Beth Israel Lahey Health
Beth Israel Deaconess Needham

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for Beth Israel Deaconess Hospital-Needham (BID Needham) is the culmination of a collaborative process that began in June 2024. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key stakeholders from throughout 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 historically underserved populations.

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 BID Needham's Community Benefits Service Area shared their needs, experiences and expertise through interviews, focus groups, a survey, and a community listening session. This assessment and planning work would not have been possible or as successful had it not been for the time and effort of the residents who engaged in this work.

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Introduction

Background

Beth Israel Deaconess Hospital–Needham (BID Needham) is a rapidly growing community hospital serving the southwest and metrowest suburbs of Boston. The hospital has 73 licensed inpatient beds with more than 900 employees and over 850 clinicians on active medical staff. With close ties to Beth Israel Deaconess Medical Center in Boston, BID Needham offers centers of excellence in digestive health, surgical services, and cancer care.

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 2025 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 500 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 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 2022 and the report, along with the associated 2023-2025 IS, was approved by the BID Needham Board of Trustees on September 8, 2022. The 2022 CHNA report was posted on BID Needham's website before September 30, 2022 and, per federal compliance requirements, made available in paper copy without charge upon request.

The assessment and planning work for this current report was conducted between June 2024 and September 2025 and BID Needham's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 4, 2025.

Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within 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. 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 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, accountability, community engagement, and impact.

Equity:

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

Accountability:

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

Community Engagement:

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

Impact:

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

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

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

In April of 2024, BILH hired JSI Research & Training Institute, 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 informs 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	MDPH Community Health Equity 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 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 June 2024 and February 2025, BID Needham conducted 15 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving over 500 residents, and organized a community listening session. 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.

15 interviews

with community leaders

580 survey respondents

5 focus groups

- Individuals living with disabilities
- Young adults
- English language learners
- Families in public housing
- Individuals in public housing

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 available community resources in the CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

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

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

After the prioritization process, a CHNA report was developed and 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 2025 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 2025 CHNA Report and 2026-2028 IS were submitted to BID Needham's Board of Trustees for approval.

After the Board of Trustees formally approved the 2025 CHNA report and adopted 2026-2028 IS, these documents were posted on BID Needham's website, alongside the 2022 CHNA report and 2023-2025 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 2025 assessment and planning process or past assessment processes should be directed to:

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Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community based organizations, 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, community listening session prioritization, 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.

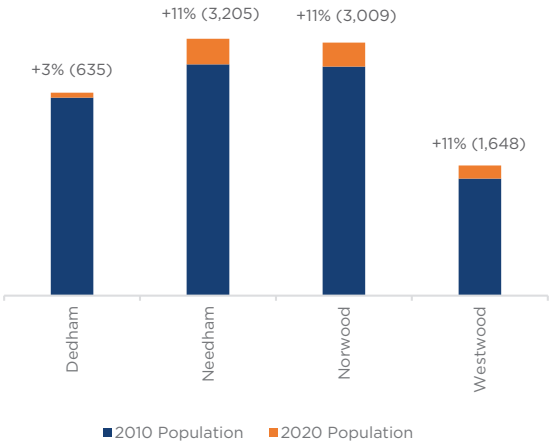
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the BID Needham were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were people of color, people who speak a language other than English, and foreign-born populations in all communities. Interviewees and focus group participants reported that these populations 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 and posed challenges related to health literacy. These barriers also contributed to social isolation and may have lead to disparities in access and health outcomes.

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

Population Growth

Between 2010 and 2020, the population in BID Needham's CBSA increased by 9%, from 96,835 to 105,332 people. Westwood, Needham, and Norwood all saw an 11% increase, while Dedham's population increased by 3%.

Population Changes by Municipality, 2010 to 2020



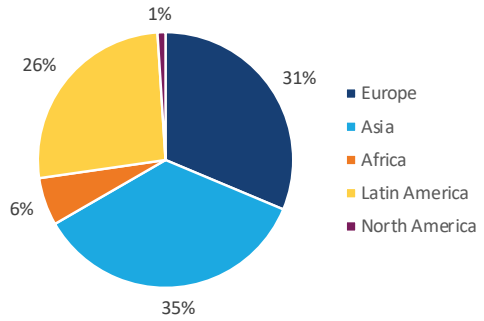
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

Nation of Origin

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

17% of the BID Needham CBSA population was foreign born.

Region of Origin Among Foreign-Born Residents in the CBSA, 2019-2023



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

Language

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

21% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

35% speak English less than "very well."

Source: US Census Bureau American Community Survey 2019-2023

Age

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

19%

of residents in the CBSA are 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 are under 18 years of age.

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

Gender Identity and Sexual Orientation

Massachusetts has the tenth largest percentage of lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA+) adults, by state. LGBTQIA+ individuals face issues of disproportionate violence , socioeconomic inequality, and health disparities.[6]

7%

of adults in Massachusetts identify as LGBTQIA+.

Source: Gallup/Williams, 2023

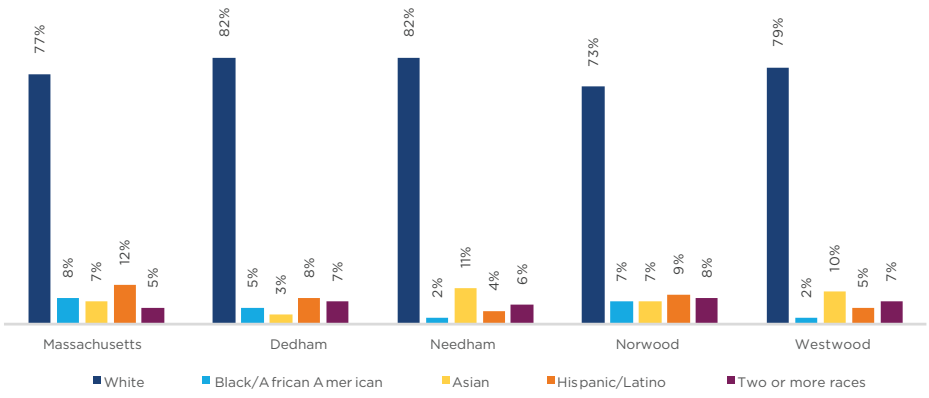
21% of LGBTQIA+ adults in Massachusetts are raising children

Source: Gallup/Williams, 2019

Race and Ethnicity

BID Needham's CBSA is diverse in terms of race and ethnicity. Compared to the Commonwealth overall, Needham and Westwood have higher percentages of Asian residents, and all municipalities have higher percentages of residents who identify as two or more races.

Race/Ethnicity by Municipality, 2019-2023



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

Household Composition

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

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, 2019-2023

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.[8]

Information gathered through interviews, focus groups, the listening session, and the 2025 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, economic insecurity, food insecurity/nutrition, transportation, and language and cultural barriers to servces.

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. Interviewees, focus groups, and listening session participants observed that housing costs were having a widespread impact across nearly all segments of the CBSA population. This effect was particularly pronounced for older adults and those living on fixed incomes, who faced heightened economic insecurity. Even individuals and families in middle and upper-middle income brackets reported experiencing financial strain due to the high cost of housing.

Food insecurity, food scarcity, and hunger were cited as significant challenges, especially for individuals and families under economic strain. Interviewees, focus group participants, and listening session participants explained that factors such as job loss, the difficulty of finding livable-wage employment, or reliance on inadequate fixed incomes all contribute to food insecurity, making it harder for people to afford healthy diets. They also emphasized that living costs continue to rise at a faster pace than wages, exacerbating the financial burden on households.

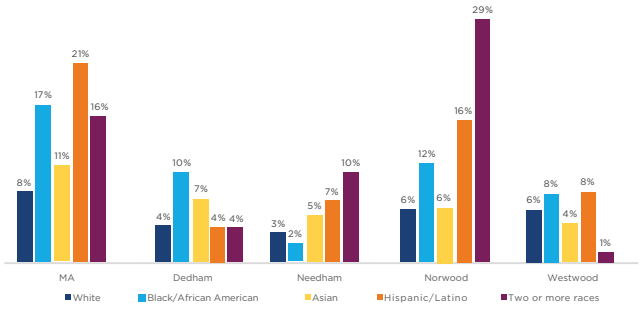
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

Economic Stability

Economic stability is affected by income/poverty, financial resources, employment and work environment, which allow people the ability to access the resources needed to lead a healthy life.[9] Lower-than-average life expectancy is highly correlated with low-income status.[10] Those who experience economic instability are also more likely not to have health insurance or to have health insurance plans with very limited benefits. Research has shown that those who are uninsured or have limited health insurance benefits are substantially less likely to access health care services.[11]

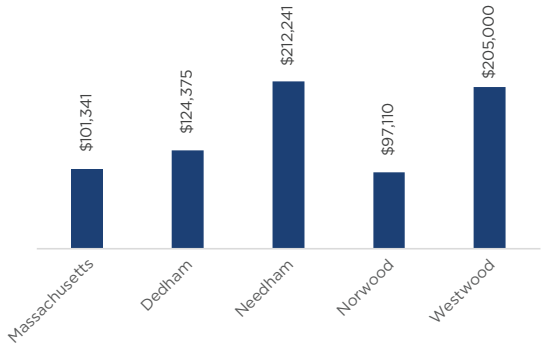
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains essential for meeting basic needs and preventing further economic insecurity.

Percentage of Residents Living Below the Poverty Level, 2019-2023



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

Median Household Income, 2019-2023

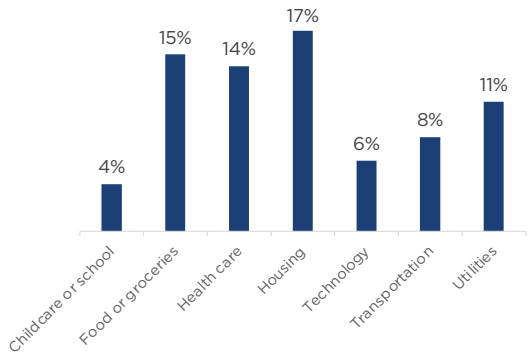


Source: US Census Bureau American Community Survey, 2019-2023

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 cumulative disadvantage over time.[12] 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 CBSA municipalities except Norwood.

In the 2025 BID Needham Community Health Survey, survey respondents reported trouble paying or certain expenses in the past 12 months. Survey results indicate that people struggled with expenses related to housing, food or groceries, and heath care.

Percentage Who Had Trouble Paying for Expenses in the Past 12 Months



Source: 2025 BID Needham Community Health Survey

Education

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

95% of CBSA residents 25 years of age and older have a high school degree or higher.

64% of CBSA residents 25 years of age and older have a Bachelor's degree or higher.

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

Social Determinants of Health

Food Insecurity and Nutrition

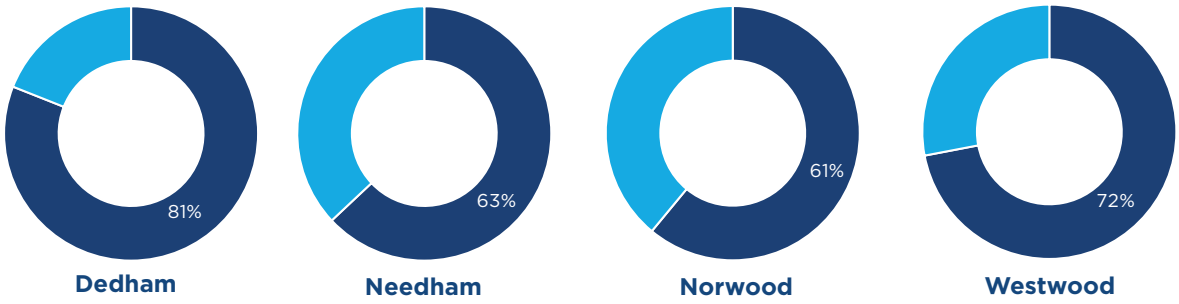
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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.

6%

of CBSA households received Supplemental Nutrition Assistance Program (SNAP) benefits within the past year. SNAP provides benefits to low-income families to help purchase healthy foods. The data below shows the percentage of residents who are eligible for SNAP benefits but not enrolled, highlighting a gap in food assistance access that may reflect barriers related to awareness, enrollment processes, or other inequities.

Percentage of Residents Who Are Likely Eligible for SNAP but Aren't Receiving Benefits, 2023



Source: The Food Bank of Western Massachusetts and the Massachusetts Law Reform Institute

Neighborhood and Built Environment

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

Housing

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

Interviewees, focus groups, and 2025 BID Needham Community Health Survey respondents expressed concern over the limited options for affordable housing throughout the CBSA.

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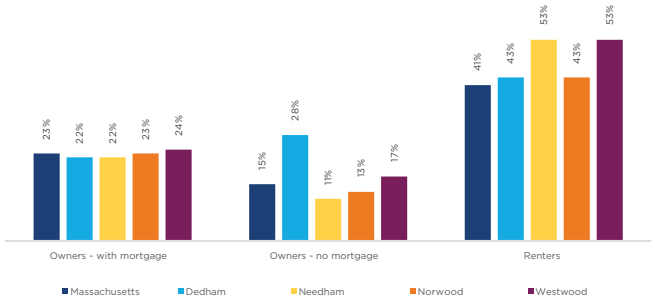
The percentage of owner-occupied housing units with a mortgage who had housing costs in excess of 35% of household income was similar to the Commonwealth in all municipalities. Among owner-occupied units without a mortgage, housing costs were higher than the Commonwealth in Dedham and Westwood. The percentage of renters paying in excess of 35% of household income was higher than the Commonwealth in all municipalities.

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



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

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

52% of 2025 BID Needham Community Health Survey respondents said "more affordable housing."

17% of 2025 BID Needham Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 BID Needham Community Health Survey

Transportation

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

Transportation was identified as a significant 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.

Source: 2025 BID Needham Community Health Survey

7% of housing units in the BID Needham CBSA did not have an available vehicle.

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

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 2025 BID Needham Community Health Survey prioritized these improvements to the built environment.

22% of 2025 BID Needham Community Health Survey respondents identified a need for better roads.

33% of 2025 BID Needham Community Health Survey respondents identified a need for better sidewalks and trails.

Source: 2025 BID Needham Community Health Survey

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.

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

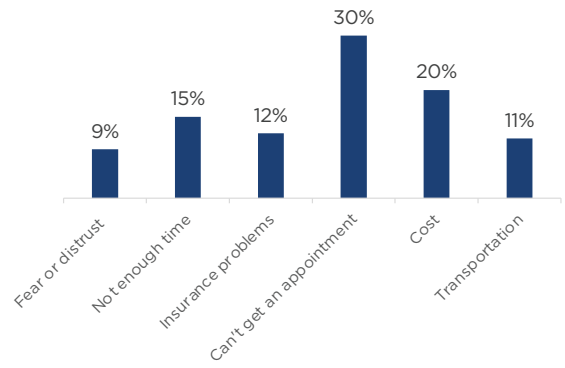
Interviewees, focus groups, and listening session participants also reflected on the high costs of care, including prescription medications, particularly for those who were uninsured or who had limited health insurance benefits. It can be challenging for low-resourced individuals and families to access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

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

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffectiv communication, and issues of patient safety.[16]

What barriers keep you from getting needed health care?



Source: 2025 BID Needham Community Health Survey

Populations facing barriers and disparities

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

"I'm unable to get a PCP in my area. [There are] no PCP offices accepting new patients. I must drive 30+ minutes to see a mid-level provider, not even my selected PCP. When I call for an appointment, I am directed to seek an appointment at an urgent care because the PCP is not available for a few months."

-Interviewee

Community Connections and Information Sharing

A great strength of BID Needham 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.

"Organizations in this area work together intentionally. There are strong relationships between them that have been able to be sustained over time. I have always been deeply impressed by how hard organizations work to maintain connections."

-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). The leading behavioral risk factors include an unhealthy diet, physical inactivity and tobacco, alcohol, and marijuana use.[17]

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. 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.[18] Access to affordable healthy foods is essential to a healthy diet.

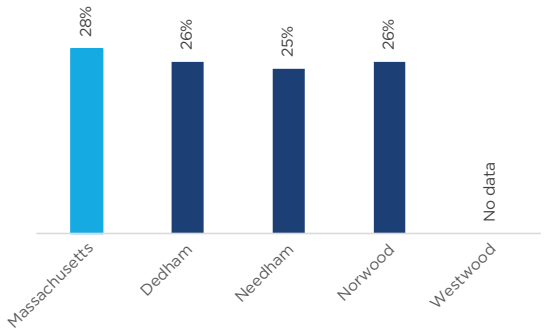
13% of BID Needham Community Health Survey respondents said they would like their community to have better access to healthy food.

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 lower than the Commonwealth in all CBSA municipalities.

Percentage of Adults Who are Obese, 2022



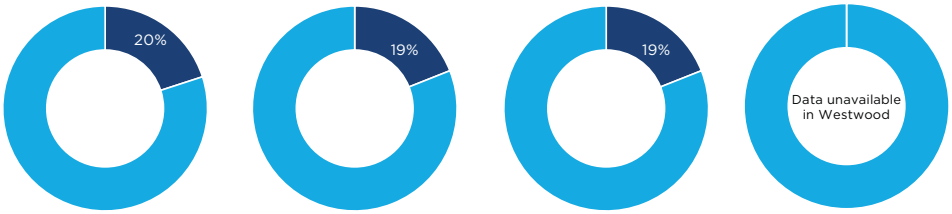
Source: CDC PLACES, 2022

Alcohol, Marijuana, and Tobacco Use

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

Interviewees reported concerns around the increase in use and normalization of alcohol and marijuana use - for the population at large, but also for youth.

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC PLACES, 2022

Health Conditions

The assessment gathered information related to the conditions that are known to be the leading causes of death and illness. These conditions include chronic and 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 out of date and was not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, the listening session, and the 2025 BID Needham Community Health Survey was of critical importance.

Mental Health

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

In addition to the overall burden and prevalence of mental health issues, Interviewees also shared that they felt that stigma around behavioral health issues had improved since 2022, and that individuals, especially young adults, were more willing to share behavioral health needs and seek treatment or support.

42% of Needham High School students reported that they felt nervous, anxious, or on edge more than half the days in the last two weeks.

Source: Needham High School MetroWest Adolescent Health Survey, 2021

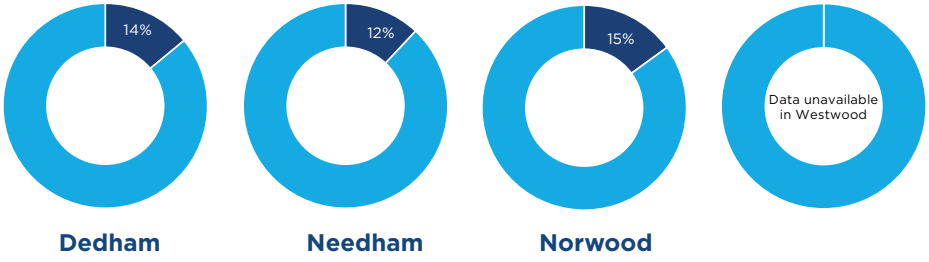
12% of Needham High School students reported having seriously considered suicide in their lifetime.

Source: Needham High School MetroWest Adolescent Health Survey, 2021

52%

of 2025 BID Needham Community Health Survey respondents identified mental health as a health issue that matters most in their community.

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



Source: CDC PLACES, 2022

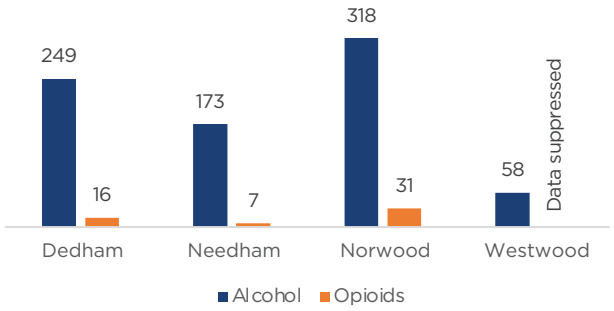
Health Conditions

Substance use remained a major issue in the CBSA, with ongoing concern about opioids and alcohol. It was also recognized as closely connected to other community health challenges like 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.

Looking across the service area, there were more alcohol-related emergency visits than there were opioid-related visits. The highest number of visits for both substances were in Norwood.

Alcohol and Opioid Related Emergency Room Visits, July 2023-June 2024



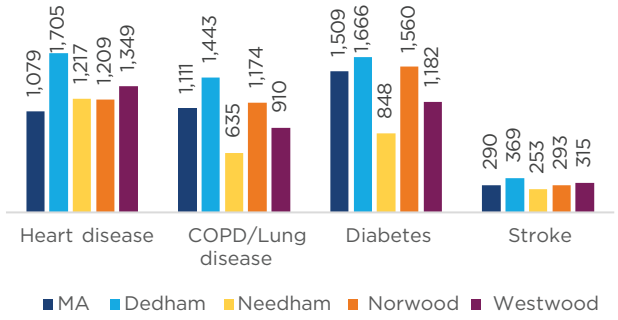
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

Chronic and Complex Conditions

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

Looking across four of the more common chronic/complex conditions, inpatient discharge rates for diabetes among adults 65 years and older were higher than the Commonwealth in all CBSA municipalities. Looking across other conditions, inpatient discharge rates were consistently higher than the Commonwealth in Dedham and Norwood.

Inpatient Discharge Rates Per 100,000 Among Those 65 and Older, 2024



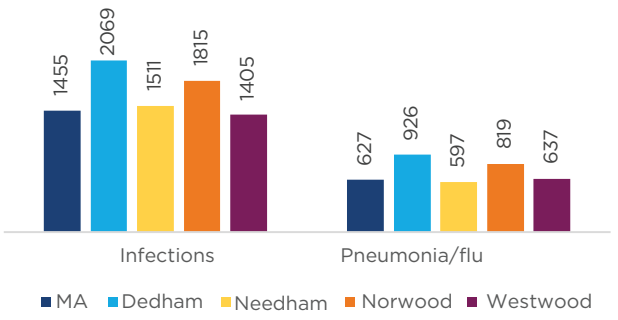
Source: Center for Health Information and Analysis, 2024

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 the listening session 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 Dedham, Needham, and Norwood had higher inpatient discharge rates for infections than the Commonwealth. Dedham, Norwood, and Westwood had higher inpatient discharge rates for pneumonia/flu.

Inpatient Discharge Rates Per 100,000 Among Those 65 and Older, 2024



Source: Center for Health Information and Analysis, 2024

Priorities

Federal and Commonwealth Community Benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, BID Needham's CBAC and community residents, through the community listening session, 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 • Maternal health equity	• Built environment • Social environment • Housing • Violence • Education • Employment
Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy	*Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)*

Community Health Priorities and Priority Cohorts

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**
- **Individuals Living with Disabilities**

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, 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, transportation barriers, language and cultural barriers to services, food insecurity, economic insecurity, health insurance and cost barriers, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive and navigation services for individuals with substance use disorder, community-based education and prevention, trauma, conditions associated with aging, healthy eating and active living, and caregiver support.

Implementation Strategy

BID Needham's current 2023-2025 IS was developed in 2022 and addressed the priority areas identified by the 2022 CHNA. The 2025 CHNA provides new guidance and invaluable insight on the characteristics of 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 2026-2028 IS.

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

Below is a brief discussion of the resources that 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. BID Needham supports residents in its CBSA by providing financial assistance to individuals who are low-resourced and are unable to pay for care and services. Moving forward, BID Needham will continue to provide free or discounted health services to persons who meet the organization's eligibility criteria.

Recognizing that community benefits planning is ongoing and will change with continued community input, 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:

- Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.
- Advocate for and support policies and systems that improve access to care.
- Support community/regional programs and partnerships to enhance access to affordable and safe transportation.

SOCIAL DETERMINANTS OF HEALTH

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

Strategies to address the priority:

- Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.
- Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.

SOCIAL DETERMINANTS OF HEALTH (CONTINUED)

Strategies to address the priority:

- Support programs and activities that increase employment, earnings and financial security.
- Support programs and activities that foster social connections and strengthen community cohesion and resilience.
- Provide and promote career support services and career mobility programs to hospital employees, employees of other community partner organizations, and community residents.
- Advocate for and support policies and systems that address social determinants of health.

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

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

Evaluation of Impact of 2023-2025 Implementation Strategy

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

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

Priority Area	Summary of Accomplishments and Outcomes
Social Determinants of Health	BID Needham addressed social determinants through housing support, food access, transportation, and multi-sector partnerships. Programs like Family Promise Metrowest prevented homelessness for 207 families. The hospital helped distribute nearly 85,000 bags of food, thousands of meals, and over 9,000 pounds of produce. BID Needham supported Neighbor Brigade's food and ride assistance and invested in local coalitions such as the Needham Resilience Network and Community Crisis Intervention Team. The hospital also strengthened cross-sector collaboration through its Community Resource Group and awarded community grants to address emerging needs.
Equitable Access to Care	BID Needham advanced equitable care by investing in workforce development, interpreter services, financial counseling, and transportation assistance. Staff participated in ESOL, academic advising, and college courses, with 33 community trainees hired at the hospital. Interpreter services supported over 11,000 patients across 200+ languages. Financial counselors assisted more than 400 patients, and over 2,500 rides were provided to those facing transportation barriers. The hospital also distributed over 2,000 essential items through its emergency department closet, supported primary care access for nearly 3,800 new patients, and expanded its efforts through committee work and training initiatives.
Mental Health and Substance Use	BID Needham expanded behavioral health services through school programs, clinical partnerships, and community education. Programs like SALSA (Students Advocating for Life without Substance Abuse) engaged over 242 youth, and clinician training increased capacity to support emerging mental health needs. The hospital offered integrated care, crisis evaluations, and ED based consults, with Gosnold and Riverside providing nearly 700 total consults. Referral programs assisted over 330 residents, and medication disposal efforts collected hundreds of pounds of medications. Support groups reached dozens of older adults, and partnerships through SPAN (Substance Prevention Alliance of Needham) advanced prevention and reduced stigma around mental health and substance use.
Complex and Chronic Conditions	BID Needham supported chronic disease prevention and management through partnerships, education, and healthy aging programs. The hospital collaborated with schools to ensure access to medications like EpiPens and provided primary care support to at-risk populations. The Needham Healthy Aging Initiative engaged nearly 1,900 participants, and Livestrong served cancer survivors, graduating 33 people. Though some programs paused due to staffing, they are expected to resume, with continued efforts to help older adults and low-income residents access coordinated care and age in place with improved quality of life.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: 2026-2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

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

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

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

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

Are there any questions before we begin?

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

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

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

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

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

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

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

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

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

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

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

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

BID Needham
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Tim McDonald (Director of Health and Human Services) and Tiffany Benoit (Asst. Director of Public Health), Town of Needham
- Kylee Foley, Director of Public Health, Town of Dedham
- Stacey Lane, Superintendent/Director of Health Department, Town of Norwood
- Jared Orsini, Health Director, Town of Westwood
- Kim Fisher, Chief Behavioral Health Strategy Officer, Riverside Community Care
- Lina Arena-DeRosa, Director of the Westwood Council on Aging, Town of Westwood
- Rep. Denise Garlick, State Representative (13th Norfolk District)
- Sean Barnicle, Executive Director, Norwood Housing Authority
- Katy Colthart, Director, Westwood Youth and Family Services
- Sandy Robinson, Executive Director, Needham Community Council
- Dr. Nichole Argo and Dr. Beth Pinals, Co-Directors, Needham Resilience Network
- Danielle Conti, Executive Director, Family Promise MetroWest
- Mark Carney, Director of Health, Wellness, and Physical Education, Dedham Public Schools
- Paula Jacobson, Executive Director, Charles River YMCA
- Ari Barbanell, Executive Director, Circle of Hope

Community Health Priority Areas

Social Determinants of Health

- Economic Insecurity
    - Rising cost of living; single-income woman-led households are especially impacted
    - Rising clothing, hygiene, and school needs; organizations use donations to fill gap
- Transportation
    - Especially impactful for low-income families and older adults
    - While many transportation resources exist, information is disjointed making it challenging to access the discounts and scheduling information
    - Limited bus routes are available, although the commuter rail helps connect to Boston
- Community Inclusivity
    - Stigma related to providing services in a largely affluent area; community may be unaware of the economic diversity of the region
- Housing
    - Lack of affordable housing and transitional housing; housing costs continue to rise
        - Much of the affordable housing that is available is unkept and unsafe
    - Lack of spaces or resources for homeless or unhoused individuals
- Administrative barriers to accessing resources (forms, meetings during working hours, etc.)
- Food costs are rising, making it difficult for individuals to afford produce and healthy meals

Access to Care

- More people are seeking care, leading to longer wait times.

    - Telehealth appointments have helped reduce the wait, especially for youth health, but in-person appointments are preferred
- Loss of nurses and other medical providers after COVID; need for additional supports to prevent burnout
- Working to expand preventative care and screening services to community spaces, including senior centers and apartment complexes
- Closure of Norwood Hospital caused many individuals to need to find new providers
    - Transportation to the Needham Hospital is more challenging
    - This was a core issue in multiple interviews
- Language and Cultural Barriers
    - "It's hard to cater to every language, one of the difficulties is translation services and culturally competent care. Language barrier is a huge barrier for them to feel comfortable with their providers."
    - Lack of providers who can provide culturally competent care
- Older adults who have lower computer literacy rely on caregivers and family members as healthcare offices switch to virtual communications and scheduling
- Lack of providers overall
    - Many providers are not accepting new patients or do not accept MassHealth
    - The community would benefit from an increase in peer services and recovery coaching
- Challenge for many individuals to navigate the health system
    - Need for health advocates who provide guidance and information
    - Lack of wraparound care is a challenge when individuals are discharged and need to arrange further care and follow-ups
    - "Lack of care coordination - many people are managing many different providers - but this is a big missing gap."

Mental Health and Substance Use

- Lack of mental health care, especially in-patient care and providers who accept MassHealth
- Interviewees highlighted the need for Mental Health First Aid training
- Chronic absenteeism is a challenge across the state
- Mental Health
    - Youth mental health, anxiety, and peer pressure
    - Rising loneliness and isolation in older adults; challenging to ask for help
    - Impacts of COVID-19
    - Depression, seasonal affective disorder
    - Cultural acceptance and interpretation of mental health
    - Long-term impacts of trauma
- Substance Use
    - Opioids, alcohol
    - Youth substance use (vaping, alcohol, marijuana)
    - Stigma

Chronic and Complex Conditions

- Heart disease, tick borne diseases, cancer, hypertension, COPD, diabetes, dementia, obesity, mobility issues, and asthma are common chronic conditions in the area
- Need for additional caregiver supports

- Interviewees expressed interest in the revival of a lecture series based on chronic conditions (diabetes, heart disease, obesity, etc.)

Priority Populations

- Agreement across interviewees that the following populations should continue to be the priority, as they face the most significant barriers to care and services:
    - Youth
    - Racially/ethnically/linguistically diverse (including immigrants and refugees – primarily those that have newly arrived)
    - Low-resourced/low-income populations
    - Older Adults

- Interviewees also identified concerns for new parents, pregnant people, individuals living with disabilities, and LGBTQIA+ individuals.

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout Needham, Westwood, and Dedham
    - Specific organizations identified as critical resources: Substance Prevention Alliance of Needham (SPAN), Domestic Violence Coalitions, Community Crisis Intervention Team (CCIT), The Ride, Hospital to Home, HESCO, Commission for the Blind, New Life Furniture, Women's Commission, Riverside Mental Health, Charles River Community Health, Boston Public Health Commission, Room 2 Grow, Hope and Comfort, City Connects, Haitian Mental Health Network, Westwood Community Chest, Dedham Youth Commission, Opioid Abatement Task Force, Mental Health Stakeholder Group, Ward Farm, Pink Provider Network Collaborative, Needham Youth and Family Services, Needham Community Farm
- Schools, youth organizations, senior centers, libraries, food pantries, religious organizations, health departments, emergency services, housing authorities, and recreation departments were common sources of partnerships across interviews
- Harm reduction can be a challenging issue for collaboration, not all organizations are willing to discuss it
- Few organizations cover populations across the lifespan, most target specific age groups
- Lack of financial resources; competition between organization for the limited funding

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

BID Needham
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: English language learners
Location: Zoom
Date, time: 10/7/2024
Facilitator: JSI
Approximate number of participants: 3

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. I just moved to Needham nine months ago with my children. My family and I have seen that the neighborhood is healthy. They have healthy habits. The community seems physically healthy. The mental health of the community is harder to see.
    ii. I've been here since 2011, it was hard since my family was back in my home country and I only live with my immediate family–my husband and kids. My mental health was up and down. In terms of physical health, I've had health issues since I was born. I have to be more careful since I had a heart surgery when I was young. Health care is hard to get though due to long wait times. Sometimes I decide to go to my home country to get what I need. I do my best to stay healthy (both physical and mental).
    iii. I came to the US for my son's education. The most important things are nutrition, exercises, and mental health. At my age, mental health is very important. I try to do the three things to the best of my ability. My kids went to college so I'm living alone and am feeling alone.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Immigration is hard, there have been big nutritional changes. You don't always find the same kinds of food or produce. Maintaining physical activity is hard until you get the groove of things. Mental health is always a challenge when you move with different people or communities.
    ii. The challenges depend on a person's age. Kids in college and young people don't take care of their physical health as much since they go to sleep late (1am) which isn't good for their long-term health. They might go to the gym everyday but still may have bad habits. The whole society has some bad habits. I recently read an article about food colors [dye] and how unhealthy they are – I'm concerned

about that. FDA should do something since many of these things aren't allowed in other countries.

iii. I agree. Red 40 and yellow 60 are banned by other countries, especially in snack foods. My family isn't allowed to eat certain foods. It's so hard to find things they can eat because most foods have these kinds of ingredients. I was so shocked by the portions of the foods here – they are so huge. I've been trying to control my portion sizes.

iv. I have concerns with nutrition – the life expectancy of Americans is increasing and the main issue is nutrition. It's not a major concern for me or my husband since we know how to pick foods but it's a concern for my kids.

Question 2

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

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

a. I find someone to talk to – either my husband or brother or friends. It depends on the problem I'm facing. I'm scared that I'm going to put all my problems on someone else so I sometimes keep everything to myself which isn't great. I'm far away from my parents (Thailand) who are old and far away. I am a professional overthinker.

b. I try to keep busy every minute – I read a book, listen to books, do housework, learn English, and go to the YMCA.

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

a. There is nothing stopping me – in my home country, my work kept me from having time with the kids. Once I arrived in America, since I'm not working for now, I try to stay busy (YMCA). Keeping physically busy improves mental health. Here we have less control over working compared to Brazil. We used to work 10-12 hours a day, here people don't do that. It's easier to have time to exercise or do another activity.

b. It is harder to get mentally healthy when your physical health isn't as good.

Question 3

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

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

a. In Needham, there's a lot of immigration. My two kids (6th and 8th grade) have friends from all over the world. Needham is open to different populations. Some struggle more than others, but in Needham we have an open-minded community about immigration and social needs.

b. There's community support for immigrant families that need help (like ones that just moved here and need clothes and necessities). The community in Needham helps each other. The cost of living in Massachusetts is very high. A certain family that just moved in may not be able to afford to live here. One family may need to work several jobs to afford rent here. Childcare fees are super high here. Not sure if there are groups that can help with that. Even harder for single moms to survive here. My daughter's school is the most diverse with a lot of new immigrants. That school doesn't have enough money so they can't keep up with other school districts. The taxes are very high.
c. There are some affordable houses here. My children didn't speak English when they got here, but there has been a lot of support from public schools – vaccines, ELL classes. For families with little kids, we don't have public schools until 5 years old. Until that age, it's difficult not to pay a lot of money to put kids in private schools.
d. I'm living in Needham, but my kids went to Dedham schools. We don't have to pay a lot of money for rent here. I don't work so I feel out of touch with the community.
e. Safety issues all around the country are impacting physical and mental health

Question 4

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

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?

a. Schools – the support they can give to the children is amazing. In my country it is a different system – here it is much better. You don't find this level of school support in other countries. I haven't seen a lot of senior centers. The preservation and maintenance of parks is always updated. There are a lot of open parks for kids and teens. Lots of squares. I've seen a lot of doctor's offices and dentists. Needham has one of the most important autism centers in Massachusetts. Senior housing is spread all over the town.
b. Needham has programs for kids, seniors, and families all the time. My family occasionally joins town activities. Sometimes we pay membership fees or it's free. It's great they have these programs. The school also has funds for families that need it for after school. The library also has a lot of activities.
c. Needham community classes has a lot of programs and classes, some to help immigrants find jobs, like Christmas dinners.
d. I've seen many events – Needham town hall, churches, etc. that can help to increase health.

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

a. Commerce – Needham has a lot of local small businesses, but we don't have great supermarkets. Small businesses are more expensive. It's great to support local places, but it's hard to compare when you can pay less for things a 10 minute drive away. There aren't chains for things like furniture.

BID Needham
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Westwood Disability Council
Location: Westwood, MA
Date, time: 10/29/2024
Facilitator: JSI
Approximate number of participants: 10

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Physical inactivity was seen as a widespread issue, both personally and in the broader community. People talked about trying to sit less, walk more, and stay active even in small ways (e.g., grocery shopping, taking stairs).
    ii. Many participants emphasized diet as a key focus—trying to cook more meals at home, eat more vegetables, or reduce processed foods.
    iii. Make sure to keep up with doctor visits, monitor medications, and follow care plans.
    iv. Stress management plays a role in staying physically healthy—deep breathing, mindfulness, or just taking quiet time helps keep our bodies from feeling worn down.
    v. We try to walk or move daily, even if it's just short trips—around the block, inside the house, or during errands. Movement, in any form, is important.
    vi. Focus on healthy eating - healthier ingredients, portion control
    vii. Go to gym nearby
    viii. Resistance bands, pedal bikes, or chair yoga videos—when going to the gym isn't realistic.
    ix. We focus on getting enough rest
    x. Health eating active living, weight control
    xi. Chronic conditions like diabetes, heart disease, and high blood pressure were frequently mentioned—many participants, or their loved ones, are actively managing these with medications, diet, and doctor visits.
    xii. Several people brought up weight management as a health goal—often in connection with preventing or controlling diabetes, improving mobility, or boosting energy levels.
    xiii. A few participants highlighted preventive care—keeping up with annual checkups, vaccines, and screenings—as an important but often overlooked aspect of physical health.

xiv. Access to care varies widely—some participants had regular access to primary care, specialists, and preventive services, while others faced barriers like transportation, long wait times, or difficulty finding providers who understand disability-related needs.
xv. It is important for caregivers who often put their own health last, who prioritize the needs of loved ones over their own appointments, exercise, or rest to take care of themselves also.
xvi. Telehealth has improved access for some, but others—especially people needing physical exams or those without strong internet access—found it limiting. There's also concern that virtual care may overlook physical assessments and in-person support needs.

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

i. People with limited income or disabilities noted challenges with food access and prep.
ii. Mental health was tied closely to physical health—depression, anxiety, and stress were mentioned as barriers to staying active or eating well, especially among caregivers or those with chronic illnesses.
iii. Insurance and cost were major barriers—some noted delays in treatment due to coverage issues, high co-pays, or services not being covered (e.g., physical therapy, assistive devices, or home health).
iv. Mental health services were often hard to access—particularly for caregivers who are managing stress or burnout, and for people with disabilities whose physical health impacts their emotional well-being.
v. A number expressed frustration with lack of coordination across providers.
vi. Time – Between work, family, caregiving, and daily responsibilities, it's hard to find time for exercise, meal planning, or rest.
vii. Cost and affordability – Healthy food, gym memberships, physical therapy—it all adds up. Sometimes it's just not in the budget.
viii. Transportation – Getting to appointments, grocery stores with fresh food, or community centers is hard without reliable transportation.
ix. Fatigue and low energy – Some days, it takes all my energy just to get through basic tasks. There's not always enough left for extra movement or cooking.
x. Mental health – Anxiety, depression, or stress can drain motivation. It's hard to focus on physical health when you're overwhelmed mentally.
xi. Caring for others – As a caregiver, I tend to put everyone else first. By the time I think about my own health, the day is over.

Question 2

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

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

a. We spent a lot of time talking about the therapeutic benefits of service dogs. They can have an incredible impact on mental health—they provide not only practical support but also emotional stability, companionship, and a sense of safety, helping reduce anxiety, interrupt panic attacks, and ease daily stress.
b. Physical activity—movement helps us manage stress and feel better mentally, even when it's light stretching or walking.
c. Spending time outside—fresh air, sunshine, even a short walk or sitting on the porch helps reset our minds and improve mood.
d. Talking to someone—friends, family, support groups, or therapists. Just having someone to listen to me makes a big difference.
e. Practicing gratitude—some of us keep journals or just take time to notice what's going well, especially during tough days.
f. Spiritual or religious practices—prayer, meditation, or attending services gives comfort and a sense of connection for some.

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

a. Mental health issues are paramount; the biggest issues right now are among youth and older adults
b. Access to mental health care is still a major challenge—long waitlists, high costs, lack of nearby providers, and difficulty finding someone who understands disability or cultural context make it hard for people to get the support they need.
c. There's a strong need for more consistent, affordable, and stigma-free mental health treatment—many people want help managing anxiety, depression, trauma, or caregiver stress, but don't know where to start or feel overwhelmed by the system.
d. Mental health screenings aren't always part of routine care, and when they are, they can feel rushed or surface-level. People want providers to take the time to really understand what they're going through—not just check a box.
e. Lack of access to mental health care—finding a therapist is tough, especially one who takes insurance, understands disability, or has availability. Waitlists can be months long.
f. Stigma—in some families and communities, talking about mental health is still taboo. People feel pressure to "just push through" instead of seeking support. Although there was a strong sentiment that this was getting better, particularly in youth
g. Isolation and loneliness, especially among older adults, youth, people with limited mobility, and those who are caregivers. It's easy to feel disconnected or unsupported.
h. Financial barriers—therapy, medication, and self-care activities can be expensive, and not everyone can afford what helps them feel better.
i. Inconsistent support systems—friends and family may mean well but don't always understand, and it's hard to open up when you don't feel truly heard.

j. Navigating the system is overwhelming—even when help is available, figuring out where to go, what's covered, and how to access it can feel like a full-time job.

Question 3

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

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

a. Affordable housing is a huge challenge—rents are rising, waitlists for accessible or subsidized units are long, and people with disabilities often get pushed to the margins.
b. Transportation is a major barrier, especially for those who don't drive or can't afford a car. Public transit is limited, unreliable, or not accessible in some areas.
c. Food insecurity is real, even for people who are working or receiving benefits. Healthy food is expensive
d. Social isolation is common, especially for older adults, people with disabilities, and caregivers. There aren't enough accessible programs or community-based supports to stay connected.
e. Lack of job opportunities—especially flexible or accommodating jobs. Many people feel stuck between not being able to work and not being able to afford life on benefits.
f. Mental health resources are not integrated into the community—there's a disconnect between where people live and where they can get the help they need.
g. Access to digital resources is uneven—not everyone has a smartphone, internet, or digital literacy, which affects access to appointments, benefits, and information.

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

a. Older Adults / Seniors
    i. May face mobility limitations, social isolation, or transportation challenges—especially if they no longer drive.
    ii. Fixed incomes may not keep up with local costs, making housing and healthcare difficult to afford.
    iii. May struggle to access tech-based services (telehealth, digital benefits platforms).
b. Youth and Teens
    i. Lack safe and accessible places to gather
    ii. Mental health needs may go unnoticed or be stigmatized in high-achieving school environments.
c. Low-Income Families
    i. Even in affluent areas, there are often families living paycheck to paycheck, particularly renters or those in subsidized housing
d. Non-English Speakers / Immigrants

e. People with Disabilities
    i. May find that public buildings, sidewalks, and recreation areas are not fully accessible.
    ii. Services like transportation, home care, or behavioral health supports may be scarce or hard to navigate.

Question 4

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

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

Did not get to this question

BID Needham
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Dedham Teens
Location: Zoom
Date, time: 11/4/2024
Facilitator: JSI
Approximate number of participants: 3

Question 1

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

a. **Think about yourself and other people your age. What sort of things do people your age do to stay physically healthy?**
    i. I play sports or go to the gym to keep my physical health in check
    ii. There's a balance (between going to the gym, running, and sports) – sports are more important in people's lives since people in high school do sports as an extracurricular
        1. A lot of school sports
            a. People play a different sport each season
        2. The main thing people do to stay healthy is play sports
    iii. Some people will use the school gym to work out
    iv. Participate in school sports, go to the gym, or go for a run
    v. We have a wellness class. Half of the school year they do some physical activity (playing games like frisbee); the other half is learning about drugs and alcohol
    vi. Drink water. My parents say our generation drinks a lot more water than past generations. When they were in high school they didn't have water bottles.

b. **What prevents people your age from being physically healthy?**
    i. Not having time with school and studying
    ii. Studying
    iii. Sometimes I just don't want to go (to the gym)
    iv. One participant had an eating disorder and had to go to the hospital
        1. Participant's friend also had an eating disorder
        2. When the participant was at the hospital (or rehab), they saw another girl who went to their school
        3. Eating disorders are much more prevalent than people realize

Question 2

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

a. Think about yourself and others your age. What sort of things do you and the people you know do to stay mentally healthy?

a. hanging out with friends – to distract themselves from the stress they have at school
b. Doing a hobby relaxes people
c. Baking, reading, sleeping
d. Therapy dogs come to the school
e. Run cross-country and play sports
    i. Go to pasta dinners with the team to get excited about competitions

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

a. Studying and doing homework
b. Sports take up a lot of time
c. Academics are over competitive
    i. People at school say their scores and share that they stayed up until 1am studying
    ii. For example: in a computer science class, two people were talking about their SAT scores. One said "I'm not saying (their score)" the other said "oh did you get a 1450? That's bad." The participant who overheard the conversation was not offended, but noted that a 1450 is not a bad score, so that conversation was way too competitive
d. You want to spend time with the people you play sports with, but you also want to balance that with spending time with your family, so have to choose which you want to prioritize
e. If you're really into sports, then you might forget to do your homework which could impact your grades (and mental health)
    i. You have to find a balance to be good in both
f. I feel better when I go to practice and have that socialization with my teammates and we have a lot of fun.
    i. Sometimes I get anxious when there are a lot of competitions coming up
    ii. I get worried about every physical aspect – if I have a tiny pain in my foot, I overthink it… that's not a good level of stress
    iii. I try to tell myself that it doesn't really matter – if you have one bad race, that you should just try your best
g. Talking to your coach or teammates about any stress that you're having might help too
h. In tennis practice or matches, taking a break or just not doing anything for 5 minutes definitely helps to destress

Question 3

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

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

a. Having parents, friends, siblings, teachers, and guidance counselors that you feel comfortable talking to
b. Parents help with trying to stay physically healthy (mom will go to the gym and invite me)
c. Guidance counselors – there's a lot of people in your school (teachers) that can help (students are assigned guidance counselors)

b. What do they do to show that they support you?

a. Sometimes if a guidance counselor notices that you might be having a bad grade in a subject, they'll email you to schedule a time to talk about it
    i. If they notice that you're down they might come try to talk to you privately
    ii. Having them reach out to you helps (the guidance counselors also try to reiterate that they support the student)
b. Getting help with college guidance is good for stress
c. A participant had a hard schedule and didn't want to take Spanish, so they switched out of it to a piano class and it is a lot more fun
d. Making sure you get the right attention at school
    i. For example, getting more time on tests because the student has ADHD
e. When I have a problem, my parents will help me find solutions by talking it out and helping me decide what is the best way to move forward
    i. Talking to parents
f. If you have a friend issue, talking to people your own age can help (as opposed to a parent or counselor)
g. One participant said their parents help them write emails when they are feeling stressed

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

a. No I can't think of any
    i. I feel like our school provides a lot of great resources; if you feel stressed there is always something you can do to help yourself
b. Emphasis on feeling support from people
    i. Mainly guidance counselors
c. Peer tutoring
d. Outside community sports teams that are separate from the high school

Question 4

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

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

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

- Guidance counselors and teachers are helpful but they can cause stress too; especially when you can't choose who your counselor is and if you get along with them
- Social media causes stress, especially if you're on it too much. It can lead to procrastination and not doing your work; or you get insecurities from watching people online which can cause stress
    - A lot of people are on social media during passing periods or during free block and lunch
    - The purpose (of social media) is for people to interact together, see things that they wouldn't see otherwise
    - Friends will talk about the people they see on TikTok and it shows that they have different "for you" pages
    - On snapchat and instagram it's more about connecting with legit friends (vs TikTok is random people)
- Not necessarily for high schoolers, but once you get out of college, jobs cause stress
    - Some of my cousins are young adults and went to college and it's hard to find good jobs

BID Needham
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Norwood Housing Authority Families and Parents
Location: Zoom
Date, time: 11/7/2024
Facilitator: JSI
Approximate number of participants: 5

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Still try to fit in movement and exercise into my day. I try to go outside
    ii. Eating healthy foods – this can be challenging when you have picky eaters because you're eating what they're eating
    iii. Walk to school for pickup and drop off
    iv. Anything physical
    v. Mother of older children: "What I find that I have to do, is when I'm working, I have to set time for me to go take a 15-minute walk in the afternoon. If I don't do that, it's just not going to happen. I have to put myself first even though there's other things that have to be done. I have to take time for myself because I won't be that much of a help to others if I'm not helping myself."
    vi. Bring lunch to work
        1. have kids pack their lunches instead of buying at school
    vii. Try to make dinner more often than get takeout when possible
    viii. Have exercise equipment in home (not enough time to go to the gym)
    ix. Walk to places instead of driving
    x. Take the furthest parking spot in the parking lot (especially in nice weather)
        1. Even while grocery shopping
    xi. It feels more important to get back to good health as I get closer to 40
    xii. Preparing the food yourself

b. **What stops you from being as physically healthy as you'd like to be?**
    i. It can be challenging having kids – it was easier to prioritize physical health before having kids
        1. My kids and time
        2. I recently joined a new gym and it is a struggle. I feel guilty for taking 45 minutes when your kids are saying "where have you been all day"
        3. I am a mom of young kids, so their health takes priority over time for yourself

        a. You have to prioritize them
    4. Older kids still need time
    5. Being a mother, your help [for yourself] does take a backburner
        a. Putting off doctors appointments even though my daughters are regularly scheduled
        b. Putting kids' physical needs first
        c. Another mom's daughter had surgery last week and mom literally felt like she didn't' take care of herself
- **ii.** The biggest barrier is time; where can I find the time in my otherwise busy day
    1. I am a mom with older kids; it's still time (as the biggest barrier)
- iii. The biggest barrier is not having the time or energy; you make that decision that is quicker (buying food instead of grocery shopping / preparing)
- iv. My older daughter is home from college with strep and covid – she can't stay at school and I have to take care of her
    1. It never stops, time is always a constraint
- v. Energy is a big part of it
    1. balancing work, household, and kids; physical health is on the backburner compared to those things

c. Are there any hacks or tips you've found that give you more time?

- i. There comes a point when you have to be selfish
    1. Other people wouldn't say it's selfish but it feels like it is! You have to rewire your thought process to realize that taking care of yourself isn't selfish
- ii. Mom guilt
- iii. It comes down to little moments; you have to be intentional
    1. Take five minutes to check out of work; be outside for five minutes
        a. Like how dads hide in the bathroom
- iv. Put an earbud in to listen to an audiobook, but cover it with your hair so that you can listen to something while playing mindlessly with your kids
    1. Create time to mentally check out while being physically present

Question 2

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

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

- a. Therapy
    - i. I regularly see a therapist – there is a stigma around it, and I make the time to prioritize it. I'm learning that you don't have to have a problem to see a therapist, it's just a helpful outside perspective on things in my mind, to help me regulate
    - ii. Whether you need it or not, it's nice to have somebody impartial

1. We are lucky in Norwood to have riverside community health and other places that are sliding scale (if you're on a budget)

b. Having connection with people (therapy is helpful with that)
    i. Forcing yourself to go out for coffee with a friend
c. I advocate for being selfish
    i. Repetition: it's not selfish! you have to take care of yourself first
d. Physical health and movement helps
e. Meditational tapping and meditation with movement – it rewires negative thoughts
    i. It is free; you can get the app on your phone
f. Audible – listen when you're doing other things to check out or get some "me" time
g. Calm app
    i. every morning she does the daily meditation when she wakes up
    ii. You can also write something you're grateful for (she puts 1-3 things she's grateful for) – grounding, gives her a better perspective
    iii. 10 minutes a day
    iv. Free
h. Waking up early to take time for yourself
    i. I usually get up at 6:40 and get the kids up by 6:50
    ii. Getting up early struck a chord with me – make a point to get up and get out of whatever mood I might be waking up in
i. You shouldn't start the day by hopping right on your phone; it's very easy to start scrolling right away
    i. Mental health goal: put your phone in the other room, start the day NOT on your phone
    ii. A morning routine is important
        1. Having tea
        2. Let your kids have screen time before school so you can make their lunch in peace

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

a. I am mindful about my mental health… but what gets in the way is going back to the "mom load" – trying to juggle everything
    i. I know that at the end of the day, what looks like "healthy coping" is different from what's realistic
    ii. What's thought of as healthy: a bath, alone time, and tea takes ENERGY!
    iii. Realistic coping strategies: maybe having a glass of wine
        1. This is a quick fix; it's easier to have a poorer coping strategy even if it doesn't make you feel better the next day
b. I worry about my parents
    i. They're older and I don't live nearby them
    ii. The energy I spend thinking and worrying about them (it's really hard not to) weighs on my mental health

iii. I try to think about it in a way that's not going to take up my time but it feels like lately it's on my mind a lot

c. My dad had a really bad health issue a couple years ago, so for 6-8 months when he was in hardcore treatment, it was all encompassing
    i. It is out of your control, very time consuming, very serious, you're constantly worried about them
    ii. It takes space in your head
d. Kids and time – it's just a LOT
    i. Having a teenager and a young child; it gets in the way; when are you worried about them and catering to them
e. Mental space of worrying about things that are out of our control but we can't do anything about
f. Mental load
    i. We need a village!
    ii. The societal expectations that are put on women in this day and age – having more expectations and less support

c. What about when you have time to exercise or go to the gym? Do you notice it affecting your mental health in a positive way?

a. Over covid, I neglected my physical and mental health
    i. Before having kids, I was in the best physical and mental shape
    ii. Post-covid, I decided to get into better shape and take care of myself. I noticed that I feel pretty good mentally (after a month and a half), but instead of energizing me, I'm feeling sore and tired a lot! I feel rickety.
    iii. I remember when I was younger and consistent with exercise, it made me feel vibrant and alive, but not it makes me feel old and sore
    iv. Diet will take a backseat for me, because I don't have time to prepare something my body needs… so nutritionist is on the list
        1. (Talked about how dietary needs can change when you're in a different phase of life or depending on what exercise you do. You need fuel!)
        2. Do you take magnesium? I take it as a supplement and it made a world of a difference
        3. I'm now anemic, so good point, vitamins and supplements might help
b. When I have time to do it (exercise) I feel better emotionally - my tank is full
c. It's hard to know what to prioritize.
    i. I am supposed to go to the dermatologist, OBGYN, etc. I want to know what is the most important to prioritize if I don't have time (to do everything)

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to

food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

- **a. What social factors are most problematic in your community?**
    - a. Cost of food and groceries
    - b. Financial Insecurity
    - c. Long commute
        - i. Because of the nature of my work, I really have to be here (in person) but the commute is a grind. It takes a toll on me.
        - ii. I was just in Indianapolis at a conference and I noticed that everyone drove so politely there. No one honked, people slowed down for you… that's not the case for the northeast. Everyone's aggressive and doesn't have the time to give everyone the attention or friendliness they deserve
            1. I am scared of road rage – you hear scary stories about it. You don't want to feed into the rage
            2. You should listen to an audiobook that's relaxing during the commute (or a funny podcast)
        - iii. We are rushed and angry (in the northeast) and have an overdrive for productivity; when you travel elsewhere, people are generally polite and it's a noticeable difference!
    - d. I have been doing some work at the emergency assistance shelter and I think we have a way to go with language accessibility
        - i. It is surprising to me that there's not a clear and simple way to make language accessible (it shouldn't be that hard to translate for people)
        - ii. Good translation programs cost money
    - e. There are a lot of limitations if you don't have a car or if you can't drive
    - f. If you don't have a lot of money, it is hard to get food. That's a basic need that's not getting met
        - i. Even though we have robust services, like a food pantry, you can tell there's a community need for more
        - ii. The farmer's market here is great; they put money on the SNAP cards and give out coupons
    - g. There's a divide between the young and the elderly - lack of education and technology
        - i. The elderly can't get onto Zoom; impacted by not having the technology or technical skills, that everyone else has
        - ii. Folks that don't have technology; they have to go to the library which has limited hours or costs money to use

Question 4

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

- **a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**

a. Norwood food bank – great resource for food insecurity
b. Riverside community health – mental health organization
c. William James Interface – referral service
d. Norwood civic center – a lot of great affordable programming for all ages; they also work with people to give them access to the programs to cover fees
e. 178 Tremont Street – has discount transportation; if a person has standard MassHealth, they bring a letter and their ID to get discounts on the T
    i. They also have a place for children – they help parents with young children; from babies to fifth grade
    ii. Some summer camp options, childcare, or afterschool programs
f. MassHealth will sometimes help with transportation to medical sites

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

a. The biggest gap is that we don't have a place where there's a physical community board
    i. Not everybody has access to technology and email. I will often go to facebook to get community information. There should be a physical community board for people who can't access that information online or virtually
    ii. So many people say "how do you know about this/that?" and the answer is usually Facebook; especially for kids events and community events

c. Where would you put a physical community board?

a. Civic Center
b. Town Hall
c. Create three and make them weatherproof. Put them in the center of town, in South Norwood, and in North Norwood

Question 5

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

- Would the hospital consider transportation for folks for doctors appointments or follow ups?
    - It can be a sliding scale or free of charge. Maybe they can give vouchers for free uber rides to doctors appointments.
    - There are people on Facebook asking for people to give them a ride
    - I can only imagine how overwhelming it would be for someone who can't get to a specialist appointment, and then can't get the care they need
    - It can be a full-time job to get care when you are older or have chronic conditions, or are lacking basic needs, etc.
- Navigating MyChart and sending messages in the portal is hard for a lot of people
    - We need to have more support for this
    - It must be so hard for people with a barrier (language, age, intelligence)

BID Needham
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals in affordable housing
Location: Norwood Housing Authority
Date, time: 11/15/2024
Facilitator: JSI
Approximate number of participants: 10

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Going to the senior center and going to exercise classes to stay flexible. At their age, exercise is about strengthening and being flexible.
    ii. Stay busy
    iii. Go for walks every day, weather permitting. If the weather doesn't permit, they walk in their apartment.
    iv. Walk around a lot.
    v. Good meal prep.
    vi. Walk downtown and back.
    vii. Exercise before they start their morning. Put music on and clean throughout the day.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Getting old
    ii. Vertigo, and trying not to fall. Limited in their exercise, but tries to eat healthy.
    iii. Sabotages themself. Talks themself out of doing things. Wants to be more accountable by bringing more people in to do healthy activities with.
    iv. Weather. Can't get out when the weather is bad.
    v. Norwood Hospital closing. Many respondents in the group received their healthcare from Norwood Hospital. The flood several years ago closed the main building, but there were plans to rebuild. They found out on November 1, 2024 that the company that was going to rebuild has declared bankruptcy, so Norwood Hospital's satellite offices and specialty practices will also be closed. The closest place to receive care now is BID Needham, but that is not easy for folks to get to.
    vi. Seniors are not as computer literate and healthcare offices are going virtual for everything (appointment scheduling, test results, appointment reminders, etc.). Seniors are relying on family and caregivers to coordinate care.

Question 2

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

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

a. Reading mysteries. The participant is blind in one eye, so they listen to audiobooks
b. Word searches, coloring, playing the keyboard
c. Reading and sewing
d. Spending a lot of time checking-in with their siblings. They are from a large family and they talk to family every week or every two weeks. They maintain a relationship with their grandson.
e. Attend a vision loss support group. It used to meet at the Carroll Center, but transitioned to Zoom during COVID. Facetimes every single night with other friends who live alone. The support group meets once a month, but friends talk every night .
f. Facetimes every night with family and friends in the Philippines. Family comes over.
g. Babysits grandkids. They have a good sized family. They like to hack around on the golf course, but it is getting expensive lately. They garden and it is relaxing. Gardening keeps your mind busy; stops you from thinking about reality.
h. Stay busy by cleaning the house, washing clothes, grocery shopping, going for walks, and talking to friends

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

a. Overthinking; the news is all bad. They try to find the good in things, but sometimes your brain goes to the negative.
b. Depression comes on everyone at certain times. Seasonal Affective Disorder contributes to this.
c. Being home and living alone. They try to keep busy to keep negative thoughts away.
d. Isolation. If you don't get out, nobody else is either.

Question 3

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

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

a. Transportation. They use The Ride a lot. It is great that Uber and Lyft are connected with The Ride because you don't have to schedule days out. It si an inexpensive option for transportation. Norwood has trains, buses, The Ride, Lyft, and Uber. You can go out of

town. There are lots of resources, but knowing about them, the discounts, and scheduling is tough.

b. As a driver, I fear losing the ability to drive. I would need to learn how to navigate the transportation system if that happens. I would need to ask friends for help. It is tough to ask for help.
c. Not having the hospital up and running is an issue, especially for seniors. They might not want to go to a hospital they aren't familiar with.
d. There are a lot of urgent cares in the area. I usually go to BID Needham, but if it's an emergency call, they have to go to Boston. If they have to be lifeflighted to Boston, they need a medical flight (gone now that Norwood Hospital is closed).
e. If you don't know about resources, you can't access them

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

a. People who are disabled and seniors
b. People who don't have access to computer or technology

Question 4

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

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?

a. Norwood has a great senior center; socialization, transportation, food. It is good to have something like this in the neighborhood.
b. The VA has a Hospital to Home program(eight nurses that are on call; their apartment is the home base). Got a participant a new mattress, and is getting them a new walker. Hospital to Home is going to be expanded to other hospitals outside of the VA. There is a social worker involved in this program as well.
    i. Through the VA (different program than Hospital to Home), someone comes in and cleans
c. Visiting nurses come twice a week to help set up meds for the week.
d. HESCO Options Program (elder services program) in Massachusetts
e. Civic center in Norwood
f. Commission for the Blind
g. The city is supposed to be getting more audible signals
h. Norwood Library brings books to a participant
i. Perkins Library; if you have any reading disability (dyslexia, dementia, vision impairment), they will send you books, send you a machine and teach you how to use it. Bard and Bookshare (online)
j. Food pantry

k. New Life Furniture - donates to folks who need furniture
l. Several churches in towns have resources for their congregants, but there has been crossover
m. Women's Commission
n. St. Vincent de Paul
o. Family Services
p. Riverside Mental Health
q. Jazz band at the library on Sunday afternoons; there is lots of activity when the weather is warm

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?

a. Losing the hospital had a big impact on available resources. Norwood Hospital was the center of the town. Along with the hospital being lost, all the satellite places they use for special services are closing. They lost doctors because doctors who were in the Steward system left, and now they may be at practices that don't accept their insurance.
b. Walking club
c. There are not a lot of resources for kids. The bowling alley in town just closed and there are no movie theaters. If it's not a school activity, what do kids do in Norwood? The Civic Center has a lot of programs for younger kids, but not as much for tween and teens

Question 5

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

- Additional calls or check-ins at night. You can get out during the day, but not at night or during the winter months. Check-in to make sure people are okay.
- A local hospital or healthcare facility
- Primary Care Physicians are a need

Community Listening Sessions

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

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

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

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

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

Goals:

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

BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

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

Participants will be asked to:

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

ROLE OF COMMUNITY FACILITATOR

Establish ground rules

Initiate and guide discussion

Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

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

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

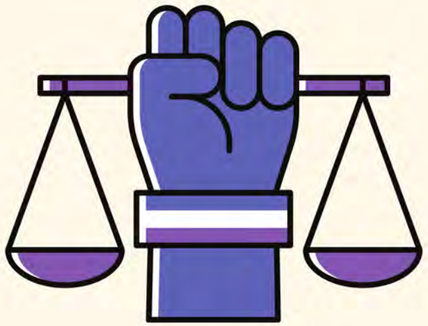
Will include a list of Community Facilitator/Notetaker pairings and contact info for all event staff

LET'S REVIEW.

REMEMBER: YOU HAVE SUPPORT.

CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic

Patient

Enthusiastic

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Consider accessibility

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

THANK YOU!

Feel free to send in any questions to Madison

madison_maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

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

Ground rules and introductions (5 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Area 2: Access to Care (12 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wrap up (1 minute)

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

Beth Israel Deaconess Hospital-Needham Community Listening Session

February 25, 2025 | 9:00-10:30am

Beth Israel Lahey Health

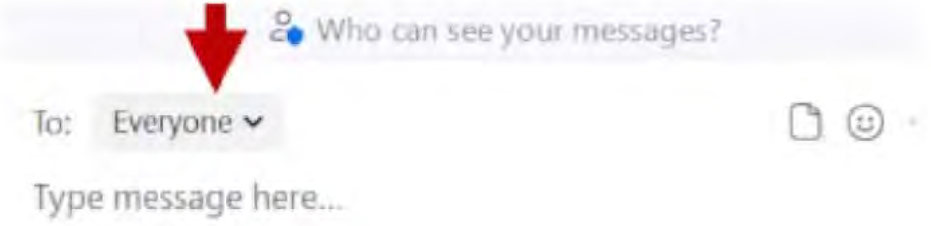
BID Needham Community Listening Session

Meeting Guidelines

- Please remain on **mute** until we move to Breakout Sessions

- Start your **video** if possible

- **Tech Support** is available – chat with “Tech Support” in Chat



BID Needham Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health

Beth Israel Deaconess Needham

BID Needham Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
9:00-9:05	Zoom orientation and Welcome	JSI
9:05-9:10	Overview of assessment purpose, process, and guiding principles	Jill Carter, Community Benefits & Community Relations Manager, BID Needham
9:10-9:25	Presentation of preliminary themes and data findings	JSI
9:25-9:30	Transition to Breakout Groups	JSI
9:30-10:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
10:25-10:30	Wrap up and Next Steps	Jill Carter

Assessment Purpose and Process

Assessment Purpose and Process

Purpose

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

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

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

Beth Israel Lahey Health
Beth Israel Deaconess Needham

Community Benefits Service Area

H Beth Israel Deaconess Hospital-Needham
1 Beth Israel Deaconess Hospital - Needham, Physical and Occupational Therapy

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

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

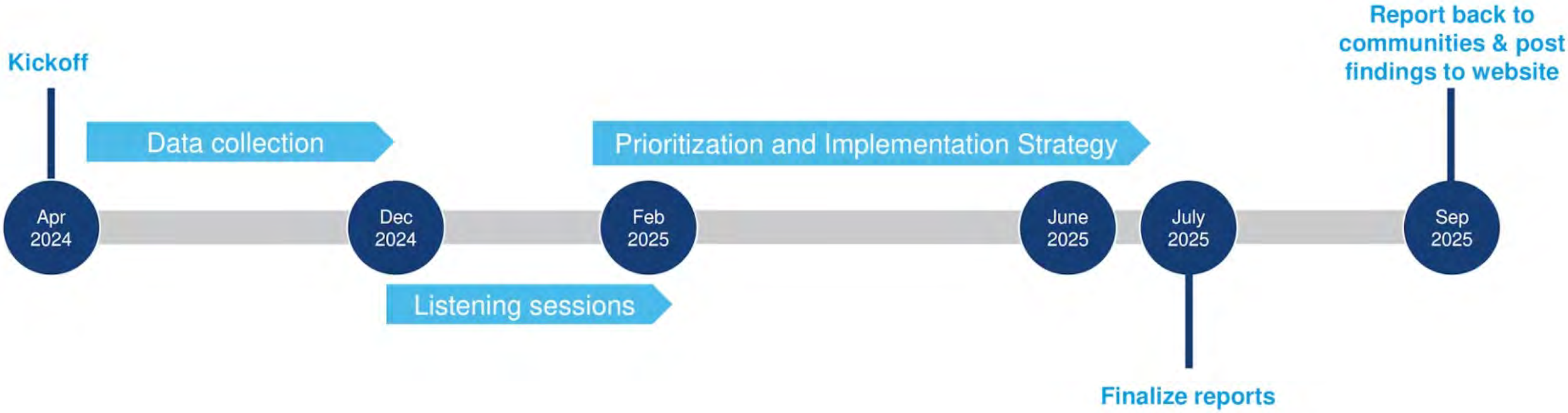
Community Engagement: Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

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

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

Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process

Meeting goals

Goals:

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

FY25 CHNA Progress
Activities to date

Collection of secondary data, e.g.:

- US Census Bureau
- Center for Health Information and Analytics (CHIA)
- County Health Rankings
- Behavioral Risk Factor Surveillance Survey
- Youth Risk Behavior Surveys
- CDC and National Vital Statistics
- Other local sources of data

15 Interviews

580 FY25 BID Needham Community Health Survey Respondents

5 Focus Groups

- Individuals with disabilities *(Westwood Disabilities Council)*
- Teens (*Dedham, Needham, and Westwood Youth & Family Services)*
- ESOL Learners (*Needham Community Council*)
- Families in public housing (*Norwood Housing Authority*)
- Individuals in public housing *(Norwood Housing Authority)*

FY25 CHNA Progress

FY25 BID Needham Community Health Survey Responses

580 responses

(Represents a 19% increase from 488 responses in FY22)

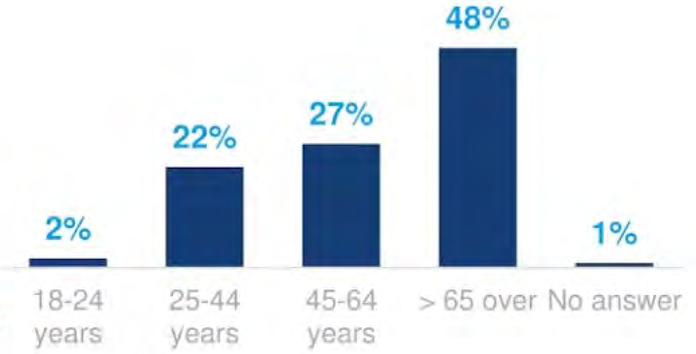
7% of respondents report a language other than English as the primary language spoken in their home **(up from 5% in FY22)**

78% of the respondents are women **(down from 86% in FY22)**

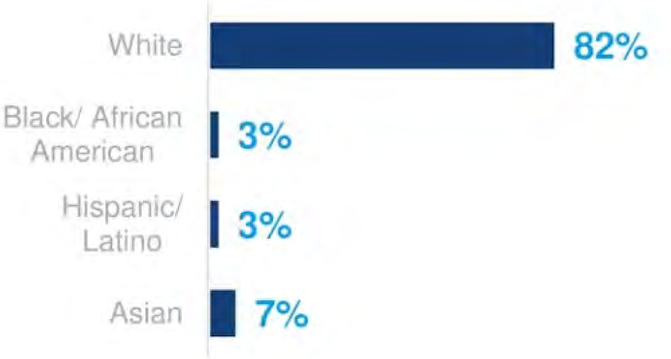
17% of the respondents identify as living with a disability **(up from 11% in FY22)**

8% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(up from 5% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 18 in FY25 compared to only 5 in FY22
- **Hispanic respondents:** 3% in FY25 compared to 4% in FY22
- **Asian respondents:** 7% in FY25 compared to 4% in FY22
- **Black/African American respondents:** 3% in FY25 compared to 2% in FY22

FY25 CHNA Progress

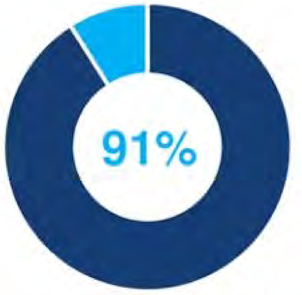
Community Benefits Service Area Strengths

FROM INTERVIEWS & FOCUS GROUPS:

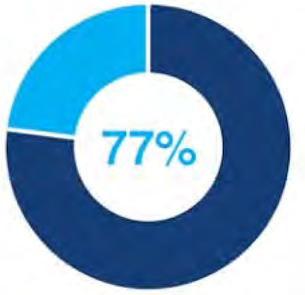
- Strong partnerships between community organizations have been sustained over time, and have only become stronger since COVID
- Greater network of resources for historically underserved populations and more recognition of diverse populations and needs
- Local school systems are strong and are a critical resource for youth and families

FROM FY25 BID NEEDHAM COMMUNITY HEALTH SURVEY:

said they **feel like they belong** in their community
(compared to 90% in FY22)



said they are **satisfied with quality of life in their community**
(compared to 92% in FY22)



said the community **Is a good place to grow old**
(compared to 70% in FY22)

FY25 CHNA Progress

Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

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

FY25 CHNA Progress

Preliminary Themes: Social Determinants of Health

Primary concerns:

- Housing issues (affordability, displacement, homelessness)
- Transportation
- Access to affordable healthy food
- Economic insecurity and high cost of living
- Language and cultural barriers to services

"There is not enough housing – period – but there is certainly not enough truly affordable housing. Our communities are trying to hold on to as much local control as possible, but these are bedroom communities of Boston. People can't afford to live here anymore."

– Interviewee

When asked what they'd like to improve in their community, **52%** of FY25 Community Health Survey respondents reported **more affordable housing** (#1 response) **(compared to 57% in FY22)**

When asked what they'd like to improve in their community, **34%** of FY25 Community Health Survey respondents reported **better access to public transportation (also 34% in FY22)**

15% of FY25 Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

FY25 CHNA Progress

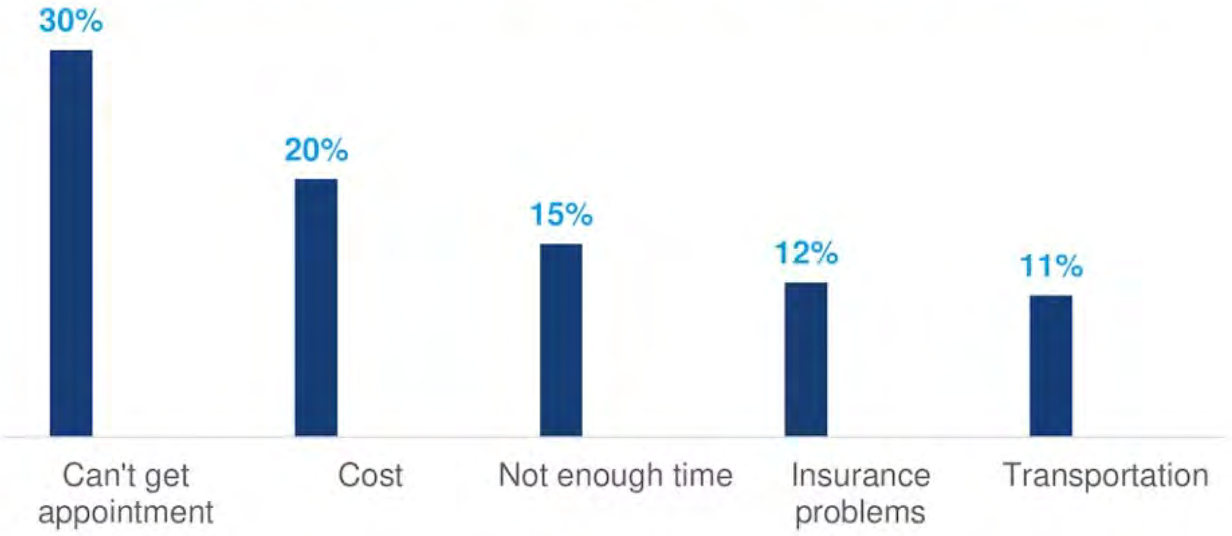
Preliminary Themes: Equitable Access to Care

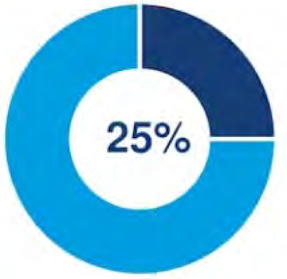
Primary concerns:

- Long wait times for primary care and behavioral health care (acknowledging that workforce was identified as an issue among providers)
- Health insurance and cost barriers
- Language and cultural barriers to care
- Navigating a complex health care system

"I'm unable to get a PCP in my area. [There are] no PCP offices accepting new patients. I must drive 30+ minutes to see a mid-level provider, not even my selected PCP. When I call for an appointment, I am directed to seek an appointment at an urgent care because the PCP is not available for a few months."
*- **Survey respondent***

What barriers keep you from getting needed health care?
(Top 5 responses from FY25 BID Needham Community Health Survey)





25% of FY25 BID Needham Community Health Survey respondents reported that health care in their community does not meet people's physical health needs

FY25 CHNA Progress

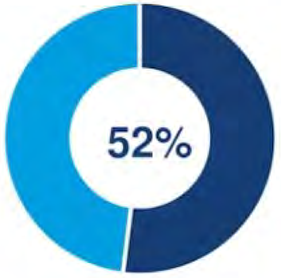
Preliminary Themes: Mental Health and Substance Use

Primary Concerns:

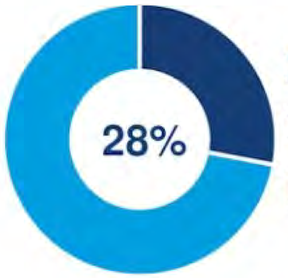
- Youth mental health
- Depression, anxiety, and stress
- Social isolation and mental health issues among older adults
- Substance use (alcohol, marijuana)
- Youth substance use (alcohol, vaping)
- Need for more prevention and education

"Stigma [related to mental health] has gone way down. People are now vocal about mental health and their needs in ways we haven't seen before. This is a really positive change, but we still don't have the resources to meet the need."
-Interviewee

AMONG FY25 BID NEEDHAM COMMUNITY HEALTH SURVEY RESPONDENTS:



52% identified mental health as a heath issue that matters most in their community (#2 response)



28% reported that mental health care in the community does not meet people's needs

FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

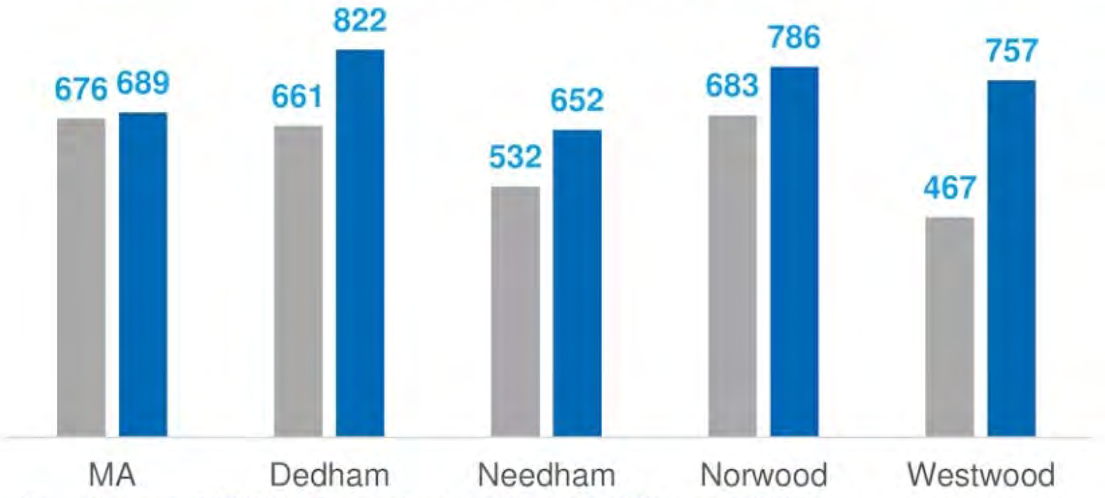
Primary Concerns:

- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Cardiovascular disease
- Healthy eating/active living programs
- Cancer
- Diabetes
- Caregiver support

AMONG FY25 BID NEEDHAM COMMUNITY HEALTH SURVEY RESPONDENTS:

61% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community (#1 response)

Age-adjusted All-Cause Mortality Rate, 2019 vs. 2021 (rates per 100,000)



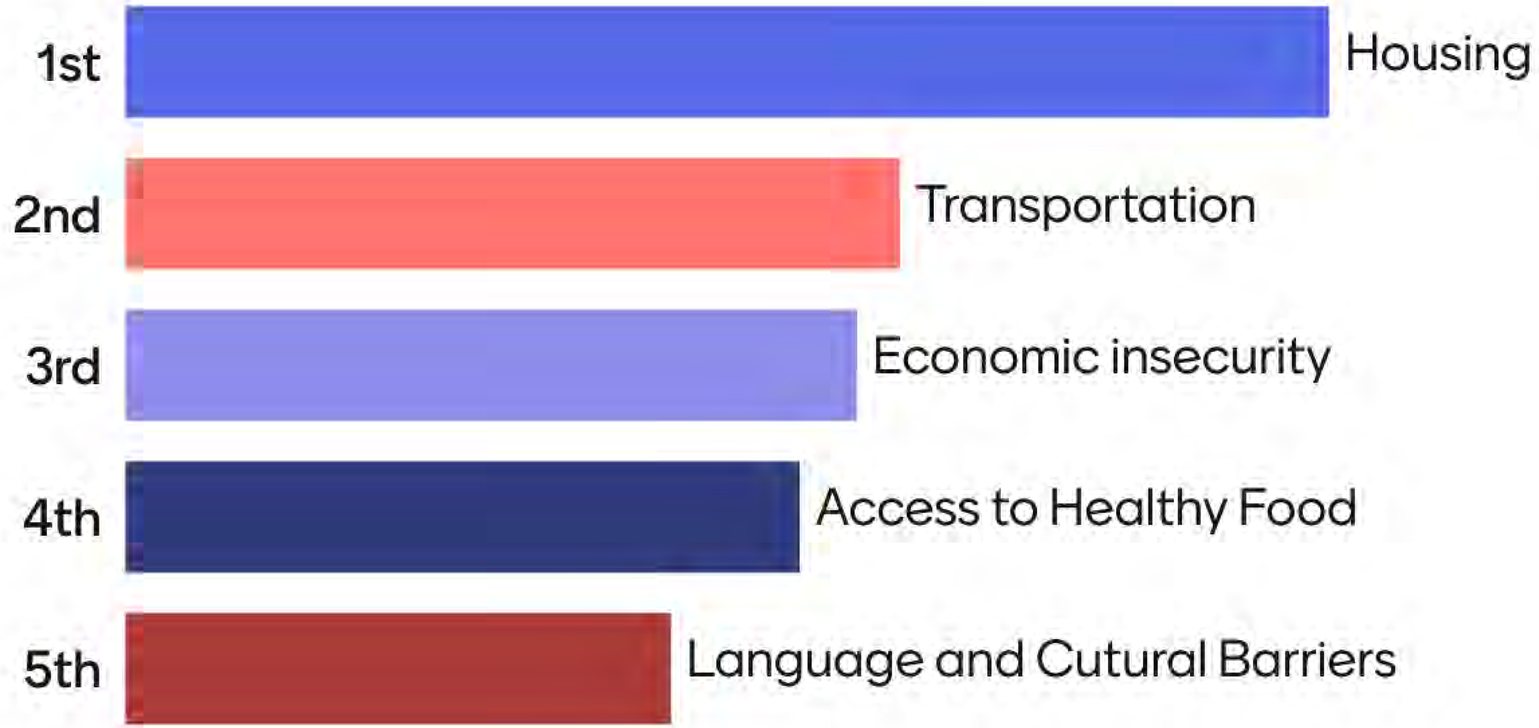
Data Source: MDPH, Massachusetts Deaths, 2019 and 2021

"I have concerns about nutrition. The life expectancy of Americans is decreasing, and I think the main issue is nutrition. It's not a major concern for me or my husband since we know how to pick foods, but it's a concern for my kids."

-Focus group participant

Instructions

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



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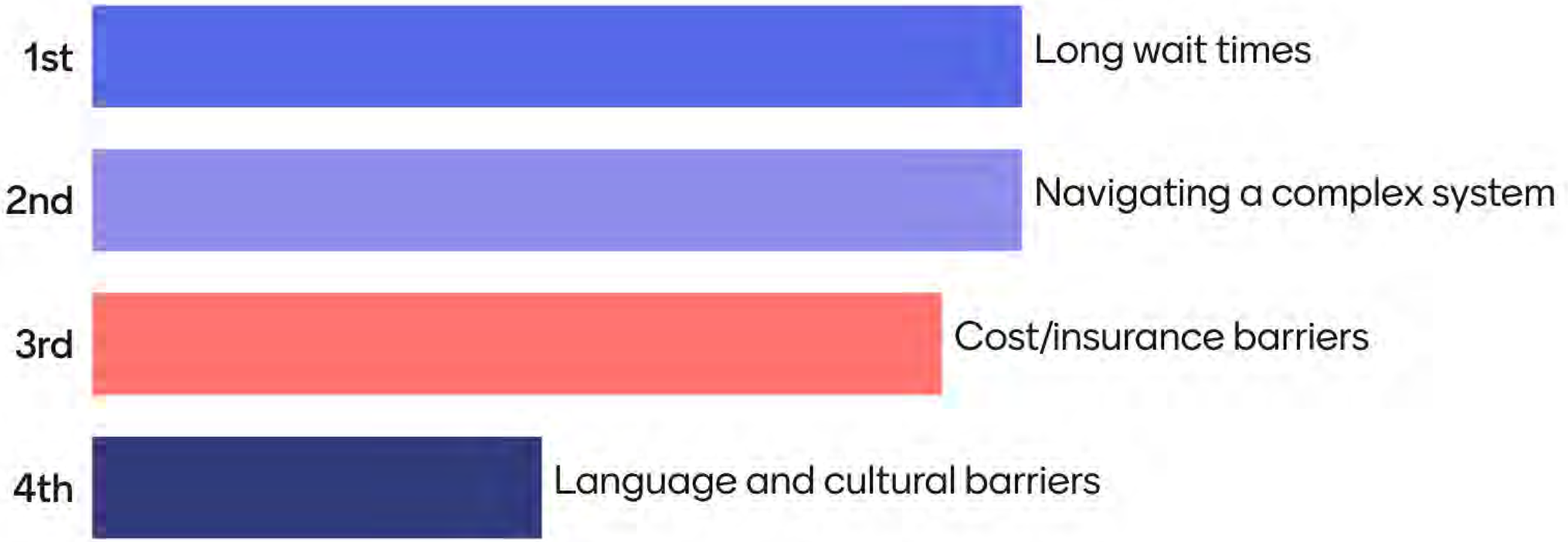
Access to Care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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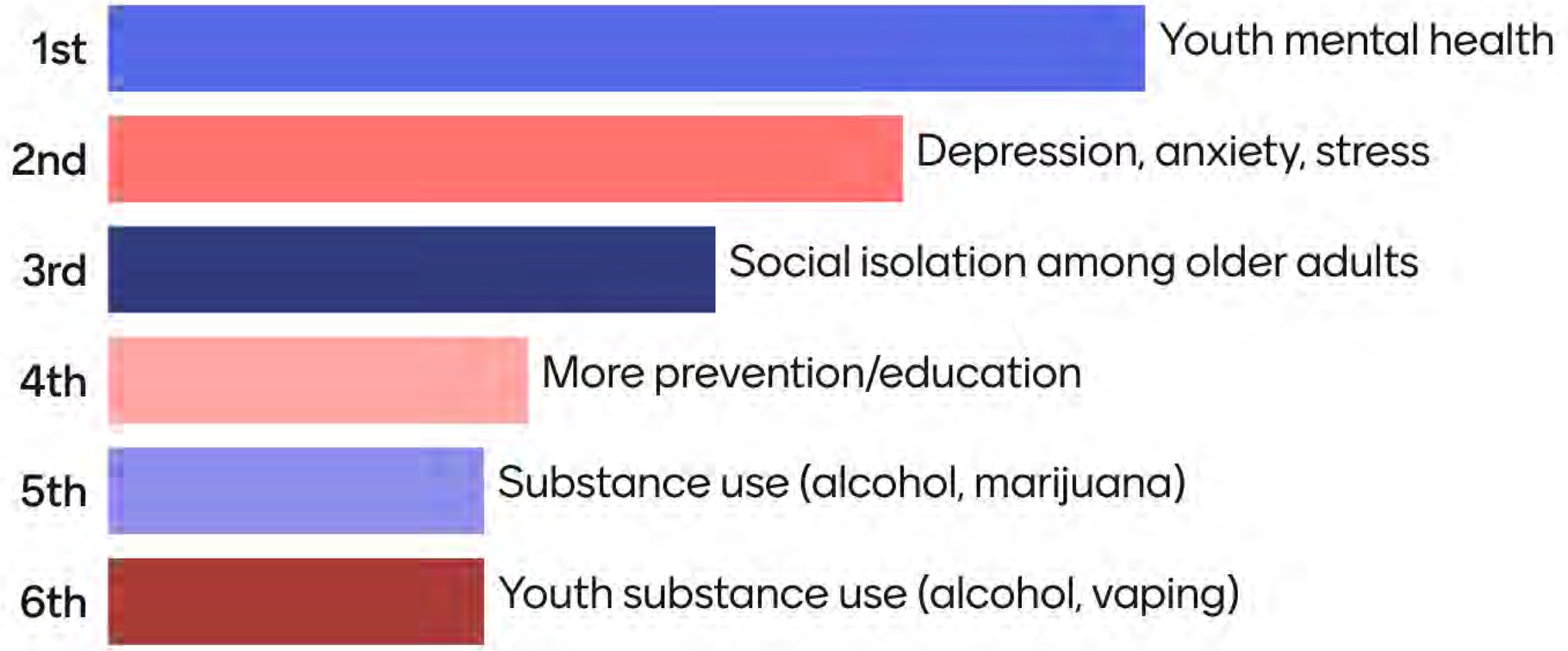
Mental Health and Substance Use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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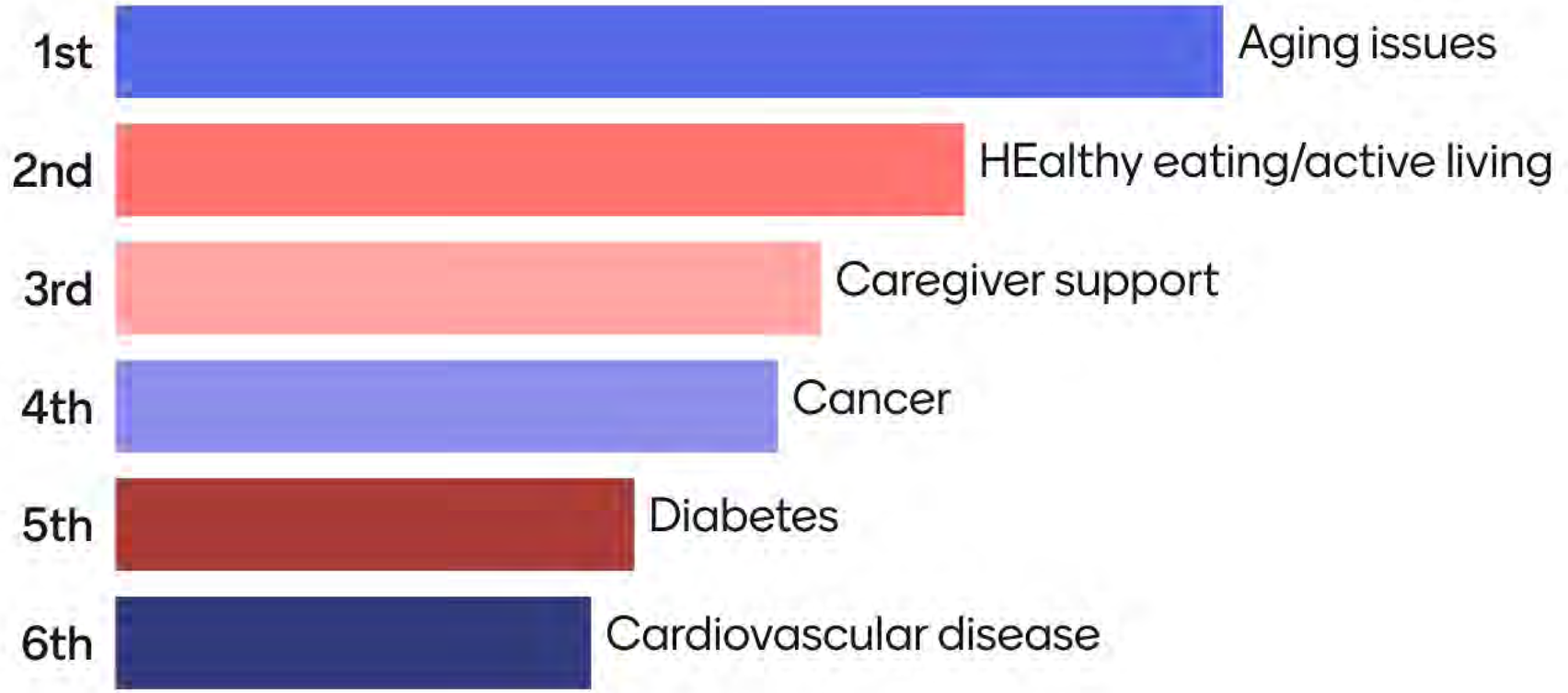
Chronic/Complex Conditions: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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Breakout Sessions

Reconvene

Wrap-up
BID Needham Hospital Community Benefits

Jill Carter
Manager, Community Benefits & Community Relations
Beth Israel Deaconess Needham
jcarte11@bidneedham.org

Community Health & Community Benefits Information on website:
https://bidneedham.org/about/community-benefits-needs

Community Benefits Annual Meeting in September (date TBD)

Thank you!

Appendix B:
Data Book

Secondary Data

Demographics

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Demographics							
Population							US Census Bureau, American Community Survey 2019-2023
Total population	6992395	724540	25109	32059	31380	16213	
Male	48.9%	48.5%	48.1%	48.0%	48.8%	47.6%	
Female	51.1%	51.5%	51.9%	52.0%	51.2%	52.4%	
Age Distribution							US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.2%	5.1%	4.7%	6.1%	5.1%	
5 to 9 years	5.2%	5.5%	5.0%	8.9%	4.9%	8.4%	
10 to 14 years	5.7%	6.1%	5.3%	9.2%	5.3%	7.8%	
15 to 19 years	6.5%	6.4%	4.6%	7.6%	5.0%	7.4%	
20 to 24 years	6.8%	6.1%	6.6%	4.0%	5.2%	5.4%	
25 to 34 years	14.1%	12.9%	11.9%	4.8%	16.8%	8.5%	
35 to 44 years	12.9%	13.2%	13.4%	14.3%	13.3%	10.0%	
45 to 54 years	12.6%	13.3%	13.6%	15.5%	12.4%	15.0%	
55 to 59 years	7.0%	7.3%	6.8%	7.5%	6.2%	8.4%	
60 to 64 years	6.8%	6.7%	7.5%	6.0%	6.3%	5.6%	
65 to 74 years	10.3%	10.0%	10.6%	9.3%	9.5%	7.5%	
75 to 84 years	4.9%	4.9%	5.4%	4.5%	5.7%	6.5%	
85 years and over	2.2%	2.4%	4.3%	3.7%	3.6%	4.4%	
Under 18 years of age	19.6%	20.7%	18.7%	28.1%	19.3%	26.5%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Over 65 years of age	17.5%	17.4%	20.3%	17.5%	18.7%	18.3%	
Race/Ethnicity							US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.7%	71.4%	82.4%	81.7%	73.0%	78.8%	
Black or African American alone (%)	7.0%	7.2%	5.1%	1.5%	7.0%	1.6%	
American Indian and Alaska Native (%) alone	0.2%	0.1%	0.0%	0.1%	0.0%	0.0%	
Asian alone (%)	7.1%	12.1%	3.1%	10.5%	6.8%	10.0%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.1%	0.2%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	2.3%	2.4%	0.3%	5.6%	2.3%	
Two or More Races (%)	9.5%	6.8%	6.8%	5.7%	7.5%	7.2%	
Hispanic or Latino of Any Race (%)	12.9%	5.5%	7.5%	3.7%	9.1%	5.3%	
Foreign-born							US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	138,392	3,315	5,349	6,768	1,907	
Naturalized U.S. citizen	54.5%	60.1%	61.5%	71.8%	46.0%	74.0%	
Not a U.S. citizen	45.5%	39.9%	38.5%	28.2%	54.0%	26.0%	
Region of birth: Europe	18.1%	20.0%	40.9%	38.2%	21.3%	27.8%	
Region of birth: Asia	30.5%	47.6%	21.3%	42.3%	30.7%	56.2%	
Region of birth: Africa	9.5%	7.3%	5.2%	6.1%	6.7%	2.6%	
Region of birth: Oceania	0.3%	0.3%	0.3%	0.6%	0.2%	0.3%	
Region of birth: Latin America	39.4%	22.8%	29.4%	11.3%	40.4%	12.0%	
Region of birth: Northern America	2.2%	2.0%	3.0%	1.6%	0.8%	1.2%	

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			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Language							US Census Bureau, American Community Survey 2019-2023
English only	75.2%	77.0%	83.7%	79.9%	73.3%	84.0%	
Language other than English	24.8%	23.0%	16.3%	20.1%	26.7%	16.0%	
Speak English less than "very well"	9.7%	8.4%	6.2%	4.6%	12.3%	3.4%	
Spanish	9.6%	3.5%	5.4%	2.8%	7.3%	2.8%	
Speak English less than "very well"	4.1%	0.9%	2.1%	0.4%	3.1%	1.0%	
Other Indo-European languages	9.2%	9.0%	7.3%	9.4%	13.9%	6.6%	
Speak English less than "very well"	3.2%	2.8%	3.1%	1.9%	7.5%	0.9%	
Asian and Pacific Islander languages	4.4%	8.6%	2.0%	5.1%	3.7%	5.5%	
Speak English less than "very well"	1.9%	4.3%	0.7%	1.7%	1.4%	1.5%	
Other languages	1.6%	1.9%	1.6%	2.9%	1.7%	1.1%	
Speak English less than "very well"	0.4%	0.4%	0.4%	0.6%	0.3%	0.1%	
Employment							US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	4.9%	3.6%	4.5%	3.5%	1.8%	
Unemployment rate by race/ethnicity							
White alone	4.5%	4.6%	3.8%	4.4%	4.3%	2.1%	
Black or African American alone	7.9%	8.0%	0.9%	13.4%	4.2%	0.0%	
American Indian and Alaska Native alone	6.9%	16.0%	-	0.0%	0.0%	-	

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			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Asian alone	4.0%	4.1%	4.9%	3.6%	0.5%	0.8%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	-	-	-	-	
Some other race alone	8.0%	6.1%	5.6%	0.0%	1.2%	0.0%	
Two or more races	7.9%	6.2%	1.1%	6.2%	0.4%	0.0%	
Hispanic or Latino origin (of any race)	8.1%	5.5%	0.0%	5.7%	1.6%	0.0%	
Unemployment rate by educational attainment							
Less than high school graduate	9.1%	7.5%	1.1%	0.0%	4.3%	0.0%	
High school graduate (includes equivalency)	6.4%	7.1%	1.9%	0.5%	3.8%	4.2%	
Some college or associate's degree	5.2%	5.1%	1.7%	5.6%	4.3%	1.0%	
Bachelor's degree or higher	2.7%	2.6%	2.4%	3.8%	1.9%	0.7%	
Income and Poverty							US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	126,497	124,375	212,241	97,110	205,000	
Population living below the federal poverty line in the last 12 months							
Individuals	10.0%	6.6%	4.6%	3.8%	8.2%	5.0%	
Families	6.6%	4.7%	3.7%	1.8%	3.0%	3.9%	
Individuals under 18 years of age	11.8%	5.8%	3.2%	2.5%	11.5%	2.1%	
Individuals over 65 years of age	10.2%	8.7%	9.5%	6.4%	8.8%	6.2%	
Female head of household, no spouse	19.1%	14.9%	9.0%	11.1%	23.0%	6.4%	
White alone	7.6%	5.6%	4.3%	3.1%	5.8%	5.5%	

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			Areas of Interest				
	Massachusetts	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Black or African American alone	17.1%	11.7%	9.6%	1.8%	11.9%	7.9%	
American Indian and Alaska Native alone	19.1%	11.1%	-	0.0%	0.0%	-	
Asian alone	11.0%	8.1%	7.3%	4.8%	6.3%	4.1%	
Native Hawaiian and Other Pacific Islander alone	21.7%	40.9%	0.0%	57.7%	-	-	
Some other race alone	20.1%	12.3%	1.9%	0.0%	8.7%	0.0%	
Two or more races	15.7%	7.4%	3.7%	10.1%	29.2%	1.4%	
Hispanic or Latino origin (of any race)	20.6%	9.4%	3.7%	7.0%	15.8%	7.9%	
Less than high school graduate	24.4%	19.5%	15.6%	8.2%	15.6%	11.8%	
High school graduate (includes equivalency)	12.7%	10.4%	8.4%	6.9%	11.9%	13.1%	
Some college, associate's degree	9.2%	8.2%	6.0%	5.3%	7.9%	4.4%	
Bachelor's degree or higher	4.0%	3.2%	2.7%	3.0%	3.2%	1.7%	
With Social Security	29.8%	28.6%	33.6%	26.6%	29.9%	32.6%	
With retirement income	22.9%	22.7%	24.9%	22.1%	23.7%	24.0%	
With Supplemental Security Income	5.6%	3.8%	2.7%	3.1%	4.5%	4.8%	
With cash public assistance income	3.5%	2.5%	3.6%	2.2%	2.0%	1.5%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.7%	7.4%	3.0%	9.1%	1.7%	
Housing							US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	95.9%	96.7%	97.0%	95.3%	96.0%	
Owner-occupied	62.6%	68.5%	72.7%	84.3%	51.8%	87.2%	
Renter-occupied	37.4%	31.5%	27.3%	15.7%	48.2%	12.8%	

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			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Lacking complete plumbing facilities	0.3%	0.3%	0.1%	0.8%	0.5%	0.0%	
Lacking complete kitchen facilities	0.8%	0.7%	1.1%	1.0%	0.9%	0.6%	
No telephone service available	0.8%	0.5%	0.2%	1.1%	1.7%	0.1%	
Monthly housing costs <35% of total household income							
Among owner-occupied units with a mortgage	22.7%	21.6%	21.5%	21.5%	22.5%	23.6%	
Among owner-occupied units without a mortgage	15.4%	16.9%	27.9%	11.1%	12.8%	16.6%	
Among occupied units paying rent	41.3%	40.7%	43.4%	52.5%	42.6%	52.7%	
Access to Technology							US Census Bureau, American Community Survey 2019-2023
Among households							
Has smartphone	89.2%	90.7%	85.3%	91.6%	88.6%	89.6%	
Has desktop or laptop	83.2%	87.7%	85.4%	90.4%	86.6%	93.7%	
With a computer	95.1%	96.5%	94.7%	97.3%	96.1%	98.4%	
With a broadband Internet subscription	91.8%	94.2%	91.0%	94.8%	94.3%	94.9%	
Transportation							US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	59.0%	65.2%	57.5%	63.3%	60.6%	
Car, truck, or van -- carpooled	6.9%	5.6%	6.9%	3.8%	9.2%	9.8%	
Public transportation (excluding taxicab)	7.0%	9.5%	5.4%	7.6%	9.6%	5.8%	
Walked	4.2%	3.2%	2.6%	1.9%	1.6%	0.1%	

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			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Other means	2.5%	2.1%	1.2%	0.3%	1.8%	0.3%	
Worked from home	16.7%	20.6%	18.6%	28.8%	14.6%	23.4%	
Mean travel time to work (minutes)	29.3	32.9	30.2	28.6	31.2	30.2	
Vehicles available among occupied housing units							
No vehicles available	11.8%	8.9%	7.9%	6.7%	6.6%	4.1%	
1 vehicle available	35.8%	35.4%	36.0%	23.1%	42.9%	23.5%	
2 vehicles available	35.8%	39.1%	40.2%	54.5%	36.1%	46.4%	
3 or more vehicles available	16.6%	16.6%	16.0%	15.7%	14.4%	26.0%	
Education							US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older							
Less than 9th grade	4.2%	3.0%	1.5%	1.1%	4.0%	2.4%	
9th to 12th grade, no diploma	4.4%	2.7%	4.4%	1.5%	2.8%	2.0%	
High school graduate (includes equivalency)	22.8%	17.4%	20.4%	7.0%	19.7%	9.4%	
Some college, no degree	14.4%	12.4%	12.3%	6.5%	13.5%	9.2%	
Associate's degree	7.5%	7.0%	6.3%	3.0%	6.9%	5.9%	
Bachelor's degree	25.3%	30.0%	29.2%	29.7%	30.8%	35.5%	
Graduate or professional degree	21.4%	27.7%	25.9%	51.2%	22.3%	35.5%	
High school graduate or higher	91.4%	94.4%	94.1%	97.3%	93.2%	95.5%	
Bachelor's degree or higher	46.6%	57.6%	55.1%	80.8%	53.1%	71.0%	
Educational attainment by race/ethnicity							
White alone	(X)	(X)	(X)	(X)	(X)	(X)	

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			Areas of Interest				
	Massachusetts	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
High school graduate or higher	94.6%	97.0%	95.6%	98.2%	95.3%	96.8%	
Bachelor's degree or higher	49.4%	59.3%	56.3%	81.2%	52.2%	69.5%	
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	87.1%	90.0%	86.2%	78.5%	91.1%	100.0%	
Bachelor's degree or higher	30.7%	39.4%	39.9%	43.3%	41.1%	33.5%	
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	75.2%	78.6%	-	100.0%	78.6%	-	
Bachelor's degree or higher	24.4%	41.8%	-	0.0%	78.6%	-	
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	84.2%	92.6%	93.8%	96.5%	94.9%	
Bachelor's degree or higher	64.0%	61.0%	71.3%	84.0%	88.8%	85.1%	
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	65.9%	-	100.0%	-	-	
Bachelor's degree or higher	40.0%	44.5%	-	100.0%	-	-	
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	71.6%	81.9%	91.4%	100.0%	72.7%	74.1%	
Bachelor's degree or higher	20.0%	40.3%	58.1%	100.0%	46.6%	74.1%	
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	80.6%	92.3%	80.6%	97.3%	80.2%	83.2%	
Bachelor's degree or higher	33.6%	57.3%	39.3%	82.2%	42.7%	83.2%	
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	73.4%	90.0%	84.4%	96.8%	77.7%	65.7%	
Bachelor's degree or higher	23.3%	53.2%	46.9%	88.0%	34.1%	62.1%	

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			Areas of Interest				
	Massachusetts	**Norfolk County**	**Dedham**	**Needham**	**Norwood**	**Westwood**	**Source**
Health insurance coverage among civilian noninstitutionalized population (%)							US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	98.1%	98.3%	98.8%	97.9%	99.3%	
With private health insurance	73.8%	82.0%	84.7%	91.1%	75.4%	93.0%	
With public coverage	37.1%	29.1%	29.5%	19.5%	36.5%	21.1%	
No health insurance coverage	2.6%	1.9%	1.7%	1.2%	2.1%	0.7%	
Disability							US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	9.7%	11.6%	7.0%	10.7%	9.0%	
Under 18 with a disability	4.9%	3.6%	5.8%	1.8%	3.7%	0.9%	
18-64	9.4%	6.9%	8.3%	3.2%	8.5%	5.5%	
65+	30.2%	27.3%	27.7%	27.8%	26.3%	32.1%	

Health Status

			Areas of Interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Access to Care							
Ratio of population to primary care physicians	103.5	125.7	125.7	125.7	125.7	125.7	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.1	144.9	145.2	145.0	145.2	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	16.4	7.9	12.5	66.4	0.0	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health							
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	14.7	13.1	13.1	11.2	13.8	11.2	Behavioral Risk Factor Surveillance System, 2021
Mortality rate (crude rate per 100,000)	900.2	871.1					CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	233.2					Massachusetts Death Report, 2021
Risk Factors							
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	2.2	0.0	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.1	7.1	4.2	12.7	4.6	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	35.7	30.3	21.8	2.9	63.1	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	28.5	24.2	28.5	no data	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	23.9	21.6	24.9	no data	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	30.8	30.5	31.2	no data	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	17.6	13.1	18	no data	BRFSS, 2022
Chronic Conditions							
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	11.3	10.3	11.5	no data	BRFSS, 2022

			Areas of Interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	7.6	6.2	7.9	no data	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	5	3.4	5	no data	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	5.3	4.4	5.3	no data	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	2.4	1.9	2.5	no data	BRFSS, 2022
Cancer							
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	85.2	86.7	85.4	no data	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	64.8	68.1	64.6	no data	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)							
All sites	449.4	462.7	463.0	463.6	463.0	464.9	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	56.3	57.8	55.3	56.1	56.9	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	117.7	115.7	117.2	115.2	120.3	State Cancer Profiles, 2016-2020
Prevention and Screening							
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	78.2	78.8	78.6	no data	Behavioral Risk Factor Surveillance System, 2022
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	89.3	90.2	88.6	no data	Behavioral Risk Factor Surveillance System, 2021
Communicable and Infectious Disease							
STI infection cases (per 100,000)							
Chlamydia	385.8	358.2	264.0	264.0	264.0	264.0	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	6.9	6.9	6.9	6.9	6.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021

			Areas of Interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Gonorrhea	214.0	64.0	64.0	64.0	64.0	64.0	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	234.1	234.1	234.1	234.1	234.1	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	1.7	1.7	1.7	1.7	1.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19							
Percent of Adults Fully Vaccinated	78.1	87.8	85.8	85.8	85.8	85.8	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	3.8	3.8	3.8	3.8	3.8	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use							
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	10.6	7	10.6	no data	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	Data unavailable	22.1	22.4	21	no data	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	26.0	26.0	26.0	26.0	26.0	CDC- National Vital Statistics System, 2016-2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	38.5					
Female Drug Overdose Mortality Rate (per 100,000)	17.6	14.2					
Substance-related deaths (Age-adjusted rate per 100k)							
Any substance	61.9	40.3	54.9	23.4	50.6	0.0	
Opioid-related deaths	33.7	21.8	38.3	*	18.5	0.0	
Alcohol-related deaths	29.1	18.6	30.1	*	25.9	0.0	
Stimulant-related deaths	23.0	13.6	24.4	0.0	*	0.0	
Substance-related ER visits (age-adjusted rate per 100K)							

			Areas of Interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Any substance-related ER visits	1605.7	1182.2	1231.6	754.1	1266.8	544.8	
Opioid-related ER visits	169.3	89.8	82.9	32.0	122.8	*	
Opioid-related EMS Incidents	248.8	138.6	161.6	37.4	120.2	55.3	
Alcohol-related ER visits	1235.6	929.9	982.1	628.6	1004.0	390.1	
Stimulant-related ER visits	15.7	9.9	*	*	18.4	0.0	
Substance Addiction Services							
Individuals admitted to BSAS services (crude rate per 100k)	588.4	352.4	362.7	93.5	417.6	92.2	
Number of BSAS providers		88.0	1.0	3.0	9.0	0.0	
Number of clients of BSAS services (residents)		1540.0	53.0	16.0	63.0	*	
Avg. distance to BSAS provider (miles)	17.0	19.0	20.0	30.0	17.0	18.0	
Buprenorphine RX's filled	9982.0	7796.8	8196.7	1339.9	10423.6	2748.1	
Individuals who received buprenorphine RX's		668.1	666.3	121.5	860.5	252.1	
Naloxone kits received		16008.0	124.0	135.0	480.0	40.0	
Naloxone kids: Opioid deaths Ratio		55.0	12.0	*	97.0	-	
Fentanyl test strips received		21900.0	3800.0	300.0	1600.0	0.0	
Environmental Health							
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	55.9	100.0	44.5	33.1	34.2	Population in Neighborhoods Meeting Environmental Justice Health Criteria , Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead screening %	68.0		78.0	76.0	79.0	84.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021

			Areas of Interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Prevalence of Blood Lead Levels (per 1,000)	13.6		3.8	2.6	9.6	0.0	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0		75.0	67.0	72.0	65.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		18.6	8.4	24.6	12.8	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9		9.8	6.2	9.3	11.1	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	7.0	NS	NS	NS	0.0	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3					EPA - National Air Toxics Assessment, 2018
Mental Health							
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	41.2	41.2		41.2	41.2	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	22.3	20.8	22.3	no data	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	30.4	29	31.2	no data	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	20.2	18.3	21.7	no data	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	15.6	12.9	15.7	no data	Behavioral Risk Factor Surveillance System, 2022

			Areas of Interest				
	MA	Norfolk County	Dedham	Needham	Norwood	Westwood	Source
Adults Age 18+ with depression (crude %)	20.9	19.2	20.0	18.6	20.6	18.7	Behavioral Risk Factor Surveillance System, 2021
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.0	0.2	0.1	0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health							
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	6.9	6.9	6.9	6.9	County Health Rankings, 2016-2022
Safety/Crime							
Property Crimes Offenses (#)							Massachusetts Crime Statistics, 2023
Burglary	10028.0		4.0	21.0	18.0	11.0	
Larceny-theft	60647.0		156.0	142.0	247.0	131.0	
Motor vehicle theft	7224.0		8.0	7.0	23.0	7.0	
Arson	377.0		0.0	0.0	1.0	1.0	
Crimes Against Persons Offenses (#)							
Murder/non-negligent manslaughter	162.0		0.0	0.0	0.0	0.0	
Sex offenses	4365.0		5.0	17.0	7.0	3.0	
Assaults	72086.0		112.0	80.0	172.0	60.0	
Human trafficking	0.0		0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)							
Race/Ethnicity/Ancestry Bias	222.0		1.0		0.0		
Religious Bias	88.0		0.0		1.0		
Sexual Orientation Bias	80.0		0.0		0.0		
Gender Identity Bias	22.0		0.0		0.0		
Gender Bias	2.0		0.0		0.0		
Disability Bias	0.0		0.0		0.0		

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

Note 1: Sample sizes (N) and percentages are displayed below for each survey question. The percentages are weighted by statewide age, race and gender identity distributions. See data notes for more information.

Note 2: The CHES was not designed to be a representative survey of all MA residents and percentages displayed may not be representative of the state.

			MASSACHUSETTS		Norfolk		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	1908	1.30%	*	*	*	*
		Worried about losing	1908	2.60%	163	3.70%	*	*
Housing	Current living situation	Steady place	1908	95.10%	163	95.70%	109	96.30%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	155	15.50%	106	11.30%
		Never	1963	87.80%	164	93.90%	110	94.50%
		Sometimes	1963	9.90%	164	4.30%	*	*
Basic Needs	Food insecurity, past month	A lot	1963	2.30%	*	*	*	*
		No internet	1938	1.30%	*	*	*	*
		Does not work well	1938	6.60%	*	*	*	*
Basic Needs	Current internet access	Works well	1938	92.20%	164	98.20%	110	99.10%
		Somewhat or strongly disagree	1864	2.50%	*	*	*	*
		Somewhat agree	1864	14.60%	160	6.30%	*	*
Neighborhood	Able to get where you need to go	Strongly agree	1864	82.80%	160	93.10%	108	97.20%
		Never	1833	65.00%	159	79.20%	107	81.30%
		Rarely	1833	22.80%	159	16.40%	107	15.00%
		Somewhat often	1833	8.50%	159	3.80%	*	*
Neighborhood	Experienced neighborhood violence, lifetime	Very often	1833	3.70%	*	*	*	*
		No	1739	3.90%	*	*	*	*
		Yes, adult in home	1739	80.50%	152	86.80%	101	91.10%
Safety & Support	Have someone to talk to if needed help	Yes, adult outside home	1739	37.30%	152	35.50%	101	28.70%

			MASSACHUSETT S		Norfolk		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		Yes, friend or non-adult family	1739	43.00%	152	39.50%	101	34.70%
Safety & Support	Feel safe with my family/caregivers	Not at all	1768	1.00%	*	*	*	*
		Somewhat	1768	7.70%	155	4.50%	*	*
		Very much	1768	91.30%	155	94.80%	104	99.00%
Safety & Support	Feel I belong at school	Not at all	1760	5.90%	*	*	*	*
		Somewhat	1760	29.10%	155	21.90%	104	16.30%
		Very much	1760	65.00%	155	76.80%	104	83.70%
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	*	*	*	*
		Somewhat	1745	17.10%	153	12.40%	103	6.80%
		Very much	1745	80.50%	153	86.90%	103	93.20%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	155	63.20%	104	58.70%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	155	3.90%	*	*
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	155	20.00%	104	12.50%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	155	10.30%	104	8.70%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	155	5.80%	104	4.80%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	155	9.70%	104	9.60%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	155	68.40%	104	60.60%
Safety & Support	Experienced intimate partner violence	Ever	1589	13.10%	122	9.00%	*	*
		In past year	1567	7.80%	122	4.10%	*	*
Safety & Support	Experienced household violence	Ever	1536	14.20%	118	7.60%	72	8.30%
		In past year	1519	5.50%	118	4.20%	*	*
Safety & Support	Experienced sexual violence	Ever	1558	9.20%	121	6.60%	*	*
		In past year	1551	3.10%	*	*	*	*

			MASSACHUSETT S		Norfolk		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Experienced discrimination	Ever	1674	45.20%	152	35.50%	102	25.50%
		In past year	1674	19.60%	152	15.80%	102	7.80%
Employment	Worked for pay, past year	No	1652	51.50%	149	62.40%	99	68.70%
		Yes, <10 hours per week	1652	18.10%	149	22.80%	99	23.20%
		Yes, 11-19 hours per week	1652	13.30%	149	7.40%	*	*
		Yes, 20-34 hours per week	1652	10.30%	*	*	*	*
		Yes, >35 hours per week	1652	6.80%	149	4.70%	*	*
Education	Educational challenges, past year	None of these	1484	66.80%	142	77.50%	94	84.00%
		Frequent absences	1484	7.60%	*	*	*	*
		Needed more support in school	1484	7.00%	142	3.50%	*	*
		Needed more support outside school	1484	6.30%	*	*	*	*
		Safety concerns	1484	5.10%	*	*	*	*
		Temperature in classroom	1484	18.50%	142	18.30%	94	13.80%
Education	Hurt or harrassed by school staff, past year	Never	1503	87.70%	143	93.00%	94	94.70%
		Once or twice	1503	9.10%	143	6.30%	94	5.30%
		Monthly	1503	1.60%	*	*	*	*
		Daily	1503	1.60%	*	*	*	*
Education	Helpful school resources provided	College-preparation	1459	57.90%	142	64.10%	93	64.50%
		Extracurricular activities	1459	74.40%	142	83.10%	93	79.60%
		Guidance conselour	1459	58.80%	142	66.90%	93	63.40%
		Programs to reduce bullying, violence, etc.	1459	19.10%	142	19.00%	93	21.50%
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	*	*	*	*
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	*	*	*	*

			MASSACHUSETT S		Norfolk		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those needing care)	Yes	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those needing care)	Yes	62	7.90%	*	*	*	*
Healthcare Access	ANY unmet heath care need, past year (among those needing any care)	Yes	857	10.30%	67	7.50%	*	*
Mental Health	Psychological distress, past month	Low	1376	22.10%	101	22.80%	57	21.10%
		Medium	1376	33.00%	101	38.60%	57	40.40%
		High	1376	18.40%	101	21.80%	57	22.80%
		Very high	1376	26.60%	101	16.80%	57	15.80%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	136	6.60%	*	*
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%	104	13.50%	61	11.50%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	136	3.70%	*	*
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	134	8.20%	89	6.70%
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	134	5.20%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	134	7.50%	89	5.60%

			MASSACHUSETT S		Norfolk		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	*	*	*	*
		Not sure	1445	5.70%	128	5.50%	82	8.50%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%	70	21.40%	50	24.00%
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%	70	7.10%	50	10.00%
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%	70	22.90%	50	22.00%
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%	70	20.00%	50	20.00%
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%	70	21.40%	50	22.00%

			MASSACHUSETT S		Norfolk		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	Unable to work due to weather, past 5 years1	Yes	767	7.60%	*	*	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years1	Yes	767	33.30%	70	31.40%	50	26.00%
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%	70	48.60%	50	48.00%

Community Health Equity Survey (CHES) – Adult

			MASSACHUSETTS		NORFOLK		Dedham		Needham		Norwood	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	1313	1.10%	*	*	*	*	*	*
		Worried about losing	14888	8.00%	1313	6.60%	*	*	*	*	*	*
Housing	Current living situation	Steady place	14888	89.30%	1313	92.10%	34	94.10%	75	98.70%	81	95.10%
Housing	Issues in current housing2	Yes, at least one	11103	37.00%	1006	31.70%	*	*	55	30.90%	61	29.50%
Basic Needs	Trouble paying for childcare/school1	Yes	7486	4.60%	630	4.00%	*	*	*	*	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food)1	Yes	7486	18.80%	630	11.70%	*	*	*	*	*	*
Basic Needs	Trouble paying for health care1	Yes	7486	15.00%	630	10.30%	*	*	*	*	46	13.00%
Basic Needs	Trouble paying for housing1	Yes	7486	19.40%	630	11.10%	*	*	*	*	*	*
Basic Needs	Trouble paying for technology1	Yes	7486	8.40%	630	4.90%	*	*	*	*	*	*
Basic Needs	Trouble paying for transportation1	Yes	7486	12.60%	630	7.60%	*	*	*	*	*	*
Basic Needs	Trouble paying for utilities1	Yes	7486	17.20%	630	9.40%	*	*	*	*	*	*
Basic Needs	Trouble paying for ANY basic needs1	Yes	7486	35.20%	630	24.90%	*	*	*	*	46	19.60%
Basic Needs	Applied for/received economic assisstance	Yes	14928	20.30%	1317	13.40%	*	*	75	6.70%	81	13.60%
		Not enough money	13814	16.50%	1201	11.00%	33	15.20%	*	*	*	*
		Just enough money	13814	31.10%	1201	28.10%	33	18.20%	64	14.10%	72	31.90%
Basic Needs	End of month finances	Money left over	13814	52.40%	1201	60.90%	33	66.70%	64	81.30%	72	62.50%
		No internet	11425	3.00%	1030	0.90%	*	*	*	*	*	*
		Does not work well	11425	9.30%	1030	6.10%	*	*	*	*	*	*
Basic Needs	Current internet access2	Works well	11425	87.70%	1030	93.00%	*	*	57	100.00 %	63	95.20%
Neighborhood	Able to get where you need to go2	Somewhat or strongly disagree	11064	7.00%	968	4.90%	*	*	*	*	*	*

			MASSACHUSETTS		NORFOLK		Dedham		Needham		Norwood	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Somewhat agree	11064	22.00%	968	17.30%	*	*	51	19.60%	64	17.20%
		Strongly agree	11064	71.00%	968	77.90%	*	*	51	72.50%	64	78.10%
		Never	11008	58.60%	967	64.60%	*	*	51	70.60%	64	68.80%
		Rarely	11008	28.90%	967	28.70%	*	*	51	27.50%	64	20.30%
	Experienced neighborhood	Somewhat often	11008	9.10%	967	5.50%	*	*	*	*	64	10.90%
Neighborhood	violence, lifetime	Very often	11008	3.40%	967	1.10%	*	*	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	1285	84.10%	33	87.90%	72	83.30%	79	92.40%
		Not sure	14393	6.50%	1285	5.60%	*	*	72	8.30%	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	1281	75.40%	32	75.00%	71	76.10%	79	83.50%
		Not sure	14366	10.20%	1281	9.90%	*	*	71	12.70%	79	8.90%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	1281	73.00%	33	66.70%	71	80.30%	79	68.40%
		Not sure	14325	12.90%	1281	10.80%	33	15.20%	71	7.00%	79	15.20%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	1277	83.60%	33	78.80%	71	84.50%	79	86.10%
		Not sure	14336	7.00%	1277	6.10%	*	*	71	8.50%	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	1266	66.70%	33	69.70%	69	59.40%	78	73.10%
		Not sure	14247	16.30%	1266	16.40%	33	15.20%	69	24.60%	78	16.70%
Safety & Support	Experienced intimate partner violencea	Ever	13621	29.70%	1207	23.80%	33	30.30%	70	18.60%	75	18.70%
		In past year	13359	4.50%	1195	3.20%	*	*	*	*	*	*
Safety & Support	Experienced sexual violenceb	Ever	13628	21.00%	1211	18.10%	33	24.20%	66	12.10%	76	19.70%
		In past year	13593	1.40%	1210	0.40%	*	*	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	1256	57.60%	34	64.70%	71	50.70%	79	46.80%
		In past year	14130	18.00%	1256	16.80%	34	23.50%	71	16.90%	79	12.70%
Employment	Have multiple jobs (among all workers)	Yes	6896	20.90%	563	21.00%	*	*	*	*	47	14.90%
		At home only	9173	7.50%	771	10.00%	*	*	39	12.80%	63	7.90%
		Outside home only	9173	54.60%	771	43.70%	*	*	39	35.90%	63	61.90%
Employment	Location of work (among all workers)	Both at home/outside home	9173	37.40%	771	46.00%	*	*	39	51.30%	63	30.20%

			MASSACHUSETTS		NORFOLK		Dedham		Needham		Norwood	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Employment	Paid sick leave at work (among all workers)	Yes	6903	75.30%	564	74.30%	*	*	*	*	48	81.30%
		Not sure	6903	4.20%	564	4.40%	*	*	*	*	*	*
Healthcare Access	Reported chronic condition 1	Yes	6821	65.20%	635	65.00%	*	*	37	62.20%	33	63.60%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care)2	Yes	3455	7.60%	331	6.00%	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care)2	Yes	1674	9.00%	152	4.60%	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	275	8.70%	*	*	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	40	27.50%	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	222	21.60%	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)2	Yes	998	7.00%	77	10.40%	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care)2	Yes	109	13.90%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	72	11.10%	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)2	Yes	6941	15.20%	635	13.70%	*	*	*	*	*	*
Healthcare Access	Telehealth visit, past year1	One or more visit	6747	51.20%	636	56.10%	*	*	39	61.50%	33	60.60%

			MASSACHUSETTS		NORFOLK		Dedham		Needham		Norwood	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Offered, didn't have	6747	7.00%	636	6.90%	*	*	*	*	*	*
		Not offered	6747	22.10%	636	20.80%	*	*	39	20.50%	33	30.30%
		No healthcare visits	6747	20.30%	636	16.70%	*	*	39	12.80%	*	*
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	394	18.80%	*	*	*	*	*	*
		Not sure	4184	3.80%	394	4.60%	*	*	*	*	*	*
		Low	13267	36.80%	1183	40.20%	32	34.40%	67	43.30%	75	33.30%
		Medium	13267	32.00%	1183	35.20%	32	40.60%	67	44.80%	75	34.70%
		High	13267	13.90%	1183	11.70%	*	*	*	*	75	20.00%
Mental Health	Psychological distress, past month	Very high	13267	17.30%	1183	12.80%	32	18.80%	*	*	75	12.00%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	906	9.70%	*	*	*	*	*	*
Mental Health	Suicide ideation, past yearc	Yes	13036	7.40%	1168	4.70%	*	*	*	*	*	*
Substance Use	Tobacco use, past month2	Yes	10305	14.10%	908	6.30%	*	*	*	*	60	8.30%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	1209	52.10%	32	50.00%	70	62.90%	76	64.50%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	1221	4.40%	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	1224	5.00%	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	1223	10.80%	33	21.20%	70	10.00%	77	10.40%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	1224	13.20%	33	21.20%	70	14.30%	77	11.70%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	1224	0.40%	*	*	*	*	*	*
Substance Use	Fentanyl use, pasy year	Yes	13626	0.60%	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	*	*	*	*	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	13626	0.60%	*	*	*	*	*	*	*	*

			MASSACHUSETTS		NORFOLK		Dedham		Needham		Norwood	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	1224	1.30%	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	1224	0.70%	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	1224	1.10%	*	*	*	*	*	*
Emerging Issues	COVID-19 vaccinatination, past year1	Yes	6729	67.80%	636	78.50%	*	*	38	84.20%	32	68.80%
		Not sure	6729	3.60%	636	2.50%	*	*	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)2	Yes	6196	22.00%	554	15.50%	*	*	*	*	46	26.10%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years2	Yes	10422	37.40%	902	38.50%	*	*	52	34.60%	60	38.30%
Emerging Issues	Flooding in home or on street, past 5 years2	Yes	10422	11.00%	902	10.90%	*	*	*	*	60	25.00%
Emerging Issues	More ticks or mosquitoes, past 5 years2	Yes	10422	32.20%	902	23.90%	*	*	52	28.80%	60	26.70%
Emerging Issues	Power outages, past 5 years2	Yes	10422	24.50%	902	20.40%	*	*	52	15.40%	60	18.30%
Emerging Issues	School cancellation due to weather, past 5 years2	Yes	10422	17.60%	902	15.20%	*	*	52	19.20%	60	15.00%
Emerging Issues	Unable to work due to weather, past 5 years2	Yes	10422	14.80%	902	10.90%	*	*	*	*	60	15.00%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years2	Yes	10422	28.30%	902	24.50%	*	*	52	21.20%	60	31.70%
Emerging Issues	Other climate impact, past 5 years2	Yes	10422	1.70%	902	1.90%	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years2	Yes	10422	67.20%	902	63.30%	*	*	52	63.50%	60	60.00%

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

CHIA Ages 0-17

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
All Causes					
FY24 ED Volume (all cause) rate per 100,000	4923	3260	3285	3410	2551
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1451	1107	1515	1102
Allergy					
FY24 ED Volume rate per 100,000	293	270	463	226	260
FY24 Inpatient Discharges rate per 100,000	29	23	9		12
Asthma					
FY24 ED Volume rate per 100,000	347	266	265	331	191
FY24 Inpatient Discharges rate per 100,000	67	51	40	57	49
Attention Deficit Hyperactivity Disorder					
FY24 ED Volume rate per 100,000	77	67	87	108	37
FY24 Inpatient Discharges rate per 100,000	27	15	31	15	18
Complication of Medical Care					
FY24 ED Volume rate per 100,000	33	27	28	41	24
FY24 Inpatient Discharges rate per 100,000	49	27	21	12	6
Diabetes					
FY24 ED Volume rate per 100,000	21	3	21	15	37
FY24 Inpatient Discharges rate per 100,000	8	3	12		12
HIV/AIDS					
FY24 ED Volume rate per 100,000	0				
FY24 Inpatient Discharges rate per 100,000	0				
Infection					
FY24 ED Volume rate per 100,000	1314	731	578	906	414
FY24 Inpatient Discharges rate per 100,000	131	83	78	111	130
Injuries					
FY24 ED Volume rate per 100,000	922	636	1004	526	644

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
FY24 Inpatient Discharges rate per 100,000	49	31	28	41	37
Learning Disorders					
FY24 ED Volume rate per 100,000	22	23	3	35	30
FY24 Inpatient Discharges rate per 100,000	24	19	6	12	37
Mental Health					
FY24 ED Volume rate per 100,000	292	214	256	261	154
FY24 Inpatient Discharges rate per 100,000	75	63	81	79	37
Obesity					
FY24 ED Volume rate per 100,000	7	3		3	
FY24 Inpatient Discharges rate per 100,000	12	11	6	6	
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	150	75	25	127	49
FY24 Inpatient Discharges rate per 100,000	32	19	15	44	24
Poisonings					
FY24 ED Volume rate per 100,000	59	23	34	44	30
FY24 Inpatient Discharges rate per 100,000	6		3		
STIs					
FY24 ED Volume rate per 100,000	4	3			6
FY24 Inpatient Discharges rate per 100,000	1				
Substance Use					
FY24 ED Volume rate per 100,000	48	31	40	25	37
FY24 Inpatient Discharges rate per 100,000	11	11	3	22	
Age 0-17 Total	4923	3260	3285	3410	2551

CHIA Ages 18-44

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
All Cause					
FY24 ED Volume (all cause) rate per 100,000	11106	7240	3745	7433	3597
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	2278	1336	2233	1387
Allergy					
FY24 ED Volume rate per 100,000	952	1304	472	826	613
FY24 Inpatient Discharges rate per 100,000	206	170	56	220	105
Asthma					
FY24 ED Volume rate per 100,000	552	469	215	469	229
FY24 Inpatient Discharges rate per 100,000	266	254	134	201	55
Breast Cancer					
FY24 ED Volume rate per 100,000	7	7	9	12	
FY24 Inpatient Discharges rate per 100,000	9	11	9	25	12
CHF					
FY24 ED Volume rate per 100,000	14	7		22	
FY24 Inpatient Discharges rate per 100,000	50	39	12	86	
Complication of Medical Care					
FY24 ED Volume rate per 100,000	120	131	93	92	136
FY24 Inpatient Discharges rate per 100,000	645	763	441	765	377
COPD and Lung Disease					
FY24 ED Volume rate per 100,000	30	15		12	18
FY24 Inpatient Discharges rate per 100,000	40	75	9	15	12
Diabetes					
FY24 ED Volume rate per 100,000	309	226	59	309	37
FY24 Inpatient Discharges rate per 100,000	173	75	75	197	12

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
GYN Cancer					
FY24 ED Volume rate per 100,000	2				
FY24 Inpatient Discharges rate per 100,000	4			6	
Heart Disease					
FY24 ED Volume rate per 100,000	12		3	3	
FY24 Inpatient Discharges rate per 100,000	56	51	15	38	18
Hepatitis					
FY24 ED Volume rate per 100,000	26	19			
FY24 Inpatient Discharges rate per 100,000	70	59	21	19	12
HIV/AIDS					
FY24 ED Volume rate per 100,000	24	11		22	12
FY24 Inpatient Discharges rate per 100,000	14		3	22	
Hypertension					
FY24 ED Volume rate per 100,000	447	262	125	392	74
FY24 Inpatient Discharges rate per 100,000	210	135	37	165	55
Infection					
FY24 ED Volume rate per 100,000	1595	998	513	1046	489
FY24 Inpatient Discharges rate per 100,000	338	298	147	306	204
Injuries					
FY24 ED Volume rate per 100,000	1775	1129	751	1269	569
FY24 Inpatient Discharges rate per 100,000	237	218	100	181	61
Liver Disease					
FY24 ED Volume rate per 100,000	99	79	37	105	12
FY24 Inpatient Discharges rate per 100,000	191	127	84	121	43
Mental Health					
FY24 ED Volume rate per 100,000	1310	795	341	727	303
FY24 Inpatient Discharges rate per 100,000	834	795	416	705	377
Obesity					
FY24 ED Volume rate per 100,000	135	59	34	79	30

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
FY24 Inpatient Discharges rate per 100,000	324	194	93	271	43
Other Cancer					
FY24 ED Volume rate per 100,000	12	7	12	12	
FY24 Inpatient Discharges rate per 100,000	23	31	12	19	12
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	122	55	53	79	43
FY24 Inpatient Discharges rate per 100,000	85	119	40	95	92
Poisonings					
FY24 ED Volume rate per 100,000	182	139	37	130	30
FY24 Inpatient Discharges rate per 100,000	33	43	9	19	12
Prostate Cancer					
FY24 ED Volume rate per 100,000	0				
FY24 Inpatient Discharges rate per 100,000	0				
STIs					
FY24 ED Volume rate per 100,000	77	67	6	41	24
FY24 Inpatient Discharges rate per 100,000	37	43	12	28	24
Stroke and Other Neurovascular Diseases					
FY24 ED Volume rate per 100,000	8	3	3	12	
FY24 Inpatient Discharges rate per 100,000	19	11	6	9	12
Substance Use					
FY24 ED Volume rate per 100,000	2079	1280	362	759	322
FY24 Inpatient Discharges rate per 100,000	588	473	103	271	92
Tuberculosis					
FY24 ED Volume rate per 100,000	2				
FY24 Inpatient Discharges rate per 100,000	8	7			
Age 18-44 Total	11106	7240	3745	7433	3597

CHIA– Ages 45-64

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
All Cause					
FY24 ED Volume (all cause) rate per 100,000	6844	5097	3288	4766	3238
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	1980	985	2396	1424
Allergy					
FY24 ED Volume rate per 100,000	797	1208	325	663	427
FY24 Inpatient Discharges rate per 100,000	330	214	143	277	161
Asthma					
FY24 ED Volume rate per 100,000	299	214	209	210	185
FY24 Inpatient Discharges rate per 100,000	254	198	103	226	130
Breast Cancer					
FY24 ED Volume rate per 100,000	40	31	62	41	68
FY24 Inpatient Discharges rate per 100,000	57	75	68	70	55
CHF					
FY24 ED Volume rate per 100,000	78	75	28	134	43
FY24 Inpatient Discharges rate per 100,000	344	322	128	555	185
Complication of Medical Care					
FY24 ED Volume rate per 100,000	100	166	46	92	86
FY24 Inpatient Discharges rate per 100,000	428	421	225	433	340
COPD and Lung Disease					
FY24 ED Volume rate per 100,000	239	91	37	185	61
FY24 Inpatient Discharges rate per 100,000	415	330	90	494	86
Diabetes					
FY24 ED Volume rate per 100,000	759	429	244	657	204
FY24 Inpatient Discharges rate per 100,000	688	425	209	759	272

GYN Cancer					
FY24 ED Volume rate per 100,000	4		6	9	
FY24 Inpatient Discharges rate per 100,000	16	43	21	60	
Heart Disease					
FY24 ED Volume rate per 100,000	37	35	18	25	37
FY24 Inpatient Discharges rate per 100,000	280	294	87	357	179
Hepatitis					
FY24 ED Volume rate per 100,000	23	7	3	6	
FY24 Inpatient Discharges rate per 100,000	83	67	6	19	6
HIV/AIDS					
FY24 ED Volume rate per 100,000	34	11	6	6	6
FY24 Inpatient Discharges rate per 100,000	34	19	6	19	
Hypertension					
FY24 ED Volume rate per 100,000	1377	990	619	1056	681
FY24 Inpatient Discharges rate per 100,000	918	723	312	855	408
Infection					
FY24 ED Volume rate per 100,000	813	596	362	523	340
FY24 Inpatient Discharges rate per 100,000	627	528	206	695	439
Injuries					
FY24 ED Volume rate per 100,000	1351	1057	757	995	520
FY24 Inpatient Discharges rate per 100,000	534	441	212	590	247
Liver Disease					
FY24 ED Volume rate per 100,000	113	115	53	108	43
FY24 Inpatient Discharges rate per 100,000	383	326	184	347	291
Mental Health					
FY24 ED Volume rate per 100,000	703	238	162	354	142
FY24 Inpatient Discharges rate per 100,000	1042	994	469	1110	507
Obesity					
FY24 ED Volume rate per 100,000	138	27	25	54	61
FY24 Inpatient Discharges rate per 100,000	619	493	165	673	284
Other Cancer					

FY24 ED Volume rate per 100,000	30	19	50	15	49
FY24 Inpatient Discharges rate per 100,000	100	59	93	108	99
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	73	55	28	63	24
FY24 Inpatient Discharges rate per 100,000	228	166	59	271	123
Poisonings					
FY24 ED Volume rate per 100,000	82	23	40	47	30
FY24 Inpatient Discharges rate per 100,000	36	27	6	25	6
Prostate Cancer					
FY24 ED Volume rate per 100,000	12	3	15	6	24
FY24 Inpatient Discharges rate per 100,000	28	7	28	19	
STIs					
FY24 ED Volume rate per 100,000	10	7		6	
FY24 Inpatient Discharges rate per 100,000	6	7	3	12	
Stroke and Other Neurovascular Diseases					
FY24 ED Volume rate per 100,000	24	47	9	41	6
FY24 Inpatient Discharges rate per 100,000	92	95	34	108	86
Substance Use					
FY24 ED Volume rate per 100,000	1492	763	140	577	260
FY24 Inpatient Discharges rate per 100,000	858	660	153	670	235
Tuberculosis					
FY24 ED Volume rate per 100,000	1				
FY24 Inpatient Discharges rate per 100,000	11		9	6	
Age 45-64 Total	6844	5097	3288	4766	3238

CHIA– Ages 65+

	BID Needham Hospital Community Benefits Service Area				
	MA	Dedham	Needham	Norwood	Westwood
All Causes					
FY24 ED Volume (all cause) rate per 100,000	5485	6294	5438	4597	5176
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	5821	3961	5088	4687
Allergy					
FY24 ED Volume rate per 100,000	798	1399	538	561	1009
FY24 Inpatient Discharges rate per 100,000	671	763	366	574	644
Asthma					
FY24 ED Volume rate per 100,000	155	190	200	153	154
FY24 Inpatient Discharges rate per 100,000	314	385	291	277	328
Breast Cancer					
FY24 ED Volume rate per 100,000	69	95	150	73	185
FY24 Inpatient Discharges rate per 100,000	216	385	253	293	445
CHF					
FY24 ED Volume rate per 100,000	270	457	312	271	272
FY24 Inpatient Discharges rate per 100,000	1445	2222	1248	1662	1405
Complication of Medical Care					
FY24 ED Volume rate per 100,000	158	123	190	194	241
FY24 Inpatient Discharges rate per 100,000	809	1061	732	979	941
COPD and Lung Disease					
FY24 ED Volume rate per 100,000	350	337	281	239	260
FY24 Inpatient Discharges rate per 100,000	1111	1443	635	1174	910
Diabetes					
FY24 ED Volume rate per 100,000	860	898	660	807	582
FY24 Inpatient Discharges rate per 100,000	1509	1666	848	1560	1182
GYN Cancer					
FY24 ED Volume rate per 100,000	7	15	12	3	30

FY24 Inpatient Discharges rate per 100,000	27	71	12	31	61
Heart Disease					
FY24 ED Volume rate per 100,000	90	119	97	73	99
FY24 Inpatient Discharges rate per 100,000	1079	1705	1217	1209	1349
Hepatitis					
FY24 ED Volume rate per 100,000	7				
FY24 Inpatient Discharges rate per 100,000	51	51	15	35	18
HIV/AIDS					
FY24 ED Volume rate per 100,000	7		3	15	
FY24 Inpatient Discharges rate per 100,000	14	7		12	
Hypertension					
FY24 ED Volume rate per 100,000	1774	2182	2343	1885	2136
FY24 Inpatient Discharges rate per 100,000	1758	2003	1448	1837	1888
Infection					
FY24 ED Volume rate per 100,000	718	838	713	654	687
FY24 Inpatient Discharges rate per 100,000	1455	2059	1511	1815	1405
Injuries					
FY24 ED Volume rate per 100,000	1257	1562	1605	1193	1331
FY24 Inpatient Discharges rate per 100,000	1365	2123	1426	1636	1665
Liver Disease					
FY24 ED Volume rate per 100,000	65	87	53	35	18
FY24 Inpatient Discharges rate per 100,000	421	500	381	338	359
Mental Health					
FY24 ED Volume rate per 100,000	347	166	159	156	173
FY24 Inpatient Discharges rate per 100,000	1456	2170	1257	1802	1665
Obesity					
FY24 ED Volume rate per 100,000	72	31	28	31	24
FY24 Inpatient Discharges rate per 100,000	764	707	316	772	458
Other Cancer					
FY24 ED Volume rate per 100,000	58	87	147	54	111
FY24 Inpatient Discharges rate per 100,000	285	441	306	293	402

Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	79	123	71	70	123
FY24 Inpatient Discharges rate per 100,000	627	926	597	819	637
Poisonings					
FY24 ED Volume rate per 100,000	30	39	31	19	24
FY24 Inpatient Discharges rate per 100,000	44	63	28	35	43
Prostate Cancer					
FY24 ED Volume rate per 100,000	62	71	194	57	130
FY24 Inpatient Discharges rate per 100,000	221	270	409	226	278
STIs					
FY24 ED Volume rate per 100,000	1	3	3		
FY24 Inpatient Discharges rate per 100,000	7	3	6	3	12
Stroke and Other Neurovascular Diseases					
FY24 ED Volume rate per 100,000	63	91	46	60	49
FY24 Inpatient Discharges rate per 100,000	290	369	253	293	315
Substance Use					
FY24 ED Volume rate per 100,000	391	306	56	92	37
FY24 Inpatient Discharges rate per 100,000	552	596	222	456	260
Tuberculosis					
FY24 ED Volume rate per 100,000	1				
FY24 Inpatient Discharges rate per 100,000	15	15	9	9	
Age 65+ Total	5485	6294	5438	5088	5176

Community Health Survey

- FY25 BID Needham Community Health Survey
  - Survey output

Beth Israel Lahey Health

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

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

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

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

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

Select a language

About Your Community

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

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

Zip code: _____

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

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

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

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

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

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

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

Health and Access to care

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

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

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

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

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

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

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

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

About You

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

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

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

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

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

11. What is your sexual orientation?

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

12. What is your current gender identity?

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

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

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

14. What is your age?

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

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

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

16. Are you currently:

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

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

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

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

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

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

May14, 2024

Beth Israel Lahey Health

Enter to Win a $100.00 Gift Card!

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

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

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

   First Name: _____

   Email: _____

   Daytime Phone #: _____

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

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

FY25 BILH CHNA Survey - BID Needham

Response Counts

Completion Rate:	**92.2%**		
	Complete		535
	Partial		45

Totals: 580

1. Select a language.

Value	Percent	Responses
Take the survey in English	96.8%	550
شارك في الاستطلاع باللغة العربية	0.2%	1
参加简体中文调查	0.9%	5
參加繁體中文調查	0.2%	1
Reponn sondaj la nan lang kreyòl ayisyen	0.5%	3
हिंदी में सर्वेक्षण में भाग लें	0.4%	2
Пройдите анкету на русском языке	0.5%	3
Responda la encuesta en español	0.5%	3

Totals: 568

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

Value	Percent	Responses
I live in this community	89.3%	516
I work in this community	24.6%	142
Other, please specify:	4.5%	26

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

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
I feel like I belong in my community. Count Row %	235 40.7%	275 47.7%	30 5.2%	13 2.3%	24 4.2%	577
Overall, I am satisfied with the quality of life in my community. *(Think about health care, raising children, getting older, job opportunities, safety, and support.)* Count Row %	218 38.9%	290 51.7%	26 4.6%	18 3.2%	9 1.6%	561
My community is a good place to raise children. *(Think about things like schools, daycare, after-school programs, housing, and places to play)* Count Row %	271 47.6%	217 38.1%	21 3.7%	10 1.8%	50 8.8%	569
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 %	185 32.3%	258 45.0%	79 13.8%	19 3.3%	32 5.6%	573
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	211 37.1%	280 49.2%	45 7.9%	10 1.8%	23 4.0%	569
My community feels safe. Count Row %	288 50.6%	246 43.2%	19 3.3%	10 1.8%	6 1.1%	569

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	224 39.5%	257 45.3%	45 7.9%	13 2.3%	28 4.9%	567
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	101 17.8%	221 39.0%	75 13.2%	21 3.7%	149 26.3%	567
My community offers people options for staying cool during extreme heat. Count Row %	152 26.9%	236 41.7%	44 7.8%	12 2.1%	122 21.6%	566
My community has services that support people during times of stress and need. Count Row %	132 23.4%	253 44.8%	48 8.5%	13 2.3%	119 21.1%	565
I believe that all residents, including myself, can make the community a better place to live. Count Row %	272 48.3%	259 46.0%	14 2.5%	8 1.4%	10 1.8%	563
Totals Total Responses						577

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

Value	Percent	Responses
Better access to good jobs	10.3%	57
Better access to health care	25.7%	142
Better access to healthy food	12.5%	69
Better access to internet	6.7%	37
Better access to public transportation	34.2%	189
Better parks and recreation	13.2%	73
Better roads	21.7%	120
Better schools	14.1%	78
Better sidewalks and trails	32.5%	180
Cleaner environment	14.3%	79
Lower crime and violence	10.8%	60
More affordable childcare	23.9%	132
More affordable housing	52.4%	290
More arts and cultural events	23.9%	132
More effective city services (like water, trash, fire department, and police)	13.7%	76
More inclusion for diverse members of the community	25.1%	139

Value	Percent	Responses
Stronger community leadership	12.3%	68
Stronger sense of community	13.9%	77
Other, please specify:	8.7%	48

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	52 9.6%	84 15.4%	260 47.8%	126 23.2%	22 4.0%	544
Health care in my community meets the mental health needs of people like me. Count Row %	40 7.6%	105 20.0%	226 43.1%	64 12.2%	89 17.0%	524
Totals Total Responses						544

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

Value	Percent	Responses
A doctor's or nurse's office	87.2%	485
A public health clinic or community health center	3.2%	18
Urgent care provider	4.3%	24
A hospital emergency room	0.9%	5
No usual place	2.2%	12
Other, please specify:	2.2%	12

Totals: 556

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

Value	Percent	Responses
Fear or distrust of the health care system	8.5%	46
Not enough time	14.7%	80
Insurance problems	12.2%	66
No providers or staff speak my language	1.3%	7
Can’t get an appointment	30.0%	163
Cost	19.9%	108
Concern about COVID or other disease exposure	3.9%	21
Transportation	10.7%	58
Other, please specify:	9.4%	51
No barriers	41.8%	227

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

Value	Percent	Responses
Aging problems (like arthritis, falls, hearing/vision loss)	61.3%	321
Alcohol or drug misuse	24.2%	127
Asthma	5.3%	28
Cancer	19.8%	104
Child abuse/neglect	3.2%	17
Diabetes	14.3%	75
Domestic violence	6.1%	32
Environment (like air quality, traffic, noise)	21.6%	113
Heart disease and stroke	24.0%	126
Hunger/malnutrition	6.7%	35
Homelessness	7.3%	38
Housing	33.8%	177
Mental health (anxiety, depression, etc.)	51.5%	270
Obesity	14.9%	78
Poor diet/inactivity	13.2%	69
Poverty	6.3%	33

Value	Percent	Responses
Smoking	5.9%	31
Suicide	7.1%	37
Trauma	4.4%	23
Underage drinking	10.9%	57
Vaping/E-cigarettes	11.8%	62
Violence	4.2%	22
Youth use of social media	27.7%	145
Infant death	0.8%	4
Rape/sexual assault	1.3%	7
Sexually transmitted infections (STIs)	1.0%	5
Teenage pregnancy	0.4%	2

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

Value	Percent	Responses
12th grade or lower (no diploma)	2.2%	12
High school (including GED, vocational high school)	5.7%	31
Started college but not finished	7.3%	40
Vocational, trade, or technical program after high school	3.1%	17
Associate degree (for example, AA, AS)	9.3%	51
Bachelor's degree (for example, BA, BS, AB)	32.9%	180
Graduate degree (for example, master's, professional, doctorate)	37.5%	205
Other, please specify:	1.3%	7
Prefer not to answer	0.7%	4

Totals: 547

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

Value	Percent	Responses
American Indian or Alaska Native	0.7%	4
Asian	7.3%	40
Black or African American	2.7%	15
Hispanic or Latine/a/o	2.9%	16
Middle Eastern or North African	0.9%	5
Native Hawaiian or Pacific Islander	0.5%	3
White	81.9%	448
Other, please specify:	1.8%	10
Prefer not to answer	4.4%	24

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.7%	9
Bisexual and/or Pansexual	3.3%	18
Gay or Lesbian	1.8%	10
Straight (Heterosexual)	85.6%	464
Queer	0.6%	3
Questioning/I am not sure of my sexuality	0.2%	1
I use a different term, please specify:	0.7%	4
I do not understand what this question is asking	0.7%	4
I prefer not to answer	5.4%	29

Totals: 542

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	78.3%	426
Male, Man	18.8%	102
Nonbinary, Genderqueer, not exclusively male or female	0.2%	1
Questioning/I am not sure of my gender identity	0.2%	1
I do not understand what this question is asking	0.2%	1
I prefer not to answer	2.4%	13

Totals: 544

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

Value	Percent	Responses
Childcare or school	4.2%	22
Food or groceries	14.9%	78
Formula or baby food	0.8%	4
Health care (appointments, medicine, insurance)	13.8%	72
Housing (rent, mortgage, taxes, insurance)	16.9%	88
Technology (computer, phone, internet)	6.1%	32
Transportation (car payment, gas, public transit)	8.4%	44
Utilities (electricity, water, gas)	10.9%	57
Other, please specify:	1.9%	10
None of the above	68.0%	355

14. What is your age?

Value	Percent	Responses
18-24	1.5%	8
25-44	21.6%	119
45-64	26.9%	148
65-74	22.9%	126
75-84	17.4%	96
85 and over	8.0%	44
Prefer not to answer	1.8%	10

Totals: 551

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

Value	Percent	Responses
Armenian	1.8%	10
Chinese (including Mandarin and Cantonese)	1.8%	10
English	91.6%	504
Haitian Creole	1.3%	7
Hindi	2.0%	11
Portuguese	0.7%	4
Russian	0.9%	5
Spanish	2.5%	14
Vietnamese	0.4%	2
Other, please specify:	2.5%	14
Prefer not to answer	1.5%	8

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	30.1%	165
Employed part-time (Less than 40 hours per week)	13.3%	73
Self-employed (Full- or part-time)	4.9%	27
A stay-at-home parent	3.1%	17
A student (Full- or part-time)	0.5%	3
Unemployed	2.6%	14
Unable to work for health reasons	2.9%	16
Retired	38.3%	210
Other, please specify:	2.7%	15
Prefer not to answer	1.5%	8

Totals: 548

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

Value	Percent	Responses
Yes	16.8%	91
No	77.9%	422
Prefer not to answer	5.4%	29

Totals: 542

18. I currently:

Value	Percent	Responses
Rent my home	19.3%	105
Own my home (with or without a mortgage)	64.3%	350
Live with parent or other caretakers who pay for my housing	4.2%	23
Live with family or roommates and share costs	2.9%	16
Live in a shelter, halfway house, or other temporary housing	0.7%	4
Live in senior housing or assisted living	6.6%	36
I do not currently have permanent housing	0.7%	4
Other	1.1%	6

Totals: 544

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

Value	Percent	Responses
I have always lived in the United States	84.5%	462
Less than one year	0.4%	2
1 to 3 years	1.5%	8
4 to 6 years	0.7%	4
More than 6 years, but not my whole life	12.1%	66
Prefer not to answer	0.9%	5

Totals: 547

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

Value	Percent	Responses
My neighborhood or building	61.2%	316
Faith community (such as a church, mosque, temple, or faith-based organization)	30.2%	156
School community (such as a college or education program that you attend or a school that your child attends)	12.6%	65
Work community (such as your place of employment or a professional association)	31.8%	164
A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)	10.7%	55
A shared interest group (such as a club, sports team, political group, or advocacy group)	34.1%	176
Another city or town where I do not live	14.1%	73
Other, please feel free to share:	8.7%	45

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

Value	Percent	Responses
Yes	39.9%	115
No	60.1%	173

Totals: 288

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
	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
	Executive Office of Elder Affairs	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	Find Help	Provides resources for financial assistance, food pantries, medical care, and other free or reduced-cost help.			www.findhelp.org
	Mass 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Behavioral Health Help Line	Available 24 hours a day, 7 days a week, connects individuals and families to the full range of treatment services for mental health and substance use.		833.773.2445	www.masshelpline.com
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 10th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-aging-independence

Statewide Resources	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 Behavioral Health Help Line (BHHL) Treatment Connection	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.		833.773.2445	www.masshelpline.com/MABHHLTreatmentConnectionResourceDirectory
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for substance use treatment, recovery, and problem gambling services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		988	www.suicidepreventionlifeline.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	www.projectbread.org/foodsource-hotline
	SafeLink	Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence.		877.785.2020	www.casamyrna.org/get-support/safelink
	SAMHSA's National Helpline	Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders.		800.662.HELP (4357)	www.samhsa.gov/find-help/helplines/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps?

	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		988	www.veteranscrisisline.net
Domestic Violence					
	Boston Area Rape Crisis Center-Family Justice Center	Provides free, confidential support and services to survivors of sexual violence.	99 Bishop Allen Dr Cambridge	617.492.8306 24/7 Hotline: 800.841.8371	www.barcc.org
	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	617.770.4065 24 Hour Hotline: 617.471.1234	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.	600 Washington St 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
	Needham Community Farm	Increases access to healthy produce for those in our community who experience food insecurity.	PO Box 920877 Needham	781.343.1106	www.needhamfarm.org
	Needham Farmer's Market	Promotes sustainable agriculture, supporting local farmers and artisans, and provides with access to fresh, healthy, and locally-produced food	270 Garden St Needham	781.888.1550	www.needhamfarmersmarket.org
	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.	21 Highland Circle Needham	781.444.3011	www.needhamhousing.org
	Neighborworks Housing Solutions	Develops affordable housing, provides housing resources and education.	68 Legion Parkway Brockton	617.770.2227	www.nhsmass.org
	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
	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.bilhbehavioral.org
	Dana Behavioral Health	Provides psychology, psychiatry, and medication management.	220 Reservoir St Ste 21 & 28 Needham	781.429.7755	www.danabehavioralhealth.org
Mental Health and Substance Use	Riverside Community Behavioral Health Center	Provides treatment for mental health, substance use, and co-occurring disorders.	190 Lenox St Norwood	781.769.8670	www.riversidecc.org/adult-services/mental-health-substance-use-adults/community-behavioral-health-centers-adults/

	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
	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/town-departments/council-on-aging
	HESSCO	Provide supportive services for older adults.	545 South St Ste 300 Walpole	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
Senior Services	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	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 2023-2025 Implementation Strategy

Beth Israel Deaconess Hospital-Needham

Evaluation of 2023-2025 Implementation Strategy

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

Priority: Equitable Access to Care

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• BID Needham employees • Older adults • Youth • Older adults • Low-resourced populations • Racially, ethnically, linguistically diverse populations • Youth	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.	• Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English as a second language (ESOL) classes and other trainings • Clinical training site for community colleges	• Number of BID Needham employees who participated in hospital-sponsored career and academic advising (FY23: 55; FY24: 71) • Number of BID Needham employees who participated in hospital-sponsored community college courses (FY23: 12; FY24: 18) • Number of BID Needham employees who participated in hospital-sponsored ESOL courses (FY23: 1; FY24: 2) • Number of community members trained at BID Needham (FY23: 22) • Number of community members who trained & then hired at BID Needham (FY24: 19)

● Racially, ethnically, linguistically diverse populations	Promote equitable care, health equity, and health literacy for patients and community residents, especially those who face cultural and linguistic barriers.	● Interpreter Services	● Number of patients assisted by interpreter services (FY23: 4,931; FY24: 6,134) ● Number of languages provided via interpreter services (FY23: over 200 offered; FY24: over 200 offered)
● Low-resourced populations	Promote access to health care, health insurance, patient financial counselors, needed medications and other essentials for patients who are uninsured or underinsured.	● Financial counselors ● Circle of Hope Emergency Department Essentials Closet ● Community Council Medical/Emergency transportation program ● Hospital Transportation Assistance ● Senior Volunteer Program ● Primary care support	● Number of patients assisted by financial counselors o FY23: 180 o FY24: 226 ● Number of clothing, shoes and hygiene products distributed through Circle of Hope Emergency Department Essentials program o FY23: 1,204 items o FY24: 1,016 items ● Number of rides provided through hospital transportation assistance: o FY23: 1,046 o FY24: 1,486 ● Number of senior volunteers at BID Needham o FY23: 20 FY24: 25 ● Number of new patients enrolled in primary care practices in BID Needham's CBSA: o o FY23: 1,801 o o FY24: 1,994

Priority: 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.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Youth ● Older adults ● Racially, ethnically, linguistically diverse populations ● Low-resourced populations	Support impactful programs that address issues associated with the social determinants of health.	● Neighbor Brigade food and transportation assistance ● Provide community grants to address need	● Number of Neighbor Brigade participants (FY23: 450 participants; FY24: 600)
● Youth ● Older adults ● Racially, ethnically, linguistically diverse populations, ● Low-resourced populations	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.	● Needham Youth Resource Network ● Needham & Norwood Community Crisis Intervention Team (CCIT)	● Resources obtained through Needham Youth Resource Network: (FY23: 24; FY24: 25) ● Number of new partnerships developed in Social Determinants of Health priority:(FY23: 0; FY24: 2) ● Number of new policies /protocols implemented by CCIT: Not available for FY23; FY24: 1) ● Number of residents assisted by CCIT: (FY23: 354; FY24: 493)

● Community-based organizations serving priority cohorts	Promote collaboration, share knowledge and coordinate activities with internal colleagues & external partners.	● Community Resource Group	● Number of resources shared through BID Needham Community Resource Group (BID Needham newsletter and Annual Community Benefits meeting): (FY23: 25; FY24: 28) ● Number of sectors represented through BID Needham Community Resource Group: (FY23: 10; FY24: 10) ● Number of new partnerships developed in community: (FY23: 1; FY24: 4) ● Increased communication among partners: (FY23: no data available; FY24: 2)
● Low-resourced populations	Support impactful programs that stabilize or create access to affordable housing.	● Family Promise Metrowest Homeless Prevention Program	● Number of participants in Family Promise Metrowest Homeless Prevention program: (FY23: 84 families; FY24: 123 families) ● Number of families prevented from homelessness through Family Promise Metrowest Homeless Prevention (FY23: 84 families; FY24: 123 families)

● Low-resourced populations ● Older adults	Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	● Dedham Food Pantry ● Produce distribution (Westwood, Needham) ● Needham Traveling Meals Program	● Bags of food distributed through Dedham Food Pantry: (FY23: 39,990; FY24: 44,325) ● Pounds of food distributed through Needham Community Farm (FY23: 4,000 pounds; FY24: 5,500) ● Number of adults provided CSA Vegetable Share through Westwood Council on Aging (FY23: 35; FY24: 40) ● Number of meals provided food through Needham Traveling Meals program (FY23: 9,570 meals; FY24: 10,947)

Priority: Mental Health and Substance Use

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	Enhance relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills.	• Students Advocating Life without Substance Abuse (SALSA) • Advanced training on emerging needs for mental health workers	• Number of students engaged through SALSA (FY23: 122 students; FY24: 120 students) • Number of volunteers and hours through SALSA (FY23: 1,661 hours; FY24: 1,500) • Increased skills, and confidence and ability to use skills through Riverside training (FY23: increased confidence reflected in staff reports; FY24: 115 clinicians attended training)
• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	Build the capacity of community members to understand the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.	• Ongoing community education/talks • Explore possibility of community training for suicide prevention or Mental Health First Aid	• Number of community members trained/ educated through community events (FY23: 100; FY24: 63) • Increased skills and increased confidence in ability to use skills obtained through Mental Health First Aid (FY23: program not funded; FY24: 75% of attendees completed all pre- and post-training requirements to receive Mental Health First Aid certification)
• Youth • Older adults • Racially, ethnically, linguistically diverse populations • Low-resourced populations	Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	• Integrated Behavioral Health • BILH Collaborative Care • Interface (Westwood and Needham) • Pilot Behavioral Health programming that will improve care	• Policies implemented/training for staff (Baseline(FY23): The Opioid Taskforce disbanded as their policies were written and accepted by BID Needham and there was no further need for the committee; Year 1(FY24): program ended) • Number of Collaborative Care practices (FY23: 3; FY24: 4)

		• Prescription medication & sharps disposal
		• Opioid Taskforce
		• Medication Assisted Treatment in the Emergency Department
			• Number of integrated BH consultations at BID Needham
			  o FY23: Gosnold provided 93 consults in the ED and 105 consults on the medical floors
			  o FY24: Gosnold provided 160 consults in the ED and 146 consults on the medical floors
			  o FY23: Riverside provided 183 crisis evaluations
			• Number of residents assisted through Westwood Interface Referral Program (FY23: 87: FY24: 84)
			• Number of residents assisted through Needham Interface Referral Program (FY23: n/a; FY24: 162)
			• Number of patients assisted through Behavioral Health pilot programs (FY23: data unavailable, as the programs were starting implementation; FY24: 80 patients referred to digital mental health program)
			• Pounds of medication and sharps collected (FY23: 380 gallons of medication; FY24: 225 pounds)

• Youth
• Older adults
• Racially, ethnically, linguistically diverse populations
• Low-resourced populations
	Support impactful programs that address issues associated with mental health and substance use.	• Dedham Council on Aging Social Worker/Support Groups
		• Substance Prevention Alliance of Needham (SPAN)
			• Number of support groups held and number of attendees at Dedham Council on Aging
			  o FY23: 3 programs, 137 individuals
			  o FY24: 3 programs, average of 20 participants each week
			• Number of sectors represented in SPAN (FY23: 8; FY24: 6)
			• Amount of new resources obtained through SPAN: (FY23: 10; FY24: 1)

			● Number of new partnerships developed in mental health/substance use priority: (FY23: 3; FY24: 2) ● Skill building/education shared (FY23: data unavailable; FY24: 2 MHFA sessions were offered)

Priority: Complex and Chronic Conditions

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Older adults ● Racially, ethnically, linguistically diverse populations ● Low-resourced populations ● Youth	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.	● Primary care support ● Partnerships with Emergency Medical Technicians (EMTs) ● School medication partnerships	● Number of medications provided to schools (FY23: no data available as the medications were not needed in FY23; FY24: 4 EPI pen kits provided) ● Number of students benefiting from medications (FY23: program not funded; FY24: 5)
● Older adults	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.	● Needham Healthy Aging Initiative ● Greater Boston JCC Educational talks ● Livestrong	● Number of Needham Healthy Aging participants (FY23: 1,877; FY24: Program completed) ● Number of attendees at JCC Education talks (FY23: program not funded; FY24: 40) ● Number of Livestrong graduates (FY23: 15; FY24: 18 participants)

Appendix E:
FY26-FY28 Implementation Strategy

Beth Israel Lahey Health
Beth Israel Deaconess Needham

FY26–FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Hospital–Needham (BID Needham) is a rapidly growing community hospital serving the southwest and metrowest suburbs of Boston. The hospital has 73 licensed inpatient beds with more than 900 employees and over 850 clinicians on active medical staff. With close ties to Beth Israel Deaconess Medical Center in Boston, BID Needham offers centers of excellence in digestive health, surgical services and cancer care.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. 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 a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

BID Needham collected a wide range of quantitative data to characterize the communities served across the hospital's 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 were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk and crafting a collaborative, evidence-informed Implementation Strategy (IS). Between June 2024 and February 2025, BID Needham conducted 15 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 500 residents, and organized a community listening session. 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. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, BID Needham's CBAC and community residents, through the community listening session, formally prioritized the community health issues and cohorts that they believed should be the focus of 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 BID Needham'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 is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the systemic, fair, and just treatment of all people
- 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. 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 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. 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 populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities. 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.

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 overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.

BID Needham Priority Cohorts

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

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, issues related to the built environment (i.e., improving roads/sidewalks) 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, transportation barriers, language and cultural barriers to services, food insecurity, economic insecurity, health insurance and cost barriers, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive and navigation services for individuals with substance use disorder, community-based education and prevention, trauma, conditions associated with aging, healthy eating and active living, and caregiver support.

BID Needham Community Health Priority Areas

Implementation Strategy Details

Priority: Equitable Access to Care

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations • Older adults • Individuals living with disabilities	• Health insurance eligibility and enrollment assistance activities • Financial counseling activities • Programs and activities to support culturally/ linguistically competent care and interpreter services • Expanded access to primary care, medical specialty care, and other clinical services for Medicaid covered, uninsured, and underinsured populations	• # of people served • # of people enrolled • # of clinical practices supported • # of sessions conducted	• Hospital-based activities
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation.	• Older adults • Low-resourced populations • Youth	• Transportation and rideshare assistance programs	• # of individuals served • # of rides provided	• Local/regional transportation agencies • Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and systems that improve access to care.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Social Determinants of Health

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

Information gathered through interviews, focus groups, listening session, and the 2025 BID Needham Community Health Survey reinforced that these issues have considerable impacts on health status and access to care in the region, especially issues related to housing, food insecurity, nutrition, transportation, and economic instability.

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• Low-resourced populations • Individuals living with disabilities • Older adults	• Food access, nutrition support, and education programs and activities	• # of people served • # of meals provided • Pounds of produce distributed	• Private, non-profit, health-related agencies • Local public agencies
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• Low-resourced populations	• Community investment and affordable housing initiatives • Housing assistance, navigation, and resident support activities	• # of people served • Dollars invested • # of people who secured housing	• Housing support and community development agencies
Support programs and activities that increase employment, earnings, and financial security	• All priority populations	• To be determined	• # of people served • # of encounters • # of items provided	• Private, non-profit, health-related agencies • Hospital-based activities

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that foster social connections and strengthen community cohesion and resilience.	• Older adults	• Community connection and social engagement activities	• # of people served • # of volunteers participating • # of meals provided	• Elder services agencies
Provide and promote career support services and career mobility programs to hospital employees, employees of other community partner organizations, and community residents.	• All priority populations	• Career advancement and mobility programs	• # of students served • # of people served • # of people hired • # of classes/ programs organized • # of employees served	• Vocational and technical schools • Cultural, linguistic, and advocacy programs • Hospital-based activities
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

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

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• All priority populations	• Medication and needle disposal programs	• Pounds of medication disposed of	• Hospital-based activities
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Patient care navigator programs • Support groups (peer and professional-led) • Expand access to mental health and substance use services for individuals and families • Primary care and behavioral health integration and collaborative care programs • Health education, awareness, and wellness activities • Crisis intervention and early response programs and activities	• # of people served • # of referrals made • # of classes and support groups organized • # of clinical practices supported • # of volunteer hours	• Private, non-profit, health related agencies • Local health departments • Elder services agencies • Clinical service providers • Emergency services • Schools • Hospital-based activities
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activity

Priority: Chronic and Complex Conditions

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

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

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

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

General Regulatory Information

Contact Person:	Jill Carter, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 4, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 4, 2025
Date written plan was required to be adopted	February 15, 2026
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 8, 2022
Name and EIN of hospital organization operating hospital facility:	Beth Israel Deaconess Hospital-Needham: 04-3229679
Address of hospital organization:	148 Chestnut St. Needham, MA 02492

Beth Israel Lahey Health
Beth Israel Deaconess Needham