham partnered with SPAN to bring a talk to middle school parents, about "Navigating Screentime, Digital Socializing and Parenting During COVID-19." Featuring Dr. Jill Walsh, the virtual program was attended by 177 people, with 98% reporting that the information was useful (FY21). • BID Needham offered a free, virtual talk on mental well-being (FY22).
			• Support **Substance Use Prevention Programming** and curriculum in local schools.	• BID Needham provided a $5,000 grant to Students Advocating Life without Substance Abuse (SALSA) and their 8th grade resilience and refusal training in Needham Public Schools. This program, which has become part of the 8th grade curriculum, trains high school students to go into 8th grade classrooms and talk about the pressures of using substances, and how to say no. Students are taught refusal skills and have the opportunity to practice them in role-play exercises with the high school students. 100 high school students teach

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
				approximately 500 8th graders each year (FY20-22).
Goal 2: **Enhance access to mental health and substance use screening, assessment and treatment services**				
Strategy	**Population**	**Objectives**	**Activities**	**Progress, Outcomes and Impact**
Enhance access to mental health and substance use screening, assessment, and treatment services	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Promote cross-sector partnership, collaboration, and information sharing across the broad health system to address access to mental health and substance use services • Increase access to clinical and non-clinical support services for those with mental health and substance use issues, with an emphasis on priority populations • Increase access to peer support for those with mental health and substance use and their family, friends, and caregivers • Reduce inappropriate use of ED and other acute care services • Increase access to screening, education, referral, and patient engagement services for those identified	• **Participate in local and regional coalitions and task forces** to promote collaboration, share knowledge, and coordinate community health improvement activities	• A hospital representative participates in Youth Resource Network roundtable discussions, serving Needham families. The goal of the meeting is to identify specific needs and potential resources that will help the family and change their current situation (FY20-22). • During 2020, as residents were scrambling to find resources amid the pandemic, Needham social service providers, including BIDN, convened to centralize information and resources for mental and physical health and social determinants of health. "Get Connected Needham" is housed on the Town of Needham website and was shared by many organizations in Needham to make resources easier to locate (FY20). • BIDN is represented on the Needham Resilience Network, an organization committed to safety, unity and belonging. The hospital provided a $25,000 grant for the organization's start-up costs (FY22). • The hospital has two representatives on the Substance Prevention Alliance of Needham (FY20-22).
			• **Provide health insurance enrollment counseling/assistance and patient navigation support services** to uninsured or underinsured residents and patients with mental health and substance use issues	• BID Needham's financial counselors offer insurance enrollment assistance (FY20-22). • Behavioral Health navigation in the Emergency Department is arranged by a state-funded social worker, who is

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to mental health and substance use screening, assessment, and treatment services	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	with or at-risk of mental health and substance use issues in clinical and non-clinical settings, with an emphasis on priority populations • Increase access to insurance, patient navigation support, and other enabling/ supportive services for those with mental health and substance use issues, with an emphasis on priority populations • Increase access to peer recovery coaches for those with substance use/misuse issues • Reduce elder health isolation and depression • Increase the number of practice settings with integrated behavioral health and primary care/specialty care services • Increase primary care and specialty care follow-up after discharge from hospital settings		employed by Riverside in the Needham ED (FY21).
			• Support the **Interface Mental Health Hotline,** which provides education and referral services for those seeking mental health counseling services	• BID Needham supports the Interface programs in Needham and Medfield (not CBSA). The hospital provides $6,000 per year per program, with an average of 150 cases per year (FY20-22).
			• Look into developing **integrated behavioral health services (mental health and substance use) in Primary Care and other specialty care settings** (Impact Model) for those with or at-risk of mental health issues, including screening, assessment, and treatment	• The BIDHC Collaborative Care model provides social workers in PCP offices to support the mental health needs of patients. This program is supported by BID Needham (FY20-22). • A Psychologist is employed to provide consultations on the inpatient units, and a Director of Clinical Liaison Psychiatry provides weekday telephone support for providers (FY20-22). • BIDN hired a Director of BH, and received funding from the state to embed a social worker in the ED (FY21). • The hospital provides staff to offer supervision to behavioral health patients in the Emergency Room who may be a risk to themselves or others. • Patients seeking ED care for mental health conditions are referred to Riverside, BIDN's contracted Emergency Service Provider (ESP), for an evaluation. As part of this partnership, Riverside manages the bed search and placement process for all patients requiring inpatient level of care (FY20-22).
			• Explore **partnerships with elder service providers** that reach out to and serve	• BIDN offers a Senior and Student Volunteer Program, which offers increased access to social experiences for older adults and

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to mental health and substance use screening, assessment, and treatment services	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	See above	isolated older adults not currently engaged in Council on Aging activities	mentorship for students. The program ran through March 2020, was on hold during the remainder of 2020 and some of 2021, but has returned in a limited capacity following COVID-19 (FY20-22).
			• Explore partnerships with Local Health Departments, substance use providers, and BID–Needham departments to implement **Peer Recovery Coach Programs** geared to linking those with substance use/misuse issues to peer recovery coaches who provide recovery, case management, and navigation support	• BID Needham was not able to implement a peer recovery coach program during COVID, but the hospital has a plan and funding for implementation in late FY22 and FY23.
			• Research implementation of a **BID–Needham Bridge Program** for those suffering from substance use disorder that screens, identifies, assesses, initiates treatment, and links participants to long-term SUD services in the community	• BID Needham was not able implement a bridge program during COVID, but the hospital has a plan and funding to pilot a digital psychiatry program in late FY22 or early FY23.
			• Support the **Community Crisis Intervention Team (CCIT)**, a partnership between hospital emergency departments, public safety officials, and behavioral health providers geared to reaching out to, referring, and engaging substance users/misusers in treatment	• BID Needham representatives serve on the Needham and Norwood CCIT and attend regular meetings. The hospital provides data to the group for use in evaluating metrics related to substance use, BH and other chronic conditions (FY20-22). • Hospital pharmacy staff participated in the Charles River Opioid Taskforce in order to identify ways to address opioid misuse in the region.
			• Explore partnerships with community-based organizations that provide **social engagement activities for those who are isolated** or struggling with mental health issues	• BID Needham awarded a grant to Plugged-In Band Program to provide scholarships to students who are unable to pay tuition. The grant provided approximately 14 full scholarships (FY20-21). • The hospital funded Walker's "Camp Awesome" summer program, which

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to mental health and substance use screening, assessment, and treatment services	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	**See above**	• Explore partnerships with community-based organizations that provide **social engagement activities for those who are isolated** or struggling with mental health issues	incorporated field trips for 19 students (FY20-21). • BID Needham supported St. Joe's Summer Theater Program, which offers a drug-free, tobacco-free, and alcohol-free space for teens to create, socialize, and have fun. More than 30 students attended the program (FY21). • BID Needham provided grants to Dover Parks & Rec for outdoor youth programming. An average of 30 students attended (FY20-21). • BID Needham provided a scholarship fund to Parent Talk, a local organization for parents of young children. The organization provides a network for parents, along with programming and opportunities to play and connect. The program was put on hold for FY21 during COVID (FY20).

Goal 3: Decrease the number of prescription drugs and other harmful drugs from the community

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Decrease the number of prescription drugs and other harmful drugs from the community	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Decrease the availability of unused prescription drugs • Increase the # of opportunities that residents of the service area can give back unused prescriptions	• Support **"Drug Take Back Days"** with Commonwealth and local law enforcement and other community-based partners	• The hospital continues to support the Needham Drug Take Back Day by promoting in the employee newsletter and on social media (FY20-22). • The hospital provided a grant to Needham Public Health for a pilot project to train and distribute Narcan to the community (FY21).
			• Maintain **Prescription Drug Disposal Kiosk** in the lobby of the hospital to provide a safe place for the community to dispose of unwanted/ unneeded drugs	• The hospital manages a prescription drug disposal kiosk, as well as a sharps kiosk, in the main lobby. The kiosks were closed during the pandemic, but have reopened in FY21 (FY20-22).
			• Continue BID–Needham Opioid Taskforce to decrease use of and prescribing of opioids in the hospital, and to educate patients on opioid use and alternatives for pain management.	• The opioid taskforce continues to meet and work on goals toward reducing opioid prescribing (FY20-22).

Priority Area 2: Chronic and Complex Conditions and their Risk Factors

Goal 1: Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings				
Straegy	**Population**	**Objectives**	**Activities**	**Progress, Outcomes and Impact**
Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who are educated about chronic disease risk factors and protective behaviors • Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services • Increase the number of people with chronic/complex conditions whose conditions are under control	• **Participate in coalitions and task forces** to promote collaboration, share knowledge, and coordinate community health improvement activities	• A BIDN representative served on the planning board for CHNA 18 and helped with the distribution of grants. The organization disbanded in FY22 (FY20-21). • The hospital convenes local organizations one to two times per year to share resources, ideas and partnership opportunities. The "Community Resource Group" meetings have been very successful (FY20-22).
			• Partner with community groups to offer **wellness, fitness education and other events** as part of comprehensive chronic disease management for underserved community members, and other priority population segments	• The hospital partners with Needham Public Health and the Needham Council on Aging to support a "healthy aging" initiative, funded by DON funds of $31,000 per year. The program has adapted during the pandemic but has included evidence-based strength and balance programs and subsidized the COA fitness center use for seniors to promote wellness and fitness (FY20-22). • BIDN collaborates annually with BIDMC and the Boston JCC to host three free, public health-focused education talks (FY20-22). • BIDN provided a grant to Livable Dedham for adult, outdoor exercise equipment at a public park at Gonzalez Field in Dedham (FY20). • The hospital supports local initiatives that raise funds for healthy living, such as the

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who are educated about chronic disease risk factors and protective behaviors • Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services • Increase the number of people with chronic/complex conditions whose conditions are under control		BiggSteps Race (FY20, FY22) and Three Squares Ride for Food (FY20-FY22).
			• Provide **First Aid, CPR and Stroke Management Trainings** to residents, service providers, and first responders as part of comprehensive chronic disease prevention and management efforts	• BID Needham has an ongoing partnership with local EMTs to train first responders in how to identify a stroke in the field. This process expedites care for stroke patients, ensuring that they receive life-saving care as soon as possible (FY20-22). • The hospital restocks ambulances with medications to ensure that access to medications and supplies are available (FY20-22). • First aid and CPR were offered to the community in FY20, but were discontinued in FY21 and FY22 due to the pandemic. • Each school year, BID Needham donates epi-pens to the Needham Public Schools and syringes to Needham Public Health for flu shots (FY20-22).
			• Provide evidence-based **health education on risk/protective factors, and self-management support programs** through partnerships with community-based organizations	• BID Needham provides an annual grant to the Charles River YMCA to support the Livestrong program, offered free of charge to cancer patients. An average of 30 individuals graduate from the program each year, regaining strength and the ability to return to activity after cancer (FY20-22). • HESSCO and the Westwood Council on Aging were awarded a grant to offer Medical Nutrition Therapy (MNT). Registered dietitians provided individual coaching sessions on health and nutrition, and offered referrals to additional supports and resources. (FY20).

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who are educated about chronic disease risk factors and protective behaviors • Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services • Increase the number of people with chronic/complex conditions whose conditions are under control	• Support **screening, education, and referral programs** in clinical and non-clinical settings	• BID Needham provides financial support to Beth Israel Deaconess Healthcare Primary Care Offices within the community benefits service area to ensure access to care for local residents (FY20-22). • BID Needham provided grant funding to Family Promise MetroWest to support "The Family Health Initiative." This program empowers homeless parents who are part of the Family Promise program to become stronger health advocates while addressing the comprehensive health needs of their families (FY20).
			• Promote enhanced **care transitions, care coordination and follow-up care programs** targeting those with chronic/complex conditions after discharge from the Hospital	• BID Needham provides Charles River Center with an annual grant to address one of their outstanding health needs. In FY20, ear lobe pulse oximeters and portable vital sign machines were purchased, and in FY21, AED machines were purchased. • BID Needham has a Utilization Review Committee that meets monthly to review all readmissions to the hospital within 30 days of discharge. The committee looks to identify specific causes for the readmission, such as discharge plans, care transitions, and previous conditions (FY20-22). • BID Needham subsidizes a chronic heart failure (CHF) nurse for 36 hours a week. The nurse follows high-risk CHF patients by making frequent calls to assess for symptoms, medication changes, tests, or procedures that need to be done, education on prevention of CHF

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
See above	See above	See above		exacerbation, dietary teaching, and referrals (FY20-22).
			• Provide **Community Health Mini Grants** to community partners to support evidence-based programs that promote health education, screening, referral, and chronic disease management for priority populations	• BID Needham offered community grants to several organizations. Programs are listed throughout this document (FY20-22).

Goal 2: Reduce the prevalence of tobacco use

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Reduce the prevalence of tobacco use	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who quit smoking cigarettes, vaping, or using e-cigarettes • Increase access to tobacco, vaping/e-cigarette cessation programs	• Support ***Smoking Cessation Programs*** geared to reducing tobacco, vaping and e-cigarette use	• The hospital was working pre-COVID to create a support group for those in public housing with tobacco addiction, but this was postponed due to COVID.
			• Provide community education on the risks of vaping and tobacco use	• Partnering with the Boston JCC, a community talk called “New Look of Nicotine Addiction” was hosted (FY20). • The BIDN Respiratory Team held an Information table at Needham High School to demonstrate the effects of vaping on the lungs. This was going to be an annual event, but was temporarily discontinued due to COVID (FY20). • A respiratory information table was held in the hospital to provide information to hospital patients (FY20).

Priority Area 3: Social Determinants of Health and Access to Care

Goal 1: Enhance access to care and reduce the impact of social determinants				
Strategy	**Population**	**Objectives**	**Activities**	**Progress, Outcomes and Impact**
Enhance access to care and reduce the impact of social determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase partnerships and collaboration with social service and other community-based organizations • Increase educational opportunities related to the importance and impact of social determinants • Decrease the number of people who struggle with financial insecurity • Increase access to low cost healthy foods with an emphasis on priority population segments • Increase access to affordable, safe transportation options with an emphasis on priority population segments • Increase training and employment opportunities for low to moderate income residents with an emphasis on priority population segments	• **Participate in regional and local task forces and coalitions** to promote collaboration, share knowledge, and coordinate community health improvement activities	• The hospital has representation on several task forces and coalitions such as Local Emergency Planning Coalition, Community Crisis Intervention Teams in Needham and Norwood, Needham Resilience Network and the Youth Resource Network. These committees address a range of resident needs from mental health and substance use, to management of chronic conditions, and social determinants of health such as housing, food insecurity, childcare and employment (FY20-22).
			• Provide **Community Health Mini Grants** to community partners to support evidence-based programs that address social determinants and access to care	• BIDN supported Family Promise Metrowest with a grant for their LIFE program (Local Initiative for Family Empowerment). This homelessness prevention program supports families who are at risk of eviction but not yet homeless. 33 families were supported (FY21-22). • WELCOMEBACKpacks is an ongoing, monthly program that addresses the large disparities in resources held by incarcerated men and women at the time of their release from prison. Backpacks, containing hygiene and safety supplies, and other necessities and resources, are delivered to the prisons where each identified person is awaiting release. 60 backpacks were provided (FY21). • BID Needham awarded $1,000 to Circle of Hope for their health and dignity project

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to care and reduce the impact of social determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people assisted with insurance and other public program enrollment, and patient navigation • Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports	• Provide **Community Health Mini Grants** to community partners to support evidence-based programs that address social determinants and access to care	with The Dedham Food Pantry. The organization donated 720 essential health and hygiene items (shampoo, body wash, deodorant, menstrual pads, and body lotion) to the Dedham Food Pantry for efficient distribution to Dedham families and individuals in need (FY20).
			• Support farmers markets and other food access initiatives that provide fresh, locally-grown produce to low to moderate income, underserved populations	• The hospital provided funding to the Needham Farmer's Market (NFM) to bring fresh produce to Needham's town center. NFM serves low-income individuals, families, and seniors through SNAP, EBT, HIP, WIC, Senior Coupons, and other State programs. More than 12,000 shoppers attended the market (FY20-22). • BID Needham is an ongoing supporter of The Three Squares Ride for Food, which supports several local food access organizations (FY20-22).
			• Support local food access organizations and **Initiatives** to provide nutrition education and food access to low and moderate income populations living in public housing, school-based after-school programs, Councils on Aging, and other community venues	• BID Needham continued to support the Needham Community Farm in their mission to provide fresh, locally grown produce to the underserved through a "Mobile Market." A weekly produce delivery was taken to Needham Housing Authority sites and distributed free of charge from June through October, along with resources for storing, prepping, and using produce (FY20-22). • The Needham Community Farm also provides gardening programming and education in the Needham Housing Authority, which is also supported with the BID Needham grant (FY20-22). • The Dedham Food Pantry was awarded a grant to provide an estimated 15,000

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to care and reduce the impact of social determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people assisted with insurance and other public program enrollment, and patient navigation • Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports	• Support local food access organizations and **Initiatives** to provide nutrition education and food access to low and moderate income populations living in public housing, school-based after-school programs, Councils on Aging, and other community venues	pounds of food to Dedham residents. The Food Pantry saw a large increase in demand during the pandemic (FY20-22). • Mass Bay Community College was awarded a grant for their Summer Meal Scholarship Program, to provide funds to students on a weekly basis to purchase food during the summer. 12 students benefited from this program (FY21). • BID Needham supports the Needham traveling meals program, and provided more than 9,500 meals to homebound seniors (FY20-22).
			• Support **wellness and nutrition education events** in partnership with community partners	• In FY20, Westwood and Dedham Councils on Aging received grants to offer fresh produce from a local farm share to seniors in their communities, benefitting 40 seniors. • In FY21, BID Needham awarded grants to the Dover, Westwood and Needham Councils on Aging to address food insecurity and isolation. Dover offered a "Grab and Go" meal program and social check-in, providing more than 700 meals. Needham offered a "Sunday Supper" program, delivering almost 600 meals, and Westwood provided shelf-stable food boxes to more than 20 seniors.
			• Provide **enrollment counseling/ assistance and patient navigation support services** to uninsured or underinsured residents to enhance access to care	• BID Needham provides Certified Application Counselors to assist with financial counseling, benefit enrollment assistance, and payment planning to the underserved and uninsured in our community. An average of 100 patients per year are provided this service.

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to care and reduce the impact of social determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people assisted with insurance and other public program enrollment, and patient navigation • Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports	• Provide **enrollment counseling/ assistance and patient navigation support services** to uninsured or underinsured residents to enhance access to care	• Due to an increase in patients without basic clothing items, such as clothing, shoes, coats and personal hygiene products, BID Needham and Circle of Hope partnered to create an "ED Essentials Closet" in the emergency room. These are offered to patients at BID Needham before discharge, based on need (FY21-22).
			• Provide **linguistically and culturally appropriate health education and care management support**	• BID Needham offers several options for linguistically and culturally appropriate care, including video remote interpretive services (accessed 1,300 times) and telephonic interpretation sessions (used 710 times) (FY20-22).
			• Explore **transportation access partnerships** with regional transportation providers and other community partners to enhance access to affordable, safe, accessible transportation options	• BID Needham provides a grant to support the Needham Community Council's medical transportation program, which uses a central dispatch and Lyft to take residents to medical appointments (FY20-22). • Neighbor Brigade was awarded a grant to help underserved residents when facing sudden crisis, such as cancer diagnosis or other illness, as well as assist with managing day-to-day tasks such as meal preparation and rides to medical appointments (FY20-22). • To assist patients with getting to medical appointments, BID Needham provides rides to/from the hospital, using ride-share vouchers (FY20-22).
			• Organize and support **workforce mentorship and training programs** to enhance job training, skills development, and career advancement	• BID Needham supported Needham Steps Up, a mentorship program that empowers eligible, underserved students in the Needham Public Schools, and provides access to the resources necessary to

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Enhance access to care and reduce the impact of social determinants	See above	See above	• Organize and support **workforce mentorship and training programs** to enhance job training, skills development, and career advancement	successfully navigate high school and achieve post-secondary goals (FY21). • The hospital supported a "life skills" conference at Needham High School, which prepared students for the transition from school to college or independent living (FY20).

Goal 1: Enhance access to care and reduce the impact of social determinants

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Reduce Elder Falls and Promote Aging in Place	• Older Adults	• Reduce fear of falling • Reduce Falls • Increase activity levels • Reduce preventable Emergency Department and inpatient visits • Increase the number of older adults living independently in their homes	• Support **Safety at Home Program** for older adults to promote aging in place and reduce falls	• Needham Public Health discontinued the Safety at Home Program in FY20 due to COVID. The Needham DPH hopes to restart the program in FY23.
			• Support the **Fall Prevention Committee** to reduce Falls	• BID Needham's internal fall prevention committee meets regularly to evaluate patients at risk of falls, and to provide training and prevention measures to support this population (FY20-22).
			• Organize **Matter of Balance workshops** for priority populations	• The Matter of Balance workshops are provided through the Needham Council on Aging, with funding from BID Needham, as part of the Healthy Aging Initiative (FY20-22).
			• Support other elder service programming to encourage aging in place	.BID Needham supported VNA Care Network's home-health services with a $2,500 grant. This grant provided training to clinicians and social workers to educate them on resources available to at-risk patients. This may include accessing and navigating community resources and government relief programs, education, and counseling to support the patient's health goals (FY20-22).

Strategy	Population	Objectives	Activities	Progress, Outcomes and Impact
Reduce Elder Falls and Promote Aging in Place	• Older Adults	• Reduce fear of falling • Reduce Falls • Increase activity levels • Reduce preventable Emergency Department and inpatient visits • Increase the number of older adults living independently in their homes	• Support other elder service programming to encourage aging in place	• Dedham Council on Aging is awarded an annual grant to address the needs of seniors in the community. In FY20, the grant was focused on food access, and in FY21 on technology access by providing ipads and WIFI to seniors (FY20-22).
			• Continue 5-year commitment to address healthy aging, with Needham Public Health and Needham Council on Aging	• BID Needham continued to support this partnership with DON funds of $31,000 per year. The program has evolved during COVID but continues to support the mental, physical and social needs of Needham seniors. The initiative provides strength and balance classes, social programs, food delivery (during COVID) and use of the COA fitness center.

Appendix E:
2023-2025 Implementation Strategy

Beth Israel Lahey Health
Beth Israel Deaconess Needham

FY23-FY25
Implementation Strategy

Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Hospital-Needham (BID Needham) is a 58-bed acute care community hospital in Needham, Massachusetts that has been nationally recognized for quality and safety. BID Needham's mission is to provide safe, high-quality, community-based health care and access to tertiary care in close collaboration with Beth Israel Deaconess Medical Center. BID Needham commits to its mission by providing the highest quality care focused on patient safety and has been fulfilling this vision for more than 100 years. The entire BID Needham team, including employees, physicians, volunteers, and students are dedicated to exceeding the expectations of patients, families, the community, and each other. BID Needham has been recognized by several organizations for quality and safety, including the Gold Seal of Approval® from The Joint Commission and a first-place Accountable Care Compass Award from the Massachusetts Health & Hospital Association.

The 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 BID Needham's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BID Needham'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 BID Needham's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, those who are in substance use recovery, and those who experience barriers to care or disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

BID Needham collected a wide range of quantitative data to characterize the communities served across its Community Benefits Service Area (CBSA). BID Needham 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 levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative and evidence-informed Implementation Strategy (IS). Between October 2021 and February 2022, BID Needham conducted 18 one-on-one interviews with key collaborators in the community, facilitated four focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 480 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 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. Accordingly, using an interactive, anonymous polling software, BID Needham'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 BID Needham's IS. This prioritization process helps to ensure that BID Needham maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

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

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

The following goals and strategies were developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute to the 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, BID Needham'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. BID Needham is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

BID Needham's CBSA includes the four municipalities of Dedham, Needham, Norwood, and Westwood, located in the Metrowest area to the south and west of Boston, 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). There is also diversity with respect to community needs. There are segments of the BID Needham'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. BID Needham 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. The hospital is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

BID Needham's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, BID Needham focuses the bulk of its community benefits resources to improve the health status of those who face health disparities, experience poverty, or have been historically underserved. By prioritizing these cohorts, BID Needham is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

Beth Israel Lahey Health
Beth Israel Deaconess Needham

Community Benefits Service Area

Beth Israel Deaconess Hospital-Needham

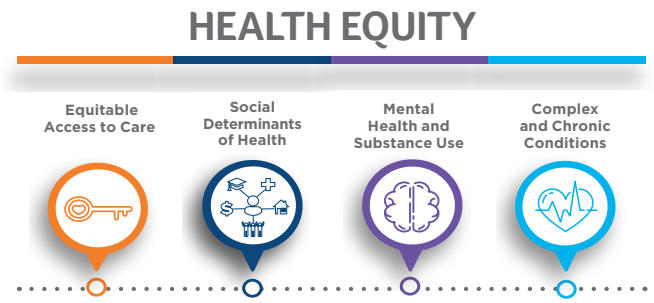
Prioritized Community Health Needs and Cohorts

BID Needham is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving 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.

BID Needham Priority Cohorts

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

BID Needham Community Health Priority Areas



Community Health Needs Not Prioritized by BID Needham

It is important to note that there are community health needs that were identified by BID Needham's assessment hat were not prioritized for investment or included in BID Needham's IS. Specifically, supporting education across the lifespan, affordability of childcare, digital divide, tackling misinformation, connections between police and community, and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in BID Needham's IS. While these issues are important, BID Needham'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, BID Needham recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. BID Needham 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 BID Needham's IS

The issues that were identified in the BID Needham CHNA and are addressed in some way in its IS are housing issues, food insecurity, transportation, economic insecurity, navigation of healthcare system, linguistic access barriers, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, culturally appropriate/competent health and community services, cross sector partnerships/collaboration/ responses, linguistic access/barriers to community resources/services, alcohol use prevention/treatment, vaping, marijuana use, opioid use, health education and awareness on risk factors and resources, resource inventory, fostering sense of community and belonging, and cross sector collaboration/partnerships/information sharing/referrals.

Implementation Strategy Details

Priority: Equitable Access to Care

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

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

Resources/Financial Investment: BID Needham 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 BID Needham and/or its partners to improve the health of those living in its CBSA. Finally, BID Needham supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, BID Needham 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
Provide and promote career support services and career mobility programs to hospital employees and support job-training programs that strengthen the local workforce and address underemployment.	• BID Needham employees • Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	• Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English as a second language (ESOL) classes/other trainings • Clinical training site for community colleges	• # of employees who participated • # of community members trained • # of community members hired	• BILH Workforce Development • Merrimack College • Mass Bay Community College	Social Determinants of Health
Promote equitable care, health equity and health literacy for patients and community residents, especially those who face cultural and linguistic barriers.	Racially, ethnically, linguistically diverse populations	• Interpreter Services	• # of patients assisted • # of languages provided	• BID Needham Interpreter Services Dept.	Not Applicable

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	• Financial counselors • Circle of Hope Emergency Department Essentials Closet • Community Council Medical/Emergency transportation program • Hospital Transportation Assistance • Senior Volunteer Program • Primary care support	• # of patients assisted • Clothing/shoes/ hygiene products distributed • # of rides provided • # of senior volunteers • # of patients	• Circle of Hope • Needham Community Council • BILH Primary Care	• Social Determinants of Health • Mental Health

Priority: Social Determinants of Health

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

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

Resources/Financial Investment: BID Needham 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 BID Needham and/or its partners to improve the health of those living in its CBSA. Finally, BID Needham supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, BID Needham 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 outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support impactful programs that address issues associated with the social determinants of health.	• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	• Neighbor Brigade food and transportation assistance • Provide an opportunity for grant funding to community	• Amount of funding distributed • # of participants and their demographics • #/units of food provided • # of rides provided	Neighbor Brigade	Mental Health
Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.	• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	• Needham Youth Resource Network • Needham & Norwood Community Crisis Intervention Team (CCIT)	• Sectors represented • Amount of resources obtained • # of new partnerships developed • Skill building/ education shared • # new policies/protocols implemented • # residents assisted by CCIT	• Needham Youth Resource Network • Needham & Norwood CCIT	Mental Health

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote collaboration, share knowledge and coordinate activities with internal colleagues & external partners.	Community-based organizations serving priority cohorts	Community Resource Group	• # of resources shared • # of sectors represented • # of new partnerships developed • Increased communication among partners	Partner representatives in community resource groups	Equitable Access to Care
Support impactful programs that stabilize or create access to affordable housing.	Low-resourced populations	Family Promise Metrowest Homeless Prevention Program	• # of participants and their demographics • # of families prevented from homelessness	Family Promise	Mental Health
Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	• Low-resourced populations • Older adults	• Dedham Food pantry • Produce distribution (Westwood, Needham) • Needham Traveling Meals Program	• Pounds of food distributed • # of individuals provided food and their demographics	• Dedham Food Pantry • Westwood Council on Aging • Needham Community Farm • Town of Needham	Mental Health

Priority: Mental Health and Substance Use

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

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Those who participated in the assessment also reflected on stigma, shame, and isolation that those with mental health 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 and economic insecurity. Interviewees, focus group and listening session participants also reported that alcohol use is normalized, and use is prevalent among both adults and youth.

Resources/Financial Investment: BID Needham 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 BID Needham and/or its partners to improve the health of those living in its CBSA. Finally, BID Needham supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, BID Needham will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Enhance relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills.	• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	• Support Students Advocating for Life Without Substance Abuse (SALSA) • Advanced training on emerging needs for mental health workers	• # of students engaged • # of volunteers and hours • Increased skills • Increased confidence in ability to use skills	• SALSA (Needham) • Walker • Riverside Community Care	Workforce Development
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.	• Youth • Older adults • Racially, ethnically, linguistically diverse populations, • Low-resourced populations	• Ongoing community education/talks • Explore possibility of community training for suicide prevention or Mental Health First Aid	• # of community members trained/ educated • Increased skills • Increased confidence in ability to use skills	• Substance Prevention Alliance of Needham (SPAN) • Becca Schmill Foundation	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
Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	• Integrated Behavioral Health • BILH Collaborative Care • Interface (Westwood and Needham) • Pilot Behavioral Health programming that will improve care • Prescription medication & sharps disposal • Opioid Taskforce • Medication Assisted Treatment in the Emergency Department	• # of patients assisted • # of integrated BH consultations • # of practices • Pounds of medications and sharps collected • Policies implemented/ trainings for staff • # of patients	• BILH Behavioral Services • Towns of Needham and Westwood • Riverside Community Care	Equitable Access to Care
Support impactful programs that address issues associated with mental health and substance use.	• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	• Dedham Council on Aging Social Worker/Support Groups • Substance Prevention Alliance of Needham (SPAN)	• # of support groups held/# attended • # of seniors participating • Sectors represented • Amount of resources obtained • # of new partnerships developed • Skill building/education shared	• Dedham Council on Aging • SPAN	Not Applicable

Priority: Chronic and Complex Conditions

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

Resources/Financial Investment: BID Needham 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 BID Needham and/or its partners to improve the health of those living in its CBSA. Finally, BID Needham supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, BID Needham 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.	• Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations • Youth	• Primary care support • Partnerships with Emergency Medical Technicians (EMTs) • School medication partnerships	• Amount of funds spent on medication restocks • # of medications provided to schools • # of students benefiting from medications	• BILH Primary Care • Local EMTs • Needham Public Schools	Not Applicable
Ensure older adults and those with complex/chronic conditions have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.	• Older adults	• Needham Healthy Aging Initiative • Greater Boston JCC education talks • Livestrong	• # of participants and their demographics • # of attendees • # of Livestrong graduates	• Town of Needham • Greater Boston JCC • Charles River YMCA	Social Determinants of Health

General Regulatory Information

Contact Person:	Alyssa Kence, Director of Community Benefits
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:	Beth Israel Deaconess Hospital-Needham 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:	Beth Israel Deaconess Hospital–Needham 04-3229679
Address of hospital organization:	148 Chestnut Street Needham, MA 02492

Beth Israel Lahey Health
Beth Israel Deaconess Needham